IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF SCOTT JAMES WIDMER

Date of Document: 21 July 2015
Filed on behalf of: State of Victoria
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[redacted]

I, SCOTT JAMES WIDMER, Executive Director, Service Design & Operations, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne, SAY:

1. I am an Executive Director of Service Design & Operations in the Department of Health and Human Services (**DHHS**).

2. I have held this position since 1 May 2015 and report to the Deputy Secretary, Service Design & Operations. In this role, I am responsible for the Human Services Design branch, the Service Outcomes branch and the Service Implementation and Support branch in the Service Design and Operations division of the Department. These branches design, develop and implement policies and programs for a range of human services delivered in the Families and Children portfolio and the Housing, Disability and Ageing portfolio.

3. Relevantly, the Human Services Design branch is responsible for, among other things, the policy and program development of family violence and sexual assault services funded by DHHS.

4. Prior to my current role, I held two other roles in DHHS:

   4.1 between September 2014 and May 2015, I was the Acting Director of the Human Services Design and Development branch. In this role I managed a branch comprising the current Human Services Design and Service Outcomes branches; and

   4.2 between July 2013 and September 2014, I was the Director of the Royal Commission Response branch, responsible for managing DHHS' response to the Royal Commission into Institutional Child Sexual Abuse.

5. From July 2012 to July 2013, I was the Director, Casino Review at the Victorian Commission for Gambling and Liquor Regulation. In that role, I conducted a statutory review of the Melbourne Casino.

6. From 2005 to 2012, I worked in a range of legal and legal policy roles for the Department of Premier and Cabinet, Victoria, including a role responsible for developing the legislation creating the Independent Broad-based Anti-corruption Commission.

7. Prior to that, I was a Senior State Solicitor in the Office of the Attorney-General of Samoa and a solicitor at Freehills.

8. I hold a Bachelor of Laws and a Bachelor of Arts from the University of Melbourne. I am admitted to practice in the Supreme Court of Victoria, the High Court of Australia and Supreme Court of Samoa. I also hold a Masters of Public Policy and Management from the University of Melbourne.

9. I have received a notice from the Royal Commission into Family Violence requiring me to attend to give evidence at the Royal Commission and to provide a written witness statement prior to attending.

10. I understand that the Royal Commission has sought my evidence on the topic of family violence risk assessment and risk management. My statement will cover:

    10.1 the way family violence risk is identified, assessed and managed in Victoria, with a primary focus on the Family Violence Risk Assessment and Risk Management Framework (also known as the Common Risk Assessment Framework or CRAF);

    10.2 the Risk Assessment and Management Panels that are a specialist response for women and children at the highest risk (meaning "serious and imminent threat to an individual's life, health, safety or welfare", as defined in the Draft guidelines for the establishment and operation of the Strengthening Risk Management Program (May 2015), which has been trialled and is being developed for statewide rollout; and

    10.3 other responses for managing risk to women and children experiencing family violence including the trialling of new technologies such as CCTV and safety cards.

OVERVIEW OF VICTORIA'S INTEGRATED FAMILY VIOLENCE SYSTEM AND DHHS FUNDED FAMILY VIOLENCE SERVICES

11. Since 2005, the Victorian Government has invested in the development of an integrated family violence system (IFVS) in which service providers across different systems work together to improve the safety of people who experience family violence.

12. The aim of the IFVS was to establish a common understanding of family violence and the needs of families across all service systems to enable victims to receive consistent, timely and appropriate responses, regardless of where they entered the system.

13. In developing the IFVS, it was recognised that a range of services and referral pathways across these multiple systems may be required to improve the safety and wellbeing outcomes of victims of family violence.

14. The development of the IFVS required legislative and service reform, including the introduction of the *Family Violence Protection Act 2008.* Other witnesses have already discussed the development of the IFVS. I refer, in particular, to the evidence of Assistant Commissioner, Wendy Steendam, and Rhonda Cumberland, CEO, Good Shepherd, in *Module 1: What is family violence and who experiences it including causes and contributing factors.* In broad terms, family violence services funded by DHHS provide:

    14.1 services that meet the accommodation and housing needs of women and children such as crisis accommodation including women's refuges through to private rental brokerage, as well as more recent initiatives such as the Safe at Home program that supports women to remain safely in their homes. For more detail, I refer the Royal Commission to evidence given by my colleague, Mr Arthur Rogers, in his witness statement on *Module 7: Homelessness.*

    14.2 other non-accommodation crisis and post-crisis response services to address the consequences of family violence such as: the Safe Steps statewide crisis response; case management support/outreach; intensive case management for women with complex needs; counselling and support for women and children; men's behaviour change programs; and men's case management services.

    14.3 Indigenous-specific services to meet the needs of Aboriginal families experiencing family violence including: Aboriginal refuges; intensive case

management and legal assistance for Aboriginal women and children; healing and timeout services; and men's case management services.

14.4 family violence prevention and early intervention services including the Families at Home program, which is identifying family violence early and preventing homelessness in the northern suburbs of Melbourne and the Adolescent Family Violence program for adolescents who use violence against family members.

A COMMON APPROACH TO IDENTIFYING, ASSESSING AND MANAGING RISK IN VICTORIA

15. The CRAF was launched in 2007 following extensive consultation with over 500 stakeholders including the police, the courts and mainstream and family violence service providers. The launch of CRAF was an important part of supporting Victoria's integrated response to family violence. The CRAF aimed to establish a common approach to family violence risk assessment and risk management. At the time of its launch, I understand it was the first statewide risk assessment and management model in Australia.

16. The CRAF is a framework designed to assist a wide range of professionals and organisations to identify risk factors associated with family violence and respond consistently and appropriately to people experiencing family violence.

17. There have been two editions of the CRAF practice manual (**CRAF manual**). The first edition was published in 2007 (**Attachment SW-1**). During 2011, consultation was undertaken with over 30 organisations and services to revise the CRAF manual. These included family violence specialists, subject matter experts, peak organisations and government agencies. A revised edition of the CRAF manual (**Attachment SW-2**) was published in 2012. This is the current version of the CRAF manual. A fact sheet on the release of the second edition of the CRAF manual explaining the revisions made to it is also attached (**Attachment SW-3**).

What the CRAF comprises

18. The CRAF manual comprises the following elements:

18.1 the framework;

18.2 contextual information necessary to use it effectively; and

18.3 Practice Guides 1 to 3.

19. Six components underpin the framework, which supports effective identification and response to victims of family violence. These are:

    19.1 a shared understanding of risk and family violence across all service providers;

    19.2 a standardised approach to recognising and assessing risk;

    19.3 appropriate referral pathways and information sharing;

    19.4 risk management strategies that include ongoing assessment and case management;

    19.5 consistent data collection and analysis to ensure the system is able to respond to changing priorities; and

    19.6 quality assurance strategies and measures that underpin a philosophy of continuous improvement.

20. Creating a shared understanding of different forms of family violence, as part of Component 1, is a key aim of the CRAF. This is principally informed by the definition of family violence in section 5 of the *Family Violence Protection Act 2008*, which recognises the different ways in which perpetrators of violence exert their power and control and that anyone can be a victim of family violence.

21. The assessment tools supporting the CRAF, however, have been primarily designed for identifying and assessing family violence perpetrated by men against their intimate female partner and children. Intimate partner violence continues to be the predominant form of family violence, as identified in Victorian police incident data in 2013-14.

22. The CRAF is also underpinned by the following principles:

    22.1 family violence is a fundamental violation of human rights and is unacceptable in any form;

    22.2 physical or sexual violence within the family is a crime that warrants a strong and effective justice response;

    22.3 responses to family violence must recognise and address the power imbalance and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children);

22.4 the safety of women and children who have experienced or are experiencing family violence is paramount in any response;

22.5 men who use violence should be held accountable and challenged to take responsibility for their actions;

22.6 family violence affects the entire community and occurs right across society regardless of location, socioeconomic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion, responses must take into account the needs and experiences of people from diverse backgrounds and communities;

22.7 family violence is not acceptable in any community or culture;

22.8 responses to family violence are most effective when they are integrated and designed to enhance the safety of women and children; and

22.9 the whole community is responsible for preventing family violence, so there needs to be a community-wide understanding that family violence is unacceptable.

23. The CRAF recognises that there are many different ways that victims and perpetrators of family violence may interact with services. Accordingly, the three practice guides are tailored for use by different professionals – namely:

23.1 Practice Guide 1 is targeted at professionals working in mainstream settings who might encounter people they believe to be victims of family violence such as:

(a) maternal and child health nurses;

(b) general practitioners;

(c) teachers; and

(d) health care providers.

23.2 Practice Guide 2 is targeted at professionals who work with victims of family violence and play a role in initial risk assessment, but for whom responses to family violence are not their only core business such as:

(a) professionals working in community legal services;

(b) members of Victoria Police;

(c) professionals working in court settings;

(d) professionals working in child protection; and

(e) professionals working in housing and homelessness services.

23.3 Practice Guide 3 is for specialist family violence professionals working with women and children who are victims of family violence such as those working within:

(a) specialist women and men's family violence services;

(b) specialist family violence accommodation services; and

(c) specialist family violence courts.

24. A more comprehensive list of the types of professionals who should use each practice guide is set out on page 15 of the CRAF manual.

How CRAF supports professionals to assess risk

25. The risk assessment approach in the CRAF manual combines the following elements to determine the level of risk to an individual or family:

25.1 the victim's own assessment of their level of risk;

25.2 evidence-based risk factors in the Aide Memoire (see pages 75 and 95 of the CRAF which sets out these risk factors, including those that may indicate an increased risk of the victim being killed or almost killed); and

25.3 the practitioner's professional judgement.

26. This approach to risk assessment is known as 'structured professional judgement'. It combines the clinical approach (which primarily utilises professional opinion) and the actuarial approach (which integrates statistical evidence into assessment) (pages 18-19).

27. Page 19 of the CRAF sets out why this approach was adopted:

"While there is no scientific or completely accurate method of assessing risk to victims of family violence, it is known that a structured professional

judgement approach to assessing such risk is more accurate than relying on clinical judgement or actuarial approaches alone".

28. Professional judgement, therefore, plays a part in all three practice guides. However, the level of judgement required of professionals depends on their role and familiarity with family violence. For instance, the worker might only need to undertake initial identification (this is the aim of Practice Guide 1 for mainstream professionals) or preliminary assessment of risk (this is the aim of Practice Guide 2 for professionals who work with family violence victims, but for whom this is not their only core business). Only specialist family violence professionals are expected to undertake a comprehensive risk assessment that tiers risk levels (Practice Guide 3). There are three risk levels set out in Practice Guide 3 as follows: at risk; elevated risk; and requires immediate protection.

How CRAF supports professionals to manage risk

29. Once risk is identified, the management of that risk in the CRAF is underpinned by the range of specialist services available for victims of family violence. In addition, referral to a range of other services, such as police, courts, housing, drug and alcohol or mental health services, might be appropriate.

30. The CRAF sets out how risk is to be managed in the three practice guides. Again, the practice guides indicate that what is expected of various professionals in terms of risk management depends on their role and expertise in relation to family violence.

31. In Practice Guide 1, mainstream professionals who identify that family violence is occurring are provided options for how to respond and refer onto police and/or specialist family violence services for assistance and assessment. The response depends on the immediacy of danger and the willingness of the victim to receive assistance. Where children are involved, professionals need to consider if a referral to Child Protection (in the case of risk of significant harm) or Child FIRST (where there are wellbeing concerns) is required. A flowchart on page 60 of the CRAF sets out these response pathways.

32. For professionals working with victims of family violence, but for whom this is not their only core business, Practice Guide 2 (page 71) states that action is required if risk is present. This requires:

    32.1 immediate referral to an appropriate specialist family violence provider;

32.2 consideration of referral to police (if a crime has been committed) or legal centre or court (if an Intervention Order is required);

32.3 consideration of whether a Child Protection report or Child FIRST referral is appropriate; and

32.4 development of a safety plan with the victim.

33. At a minimum, the safety plan should:

33.1 list the contact numbers for a family violence organisation;

33.2 list emergency contact numbers;

33.3 identify a safe place for the victim to go to if in danger and how to get there;

33.4 identify a friend, family member or neighbour who can assist in an emergency and how to contact them;

33.5 identify a way for the victim to get access to money in an emergency;

33.6 identify a place to store valuables and important documents so that the victim can access them when needed; and

33.7 specifically address any barriers to the victim implementing the safety plan (for example, leaving a pet behind or mobility difficulties).

34. Specialist family violence professionals under Practice Guide 3 are expected to take action based on the assessed risk level. Regardless of the level of risk, specialist family violence professionals are expected to develop a risk management plan for the victim that includes help and support to develop a safety plan as described above (page 88).

35. Additional core elements of a risk assessment plan include:

35.1 information and advice about their legal rights;

35.2 advice about possible referral pathways for counselling or other appropriate services;

35.3 the names and telephone numbers of people they can call if they believe their level of risk has altered;

35.4 a report to Child Protection if required as a result of the risk assessment; and

35.5 advice about appropriate ongoing support options.

36. The CRAF manual also provides additional guidance in relation to the management of victims who are assessed at elevated risk or require immediate attention, including those who refuse assistance.

37. The CRAF manual states that victims in need of immediate protection require ongoing, high levels of support from a specialist family violence service and immediate assistance from police and courts.

38. Where a victim is assessed as being at elevated risk or as requiring immediate protection, but chooses not to engage or respond to recommendations from family violence professionals or police, the CRAF manual states (page 88) that the specialist professional must ensure:

38.1 the victim is given every opportunity to understand their current risk level;

38.2 the victim has a clear understanding of their rights under the law and in relation to their own safety and that of any children involved;

38.3 a safety plan has been discussed with the victim and options have been provided for developing such a plan;

38.4 the risk assessment is documented;

38.5 a number of appropriate and relevant options for support and counselling have been offered; and

38.6 the victim is made aware that they can seek assistance from the specialist professional or another service provider at any time in the future.

39. If the specialist professional believes the victim is in need of immediate protection and that a crime is likely to be committed by the perpetrator, that professional can make contact with the police without the victim's consent (page 89).

40. A list of common referral points for victims and perpetrators of violence is provided on pages 43 to 45 of the CRAF manual. This is supported by a service directory published on *The Lookout* family violence practitioners' website (see paragraph 75 below). Professionals who are CRAF-trained also receive a printed referral options booklet (**Attachment SW-4**). Service directory information is updated regularly so professionals using the CRAF manual have current referral information at hand.

41. Practice Guides 2 and 3 provide a risk assessment template for professionals to use to record information. The CRAF manual states that this assessment template should form part of the basis of any referrals to another organisation (with the victim's consent) (see pages 70, 89 and 91). This supports the aim of an integrated service response to family violence by encouraging consistency between service providers' assessments and building a collaborative response to securing victim safety. It also improves service delivery, as victims are not required to re-tell their story to each agency they are referred on to. The CRAF manual also emphasises the importance of new service providers revisiting the original assessment with the victim to ensure currency of information and to provide the victim with an opportunity to elaborate on the information initially provided (see page 91).

42. In addition to the CRAF, the *Domestic Violence Victoria Code of Practice* (2006) (**Code**) was developed to increase service integration (see **Attachment SW-5**). The Code sets out further detailed guidance for how specialist family violence professionals should work with women and children to ensure consistent, transparent and accountable practice across all services.

43. I understand that all agencies that receive DHHS funding to provide family violence specialist services are currently required to use the Code under their 2015-16 funding and service agreements.

44. The Code was published in 2006 and predates both the CRAF and the *Family Violence Protection Act 2008.* However, the CRAF manual (page 18) notes that the CRAF manual's approach is designed to be consistent with the Code.

Examples of additional resources to support risk assessment and risk management of specific key cohorts

45. There are a number of additional resources that complement the CRAF by providing additional assistance to professionals to assess and manage risks for particular cohorts.

Children

46. Family violence practitioners and adult focused services also have access to the *Assessing children and young people experiencing family violence: A practice guide for family violence practitioners* (**Assessing children and young people experiencing family violence guide**) (**Attachment SW-6**), which was produced by DHHS in 2013. This guide aims to assist practitioners assess the safety and needs of children and young people affected by family violence.

47. It is informed by the *Best Interests Case Practice* model used by Child Protection, which focuses on the best interests of the child or young person. For further information on this model, I refer the Royal Commission to the evidence of Ms Beth Allen in *Module 3 Children – Intervention and Response*.

48. The Assessing children and young people experiencing family violence guide establishes an overarching structure and tools tailored specifically for assessing the safety and needs of children and young people affected by family violence. It makes clear that the best interests and safety of the child are paramount and that a child's needs and risk must be subject to an individual assessment, as these will not necessarily be the same as their mother's.

Men

49. In 2009, DHHS published *Men who use violent and controlling behaviours: A framework for comprehensive assessment in men's behaviour change programs* (**MBCP framework**) (**Attachment SW-7**).

50. The development of the MBCP framework was a response to needs identified by providers of men's behaviour change programs for a common resource for comprehensive assessment of perpetrators that would:

    50.1 foster equity of service provision across the state;

    50.2 facilitate referral and information-sharing between men's behaviour change programs, and also between these programs and other service providers in the integrated family violence system;

    50.3 promote the programs' accountability to women and children, especially in terms of safety; and

    50.4 contribute to the provision of relevant and quality services to women, children and men.

51. The MBCP framework is for use by DHHS funded men's behaviour change programs. The MBCP's peak, No to Violence, has set minimum standards for delivery of these programs and require assessment workers to be suitably qualified – either:

    51.1 be a Level 3 (A) Facilitator, or

51.2 to have a Graduate Certificate of Social Science (Male Family Violence – Group Facilitation) and at least 200 hours of experience facilitating men's behaviour change groups.

52. The MBCP framework includes two practice guides to assist MBCP workers conduct an initial assessment and ongoing review. The first guide, among other things, helps assessors determine the perpetrator's suitability for the program; while the second guide supports ongoing assessment across a number of areas including charting change in the perpetrator's motivation and behaviour over time.

Who uses CRAF?

53. CRAF is available for use by all professionals who might come into contact with victims of family violence, from workers in mainstream universal services through to more specialised family violence settings. The CRAF is available both in hard copy and digital formats, as well as online on The Lookout family violence practitioner website (see paragraph 75 below for more detail) and the DHHS website.

54. I understand that, currently, all DHHS funded family violence service providers are required by their funding and service agreement to use the CRAF. I understand that it is widely used by statewide services such as SafeSteps and InTouch. I also understand that the peak organisations in the family violence sector such as Domestic Violence Victoria and No To Violence promote its use among their members and other professionals.

55. A range of other workforces have incorporated elements of the CRAF as appropriate into their own risk assessment and management sector tools and processes.

56. This means that for some workforces, family violence identification, risk screening or assessment, which is consistent with, or based on, the CRAF, has been incorporated as part of their business-as-usual processes. This includes:

56.1 Victoria Police whose members are required to use the L17 risk assessment form (**Attachment SW-8**) to make an assessment of risk on each occasion police are called to attend a family violence incident. The L17 risk assessment form was developed prior to, but aligns with, the CRAF.

56.2 Maternal and Child Health Nurses (**MCHN**) who use CRAF-based family violence identification and referral processes as part of their Key Age and Stage (**KAS**) Framework (**Attachment SW-9**). The KAS Framework requires

MCHNs to screen all mothers for family violence and undertake safety planning if family violence is identified at the baby's four week home visit.

56.3 Primary Care Partnerships who have incorporated family violence screening and referral tools, which are informed by CRAF, into their Victorian Service Coordination Practice Manual 2012 and Service Co-ordination Tool Templates (**Attachment SW-10**).

56.4 Alcohol and drug treatment services, which have included family violence identification and assessment and CRAF recording templates in their Adult Alcohol and other Drug Screening and Assessment Instrument: Clinician Guide and supporting module (**Attachment SW-11**).

56.5 Magistrates' Court Registrars who have reflected elements of CRAF in the forms used by all Registrars and Applicant Support Workers to assist parties with applications for intervention orders (**Attachment SW-12**).

57. While CRAF has been used and adapted by a wide range of organisations, the use of only one tool (such as CRAF) in all circumstances may not always be appropriate. This is because the CRAF is designed to assess the risk of family violence. It is not designed to support the assessment of other factors including mental health and substance abuse risks, which may co-occur with family violence. To provide a comprehensive service response that meets the range of issues a client might potentially present with in addition to family violence, assessments other than, or in addition to, the CRAF might be necessary.

58. It may also be appropriate for other professionals, particularly workforces such as Child Protection with a particular legislated mandate in relation to the protection of children, to use a different assessment framework focused on the best interests of the child or young person. For further detail, I refer to the evidence given to the Royal Commission by my colleague, Ms Beth Allen, in *Module 3: Children Intervention and Response*.

How has CRAF been implemented?

59. Since the launch of CRAF in 2007, a number of implementation initiatives have been undertaken to embed it across Victoria. Increasing competencies of different sectors to identify and respond to family violence through CRAF training and professional development has been a central part of implementation.

Government responsibility for implementing the CRAF

60. The Office for Women's Policy (**OWP**), which was located in the then Department of Planning and Community Development, was originally responsible for the development and implementation of the CRAF.

61. In 2010, the women's policy portfolio under the OWP was moved from the Department of Planning and Community Development to the (then) Department of Human Services, and became the Office of Women's Affairs. Management of the CRAF and responsibility for its implementation also moved with the women's policy portfolio to the Office of Women's Affairs in the (then) Department of Human Services.

62. On 1 January 2015, new machinery of government changes took effect in Victoria that transferred responsibility for women's policy and the Office of Women's Affairs to the Department of Premier and Cabinet. However, it was decided that the now DHHS retain responsibility for CRAF, given its operational links with the family violence services sector. The Service Design and Operations division of DHHS, of which I am an Executive Director, assumed this responsibility in January 2015.

Funding for CRAF implementation initiatives

63. The 2007-08 State Budget allocated $2 million over three years for CRAF implementation initiatives, including training. The 2010-11 State Budget allocated $2.7 million over four years for CRAF implementation, including training.

64. There is now ongoing funding for CRAF implementation, including training. The 2014-15 State Budget committed $0.8 million annually (indexed and ongoing) for CRAF implementation initiatives, including training.

65. In 2015-16 implementation of the CRAF initiatives will include:

    65.1 delivery of statewide cross-sectoral risk assessment and risk management training (around 59 training sessions in 2015-16) and Identifying Family Violence regional sessions (up to 480 sessions in 2015-16 and 2016-17);

    65.2 expansion of The Lookout website to increase technical capacity, support and enhanced community of practice and expert moderators; and

    65.3 development of risk assessment and risk management e-learning modules (e-learning modules). Supplementing face-to-face training with a suite of e-

learning modules is intended to provide a flexible and cost-effective way to deliver CRAF-related professional development to more users.

Who is trained in CRAF?

66. CRAF training is delivered through two types of sessions, which align with the practice guides. The Risk Assessment session is designed for practitioners who use Practice Guides 1 and 2, while the Risk Assessment for Specialist Family Violence Workers is tailored for practitioners using Practice Guide 3. These are designed according to the levels of family violence expertise and what is required of different professionals. Training is available to professionals ranging from those working in mainstream settings through to specialist family violence services.

67. In addition to the two session types, Train the Trainer sessions are also delivered to specialist family violence professionals who have the commitment and ability to assist with delivering the basic Risk Assessment session.

68. Enrolment is available to anyone through an online process on *The Lookout* family violence practitioner website (see paragraph 75 below).

69. Since the launch of CRAF, the following sectors have been prioritised for targeted training:

69.1 those working with vulnerable cohorts who are statistically more likely to experience violence (for example, women with a disability, Aboriginal communities and new mothers);

69.2 those who are known to provide services that family violence victims commonly access: for example, General Practitioners, homelessness services, counselling and mediation services, Child Protection workers and hospital staff as part of the government funded *Strengthening Hospitals Response to Family Violence* initiative. (This pilot initiative run at the Royal Woman's Hospital (through its emergency department) and Bendigo Health (emergency department, maternity and mental health units) aims to harness the potential of health professionals as early contacts for women experiencing violence and empower and support women and improve how hospitals identify, respond, and refer women experiencing family violence).

70. Priority sectors for CRAF training in 2015-16 are currently being determined. It is intended that a continued focus will be given to sectors working at the "front line"

responding to people experiencing family violence such as Child Protection, Victoria Police and homelessness workers.

71. To enhance the take-up of CRAF training among these sectors, DHHS has actively promoted and prioritised enrolment from these workforces. In addition, to make CRAF training more relevant and targeted to sectors prioritised for training, a number of adapted CRAF training materials and resources have been developed for professionals working with CALD communities; General Practitioners; Maternal Child Health Nurses (**Attachment SW-13**) and Magistrates Court Registrars (**Attachment SW-14**). Training materials for professionals working with Aboriginal communities are currently being developed.

72. Domestic Violence Resource Centre of Victoria, which has been the Department's training delivery partner as part of different consortia, reports that over 6,500 professionals from various backgrounds have been trained in CRAF since 2008.

73. The table below provides a breakdown of participants who have attended in CRAF training between 2009 to 2013:

	2009 (including 2008 pilot)	**2010**	**Nov 2011-Dec 2013**
Train the trainer	132		97
Comprehensive	470	206	874
Preliminary	596	268	1985
Priority cohort training • MCHN • Magistrate Court Registrars • Corrections • CALD • GPs	 770 275	 118	 243 48
Total participants	**2,243**	**592**	**3,247**

* Note: Domestic Violence Resource Centre of Victoria reports that a further 500 people have been trained since 2013. A breakdown of people trained in CRAF for 2014 onwards is not yet available.

Other relevant CRAF implementation initiatives

74. There are also a range of other CRAF implementation initiatives based around awareness raising and the promotion of best practice, which is making a contribution towards embedding a shared understanding and response to family violence.

75. These include:

75.1 the Professional Development Strategy, which commenced in 2011, aimed to increase workforce capacity to identify and respond to family violence and strengthen appropriate and consistent responses to family violence. One of the critical elements of this plan involves incorporation of CRAF training as part of the curriculum in courses that train and develop future workforces such as at TAFE and universities. Curriculum materials have been developed and trialled in a number of locations and are widely used by Swinburne University of Technology for delivery in a number of its health and community work areas. Swinburne University is currently finalising a report on the outcomes of the trials for DHHS.

75.2 delivery of *Identifying Family Violence* regional information sessions that are locally targeted to workplaces, community groups and services to raise general awareness levels around family violence. The sessions were delivered in 2010 and 2011 by a number of regional family violence agencies at a cost of around $180,000.

75.3 development of *The Lookout* family violence practitioner website which was launched in December 2013. This is an accessible and interactive "one stop shop" covering a wide range of information on the integrated family violence system and resources. It also provides a community of practice platform to enable sharing of best practice around new developments in risk assessment and management of family violence. Further, it is a valuable source of information and advice for individuals experiencing family violence and their support networks.

What is working?

76. As noted earlier in my statement, Victoria was a leader in introducing a statewide common risk assessment and management framework for identifying and responding to family violence. As CRAF was the result of a significant collaborative effort between the government and the non-government sector, I understand that it has had wide support from stakeholders.

77. In my view, the CRAF has the following strengths:

77.1 it provides a clear articulation of what family violence is and provides a consistent framework for all agencies to "speak" a common language in terms of family violence risk assessment and risk management. This is important

because an integrated service response to family violence depends on all agencies having a shared understanding of family violence and risk.

77.2 it assesses and manages risk *jointly* with the victim, rather than it being an assessment conducted on a victim. In this sense, the CRAF places a strong value on the victim's own assessment of their risk.

77.3 it has been deliberately designed to be flexible and adaptable for use by a wide range of professionals at a level appropriate to their level of family violence expertise. This recognises the different roles and specialties of various workers and sectors.

78. There have been two evaluations conducted (in 2009 (**Attachment SW-15**) and 2012 (**Attachment SW-16**)) of CRAF training. There has not been an evaluation of the efficacy of the CRAF itself. The 2009 evaluation of CRAF training found:

78.1 effective training coverage was achieved for specialist family violence services and Victoria Police;

78.2 total training coverage was offered and effectively achieved for Magistrates Court Registrars and Maternal Child Health Nurses; and

78.3 there was strong engagement and significant numbers of participants trained from sexual assault services, ChildFIRST/integrated family services, Child Protection, homelessness services, disability services, counselling and mediation services and in some regions, family violence specific Indigenous services.

What opportunities exist for improvement?

79. There are a number of opportunities for improvement of the CRAF and family violence risk assessment and management more generally in Victoria.

80. Whilst the introduction of CRAF in Victoria was an innovative and leading development, eight years have elapsed since it was first developed. Since then, there has been growth in knowledge and research and enhancements in family violence professional practice. Professionals have had the opportunity to use CRAF extensively and better understand its strengths and weaknesses. A number of other jurisdictions (including New South Wales, Western Australia and South Australia) have also introduced family violence risk assessment and management tools. Further, over time a number of other frameworks, policies and guides have been developed that intersect with or complement the CRAF.

81. In light of this, in March 2015, DHHS commenced planning for a comprehensive review of CRAF. The scope of this review will be determined in collaboration with sector partners. Without pre-empting those discussions, I expect it will examine, among other things, the approach and suitability of CRAF to ensure it reflects the most up-to-date evidence and international best practice on:

    81.1 effective risk assessment (including emerging area such as technology-facilitated family violence);

    81.2 guidance on risk management;

    81.3 embedding the use and training of CRAF;

    81.4 responding to the needs of diverse communities (including CALD and Aboriginal communities);

    81.5 responding to other forms of family violence;

    81.6 assessment of children and young people;

    81.7 information sharing, particularly in relation to the perpetrator; and

    81.8 risk assessment of perpetrators.

82. This review is planned to commence in the third quarter of 2015-16. This will allow for relevant recommendations or findings of the Royal Commission to be incorporated.

Effective risk assessment

83. The CRAF provides limited guidance about how to use the identified risk factors to develop a risk assessment or to tier that risk. For example, the CRAF does not weight or "score" the risk factors set out in the Aide, rather an asterisk simply denotes certain factors that may indicate a higher risk of the victim being killed or almost killed. In contrast, a number of other Australian jurisdictions provide more guidance on assessing and tiering risk (for example, South Australia and Tasmania). Scales and matrices are used to record and analyse evidence-based risk factors and produce a risk score.

84. A more guided form of risk assessment – for example, a validated tool that weights risk to produce a risk score or otherwise inform an assessment of risk – has the potential to be particularly useful for professionals using Practice Guide 1 or 2 who may not feel sufficiently confident to analyse risk without further guidance.

85. Victoria Police, in consultation with DHHS, is currently in the process of adopting this approach through a review and redesign of the L17 referral forms to support police members undertake a process of more guided risk assessment.

86. Consideration should also be given to whether there is an evidence base to consider other risk factors or assessment methodologies, particularly those that might allow earlier detection of family violence.

87. The CRAF also provides limited guidance on how often risk assessments should be undertaken or updated. Risk in a family violence context is dynamic and practitioners could be assisted by greater guidance on this issue.

88. The CRAF also requires updating to reflect the use of new technologies as a tool for stalking and abusing victims and how this links with other evidence-based factors to potentially heighten risk levels for women. Best practice approaches to respond and support victims of technology-facilitated abuse should be considered.

Guidance on risk management

89. There are also opportunities to improve the risk management aspects of CRAF through clearer guidance about the appropriate service responses commensurate with risk levels. For example, the statewide rollout of RAMPs (see paragraphs 130 to 135 below) will necessitate the CRAF being updated to make more explicit the links between the CRAF and this specialist response.

90. The guidance provided in the CRAF on managing risk should also support workers to provide a response that integrates the services, including mainstream and other services, required to support victims of family violence.

91. At the same time, consideration could be given to whether family violence specialists who use the CRAF require further tools (that could form part of the CRAF), training, development or support to understand and use screening tools used by other service sectors. This could assist to ensure that the broader service needs of victims are identified and met.

Embedding the use and training of CRAF

92. Implementation of CRAF has developed over time to include training, embedding of the CRAF tool in screening systems and practices and exploring incorporation of CRAF training as part of course curricula.

93. To assist the continued implementation of CRAF, an evaluation of CRAF should enable a better understanding of the extent to which it has been effectively embedded in different workforces to date and identify any gaps or barriers, particularly in relation to "first to know" responders. This knowledge would assist to inform government on the most effective approach to ensuring wide and consistent use of CRAF.

Responding to the needs of diverse communities

94. The CRAF's recognition of diversity could also be strengthened. While contextualised training has been developed for CALD communities (see paragraph 71 above), more could be done to incorporate cultural specific issues into CRAF practice guidance. This would improve the provision of support, guidance and professional development for risk assessment and management of particularly vulnerable and complex cohorts such as those from CALD and Aboriginal communities and women with disabilities.

Responding to other forms of family violence

95. Similarly, given CRAF focuses largely on men's violence against women in intimate partner violence settings, consideration should be given to what guidance (within CRAF or through complementary resources) is required to assess and manage the risks to other specific forms of family violence. These forms of family violence include adolescent family violence, elder abuse and abuse involving Lesbian, Gay, Bisexual, Transgender and Intersex communities.

Assessment of children and young people

96. There is scope to improve assessment processes for children and young people in the context of family violence. As I note earlier, the Assessing children and young people experiencing family violence guide is a useful CRAF-based resource that assists family violence risk assessment to consider all of a child's needs, not only their safety from violence.

97. There is a need, however, to update the CRAF to incorporate or make explicit reference to this resource. Further consideration also needs to be given to how this guidance is operationalised as part of the CRAF assessment tool itself, together with training support. This could assist to reinforce the importance of family violence practitioners being alert to issues impacting on both the child and mother in different (if not separate) ways.

98. There are also further opportunities to consider new service responses to family violence that are more child-centred. For example, I understand there is a model in South Australia in which children who are assisted by family violence services receive their own case management arrangement and plan. This gives recognition to the different impacts and safety issues and needs that might arise for a child or young person experiencing family violence.

Information sharing, including specific risk assessment tools for perpetrators

99. The effectiveness of risk assessment and risk management depends on the "completeness" and currency of information that is known about the victim, the perpetrator and any children. At the moment, the CRAF prompts workers to ask for information about recent incidents, as well as the history, frequency and severity of violence experienced. However, information gathered is limited to the information the victim holds and does not systematically take into account potentially pertinent information held about the perpetrator by other services such as Corrections, Victoria Police, courts, mental health or drug and alcohol services.

100. The CRAF does provide a template for recording and sharing risk assessments. However, this requires manual sharing and updating of risk as there is not a common platform accessible by all services supporting a victim of family violence to share and update risk assessments.

101. It would also be worth exploring different models that support earlier and more effective multiagency information sharing processes that get people the right response the first time. My colleague, Ms Kathleen Forrester, Executive Director, Human Services Strategy will address service integration issues further in *Module 19 – integrating services.*

102. Consideration should also be given to how to support optimal information sharing arrangements that appropriately balance safety and privacy and other confidentiality concerns. I will address information sharing in more detail in a separate statement for the purposes of my evidence in *Module 20 – information sharing.*

Risk assessment and management of perpetrators

103. The MBCP framework referenced earlier in paragraph 49 provides a starting point for a common approach to conducting risk assessment and management of perpetrators. There are opportunities to improve this approach, for example, by more clearly guiding a coordinated response to the service needs of perpetrators.

104. Further, there is merit in considering a common risk assessment and management tool for perpetrators that can be used by other service providers. In addition to better supporting victim safety, such a perpetrator specific tool could potentially serve a number of concurrent benefits. It could assist the service system to identify which offenders need to be kept in "closer view", as well as facilitate effective perpetrator rehabilitation and support earlier intervention responses for potential perpetrators where appropriate.

RISK ASSESSMENT AND MANAGEMENT PANELS (RAMPS)

Overview of the Strengthening Risk Management Demonstration Project (SRMDP) including RAMPs

Rationale for the SRMDP pilots

105. In 2011, DHHS funded the SRMDP pilots in two local government areas, the City of Geelong and the City of Hume. The 2013 Evaluation of the Strengthening Risk Management Demonstration Projects in Victoria (**the Evaluation Report**) by Thomson Goodall Associates (**Attachment SW-17**) notes that the SRMDP was seen to be a necessary next step in strengthening risk management to provide an intentional and integrated response for women and children at the highest risk of serious harm and lethality from family violence, over and above what had been provided to date.

106. The aims of the SRMDP were:

106.1 to test the implementation and delivery of coordinated multi-agency approaches to strengthen family violence risk assessment and management;

106.2 to trial new integrated governance arrangements, roles and responsibilities and new ways of working collaboratively;

106.3 to increase the accountability of men who use violence and support men's behaviour change; and

106.4 to ensure integrated (on the ground) responses to family violence.

107. Key features of the SRMDP service model included:

107.1 a multi-agency RAMP tasked with collaboratively providing risk assessment and risk management in identified high risk family violence situations; and

107.2 the provision of an SRDMP case management response to the intended client groups (women, men and children).

108. The SRMDP model in Victoria drew on similar models in other jurisdictions, including South Australia and the Multi-Agency Risk Assessment Conferences in the United Kingdom.

109. A Fact Sheet summarising the pilots is at **Attachment SW-18**.

Establishment of the SRMDP pilots

110. On 25 March 2011, DHHS undertook a select tender process for the pilot projects and invited submissions from two agencies:

110.1 Berry Street (in the City of Hume) (**Berry Street**); and

110.2 Bethany Community Services (in the City of Geelong) (**Bethany**).

111. A submission document was prepared by the DHHS to assist service providers in the preparation and lodgment of proposals for the SRMDP pilots (**Attachment SW-19**) (**Submission Document**).

112. The Submission Document identified the City of Hume and the City of Geelong as priority municipalities in which to locate the pilots, due in part to the lack of a specialist family violence court response in either area and the high numbers of Victoria Police reported family violence incidents.

113. The two pilots were initially funded for three financial years from 2010-11 to 2012-13 as set out in the following table:

Component	Annual amount ($ '000)
Staffing	875
Establishment	40
Brokerage	58
Total	**972**

Source: Evaluation Report, p 18. Numbers do not add due to rounding. The first year of the pilots was funded on a pro-rata basis for part of 2010-11.

114. Initial funding for the pilots was provided through the National Partnership Agreement - Homelessness (**NPAH**) through the housing assistance output group. The pilots were extended for 2013-14 and 2014-15 in line with extensions of the NPAH. As of 1 July 2015, the projects are funded through the child protection and family services output group.

115. Each pilot was funded for a coordinator (1 employee full time), plus three case managers (2.6 employees full time). The Department's Submission Document (**Attachment SW-19**, above) sets out position descriptions of the intended role and functions of key staff including: SRM Coordinator; RAMP Chair; Women's case manager; Men's case manager; and Children's Case manager.

Establishment of the RAMP pilots

116. The RAMPs were a key component of the SRMDP. A RAMP was established in each pilot area with a core membership consisting of senior representatives from:

116.1 the pilot agency (namely, Berry Street or Bethany);

116.2 Victoria Police;

116.3 Corrections Victoria;

116.4 Child Protection; and

116.5 Child FIRST.

117. Each RAMP also included representatives from other relevant Government and community service providers (such as health, mental health, drug and alcohol, maternal and child health, housing/homelessness providers, Centrelink, community legal services and women's family violence services), which differed as required between the pilots.

Operation of the RAMPs pilots

118. The Berry Street and Bethany RAMPs developed their own local processes to support the operations of the RAMPs. I am advised that DHHS commissioned a project to develop a Strengthening Risk Management Guidelines and Framework document to be used by the pilot agencies and their partners. These were intended to provide a formal basis for agencies to develop Memorandums of Understanding to underpin collaborative practice and formalise agreement for all RAMP members. The local pilot agencies were to be responsible for developing these MoUs and obtaining agreement.

119. The Evaluation Report notes the Guidelines and Framework document was not published or released prior to the pilots. The Evaluation also notes that the pilot agencies found the preparation of the MoUs time consuming and challenging and obtaining sign-offs to the MoUs by members proved difficult. As a result, RAMP

members at both sites agreed "in principle" to the MoUs and that the RAMP meetings would proceed and operate generally in accordance with the expectations outlined in the unsigned MoUs, including in accordance with the advice of the then Privacy Commissioner and Victoria Police.

120. Referrals to these pilot RAMPs could be received from any person or organisation, including Victoria Police, Child Protection, family violence services, health services and others. I have attached a copy of what I understand to be the Berry Street RAMP referral form (**Attachment SW-20**) and a copy of the Bethany RAMP referral form (**Attachment SW-21**). The major difference between the operation of the two pilots was that the Berry Street RAMP received L17 forms directly from Victoria Police and developed an internal agency system to identify and triage women and children at highest risk. The Bethany RAMP did not receive L17 forms, but relied on referrals from other agencies.

121. I understand that the decision about who would be "eligible" to be considered by the pilot RAMPs was initially challenging. While there was consensus that the eligible RAMP group would include women and children at "high risk", the pilots found it difficult to agree on the actual degree of risk and harm and imminence of risk required to establish eligibility. However, the Evaluation Report noted that, over time, eligibility issues within RAMPs were largely resolved with pilots operating more cohesively in terms of eligibility screening, with the client group presented to the RAMPs falling clearly within the target group of women and children at highest risk of serious harm or death.

122. The assessment of risk in the RAMP pilots and consideration of eligibility was based on the CRAF. In light of the challenges associated with determining eligibility experienced by the RAMP pilots, the Evaluation Report recommended that consideration be given to the "development of a strengthened assessment approach/tool to facilitate identification of women and children at highest risk of serious injury or lethality" (see page 88). The Evaluation Report cites examples of weighting systems used in other jurisdictions such as South Australia where a weighted risk score exceeding a prescribed threshold would result in referrals to their RAMP equivalent.

123. DHHS intends to provide greater guidance on how to identify women at highest risk of serious injury or lethality in the draft guidelines and specialist training to support statewide rollout of the RAMPs referred to in my statement below at paragraphs 130 to 135. I expect the upcoming review of CRAF referred to earlier in my statement will examine the appropriateness of using more actuarial tools in risk assessment.

Evaluation of the RAMPS pilots

124. Overall, the evaluation of the pilots was positive and concluded that both pilots achieved the primary aim of reduced risk and improved safety for women and children at highest risk. On this basis, the Evaluation recommended that RAMPs be established across Victoria.

125. Specifically, the Evaluation Report found that:

125.1 over the 17 months from November 2011 to March 2013, 55 families were referred to a RAMP and their cases were managed over a total of 26 RAMP meetings (both pilots combined).

125.2 there were approximately 90 children in these families (both pilots combined).

125.3 the majority of cases (70 per cent) were considered only once and 30 per cent of cases were considered over multiple meetings.

125.4 both RAMPs made a significant contribution to keeping women and children at high risk safe.

125.5 both RAMPs contributed to greater coordination and service system integration, particularly among RAMP members.

125.6 both RAMPs also contributed to increased accountability of men who use violence through sharing information about the whereabouts and circumstances of perpetrators and through coordination of responses involving Victoria Police and other RAMP members.

126. Importantly, none of the women or children referred to a RAMP died or was seriously injured in the pilot areas during that time.

127. The Evaluation Report also made a number of specific recommendations to improve the future operation of any RAMPs including that:

127.1 documentation should be developed to provide a clear understanding of the model and roles and responsibilities, including guidelines, a framework and standard MoUs;

127.2 Victoria Police should provide strong leadership for the RAMPs at the local level, including that senior Victoria Police representatives Chair or co-Chair the RAMPs;

127.3 membership of all RAMPs should include, as a minimum, senior representatives from Victoria Police, family violence agencies, Corrections, and DHS Child Protection;

127.4 there should be a statewide coordination committee tasked with overseeing the rollout of RAMPs across Victoria;

127.5 RAMP Coordinator positions should be established in specialist family violence agencies, and attached to each RAMP; and

128. In addition, the Evaluation Report highlighted some issues in relation to the funded case management component of the SRMDP as follows:

128.1 while the additional SRM case management funded positions provided agencies with the capacity to spend more time identifying and engaging with women and children at high risk, there was insufficient evidence to recommend a roll out of the original pilot SRM model which comprised a dedicated case management team targeting clients at highest risk.

128.2 the evidence from the evaluation suggests that a strengthened risk management response for women and children at high risk is more appropriately provided by existing family violence outreach services, given appropriate resourcing, structures and processes.

128.3 the Hume SRMDP in particular, demonstrated that a strengthened risk management response can be effectively provided by a mainstream family violence outreach service.

128.4 during the evaluation period neither pilot agency was able to effectively establish the men's case management role.

129. The Evaluation Report specifically found that the 'traditional' case management response for men was inappropriate for the high risk dangerous target group. Rather than case management, a community based organisation could provide a "risk management" response. This includes monitoring the perpetrator's whereabouts, information sharing and collaboration with the justice system, and giving men opportunity to access community based services in order to reduce risk to women and children.

Statewide rollout of the RAMPS

130. In October 2014, $17.3 million over four years in funding was allocated by DHHS to support the expansion of the Strengthening Risk Management program statewide, which included some case management and additional practical support for women and children experiencing family violence. This funding will enable RAMPs to be rolled out across Victoria (17 in total including in the two existing pilot sites).

131. The statewide model allocates funding of between $177,500 and around $285,000 in 2015-16 per site. This funding provides for a coordinator position, brokerage funds and some case management. The original pilots were funded at approximately $400,000 per pilot. The difference in funding is because the statewide model includes a lower level of dedicated case management on the basis that the Evaluation Report found insufficient evidence to support this level of investment (see above paragraph 128).

132. The development and implementation of the statewide model has been strongly based on the recommendations of the evaluation:

132.1 DHHS has worked closely with key government and non-government sector representatives to develop the model and documentation that provides clear guidance on targeting, eligibility and roles and responsibilities. In particular, draft guidelines (**Attachment SW-22**), a draft MoU (**Attachment SW-23**) and a draft local agreement (**Attachment SW-24**) have been developed.

132.2 the establishment of whole of government coordination mechanisms to support the development and implementation of the model. Oversight has been provided by the Violence Against Women and Children Inter-departmental Committee and will continue to be provided by the Family Violence Interdepartmental Committee. Further support for implementation is being provided through a RAMP working group with representatives from across government and the family violence sector.

132.3 funding has been allocated for a co-ordinator position to support the RAMPs at each site, with a family violence agency employing the coordinator. In addition, flexible brokerage funding is attached to each site and funding for some case management services.

132.4 DHHS has worked closely with Victoria Police on the design of RAMPs. Victoria Police has agreed to co-chair each RAMP.

133. The statewide model is also incorporating good practice responses to children at high risk identified in the Evaluation Report (see pages 48 to 50). For example, the new draft guidelines specifically acknowledge the need to address children in their own right and that separate consideration be given at RAMPs to each individual child in the risk assessment, risk management and action planning phases and processes.

134. On 30 January 2015, an allocation of $0.36 million in fixed term funding was made to develop a training and capacity building package to support implementation of the statewide RAMPs rollout. DHHS has allocated funding to Domestic Violence Victoria, in conjunction with Domestic Violence Resource Centre Victoria and No to Violence to develop the training and provide support and training to core member agencies in relation to RAMPs. Domestic Violence Victoria has successfully recruited a statewide RAMP Development Officer to provide a central point of referral and support for agencies during the establishment phase of RAMPs.

135. An initial training program for RAMP members was piloted in one DHHS area in June 2015. A number of modifications are being made to the training package based on feedback from participants.

Information sharing within the RAMPs

136. Information sharing is fundamental to the successful operation of the RAMPs. In developing the statewide model, a number of challenges have been identified in relation to the capacity of the current privacy legislation to support agencies who participate in the RAMP to share information. I will address the issue of information sharing within RAMPs in more detail in my statement in relation to *Module 20: Information Sharing*.

Other risk management responses going forward

New technologies such as safety cards

137. DHHS will fund a security pilot in 2015-16 to trial additional measures to keep women and children safe in the home. This pilot is expected to operate in four locations across the state with an expression of interest process to commence shortly. The initiative will trial tools such as CCTV and safety cards to further enhance women and children's safety and keep them in their homes and community.

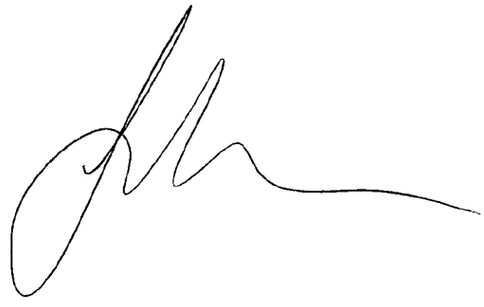
138. DHHS is keen to explore which risk cohorts this new technology could best support, beyond those at the high end of risk. For example, it would be helpful to understand the suitability of these measures for women and children at the more moderate end

of risk and if investment in tools such as CCTV and safety cards makes the crucial difference to whether they can remain in their homes and maintain connections to their local area.

"Next generation" of risk management responses

139. Risk management responses that can support victims of family violence to remain at home align with the overall direction of increasing perpetrator accountability through the justice system and strengthening and coordinating service responses to the right services are provided as early as possible. These approaches aim to reduce an over-reliance on crisis responses and deliver improved outcomes for women and children experiencing family violence.

Signed by)
Scott James Widmer)
at Melbourne)
this 21st day of July 2015)



Before me [redacted]

[redacted]

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