IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT SW-17 TO STATEMENT OF SCOTT JAMES WIDMER

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This is the attachment marked '**SW-17**' produced and shown to **SCOTT JAMES WIDMER** at the time of signing his Statement on 21 July 2015.

Before me: [redacted]

[redacted]

An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

Final Report to

Department of Human Services

Evaluation of the family violence Strengthening Risk Management Demonstration Projects in Victoria

December 2013

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Abbreviations

AFM	Affected (Aggrieved) Family Member
CALD	Culturally And Linguistically Diverse
CRAF	Common Risk Assessment Framework
DHS	Department of Human Services
DoJ	Department of Justice
DPCD	Department of Planning and Community Development
FIR	Family Incident Report
FSM	Family Safety Meeting (South Australia)
FVA	Family Violence Advisor (Victoria Police)
FVIO	Family Violence Intervention Order
IO	Intervention Order
IDVA	Independent Domestic Violence Advisor (UK)
LEAP	Law Enforcement Assistance Program (Police data base)
MARAC	Multi Agency Risk Assessment and Committee (UK)
MBCP	Men's Behaviour Change Program
MoU	Memorandum of Understanding
NFDVS	Northern Family and Domestic Violence Service (Berry Street)
NTV	No to Violence (peak body)
OoH	Office of Housing
RAMP	Risk Assessment and Management Panel
SRM	Strengthening Risk Management
SRMDP	Strengthening Risk Management Demonstration Project
WDVCS	Women's Domestic Violence Crisis Service

Project management

The evaluation of the SRMDP pilots was commissioned by the Department of Human Services Housing and Community Building Division. A Statewide Reference Group for the SRMDP was established to provide assistance and input related to the pilots, and of the evaluation.

Organisation	**Representative**
DHS – Housing & Community Building	Di Godfrey Marita Nyhuis Kaz Phillips Molly O'Shaughnessy Yvonne James
DHS – Child Youth and Families	Jenny Willox Coral Spencer Jacinta Ballinger Sandra D'Amore Suzanne Sibillin
DHS – Office of Women's Policy	Selina Getley Malia Dewse
Victoria Police	Kerryn Hynam
Aboriginal Affairs Victoria	Jeannie McIntyre
Dept of Justice – Victims Support Agency	Wendy Sanderson Krystle Edmonds
Dept Education & Early Childhood	Donna Dalling
Domestic Violence Victoria	Fiona McCormack
No To Violence	Rodney Vlais
Women's Domestic Violence Crisis Service	Deb Bryant
SAFER Research Team	Professor Cathy Humphreys Kristin Diemer
Berry Street Victoria	Gayle Correnti Felicity Rorke Melissa O'Halloran
Bethany	Bernadette McCartney Lisa Robinson Russelle Beardon Grant Boyd
DHS NWMR Service Delivery & Performance	Kathy Robb
DHS BSW Service Delivery & Performance	Leanne Hodder
By Invitation:	
inTouch Multicultural Centre Against Family Violence	Maya Avdibegovic
Women with Disabilities Victoria	Keran Howe
Elizabeth Hoffman House / VACCA	Monica Morgan / Muriel Bamblett
Coroner's Court	Carolyn Walsh

An Evaluation Reference Group met twice and provided valuable input and assistance to the Evaluation.

A number of individuals contributed time and effort to the project and we thank them for their honest and constructive input.

In particular, we would like to thank the project managers, Yvonne James and Marita Nyhuis, for their support and guidance throughout. Sincere thanks are also extended to the management and staff at Berry Street Victoria and Bethany Community Services.

We would also like to thank the members of the RAMPs, for their comments and input.

The evaluation was underpinned by a consideration of the views of women and young people. We thank them sincerely for their generosity, time and honesty in sharing their experiences and perspectives.

Project Team

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Contents **Page no.**

Executive summary

This report on the evaluation of the Victorian Strengthening Risk Management Demonstration Project (SRMDP) was commissioned by the Department of Human Services, and prepared by Thomson Goodall Associates Pty Ltd, independent evaluators and researchers. The evaluation was undertaken from May 2012 to December 2013.

The SRMDP comprised two pilots, each funded to enhance family violence risk assessment and risk management practice, and to implement a strengthened multi-agency risk assessment and risk management model for women and women with children at imminent risk of serious harm or lethality from family violence. The Demonstration Project included an evaluation of both pilots.

The SRMDP represented a logical progression in strengthening risk management, consistent with the Victorian Family Violence Reform agenda, and with the Commonwealth government's National Plan to Reduce Violence against Women and their Children. Over the preceding 20 years a number of significant criminal justice and community based initiatives had been implemented in Victoria, including changes to legislation; the introduction of several new programs and reforms; and changes to practice and working relationships. Government and non government partner organisations including the Department of Human Services, the Department of Justice, and Victoria Police, as well as other Departments, were key drivers and participants in these reforms.

Nevertheless, in the 10 years from 2000 to 2010, 150 women were killed in family violence incidents in Victoria, and many more women and children suffered serious and life threatening harm and injuries. The need for the Victorian government to develop an intentional and integrated response for this cohort, over and above what the family violence service system had provided to date, was established as a priority.

Two models of particular relevance to Victoria had been successfully implemented and evaluated overseas. Multi agency risk assessment conferences (MARACs) in the UK, and Family safety meetings (FSMs) in South Australia, informed the development and implementation of the SRMDP pilots in Victoria.

Strengthening Risk Management model

The Victorian SRMDP Pilot was established in 2011 in two local government areas – the City of Hume, and the Greater City of Geelong. The intended target group included women, and women with children, who were experiencing or at risk of family violence, with a focus on imminent risk of serious harm or lethality. In each area, the Department of Human Services funded an agency to auspice the implementation and operation of the SRMDP model – Berry Street (in the City of Hume), and Bethany Community Services (in the Greater City of Geelong). The pilots were initially funded by the Department of Human Services Housing and Community Building Division, for 2 years (ie. to June 2013), and included funding from the National Partnerships Against Homelessness (NPAH). Funding was subsequently extended beyond the 2 year pilot period to June 2014.

The SRM pilots comprised two main components which were specified in a draft service model description prepared by DHS as part of the funding submission process for the project. The first component included early identification of women and

children at highest risk, engagement, and provision of risk assessment and risk management, and where necessary, referral to the second component - a specialist Risk Assessment and Management Panel (RAMP) comprising senior staff of relevant partner agencies.

The pilot funding covered 3.5 EFT positions within each of the auspice agencies. Nominal positions were an SRM Coordinator, and 3 SRM case management positions, including women's case manager(s), children's case manager, and a case manager to work with men who use violence. Each pilot Coordinator was to be responsible for helping to establish the SRM service model and the RAMP (including obtaining 'buy in' from senior staff in a number of relevant agencies); providing on-going coordination of the RAMP and administrative support, coordinating referrals to the RAMP, and monitoring client outcomes. The Coordinator role also included oversight of the SRM identification and triage system, and supervision of SRM case management staff.

A Risk Assessment and Management Panel (RAMP) was to be established in each pilot area, with core membership to include senior representatives from the pilot auspice agency (Berry Street and Bethany Community Services), Victoria Police, DHS Child Protection, Corrections, Department of Health, and other relevant agencies and service providers. In each area, the RAMPs were to meet monthly to share information, assess the level of risk of referred cases, and to develop and coordinate risk management action plans for women and children who had been referred to the RAMP. The operation of RAMPs, and in particular the sharing of confidential information, was to be covered by a Memorandum of Understanding (MoU) between member agencies within the RAMP.

About the evaluation

The aims of the evaluation were to analyse and report on the extent to which the SRM Demonstration pilots contributed to increased safety for women and children; contributed to increased accountability by men who use violence, and to evaluate the extent to which the pilots had led to greater service system integration in responding to family violence.

The Department of Human Services specified that the evaluation should cover:

- the process for the establishment of Risk Assessment and Management Panels (RAMPs) in each pilot location
- the effectiveness of collaboration, information sharing and decision making between RAMP members
- client outcomes including increased safety for women and children and holding men accountable for their use of violence
- contribution to service system integration in responding to family violence
- recommendations for potential rollout of SRM RAMPs across Victoria.

The methodology for the evaluation included consultations with auspice agencies and other key stakeholders; client interviews; data collection and analysis; observation of RAMPs; review of RAMP minutes and action plans; review of case studies; review of other comparable initiatives; facilitation of regional forums, and a literature review. In total more than 100 individuals contributed to the evaluation.

Establishment of pilots

The establishment of the pilots in the two regions reflected differences in organisational arrangements and core business in each of the auspice agencies, and difference in the regional family violence service system contexts.

Berry Street established the SRMDP within its existing regional family violence service (Northern Family and Domestic Violence Service), which received police referrals for women and children who had experienced family violence (L17s) for the Hume LGA. The Berry Street SRM Coordinator role was provided by one individual. Berry Street combined the SRM women and children's case management role (ie. two workers, both Women and Children's workers). An SRM men's case management position was trialed for one year then discontinued. Berry Street initially established a separate SRM team, but changed the model in the second year, with the SRM service for women and children integrated into an expanded NFDVS team.

Bethany established and maintained a separate SRM team throughout the pilot, comprising a women's case manager, a children's therapeutic worker and a men's case manager. The SRM Coordinator position was shared between 2 staff members and divided into coordination and team leader tasks. Bethany is the nominated agency to receive police L17 referrals for men who have used violence, and has several men's programs. In July 2012 Bethany implemented an organisational restructure to better support the SRMDP, involving the creation of a dedicated Housing and Family Violence team.

Both pilot agencies established multi-agency Risk Assessment and Management Panels (RAMPs), and produced draft MoUs, and operating guidelines.

There were some differences in referral pathways to the SRM auspice agencies, and to the RAMPs. Berry Street developed an internal agency system to identify and triage women at highest risk, mainly based on a review of police L17 referrals for Hume, and other information.

Bethany does not receive L17 referrals from police for women, consequently the Geelong pilot relied on referrals from other agencies, particularly the specialist family violence outreach service in the region, as well as from internal Bethany programs, and other agencies.

Overall, the pilot agencies established reasonably effective models and processes to strengthen risk management for women and children at highest risk of serious harm or lethality. Both agencies drew upon their wide base of existing organisational resources and relevant internal agency programs, as well as local and regional partnerships, to support the establishment of the SRMDP. The SRM pilot agencies also experienced a number of challenges including:

- insufficient guidelines and documented strengthening risk management framework
- having to negotiate with senior staff in major and different organisations, to participate in the initiative without sufficient 'authorisation', or higher level interdepartmental arrangements
- addressing complex questions of privacy, confidentiality and working partnerships, and finalisation of MoUs for the RAMP

- securing consistent attendance at RAMP, and continuity by some key partners
- recruiting and maintaining a full complement of agency SRM staff
- establishing a viable men's case management role with the intended client group
- addressing the working relationship and partnerships with their respective women's family violence and men's family violence services and other regional service providers.

The pilot agencies responded to issues raised in the initial evaluation establishment report, and subsequently refined and strengthened SRM service models, and RAMP operating practices.

Clients assisted

Data obtained for the evaluation (pertaining to SRM case management and RAMP clients) covered the period July 2011 to March 2013. It was several months from the commencement of the pilots before the first client referrals were made to RAMP in November 2011. Over the 17 months November 2011 to March 2013, 55 households were referred to and considered at 27 RAMP meetings (both pilots combined). There were approximately 90 children included in these households. The majority of cases (70%) were considered only once, and 30% of cases were re-presented.

In addition to the 55 RAMP referrals, more than 200 households (including more than 170 children) were provided with SRM case management by the agencies. In addition to the assistance provided to children as part of the assistance provided to households, Bethany's Children's Therapeutic case work assisted a further 58 children. Both agencies generally met the expectations of DHS in terms of the number of women and children assisted by the pilots.

During the evaluation period neither pilot agency was able to provide case management to men as originally envisaged (ie. partners or former partners of women referred to RAMP). Berry Street assisted 2 men, and subsequently discontinued the men's case management position. Bethany assisted a total of 33 men, however the majority of these men were outside the 'high risk' target group. In mid 2013 Bethany introduced new approaches to working with the intended male client group in collaboration with Victoria Police and the justice system.

Evaluation of Risk Assessment and Management Panels

In both pilots, RAMPs generally met monthly for 2-3 hours, although in the year to December 2012, there were some months when there were no meetings, as there were no referrals. The number of cases considered at each RAMP varied from 1 to 6 cases, with 2 to 3 cases being the most common.

Membership for both RAMPs included the auspice agency, Victoria Police, Corrections, DHS Child Protection and ChildFIRST. The Hume RAMP also included members from health, mental health, drug and alcohol, maternal and child health and Centrelink. The Geelong RAMP included representatives from the women's family violence service, community legal services, health services, and Bethany men's family violence service, and family services. The Hume RAMP was chaired by

an independent person, and the Geelong RAMP was chaired by a senior Bethany manager.

RAMP meetings commenced several months before the first referrals were received in order to establish the RAMP model, and finalise operational matters and the MoUs. Although RAMPs commenced operating in November 2011, it took longer to finalise the MoUs, and debate continued until reasonable agreement was reached on eligibility criteria for referral to RAMP, and the assessment of 'high risk'. This was not surprising given the innovative nature of RAMPs, and the different contexts and perspectives of members.

Over the evaluation period, the RAMPs provided an integrated and valued response to women and children at high risk of severe harm and / or lethality. The two RAMPs made a significant contribution to keeping women and children at high risk, safe. The effectiveness of RAMPs is attributed to commitment of partners; senior staff from multiple agencies sharing critical information about imminent risk of serious injury or lethality, strengthening their assessment of risk, and developing creative risk management options for increased safety for women and children. The RAMPs were effective in allocating short term tasks to address immediate critical risks, and tasks to underpin effective ongoing risk management. Both RAMPs recorded specific action plans for RAMP members.

RAMPs contributed to greater coordination and service system integration, particularly among RAMP members. In addition, RAMPs contributed to increased accountability of men who use violence, through sharing information about perpetrator whereabouts and circumstances, and through coordination of responses involving Victoria Police and other RAMP members.

There is strong support by the RAMP members involved in the pilots, women who participated in interviews, and other key stakeholders, to maintain RAMPs as a key component of a Strengthening Risk Management framework, and for RAMPs to be rolled out across Victoria. There are however, several potential areas of improvement for RAMPs which were identified, including using enhanced tools to facilitate risk assessment; improving consistent attendance of members at RAMPs; improving recording of minutes and actions; and improving the efficiency of discussions and RAMP processes. It is also considered important to broaden the range of referral sources to and from RAMP.

Evaluation of SRM case management

SRM women's case managers performed an important identification, and engagement function, and demonstrated the importance of a dedicated intake and screening process to assess and prioritise all high risk L17 referrals, within a short time frame (ie. 12 to 24 hours). The pilots demonstrated the requirement for skilled family violence practitioners to provide intake and engagement functions, as well as provide ongoing case management to women and children at high risk of serious injury and lethality. Not only is it critical to maximise the chances of engagement, and develop a robust and comprehensive risk management plan, the nature of the work demands a high level of knowledge, experience and maturity in order to avoid vicarious trauma, and harmful exposure to dangerous situations.

Both SRM pilots assisted children in the context of providing assistance to their mothers, which included risk assessment and risk management. In addition, children's safety was given priority through the involvement of Child Protection,

ChildFIRST and other children's services. Both agencies referred children to a variety of services, and liaised with schools, as appropriate. Both agencies provided varying levels of therapeutic assistance. Berry Street's Turtle Program assisted a small number of children of SRM clients, and provided secondary consultation and support to the SRM women and children's case managers. Bethany's Children's Therapeutic worker directly assisted a number of children of SRM clients with case management and therapeutic interventions.

Risk assessment and management strategies, and roles and responsibilities in relation to children who have witnessed, or experienced family violence require further clarification within a strengthening risk management strategy. The pilots highlighted the need for an assessment of the safety and other urgent needs of each individual child, which takes into account the immediate and imminent risk, as well as cumulative harm. Family violence agencies require adequate skills to respond to children at risk, and to develop child centred plans. While a therapeutic response has great potential value in assisting children, where there are imminent and high risks, thus may be better undertaken post crisis within a less stressful, safer and more stable context.

A key objective of the strengthening risk management strategy is increasing the accountability of men who use violence. While RAMPs contributed to this objective, to some extent, the SRM men's case management response in first year of the pilot, was not able to contribute to this objective to any degree. The evaluation found that the 'traditional' case management response for men is not appropriate for the high risk dangerous target group. Instead of 'case management', a community based organisation could provide a 'risk management' response. This would involve monitoring the perpetrator's whereabouts, providing information and working in collaboration with the justice system, and providing the opportunity for men to access community based services in order to reduce risk to women and children. For example a strengthened 'risk management' response for men could be provided by a men's family violence service working in collaboration with Victoria Police and Corrections. Otherwise a strengthened risk management response could be provided directly by the justice system itself (eg. Corrections).

Client outcomes

Outcomes for women and children assisted by the pilots were assessed based on a number of sources including interviews with 15 women, and 3 young people who were assisted by the SRM pilots; special purpose data forms completed retrospectively by workers recording case outcome information and workers' perceptions of client outcomes, using scaled outcome measures; RAMP members views on outcomes; and analysis of 9 detailed case studies.

Both pilots achieved the primary aim of reduced risk and improved safety for women and children at highest risk. Comparatively better outcomes were achieved for women presented to RAMP. The RAMP enabled more comprehensive risk assessments and risk management plans, wider knowledge within the service system of the risks to women and children, and greater coordination compared to the 'traditional' response of the family violence service system.

The allocation of case management resources to the pilot agencies enabled efficient identification and higher rates of engagement with high risk households, where workers had more time to persist in making contact and engaging with women.

Women and children were assisted with safety plans, resulting in safer living arrangements, and a significant increase in intervention orders.

The SRM pilots also contributed to housing stability, improved health and well being, and access to relevant services and supports.

Children's safety and well being were enhanced through the safety plans for the family, and the involvement of Child Protection in RAMPs. Safety and well being for some children was also enhanced by SRM workers assisting mothers to develop insights and understanding of the effects of family violence on children. The SRM pilots also contributed to educational stability, health and well being and other outcomes for children, and made a range of referrals to children's health services, art and music groups, recreational activities. An agreed model and framework is required to ensure improved responses are provided to children who are experiencing high risk and dangerous environments, including the proactive involvement of Child Protection and Child First representatives.

The SRM pilots achieved enhanced outcomes for men to some extent (ie. holding men accountable) through RAMPs. In particular, communication and information sharing at RAMPs increased opportunities for Police and other organisations to develop strategies to hold men accountable for their behaviours. The knowledge and experience of Corrections was often valuable. However, as indicated, the SRM men's case management position was not able to achieve outcomes for men, in terms of accountability, to any significant degree.

There are significant challenges for a community based agency to engage with, and work with men who use extreme violence, and pose a serious risk to women and children. It is likely that only a minority of these men would respond (voluntarily) to a community based agency, and the outcomes for men from the SRM pilots need to be considered in this context.

While a 'reduction in risk' to women and children is a primary outcome measure for the SRM pilot, a robust, more comprehensive outcomes framework is required for the future. The evaluation identified a number of possible outcome measures including effectiveness of identification, contact and engagement of women at highest risk; the extent of achievement of 'safety plan goals'; a reduction in risk factors, using an appropriate measurement tool; and a reduction in recidivist family violence.

Conclusion

The evaluation of the SRMDP pilots confirms that a Statewide initiative to strengthen risk management is needed in Victoria to further protect the lives of women and children at risk of serious injury or lethality, and to reduce the incidence of severe and repeated family violence. Approaches to strengthen risk management for this target group have been successfully implemented in Australia and overseas.

A strong authorising environment is fundamental to the successful roll out of the initiative across Victoria. This needs to include formal and high level multi-Departmental endorsement.

The establishment of RAMPs would best occur on a regional and sub-regional basis, and would bring together key agencies which can most effectively pool their resources, information and problem solving skills to protect women and children at highest risk, from serious harm and lethality. RAMPs would be held monthly, or

more frequently if required, and would require the consistent attendance of the family violence agency, Victoria Police, Corrections and Child Protection. Other agencies would attend according to the circumstances of each case.

Each RAMP member brings a capacity to provide valuable information and particular perspectives on the level of risk, and make decisions and commitments on behalf of the organisation they represent. Appropriate levels of seniority for members would be based on their capacity or power to make executive decisions. Police leadership offers several potential advantages.

A coordination function is required for the establishment of RAMPs, and for their ongoing effectiveness and efficiency, in each region in Victoria Key roles include developing the capacity of RAMP members and the broader service system to support the SRM initiative; to contribute to the administration of RAMPs including inviting relevant RAMP members; preparation of documentation and monitoring RAMP activities. A Coordinator may coordinate one or two RAMPs depending on the levels of referral and other factors.

The SRM initiative would be integrated into existing specialist family violence outreach services. Identification, engagement, risk assessment and management and referral to RAMP (if required) would ideally be undertaken as a dedicated activity for women and children at highest risk, within existing family violence outreach services which receive police L17 referrals. Advanced skills are required for these tasks, in order to engage and work with women in dangerous situations, and also provide children with individual responses. Additional resources may be required to ensure these skills are available in agencies. The Coordinator position would also be based in these services.

While the roll out of RAMPs and the implementation of the SRM initiative with specialist family violence outreach services would result in a significant improvement in the system wide capacity to respond to and address 'high risk' family violence, there is a need to strengthen risk assessment and management across the sector more broadly. There is also a need to define, and for agencies to adopt good practice in strengthening risk management.

Recommendations

1 It is recommended that:

- the Victorian government makes a formal commitment to a statewide multi-agency integrated risk management initiative for women and children at imminent risk of serious injury or death from family violence.
- a high level Statewide coordination committee be tasked with overseeing the Statewide rollout and ongoing operation of multi-agency risk assessment and management panels (RAMPs).
- all relevant Departments and organisations designate responsibilities for ensuring leadership, participation and appropriate responses within the strengthening risk management initiative.

2 It is recommended that:

- a Framework and Guidelines document is finalised prior to the rollout of a statewide initiative. The document would comprise Guidelines including a service model description, and roles and responsibilities of all relevant parties

- a standard MoU is developed for all RAMP member agencies prior to rollout of a statewide initiative

3 It is recommended that RAMPs are established across Victoria, to deliver an integrated response to women and women with children at highest risk of serious injury and/or lethality

4 It is recommended that:

- the proposed RAMP model (Appendix 1) forms the basis for the establishment of RAMPs across Victoria
- 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 (eg. weighting system used in SA; ODARA in Canada).

5 It is recommended that:

- membership of all RAMPs includes as a minimum senior representatives from Victoria Police, family violence agencies, Corrections, and DHS Child Protection.
- agreed processes are developed for the coordination of attendance of other RAMP members, depending on referrals, and clients' needs and circumstances.

6 It is recommended that consideration is given to Victoria Police providing leadership for the SRM RAMP initiative, at the local/ regional level, including that senior Victoria Police representatives Chair or co-Chair the RAMPs

7 It is recommended that RAMP Coordinator positions are established (funded) in specialist family violence agencies, and attached to each RAMP.

8 It is recommended that:

- specialist family violence outreach services establish a dedicated activity and process to identify, contact and engage with women and children at high risk, and make referrals to RAMP as required.
- the proposed SRM rollout includes advanced practitioner staff in specialist family violence outreach agencies
- specialist family violence outreach services enhance risk assessment and risk management responses to children
- good practice for strengthened risk management in the specialised family violence sector are developed and adopted

9 It is recommended that:

- health services are prioritised for participation in the SRM initiative
- a plan is developed to strengthen identification, assessment and referral of women and children at high risk, within the health sector, and other key 'first to know' organisations in the broader service system (education, housing, income support)

10 It is recommended that:

- RAMPs include a specific focus on directly and proactively addressing the risks presented by perpetrators
- the proposed SRM initiative supports a strengthened criminal justice response to men who use violence

1 INTRODUCTION

In 2011 the Victorian government initiated and funded a Strengthening Risk Management Demonstration Project (SRMDP) aimed at assisting women and women with children at high risk of family violence. The project was also designed to increase accountability by men who use violence, and to contribute to greater service system integration, in response to family violence. The SRMDP was intended to focus on the extreme end of the family violence continuum where men perpetrate serious injury and harm, and lethality, on women and women with children.

The SRMDP was commissioned and overseen by the Victorian Department of Human Services, Housing and Community Building Division. A Statewide SRMDP Reference Group was convened, comprising senior agency staff from a range of relevant agencies, departments and peak organisations. The purpose of the Reference Group was to provide support and guidance to the demonstration projects.

Two demonstration pilot projects were funded for a 2 year period, commencing in June 2011, and completing in June 2013.[1] The projects were awarded to Bethany Community Services, to pilot the SRMDP in the City of Greater Geelong, and to Berry Street Northern Family and Domestic Violence Service, to pilot the SRMDP in the City of Hume.

The demonstration pilots represented a logical progression in strengthening risk management, consistent with the Victorian Family Violence Reform agenda, and with the Commonwealth government's National Plan to Reduce Violence against Women and their Children. The projects were broadly based on a similar strengthening risk management model established in the UK in 2003.

The aims of the SRM Demonstration Projects were:

- To test the implementation and delivery of coordinated multi-agency approaches to strengthen family violence risk assessment and management
- To trial new integrated governance arrangements
- To trial new roles and responsibilities
- To trial new ways of working collaboratively
- To support men's behaviour change
- To ensure integrated (on the ground) responses to family violence.

Key features of the Victorian SRMDP service model included a multi-agency risk assessment and management panel (RAMP), tasked with collaboratively providing risk assessment and risk management in identified high risk family violence situations; and the provision of an SRM case management response to the intended client groups.

[1] Funding for the two projects was subsequently extended for a further 12 months to June 2014.

Evaluation of the SRMDP

An independent evaluation of the Strengthening Risk Management Demonstration Project was commissioned by DHS H&CB, and undertaken by Thomson Goodall Associates (May 2012 to November 2013). An Evaluation Reference group provided input to the methodology for the evaluation.[2]

The aims of the evaluation were:

- To analyse and report on the extent to which the SRM Demonstration pilots have contributed to:
  - increased safety for women and children
  - increased accountability by men who use violence
  - greater service system integration in responding to family violence.
- To conduct an ethical evaluation process which contributes to accurate and improved understandings of effective multi agency responses to family violence.

The Terms of Reference (key tasks) for the evaluation were to:

- Evaluate the process for the establishment of Risk Assessment and Management Panels (RAMPs) in each location, and evaluate the extent to which implementation developed effective processes
- Evaluate the effectiveness of collaboration, information sharing and decision making between RAMP members, as well as the development and adherence to new integrated governance arrangements
- Evaluate client outcomes including (but not limited to) increased safety for women and children and holding men accountable for their use of violence.[3]
- Provide recommendations for potential rollout of SRM RAMPs across Victoria

Methodology

The methodology for the evaluation was agreed with the Department of Human Services, and was approved by the Department of Health and Victoria Police Human Research Ethics Committees. A summary of the methodology is presented below.

a) Inception

Initial consultations were undertaken with DHS, members of the Statewide Reference Group, and the Statewide Evaluation Working Group, to inform the development of key research questions for the evaluation.

b) Evaluation Framework

A detailed evaluation framework, methodology and work plan was developed based on the evaluation aims and Terms of Reference. A sub group of the Statewide SRM Reference Group met to consider and provide input to the evaluation framework.

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2 The evaluation reference group was a sub group of the Statewide Reference Group

3 Client outcomes for women and children will include demographic information, housing stability (education stability for children), health and wellbeing, risk assessment and safety outcomes. Client outcomes for men will include demographic information, housing stability, health and well being, risk assessment and engagement with men's behaviour change programs.

An evaluation framework document was finalised and agreed with DHS and the evaluation working group.

c) Initial meetings with participating agencies

Initial consultations were undertaken with the two pilot agencies (Bethany Community Services, and Berry Street), and included discussion and review of all relevant documentation; descriptions of the service model; agency data collection; roles and responsibilities of key stakeholders, and other process matters relevant to the evaluation.

d) Develop tools

Comprehensive data collection tools were developed for the evaluation including agency and client data collection forms; interview schedules; surveys of RAMP and SRMDP representatives; client interview schedules; topics for discussion with a range of key stakeholders; and pro formas for case studies.

e) Consultation and meetings with pilot agencies

A number of consultations, meetings and focus groups were conducted with the two pilot agencies during the course of the evaluation. Consultations were held with management, and all funded SRM staff. Meetings were held at individual pilot sites, and joint meetings were held with both pilots and DHS H&CB. Meetings provided opportunities for consultation; presentation and discussion of emerging themes and findings from the evaluation; feedback by agencies on evaluation data reports and working papers.

f) Receive data, and conduct analysis

Special data collections were designed in order to obtain information about numbers of clients assisted by the SRMDP, and other relevant information. Data were recorded by SRM Coordinators and/or case managers, on all clients presented to RAMP, and on a sample of clients provided with SRM case management during the 20 month period, from October 2011 to May 2013. A total of 204 client data records (for both agencies) were received and analysed.

g) Client interviews

Interviews were conducted with 18 clients of the pilots, comprising 15 adult women, and 3 young people aged 12, 18 and 18. SRM staff assisted in the client interview recruitment process, consistent with the approved methodology. Client interviews were based on a semi-structured interview schedule, and provided an opportunity for participants to reflect on their encounter with, and experience of the SRMDP pilots.

h) Observation of RAMP meetings

The evaluation consultants attended and observed a total of 11 RAMP meetings (6 in Hume, and 5 in Geelong).

i) Review of RAMP minutes

De-identified minutes of 27 RAMP meetings (13 meetings in Geelong, and 14 meetings in Hume) were made available to the evaluation consultants for review and analysis.

j) Survey of RAMP members

A comprehensive survey was designed for RAMP members, to elicit views on establishment of the RAMPs; on RAMP processes including decision making, communications; on operational matters (frequency and length of meetings, membership); and potential areas for improvement. A total of 20 survey documents were completed by RAMP members and analysed.

k) Individual consultation with core RAMP members

Individual consultations were undertaken with core RAMP members in both pilots, at two stages in the evaluation. Second stage consultations explored in detail some of the issues which had been raised in surveys.

l) Analysis of case studies

Pilot agencies prepared 9 detailed de-identified case studies, based on a proforma prepared by the evaluation consultants. The purpose of case studies was to enable agencies to provide a detailed description of different elements of the SRM model, including both the SRM case management, and the multi-agency (RAMP) component. A thematic analysis of 9 case studies was undertaken.

m) Consultation with other key stakeholders

Consultations were conducted with a range of other key stakeholders within Victoria and interstate. Key stakeholders included DHS H&CB, DHS Child Protection; Victoria Police, WDVCS, University of Melbourne researchers, No To Violence, Domestic Violence Victoria, Statewide family violence reference group members, and others. Consultations were undertaken with key stakeholders involved in similar strengthening risk management activities in other States (South Australia and NT).

n) Project management and liaison

Several progress reports and working papers were produced throughout the evaluation period, and 6 project management meetings were attended with DHS project management staff. The evaluation consultants attended 3 Statewide Reference Group meetings.

o) Review of literature and program information

A review of relevant literature and program documentation was ongoing throughout the evaluation. A focus for the literature review was on comparable multi-agency responses in other jurisdictions, including model components and design; outcome measures, and actuarial assessment tools.

p) Forums

Two regional forums were conducted at a late stage in the evaluation (one in Hume, one in Geelong) to present preliminary evaluation findings, and to discuss future directions for a strengthened risk management approach throughout Victoria.

q) Reporting

A number of reports and working papers were produced during the evaluation:

- An establishment report was finalised in November 2012 describing the initial establishment of each of the pilots.
- Two comprehensive data reports were prepared, the first of which was completed in December 2012. The two pilot agencies were given the opportunity to collect and provide 6 months additional data September 2013 to March 2013), in order to improve the quality of data provided in the first data collection. A second data report was produced in June 2013, comprising an analysis of 20 months of consolidated data.
- Working papers highlighting key issues and emerging themes were prepared for the Statewide reference group meetings and the joint meetings with pilot agencies and DHS H&CB.
- Draft Literature Review was produced (November 2012) and updated as new information became available.
- Draft summary report of key findings (September 2013)
- Draft and final reports (November 2013).

In total, more than 100 individuals contributed directly to the evaluation, many of whom contributed multiple times during the course of the project.

Report outline

This report is set out as follows:

Section 2 presents a summary of the background and context relevant to the introduction of the SRMDP pilots in Victoria.

Section 3 summarises key aspects of the establishment of the two SRMDPs in Victoria.

Section 4 presents an evaluation of the SRM case management component of the SRMDP pilots.

Section 5 presents an evaluation of the RAMP component of the SRMDP pilots.

Section 6 summarises client outcomes from the SRMDP (SRM case management and RAMP).

Section 7 concludes the report with a discussion of the key factors for consideration in a potential 'roll out' of a strengthening risk management initiative across Victoria.

Selected appendices are provided as supporting material.

2 BACKGROUND

2.1 Introduction

Victoria has a well established family violence service system, and has been proactive in piloting new approaches to address family violence. Innovative models are also being trialled and evaluated in other States/ Territories, and in other countries.

This section provides some select background information, relevant to the Strengthening Risk Management Demonstration Projects in Victoria.

Notably, in the early 2000s the Victorian government committed to a major policy platform to reduce, and to more effectively address the incidence of family violence in the community. Victorian family violence reforms have consistently aimed to improve the safety of women and children; ensure that men who use violence are held accountable for their actions; and ensure communities do not tolerate family violence.

Section 2.2 below summarises selected highlights of family violence reform relevant to the implementation of the SRMDP in Victoria. Reference is made to the current Victorian Action Plan (section 2.3), and current plans and strategies of Victoria Police are noted in section 2.4.

Section 2.5 presents several examples of established models in a range of contexts, highlighting responses for women and children at high risk of serious harm from family violence. Section 2.6 provides a summary of the rationale for the establishment of the SRMDP pilots in Victoria.

2.2 Family violence reform in Victoria

Selected highlights of the Victorian family violence reforms are summarised below.

- The Women's Safety Strategy 2002-2007 was launched in 2002, outlining Victoria's policy framework for a whole of government approach to address family violence.[4] This was consistent with national commitments, policies and initiatives.
- In 2005 the Victorian Statewide Steering Committee to reduce Family Violence released its report *Reforming the Family Violence System in Victoria*, and the Government funded a major family violence reform package, strengthening police, court and support services.[5] This was based on a whole of government (integrated) approach involving a wide range of government departments and program areas, peak bodies, funded service providers and other stakeholders. Key government organisations included Victoria Police (Victoria Police); Department of Justice (DoJ); Department of Human Services (DHS); Department of Planning and Community Development (DPCD); and Department of Education and Early Childhood Development (DEECD).

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4 Women's Safety Strategy

5 Victorian Statewide Steering Committee (2005) *Reforming the Family Violence System in Victoria*

- In terms of a strengthened criminal justice response to family violence, the design and implementation of new legislation gained momentum in 2002 when the Victorian Law Reform Commission (VLRC) commenced its review of family violence laws.[6] The review culminated in *The Family Violence Protection Act* (FVPA) 2008, which replaced the *Crimes (Family Violence) Act* 1987. The new legislation led to a number of changes to policies and programs in Government departments. In addition the Crimes Act 1958 (Vic) and the Evidence Act 1958 (Vic) have been reformed. The legislation provided (as one example), for the establishment of Family Violence Safety Notices, giving Victoria Police the power to exclude perpetrators from the family home for 72 hours.
- Considerable resources have been invested in implementing the new legislation and supporting associated programs, including provision of training and professional development, and updating policies, procedures, guidelines and other documentation. Significant changes have occurred within Victoria Police; within the broader justice system, in particular the Magistrates' and Children's Courts, and also within several government departments and programs, and in the community sector.
- Major court reforms have included the establishment of the Family Violence Court Division in 2005 (Heidelberg and Ballarat Courts), followed by the establishment of Specialist Family Violence Services in 2006 in Melbourne, Ringwood, Frankston, and Magistrates' Courts. A number of new positions were established in these specialist courts, as well as a small number of other courts, to assist and advise Affected Family Members (AFMs) and respondents when they attend court.
- A Common Risk Assessment Framework (CRAF) for family violence was introduced in Victoria in 2007, providing community based agencies, police and the courts with a consistent framework for assessing risk. Individual jurisdictions (eg. Victoria Police and the Magistrates' Court) have established risk assessment and management frameworks which are consistent with the CRAF. A major training program has been implemented, and training in the use of the CRAF has been broadened out to include a wider range of community based service providers.
- An Indigenous Family Violence Strategy was developed in 'Strong Culture, Strong People, Strong Families, Towards a Safer Future for Indigenous families and communities'.
- An important contextual development over the last decade has been the increased investment by government and the community sector to enable women and children to stay safely at home if they choose, with the perpetrator removed, where appropriate. Tenancy changes made under the FVPA 2008 have supported victims of family violence to become the legal tenant in rented premises (if they were not already). Programs in community based family violence services are funded to provide assistance with private rental,

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6 Victorian Law Reform Commission (VLRC) (2013)

strengthened after hours outreach services for AFMs, and other 'stay at home' initiatives.

- A range of community based services for men who use violence have been introduced, or strengthened in Victoria, with the intention of reducing, and eliminating violent behaviours, and providing greater safety for women and children. Examples include provision of emergency accommodation and case management support for perpetrators, enhanced service intake, telephone advice, counselling and referral services, and behaviour change programs.
- A systemic review of family violence deaths in Victoria was undertaken by the Coroners Court of Victoria.[7]
- Key elements of Victoria's reform strategy are to ensure communities do not tolerate family violence, and to reduce the incidence of family violence. A number of media campaigns and awareness raising initiatives (eg. ENOUGH campaign) have been conducted.
- In order to facilitate a more integrated approach, several statewide and regional advisory structures were established to facilitate the implementation of the Government's reform agenda. A Family Violence Interdepartmental Committee comprising Victoria Police, DoJ, DHS, DPCD and DEECD was established (chaired by DPCD). At regional and sub regional levels, Integrated Family Violence Committees were established, with membership comprising a wide range of community based family violence services, as well as police, Child Protection, courts, health services and schools.
- A major research program (SAFER) was funded, based at University of Melbourne. The objective of the research is to gain an understanding of how the Victorian family violence reforms are impacting on the safety and wellbeing of women and children, and on the accountability and responsibility of men who use violence. The research program has included an exploration of the perspectives and experiences of women, children and men; and the identification of the governance and collaborative processes in place to reduce the effects of family violence in Victoria.

2.3 Current Victorian Action Plan

The current Victorian action plan is described in *Victoria's Action Plan to Address Violence against Women and Children* (2102).[8] This plan highlights prevention and early intervention as critical to addressing violence against women and children, and notes that it is a priority is to target women and children at highest risk:

> *"We will act to identify women and children who are at the greatest risk of violence, and provide interventions that reduce their risk and increase their safety. Initiatives include the expansion of family violence risk assessment*

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7 Walsh, C., McIntyre, S-J., Brodie, L., Bugeja, L. & Hauge, S. 2012, *Victorian Systemic Review of Family Violence Deaths – First Report*, Coroners Court of Victoria, Melbourne, Victoria

8 Victorian government (2012) *Victoria's Action Plan to Address Violence against Women and Children*.

and management training, and resources for service professionals to identify and manage the safety of women and children at risk of violence ."[9]

The plan highlights the importance of strong and committed leadership across government and the community, and the centrality of an integrated approach.

The plan is being overseen by a Ministerial Advisory Group for Addressing Violence against Women and Children, with membership comprising Ministers of several relevant government departments, community sector organisations and peak bodies.

2.4 Current Victoria Police Strategies and Plans

Consistent with the Victorian family violence reform agenda, and complementing significant reforms within the community sector, Victoria Police has been proactive in developing a strategic response, and strengthened commitment to address family violence. Examples of major reforms include:

A new *Code of Practice for the Investigation of Family Violence*, introduced in 2004, which includes a requirement for police members to make referrals to community based organisations for AFMs, and for perpetrators.

Enhanced approaches to risk assessment and management including the use of the Family Violence Risk Assessment and Management report (commonly referred to as the L17), consistent with the CRAF.

Organisational developments designed to strengthen and provide a specialist response by Victoria Police. Examples include the creation of the roles of Family Violence Managers, Family Violence Advisers, and Family Violence Liaison Officers and the establishment of Family Violence Teams, within Victoria Police.

The strategy document notes that the role of Victoria Police in responding to family violence is to:[10]

- provide a respectful, timely, coordinated and thorough response to ensure victim safety and wellbeing, and
- hold perpetrators accountable through prompt action and thorough investigation

The Victoria Police strategy has four key objectives:

- To respond to and investigate family violence, sexual assault and child abuse more effectively
- To take a leadership role in driving integrated service delivery
- To reduce risk to children and young people of ongoing exposure to violence through prevention and early intervention
- To increase members' understanding about issues of violence against women and children, in order to provide appropriate policing responses.

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9 Idid. p4

10 Victoria Police (2009) Living Free From Violence – Upholding the Right, Victoria Police Strategy to Reduce Violence against Women and Children 2009 – 2014.

The strategy includes a detailed list of actions against each of these objectives. Strategies identified by Victoria Police to support a leadership role in driving integrated service delivery (Objective 2) include:

- participating in the development of an integrated strategy to better respond to high-risk victims and perpetrators of family violence. This includes multi-agency responses to risk management
- undertaking research and analysis of repeat family violence episodes to inform the statewide strategy to reduce repeat offending and victimisation.
- developing strategies to enhance collaboration between police, sexual assault and family violence services.

2.5 Select examples of responses to women and children at high risk of serious violence

2.5.1 Introduction

Several family violence models have been established in other jurisdictions in Australia and overseas, which specifically aim to assist women and children at high risk of serious violence and lethality.[11] The Victorian Strengthening Risk Management (SRM) initiative was broadly based on the Multi-Agency Risk Assessment Councils (MARACs) first established in the UK in 2003. At an early stage of the Victorian pilot project, staff from both pilot agencies visited the UK to learn about the implementation, and study the operation of MARACs.

The evaluation consultants obtained information about the MARACs, and information on other relevant overseas models through a review of the literature. A more detailed understanding of models in other States/ Territories in Australia was obtained through consultation and a review of literature. Selected examples are summarised below.

2.5.2 MARACs

MARACs were first introduced into the UK in 2003, and there are now more than 250 MARACs across the United Kingdom. MARACs comprise councils made up of key selected organizations which regularly meet to respond to high risk victims of domestic violence. The MARAC meetings provide a forum for information sharing and collaborative responses across a diverse range of adult and child focused services.

The purpose of MARACs is to produce coordinated (multi-agency) action plans to increase victims safety. Any agency may refer a case to a MARAC based on their assessment of risk.

Agencies that commonly attend MARACs include:

- Police
- Family violence services

[11] Further information about high risk family violence models is contained in Appendix 2, Literature review.

- Probation
- Children's Services
- Health
- Housing

There are three principal roles which support the operation of MARACs - Chairperson, MARAC Coordinators and Independent Domestic Violence Advisors. The core functions of each of these roles are briefly summarised below.[12, 13]

MARAC Chairperson

The role of the MARAC Chairperson is to ensure that member agencies have appropriate information; that meetings are used for action planning (aimed at strengthening the safety of women and children); that discussions are focused and kept to time. Another role is to facilitate consistent attendance of representatives. MARACs are mainly led and chaired by Police (93% of MARAC Chairs are Police).

MARAC Coordinators

MARAC Coordinators provide coordination and administrative support to MARACs. The two main functions are administrative support to the MARAC, and service system development. Administrative support includes preparation and distribution of agenda and documentation before meetings; preparing accurate minutes of meetings; maintaining an action list, and following up on actions agreed at meetings; ensuring data is collected; preparation of reports on the operation of MARAC, and supporting the work of the Chairperson.

Service system development responsibilities include liaison and co-ordination with local and member agencies; working closely with all MARAC partners to ensure they are familiar with processes and their role; to arrange training as required; liaising with a full range of potential referral agencies, to ensure they are aware of the MARAC; and helping ensure consistency in referral of cases from referring agencies, based on the use of a common risk identification tool.

Independent Domestic Violence Advisors

Independent Domestic Violence Advisors (IDVAs) are professional domestic violence professional staff who work with high-risk victims of domestic violence. IDVAs play a key role in MARACs acting as a representative of victims at meetings, and being the primary point of contact for victims. IDVAs often take on the ongoing case management role for MARAC cases. Tasks include assessing risk; developing safety plans; monitoring the implementation of safety plans; providing direct support; advocating on behalf of women and children with required services; providing clients with information and advice; providing court support; making referrals to MARACs if required; participating in the MARAC framework; attending and participating in meetings as required, and following up on actions agreed in the MARAC.

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12 There are several position descriptions available for these positions.

13 The SRMDP pilots also includes equivalents to these three positions (ie. Chairperson, Coordinator, and SRMDP women's case worker). The SRMDP also includes case management positions for men, and for children, which are not explicitly part of the MARAC model.

Evaluation of MARACs

A number of evaluations and reviews of MARACs have been undertaken. The earliest evaluation was undertaken in 2004 (Robinson, 2004). Subsequent reviews included the views of women (Robinson, 2005); a cost benefit analysis (CAADA, 2010); and studies on the effectiveness of specific elements of the MARAC, for example Independent Domestic Violence Advisors (Robinson, 2009).

A recent evaluation of MARACs (Cordis Bright, 2012) showed:

- The significant majority of MARACs meet monthly, or more frequently if required.
- A standardised assessment/ referral form is used (CAADA-DASH), and a referral is triggered by the number of ticks on the referral form, combined with worker professional judgement and input
- The majority (80%) of referrals to MARACs are from the Police
- The majority of MARACs (70%) discuss between 6 and 20 cases per meeting and meetings generally last up to 4 hours. MARAC 'caseloads' range between 8 and 18 cases, with most between 7 and 12 cases.
- Core agencies attending MARACs include Police, Independent Domestic Violence Advisor (IDVA), Health services (community health), Probation, Housing and Children's Services.

The UK Home Office provides funding for Coordinators and IDVAs, as well as for training and service system development.

The UK has given consideration to an enhanced response to men (as partners of women referred to MARACs), however has not progressed this. One review[14] found that due to the level of criminality and violence of the specific cohort of men, only an estimated 11% of men in the study were potentially suitable for a case management type response (and only half of these men were successfully referred to services).

2.5.3 South Australian Family Safety Framework

South Australia has established a legislated multi-agency response to women and women with children who are at risk of serious violence and lethality. The Family Safety Framework (FSF) was developed under the auspice of the South Australian Government's Women's Safety Strategy and Keeping them Safe – Child Protection Agenda.[15]

The South Australian Framework includes formal collaboration between key agencies, through specialist Family Safety Meetings, which are held fortnightly. The Framework involves an agreement across government Departments and agencies, for a multi-agency approach to responding to women and children assessed as imminent high risk of family violence.

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14 Blacklock and Debbonaire (2011) Fresh Start, Respect, UK.

15 Jayne Marshall, J., Ziersch, E. and Hudson N. (2008) Family Safety Framework, Final Evaluation Report, Office of Crime Statistics and Research, South Australian Attorney General's Department, Adelaide.

A common risk assessment Form is used to assess high risk of serious injury or death, and 'eligibility' for referral to a Family Safety Meeting. Unlike many jurisdictions, the Form includes weightings, which allow the calculation of a risk 'score', which can be used to guide workers.[16,17]

A formal risk assessment is carried out by the agency or service that receives initial contact or referral, in order to determine if a case meets the criteria for referral to a Family Safety Meeting. This includes an assessment of key risk factors that are associated with the potential for serious injury or death of the victim/s.

Women and children who are assessed to be at highest, imminent risk are referred to a local Family Safety Meeting (FSM), attended by a range of agencies, and generally chaired by SA Police. The purpose of the meeting is to share information, and to implement a Positive Action Plan for each referral.

Family Safety Meeting members include representatives from:

- South Australian Police (SAPOL) (also Chair)
- Department for Families and Communities
- Attorney-General's Department
- Department of Health
- Department of Correctional Services
- Department of Education and Children's Services
- Non-government women's domestic violence services

The South Australian Cabinet approved a trial of the Family Safety Framework at three sites, including two metropolitan regions and one non-metropolitan region, commencing in August 2007.[18] The one year trial involved 45 Family Safety Meetings, at which 67 referrals were considered.

An evaluation of the trial[19] gave broad support to the Framework, and noted the important contribution and collaboration of agencies involved, with SAPOL taking a lead role. The evaluation found that the majority of victims were assessed as being safer as a result of the intervention. Following the 2008 evaluation, the government committed to roll out the Safety Framework across South Australia.

The Framework is currently provided in 19 regions in South Australia, and it is expected to be fully rolled out by the end of 2013.

The South Australian initiative includes funding for a coordination function, which is provided by a Statewide organisation, the South Australian Victim Support Service (VSS). The VSS has a presence in most areas in which FSM meetings are held, and provides the coordination function in a way which can ensure consistency in FSM operations across the state. There are reported advantages in having a single

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16 Family Safety Framework, Practice Manual, www.officeforwomen.sa.au

17 Ibid.

18 Metropolitan areas were Holden Hill and Noarlunga (and the South Coast), and non metropolitan area was based around Port Augusta.

19 Office of Crime Statistics and Research, South Australian Attorney General's Department (2008) *Family Safety Framework – Final Evaluation Report*, November

statewide service perform the coordination function for all FSMs. A single body can facilitate the identification and reporting of common issues and systemic challenges. The South Australian model does not include funding for an enhanced or additional case management function for women and children, however funding is provided for training in the FSM model, which is delivered jointly by SAPOL and the community sector.

The implementation of the South Australian Framework is supported by a high level state-wide Committee, with members nominated by Chief Executives of the participating departments. The Committee is chaired by the Office for Women, maintains oversight of the activities outlined in the Framework, and resolves barriers or lack of participation or coordination between agencies/ systems.

Cabinet endorsement and high level support have reportedly been essential requirements for the successful roll out of the FSF in SA.

2.5.4 Other initiatives in Victoria

Two initiatives of note have been established in Victoria, which incorporate some of the functions of a targeted response to women and children at high risk of serious violence and lethality.

In the Western metropolitan region of Melbourne Victoria Police has partnered with Women's Health West family violence outreach service to establish a response to women and children who are at extreme and imminent risk of serious harm or lethality. Multi-agency meetings, called Integrated Coordinated Response Conferences (ICRCs) are held as soon as possible when an extreme risk case is identified. One case is considered per meeting, and meetings last 1-2 hours. Approximately 16 ICRCs have been convened in a 2 year period.

An evaluation of the initiative has been completed, which reported that the initiative has been successful in keeping women and children at highest risk, safe. Women attend the ICRC meetings, which include Victoria Police; women's family violence services; men's family violence services; community health services and others as required.

The second multi-agency initiative, which is led by Victoria Police in the northern metropolitan region of Melbourne, focuses on recidivist high risk family violence offenders. The initiative covers the municipalities of Darebin, Banyule and Whittlesea, and includes Berry Street (the family violence provider for the region), Child Protection, Corrections and men's services, all of whom attend meetings. Meetings are held fortnightly, generally last all day, and consider up to 16 cases per day. Referrals to the meeting are selected by Victoria Police, based on the criteria of serious risk to women and children through repeated experiences of violence.

These two Victorian initiatives are good examples of the commitment by the relevant Victoria Police members to protect women and children in extremely dangerous situations, and they highlight the value of a collaborative approach to risk management. In both cases noted, the Victoria Police response is supported by police Family Violence Teams.

Appendix 3 provides a summary comparison of select elements of the different models noted in this section.

2.6 Rationale for the SRMDP in Victoria

The functioning family violence service system in Victoria can in part be attributed to the significant reforms and integration initiatives that have been implemented in recent years, however, women and children are still being seriously harmed and murdered in family violence incidents in Victoria, in spite of the existing service system and resources.

The *Victorian Systemic Review of Family Violence Deaths*[20] estimated that more than 50% of homicides in Victoria in the period 2000 to 2010, were family violence related, and at least 25% of all homicides were caused by intimate partner violence. Apart from the trauma, harm and death to women and children, there are significant costs associated with family violence, and in particular family violence which results in serious harm or lethality.[21]

This context highlighted the need for the Victorian government to develop an intentional response to women and children at highest risk. A strengthened multi-agency risk assessment and risk management strategy was required, specifically for this highest risk group of women and children, over and above what the family violence service system had provided to date.

Two models in particular which have been successfully implemented and evaluated overseas (eg. MARACs), and in South Australia, informed the development and implementation of the pilots in Victoria.

Key features of these models included:

- multi-agency panels in regional areas, comprising senior agency representatives meeting regularly to share relevant confidential information, and to develop creative and collaborative risk management strategies, including strategies to hold perpetrators accountable.
- additional family violence resources to identify, engage and assist women and children at highest risk, and to provide a coordination role to the multi-agency panels
- formal whole of government authorisation, commitment and participation

In 2010 the Victorian government decided to trial the SRMDP pilots, to test the value of a strengthened response for women and children at highest risk.

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20 Walsh et. al. (2012)

21 For example, there are additional costs to police, Courts, and health services, and women may experience loss of income (CAADA, 2010)

3 ESTABLISHMENT OF THE SRMDP PILOTS

3.1 Introduction

This section provides a summary of the establishment of the SRMDP pilots in the City of Hume and the City of Greater Geelong.[22] The section draws on the original DHS submission document to describe the intended SRMDP model (section 3.2).

Section 3.3 summarises the actual establishment of the SRM case management models, and section 3.4 summarises key issues associated with the establishment of the RAMPs. The establishment of partnerships is discussed in section 3.5, and section 3.6 provides a summary, with learnings for future establishment.

The information presented draws on a range of sources, including an initial Establishment Report, which was produced by the evaluation consultants in December 2012. Significant changes made to each of the agency's service models during the post-establishment period, are also noted.

3.2 The Victorian Strengthening Risk Management Demonstration Project

3.2.1 Introduction

The commitment to strengthen family violence risk management across the service system has been noted in section 2 of this report. The Strengthening Risk Management Demonstration Project was specifically established by the Victorian Department of Human Services in 2011, to test the implementation and delivery of coordinated multi-agency approaches to strengthen family violence risk management.

Initial funding for the demonstration projects was made available through the Service Integration Projects initiative by the Commonwealth Government. Further funding was made available through the joint Commonwealth-State National Partnership Agreement – Homelessness (NPA-H). It was expected that the Victorian Demonstration Project would inform future directions, and provide guidance to the whole of government Family Violence Interdepartmental Committee (IDC). Contract management, design and oversight of the Demonstration project was undertaken by the DHS H&CB Division.

Building on learnings from other programs (eg. the MARAC model in the UK, and Family Safety Meetings in South Australia)[23] DHS prepared a submission document to assist service providers in the preparation and lodgment of proposals to conduct pilot demonstration projects.

Funding was to be made available for two pilots, each operating for a period of 2 years, from July 2011 to June 2013.

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22 The Terms of reference included a specific requirement to report on the establishment of the SRMDP pilots.

23 See section 2.3

The submission document provided a description of DHS' expectations including pilot objectives, definition of the target group, service model elements including staffing roles, funding and costs.

A key focus of the pilots was to be on partnership development, and multi-agency, integrated responses to women and children at high risk, and multi-agency responses to increase the accountability of men who use violence.

DHS also commissioned a project to develop a Strengthening Risk Management Guidelines and Framework document, to be used by the pilot agencies and their partners. This document was not completed.

DHS undertook a select tender process for the pilot projects. Submissions to undertake the pilots were invited from two agencies:

- Berry Street Northern Family and Domestic Violence Service (NFDVS), to cover the City of Hume
- Bethany Community Services, to cover the City of Greater Geelong.

The selection of sites for the pilots was influenced by the comparative incidence of family violence; the level of child protection notifications and intervention orders in each of the area(s); and the wish to include metropolitan and regional contexts. Each of the two agencies prepared a submission in response to the invitation from DHS. Submissions were reviewed, and following discussion and negotiation, service agreements were finalised.

The select submission process undertaken by DHS was contentious in the family violence and related service sectors. This was exacerbated by the lack of supporting guidelines and documentation made available to the pilots. Together, these factors hindered relationship development and the efficient establishment of the pilots in each of the selected regions.

3.2.2 SRMDP service model (intended)

A summary of the intended SRMDP service model, as described in the DHS submission documents, is provided below.

Target group

The intended target group for the Demonstration Projects comprised women and women with children experiencing or at risk of family violence, with a focus on high risk of serious harm or lethality. The tender submission notes:

> *While the service system is working in a more coordinated and consistent way, situations will still present where women and children are at increased risk of harm or lethality. This highlights the need to continue to evolve a system which provides for consistent and timely responses when assessing, planning and responding to the needs of women and children regardless of her circumstances, and where she may enter the family violence system.*

In addition to the focus on women and women with children experiencing violence, the pilot model included a case management component for children in identified high risk families; and for male partners/ ex partners who had perpetrated violence against the women and children engaged in the pilot.

The 'target group' for the pilots was thus intended to include women at increased risk of serious harm or lethality from family violence; including women with accompanying children; accompanying children and young people at high risk; and men who use life threatening violence.

The DHS documentation noted that the pilot models were intended to provide a focused response to:

- recidivist cases (with 3 or more repeat attendances by police)
- women and children experiencing heightened risk episodes
- child protection referrals resulting from high risk family violence situations
- women and children with complex needs and where multiple agencies are involved.

A formal definition of the target group for the pilots was intended to be finalised between the pilot agencies and DHS H&CB, informed by the anticipated SRM Guidelines and Framework, and further refined by agreement with other regional partners and providers (including the Police).

SRMDP resources

The SRM Demonstration Projects were each funded to employ a dedicated team to implement and deliver a coordinated approach to family violence risk assessment and management, through direct service provision (case management), and through establishing and supporting multi-agency Risk Assessment and Management Panels (RAMPs).

The SRM pilot agencies were expected to provide:

- a lead role to ensure timely, coordinated services and responses 'wrapped around' AFMs
- establishment and coordination of the multi-agency Risk Assessment and Management Panels (RAMPs)

In addition to funding for staffing positions, the pilots were funded for establishment and brokerage. Total funding for the two pilots is shown in Table 3.1.

Table 3.1: Funding for each SRM pilot (2011 to 2013)

Component	Amount ($'000)
Staffing	875
Establishment	40
Brokerage	58
Total	972

Source: DHS Tender submission 2011

Each pilot team was funded for a full time Coordinator (1 EFT), plus 3 case managers (2.6 EFT). The DHS submission document provided a description of the intended roles and functions of the key staff:

- RAMP Chair

- SRM Coordinator
- Women's case manager
- Men's case manager
- Children's case manager

DHS committed substantial resources to the Demonstration project in the belief it would result in useful transferable learnings. The pilots were intended to identify good practice approaches to inform a potential broader roll out of a multi-agency statewide response, to strengthen risk assessment and risk management for women and women with children in Victoria experiencing and at risk of serious violence and lethality.

Performance targets

DHS set annual case management targets of 100 individuals per annum per pilot, comprising a mix of women, children and men.[24] This relatively low target (compared to pilot resources) was flexible, to enable provision of intensive and longer term support, and trialing of different risk management and case management approaches, if required. Resources also provided for establishment and partnership development, and multi-agency coordination functions, although specific performance targets were not set for these activities.

Risk Assessment and Management Panels (RAMPs)

The RAMPs were a key component of the Demonstration Project. RAMPs were intended to be established, in order to provide a regular (monthly) multi-agency forum for risk assessment, and risk management, through information sharing, and action planning.

A key purpose of RAMPs was to ensure that all relevant information on current cases would be shared to enable a comprehensive assessment and a well informed action planning process. RAMPs were to have a broad monitoring role for high risk cases, with clearly defined actions, responsibilities and timelines to be developed for each client. The DHS document noted that RAMPs would also provide case coordination, which might include making referrals to other agencies for follow up service provision.

The intended RAMP model comprised a Chairperson, core RAMP members and non core members. Core members were to include lead agency (pilot) representatives, and representatives of partner agencies and organisations who could commit to participate. Functions of RAMP members were to include preparation and sharing of required information; assisting in risk assessment and risk management planning; and ensuring actions arising from the RAMP to protect AFMs and hold perpetrators to account, would be implemented.

RAMP core 'partner' agencies noted in the DHS document included:

- specialist family violence services (for women and children; and men's services)

[24] Targets were nominal only, in recognition that the agencies may have needed to trial a range of approaches and models.

- Victoria Police
- Corrections Victoria
- Legal services
- DHS Child Protection
- Child FIRST
- Family support services

Non-core members (who it was hoped would attend RAMP meetings as required, or provide information on a case by case basis) included:

- homelessness and housing agencies
- Centres Against Sexual Assault (CASA)
- Victims Assistance and Counselling Programs
- mental health services
- drug and alcohol services
- disability services
- health services (community, hospital, etc.)
- Aboriginal agencies
- CALD or refugee agencies
- employment, education and training providers
- maternal & child health services.

Office of Housing and Centrelink were not initially identified by DHS as core RAMP members.

Authorising environment

The DHS submission documents indicated an expectation that pilot agencies would establish new 'governance' arrangements, to underpin the regular RAMP meetings at which critical confidential information could be shared, and joint decisions made. Each member agency would however, be responsible for its own decisions.

The RAMPs were intended to be supported by Strengthening Risk Management Guidelines and a Memorandum of Understanding (MoU) that included a description of information sharing provisions (subject to privacy laws), collaborative processes, roles and responsibilities, confidentiality agreements and clearly defined decision making processes. No agreed template for a MoU was available prior to implementation, and each pilot agency needed to develop separate MoUs with their various partners. A common understanding of privacy law was fundamental to the effective operation of RAMPs, however key stakeholders (prospective RAMP members) had differing understandings and interpretations of privacy laws, as they pertained to the multi-agency forums, and the specific client cohort. It was necessary for DHS to seek clarification from the Privacy Commissioner, during the early months of the pilot. It was also necessary for Victoria Police to release information sharing guidelines for police members attending RAMPs (May/ June 2012).

At the service system level each pilot region had established integrated family violence committees and structures in place, comprising key family violence and other relevant services. The DHS model proposed that these existing regional structures would be utilised to provide support to the RAMPs.

3.3 Establishment of the SRM (case management) service models by pilot agencies

3.3.1 Introduction

This section summarises the actual SRM services models which were established by the funded agencies. Each agency established its SRM Demonstration pilot differently, according to its individual organisational and regional contexts. Both pilot agencies made changes to their service models during the course of the Demonstration Project, in response to perceived challenges, learnings and other organisational developments.

The way that the pilot agencies established their SRM service models was informed by several factors, including existing agency experience, professional knowledge and understanding of good practice in relation to high risk family violence; information provided by DHS in the submission brief; existing agency programs and structures; relationships with other key family violence providers; and knowledge gained from a study tour to the United Kingdom, where pilot agency staff visited a number of MARACs.

The study tour was reportedly beneficial, and assisted key staff in both agencies to enhance their understanding of the UK model for responding to women and children at high risk.[25] Each agency produced a brief report of their study tour, however a more intentional analysis of the adaptation of the UK MARAC model to the Victorian context and DHS pilot model, could have been undertaken.

As noted, the main service model information available to the pilot agencies was provided by DHS for the purposes of the tender submission. This was not however, intended as the basis for fully operationalising the pilot service models. In the absence of a finalised Guidelines and Framework Document, each agency developed its own SRM model documentation. This was inefficient, involved duplication of effort, and extended the establishment process.

Major establishment tasks undertaken by each pilot agency included:

- organisational development – 'locating' of the SRMDP appropriately within the organisation; staffing arrangements and recruitment of staff
- SRM service model design, development and documentation
- establishing referral pathways for the SRMDP - identification and assessment of women and children at high risk; identification and assessment of men who use violence
- partnership development, including the establishment and coordination of the RAMP

[25] Four Berry Street staff, and one Bethany staff member went on the study tour.

- preparation of MoUs and other partnership material
- promotion of the SRMDP to relevant stakeholders.

Comments in relation to each of the pilots are summarised below.

3.3.2 Bethany Community Services

Bethany Community Services is a major provider of family services in the Geelong region, and operates programs to assist men who use violence, such as men's behaviour change programs, men's case management, and enhanced service intake for men who use violence. Bethany receives L17 referrals from Victoria Police for men who use violence, and the L17 referrals for women in the region are sent to the women's family violence outreach service, Zena.

Bethany's other programs include ChildFIRST; housing and homelessness; relationship and parenting programs, family violence counselling for women; educational, skill based and therapeutic programs for children. [redacted] and as noted did not receive Police L17s for women and children. It was consequently going to be a challenge for Bethany to gain access to the intended high risk adult female client group, without established referral pathways. [redacted]

Organisational 'location' of the Geelong SRMDP

Agency management initially located the SRMDP team within the Relationship and Family Violence Services program area within Bethany. This program area includes:

- men's programs (men's behaviour change programs, men's case management, enhanced intake)
- family relationship counselling
- education and skills training
- 'parents and kids' in schools project
- specialist family violence counsellor for women.

In July 2012 Bethany implemented an organisational restructure to better support the SRMDP. This involved the creation of a dedicated Housing and Family Violence team, separate from the Relationships program area. The restructure was based on a commitment to develop a strengthened SRM team approach, enhanced supervision arrangements, organisational separation of women's and men's family violence services, and an increased focus on perpetrator accountability.

Staffing arrangements

Bethany established the following SRMDP positions:

- Coordinator plus Team Leader
- Men's case manager

- Children's case manager
- Women's case manager.

Roles are discussed briefly below.

Coordinator and Team Leader functions:

Originally the Coordinator role for the Geelong SRMDP was shared across two positions – a managerial position and a Team Leader position, with both positions responsible for other functions and program areas within Bethany. The incumbent for the managerial position, participated in the UK study tour of MARACs, and played a key role in the establishment of the Geelong SRMDP pilot.

The managerial position was responsible for establishment and overall accountability for the Geelong SRM program; development of program guidelines, tools and frameworks; partnership development, liaison and education, including achieving sign off on the MoU; supervision of the Team leader, and representation of the SRMDP at the statewide, regional and network meetings. The incumbent was also the initial Chair of the RAMP.

The team leader position was responsible for coordinating SRMDP and RAMP activities; supervision of the 3 SRMDP staff; development of data systems and meeting data and reporting requirements; and provision of administrative support to the RAMP. The team leader was also responsible for screening eligible referrals for the SRMDP program, and shared partnership development responsibilities with the Coordinator.

During the restructure of the SRMDP model in mid 2012 the Coordinator roles were shared between 3 staff, with the SRMDP Team Leader maintaining some of the original functions, plus additional SRMDP partnership development responsibilities. Over time with staffing changes, the organisational arrangements have changed again, however the direct service delivery model has been maintained as a 'team' approach (see below). The role of Chairperson is undertaken by the General Manager Community Services for Bethany.

SRM women's case manager

The Bethany SRM women's case manager provides support, assistance and case management to women and women with children experiencing family violence. During the first year of the Geelong pilot the Women's Case Manager worked with relatively high numbers of women experiencing family violence, however many of these women were outside of the intended SRMDP target group. As part of the re-structure in mid 2012, Bethany clarified and tightened the focus of the women's case management role ('high risk'), more closely aligning the model with the SRMDP objectives.

SRM children's case manager

The Bethany SRM children's role was intended to provide a response to children who were experiencing and/or witnessing high levels of severe violence. Early difficulties finding an appropriate person to fill the children's case management position, led Bethany to re-define the role as a Children's Therapeutic Case Manager.

This worker was, over time, able to assist children within the SRM program (ie. women and children who were at high risk), in ways which could contribute to the achievement of SRM outcomes. Examples of the Bethany case management role included:

- conducting individual risk assessments, developing enhanced safety plans (particularly with older children)
- ensuring safety plans were consistent with/ complemented the mother's safety plan
- conducting detailed, formal case planning and psychological assessments with individual children
- developing protective factors by making referrals and linking children with other services and resources
- providing therapeutic responses (including counselling) directly to individual children and siblings
- enhancing the mother's understanding of the importance of protecting children from exposure to family violence, in partnership with the SRM women's case manager, and
- working in collaboration with DHS Child Protection and family support services where appropriate.

SRM men's case manager

The Bethany SRM men's case manager was intended to provide a response to men whose AFMs were being assisted by the SRM women's or children's case managers, and/ or men likely to cause serious injury to women and children. The establishment report identified that in spite of the strong experience and knowledge base in the agency in working with men who use violence, the SRM men's case management position was not established optimally. Bethany encountered significant difficulties in engaging high risk men (ie. partners of SRMDP women's case management clients). [redacted]

In mid 2012, Bethany re-defined and clarified the purpose and scope of the men's case management role. The new role was more closely aligned with the SRMDP objectives; working relationships and initiatives with Victoria Police were strengthened; stronger links were made with the pre-existing Bethany programs for men who use violence; and practice was enhanced to ensure compliance with NTV principles and standards.

Recruitment

Bethany prepared position descriptions for each of the four SRMDP staff, which were broadly consistent with the DHS service specifications. The Team Leader was recruited at SW3, and the other 3 staff were initially recruited at SW2 levels. Recruitment commenced early June 2011, however Bethany experienced difficulty in

filling all the positions, so the establishment of staffing was slightly delayed. Bethany faced several challenges with SRMDP staffing and organisational arrangements throughout the first year of operation, mainly relating to a 'lack of fit' with qualifications and experience required by the complex and challenging roles. Service re-development in 2012 led to the appointment of a women's case manager, and children's therapeutic case manager with relevant qualifications and experience (each employed at SW3 levels).

Referral pathways

The majority of referrals to the Bethany SRM program came from within the agency (ie. general intake, and other relevant program areas). During the establishment period Bethany and Zena management were not able to reach agreement on a protocol relating to L17 referrals, or a partnership arrangement to enable the Bethany SRM team to gain access to women and children at highest risk. This led to Bethany broadening the eligibility criteria and referral pathways to the SRM program, at least during the first year of operation. During mid to late 2012, Bethany undertook a major review and made a number of changes to strengthen the SRMDP model. This included a refocus on the intended target group, and major investment of effort with specific external agencies, including Zena, Child Protection, Victoria Police, Corrections and Barwon Health, to develop stronger relationships and pathways into the SRM program and the RAMP (see section 5).

3.3.3 Berry Street

Agency information

Berry Street Northern Family and Domestic Violence Services is a major provider of family violence outreach services for women and children in the northern metropolitan region, and prior to the implementation of the pilot, was providing a range of programs directly relevant to women and children at high risk of serious violence and lethality.

Berry Street had established priorities, targeted client groups, working relationships with a range of relevant services, and existing referral pathways for women and children, experiencing family violence in the region. Berry Street NFDVS receives all the Police L17 referrals for the region for women and children, including for the City of Hume.

L17s for men in the region are sent to the Men's Active Referral Service (MARS) auspiced by Plenty Valley Community Health. Berry Street had no experience in providing services directly to perpetrators of violence, and no established referral pathways for men who use violence. It was consequently going to be a challenge for Berry Street to gain access to the intended male target group, without a close working relationship with MARS. This partnership did not eventuate, and Berry Street experienced a number of challenges in its efforts to establish a men's case management position in the SRMDP pilot.

Organisational location of the SRMDP

Berry Street 'located' the SRMDP within the broader Northern Family and Domestic Violence Service (NFDVS). The NFDVS comprises the following programs and service delivery components for women and children experiencing family violence:

- Intake and assessment
- Outreach and short term assistance
- Case management
- Court Support
- Northern Crisis Accommodation and Referral Service (NCARS)
- Financial Support and Information
- Repeat Police Attendance/ Recidivist List
- Housing Responses, including private rental brokerage program
- Child & Adolescent Responses (including the Turtle program)
- Indigenous program
- Secondary consultations with a wide range of service providers

Staffing arrangements

Berry Street established the following SRMDP positions:

- Coordinator
- Women's and children's case managers (2 staff)
- Men's case manager
- RAMP Chair

Positions are discussed briefly below.

Coordinator

A single person was appointed to the SRMDP Coordinator position.

Responsibilities included establishment and overall accountability for the Hume SRM program; development of program guidelines, tools and frameworks; partnership development, liaison and education, including achieving sign off on the MoU; representation of the SRMDP at the statewide, regional and network meetings; coordination of SRMDP and RAMP activities; supervision of 3 SRMDP staff; development of data systems and meeting data and reporting requirements; and administrative support to the RAMP.

A key aspect of the role involved the development and implementation of a daily triage process to identify and contact women and women with children at high risk in Hume region.

The Coordinator commenced with the SRMDP in early July 2011, and participated in the UK study tour of MARACs, together with 2 senior managers and a case manager. The Coordinator, together with Berry Street management support, played a key role in the establishment of the SRMDP pilot for women and children.

From late 2012, the dedicated Hume SRM Coordinator was made responsible for a high risk and repeat offender program, for the entire northern region catchment (but still maintaining a focus on Hume) until the end of June 2014.

Women and children's case manager(s)

During the establishment stage Berry Street negotiated with DHS to combine the intended single Women's case manager, and single Children's case manager roles, into two 'women and children' case management positions. This was deemed to be more consistent with Berry Street's philosophy of working together with women and children experiencing violence.

In this model, it was intended that the needs of accompanying children would be assessed and addressed in the context of the work with their mothers. Where required, it was also planned that a separate therapeutic response (for a proportion of identified 'SRMDP' accompanying children), would be provided through a close working relationship between the SRMDP and Berry Street's Turtle program.

Two staff were appointed to the combined SRM case management role, to work specifically with women and children at high risk of serious harm and lethality. Berry Street experienced staffing issues related to the stressful nature of the work, and which resulted in vacancies in mid 2012.

From late 2012 into 2013, the Hume SRM pilot funds were utilised to appoint 2 new staff to the NFDVS team, working across the northern region wide (theoretically filling the HSRM vacancies), and with all individual NFDVS staff potentially providing SRM case management, to identified women and children in Hume region, at high risk, as part of their case load. Berry Street was committed in principle to senior and advanced practitioner staff within the NFDVS team, providing and/or overseeing the SRM response to women and children at highest risk in Hume.

It was challenging for the external evaluation to 'keep track' of the organisational changes and use of pilot resources in the Berry Street models, particularly once the service formally moved away from operating the dedicated Hume SRM team model.

Men's Case Manager

The establishment report identified that the SRM men's case management position for the Hume SRMDP was not established optimally. The agency experienced considerable difficulty recruiting to the position. The men's case manager (once appointed) attempted to target high risk men whose affected family members had been presented to RAMP (ie. not all SRMDP clients). This was consistent with the intent of the pilot, however it became apparent that the majority of male partners were too dangerous, and/or too difficult to engage to enable a case management response, and some women would not give consent for men to be contacted, out of fear. The men's case manager provided a case management response to two male perpetrators of violence, however given the challenges, Berry Street decided to trial alternative approaches for the position. These included developing links with Corrections, and attempting to strengthen links with men's family violence services in the region, however did not constitute a direct service delivery role with men. A partner contact role was trialed for a brief period. The Hume men's case management position was subsequently discontinued in the second half of 2012.

Recruitment

Berry Street prepared position descriptions for each of the SRMDP staff. The Coordinator was recruited at SW4, and the 3 case management staff were recruited at SW3 levels. Recruitment commenced early June 2011. Three positions including the Coordinator, and a men's case manager were filled during 2011, but the second women and children's case manager did not commence until March 2012, a delay of more than 8 months. The program experienced a number of staff shortages and staff changes during 2012, and subsequently changed the staffing model. The men's case management component of the model was formally discontinued in mid 2012.

Referral pathways

The establishment of the main referral pathway into the Hume SRMDP was relatively straightforward as it was based on identifying women and children at 'high risk' from the L17 referrals which are routinely received from Victoria Police. The SRMDP Coordinator identified on a daily basis all L17s for AFMs in the City of Hume and selected those women who were considered to be at high risk of serious/ lethal violence, based on a 'triage' process.

The SRMDP team (two women and children's workers and the Coordinator) attempted to make contact with women who were assessed as being at 'high risk'. Women who were successfully contacted received a family violence response from an SRM team member (consistent with the NFDVS team model), which included risk assessment, safety planning, information and advice, referral, etc.

Women who were not assessed as requiring the assistance of RAMP, were provided with ongoing family violence assistance and/or case management (if appropriate) by a SRM case worker. Clients who were assessed as being at very high risk were provided with ongoing safety planning and case management assistance, and where appropriate, were referred to RAMP.

The SRMDP 'team' was specifically responsible for the high risk pilot in Hume until mid to late 2012. Due to staff model changes, the specialist 'women and children's' case management roles were then subsumed into the broader NFDVS team. Hume L17 referrals were still separately identified by the SRM Coordinator, however the SRMDP intake and subsequent case management functions were undertaken by NFVDS workers, and overseen by the SRM Coordinator. This may have weakened the capacity of Berry Street to effectively identify and engage with the target group, as significantly fewer referrals were made to RAMP during the period July to December 2012 when the changes were being implemented. During 2013 the service appeared to consolidate and refocus; greater attention was paid to Hume high risk cases being allocated to practitioners with advanced skills; a new Coordinator was appointed; and referrals to RAMP increased.

3.4 Establishment of RAMPs

Establishment of RAMPs was a key task for each of the pilot agencies. This involved a number of activities.

Membership

As noted, the DHS model specifications included a number of organisations as suggested RAMP members. It was a major focus during establishment for each of the auspice agencies to approach partners and convene initial multi-agency meetings. Both SRMDPs successfully established key core membership comprising:

- Auspice agency
- Victoria Police
- Corrections
- DHS Child Protection
- ChildFIRST

The Hume RAMP also included active representation from number of other partner agencies:

- North West Area Mental Health
- ReGen drug and alcohol services
- Vincent Care
- Office of Housing
- Maternal and Child Health
- Northern Health
- Centrelink

The Geelong RAMP included active representation from the men's family violence program within its own service, and also the following agencies:

- Zena Women's Services (family violence refuge and outreach)
- Family support services
- Barwon Community Legal Service

Later in the pilot Barwon Health partnered the Geelong RAMP, but was unable to attend RAMP meetings due to scheduling.

RAMP chair

Bethany initially appointed the Manager Relationships and Family Violence Services (who was also SRM Co-coordinator) as the Chair of the Geelong RAMP. This changed in July 2012 when the Executive Manager, Bethany Community Support assumed the role of RAMP Chair. In 2013 Bethany assigned a separate secretariat position to prepare and distribute RAMP information, take minutes during the meetings, and distribute minutes.

Berry Street contracted an independent person to chair the Hume RAMP. The incumbent had formerly been employed by Berry Street as a Regional Manager. The SRM Coordinator undertook all the administrative functions.

Frequency and location of meetings

Both pilots scheduled RAMP meetings monthly. The first RAMPs were:

- November 2011 (Berry Street)
- December 2011 (Bethany)

The Hume RAMP was held at Department of Justice (Corrections) offices, and the Geelong RAMP was held at Bethany's offices. During 2013 the Geelong RAMP was held in the offices of other partners, including the DHS Regional office.

Memorandum of Understanding

A Memorandum of Understanding was intended to form the basis for collaborative practice, and in particular to provide a formal agreement for all RAMP members. The pilot agencies were responsible for developing the MoUs and obtaining agreement. The preparation of the MoUs was a time consuming and challenging task for both pilots, involving several iterations and revisions. RAMP members at both sites agreed 'in principle' to the MoU but it proved extremely difficult to obtain 'sign-up' to the MoU by the majority of members. No agencies signed the document for some time. Member agencies nevertheless agreed that RAMP meetings would proceed, and operate generally in accordance with the expectations outlined in the draft MoU, including in accordance with the advice of the Privacy Commissioner and Victoria Police. It was subsequently decided that the MoU would be referred to as a Protocol, at the request of Victoria Police.

Regional oversight

It was envisaged that existing regional integrated family violence networks would oversee and support the SRMDP pilots. This did not occur at either pilot site.

3.5 Establishment of partnerships

The effective establishment and operation of the SRMDP and RAMP models were contingent on goodwill and collaboration between the pilot agency and other key agencies. The 'participation' of other agencies involved them accepting the invitation to be a partner 'core' RAMP member; making referrals to RAMP; participating in RAMP meetings; and providing services/ responses to RAMP clients in accordance with RAMP action plans.

While many partner agencies in both regions were already participating in an integrated family violence network, the pilots required RAMP members to make an additional commitment:

- to research and communicate confidential information in the interests of keeping identified women and children at highest risk, safe
- to attend monthly meetings where they would be expected to make 'on the spot' contributions, decisions and commitments
- to make referrals to the SRM/ RAMP
- to complete agreed actions post RAMP in a timely and proactive way.

In order to make this commitment of time and resources, prospective member agencies needed to clearly understand the model, and the implications of their participation.

However, the information and communication provided to the sector about the SRMDP, and the RAMP, was initially not sufficiently well developed or supported organisationally at senior levels to ensure 'buy in' by essential partners. There was a perception by some stakeholders that they were being required to participate in something (RAMPs) that they had not been consulted about, and were not familiar or comfortable with.

Importantly, the initial reluctance by some agencies to embrace the pilot is clearly attributed to a lack of formal authorisation. Senior staff in agencies and government organisations were being asked to commit time and resources based on information and requests from local community based pilot agencies, and not necessarily from higher levels within their own organisation/ Department.

By contrast the MARACs in the UK, and the South Australian Family Safety Framework (which is endorsed by Cabinet and led by Police), are 'top down' models which authorise and mandate participation by all relevant parties.

Other barriers to the smooth establishment of the Victorian pilots included sector concerns about the selection process for the pilot agencies, and concerns about potentially operating outside of privacy laws and confidentiality policies. Partnership development for both pilot agencies was thus a significant challenge.

3.6 Summary evaluation of the establishment of the SRM pilots

The evaluation identified a number of themes which were common to the establishment of the SRMDPs in the City of Greater Geelong and the City of Hume. These are summarised below.

1 The pilots drew upon a wide base of existing organisational resources and relevant internal agency programs at each site, to support the SRMDP, including family violence programs for women and children (Hume SRMDP); housing and homelessness programs; Child First, family support programs, and men's family violence programs (Geelong SRMDP). Supports included allocation of considerable management resources to the establishment and subsequent development of the pilots. Both agencies responded to issues raised in the evaluation establishment report, and refined and strengthened SRM service models throughout the pilot.

2 Overall the pilots established reasonably effective models and processes to increase risk management for women and children, although relatively inefficiently in terms of time and effort. The pilots did well to successfully establish partnerships and the RAMPs, in spite of insufficient structural, high level interdepartmental arrangements being put in place prior to implementation.

3 The pilots lacked an adequate 'authorising' structure, formally approved Guidelines and Framework documents, and agreed Memoranda of Understanding. A stronger 'authorising environment', facilitated by

ministerial endorsement, and driven by agreements at a high level within and between relevant organisations, would have been appropriate.

4 The Victorian SRMDP required the community based pilot agencies (Berry Street and Bethany) to drive the initiative. The onus was thus on each pilot agency to independently negotiate and develop MoUs and operating protocols for the multi agency response in its region. Complex questions of privacy, confidentiality and working partnerships were addressed by each pilot. This was an inefficient and frustrating process for all parties.

Each pilot agency had to negotiate with senior staff in major and different bureaucratic organisations including Victoria Police, Corrections, Centrelink, DHS Child Protection, Department of Health. As noted, some agencies were reluctant to commit time and resources (and confidential information) to an initiative driven by a local community based organisation, without 'authorisation'. The expectation that each pilot agency should do this individually in a timely way was unrealistic.

5 Governance arrangements (proposed by DHS) for the pilots included the requirement to have direct links with, and oversight by regional Integrated Family Violence networks, however this approach was not implemented in either region. Relationships between the IFV networks and the pilots were also reportedly in a state of flux, and in practice, the establishment was independently managed by the individual auspice agencies without accountability to IFV networks. The RAMPs were seen as autonomous entities. This situation may have further complicated the sector responses to the establishment of the pilots.

6 The Statewide Reference group provided valued advice and input initially, but individual members had limited authority to influence representatives in their constituent organisations to participate in, and support the pilots, and the group did not meet after September 2012.

7 Both agencies acquired useful information from their UK study tours, even though the contexts are different, and the model elements for the SRMDP were not exactly the same as the MARACs. Agency representatives reported on their findings, however further analysis describing the translation and adaptation of the MARAC model to the Australian context, and to the DHS model specification, would have been useful.

8 The SRMDP pilots underwent an establishment phase of several months, before roles were clear and programs were fully and appropriately staffed. Both agencies experienced recruiting and staffing difficulties, including lengthy periods of staffing vacancies representing more than 0.8 EFT per agency in 2011/12, which reduced their service capacity, and potentially placed additional pressure on Coordinators and SRMDP staff. In addition, periods of leave by SRM team members, and changing job descriptions and focus, impacted on the continuity and capacity of the pilots.

9 Neither pilot was able to fulfil the men's case management role as described in the DHS service model specification. The intended target group of men is

very difficult to engage in a voluntary community based program; there are duty of care concerns for staff; and alternative models for men need to be considered which focus on risk management through partnerships with criminal justice responses.

10 Both pilots experienced initial difficulties securing consistent attendance and continuity by some key partners, including DHS Child Protection, and DHS Office of Housing. This has now been largely addressed. Victoria Police and Corrections have made significant contributions to the RAMPs, as have a range of other RAMP members.

Both pilot agencies experienced challenges in the working relationships and partnerships with their respective specialist family violence women's (L17) and men's (L17) regional service providers. It will be important for DHS H&CB to address this in a potential roll out of a strengthening risk management initiative.

4 SRM AGENCY OPERATIONS

4.1 Introduction

This section reports on the services which were provided by the SRM component of the pilots, as distinct from the RAMP component. Throughout this section specific issues pertaining to the evaluation research questions are discussed, with particular reference to SRM case management.

The section draws on the detailed data reports which are provided as separate attachments to this report. The processes for data collection had a number of methodological limitations which are described in the data report. In summary these included retrospective data collection by agency staff, based on worker recollection and agency case files; and the use of subjective qualitative information by staff, particularly in relation to outcomes.

In spite of these limitations the triangulation of data from a number of sources provided a measure of verification, and overall, there is sufficient confidence in the data obtained during the evaluation to support the findings and conclusions presented in the report.

This section deals with evaluation of the pilot agency SRM operations which were implemented as part of the pilots, as district from the RAMP operations, which are discussed in Section 5.[26]

This section is set out as follows. Section 4.2 presents a summary of services provided by the pilots. Section 4.3 provides an overview of the SRM case management responses to women and children.

A description of the case management models for all 3 SRM target groups implemented by the Pilot agencies, is presented in section 4.3. Section 4.4 evaluates the service models which were put in place by the pilot agencies. A summary of key learnings in terms of good practice with women and children at high risk concludes the section (4.5).

Overall the evaluation found that each pilot experienced some similar challenges, but also some different specific difficulties in terms of implementing the SRM model in their organisational context.

Findings in relation to selected operating practices are presented throughout the various sections.[27]

4.2 Services provided

4.2.1 Overview

During the 17 month data period for the evaluation, more than 275 women (plus children) were provided with some level of SRM case management (combined data

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[26] Detailed research questions were presented in the evaluation Framework, approved by the SRM Implementation Steering Committee Working Group, and DHS in July 2012.

[27] Section 4 addresses Evaluation Question 1.2: *How effective are the operating practices which have been implemented at an SRM pilot agency level?*

from both agencies), aimed at providing immediate enhancements to safety and risk management. In addition, the situations of more than 55 women, plus accompanying children (in both pilots combined), were discussed in 27 RAMP meetings, with action plans for these families developed and executed.

This data may be compared to the nominal targets set by DHS for each pilot, of 100 women, children and men to be assisted each year, by SRM case management and/or RAMP responses. On this measure, the Hume SRMDP exceeded targets. The Geelong SRMDP did not meet the targets, however during 2013 there has been increased achievement of targets by the Geelong SRMDP.

Table 4.1: Key outputs (November 2011 to end March 2013)

Key output	Hume SRMDP	Geelong SRMDP
No. of RAMPs conducted	14	13
No. of women presented to RAMPs	38	17
No. of women provided with SRM case management	230**	44***
No. of accompanying children (estimated)	150	111
No. of children individually provided with SRM case management/ therapeutic intervention	unknown	58*
No. of men provided with SRM case management	2	33

* Children assisted by Children's Therapeutic worker. Of the 58 children, 32 were members of families assisted by Bethany SRM workers

** Estimate only, based on information provided by Berry Street (see section 4.2.2 below)

*** Geelong and Hume numbers are not directly comparable as Hume numbers are 'intake clients', and Bethany numbers are referrals from internal and external services.

Presenting family units

Approximately three quarters of the SRM clients were women with accompanying children, and 20-24% were single women (Table 4.2).

Table 4.2: Presenting family unit (SRM clients)

	Hume SRMDP (n=84)	Geelong SRMDP (n=55)
Single	20%	24%
Woman with children	76%	73%
Other family unit	4%	4%
Total	100%	100%

Source: Agency data collections (see Table 4.1 for SRM clients)

4.2.2 Hume SRMDP

The evaluation found that the Hume SRM pilot worked with the intended target group of women and women with children, at high risk of serious violence.

During the period November 2011 to the end of March 2013, Berry Street assisted an estimated 230 women in the City of Hume, deemed to be at 'high risk'. This assistance ranged from short term information and advice through to a

comprehensive case management response. All women contacted by the SRM workers in the data period were included in the agency client data base of 230, including women who were contacted but who did not subsequently engage with the service.

Data for the evaluation was based on all women who were assisted and referred to RAMP (n=38), plus a further sample of 46 women (plus accompanying children from the 230 women) who were assisted with SRM case management only (ie. not presented to RAMP). The total data set for the evaluation from the Hume SRMDP, thus comprised 84 women and accompanying children.[28]

Profile of women and children assisted

Women and women with children assisted by the Hume SRM pilot were in the high risk category, with an average of 6.5 recorded needs per client (SRM clients) and 11 recorded needs per client (RAMP clients).

In the 17 month data period:

- The ages of women and women with children assisted ranged from 19 to 62 years, with an average age of 33 years.
- Women from diverse population groups were assisted (about 40% of women assisted were born overseas).
- About three quarters of women were living in the family home upon referral. One third of women were living with the perpetrator.
- More than 150 children accompanied the women, and their needs were considered in safety and case planning.

Referrals to RAMP

The referrals to the Hume RAMP by the Hume SRM program were appropriate in terms of the intent/ targeting of the pilot. Women and children referred to RAMP were assessed as being at risk of severe harm and / or lethal violence.

The vast majority of referrals to the Hume RAMP however, were made by the SRM team, which was not the sole intent of the pilot. It was anticipated that a greater number of referrals to RAMP would be made by Victoria Police (directly), Child Protection and other community based agencies. This is discussed further in Section 5.

4.2.3 Geelong SRMDP

The Geelong SRM pilot provided SRM case management to 55 women in the 17 months from commencement in November 2011 to March 2013. Of these 55 women, 17 women were presented to RAMP. Most of the 55 women engaged with a substantive family violence case management response, as they had self referred

[28] As noted, the majority of women assisted with SRM case management were identified through the screening of L17s for the City of Hume.

or had been referred from another Bethany program area, or external agency, and had agreed to be assisted.[29]

Bethany developed a sound appreciation of the intended client group of women and children at highest risk over time, although as noted the agency had difficulty gaining access to this group in the first 12-18 months of the pilot.

The women's case management model which is now being implemented in the Geelong SRMDP has a strong focus on safety planning, and integrated, cross program responses. Throughout the pilot, the service has increasingly developed skills and a knowledge base in the provision of specialised family violence services, and now provides a valued resource in the region.

Profile of women and children assisted

Data shows that women and women with children assisted by the Geelong SRM pilot had an average of 4.1 needs per client (SRM clients) and 7.5 needs per client (RAMP clients).

In the 17 month data period:

- The ages of women and women with children assisted ranged from 18 to 62 years, with an average age of 33 years.
- Women from diverse population groups were assisted (about 18% were born overseas).
- More than 111 children accompanied the women, this included 32 children who were provided with an individual therapeutic case management response.
- 33 men were provided with an individual men's case management response. The profile of the men assisted by the men's case manager were initially not the family members of AFMs, and were generally not in the highest risk group. This was addressed during late 2102 to 2103.

Referrals to RAMP

Although the Geelong SRM case management staff were working with a wide range of clients, in terms of the family violence spectrum, the women and children presented to the Geelong RAMP were generally the intended 'high risk' group. The majority of referrals to RAMP were from the Bethany agency SRM program, however a relatively greater number of referrals to RAMP were also made from other agencies including Child Protection, Victoria Police, etc, compared to the Hume RAMP.

4.2.4 Men's case management (both pilot agencies)

Bethany provided 27 men with case management. The majority of these men were self referred, were not related to an AFM within the SRM program, and were not the intended 'high risk' target group. On average Bethany's male clients had 4 risk factors (CRAF risk factors), [redacted] Over time however, Bethany developed considerable learnings in terms

[29] Thus the number of Geelong SRM clients assisted by Bethany cannot be directly compared with Berry Street SRM clients, who were contacted by Berry Street following a Victoria Police referral using an L17.

of an appropriate 'partnership' model with the criminal justice system, for men who use extreme violence.

Berry Street attempted to work with the high risk group, but decided that a case management approach based on the intended model was inappropriate and not viable after providing support to 2 men.

The profile of men whose partners were presented to (both) RAMPs included:

- use of extreme violence and threats to AFMs, including children and extended family members
- illicit drug and alcohol use; addictions; use of ICE
- participation in criminal activities and violent behaviour, including gang membership
- complex mental health histories and presentations
- criminal records
- disregard and contempt for Victoria Police, the law, the Court system, evidenced by breaching orders, non attendance at Court, non cooperation with the Court system (eg. refusal to communicate with legal representatives of AFM), and ignoring multiple outstanding legal matters
- repeated episodes of escalating violence
- incarceration and current or previous background with Corrections (some men)

4.3 Overview of SRM case management responses to women and children[30]

4.3.1 Introduction

The evaluation found that both pilots are now providing effective and integrated case management responses to women and children at high risk. Models have evolved at an individual agency level through SRM case management to women and children, and through effective operations of RAMPs (see section 5).

The Hume SRMDP appeared to provide an effective response with a dedicated SRM team[31] in 2011 and early in 2012. A functional integrated model has been operating during 2013. The Geelong SRMDP has provided its most effective and integrated model during 2013.

Specific aspects of the SRM case management models are discussed below in terms of a number of domains. The findings relate to women and children only, and do not apply to the service models for, or agency responses to the men who perpetrated the violence, unless specifically noted.[32]

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30 Addresses Evaluation question 1.3: *Are the SRMDPs providing an effective and integrated response to clients?*

31 As noted in section 3, the specialist team model was not considered sustainable due to worker burnout, and the SRM high risk work was mainstreamed across the specialist NFDVS team.

32 Client outcomes are presented in Section 6.

4.3.2 SRM case management components

a) Referrals to pilot agencies (intake processes)

The intake processes which were implemented by the two pilot agencies differed significantly, consistent with the very different operating context for each pilot. Berry Street developed a triage process using Police L17 referrals for the City of Hume, and other information (eg. internal agency records) to identify women and children at highest levels of risk. Following initial identification, and attempts at contact and engagement, Berry Street SRM staff provided risk assessment, safety planning, and case management support to Hume clients (as appropriate), and referred women and children they assessed to be at highest risk to RAMP.

The establishment report found that approximately 20% of all L17 referrals for Hume for women, were initially classified as 'high risk', and thus eligible for an SRMDP response. Workers were successful in contacting approximately 75% of these 'high risk' women. Of these, a further 23% were assessed as being very high risk, and suitable to refer to RAMP (n=38 women).

Bethany initially relied on internal agency referrals to the SRMDP (from other Bethany programs), and referrals from other relevant agencies, as the agency had limited access to Police L17 referrals for women and children.

Referrals to the Geelong SRM program were received from a variety of sources - 47% of the women assisted were recorded as 'self referrals'; 29% of women assisted were referred from internal agency referrals (other Bethany programs); and 24% were referrals from other organisations. Of the 55 women provided with SRM case management by the Geelong pilot during the evaluation period, 17 women were assessed as being at very high risk, and were referred to RAMP.[33]

Table 4.3 summarises the source of referrals to each of the pilot agencies, for the selected sample of client data.

Table 4.3: Source of referral for women and children referred to the SRMDPs

	Hume		Geelong	
	Total no.	**Total pct**	**Total no.**	**Total pct**
Internal (Police L17)	67	80%	-	-
Internal other agency program	8	9%	16	29%
External agency	8	9%	13	24%
Self referral	1	2%	26	47%
Total	84*	100%	55	100%

Source: Agency data collection. *The 84 Berry Street clients are a sample (of 230), and the 55 Bethany clients represent the majority of SRM clients for that agency, from commencement to March 2013.

[33] As noted, for the first 12 months of the pilot, the Bethany SRM program did not receive referrals (as anticipated) from the women's service which receives Victoria Police L17 referrals for Geelong. This significantly impacted the pilot, as it meant that a number of women, children and men assisted by the Bethany SRM case managers in the first 12 months were not the cohort at highest risk of serious violence. Negotiations between the SRMDP and the women's service were underway at the time of publication of this report.

The SRM case management resources allocated to the pilots enabled the auspice agencies to develop enhanced engagement processes with women at very high risk, who may be hard to engage; provide more intensive and longer term services if required; and offer more holistic case management than is usually possible within a traditionally funded family violence outreach model.

The original Hume SRMDP model, in which the SRM team (Coordinator and SRM staff) actively identified and assessed women and children at highest risk, and then proceeded to contact and engage them, provided an effective intake model. As noted, the subsequent staffing and intake model, in which intake and engagement functions were undertaken by the Coordinator, supported by NFDVS workers, does not appear to have been as successful, as only 4 referrals were made to RAMP in the second half of 2012, compared to 19 in the first six months. During 2013, the intake process and model was further refined,[34] and referrals to RAMP increased.

In the original Geelong SRMDP intake model, there was too much reliance on referrals obtained through the agencies' general intake system, and referrals from other internal programs. This system did not enable the service to reach the intended client groups impacting achievement of targets and SRMDP objectives. The major internal review in June 2012 resulted in improved identification of women and women and children at high risk, including from a higher proportion of external referral sources. Nevertheless the SRMDP still did not have access to women referred through Victoria Police (L17s).

b) Provision of information, advice and advocacy to clients

Both pilots demonstrated good practice in sharing relevant information in a timely way to enhance the safety of women and children. The evaluation found that appropriate information sharing with key service providers, through SRM case management and through RAMP processes, was a major contributor to increased safety for women and children, and contributed to increasing the accountability of men. The agencies had a clear understanding of what information is appropriate to share ('need to know') and of duty of care principles in relation to information exchange, risk assessment and safety planning. The pilot agencies' practices in relation to exchange of relevant information was constructive and educative at RAMPs.

Both agencies demonstrated a commitment to transparency in their work with women, explaining in detail (wherever appropriate) what information would be shared and with whom, seeking consent, and providing detailed feedback to women.

The evaluation found that Berry Street SRM staff implemented good practice in relation to provision of information, advice and advocacy in the work with women and women with children. This particularly related to the way in which risk assessments and safety planning were undertaken. Provision of information, advice, and advocacy was also ongoing through the risk management process, and in the broader case management support, which was provided to some women. Strong advocacy for women and children was a key feature of the Hume pilot. Bethany significantly improved practice in all these areas during late 2012/ 2013.

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[34] See section 3.

Table 4.4: Proportion of SRM clients provided with information, advice and advocacy

	Geelong SRMDP	*Hume SRMDP*
Information, advice	56%	76%
Advocacy	40%	81%

Source: Agency data collections

c) Risk assessment and risk management processes

Throughout the course of the pilots, both agencies developed comprehensive risk assessment and risk management processes with women and children at high risk. Processes and tools were formally implemented within each organisation, based on the CRAF. Agencies continued developing and refining practice in this area, including sharpening and differentiating understandings of 'high risk'. Risk assessment and risk management language and processes were further refined during RAMP discussions. Consideration was given to specific risk assessments for accompanying children, and this is an area for further development.

SRM staff engaged women in a range of activities to enhance safety and risk management including initial and ongoing risk assessments; developing and updating agreed safety plans; assisting with Intervention Orders; changing locks and installing security measures; assisting with relocation; and maintaining effective communication arrangements with Victoria Police and other service providers, including DHS Child Protection if necessary.

d) Enhanced service provision

The SRM case management components of both pilots provided a wide range of flexible and innovative service delivery responses to women and children.

Brokerage was used in a number of instances to quickly and effectively implement components of safety plans, and to facilitate engagement (see section 4.4.9 below).

The evaluation found that women and children assisted through dedicated SRM resources generally received an enhanced response, compared with what is possible in models with higher worker to client ratios.

Specific examples of SRM case management 'enhancements' included:

- additional time and flexibility for outreach visits, home visits, advocacy and court support
- capacity to work across regions (short term) when a client relocated
- assistance with legal and immigration issues, health, education, longer term protective factors
- longer periods of support
- provision of emotional support and attention to health and well being factors

- enabling children to be linked to age/ developmentally appropriate resources, activities and specialised supports; and substantial assistance with housing related issues.

Length of support

On average SRM workers assisted women and children for 15 weeks duration (similar at both agencies). The length of support was 2-3 times longer for clients presented to RAMP, compared to those who were not presented to RAMP (Table 4.5).

Table 4.5: Average length of support (weeks) for SRM clients

	Geelong	*Hume*
Clients presented to RAMP	32	21
Clients not presented to RAMP	11	9
All clients	15	15

Source: Agency data collections

e) Ongoing assessments and referrals

SRM case managers intentionally provided ongoing risk assessments with women, and also assessed for other needs to assist women and children to maintain safety and wellbeing. SRM case managers made referrals to, and liaised with, a wide range of other service providers to consolidate risk management and on-going safety, and assist women to achieve improvements in health and well being.

Table 4.6 shows selected major needs of women and children identified during assessments; and selected key providers to whom SRM clients were referred.

Table 4.6: Major needs recorded; referrals made to other services (selected key providers)

Major needs of women and children	*Selected key providers*
Assistance with housing	Office of Housing, community based housing/ homelessness service, Private Rental Assistance Program
Financial counselling, and financial assistance	Centrelink, financial counsellor, VOCAT
Emotional support	Community health centres
Specialist counselling, psychological services	Community health centres
health and medical services	Community health, hospitals
Legal issues	Court support workers, legal aid, Women's Legal Service
Children's needs	Child protection, Maternal and child health services

Source: Agency data collections

f) Coordinated practice with other relevant agencies

Both pilot agencies showed a strong commitment to working in a coordinated and integrated way with other relevant services, to enable a strengthened multi-agency response. This was particularly evident in terms of risk assessment and risk management, however it was also evident in longer term case management where other agencies had the capacity to provide relevant services (eg. CHCs; maternal and child health services; Family First; drug and alcohol and mental health services, schools, Indigenous agencies, other). Both agencies (particularly in the detailed case studies), provided examples of effective coordinated practice, including co-case management. Further evidence to support this finding emerged in the data analysis, and in feedback from women.

g) Monitoring and Follow up

The SRM models implemented by the pilot agencies provided for women to recontact the service if required, following completion of a support period.

Data shows that SRM agencies also maintained 'open' files for an extended period, with a monitoring role, even if the active service delivery phase was dormant for a period. Some women reported that this gave them a higher degree of confidence and 'felt' safety, after having been in a very violent and 'at risk' situation, than if contact with the service had been ended too early.

h) Use of brokerage

The two pilot agencies were each provided with approximately $21,000 per annum for brokerage.

Both auspice agencies were initially cautious in allocating brokerage, however they utilised brokerage funds effectively over time to support enhanced risk management, and to facilitate engagement of women at highest risk. Brokerage was mainly used to support RAMP action plans. It was also used to support safety plans developed during SRM case management. Examples of brokerage fund usage include:

- Lock changes
- Alarm systems
- Rent assistance, bonds, arrears, PRAP
- Storage, removalist costs
- Repairs in order to secure the property
- Food supplies, clothing
- Utility costs

Table 4.7 shows that between 30% and 40% of SRM (including RAMP) clients were assisted with brokerage, and that the average brokerage expenditure was $900 to $1,000 per client assisted with brokerage.

Table 4.7: Brokerage expenditure (Oct 2011 to April 2013)

	Geelong (n=55)	*Hume (n=84)*
[redacted]	[redacted]	[redacted]
Number of clients assisted	22	28
Proportion of total SRM clients in sample	40%	33%
Average expenditure (per client)	$860	$990

Source: Agency data collection, see Analysis of Client Data Section 3.9

The brokerage component which was built into the SRMDP enabled timely and flexible solutions to support risk management for women and children at high risk. In a small number of instances, brokerage funds were expended for an urgent response, and subsequent claims were made for reimbursement from responsible departments (eg. OoH change of locks).

4.3.3 SRM case management responses to children

Accompanying children were assisted through SRM case management of their mother, and through separate services. Table 4.8 shows the number of children who were assisted by the SRM program, for each of the pilot agencies. Berry Street mainly assisted children by combining the women and children's case management positions, and assisted more than 150 children in this way. Bethany also assisted children via their mothers.[35] In addition, Berry Street assisted 2 children referred from the SRM program, and Bethany assisted 32 children of 13 SRM clients.

Table 4.8: Children assisted by SRM

	Berry Street	*Bethany*
Children assisted by SRM case management (through their mother)	150 (est.) (unknown)	111 (42 mothers)
Children of SRM clients assisted separately (included above)	3 (3)	32 (13 mothers)

Both the Berry Street Turtle program and the Bethany children's therapeutic worker provided advice and secondary consultation to women's SRM case managers.

In practice, the number of children directly assisted by the Turtle program was limited due to the capacity of the Turtle program (only 3 referrals were formally made by the SRM to the Turtle program in the data period). The Turtle program however was able to assist children in the SRM client group indirectly through secondary consultation and supervision with SRM workers, providing education and support to staff on working with the mother-child relationship, and maintaining a focus on the child.

[35] Separate case management data was not collected for these children.

4.4 SRM case management models for client groups

4.4.1 Introduction

This section examines the value of the service models which were put in place by each of the two pilot agencies. It draws together the model information provided in section 3, with the 'practice evidence' (Sections 4.2 and 4.3) to form conclusions about 'good practice' (Section 4.5)

4.4.2 Case management for women

SRM case management at both pilot sites was qualitatively similar to established family violence case management practice, however the additional SRM resources enabled a relatively greater and longer amount and type of contact with women and children identified as being at highest risk.

Geelong SRMDP

Bethany established a team model of family violence practice for women and children at high risk, and at the time of publishing this report was in the process of developing a collaborative early identification approach with the family violence agency which receives the Victoria Police L17 referrals.

The pilot strengthened the capacity in the region to assist women and children experiencing family violence, and substantial good practice knowledge in family violence and strengthening risk management with women has been achieved through the pilot. Findings indicate that the SRM work of the women's case manager position at Bethany is now effective and appropriately targeted. The women's case management position is sufficiently senior, and is well supported by the agency.

Hume SRMDP

The initial SRM team model at Berry Street provided a clear focus and enabled a dedicated response, based on police L17 referrals. Main streaming the SRM resources into the NFDVS demonstrated that a response to 'high risk' women and women with children in the City of Hume, can be provided by an experienced and skilled family violence outreach team.

The current Hume SRMDP model (ie. SRM resources integrated within the family violence outreach team) is considered replicable within other family violence outreach services across Victoria.

The Hume SRM pilot has also enabled considerable capacity building in terms of strengthening risk management throughout the Berry Street family violence service (NFDVS), and the broader regional service system.[36]

Organisational issues

There are a number of significant challenges and dangers associated with working intensively with women and children who are at serious risk from violent and often

[36] It also facilitated participation by Berry Street staff in a separate innovative model driven by Victoria Police in the Whittlesea, Darebin and Banyule areas.

criminal perpetrators. There is potential for vicarious trauma and staff burnout in specialist models that focus exclusively on high risk. This is one reason why Berry Street decided to main stream the SRM resources into to NFDVS team.

Prevention of serious harm and lethality has implications for service model design, in terms of worker safety, seniority of workers, team structures, supervision and other human resource issues. The two pilots provided some indication of the likely organisational issues which may need to be addressed in the event the SRM is rolled out across Victoria.

At a minimum, staff working with women and children in the highest risk area require skills and experience in family violence risk assessment, safety planning and risk management. A range of other strategies are also required (see section 4.5).

4.4.3 Responses for children

The impacts of family violence on children, and on the mother-child relationship, are significant, and one intent of the pilots was to trial effective SRM approaches with accompanying children in high risk families. Due to issues of demand, resource allocation, training and skill levels, the capacity of specialist family violence agencies to assess for the needs of all accompanying children in relatively limited.

The pilot agencies each used the funding for a dedicated response to accompanying children differently in their service models. Both agencies initially attempted (unsuccessfully) to recruit to a dedicated children's case manager position.

In practice the Bethany children's therapeutic worker assisted a number of children through separate safety planning, referrals, and also reported benefits from a therapeutic response.

Berry Street SRM staff reported that in their initial contact with women, children's needs were assessed wherever possible, but generally were not separately or consistently documented. Ongoing attempts to assess children's safety and other needs were reportedly made in subsequent contacts with women, and this was facilitated where children were present. Overall however, due to lack of quality data, the approach to, and outcomes of the Berry Street pilot's work with children, were not able to be meaningfully evaluated.

It is debatable whether a therapeutic response is appropriate, or an effective use of resources within an SRMDP model, where children are highly vulnerable and traumatised, and where the major and primary focus is on urgent risk management. Therapeutic work is generally undertaken within the mother child relationship post crisis (once safety has been established), and sustainable within a less stressful and more stable context.

4.4.4 Men's case management

The rationale for a men's case management position in the SRM pilots was to increase the safety of women and children, in part by increasing the accountability of men who use violence. This approach was originally conceived as a men's case manager working directly with men who were partners of women and children clients of the SRM.

As described in section 3, and section 4.2.4, neither pilot agency was successful providing a men's case management response to 'high risk' perpetrators, as was intended by the pilot. Both agencies experienced considerable difficulty attracting skilled staff to the Men's Case Management position; and were challenged to clarify the men's case management role in the context of the high risk target group. This was largely due to the profile of men in the intended target group, as well as the 'lack of fit' with the position description.

Bethany (appropriately) redesigned role for the men's case manager, to be based on 'risk management' rather than case management. Berry Street discontinued the role.

The evaluation did not establish whether the dedicated SRM men's case management position can be justified over and above what might be provided by through existing men's family violence services, and/or a redefined position working within the criminal justice system.

There are significant challenges for a community based agency to engage with and assist men who use extreme violence, and pose a serious risk to women and children. It is likely that only a minority of these men will respond (voluntarily) to a community based agency. The outcomes for men from the SRMDP, need to be considered in this context. A UK study[37] supports this view, finding that only a small proportion (11%) of this cohort may potentially be assisted by a men's behaviour change program, and only 5% actually engaged with programs.

4.5 Towards good practice in Strengthening Risk Management

Although based on only two pilots, the evaluation revealed a number of good risk assessment and risk management practices within the auspice agencies. These are summarised below in relation to women and children, children, and men.

Good practice responses to women and children at high risk

1 Dedicated intake and screening processes are required which assess and prioritise all high risk L17 referrals within a 12 to 24 hour time frame. This needs to be undertaken by skilled family violence practitioners with access to L17s, as well as other important referral sources. Specific resources need to be allocated to identify ('triage') highest risk referrals and make repeated attempts to contact women at highest risk.

2 Workers need specific (advanced practitioner) skills for intake and engagement with women at the highest level of risk. Women at high risk have higher levels of fear and less confidence that the system can keep them safe, especially if the perpetrator has a disregard for the law and/or engages in criminal and violent activities in addition to family violence. Specific (advanced practitioner) skills are required for risk assessment and safety planning., as well as the provision and/or oversight of ongoing case management with these women and children.

[37] Blacklock and Debbonaire (2011) Fresh Start, Respect, UK.

3 A focus on women and children at high risk (lethality) does require that resources and models are sited in agencies with established expertise in specialised family violence practice, and with established systems for staff support and development. Impacts on staff from working with women and children and family violence are best addressed by staff working in family violence teams, with staff having a caseload of clients who are experiencing various levels of risk and harm (ie. not just 'high risk').

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

4 Experienced staff are required, with advanced skills in working with women and children who have experienced family violence, with some case managers employed at SW3 levels. This is to ensure monitoring and mentoring of less experienced staff, supervision capacity, and best practice with women at risk of lethality. This has implications for recruitment, position descriptions and agency organisational arrangements and resources.

5 Enhanced supervision, training and professional development are required to enable staff to process and manage the impacts of high risk work. Specific training in collaborative integrated practice is essential in what can become emotionally charged interactions between partner agencies. Enhanced peer support and other opportunities for reflective practice and self care for staff are also required. Robust outcomes frameworks are required, so that staff can see the impact of their work over time.

Good practice responses to children at high risk

1 Risk assessment and safety planning should be undertaken with all children in high risk families. Responses to children in high risk family violence situations should initially occur in conjunction with safety planning and risk management for the mother, and increasing the safety of the mother should help increase the safety of her child(ren). Good practice however would always include assessment of the safety and other urgent needs of each individual child.[38]

2 Agencies should differentiate between a rapid risk assessment and safety planning response for each accompanying child in a high risk situation; ongoing risk management; ongoing case management; and post crisis therapeutic interventions for mother and child(ren).

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[38] The DHS Practice Guide "Assessing children and young people experiencing family violence", states that each child (unborn children, infants, children and young people) affected by family violence requires a response that directly engages with their needs

3 Family violence agencies require adequate skills to respond to children at high risk including children at risk of cumulative harm, and provide a child-centred approach. This could be achieved by ensuring the DHS Practice Guide is implemented in all family violence services, supported by a training strategy. This would also be progressed through the appointment of Advanced Skills practitioners in specialist family violence services, whose role could include focussing on assessment of children, and developing appropriate safety plans, practice and referral options and pathways for different needs. In this model, the safety and other needs of all accompanying children would be assessed, and plans developed.

4 A strengthened capacity to assist children post crisis, in an integrated mother-child approach, will also be important for some families. Research suggests that the longer term trauma to some children, and potentially disruptive impacts to mother child attachment arising from family violence, may be addressed by therapeutic models. Individual needs of children, assessed in the context of the mother-child relationship, have a greater likelihood of being addressed with the mother's support and assistance. Models such as the Turtle program could potentially be replicated in other settings, and co-located with family violence services.

A range of post crisis therapeutic responses for children who have witnessed and/or experienced family violence are an important component of a continuum of responses. These are qualitatively different from, and do not necessarily fit at the 'front end' crisis and safety (SRM) model, which primarily aims to keep women and children safe from serious imminent injury or death. It is however imperative to have a 'mapped' service system, with established links and priority access to post crisis services for accompanying children, as quickly as possible after the immediate safety issues have been addressed.

5 It is a priority for generalist and specialist counselling services, art, music recreational and developmental support programs to be made accessible to mothers and children as soon as possible post crisis (as needed and appropriate). In some instances brokerage monies could be used to support timely post crisis therapeutic interventions for children, particularly where there are long waiting periods in publicly funded programs.

6 Assessment and risk management of children should take into account immediate and imminent risk, as well as cumulative harm. It is important for family violence staff to create opportunities to re-assess the needs of children at every new disclosure by a women or child.

7 Children's safety and well-being may be more comprehensively considered through proactive involvement of Child Protection and Child First representatives, and children's therapeutic specialist advisers actively participating in the high risk strategy (including RAMP membership).

8 Effective intervention with children who have experienced and/or witnessed serious harm and injury include:

- linking children to age appropriate resources (child care, kindergarten, school, etc.) and programs
- supported referral to counselling and therapeutic programs, as appropriate
- providing mothers with information on the impacts of family violence on children, and strategies to support children
- advocating for appropriate access arrangements (eg. with the Court)

Good practice responses in relation to men who use extreme violence towards women and children

As noted, voluntary community based men's case management responses are generally not appropriate to hold accountable men who pose a high risk of serious harm or lethality to women and children. The experience of the pilots shows that most men in this cohort should primarily be the responsibility of the Police, the Courts, DHS Child Protection and Corrections. These men generally do not choose to engage with voluntary services and if even if compelled, they may not cooperate.

Community based agencies and RAMPs do however have a key potential role in assisting statutory organisations to exercise their responsibilities in relation to perpetrators, particularly through information exchange, and potentially through direct work with some men. For example, a strengthened 'risk management' response for men could be provided by a men's family violence service working in collaboration with Victoria Police, and/or the justice system, or could be provided directly by the justice system itself (eg. Corrections).

For the future, if a men's role focussing on the highest risk group of men were to be funded in the community sector, it would likely include the following 'good practice' elements:

1 A focus on 'risk management' and harm reduction (as opposed to 'case management') through monitoring of the perpetrator, attendance at court, information provision, and liaison visits with Victoria Police

2 Formal, strong partnerships within all components of the criminal justice system

3 Providing information about the perpetrator to specialist family violence services, Victoria Police, RAMP and relevant member agencies in order to reduce imminent serious risk for women and children

4 Facilitating (as appropriate) decisions taken by men which increase safety for women and children (eg. housing/ relocating)

5 Opportunities for behaviour change, where appropriate, through referral to men's mental health services, drug and alcohol services, counselling, and/or men's behaviour change programs as appropriate

6 Appropriate knowledge and skills to work within community based, as well as justice environments, and an ability to effectively engage men who use violence.

5 EVALUATION OF RAMPS

5.1 Introduction

The evaluation found that the RAMPs have been the most successful aspect of both pilots in terms of strengthening risk management for women and children at highest risk. Appropriate and effective operating practices have played an important part in the success of RAMPs, however, there are a number of learnings, and room for development and improvement.

Section 5.2 discusses organisational issues associated with RAMPs including high level authorisation and local leadership, chairing and coordination, membership and seniority, attendance and participation by members, frequency of meetings, and governance arrangements.

Section 5.3 reports on RAMP activities, including the number of clients assisted, eligibility screening, preparation for meetings by members, risk assessment and risk management, and reporting against action plans.

Section 5.4 reviews the effectiveness of selected RAMP organisational processes including collaboration, information sharing, communication and decision making.

Section 5.5 summarises key learnings. Section 5.6 discusses good practice for Risk Assessment and Management Panels, based on the two pilots.

5.2 RAMP organisation and membership

5.2.1 Leadership, chairing and coordination of RAMPs

Leadership

The leadership of the SRMDP and RAMPs occurred in the broader context of funding, management and oversight of the two pilots by DHS H&CB Division (see Section 3).

Consistent with the family violence reform agenda, DHS H&CB designed and commissioned the pilots, oversaw implementation and chaired a multi-departmental representative Statewide Steering Committee for strengthening risk management. Membership of this group comprised representatives of key departments/ agencies which were intended to participate in RAMPs. Reference group members did not however have management authority over regional representatives, or power to influence participation and cooperation by the regional/local representative in the pilot.

The Steering Group met bi-monthly during the establishment phase, then quarterly until September 2012. The Group has not been convened since that time. DHS H&CB representatives also attended pre-RAMP multi-agency meetings between the pilot agencies and some prospective RAMP members, to help explain and progress the establishment of RAMPs.

As noted, DHS H&CB commissioned the preparation of an SRM Guidelines and Framework document, applicable to pilot agencies, and all prospective RAMP member agencies. This document was intended to provide a formal basis for

agencies to develop partnerships and an MoU for RAMP members. The document was not published or released prior to the pilots, and is yet to be finalised and released.

During the establishment period, when the pilots were challenged to resolve privacy issues associated with exchange of information between RAMP members, DHS H&CB obtained clarification from the Privacy Commissioner. Victoria Police subsequently produced its own written advice on exchange of confidential information.

Leadership of RAMPs at the local and regional level, was a key task for the pilots. The need to clarify and 'legitimise' leadership was particularly important because multiple agencies (with different aims) were being asked to participate in RAMPs on a goodwill basis.

RAMP leadership was provided by the Coordinators and management from the pilot agencies, in terms of engaging prospective RAMP members and obtaining commitment (ie. partnership development). Leadership involved some prior work by senior management in both the pilot agencies. Berry Street supported the engagement of partners process by establishing a 'Critical friends' reference group, convened in the early months of the project. Bethany also convened a group of stakeholders, and employed a consultant to assist in the development of RAMP documentation. Both pilot agencies conducted several pre-RAMP meetings with prospective RAMP members, before launching the RAMPs and taking referrals.

The leadership provided by the auspice agencies at each pilot, initially met with limited returns, in terms of full engagement of key partners. This improved over time, but it took several months of pre-RAMP meetings before the first RAMPs were formally held. The evaluation found that the leadership role undertaken by both pilots was eventually successful and that the persistence of the Coordinators played an important role.

This was an achievement considering the complexity of the task; reticence by partners, and limited 'clout' of the pilot agencies. Over time, partnership development, and obtaining commitment from RAMP member agencies improved significantly. Stakeholders rated leadership by the auspice agencies as good overall, particularly given the prevailing issues at establishment.

The evaluation of the pilots, together with a review of other similar initiatives suggests that strengthened multi-agency risk management, and integrated practice with the highest risk cohort of women and children, requires strong leadership, and commitment and active participation by Police, as well as other agencies. Both in the UK and in the South Australia high risk models, police provide leadership, and chair the multi-agency panel meetings.

There are several potential advantages of Police assuming a leadership and/or chairing role for multi-agency Strengthening Risk Management panels. These include:

- police are a 'first to know' agency at violent/ life-threatening incidents

- Victoria Police is tasked with responding to, and preventing family violence, and has accepted a leadership role[39]
- Victoria Police has a capacity for strong consistent leadership through the authority of Senior Police members, which may have flow-on benefits to strengthen the response to family violence throughout the whole organisation
- potential for a greater focus on perpetrator accountability in RAMP meetings, including Victoria Police proactively implementing actions and sanctions in relation to perpetrators, to increase safety for women and children. A major finding emerging from this evaluation is the need to 'reframe' RAMPs to increase the focus on perpetrator accountability
- potential to strengthen Victoria Police working relationships with Corrections and Child Protection and other key organisations
- the imperative to lead task-oriented RAMP meetings, avoiding straying in case management
- potential to complement existing Victoria Police initiatives and specialist responses to recidivist family violence offenders.

> *"The active involvement of Vic Police has been instrumental in ensuring that men are held accountable. This involvement ensures that a greater degree of 'tracking' occurs. Women and children feel safer when they know that Victoria Police are monitoring men's movements"* [RAMP member}

Chairing of RAMPs

The Geelong and Hume RAMPs are both chaired by skilled and experienced human service practitioners and managers, and both RAMPs were rated well by RAMP members in terms of effective chairing. RAMP members also noted the need for greater focus, efficiencies and time keeping in meetings. In both cases, the Chairs were selected by appointees of the pilot agencies.

It is possible to reflect in hindsight on whether chairing by Victoria Police in the two pilots would have more quickly resolved issues of privacy, scope and eligibility, and facilitated quicker 'buy in' by all partners. However, specialist family violence agencies brought a wealth of experience to the critical tasks of risk assessment and risk management of women and children, and as noted, were able to effectively chair the meetings, and achieve significantly strengthened partnerships and multi-agency collaboration over time.

In conclusion it appears that a Statewide Strengthening Risk Management strategy would best be based on partnership models in which RAMPs in each Police area are chaired or co-chaired by high ranking Police members, working in close partnership with family violence and other member agencies.[40]

Coordination

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39 Victoria Police (2009)

40 The geographical coverage of RAMPs requires further consideration

The SRMDP Coordinators made a significant contribution to the leadership and efficiency function of RAMPs. The evaluation found there is a key essential role in the coordination of RAMPs, as RAMPs are complex multi-agency groups, impacted by local context and pre-existing relationships. The coordination role may best be provided by appointed staff with sufficient seniority and coordination skills within established regional family violence agencies, or by a Statewide service such as WDVCS. The Coordinator role would also include administrative support to the RAMP, collection of data, etc. and work closely with the chair.

5.2.2 RAMP member representation

'Core' RAMP members are intended to be representatives of agencies considered to be consistently important and relevant in identifying women and children at highest risk, and empowered to take actions to contribute to safety of women and children, and / or to increase the accountability of men who use violence. The actual membership thus largely determines the range of possible risk management actions which can be generated and undertaken by RAMPs.

As described in section 3, both pilots approached appropriate agencies in the establishment phase to participate as 'core' RAMP members, and over time obtained reasonably good, but not optimal agency member representation. It was thus necessary for Berry Street and Bethany management and staff to continue working at partnership development, and RAMP recruitment, throughout the entire pilot period.

Bethany initially found it relatively more difficult than Berry Street to recruit core members, and to achieve full participation. Berry Street sought to recruit a wider group of agencies initially, and encountered challenges with some agencies, particularly in terms of the MoU, privacy matters, and differing views on the scope and legitimacy of the RAMP. (e.g.: Victoria Police suspended partnership in the Hume RAMP for 3 months early in 2012). As indicated, it was not ideal that recruitment of core members, and preparation and finalisation of formal partnership agreements, was the responsibility of the pilot agencies/ Coordinators.

Main participating agencies in each RAMP are shown in Table 5.1.[41] Agencies which did not attend meetings regularly are noted.

The learnings from both pilots is that the minimum core membership essential to effective RAMP functioning are:

- Women's specialist Family violence agencies
- Victoria Police
- DHS Child protection
- Corrections

[41] Active members for the majority of the evaluation period. It is understood that more members committed since May 2013.

Table 5.1: RAMP members

Type of organisation	Hume RAMP	Geelong RAMP
Chair	Private practitioner / consultant	Senior manager, Bethany
SRMDP	Coordinator**	Coordinator**
Victoria Police	Family Violence Advisor	Family Violence Advisor
Women's Family violence outreach service		Zena Women's Services
Child Protection	Child Protection Hume and Moreland	Child Protection Geelong
Child First	Kildonan Uniting Care	Bethany Child First
Department of Justice	Corrections Victoria	Corrections Victoria
Men's Family Violence Referral Service	MARS*	Bethany Men's Service
Housing and homelessness service	Vincent Care*	Bethany Housing services
Health services	Northern Health	Barwon Health*
Community legal		Barwon Community Legal Service
Centrelink	Centrelink Social work Department	
Mental health	NWAMHS	
Drug and alcohol service	Regen D&A service	
Maternal and Child health	Hume City Council Maternal and Child Health	

* These services have not regularly attended the RAMP

** Generally, SRM Coordinators presented cases on behalf of SRMDP clients. Occasionally SRM case managers attended RAMP and presented cases, or spoke on behalf of AFMs.

Other important RAMP core members may include:

- Health, including mental health and drug and alcohol services; emergency hospital representatives; CHC as appropriate
- Maternal and Child Health
- Men's family violence services
- OoH
- Centrelink
- Community based housing and homelessness services
- Victim's services
- Child FIRST and/ or relevant family support services
- Early childhood development, education and schools
- Relevant Indigenous and CALD agencies

It should be noted that AFMs do not attend RAMP meetings, and thus do not participate in this forum. This is an issue requiring further research.

5.2.3 Attendance and participation levels

Attendance and participation levels at RAMP by the agencies which committed to the partnerships were good overall , however both pilots experienced initial (and some ongoing) challenges in obtaining consistent attendance, and collaborative participation by Victoria Police and DHS Child Protection. This improved significantly as the pilots evolved.

Corrections made a valued contribution at both RAMPs, and the Hume RAMP is hosted by Corrections. OoH (regionally) did not participate regularly at either RAMP. Health services were not active members of the Barwon RAMP, and the regional men's family violence service for Hume did not participate regularly in, or contribute to the Hume RAMP.

5.2.4 Seniority of RAMP members

In addition to obtaining the participation of appropriate types of agencies to ensure effective functioning of the RAMP, Bethany and Berry Street needed to ensure that agency representatives were sufficiently senior to have access to all relevant information; be fully briefed prior to RAMP meetings; have the authority to make decisions 'on the spot' at the RAMP; and commit to actions being completed within an agreed time frame. There were occasions when the lack of seniority of a RAMP member meant that a commitment could not be made during the meeting. The representation at both pilots, in terms of seniority, improved over time.

Commitment by members to regular attendance and constructive participation is essential for effective functioning of the RAMP. The current status of RAMPs, and 'voluntary' participation mean that risk assessment and action plans may be adversely affected if senior staff do not attend on a regular basis. This is a major concern given the potential lethal level of risk experienced by women and children referred to RAMP. Ideally a Strengthening Risk Management multi-agency model for the future would not only authorise, but support the attendance of senior staff from key member organisations to attend and participate in RAMPs.

5.2.5 Frequency of RAMP meetings

The timing of RAMP meetings is a key issue for consideration in the context of providing a timely and appropriate response to women and children at high risk of harm and potential lethality. The pilots committed to monthly RAMP meetings, although there were some months when a RAMP meeting was not held, due to the absence of any new referrals.

Several stakeholders (including RAMP members) were concerned that the scheduling of monthly RAMP meetings was too infrequent considering the urgent need for a response in cases where there is a very high level of risk and an imminent danger to women and children. This was particularly concerning when a monthly meeting was cancelled, leaving two months until the next meeting. Other RAMP members considered that monthly meetings were suitable, given that a lot of risk management work can be undertaken prior to the RAMP.

The response in Western Metropolitan Region is based on convening a meeting within 72 hours for women and children at imminent and 'extreme risk'. In some other jurisdictions (eg. South Australia) meetings are held fortnightly.

Determining the ideal frequency of RAMP meetings should be linked to the incidence of family violence in a particular area, and the number of high-risk cases which need to be considered (eg. if monthly meetings could not consider all the cases to be presented). Decisions about the geographical coverage of the RAMP, and the frequency of RAMP meetings, need to be based on the number of women and children likely to be identified as being at 'high risk' at any time.

Each of the pilots covered regional populations of slightly more than 200,000 people, and this broadly corresponds to the population coverage of high risk panels in other jurisdictions (eg. MARACs). Higher population coverage may require the establishment of more RAMPs, and/or RAMPs meeting more frequently than monthly. Decisions would also depend on the regional incidence of family violence.

5.2.6 RAMP governance arrangements[42]

Adequacy/ clarity of formal RAMP documentation (MoUs)

During the establishment period, both pilots successfully produced documentation (draft MoUs/protocols, operating practices, etc.) for multi-agency risk management panels. There was some initial exchange of draft documents and tools between the two agencies, but overall each pilot produced its' material independently. This was an inefficient and frustrating exercise for the auspice agencies, involving a duplication of effort.[43]

In spite of the delays, RAMP members were willing to meet and consider cases when all documentation was still in draft form, unsigned, or otherwise incomplete or contentious. This has been a notable achievement of the pilots.[44]

Acceptance of governance arrangements

The acceptance of governance arrangements by RAMP members has been reasonably straightforward with a couple of outstanding exceptions, and has evolved and strengthened over time. RAMP members remain primarily accountable to their own organisation/ employer, and generally view the objectives of the RAMP (eg. risk assessment, risk management) through their own organisational lens. In addition however, there is clear evidence of a peer accountability by members to the RAMP, as a risk management and decision making group. There appears to be implicit acknowledgment of the 'majority decision' of the group, and the right of the Chair to make final determinations. Overall, members appear to 'own' and respect the group's structure, and decision making processes.

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42 Addresses Evaluation Question 2.2: *How well have the RAMPs developed, and implemented (complied with), new integrated governance arrangements?*

43 As noted, this was due to the DHS SRM Guidelines document not being finalised prior to the establishment of the pilots. An equally important issue was the need for a formal whole of government mandate and multi-departmental framework for the initiative.

44 The Geelong pilot is currently in the process of reviewing and revising the RAMP documentation.

Level of compliance with agreed RAMP processes

Compliance with agreed RAMP processes by individual RAMP members, has been high overall. This includes attendance, respectful participation, and upholding professional standards in RAMP meetings.

Member agencies are accountable to RAMP in terms of commitment to attend/ send a replacement; preparation prior to meetings; completion of tasks and reporting back of allocated actions. Attendance and participation levels have been reasonably good, however as noted, would have been greater with a different authorising environment. Members consistently abide by the agenda, operating principles and processes and standards of RAMPs.

Although both RAMPs are now functioning well overall, the structures are still somewhat fragile and vulnerable to disruption, or lack of compliance and cooperation by individual members. An overarching, stronger authorising environment is required in order for the model to be consolidated at existing sites, and replicated in other areas and contexts.

5.3 RAMP activities

5.3.1 Number of clients assisted by RAMP

The pattern of referrals to RAMPs during the evaluation period was quite irregular. RAMP meetings were only held if there were cases to be discussed. In both pilots, there were occasional months where no referrals were made to the RAMPs, so no RAMP was held.

Some variation in the monthly rate of referrals of the intended high risk cohort was not unexpected, however it is important to understand the reasons for this. It is apparent that a number of factors contributed to the variation, including:

- practices within the Pilot agencies
- differing views about eligibility
- changes in SRM models and intake practices
- limited referrals from external agencies
- staff availability (ie. vacancies)
- changes in assessment practices (and eligibility)
- confidence levels in the RAMP (ie. external agencies).

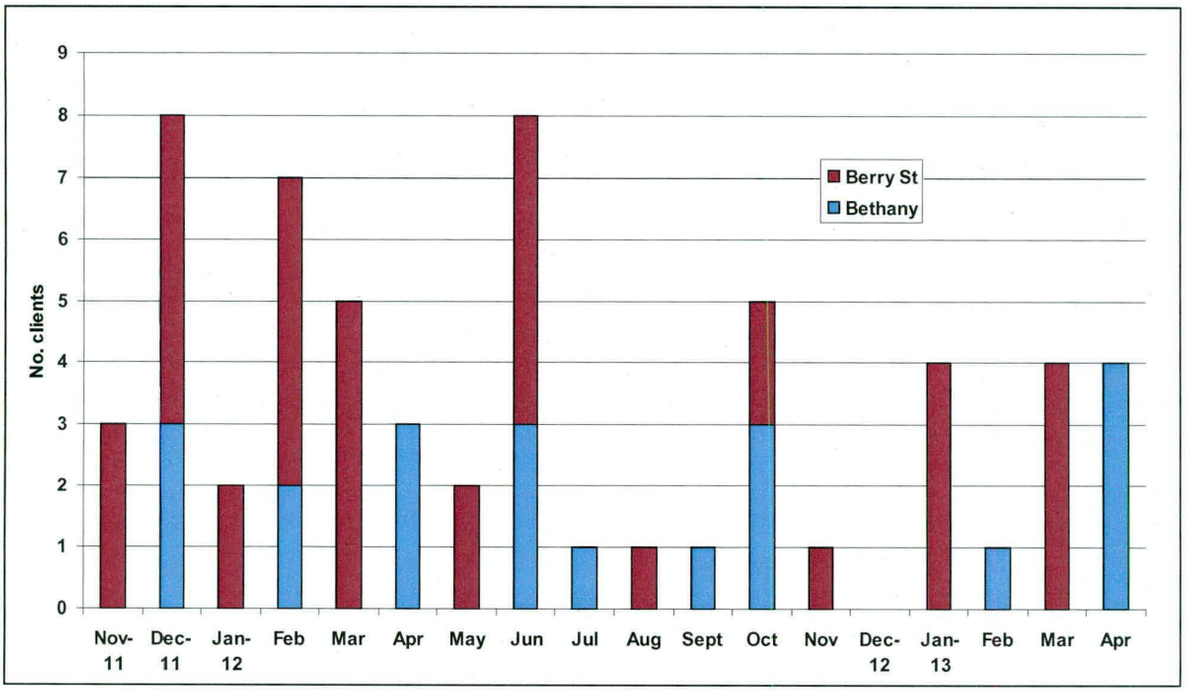
In the period from commencement (November 2011) to April 2013, the Hume RAMP considered 53 cases, comprising 40 new cases, and 12 formal reviews of re-presented previous cases. There were 28 new cases presented to the Hume RAMP up to June 2012 (7 months), and only 4 cases presented in the 6 months July 2012 to December 2012. There were 8 new cases presented in the 4 months from January 2013 to April 2013.

In the period from commencement (November 2011) to April 2013, the Geelong RAMP considered 36 cases, comprising 29 new cases, and 7 formal reviews of previous cases (ie. re-presentation and further discussion and action planning).

There were 13 new cases presented to the Geelong RAMP up to June 2012 (7 months), and only 5 cases presented in the 6 months July 2012 to December 2012. There were 5 new cases presented in the 4 months from January 2013 to April 2013.

The number of new cases considered at each RAMP varied from one, to a maximum of 5. For the future it will be important to pay attention to consistency and quality of identification and assessment of highest risk, to ensure appropriate and timely referrals to RAMP.

Chart 5.1: Referrals to RAMP (Nov 2011 to April 2013)



5.3.2 Eligibility screening

Decisions about who would be 'eligible' to be considered at RAMPs was a significant issue for the pilots. The CRAF was used as the basic guide with some additional information and professional judgements. While there was agreement that the eligible RAMP group would include women and women with children at 'high risk', pilots found it difficult to reach consensus on the actual degree of risk and harm, and imminence of risk.

Differing views among RAMP members initially presented a challenge, particularly in the Hume RAMP, where the Victoria Police threshold for high risk was different (ie. higher) from the SRM team, and from some other RAMP members. This Victoria Police view reportedly did not consider escalating recidivist violence, or cumulative harm to women and children to be an appropriate focus for the RAMP. In some instances, cases were not considered if RAMP members did not consider them eligible. In the Barwon RAMP, gaining consensus on an understanding of high risk was also challenging initially.

After the protracted establishment period, eligibility issues within RAMPs were largely resolved, and there were very few AFMs presented to RAMPs, whose cases were not deemed eligible. Over time the RAMPs operated more cohesively and effectively in terms of eligibility screening, and the client group presented to RAMP were clearly women and children at highest risk of serious harm/ lethality. The stricter focus on eligibility criteria however, may have been counterproductive, particularly in the July to December 2012 period. During this period, some women and children at high risk, who may have been eligible and appropriate to be considered at RAMP, were not given the opportunity, due to the 'lull' in referrals and influence of agency practices.

Stakeholders stated that there are eligible women and children in the highest risk group in both regions, who could benefit from presentation to RAMPs, and that numbers of referrals to RAMP are building.

5.3.3 Preparation and presentation of information

RAMP members prepare relevant information on clients prior to RAMP meetings, and time is allocated in meetings for presentation of information, and questions. RAMPs have functioned reasonably well in this area, but on occasions members have not been fully prepared; have not 'done their homework' (ie. have not read the material and conducted their own research/ inquiries); and have not assembled key relevant information concisely. It then takes time to bring everyone 'up to speed', and/or there is a delay (possibly to the next meeting) while members obtain the necessary information.

For the future, consideration could be given to the extent to which historical context needs to be elaborated in presentations to RAMP, to inform safety planning. Background information is acknowledged as potentially important in identifying patterns of abuse, escalation, specific triggers, etc., but could in many cases, be abbreviated. One RAMP member suggested:

> *"Presentations should clearly state the reason for the presentation, the reason why the AFM is at serious risk of harm, what actions are being sought (if known), and any identifiable specific outcomes"*

In both pilots, RAMP meetings were scheduled to last 2-3 hours. This generally allowed sufficient time to complete the agenda (generally up to 5 cases), although the number and complexity of cases varied each month. Key informants reported that while the time allowed for the RAMP meetings was generally acceptable, there was room for improved efficiency in preparation, and presentation of information.

5.3.4 Risk assessment

The evaluation found that over time the RAMPs developed sound practices in relation to multi-agency risk assessment, and RAMP processes generally enables comprehensive risk assessments to be developed.

This occurred through considering assessment information presented by the referring party, with reference to the CRAF, and through effective exchange of relevant information by all RAMP members who had knowledge of the client, and

the client's situation. RAMP processes generally enabled comprehensive risk assessments to be developed.

The pilots involved high levels of commitment by RAMP members, significant resources for the SRM case management and coordination roles, and were subject to considerable scrutiny through the evaluation. In spite of this, it tool over a year for the two RAMPs to reach a working consensus on 'high risk', of serious harm or lethality. A roll out of the SRM strategy statewide, without clearer guidelines to differentiate high risk of serious harm or lethality, would likely result in different interpretations due to the influence of individual (strong) views, time spent debating risk levels and eligibility, and possible adverse impacts on working relationships.

Other jurisdictions has sought to clarify 'high risk' and eligibility using tools and scales specifically for this purpose.[45]

Within the existing family violence system, the CRAF provides a useful guide to assess whether a woman (and children) requires immediate protection. In day to day practice, this information can assist family violence workers to offer women and children appropriate options, including staying at home, relocation, refuge accommodation or other options. Progress is being made in Victoria with CRAF training being provided to police, and to other sectors, however generally the specialised family violence sector still has considerably more experience, and professional knowledge and skill base in understanding and assessing for family violence risk.

The client group targeted in the pilot were women (and children) at high, imminent risk of serious harm and/or lethality, who were in need of a proactive multi-agency risk management plan and response. Two key characteristics appeared to differentiate this group – less likelihood of the women in engaging with the service system, and dangerousness, unpredictability, and lack of respect of the men to the law, court orders and court processes.

An actuarial tool and framework may assist in further refining understanding of family violence risk beyond the family violence sector. A framework could assist differentiating level and type of risk and harm including for example:

- cumulative harm to children
- escalating recidivism
- imminency of risk, urgency of required response
- type of response required eg. multi-agency panel (and determination of an eligibility for a referral to RAMP).

Using a weighted measurement tool may further assist risk assessment during RAMP meetings.

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[45] The Family Safety Framework in South Australia uses a weighted tool. The Ontario Domestic Assault Risk Assessment (ODARA) Tool is used to indicate level of risk.

5.3.5 Risk management and action plans

The evaluation found that the RAMPs developed sound practices in relation to developing multi-agency risk management plans.

Risk management plans were developed following the risk assessment, based on exchange of relevant information, by all RAMP members who have knowledge of the client, and the client's situation. This effectively involved 'brainstorming' ideas, with input by all members. The collaborative approach, and sense of peer accountability promoted the consideration of a wider range of innovative options than might otherwise have occurred.

Both RAMPs had a strong focus on risk management for women and children, through safety planning for clients, and developing action plans for RAMP members. There was however, a tendency in RAMP meetings to take the broadest perspective, and discussion frequently strayed into broader case management issues. This was mainly influenced by the breadth of case presentations by community based organisations (some of which naturally have a strong case management approach) including the family violence SRM services. The efficiency of RAMP meetings could have been enhanced by maintaining the focus on 'risk management' as distinct from 'case management'.

For the future, the focus on action plans could also be improved by each RAMP member having a checklist of possible actions which might be taken by their respective agency, and considering these against every case presented to RAMP.

Although the evaluation found that risk management planning practices are sound, there are areas for potential improvement, including areas suggested by RAMP members. These include:

- greater formality in the documentation of risk management (action) plans, including a description of the rationale for the action (expected impact), organisation/ person responsible, a description of the action, and the date for completion
- the need for an agreed network of agencies to which the RAMP could refer, so that high risk clients can be referred for longer term case management assistance and support with related needs, health and quality of life issues (as needed). It is important to ensure that all RAMP 'actions' and subsequent case management referrals are directed appropriately, and not simply referred back to family violence providers as a matter of course. The entire service system needs to take responsibility for addressing family violence and its impacts.
- preparation of a list of possible actions which might be taken by each RAMP member, for consideration (ie. as an *aide memoire*) when developing action plans.

5.3.6 Clarifying case management responsibility

Several RAMP members called for clarification of the scope of RAMPs:

> *"RAMPs should focus on immediate safety. Case conferences should be held separately external to the RAMP, and also involve other agencies relevant to the case."*

In practice, RAMPs attempted to identify service providers in the local/ regional area who could contribute to risk management and ongoing case management post RAMP, but as noted, frequently RAMPs handed case management back to the service presenting the referral. This has been a specific cause for frustration in the Hume SRMDP, where there has been a perception that the Hume SRM case managers complete the bulk of assessment and safety planning prior to RAMP, and are then (re) allocated the case, following the RAMP, together with the responsibility for undertaking the bulk of the post RAMP risk and case management. Broadening the referral base to and from the RAMP should alter this pattern.

5.3.7 Reporting against Action Plans

The evaluation found that overall, RAMP members were accountable for the completion of allocated tasks, and have a good track record in completing assigned (direct service delivery) actions. A review of RAMP minutes shows that the majority of actions fall to family violence service providers, with Victoria Police the organisation with the next most allocated actions.

Early in the pilots, the practice of reviewing previous cases, and completion of actions by RAMP members was introduced. Initially this tended to be conversational and informal, and not minuted.

After several RAMPs, formal review processes were implemented in both pilots, whereby each case from the previous meeting was reviewed, with RAMP members reporting on the progress of their agreed actions. This review process occurs at the beginning of each RAMP meeting, and progress reports are minuted.

In addition, some cases are heard more than once, where circumstances have changed significantly, and/ or risk has increased.

There is however, room for improvement in the formal reporting of progress and review of cases; and on completion of specific tasks in action plans. A high degree of accuracy and quality is required, in the event the Coroner requires access to RAMP records, and for quality purposes.

One RAMP member suggested:

> *"Introduce more formal feedback processes to ensure that the action items actually get done, and within an agreed time frame."*

A more timely process and feedback system is also required, to ensure completed actions are reported to a central person (eg. the Coordinator) and/ or to other relevant members, as soon as possible after completion, as this may have implications for ongoing risk management. The pilot model of waiting a month until the next RAMP to hear the outcome of planned actions by individual members, has

not been adequate. Ongoing monitoring of risk and interventions, is essential, with cases re-presented if risk is not being adequately managed, or has not reduced.

In this context, regular (ie. monthly) RAMP meetings should be convened to review progress, regardless of whether new referrals have been received.

5.4 Effectiveness of RAMP organisational processes[46]

5.4.1 Introduction

The effectiveness of RAMP processes are considered in terms of the following domains: collaboration and relationship development; information sharing and communication and decision making. Each of these is discussed briefly below.

5.4.2 Collaboration and relationship development

The evaluation found that collaborative RAMP processes and practices during RAMP meetings were achieved to a significant degree in both pilots, especially given the limitations associated with optional participation of members. RAMP members rated the level of collaboration as high,[47] and the evaluators confirmed this through observation.

> *"Hearing different agency perspectives, understanding and discussions around the table have been very helpful, and we have learnt much about each other's views and practices"* [RAMP member]

Collaborative practices during the RAMP, and a developing culture of respect and shared endeavour, are considered to have contributed to strengthened collaboration and working relationships outside the RAMP (ie. a positive flow on effect).

5.4.3 Information sharing

Information sharing is fundamental to multi-agency risk management, and although both pilots experienced challenges initially in relation to privacy and confidentiality issues, RAMP members now prepare and share appropriate information in a constructive and appropriate way. The privacy laws needed to be clarified and interpreted as they specifically related to the pilots (and the RAMP). This clarification was undertaken and Victoria Police issued a statement of clarification about the scope of information sharing by Victoria Police members.

Information is shared as a basis for accurate risk assessments, and for safety planning for women and children, enabling a re-assessment of risk in the light of what is shared at the RAMP, and a more comprehensive understanding of the degree of risk to women and children. This is enabled by individual RAMP members bringing important information to RAMPs of which other agencies may not be aware.

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46 Addresses Evaluation Question 2: *"Evaluate the effectiveness of collaboration, information sharing and decision making between RAMP members, and evaluate the development and adherence to new integrated governance arrangements"*, and 2.1 *"How effective are RAMP processes?"*

47 See data report – input by RAMP members

"The main strength of the RAMP is the willingness of key service providers to sit around the table and provide valuable information to ensure safety of women and children" [RAMP member]

The RAMP enables agencies to share information they would not otherwise have, and to reach a more comprehensive and common understanding of the risks"[RAMP member]

In order for the RAMP to share confidential information, requires that women and children presented to the RAMP have satisfied the eligibility criteria of 'high risk of serious injury or lethality'. This legitimises the meeting as exempt from 'normal' privacy provisions. In this context, RAMP members are more likely to (and some may only) share the information within this forum that is necessary to inform effective risk management.

It is thus essential for RAMPs to ensure that confidentiality and privacy laws are kept, and not breached. The Chair and all members have a responsibility to maintain the trust of clients, the sector, and the wider community.

It is also important to limit RAMP attendance to core members, and to non core members with direct involvement with a client. It is not appropriate for observers or other parties to witness the information exchange, and the work of the RAMP, unless the observers have a potential role in contributing to safety planning and risk management, or as a learning experience from other jurisdictions, and then only subject to signing a confidentiality agreement.

5.4.4 Communication and decision making

Communication and decision making processes at RAMP, have become increasingly effective during the pilots. There appears to be a high degree of professional respect, and all members share opportunities to express and discuss their views.

Decision making occurs organically through the assessment, safety planning and risk management discussions, and agreed actions are generally summed up by the Chair.

"A key strength is the commitment to shared problem solving and risk mitigation through a multi agency response."[RAMP member]

"The knowledge around the table is amazing, and our service has become much more aware of high risk family violence issues."[RAMP member]

"The RAMP has led to stronger relationships and better lines of communication between service providers"[RAMP member]

There are still some differences amongst RAMP members in relation to classification of what constitutes 'high risk', and it is a priority for this to be agreed for the next phase of the initiative.

As indicated written communications could be improved, through documented actions being more explicit and specific eg. in addition to 'case worker to conduct a home visit to the AFM', the action plan should specify the purpose of the visit, time frame for completion, and process for reporting back to RAMP, or specific RAMP members.

5.5 Evaluation of RAMPs - summary

RAMPs provide an integrated and valued response to women and children at high risk of severe harm and / or lethality. RAMPs provide an effective forum for multiple agencies to share critical information, about imminent risk of serious injury or lethality, and strengthen their understanding and assessment of risk in each individual case. RAMP enable a focus on men who use violence, and strategies which could be implemented to increase their accountability and increase safety for women and children. The major focus of RAMPs is on actions to protect the AFM. RAMPs need to ensure that they also consider actions to minimise/ control the risks posed by the perpetrator.

RAMPs enable agencies to creatively explore risk management options for increased safety for women and children. RAMPs efficiently allocate short term tasks to address immediate critical risks, and tasks to underpin effective ongoing risk management. Discussions at RAMP generate ideas, and provide opportunities to identify the need for, and the engagement of, other services.

A collaborative approach within RAMPs is evident in the effective decision making processes which have evolved. RAMPs have contributed to a closer alignment between different organisations of understandings of risk; and development of collaborative action plans between participating agencies, where a number of parties take on and complete complementary responsibilities. One of the major achievements or RAMPs has been the shared commitment by the participating agencies to bring about a good outcome in each individual case, and also shared commitment to collaboratively address family violence as a systemic issue.

There have been positive flow-on effects from RAMPs contributing to increased collaborative practices between participating agencies outside RAMPs. Examples include preparation specifically for RAMPs, and follow up meetings after RAMPs; learnings by member agencies about family violence and high risk, and modifying of some of their internal practices; and development of shared understandings and new initiatives.

There is strong support by RAMP members to maintain RAMPs as a key component of a Strengthening Risk Management framework, and for RAMPs to be rolled out across Victoria, pending appropriate support and resourcing.

> *"RAMP is incredibly valuable and I have witnessed many amazing discussions and decisions that have assisted in keeping highly vulnerable women and children safe from serious harm or death"*[RAMP member]

> *"The success relies on the commitment and goodwill of the RAMP members. Without resources the RAMP is a burden on stretched agencies, and the required level of cooperation may be difficult to achieve in all areas without resources for coordination. Otherwise there is a danger that RAMPs will be seen as just one more network meeting."* [RAMP member]

5.6 Towards good practice for Risk Assessment and Management Panels

The evaluation identified a number of key elements and good practices for RAMPs. These are summarised below:

1 A Statewide Strengthening Risk Management strategy would best be based on partnership models in which RAMPs in each Police area are chaired or co-chaired by high ranking Police members, working in close partnership with family violence and other member agencies.[48]

2 RAMPs are complex multi-agency groups, impacted by local context and pre-existing relationships. There is a key essential role in the coordination of RAMPs, which needs to be adequately resourced. The coordination role may best be provided by appointed staff with sufficient seniority and partnership development skills, within established regional family violence agencies. The Coordinator role would include administrative support to the RAMP, liaison with RAMP Chair and members, collection of data, distribution of information, monitoring cases and reporting.

3 'Core' RAMP members are intended to be representatives of agencies considered to be consistently important and relevant in identifying women and children at highest risk, and empowered to take actions to contribute to safety of women and children, and / or to increase the accountability of men who use violence.

4 The scope of the RAMP needs to be contained in terms of target group It is important that strict eligibility screening and criteria are maintained, as it is the highest risk client group which justifies invoking the waiver to privacy legislation in multi-agency meetings. Such clarification could be facilitated by a tool which gives different weight to various risk factors, to indicate a threshold score for high and imminent risk of harm and/or death. For the future it will be important to further clarify 'high risk' and eligibility.

5 Good practice in RAMP operations include:

- consistent attendance by senior representatives of key member organisations
- ensuring RAMP members are adequately prepared - including members committing sufficient time to research cases prior to the meeting.
- ensuring members make concise presentations (background information) and that only relevant information is exchanged by members
- consistent recording of minutes and actions using appropriate formats and level of detail

[48] The rank or level of seniority is to be determined, but would need to include executive decision making authority.

- regular review of risk management plans and completed actions, enhanced (formal) feedback processes to ensure action items are completed (and within an agreed time frame)
- maintaining the scope of RAMP discussions to risk assessment, safety and action planning (with a rapid response focus), and not straying into broader case management. A rapid response model, comprising multi-agency short term strategies to reduce/ eliminate immediate risk, is indicated. This does not negate the valuable RAMP role of referring clients to a range of service providers, for post crisis assistance, and for 'case conferencing' by relevant parties to be convened separately.[49]
- efficient time management, aiming for equitable and appropriate allocation of time for each case
- creative and comprehensive consideration of actions, using an aide memoire of options
- clear and detailed action plans and minutes, based on a proforma/ guideline.

6 Good practice requires RAMPs to have a high profile with relevant agencies, credibility, strong partnerships and sound knowledge of available services and resources. It is a priority to broaden the referral base, to and from RAMPs, to ensure a wide range of referral sources to the RAMP, and to refer for post-crisis assistance to women and children

7 RAMPs provide a good opportunity for members to identify systemic (including service system, legal system) gaps and barriers, and to ensure this information is made available to appropriate entities. Information has become apparent in RAMPs through discussion of individual situations which shed light on common barriers , and opportunities for change and improvement. The Geelong RAMP began setting aside time in RAMP meetings for brief discussion and noting of service system gaps and barriers impacting women and women with children at highest risk.

8 Determining the ideal frequency of RAMP meetings should be linked to the incidence of family violence in a particular area, and the number of high-risk cases which need to be considered (eg. if monthly meetings could not consider all the cases to be presented). Decisions about the geographical coverage of the RAMP, and the frequency of RAMP meetings, need to be based on the number of women and children likely to be identified as being at 'high risk' at any time. In the event a broader roll-out of RAMP is implemented in Victoria, learnings from the pilots indicate that monthly RAMP meetings in other Victorian regions should be sufficient, subject to the following provisos:

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[49] RAMPs should not be responsible for long term, broad based case management planning. RAMPs exist within a broader integrated service system which has capacity to provide ongoing risk management, and ongoing case management, as required.

- a strengthened risk management response is offered to women (and children) by the 'first to know agency' within 12-24 hours of being identified at the highest level of serious risk/ lethality
- strengthened risk management, including collaborative practice between family violence agencies, Victoria Police and other relevant agencies, is proactive and ongoing prior to RAMP
- an extraordinary RAMP meeting can be called immediately (within 72 hours) if an agency believes it cannot adequately manage risk, and ensure the woman's safety until the next RAMP meeting
- monthly meetings should be held at a minimum, even if there are no new referrals. RAMPs may choose to move to fortnightly meetings if this is considered necessary to respond to demand.

9 As noted, governance could be enhanced by a statewide framework which clearly defines roles and responsibilities, and accountabilities, based on a consistent, whole of government authorising structure, with direct reporting to a higher level group.

10 Reporting against an agreed outcomes framework, and providing RAMP members with information about the relative success of their action plans would be essential components of a statewide SRM strategy.

6 OUTCOMES

6.1 Introduction

The primary aims of the SRMDP were to increase safety for women and children at high risk, and to hold men accountable for their use of violence. While there may be other beneficial outcomes, (particularly from the SRM case management component), a baseline 'success' indicator for the model is risk reduction and enhanced safety for women and children.

The outcomes that are discussed in this section pertain mainly to women and children assisted by the SRMDP pilots. Assistance was provided by SRM case managers only, or SRM case managers plus RAMPs, and in a few cases by RAMPs only. Data was collected separately for 'non RAMP' and 'RAMP' clients.

The intent of the evaluation of outcomes was to ascertain if changes in safety and other quality of life dimension, and if so whether these changes were wholly or party attributed to the SRM and/ or the RAMP. For clients who were assisted by SRM case managers and RAMP, it was not possible to attribute outcomes to one or the other.

Nevertheless the nature of the information shared and the creativity of RAMPs and the agreed action plans clearly add considerable impetus to improving safety, which would not otherwise have occurred.

Outcomes were assessed based on a number of sources including interviews with 12 women who were assisted by the SRM pilots; special purpose data forms completed retrospectively by worker's recording case outcome information and worker's perceptions of client outcomes, using scaled outcome measures; perceptions of RAMP members; and 6? case studies.

While the evaluation of outcomes did not include a control group,[50] comparisons of outcomes were made between 'non RAMP clients' and 'RAMP clients'. This section comprises aggregate data from both pilots (unless otherwise indicated).

Section 6.2 reviews outcomes for women and children. Section 6.3 reviews outcomes for children, as a result of specific services. Outcomes in relation to men are summarised in Section 6.4. Good practices identified by SRM workers and RAMP members which promote positive outcomes are summarised in section 6.5.

6.2 Improved outcomes for women and children

6.2.1 Introduction

The extent to which outcomes have been achieved for the intended client group needs to be considered in context. Challenges to the achievement of positive outcomes include the high levels of assessed risk and need of women on referral into the SRMDP pilot, and the difficulty in 'controlling' the behaviour of the perpetrator.

[50] This would have required the outcomes of women assessed as being at 'high risk' being assisted by generalist family violence case workers.

It was difficult for the SRMDP pilots to engage some women due to reported fear of the perpetrator, isolation by the perpetrator, or the concerns some women had about the involvement of Child Protection.

In this context any improvements, and any reduction in risk of serious harm or lethality, are notable.

Overall the evaluation found that the SRMDPs assisted women and women with children to achieve positive outcomes across a number of domains. These included engagement with services; safety and women learning safety planning, etc. Each of these is discussed below.

6.2.2 Engagement with services

Engagement with women experiencing high risk is an essential and critical function. Research suggests that in a significant number of family violence homicides the victim was not engaged with relevant family violence services.[51]

A good outcome from the pilot was the identification and engagement of women at high risk of serious harm and/or lethality.

The evaluation found that the dedicated SRM case management model provided the capacity for improved identification of, and engagement with the high risk client group (compared to previous practice). In particular, SRMDP funded positions provided agencies with the capacity to spend more time identifying and engaging with women and children at high risk. This included the establishment of systems to prioritise high risk L17 referrals; and allocating time for workers to persist in contacting and engaging with women, and to comprehensively and accurately assess the imminence and severity of risk. The availability of brokerage to provide immediate practical assistance was also a factor in facilitating engagement of some women.

Of the women and children assessed by the SRM team as being at high risk during the data period, Berry Street was able to contact approximately 75%, and engage with approximately 60% of these women.[52]

One client interviewed reported that it took about 4 phone calls from the worker before she really engaged and agreed to be assisted. Another said that *'it took months of phone contact'*, and perseverance by the SRM team before she agreed. One client noted the importance of workers explaining clearly what they could do 'up front':

> *"I didn't want to talk to them at first because I thought they were just a counselling service. As soon as I knew they could actually do something, I let the worker help me"*

There is also an ongoing challenge to maintain engagement of women at high risk as a number of changes can occur, during the support period, including change and of contact numbers, addresses, and openness to assistance. In particular, the influence

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51 Walsh et. al. (2012)

52 Of 167 women identified as 'high risk' (based on L17s), Berry Street was able to contact 126 women. Of these women, about 80% engaged with the worker. The other 20% did not wish to be assisted, or disengaged very soon after the initial contact.

of the perpetrator can make it difficult for the women to maintain contact with a service, and/or can lead to the woman changing her mind about assistance; there may be family and community pressures to disengage; or her situation may be complicated by mental health and/or drug and alcohol issues. The SRM model allowed workers to be proactive in maintaining contact whenever possible and appropriate.

The findings in terms of outcomes also point to the need for the specialist family violence sector and the wider sector to strengthen identification and risk assessment practices, thus broadening the referral base beyond L17s. This will be particularly important for the proportion of women who do not contact, or engage with the family violence service system.

6.2.3 Increased safety

The evaluation found that the SRMDP contributed significantly to improved safety for women and children. This was evidenced by reported changes and improvements in several areas.

Safety plans

The SRMDP staff developed comprehensive safety plans for clients. From commencement of service to case closure the proportion of SRM clients with Intervention Orders more than doubled; safer living arrangements were established (fewer women living with perpetrators); security measures and new locks were installed; a significant increase in emergency procedures for women and children were put in place, including agreed procedures for contacting Police; and there was an increase in the proportion of women who re-located to a safer living arrangement. For those women and children presented to RAMP, their safety plans were subject to significant review and updating.

The vast majority of RAMP members (both pilots) reported that the RAMP enabled more comprehensive risk assessments and risk management plans for women and children at risk of serious violence, compared to the information and knowledge base of any one or two RAMP member agencies.

Clients interviewed all reported that the SRM worker had established a safety plan with them. In several cases women described in detail the actions taken by the worker (sometimes in collaboration with the police) to put the safety plan in place, including helping arrange new locks and security systems, and removal of ex-partner's belongings.

In some cases, women presented to RAMP were directly linked with a nominated Victoria Police member who she could contact in the knowledge that she would receive an immediate and priority response. This reportedly increased felt and actual safety for these women.

Case manager assessment

Case managers recorded substantial ('great or very great') improvements in safety and security for nearly half of all women referred to RAMP, based on subjective retrospective assessments of workers. Safety for women who were not referred to

RAMP was achieved proportionally less often, with substantial improvements in safety recorded for about one third of (non RAMP) women.

Analysis of risk data (based on the CRAF) indicates that the risk management planning of the RAMP, together with the SRM case work undertaken with women and children, were effective in reducing the assessed risk by the perpetrator (from initial assessment to case closure). The data shows that following the RAMP, risk factors pertaining to about 70% of perpetrators reduced significantly; for the remaining 30% many risk factors were still present at case closure. For a small proportion of women (around 10%) workers reported that it was difficult to reduce risk.

SRM workers recorded a similar reduction in assessed levels of fear of women. At referral the majority of women were assessed as having 'very' or 'high' levels of fear. At case closure the majority of women were assessed as having 'low' levels of fear.

For the future, an outcomes framework is required which meaningfully records safety outcomes. Victoria Police and Court data (assaults, callouts, injuries, breaches, etc.) will need to be collected and analysed.

Client views

Women assisted by the SRMDP who participated in evaluation interviews, all reported a significant improvement in feeling safer as a result of the SRMDP. An increased feeling of safety was associated with having a clear safety plan:

> *"we go over it (safety plan) every week with the worker. . . .I feel much safer as a result".*

There was increased confidence in a police response:

> *"I've got real evidence now that the Police will come if it happens again"*

Some women felt safer because they were provided with information on the perpetrator (whereabouts, release dates from prison, etc.). Two of the women interviewed stated that they felt safer because their ex-partner was in jail. There was an expectation, however of increased danger following release from prison, but that the SRM family violence service would be available to assist.

Views of RAMP members

The majority of RAMP members reported that they believed the RAMP contributed to increased safety of women and children at very high risk, to a 'great or very great extent'. Member reported however, that they considered the RAMP less effective in contributing to holding men accountable.

6.2.4 Other outcomes

The evaluation found that the case management component of the pilot also enabled a range of other outcomes which were associated with improved safety for women and children.

Housing stability[53]

The majority of women and women with children assisted by the SRMDP required some type of assistance with housing (eg. re-locating, taking over a lease). SRM workers reported however, that actual housing stability was improved for only a minority of clients.

Housing stability is impacted by the number of moves necessitated by risk and violence, and the availability of alternative housing options. For high risk clients, staying in the family home, whilst desirable, may not be a safe option, regardless of new safety measures which have been put in place.

> *"We are reasonably comfortable at the moment, but may need to move again once my ex comes out of jail"*

The capacity to assist women and women with children at high risk, with timely, flexible housing options is an area requiring urgent attention. In some cases the time frame required to assist women to establish stable housing was longer than the SRM support period. Participation by the OoH in the RAMP is one key strategy to help with housing stability.

All the women interviewed for the evaluation reported that they were more comfortable with their housing situation after being assisted, compared to when they first commenced with the program. Most women interviewed had re-located. Comments included:

> *"We are comfortable and settled now, and hoping to stay for a very long time"*

Health and well being

The evaluation found that the pilot contributed to improved health and well being of the majority of women in the data sample *'to some extent'*. SRM workers addressed various needs affecting health and well-being through a case management approach, and through discussions at RAMP with a wider range of support agencies. Pilot agencies recorded a significant number of referrals to counselling services, community and other health related services.

Women assisted by the SRMDP who participated in evaluation interviews reported improvements in their health and well being. This in part was attributed to reduced levels of fear, and also to be able to get other issues addressed once they were safe.

Achievement of other case plan goals

SRM staff assessed the extent to which other case plan goals, in addition to safety planning, had been achieved. A higher proportion of case plans goals were achieved for women referred to RAMP, compared to those who were not. Pilot agencies indicated that it was relatively difficult for a significant minority of women to fully achieve case plan goals, other than safety and security. However many women assisted with SRM case management were able to achieve some or many of their case plan goals.

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[53] 'Housing stability' requires further definition as an outcome indicator. One or two housing moves may result in a reduction in risk, whereas multiple and frequent moves may indicate unresolved perpetrator risk

Access to relevant services and supports

The evaluation found that the SRMDP contributed to improved access to relevant services and support for women at increased risk. More than two thirds of women presented to RAMP were assisted to access a number of relevant services and supports. Pilot agencies had more limited success in assisting non RAMP clients to access relevant services and supports.

Women assisted by the SRMDP who participated in interviews reported that the SRMDP had been very significant in assisting them to gain access to services for themselves and their children. This included transport to Court, links and referrals to a wide range of community services.

Several clients stated they had been isolated from services, and were unfamiliar with the service system. The SRMDP assisted women and children to link and engage with relevant services, where there had been no previous agency involvement.

"If I had known I could get this help, I would have come 7 years ago"

6.3 Outcomes for children

6.3.1 Engagement with SRMDP and other relevant services

The SRM pilots focused on achieving immediate safety and case planning for women, and provided support to mothers in terms of protective behaviors, and provision of safe environments. In addition, SRM workers conducted individual assessments and made referrals for some children, to age and developmentally appropriate resources and programs.

The Bethany SRM Children's worker separately engaged with a number of children (n=32) who were part of the SRM program, provided a therapeutic response, and developed separate safety plans with older children.

The Berry Street case management approach primarily considered the child's needs in the context of the family's level of safety, however did provide individual assessment and referrals for some children. The majority of women interviewed noted that the Berry Street SRM worker did not provide a separate response for their children. Women did note that a number of things were organised for their children, and referrals made. However, some women expressed dissatisfaction with a lack of timely counselling or therapeutic options for their children.

6.3.2 Increased safety

SRM staff reported that children's safety was enhanced as part of the safety plan for the family. The safety of children was also increased by pilot agencies making referrals to Child Protection (as well as advocacy and liaison), and by the involvement of Child Protection in RAMPs. Both agencies explicitly included children in risk assessment and safety plans.

SRM staff in both pilots considered that the SRMDP had contributed to children's safety *'to some extent'* for about half the children, and *'to a great or very great extent'* for about 40% of children. There were about 10% of cases, where workers

recorded little or no perceived improvement in children's safety. Safety outcomes were slightly better for those children whose families were referred to RAMP.

SRMDP staff assisted some women to develop insights into the effects of trauma on children, which led to greater resolve to protect the children from violence. SRMDP assisted with changing access and custody arrangements for children in order to achieve increased safety.

6.3.4 Other outcomes for children

Educational stability

Data suggests that the SRMDP contributed to an improvement in educational stability *'to some or a great extent'* for about two thirds of children whose mothers were assisted by SRM case management and/ or RAMP. For the other one third of children workers recorded little or no improvement in educational stability, or children maintaining attendance at school and age appropriate activities. Outcomes were generally poorer for short term clients. A higher number of positive outcomes in educational stability were recorded for children whose families were referred to RAMP, compared to children whose families were not referred to RAMP.

Health and well being

Data indicates that the SRMDP contributed to an improvement in the health and well being of children *'to some, or a great extent'*, for about two thirds of children, but *very little or not at all* for one third of children. A similar pattern was identified in related measures for women (the mothers of these children).

SRM staff reported very little improvement in parenting and the home environment for about 30% of children (both pilots), and Bethany data indicated that there had been no reduction in the risk of physical or psychological harm for about one third of children.

In several cases there was an improvement in children's behaviour and symptoms, for example a reduction in aggression, anxiety, and an improvement in confidence.

Achievement of other case plan goals

Data suggests the SRMDP contributed to the achievement of other case plan goals for approximately two thirds of accompanying children, including meeting various support. There were however, about one third of children for whom staff reported case plan goals were not achieved, and where other support needs were addressed to a minor extent, or not at all.

Access to other relevant services and supports

Both SRM pilot agencies made a number of referrals of children, to a wide range of services and resources, for example Child Protection, ChildFirst, CAMHS, CHCs, counselling, MCHN, GPs, paediatricians, social workers, child care and school welfare staff. Referrals were made to Bright Futures Programs, art and music groups for mothers and children, recreational activities and outings. SRM staff and women who were interviewed reported that children who participated in these opportunities

experienced increased benefits, and potential for healthy development and peer interaction.

6.4 Outcomes in relation to men [54]

6.4.1 RAMP level

The evaluation found that the multi-agency communication and information sharing at RAMP increased opportunities for Police and other organisations to develop strategies to hold men accountable for their behaviours. The value of multi-agency forums as a means to hold men accountable is also affirmed by the Victoria Police led initiative in the region covering Darebin, Whittlesea and Banyule.

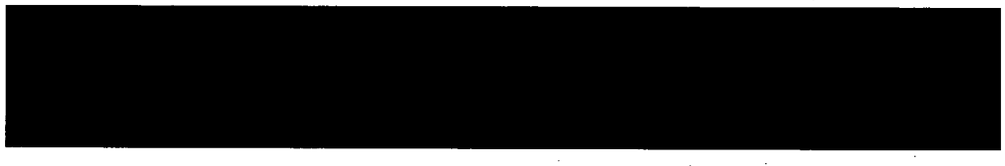
RAMP members reported that holding men accountable has been a major focus of the action planning undertaken by the RAMP; and that the work undertaken by RAMP members (following the meeting) has contributed to holding the perpetrator accountable, and/ or limiting the opportunities for the perpetrator to inflict further violence on women and children. These views are supported to some extent by the RAMP action plans, although overall there were fewer actions recorded in relation to men who use violence, compared to actions recorded for women and children. Victoria Police and Corrections representatives both affirm the significant value of RAMPs in contributing to their work in holding men accountable.

For the future it will be important to increase the focus within RAMPs on holding men accountable, and to increase the specific actions for Victoria Police and Corrections in particular, as a result of RAMPs.

6.4.2 Agency level

Pilot agencies were not able to demonstrate substantial success in holding men accountable, through the Men's Case Management (MCM) position. Possible reasons for this include the profile of the client group (dangerous, difficult to engage, requiring a criminal justice response); insufficient clarity and definition (initially) of an appropriate MCM model for this cohort; and staffing and auspice arrangement challenges.

Berry Street was not able to successfully implement the MCM position, and was only able to assist 2 men before discontinuing the position. The service also experienced significant challenges in attempting to achieve a viable partnership with the sub regional men's service to enable the delivery/ co-location of the men's case management role. This did not eventuate, and as noted, the regional men's service was not represented regularly at RAMP. Outcomes from direct work with men were thus minimal.



[54] Addresses evaluation question 3.2: "To what extent does the SRMDP hold men accountable for their behaviour?"

[redacted]

6.5 Summary of evaluation findings

The SRMDP pilots achieved some success in reducing risk, and increasing safety for a majority of women and children assisted. In particular, RAMPs made a significant contribution to safety of women and children, and better outcomes were achieved for women referred to RAMP, compared to women who were provided with SRM support only, but not presented to RAMP. It is difficult however to hypothesise about the risk and safety outcomes for women and children, had the SRMDP not been implemented.

The findings in terms of outcomes point to the need for the specialist family violence sector and the wider sector to strengthen identification and risk assessment practices for women and children at highest risk, and to broaden the referral base beyond L17s. This will be particularly important for the proportion of women who do not currently contact, or engage with the family violence service system.

For the future it will be important to increase the focus within RAMPs on holding men accountable, and to increase the specific actions for Victoria Police and Corrections in particular, as a result of RAMPs.

A number of good practice elements, which were closely associated with, or directly contributed to positive client outcomes are provided below. These are not exhaustive, and overlap to some extent with good practice elements described in previous sections.

6.6 Towards good practice

There are a number of good practices identified by SRM workers and RAMP members which promote positive outcomes for women and children at high risk. These include:

Strengthening risk management (agency based) practice elements

- 'Promotion' of the service, making women aware of the particular services provided, and the special response to high and imminent risk; and promotion to relevant organisations (eg. maternal and child health services, schools)
- Effective identification of, and engagement with women and children at high risk, and recognising that engagement is an on-going process
- Undertaking initial, and on-going risk assessments at every subsequent contact
- Development of robust and comprehensive safety plans through collaboration with women and children
- Enhancing women's understanding of the impact on the children, and helping women to develop strong protective behaviours towards children

- maintaining engagement by women with SRMDP staff, and provision of ongoing SRM assistance throughout the support period, including assistance with legal proceedings (criminal and family law).
- Accessing THM and other housing and practical support as a rapid risk management response, and to facilitate engagement.
- Accessing and utilising brokerage, and providing practical responses, eg: increased security, locks changed, immediate access to brokerage to assist woman to secure private rental
- Effective coordination and communication with other specialist services - including Child Protection, health services, mental health services, internal agency services
- Undertaking individual assessments with each child
- Providing a flexible SRM model – in terms of frequency and timing of contact; location and length of meetings/ discussions with women; communications; response to crisis; longer term support; flexible and creative forms of assistance
- Active advocacy and a rights based approach in liaison with other key services
- Provision of consistent and persistent support (eg. it took 10 months from initial flagging of high risk to make contact with one client)
- Assisting women and children to gain access to counselling support

Children – practice elements promoting positive outcomes for children

- Effective working relationship with Child Protection
- Including children in all risk assessment and management plans, and completing thorough assessments of children's needs.
- Access to a child focused therapeutic service (including undertaking joint assessments)
- Liaising with Child First providers
- Addressing housing and access to childcare
- Providing women with information on the impact of family violence on children
- Advocating for appropriate access arrangements (eg. with the Court)
- Linking children to age appropriate resources (child care, kindergarten, etc.) and programs (eg Bright Futures), and to counselling and/or therapeutic services
- A child centred approach to case management with women experiencing family violence, including conducting individual risk assessment and safety planning
- Providing adequate and appropriate support to women to facilitate safe environments for children

RAMP practice elements

- Development of appropriate referral base, and referral pathways and processes for women and children at high risk
- Sharing of relevant information
- Clear (and creative) action plans
- Proactive follow up from RAMP
- Collaborative work especially between family violence agencies and Victoria Police (both within and outside the RAMP)
- Focus by RAMP on keeping men accountable
- Involvement of all key agencies at the same time

Criminal justice system – practice elements promoting positive outcomes

- Police leadership and commitment
- Appropriate police actions in relation to women and children and the perpetrator, including pro-active approaches, obtaining intervention orders and responding to breaches)
- Court actions – making orders
- Corrections actions – providing a focus on the perpetrator

Outcome measures

A key aspect of a Strengthening Risk Management initiative for Victoria is an agreed meaningful outcomes framework. There are a number of possible outcome measures which might be useful, for example:

- the accuracy of identification of high risk (ie. using the L17 and other information)
- the level of contact made with women and children identified as being at high risk
- the level of initial, and ongoing engagement with women who are contacted
- the achievement of 'safety plan goals' (ie. the extent which a number of safety plan strategies are in place before and after SRM/ RAMP involvement)
- the achievement of 'case plan goals' which directly and indirectly support safety (eg. housing, income support)
- a reduction in risk factors (using an appropriate measurement tool), tracking cases presented to RAMP
- a reduction in recidivist family violence.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The Evaluation Brief and Terms of Reference require that recommendations are made in relation to the potential roll out of SRM RAMPs across Victoria.

The evaluation of the two pilots confirms that a Statewide initiative to strengthen risk management is needed in Victoria to further protect the lives of women and children at imminent risk of serious injury or homicide, and to reduce the incidence of severe and repeated family violence. Approaches to strengthen risk management for this target group have been successfully implemented elsewhere in Australia and overseas.

The starting point for the successful roll out of the initiative across Victoria is a strong, authorising, whole of government commitment to strengthen risk management for women and children at highest risk. This needs to include formal and high level multi-Departmental endorsement and support, and formalised guidelines and frameworks (Section 7.2).

The recommended establishment of Risk Assessment and Management Panels across Victoria would best be undertaken on a regional and sub-regional basis, and would bring together key agencies which can most effectively pool their resources, information, problem solving skills, and powers of intervention to protect women and children at highest risk, from serious harm and lethality (Section 7.3). The proposed model is summarised in Section 7.4.

Each RAMP member needs a capacity to provide valuable information and particular perspectives on the level of risk, and make decisions and commitments on behalf of the organisation they represent. Police leadership of RAMPs in collaboration with community based organisations, offers several potential advantages.

A coordination function is required for the establishment of RAMPs, and for their ongoing effectiveness and efficiency. Key coordination roles are to develop the capacity of RAMP members and the broader service system to support the SRM initiative, and to contribute to the administration of RAMPs.

The proposed roll out of RAMPs represents a significant improvement in the system wide capacity in Victoria to respond to and address 'high risk' family violence. It is also a priority to strengthen risk assessment and management across the specialised family violence sector (Section 7.5), and in the wider service system (Section 7.6).

Finally, a greater focus on the risks posed by perpetrators will be an important element of the proposed SRM initiative for women and children at imminent risk of serious harm or lethality.

7.2 Authorising environment for a strengthening risk management initiative in Victoria

Whole of government approach

An integrated, multi-agency strategy to address extreme family violence towards women and children, is required in Victoria. This is essential in order to increase the safety of the cohort of women and children who are at highest risk of serious harm and lethality from family violence, and to increase the accountability of the men who are threatening to perpetrate this level of violence.

As noted in section 3, the establishment of the Victorian Pilots was a protracted and inefficient process, largely due to the absence of a clear authorising environment. Each Pilot agency independently needed to identify and contact potential agencies and RAMP members; provide information and explain the proposed function of the RAMP and role of RAMP members; clarify sensitive privacy and confidentiality issues; negotiate and obtain in principle commitment from these large key agencies (and bureaucracies) to participate; finalise interagency agreements and subsequently ensure that RAMP members from other agencies, of an appropriate seniority level, consistently attended meetings.

In reality, it took both Pilot agencies several months before RAMPs commenced functioning effectively. Both Hume and Geelong RAMPs experienced problems with achieving "buy-in" and regular attendance from all key partners; some agencies were notably absent from the Panels during the first year of the pilots; and some agencies were very slow to make a commitment. While both Pilot auspice agencies can be commended for successful establishment of the RAMPs, a more strategic and efficient process will be essential to support the proposed roll-out of the multi agency RAMPs more broadly across Victoria.

The successful implementation of a strengthened risk management initiative for Victoria thus requires a whole of government commitment in collaboration with the community sector, including support from all key Ministers and Departmental executive levels. This level of commitment is necessary to ensure participation, collaboration and input to decision making, and active support of the initiative by senior staff in Divisional, regional and local contexts.

This approach is essential to the proposed initiative, and requires the explicit, formal endorsement and ongoing commitment of relevant Ministers and government departments. Precedents include the UK, where the Home Office, building on the work of CAADA, has provided an authorising environment, support and resources, for the operation of Multi Agency Risk Assessment Committees since 2002.[55]

The South Australian roll out of the family Safety Framework was also supported by top down leadership in order to obtain the collaboration "on the ground" of several key government and non government agencies and organisations. Cabinet endorsement, and championing by key parties provided the necessary authorisation

[55] There are now approximately 250 MARACs in the UK, which have been established over the last 10 years. The UK government is continuing to give consideration to whether MARACs should become statutory bodies with greater authority, and with powers of decision making and direction to partners.

to ensure this collaboration. Even with this level of support it has still taken several years to fully operationalise and achieve statewide coverage of the FSM program in South Australia (2009 to 2013).

There is considerable capacity within Victoria to provide an appropriate authorising environment to strengthen risk management with the highest risk group.[56] The current Victorian government's *Action Plan to Address Violence against Women and Children* (2012) provides a good foundation to strengthen an integrated risk management response, and describes a range of relevant and complementary initiatives.

As noted in section 2, a Ministerial Addressing Violence Against Women and Children Advisory Group has been established in Victoria, comprising sectoral representatives and key Ministers, to identify major and emerging issues, and support the implementation of the Action Plan. Individual ministers may choose to convene their own advisory forums. The Ministerial Advisory Group on family violence thus appears to be the appropriate forum to progress the Victorian high risk multi agency initiative as a "special project". One option would be to establish a new High Risk Working Committee as a sub Committee of the current Ministerial Addressing Violence Against Women and Children Advisory Group.

In addition, each relevant government Department and organisational entity needs to establish a distinct focus on strengthening risk management, and consider ways to support the SRM initiative. Considerations include the allocation of staff resources and priorities, and the development of policies and practices which will help ensure commitment and involvement by central and regional staff of appropriate seniority. This may be achieved by assigning a responsibility to a particular individual or group within each Department/organisation for oversight of, and accountability for participation in the proposed SRM initiative.

1	*It is recommended that:*
-	*the Victorian government makes a formal commitment to a statewide multi-agency integrated risk management initiative for women and children at imminent risk of serious injury or death from family violence.*
-	*a high level Statewide coordination committee be tasked with overseeing the Statewide rollout and ongoing operation of multi-agency risk assessment and management panels (RAMPs).*
-	*all relevant Departments and organisations designate responsibilities for ensuring leadership, participation and appropriate responses within the strengthening risk management initiative.*

[56] This is consistent with Victoria's commitment and track record in tackling family violence. Examples of achievements to date include the establishment of new legislation (FVPA), new structures designed to promote an integrated approach involving relevant government Departments, the development of programs and policies in the key Departments of Justice and Human Services, as well as notable changes to practices within Victoria Police. At a local level Integrated Family Violence Groups have been established, supported by funded Regional Integration Coordinators.

Guidelines, framework and MoUs

A strengthening risk management strategy in Victoria needs to be supported by clear documentation to facilitate understanding and 'buy in' by all relevant agencies and organisations.

Guidelines need to cover strengthening risk management as it applies to all RAMPs and RAMP member agencies including Victoria Police, specialist family violence agencies (women's and men's services which receive police L17 referrals), DHS Child Protection, Corrections and organisations and agencies in the broader service system, in particular health, and education.

Guidelines would include a model description comprising governance arrangements; roles of the Chairperson and the Coordinator; roles and responsibilities of member agencies, and reporting and accountability frameworks; data collection and record keeping requirements; confidentiality and privacy provisions.

The evaluation highlighted the value of the RAMP for key relevant agencies to share information, enhance risk assessments, identify creative responses, and develop risk management and action plans. Communication, decision making and feedback processes need to be incorporated in a Guidelines document, and operational guidelines clearly described.

At the local level, agencies relevant to the SRM initiative need a clear understanding of their roles and responsibilities, and the way in which they are required to collaborate, and participate as RAMP members. A basis for agreement between agencies is essential, prior to the statewide roll-out of the SRM initiative.

A standard multi-departmental and multi-agency Memorandum of Understanding (MoU) or similar, needs to be developed, and adapted to regional greed at a departmental level, prior to the rollout. The MoU would clarify the authorisation of local collaboration, information sharing, and decision making by RAMP members, and would support the establishment of RAMPs across the State.

2	*It is recommended that:*
-	*a Framework and Guidelines document is finalised prior to the rollout of a statewide initiative. The document would comprise Guidelines including a service model description, and roles and responsibilities of all relevant parties*
-	*a standard MoU is developed for all RAMP member agencies prior to rollout of a statewide initiative*

7.3 Strengthening risk management through multi-agency risk assessment and management panels (RAMPs)

The Pilots demonstrated clearly showed the benefits of Risk Assessment and Management Panels (RAMPs) for providing an enhanced response to women and women with children, who are most at risk. In particular RAMPs contributed to improved risk assessment through sharing information; and developing additional and creative risk management responses; RAMPs facilitated joint, timely decision making and action plans, and significantly improved risk management.

The RAMP is primarily a facilitating structure, and does not have any separate organisational authority, nor does it provide services or take actions as a single entity. Any decisions made are agreed to by the members, and designated actions become the responsibility of the relevant agency. Individual RAMP member agencies agree to accept and/or 'own' RAMP decisions, and accept responsibility for completing allocated actions. Individual members are formally accountable to their own agencies, and by agreement accountable to RAMP and other RAMP members, for the completion of their agreed actions.

Similar strategies to RAMPs have been shown to be effective overseas and in Australia. In particular, Multi Agency Risk Assessment Conferences (MARACs), which have been operating in the UK since 2003, have demonstrated the value of a specialised, integrated response, through independent evaluations. Family Safety Meetings (which are similar to MARACs) were established in South Australia in 2009, following the evaluation of two pilots, and report similar positive results.

The two Victorian pilots have demonstrated the achievement of enhanced safety outcomes for women and children at highest risk, as well as other significant benefits. RAMPs are potentially important in identifying systemic gaps and barriers; in contributing to enhanced collaboration between key agencies; in facilitating enhanced practices within individual agencies; and in contributing to the capacity of the family violence and broader service system to identify, engage and respond to women and children at highest risk.

The number and location of RAMPs to be established in Victoria should be based on a number of factors including the incidence of family violence, and geographical boundaries for police, and local government. As a guide, in the UK and South Australia there is one RAMP per 100,000 population of adult females.[57]

The two Pilots which were evaluated in Victoria provided sufficient coverage of two local government areas, the City of Hume (population of 180,000), and the Greater City of Geelong (population of about 220,000). In the UK there are approximately 250 MARACs for a population of 63 million, corresponding to one MARAC per 250,000 people. This suggests that there could be one RAMP for regions with populations of 200-250,000 people. In Victoria this would equate to about 30 RAMPs.

The geographical boundaries of RAMPs could be aligned with local government areas, however some RAMPs might cover one local government area, and some could cover two or more areas. Boundaries could also take into consideration Victoria Police Divisions and Police Service Areas (which correspond to LGA boundaries). The incidence of family violence can vary by LGA, and will also need to be taken into consideration.

3	*It is recommended that RAMPs are established across Victoria, to deliver an integrated response to women and women with children at highest risk of serious injury and/or lethality*

[57] CAADA (2012)

7.4 RAMP model

Introduction

The purpose of RAMPs is to provide a forum in which key agencies are authorised to share relevant information, in order to reduce the risk of serious harm to women and children from dangerous perpetrators. The proposed Victorian RAMPs would perform similar functions to the pilots, to MARACs in the UK, and FSMs in South Australia.

Appendix 1 outlines key model elements (draft) of a multi-agency strengthening risk management model, including aims and objectives, target group, membership, and coordination. Once finalised, a description of the RAMP model would be incorporated into the Guidelines and Framework documents.

The two main tasks of RAMPs are to assess the level of risk based on available information and experience; and to develop creative action plans to address the identified risks. These include both protecting women and children, and actively seeking to prevent the perpetrator from injuring or killing them.

Assessment of high risk

The proposed roll out of RAMPs is intended to assist women and women with children assessed as being at high and imminent risk of serious harm or lethality, and to increase the accountability of men who use violence. It is important that there is a commonly agreed and accepted definition and understanding between all parties of 'high and imminent risk of serious harm or lethality'.

Referral to a RAMP requires consideration of whether the serious threat is imminent, that is, a current serious threat to life or health, and/ or where a serious threat to life or health will develop if no action is taken.

The assessment of risk in the Pilot projects was based on the CRAF, with referrals to RAMP being made based on information from, and interpretation of the CRAF, together with the professional judgement of SRM workers and other referring workers.

In terms of an assessment guide, the greater number of ticks on the CRAF indicate higher risk overall, however the number of ticks does not necessarily indicate relative risk, or imminence, as some indicators may carry more risk than others. Protective factors can also offset risk, and professional judgement always needs to be exercised in risk assessment. In some situations there may only be a few factors known with certainty, but the situation might still be considered 'high risk'.

It took several months before there was general agreement between RAMP members about definitions of the level and imminence of risk, for women and children being referred to the RAMP.

Guidelines for the referral of women to MARACs in the UK indicate that workers use their own professional judgement, combined with the number of ticks on the CAADA-DASH Risk Identification Checklist (RIC), plus indicators of escalating violence. The CAADA Guidelines state that 14 or more ticks (out of 24) should trigger a referral

to a MARAC. This may suggest that CAADA considers that each of the risk indicators carries similar weight.

In other jurisdictions such as South Australia, assessment tools have been developed in order to score the level of risk. Thus, there are weights associated with each risk factor, and an overall score can be calculated. If the score exceeds a threshold, then the woman is automatically referred to a Family Safety Meeting. Referral may also be at the Coordinator's/ worker's discretion for those women who do not exceed the threshold.

In some other jurisdictions assessment tools have been developed and validated - such as the Ontario Domestic Assault Risk Assessment (ODARA) Tool. This tool is used in several Canadian provinces, and other jurisdictions. Validated tools have been considered useful in cases where women and children are at risk of being killed, and where a Coronial inquest is likely, if no action is taken.

Further clarification and agreement on the 'high risk' target group in Victoria would be an advantage in the proposed Victorian SRM initiative. This would promote clarity, and help ensure that all women and children who fall into this target group, are more consistently identified, referred to RAMP, and responded to in an integrated timely way. Development of an actuarial tool, to be used in conjunction with the CRAF, could assist workers to assess (or quantify) 'highest risk' and imminence, and would support the effective roll out of the RAMPs. This approach would need to be supported by eligibility guidelines and training.

4	*It is recommended that:*
-	*the proposed RAMP model (Appendix 1) forms the basis for the establishment of RAMPs across Victoria*
-	*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 (eg. weighting system used in SA; ODARA in Canada).*

Membership of RAMPs

The evaluation of the Pilots (and other research) shows that a targeted integrated response to women and children at imminent risk of serious harm and lethality needs to comprise a mix of member organisations which can:

- be 'first to know' agencies with resources and capacity to identify imminent risk of serious injury/ lethality (Victoria Police, specialist family violence services, health services)
- provide crisis assistance to ensure safety for women and children, including safer accommodation options (eg. family violence outreach services, refuges, OoH)
- assist in the implementation of a safety plan (family violence services, other community services, Victoria Police, etc.)
- represent the interests and safety of children (eg. Child Protection, Child First, education)

- facilitate immediate protection from harm for women and children by taking timely action to intervene with the perpetrator (eg. Victoria Police; Corrections; specialist men's family violence services)
- develop strategies to monitor and address/limit the violent behaviour of the perpetrator over time (Police, Corrections, men's family violence services)
- assist women and children to make considered decisions (eg. family violence services, legal services)
- provide relevant information and services which contribute to safer and sustainable outcomes (eg. Centrelink, Corrections, health services)
- ensure women's cultural backgrounds and experiences are understood and included in risk assessment and safety planning (Indigenous and culturally specific organisations)

The evaluation confirmed the importance of the following organisations participating in RAMPs:

- Victoria Police (Chair) *
- Specialist family violence services (women's and men's services receiving L17s) *
- DHS Child Protection *
- Department of Justice – Corrections *
- DHS Office of Housing
- Department of Health – community based mental health, drug and alcohol, maternal and child health services, hospital emergency and maternity departments
- Centrelink
- Housing and homelessness service
- Child First
- Education/ schools representative
- Indigenous agencies
- CALD agencies

The first four organisations (marked with *), are considered essential to an effective RAMP and would be required to attend all RAMP meetings.

Ideally other RAMP members would be invited to RAMP meetings by the Coordinator if they were considered to have information or capacity which could be relevant to a particular case. An agreed process is required (and reflected in the MoU) to help ensure that all organisations with relevant information attend RAMPs.

Seniority of RAMP members

Each RAMP representative needs to have sufficient seniority in their organisation to be able to:

- obtain relevant information and detailed briefings prior to RAMPs
- disclose relevant (confidential) information to directly prevent serious injury or lethality of women and children, and

- make decisions during the course of a RAMP meeting which commit their organisation and resources to a particular course of action within the required time frame, to increase safety for women and children.

The appropriate seniority for RAMP member representation (executive decision making power) needs to be comparable across organisations, with clear reporting and accountability arrangements in each member organisation.

5	*It is recommended that:*
-	*membership of all RAMPs includes as a minimum senior representatives from Victoria Police, family violence agencies, Corrections, and DHS Child Protection.*
-	*agreed processes are developed for the coordination of attendance of other RAMP members, depending on referrals, and clients' needs and circumstances.*

Leadership of RAMPs at local/ regional levels

Victoria Police is committed to providing leadership in responding to family violence in Victoria,[58] and the police and the criminal justice system, as well as the specialised family violence service system, have a lot to gain from effective RAMPs in terms of meeting their objectives.[59] Leadership of RAMPs thus requires close collaboration between Victoria Police and community based family violence agencies.

Police leadership of RAMPs, including senior Victoria Police members chairing RAMP meetings, has several potential advantages. These include maintaining a focus on the target group, perpetrator accountability, risk management, police led action plans, and a capacity to encourage regular attendance of all members. This has been evidenced in both the UK and South Australian high risk panels (MARACs and FSMs), where police leadership provides a strong criminal justice focus.

Victoria Police has made a particular commitment to address recidivist family violence. In selected area in Victoria, Victoria Police family violence teams identify and respond to recidivist family violence offenders, recognising that some recidivists engage in other criminal activities. Victoria Police also works closely with some community based organisations to strengthen risk management and enhance safety of women and children at risk from repeat offenders. Because many recidivist perpetrators are also 'high risk' perpetrators, aspects of the Victoria Police recidivist response are complementary to the proposed 'high risk' SRM initiative. There may be opportunities for existing recidivist family violence initiatives to coordinate with the SRM initiative. This could add considerable focus at RAMPs on perpetrator accountability.

6	*It is recommended that consideration is given to Victoria Police providing leadership for the SRM RAMP initiative, at the local/ regional level, including that senior Victoria Police representatives Chair or co-Chair the RAMPs*

58 Victoria Police (2009)

59 Benefit cost analysis show the greatest savings from MARACs accrue to the police and then the criminal justice system (CAADA, 2010).

Coordination of RAMPs

The two Victorian Pilots comprised a funded Coordinator position, modelled on the MARAC Coordinator role in the UK. The evaluation found that a dedicated coordination role is an important and necessary function in a multi-agency model, in order to ensure the effective and efficient operation of RAMPs. The proposed RAMP coordination function comprises operational and administrative support, as well as agency and system development components. Coordination is particularly important in the establishment phase of RAMPs.

Important operational support tasks of the Coordinator position include reviewing/ screening eligible referrals; ensuring that RAMP members have relevant information prior to RAMP meetings; keeping records of RAMP discussions and decisions; collecting data and reporting on activities, and assisting the RAMP Chair as required. System development tasks include ensuring that all RAMP members are familiar with RAMP processes, and their roles and responsibilities; partnership development and maintenance; liaising with the full range of potential referral agencies; promoting consistency in referrals; maintaining a tracking system of RAMP cases; and collecting information and reporting on systemic gaps and barriers.

The two Pilot Coordinator positions had responsibility for most of these tasks.

Other risk management initiatives have also recognised the importance of a coordination role in a multi-agency model. In South Australia the Victim Support Service is funded to provide coordinators for all Family Safety Meetings throughout the State. The provision of the coordination function by a single Statewide agency can promote consistent quality in RAMP operations across the State, and provide statewide reports on performance, and service system gaps and barriers.

In the UK, MARAC Coordinators are funded by the Home Office to perform coordination tasks, with Coordinators attached to one or two MARACs. The Victorian Pilots showed that the coordination role can be effectively provided by individual regionally based coordinators. If this model is implemented in a statewide rollout, a monitoring and reporting strategy will be required.

Each of the proposed RAMPs in Victoria (eg. up to 30 statewide) would require dedicated coordinator resources. Ideally Coordination positions would be based in the specialist family violence agencies which receive L17 referrals from police.

7	*It is recommended that RAMP Coordinator positions are established (funded) in specialist family violence agencies, and attached to each RAMP.*

7.5 Strengthening risk management in the specialised family violence sector

Strengthening risk management for women and children in the specialist family violence service system is a priority. The evaluation confirmed that accurately identifying, contacting and engaging women at highest risk is challenging and time consuming. Dedicated resources are required to allow workers to identify and prioritise highest risk referrals and make repeated attempts to contact and engage women at highest risk, and make referrals to RAMP, as appropriate.

This activity is best provided by specialist family violence outreach agencies which receive police L17 referrals. These agencies would conduct intake and screening processes utilising the CRAF (and/ or a refined actuarial tool) which assess and prioritise all high risk L17 referrals, and do so within a 12 to 24 hour time frame.

The pilot projects did not demonstrate a strong case for funding dedicated specialist SRM teams, but found that this activity can effectively be undertaken by existing specialist family violence services, provided there are appropriate good practices and processes in place, and workers have appropriate skills.

The evaluation established that there is a need for the proposed SRM initiative to include family violence practitioners with advanced skills, to identify and engage with women at highest risk, and to provide and supervise risk assessment and risk management with these women and children. Women are often fearful of the consequences of engaging with family violence services, and not aware of the services and opportunities for greater safety which might be available to them. Maintaining engagement with, and supporting women and children at highest risk requires skills and persistence, and an appropriate level of seniority and experience. Practitioners also require advanced skills in order to deal with situations which are often dangerous and traumatic.

The evaluation also highlighted the need for family violence outreach services to provide an enhanced and more consistent response to individual accompanying children at high risk of family violence, including risk assessment, safety plans, and referral to a range of age appropriate services, as required. This adds further support to the need for practitioners with advanced skills.

Finally, family violence outreach services need to have the capacity to provide ongoing case management (in addition to risk management) to women and women with children at highest risk of serious harm or lethality.

All family violence services can potentially achieve improvements in risk management practices with the highest risk group of women and children. It is expected that a significant proportion of referrals to RAMP will be from these family violence agencies, following identification and engagement. Specialist family violence services which do not receive L17 referrals need to utilise the CRAF, and consult with RAMP Coordinators on the level and imminence of risk and harm, and appropriateness of referral to a RAMP. In addition, a proportion of women experiencing violence do not contact police, and may self refer, or come to the attention of other service types.

The evaluation identified a number of good risk assessment and risk management practices (section 4.5). Good practice in strengthening risk management in all family violence services needs to be further defined and adopted by the family violence sector.

8	*It is recommended that:*
-	*specialist family violence outreach services establish a dedicated activity and process to identify, contact and engage with women and children at high risk, and make referrals to RAMP as required.*
-	*the proposed SRM rollout includes advanced practitioner staff in specialist family violence outreach agencies*
-	*specialist family violence outreach services enhance risk assessment and risk management responses to children*
-	*good practice for strengthened risk management in the specialised family violence sector are developed and adopted*

7.6 Strengthening risk management across the wider system

Broadening the referral base

The proposed Strengthening Risk Management initiative in Victoria needs to prioritise strengthened risk assessment and management practices in the wider service system to ensure that women and children at highest risk are identified and engaged by all 'first to know' agencies. This would include expanding the capacity of the service system to identify and engage with women and children at high risk, and to make appropriate referrals to specialist family violence services, police and/or RAMPs.

Research indicates that it can take several years for women at high risk of serious family violence to find effective help.[60] During this time some women may be assisted by generic and specialist (non family violence specific) services. In particular women with injuries from family violence may come into contact with ambulance services, emergency hospital departments, and health and community based services. Women and children experiencing family violence may also come into contact with maternal and child health, mental health, and drug and alcohol services.

There are approximately 600 reported attendances at emergency departments per annum in Victoria which result from family violence. This is likely to significantly understate attendances as women may not always accurately disclose the reason for the injury; medical staff may not inquire and/or may not make referrals to police, or a family violence service.[61]

Other jurisdictions have recognised the importance of improved identification and engagement practices within the health care sector. CAADA (2012) has recommended that additional Independent Domestic Violence Advisors be based in selected UK hospital emergency and maternity departments, and education and training material has been developed for medical and health care practitioners.

In Victoria CRAF training has made a significant contribution to family violence capacity building with police, and some other sectors, and this could be built on with the roll out of the RAMPs.

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60 Diemer (2012)

61 Diemer (2012), p.59. Victims Support Agency.

The Pilot agencies were able to expand the referral base to RAMPs to some degree, although the majority of referrals to RAMPs originated from the pilot agencies themselves. Targeting key sectors to improve identification, assessment and referral practices and to achieve expansion of the referral base to RAMPs, should remain a key priority in the SRM initiative.

The potential contribution of the health sector to identify and respond to family violence has been highlighted by the Victorian Coroner. The Coroner notes that for health services, familiarity with best practice guidelines for assisting victims, coupled with a sound understanding of the range of specialist and mainstream services that can provide further support, is essential.[62]

Key strategies for the Victorian roll-out might include:

- achieving high level commitment by all key program areas within the Department of Health, to participate in the SRM initiative. This would include clarifying ways in which participation could be operationalised at the local and regional level, and this would be reflected in MoUs
- other strategies to improve the skills, and enhance the level of assistance by health services regarding women and children presenting with injuries which might have been caused by family violence
- broadening the referral base to be a key priority of the SRM roll out. Strategies could include ongoing education and training, relevant material in the Framework and Guidelines document pertaining to individual sectors, promotion of RAMPs, and training in the use of appropriate assessment tools

9	*It is recommended that:*
-	*health services are prioritised for participation in the SRM initiative*
-	*a plan is developed to strengthen identification, assessment and referral of women and children at high risk, within the health sector, and other key 'first to know' organisations in the broader service system (education, housing, income support)*

Strengthening criminal justice responses to men

The pilots demonstrated that a 'traditional' men's case management position in community based agencies is not effective with the most violent and dangerous perpetrators of family violence. It was recognised however that a strengthening risk management strategy needs to incorporate an increased focus on monitoring perpetrators and responding to the risk posed by perpetrators, directly and collaboratively, in order to reduce risk to women and children.

Responsibility for taking actions in relation to men who use extreme violence is the domain of Victoria Police and Corrections. Corrections representatives made significant constructive contributions to risk management for women and children in the Geelong and Hume RAMPs. It was also acknowledged that there are opportunities for Corrections to develop greater knowledge and understanding of family violence, and develop proactive responses, for example with Community Corrections Orders and parole conditions. In terms of Victoria Police, the strength of

[62] Walsh et. al. (2012), p 48.

responses to men who use violence may depend on available resources, priorities, and the capacity of local police in different areas (eg. not all police areas have police family violence teams/ units).

Community based and other organisations can potentially play an important role, working in partnership with Victoria Police and Corrections. This could include a monitoring role, and provision of information to assist police, Corrections and RAMPs in relation to perpetrators. Community based organisations can provide a 'risk management' function by actively monitoring the whereabouts of perpetrators, by attendance at court, liaison with family violence services provided to women, and liaising with police and Corrections. In some instances community based organisations may have the opportunity to engage men with a view to changing their behaviour (this might include MBCPs, mental health or drug and alcohol services), however it is important to differentiate the role from other men's case management practice.

10	*It is recommended that:*
-	*RAMPs include a specific focus on directly and proactively addressing the risks presented by perpetrators*
-	*the proposed SRM initiative supports a strengthened criminal justice response to men who use violence*

APPENDIX 1: PROPOSED SRM MODEL

1 Introduction

This section provides a draft outline for a proposed model framework for a strengthened multi-agency risk management strategy in Victoria for women and children at imminent risk of severe injury or death. It is expected that Strengthening Risk Management Framework and Guidelines would include a description of the SRM model.

2 Rationale

The aim of the proposed SRM strategy is to increase the safety of women and children at high risk of serious harm and lethality from family violence, and to increase the accountability of the men who are threatening to perpetrate this level of violence.

An integrated multi-agency strategy is required to effectively respond to women and children, and to men, in this cohort. The strategy is premised on enhancing the capacity of the family violence and broader service system; and the establishment and operation of a coordinated multi-agency Risk Assessment Management Panel (RAMP) model, which will be replicated in locations across Victoria, to ensure full Statewide coverage.

The strengthened response needs to include a capacity to:

- identify women and children at highest, imminent risk of serious harm or death in Victoria
- engage women and women with children at highest risk in risk assessment and safety planning
- make referrals to RAMPs
- provide ongoing coordinated risk management
- increase the accountability of the perpetrator for his actions, and reduce the capacity of the perpetrator to inflict serious injury or kill his family members.

3 Target group

The proposed SRM strategy is intended to assist women and women with children assessed as being at high imminent risk of serious harm or lethality, and to increase the accountability of men who use violence. 'High risk' is assessed using an agreed tool which identifies a range of risk factors, combined with the professional judgement of the referring agency worker, and the level of risk and fear assessed by women and children. Referral to a RAMP requires consideration of whether the serious threat is imminent, that is, a current serious threat to life or health, and/ or where a serious threat to life or health will develop if no action is taken.

4 Multi-agency Risk Assessment and Management Panels (RAMPs)

4.1 Aim of RAMPs

The primary aims of the RAMP are:

a) To reduce risk and harm to women and children at imminent risk of serious harm and lethality from family violence. This includes preventing/reducing the likelihood of death and life threatening assaults on women and children.

b) To improve the accountability of perpetrators for threatened and actual use of violence. This is achieved by supporting a criminal justice system response to perpetrators; sharing information about the whereabouts and activities of the perpetrator, including criminal actions and breaches, likely movements (including release from jail), and perpetrator actions affecting the AFM.

c) To accurately and comprehensively assess the imminent and ongoing risk to women and children

d) To develop coordinated action plans involving all relevant organisations, based on sharing all relevant information.

e) To proactively address the immediate safety needs of women and children.

f) To strengthen the resources and capacities of individual organisations and agencies, to assist women and children at risk of serious violence. This is achieved through service system capacity building in risk assessment, safety planning and risk management; strengthening rapid coordinated risk mitigation responses for women and children at highest risk.

g) To identify service gaps and barriers to safety for women and children are addressed.

h) To develop more integrated interagency working relationships and shared perspectives on risk assessment and management.

The RAMP does not override the individual autonomy/ responsibility of any member organisation. The RAMP does not replace the role and functions of each of the agencies attending the RAMP.

4.2 Key objectives of the RAMP

Key objectives of the RAMP are to:

a) Achieve a shared/ agreed position on the level, type and imminence of risk and harm; agree on what constitutes breaches and threats to the safety of women and children; and the types and levels of responses which are appropriate

b) Share relevant information, based on an agreed protocol and measures to safeguard information in accordance with privacy principles

c) Undertake creative problem solving and safety planning for women and children

d) Develop risk reduction/ risk management action plans, including deciding actions for statutory and community based member organisations to complete

e) Coordinate actions to maximise the safety of women and children

f) Ensure a focus on increasing accountability by perpetrators

g) Enable/ facilitate ongoing communication between members

h) Ensure delegated actions are completed in a timely and safe manner

i) Document agreed actions and maintain records to a standard required by an external review (eg. the Coroner)

j) Undertake (internal) reviews of cases considering risk levels, efficacy of the plan, and learnings

k) Identify and document service system gaps and barriers impacting the safety of women and children, and the capacity to hold perpetrators accountable

l) Promote the efficacy of the RAMP process across all relevant sectors.

4.3 RAMP membership

The membership of RAMPs include:

- Victoria Police (Chair)
- Family violence outreach service
- DHS Child Protection
- DHS Office of Housing
- Department of Health – mental health, and drug and alcohol, maternal and child health, hospital emergency department
- Department of Justice – Corrections
- Centrelink
- Men's family violence service
- Housing and homelessness service
- Child First
- Education/ schools representative
- Indigenous agency
- CALD agency

Each member agency will appoint a specific delegate to RAMP, and include the RAMP role in the delegate's position description.

Seniority of RAMP members

Members of the RAMP are sufficiently senior that they are able to:

- obtain relevant information and briefings prior to RAMPs
- disclose relevant confidential information which potentially affects the safety of women and children, and
- make decisions during the course of a RAMP meeting which commit their organisation and resources to a particular course of action within the required time frame

The SRM Framework and Guidelines will designate appropriate levels in all member organisations, for RAMP representation.

Chairing the RAMP

Leadership of RAMPs requires close collaboration between Victoria Police and community based family violence agencies. In the initial roll out of the SRM strategy senior Victoria Police members will chair RAMP meetings. A guide to chairing RAMP meetings will be outlined in the SRM Framework and Guidelines document. There are precedents for this model in UK and South Australia.

4.4 Coordination of RAMPs

Coordination of RAMPs involves several important administrative tasks. These include:

The Coordination function comprises a number of important operational support tasks, including:

a) review/ screen eligible referrals (including ensuring that referring agencies provide adequately and timely information)

b) ensure that RAMP members have prepared relevant information prior to RAMP meetings

c) keep records of RAMP discussions and decisions (ie. minutes and action plans) to a satisfactory standard (including the capacity to provide appropriate information in the event of an incident or death)

d) ensure effective communication between RAMP members

e) ensure required communications and coordination of member activities

f) ensure that privacy and confidentiality protocols are maintained

g) collect data and reporting on activities

h) assist the RAMP Chair as required.

Agency and service system development tasks include:

a) liaise with and co-ordinate with local agencies to develop, maintain and review MoUs (including eligibility for RAMP)

b) work with core member agencies to ensure that all relevant members of staff are familiar with the RAMP process, and their role and responsibilities within it, and receive appropriate training as necessary.

c) liaise with the full range of potential referral agencies, in particular those working with minority or hard to reach groups to ensure access and culturally appropriate responses.

d) ensure consistency in referral of cases from a range of potential referring agencies based on the use of an agreed tool and referral form.

e) maintain a tracking system of RAMP cases which have been 'flagged' for twelve months following the last incident, and to notify colleagues when twelve months have passed so that these flags can be removed from their respective systems

f) collect information and report on systemic gasps and barriers.

4.5 Location of RAMPs

The location of individual RAMPs and the geographic area(s) served, will take into consideration a number of factors, including:

a) the number and type of family violence incidents per area

b) the level of repeat offending (recidivism), and criminality

c) Police Divisional and other boundaries

d) DHS boundaries

e) existing multi-agency responses to women and children at high risk.

At a minimum, RAMPs will be established in every DHS sub-region, or Victorian Police Division.

4.6 Actions plans to keep men accountable

Essentially RAMP actions plans need to address 3 key questions:

- what actions are required to keep women safe?
- what actions are required to keep children safe?
- what actions are required to prevent the perpetrator from using violence, and to keep the man accountable?

RAMPs should include a focus on ways of holding men accountable. Although men who pose a serious threat of violence and lethality are primarily the responsibility of the criminal justice system, community based organisations, and in particular men's services can provide support to the criminal justice system in holding men accountable.

Sufficient consideration needs to be given to holding men accountable during RAMP deliberations. This may be addressed in part by police leadership of the RAMP; by ensuring that both Corrections and men's family violence services are represented at RAMP; and that strategies for holding the perpetrator accountable are considered as a specific agenda item for each case referred to RAMP.

A catalogue/ list of possible actions would provide a comprehensive aide memoire, and help ensure that RAMPs consider all possibilities. Examples would be included in the Guidelines for effective operation of RAMPs.

4.7 Level of referrals and frequency of RAMPs

The number of cases to be considered by a RAMP should depend on the number of women and children assessed to be at high risk of imminent severe injury or death, and not limited by the capacity of the RAMP. RAMPs are ideally scheduled monthly but may convene more urgently for women and children considered to be at 'extreme risk', or more frequently in the event of a higher volume of referrals.

4.8 Reporting, accountability, governance of RAMPs

RAMPs are accountable for responding to referrals in a timely manner; providing a forum for sharing information and coordinating actions; providing risk assessment and management; maintaining appropriate documentation; maintaining confidentiality; and ensuring that members attend. RAMPs are responsible for the safety of women and children through the actions of the member organisations.

5 Identification of women and children at highest risk in Victoria

The SRM framework will include strategies to identify women and children at highest risk, combining Victoria Police referrals (using the L17 form), with referrals from a wide range of other agencies.

Victoria Police will continue to use the L17 form to provide the main source of initial identification, based on Police attendance at a family violence incident, and subsequent information. L17 forms are faxed to nominated regional women's family violence services. These family violence services review the L17 form, and any other available information, and seek to contact the AFM.[63]

Women at high risk may also be identified by a range of other organisations including hospital and health services, Child Protection practitioners, family support services, schools, etc.[64]

An effective response to the high risk target group requires a diversified system of identification and referral, with referrals originating from a number of possible sources. It is important that a range of relevant service types are part of the specialised high risk response. All potential referral sources should have the appropriate knowledge and skill to identify women at highest risk of serious harm or lethality, and make a referral to a RAMP.

6 Engagement of women and children at risk

Effective risk management with women and children at highest risk of serious assault or death requires that women and children are engaged with, and consent to accept assistance from one or more organisations which can help to keep them safe. In some rare instances of highest risk, risk management will be undertaken on behalf of the woman without consent, if efforts at engagement are not successful. Engagement requires persistence by services, flexibility, and appropriate skills in engagement and persuasion.[65] Engagement will be facilitated by skilled advanced practitioner staff, and by the use of brokerage to enhance safety, and provide other forms of practical assistance, when appropriate.

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63 Where demand exceeds capacity of many family violence services in Victoria, a prioritisation (ie. 'triage') system has been developed. This includes family violence agencies collecting all available information, prioritising cases based on the assessed level of risk, and selecting the highest risk cases for persistent attempts at contact and engagement.

64 To date, within the pilot project the major source of high risk referrals has originated from the Police, and from women self referring to family violence services.

65 The pilot SRM resources helped to maximise the opportunities for engaging women and children, allowing more time to engage with women who are fearful, and provided opportunities for the staff with the highest level of skills to be involved.

Risk management requires that men who use violence are actively monitored/ pursued/ and engaged by the Police, the justice system and the community sector, to influence (and limit) the risk he poses, and to hold him accountable for his actions.

7 Strengthening risk management processes

The SRM framework requires an enhanced risk assessment tool, to facilitate consistent identification of 'highest risk' by multiple agencies and organisation types. The CRAF is currently used as a basis for risk assessment in Victoria, combined with other information to identify women and children at highest risk. For example, the Victoria Police L17 form is based on the CRAF. The current CRAF, while broadly used and useful, does not necessarily provide a sufficiently clear basis for differentiating the highest risk group. There are a number of examples of tools used in other jurisdictions which provide greater capacity to identify 'highest risk', based on weighting risk factors.[66] The SRM framework in Victoria requires a tool with capacity to weight risk factors.

Family violence risk assessment in the SRM framework is a cumulative process which generally occurs at several points in time, and potentially involves multiple organisations. Referral to a RAMP frequently involves two (or more) prior assessments, or a multi-stage process, and may involve several organisations.[67]

The SRM framework requires that organisations most likely to encounter and engage with women and children at risk of family violence, have a clear and common understanding of the RAMP model, and of what constitutes 'high risk'. This necessitates training in the use of the tool and the model, and SRM processes. Training in the use of the CRAF has been a key component of the Victorian integrated family violence reforms. This could be used as the basis for future SRM training, potentially with Victoria Police co-facilitating the training.[68]

8 SRM Framework and Guidelines

The SRM Framework and Guidelines document will include:

a) A model description outlining RAMP mandate and scope of responsibilities

b) Roles and responsibilities of members, and other organisations.

c) Roles and responsibilities of the Coordinator

d) A standard basis for agreement between relevant organisations, ie. Memorandum of Understanding

e) Reporting and accountability frameworks including accountability to the interdepartmental Statewide SRM committee

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66 Some of these tools have been validated, but many have not.

67 In the case of the Berry Street pilot, the majority of women and children at highest risk were initially assessed by Victoria Police as a result of attending a family violence incident. Berry Street followed up the (L17) referral with a family violence risk assessment. In the case of the Bethany pilot the more frequent pathway was for a community based organisation to conduct an initial assessment (and referral), followed by a family violence risk assessment being conducted by the SRMDP Coordinator.

68 This occurs in South Australia and Northern Territory (Alice Springs).

f) Data collection requirements

g) Record keeping requirements

h) Confidentiality and privacy provisions

i) Basis for agreement with relevant Commonwealth organisations (eg. Centrelink) whose members attend RAMP

j) Relevant training and promotion material

9 Strengthening risk management - performance measurement

The performance of the SRM initiative will be monitored using appropriate key performance indicators. These may include:

Output measures

- Number of cases referred to RAMP, by source of referral
- Number of cases considered by RAMP, new and repeat
- Number and type of actions initiated by RAMP

Outcome measures

- Improved safety for women and children
- Reduction in level of repeat victimisation
- Reduction in levels of breaches and criminal behaviour by perpetrator

Service system measures

- Number and frequency of RAMPs held
- Number and types of participating agencies, and attendance rates
- Proportion of delegated actions completed.

Appendix 2: Brief Review of Literature

1 Introduction

This literature review provides a summary of selected recent reports and studies related to specific aspects of the evaluation. The main focus of this literature review (in progress) is on multi-agency models for women and children at high risk. Of particular interest are models which have been established in Australia, and in the UK. The design of the Victorian SRMDP Pilots has been informed by Multi Agency Risk Assessment Conferences (MARACs) which were first established in Wales in 2003.

Over the past 10 years there has been increasing acceptance across jurisdictions that a multi-agency approach is essential in order to prevent family violence which results in serious injury and/ or the death of women and children. Several Australian states have progressed the establishment of multi-agency responses, including some which have developed special arrangements for high risk cases.

2 MARACs (UK)

2.1 Introduction

Over the past 10 years there have been several reviews of MARACs, and a considerable body of practice literature (eg. guidelines and toolkits) has been developed.[69]

MARACs comprise meetings of key selected organizations which regularly respond to high risk victims of domestic violence. The purpose of MARACs is to produce coordinated action plans to increase victims safety. Agencies that commonly attend MARACs include:

- Police
- Family violence services
- Probation
- Children's Services
- Health
- Housing

Any agency may refer a case to a MARAC based on their assessment of risk.

The MARAC provides a forum for information sharing and collaborative responses across a diverse range of adult and child focused services. There are currently about 250 MARACs across England and Wales.

2.2 Key roles

The three principal MARAC roles are Chairperson, Coordinators and Independent Domestic Violence . The roles of each of these are summarised below.[70]

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69 See http://www.caada.org.uk/resources/resources.html

70 There are several position descriptions available on the web.

MARAC Chair person

The role of the Chairperson is to ensure that agencies have appropriate information; that meetings are used for action planning and keep discussions focused and to time; to facilitate consistent attendance of representatives

MARAC Coordinators

MARAC Coordinators provide coordination and administrative support to MARACs. Tasks include:

- to liaise with and co-ordinate with local agencies
- to prepare reports on the operation of MARAC (for the Steering Group)
- to work closely with all MARAC partners to ensure they are familiar with processes, their role, and to arrange training as required
- liaise with a full range of potential referral agencies, to ensure they are aware of the MARAC
- to help ensure consistency in referral of cases from referring agencies, based on the use of a common risk identification tool
- prepare and distribute the agenda and documentation before the meeting
- to help ensure that any specialists required attend the meeting
- to prepare accurate minutes of the meeting; to maintain an action list, and follow up on actions agreed at the meeting
- to ensure that the right amount of information is shared; and that confidentiality is maintained when handling data
- to maintain a tracking system of MARAC cases which have been flagged, for 12 months following the referral
- to ensure that data is collected, so that outputs and outcomes from MARACs can be collected
- to support the work of the Chairperson.

Independent Domestic Violence Representatives

IDVAs are professional domestic violence workers who work with high-risk victims of domestic violence. IDVAs play a key role in MARACs acting as a representative of the victim at the meeting and being the primary point of contact for victims. IDVAs are often the ongoing case manager of MARAC cases.

Tasks include:

- to provide a pro-active service to women and children at high risk, and provide a service which is appropriate to the level of risk, offering a premium service to those at high risk
- to assess their level of risk, discuss suitable options
- to develop safety plans, and monitor the implementation of safety plans
- to offer face to face support to women and children referred to the agency
- to work in partnership and advocate on behalf of women and children with housing, social services, police, magistrates, substance misuse agencies, refuges and other relevant services
- to provide clients with advice on rights and options, including civil and criminal remedies

- to provide support through the criminal justice process, including accompanying women to court
- to refer very high risk clients to MARACs
- to participate in the MARAC framework, attend and participate in meetings as required, and follow up on actions agreed in the MARAC

2.3 Key principles

A wealth of information about MARACs is available though a number of reports, as well as guidelines and tools which have been developed.

Key principles of an effective MARAC are listed below.

Exhibit 1: Ten principles of an effective MARAC

1	Identification – all agencies have protocols and systems for identifying and referring high-risk cases to MARAC in a timely way.
2	Referral criteria – the MARAC has clear and transparent referral criteria that include visible high risk, professional judgment and escalation.
3	Representation – the relevant statutory agencies, specialist domestic violence services and voluntary and community organisations are appropriately represented at MARAC.
4	Engagement with the victim – the victim is at the centre of the process. An effective advocate, most commonly the IDVA, is identified to represent and support the victim within the MARAC process.
5	Research and information Sharing – all agencies research their files and information systems and bring relevant, proportionate and up-to-date information which is shared and stored in accordance with legislation by all attendees who hold information on each case discussed.
6	Action planning – comprehensive, SMART action plans are developed which address the risks identified at the meeting.
7	Volume – the volume of cases referred to the MARAC should be commensurate with the local population.
8	Administration – the administration of the MARAC promotes safety, efficiency and accountability.
9	Strategy and governance – the MARAC process is embedded in key local partnerships to promote sustainability.
10	Equality – the MARAC demonstrates that it is a process which is structured to deliver equality of outcomes to all.

Source: CAADA, 2010.

2.4 Evaluations of MARACs

A number of reviews of MARACs have been undertaken. The earliest evaluation was undertaken in 2004 (Robinson, 2004). Subsequent reviews included the views of women (Robinson, 2005), a cost benefit analysis (CAADA, 2010), and studies on the

effectiveness of specific elements of the MARAC, for example Independent Domestic Violence Advisors (Robinson, 2009).

In 2010/11 a comprehensive evaluation of Multi-Agency Risk Assessment Conferences (MARACs) was undertaken by Cordis Bright. The research methodology involved a survey of MARAC chairs, MARAC Coordinators, and Independent Domestic Violence Advisors. The Survey was targeted to around 150 MARACs, and a relatively high response rate was achieved (636 survey respondents). Survey responses were complemented by in-depth studies of 4 MARACs. The following is a summary of the report's findings, which have particular relevance to the Victorian SRMDP Pilots.

a) MARACs are mainly led by Police (93% of MARAC Chairs are Police)

b) The significant majority of MARACs meet monthly, or more frequently if required.

c) A standardised referral form is used, and risk threshold levels are generally considered clear (84% of respondents agreed). A referral is triggered by the number of ticks on the referral form (80% of respondents reported that 14 to 16 ticks are required to trigger a referral. 75% of referrals to MARACs are discussed, with 'insufficient risk' being the main reasons for cases not being considered.

d) The majority (80%) of referrals are from the Police, and it was acknowledged that there was a need to expand the referral base.

e) The majority of MARACs (70%) discuss between 6 and 20 cases per meeting and meetings generally last up to 4 hours. MARAC 'caseloads' range between 8 and 18 cases, with most between 7 and 12 cases.

f) There is a clear administrative task required in preparation, and following up work for MARACs. This includes organising meetings, processing referrals and risk assessments, preparing agendas and papers, and managing the oversight of agreed actions. Most of this is done by Domestic Violence Coordinators.

g) Core agencies attending MARACs include Police, Independent Domestic Violence Advisor (IDVA), Health services (community health), Probation, Housing and Children's Services.

h) The MARACs are generating effective actions which include clearly assigning responsibilities, and linking and coordinating responsible agencies. However there has been insufficient analysis of what works well and what does not, with a view to practice development.

i) Agencies consider that the advantages of a statutory MARAC outweigh the disadvantages. This would ensure agency attendance; ensure adequate seniority; ensure that agencies are accountable for their actions; give MARACs and their role more weight and profile; and enhance the security of funding for key roles.

Selected key areas for improvement were identified:

a) MARACs could be more effective by improving responses to dealing with perpetrators

b) Clarifying the role of health professionals, and identifying which health professionals were most suitable to attend the MARAC

c) Better time keeping and meeting efficiency

d) Ensuring the right level of seniority of agency representatives.

CAADA undertakes independent research based on an outcomes measurement tool designed specifically for the family violence sector. CAADA provides the tool to family violence services which collect data, and return it to CAADA for evaluation. In 2012 CAADA analysed data for 2,500 victims. More than half were referred to MARACs. The outcome analysis showed that the majority reported improved safety and wellbeing outcomes. IDVAs assessed that 74% of victims in the dataset experienced a reduction in risk levels, and 63% reported a total cessation of abuse at case closure. The safety of victims was significantly improved through good action planning at MARACs. The data also showed that more intensive the support the better the outcomes.

CAADA has estimated that, on average, 1 MARAC coordinator and 4 IDVAs are required for every 100,000 of the adult female population

2.5 Funding arrangements and benefits

The UK government provides part funding for IDVAs and MARAC coordinator positions. Grant funding was initially made available in 2006, and the grant program was re-funded in 2010 for a further 4 years. The maximum bid for a grant to contribute to an IDVA position is £20,000, and for a MARAC coordinator, it is £15,000.

CAADA estimates that high risk services cost approximately £70 million to operate. This is based on:

Table A2.1: High risk family violence program costs

Component	Number	Base unit cost (£)	Total cost (£ million)
IDVAs	500	25,000	19m
Coordinators	260	20,000	7m
Indirect costs of MARAC meetings	260	11,900 per meeting	44m
Total			£71m

Source: CAADA (2012)

The estimate of indirect costs is based on the time contribution of people attending MARACs, including police, and 10 other agency representatives. It is assumed that each member attending spends 4 days time per MARAC, which includes preparation, attendance, and completing follow up actions. This is a 'maximum' estimate, as

some of this work may have been undertaken by MARAC representatives in any event. In calculating the total cost of MARACs (£44m) it is assumed that a proportion of meetings are held fortnightly.

CAADA has undertaken several studies on the value of high risk services and estimates that for high risk services for every £1 spent, £2.90 is saved.[71]

CAADA estimates that the annual saving per victim is £14,200 based on savings in health care, police, criminal justice support, housing and children's services. The major savings accrue to police, criminal justice and health services. The benefit does not include the benefit of reduced physical and emotional harm or improved quality of life for victims. Nor does it include productivity gains from increased workforce participation.

Previous studies were undertaken by Walby and Allen (2004) which showed that domestic abuse costs in the UK were about £3.0 billion per annum, and high risk violence accounted for nearly £2.4 billion.

3 Western Metropolitan Region High Risk Client Strategy

Police and family violence services established an Integrated Family Violence High Risk Client Strategy in the Western Metropolitan Region of Melbourne in 2009.

Early in 2008 Victoria Police facilitated a workshop with family violence services in WMR. The workshop developed a framework to identify, assess and provide case/ risk management to clients deemed to be at 'high risk' of family violence. The framework included a collaborative approach, to sharing information, enhancing understanding of agencies' capabilities and limitations, and a more efficient way to improve safety for women and children.

The initial identification of a high risk client is provided by the Police indicating a 'high risk client' on the Police L17 form. The degree and type of 'high risk' is further determined by family violence service providers, following a comprehensive risk assessment.

In addition, community based family violence service providers (FVSPs) can identify women as high risk clients, independently of police 'high risk' referrals.

The FVSP consults with the relevant Police Family Violence Liaison Officer (FVLO), and when appropriate, a formal notification made to the Police. Notifications are also sent to the Police Family Violence Advisor (FVA).

Following an assessment, where a client is deemed high risk, an Integrated Coordination and Response Conference (ICRC) is scheduled, as soon as possible, and not longer than 7 days after the notification. A police member (eg. FVLO) is nominated to act as a 'case officer' for the high risk client and this member must attend the ICRC. A follow up ICRC is conducted within 4 weeks of the first meeting to review progress. ICRCs are conducted formally, and involve all relevant parties, and if possible and where appropriate, also include the client and family members.

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71 CAADA (2012)

The agency that makes the formal notification of a high risk client is responsible for arranging the meeting, inviting attendees, providing the venue, providing the chair; recording the action notes; and monitoring and reporting. The WMR high risk client strategy was evaluated in 2013, and results of the evaluation are pending.

4 South Australian Family Safety Framework

South Australia has established a legislated multi-agency response to women who are at risk of serious violence and lethality. The Family Safety Framework (FSF) was developed under the auspice of the South Australian Government's Women's Safety Strategy and Keeping them Safe – Child Protection Agenda.[72]

The Framework includes collaboration between various agencies, and referral to specialist Family Safety Meetings, which are held fortnightly. The Framework involves an agreement across Departments and agencies for a consistent understanding and approach to responding to women and children assessed as imminent high risk.

A common risk assessment Form is used to assess high risk of serious injury or death. Unlike many jurisdictions, the Form includes weightings, which allow the calculation of a risk 'score', which can be used to guide workers.[73][74] In other jurisdictions, risk assessment tools generally indicate the number of risk factors which are present, mainly focusing on the actions of the perpetrator, and there has been some consideration by academics, non government organisations and others to developing a weighted 'score' to indicate relative risk. South Australia has implemented such a system.

Women and children who are assessed to be at high risk are referred to a local Family Safety Meeting (FSM), attended by a range of agencies, and generally chaired by SA Police. The purpose of the meeting is to share information under the auspice of a specially developed Information Sharing Protocol and to implement a Positive Action Plan for each referral.

The agencies involved in the Information Protocol are:

- South Australian Police (SAPOL)
- Department for Families and Communities (DFC)
- Attorney-Generals Department (Justice)
- Department of Health
- Department of Correctional Services (DCS)
- Department of Education and Children's Services (DECS)
- Non-government women's domestic violence services

The South Australian Cabinet approved a trial of the Family Safety Framework at three sites, including two metropolitan regions and one non-metropolitan region,

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72 Jayne Marshall, J., Ziersch, E. and Hudson N. (2008) Family Safety Framework, Final Evaluation Report, Office of Crime Statistics and Research, South Australian Attorney General's Department, Adelaide.

73 Family Safety Framework, Practice Manual, www.officeforwomen.sa.au

74 Ibid.

commencing in 2007.[75] During the trial period (August 2007 to September 2008), 45 Family Safety Meetings involving 67 referrals were held at the trial sites.

In 2008 an evaluation of the Framework was conducted by the Office of Crime Statistics and Research within the Attorney-General's Department. The evaluation gave broad support to the Framework and noted the important contribution and collaboration of agencies involved, with SAPOL taking a lead role.

The evaluation found that the majority of victims were assessed as safer as a result of the intervention. Specifically, 62% of victims went from 'high' to 'low' risk and three quarters (75%) of referrals had no SAPOL record of re-victimisation for at least three months after referral.[76] Following the 2008 evaluation the government decided to roll out the Safety Framework across South Australia.

The implementation of the Framework is supported by a high level state-wide Committee with members nominated by Chief Executives of the participating departments. The Committee is chaired by the Office for Women and maintains oversight of the activities of the Framework, and resolves barriers or lack of participation or coordination between agencies/ systems. The Framework is currently provided in 13 regions in South Australia, and it is expected to be fully rolled out by the end of 2013.

Common Risk Assessment

A formal risk assessment is carried out by the agency or service that receives initial contact or referral, in order to determine if a case meets the criteria for referral to a Family Safety Meeting.

This provides an assessment of key risk factors that are associated with the potential for serious injury or death of the victim/s. The assessment tool consists of a 40 point checklist covering:

- The victim's perception of risk within the previous month, including specific fears for themselves, and their children.
- Historical patterns of behaviour especially of the perpetrator- previous convictions for abusive behaviour; jealousy; increase in intensity of abuse.
- Specific factors associated with an incident – eg. use of weapon, threats to kill.
- Aggravating factors – eg. drugs, alcohol, financial.
- Other factors - pregnancy, separation, child access.

Each item ticked on the checklist has a weighting and is scored, with scores of 45 or more indicating high risk (maximum score of 181).

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75 Metropolitan areas were Holden Hill and Noarlunga (and the South Coast), and non metropolitan area was based around Port Augusta.

76 Office of.Crime Statistics and Research, South Australian Attorney General's Department (2008) *Family Safety Framework – Final Evaluation Report*, November.

5 Other multi agency models for women at high risk

5.1 New South Wales

Significant family violence reform processes have been underway in NSW for several years. A consultation process commenced in 2009 and independent consultants were appointed to develop a reform plan (KPMG, 2012). A draft report was produced in December 2012 describing a reform program similar to that which has been established in Victoria. In particular the report recommended the establishment of Safety Action Meetings (SAMs), along similar lines to the Victorian RAMPs. The report proposed that the SAMs be chaired by Police (preferably Inspector level).

It is understood that the NSW government has largely adopted the report's recommendations, and have established a new program called "It Stops Here" (NSW Government, 2013). There has also been a domestic violence justice strategy established (NSW Attorney General, 2012).

Key features of the new program include a common Risk Identification Tool (similar to the CRAF) to help identify people at high risk of further violence; central referral points in each local area to ensure support services relevant to the victims needs are quickly engaged in a coordinated manner; and the establishment of Safety Action Meetings for women at serious threat of severe harm or lethality. The central referral points are likely to be based in pre-existing family violence services.

If a woman is assessed by police, or staff at the Central Referral Point as "at serious threat", they will be referred to the Safety Action Meeting. Safety Action Meetings bring together local agencies and service providers to discuss the risks facing an individual, and to develop a comprehensive Safety Action Plan to address those risks.

An assessment of "at serious threat" means that more than half of the risk factors on the Risk Identification Tool are present, or based on a worker's professional judgement. The SAMs will be chaired by a senior representative of the Police. A coordinator will be appointed in each Central Referral Point to administer and support Safety Action Meetings and assist the Chair. SAMs will produce a Safety Action Plan that includes each agency's commitment to carry out, follow up and report on agreed actions within an established timeframe. Participants will report back to the coordinator when their actions have been completed.

It is understood that these reforms will start to be rolled out late in 2013.[77]

5.2 Western Australia

Western Australia has adopted a Case Management Coordination approach to responding to women at high risk of violence, and holds Case Management Group meetings to share information, assess risk, and develop safety plans. Meetings are held fortnightly or monthly, as required. Case management Groups consist of representatives from the following core agencies:

- the referring agency

[77] Funding for the proposed reforms is not known at this stage.

- Department for Child Protection
- Western Australian Police
- Department of Corrective Services
- the local women's family violence refuge or advocacy service
- perpetrator program facilitators.

Other agencies are invited, as required. There three key roles. The case manager has overall responsibility for the case, including liaison with the victim, and ensures that the experiences and opinions of the victim are represented in the meetings. The Chairperson facilitates the meeting, and responsibility for Chairing is rotated amongst the core agencies. A Coordinator organises the meetings, and organises and stores information. A Governance and Operations Manual describes the accountability framework and the operation of these meetings.[78] Each CMC Group reports to a Regional Family and Domestic Violence Coordination Group. At a State level the CMC approach is overseen by a Senior Officers Group. Initial and subsequent assessment of risk is based on a Referral and Assessment Form,[79] similar to the CRAF.

5.3 New Zealand

Over the last decade New Zealand has established a number of multi-agency initiatives to respond to family violence. In particular the Family Violence Interagency Response System (FVIARS) was established in 2006. This involved joint meetings between Police, Child, Youth and family agencies, and Women's refuges. An initial evaluation of FVIARS was conducted in 2010 (Carswell, et. al., 2010) which identified a range of benefits and positive outcomes from formalising collaboration.

The reviews of the initiative found that the meetings covered victims at a range of assessed risk levels. By 2012 FVIARS were operating in almost all New Zealand Police districts, including some which were conducting specific high-risk case meetings.

The FVIARS were subsequently assessed as not being able to provide a response sufficient to address the safety issues associated with high-risk cases. The NZ Family Violence Death Review Committee (FVDRC) (2013) recommended that a separate multi-agency case management process for high risk cases be established. The actual form that this may take (referral, risk assessment, and responses) is currently being considered by the National FVIARS Working Group. Key features proposed by the FVDRC include the inclusion of core agencies; multi-agency referral entry; the use of common risk tools, including risk assessment for lethality; multi-agency risk management, safety planning and case review; and a dedicated coordinator. Under the circumstances, it appears likely that a high-risk strategy will be established in the next year, building upon the already established FVIARS.

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78 Department for Child Protection (2011a)

79 Similar to the CRAF, see Department for Child Protection (2011b).

5.4 British Columbia (Canada)

The government of British Columbia released the revised Violence Against Women In Relationships Policy (VAWIR) in December 2010.[80] This policy set out roles and responsibilities for police, justice system and child welfare workers in 'violence in relationship' cases. The revised policy included a Highest Risk Protocol directing that a multi-agency collaborative approach will be used in managing "highest risk" domestic violence cases. The protocol is based on a collaborative case management response provided by five core agencies - Police, Crown counsel, Corrections staff, victim service workers and child welfare workers. Other relevant agencies are involved on a case by case basis. The policy also included the adoption of the B-SAFER risk assessment tool, including for use by police.

The protocol was developed in recognition of the need for increased collaborative action among justice and child welfare partners in domestic violence cases of the highest risk. Information sharing is acknowledged as being integral to enhanced coordination and collaboration in highest risk cases. The protocol was designed to facilitate the flow of critical information to support informed and effective decision making in highest risk cases.

Police identify high risk cases (highest risk of serious bodily harm, or death) and make referrals to the other core agencies. A key feature is the involvement of the Crown counsel (or Police prosecutor), who prepares the case, and makes applications to the Court in order to ensure the safety of the victim. While the protocol does not necessarily require members physically meeting together in one place, this is a common practice, and local High Risk Teams have been established.

5.5 USA

A brief review of USA initiatives focusing on responses to 'high risk' family violence indicates that there have been isolated occurrences of formal team based approaches, and the use of specific tools to measure high risk.

In 2005 the Jeanne Geiger Crisis Center in Newburyport, Massachusetts implemented a High Risk Case Response Team. The Team uses the Danger Assessment to identify victims at greatest risk, and develops individualised intervention plans. In addition a team of law enforcement, prosecutors, probation officers and victim advocates increases monitoring of high risk offenders and sharing of information. The information is used to search for open warrants, make arrests, connect victims with services, and use pretrial conditions to keep offenders in custody. From 2005 to 2011 the high risk team provided risk management to 106 high risk cases, and there were no homicides in any of these cases.

In 2012 the US Justice Department[81] funded project to create a new model based on two programs: Domestic High Risk Assessment Team used in Massachusetts and the Lethality Assessment Program from the Maryland Network Against Domestic Violence. This initiative will evaluate the replication of these models in twelve

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80 Government of British Columbia (2010)

81 US Department of Justice Office on Violence Against Women (2012) Domestic Violence Homicide Prevention Demonstration Initiative.

communities, followed by additional testing in six communities. The goal is to have high risk systems in place in all communities in the next 5-10 year period.

A frequently used tool to assess for partner homicide is The Danger Assessment. This was developed by Campbell in 1985, and has evolved into a screening tool, and subjected to a number of validation studies.[82]

Several States and counties have established collaborative programs called DVERT, or Domestic Violence Enhanced Response teams.

The first DVERT was established in 1998 in Colorado Springs. The Colorado Springs (Colorado) Police Department developed a well-documented, comprehensive example of a co-response to enhance safety for victims of domestic violence. The Domestic Violence Enhanced Response Team (DVERT) reviews cases referred by any of the partner agencies, not only the police, and selects those where the victim is exposed to serious imminent danger. Three levels of risk are assessed, and DVERT team members work with the highest level. DVERT team members from criminal justice, social service, and community-based programs conduct outreach and provide services to the victim. An evaluation affirmed the value of his model and revealed that DVERT staff modified policies and procedures as necessary to ensure that victim needs are being met (Uchida et al. 2001). According to some Counties, DVERT is a nationally recognised model of intervention.

6 Responding to high risk perpetrators

6.1 Introduction

In the last decade there has been considerable debate about the effectiveness of treatment programs for male perpetrators, with the most significant criticism being the lack of empirical evidence for the effectiveness of Duluth type behaviour programs for men, and the lack of a clearly articulated and agreed model of change (Day et al. 2009). Moreover responses such as men's behaviour change programs rely on a 'one size fits all' approach, and do not always adequately match interventions with particular needs, and levels of risk. Day et al. (2009) argue for more differentiated and tailored responses, which are matched to the characteristics and/or the behaviours of each perpetrator, however it is also acknowledged that for some men, especially the most violent and lethal offenders, a community based response alone will be insufficient.

Case management approaches have been established as supplementary to men's behaviour change programs, primarily to address other issues which might interfere with behaviour change (eg. mental health or drug and alcohol issues), and to help re-inforce progress towards change. These approaches have not been proven to add measurable value to existing behaviour change programs (Gondolf, 2008; Gondolf, 2011).

High risk perpetrators of violence commonly display multiple issues relating to mental health, substance abuse and socioeconomic disadvantage. Salter (2012)

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82 Campbell, J, Webster, D & Glass, N (2009). "The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide". ***Journal of Interpersonal Violence***, 24

suggests that these men are less concerned about the impact of arrest and other domestic violence interventions on their employment or social status; may react to an arrest or some other intervention by escalating rather than reducing or ceasing their violence; and that they repeatedly breach protection and exclusion orders. This group of men do not respond well to counseling or treatment, and are likely to exhibit other forms of violence, and involvement with the criminal justice system.[83]

6.2 Definition of 'high risk' offenders

While the term 'high risk' is commonly used, there are a range of interpretations.[84] It can refer to the likely *frequency* of future offending and/or to the likely *seriousness* of future offending. While it is assumed that the seriousness of violence commonly escalates over time, Salter (2012) points to research which has found that a sizeable minority of domestic homicides are not preceded by an escalating pattern of violence towards the victim (Dobash & Dobash 2009).

Salter notes the different conceptions of 'high risk' among different organisations. Police and Corrections may focus on the medium-to-long term and aggregated view of risk, and be less sensitised to the imminent risk or the harms associated with particular forms of violence, both of which are pressing concerns for domestic violence workers. Family violence workers often take into account the 'who, what, where, when, and how' of violence and not solely the future possibility of any violence (Kropp 2008, p. 203).

Moreover, Salter (2012) notes that a woman's own assessment of risk may include predictions of future violence as well as a range of other emotional and practical considerations (Griffin *et al.* 2002).

Several authors note that there are limits to the utility of risk assessment, especially given that a number of homicides have occurred with no little prior warning.

6.3 Services for high risk offenders

Salter (2012) argues that higher risk offenders should receive more intensive services; the particular needs of offenders that are related to their offending should be addressed in treatment; and that treatment approaches should be tailored to the learning styles of individuals. He also suggests that therapeutic responses have focused on broad sociopolitical antecedents of domestic violence without paying adequate attention to the different ways that misogyny and male violence is enmeshed in the life histories, circumstances and psychology of offenders. The profile of 'high risk' offenders common to virtually all studies is the typical profile of a 'complex needs' client who requires individualised and sometimes intensive and highly specialised treatment in order to achieve genuine and lasting change, although such forms of treatment are rarely available specifically to domestic violence offenders.

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83 Salter, M. (2012), 'Managing Recidivism Amongst High-Risk Violent Men', *Australian Family & Domestic Violence Clearinghouse Issues Series*, 23.

84 Sherman L 2007, 'The power few: experimental criminology and the reduction of harm', *Journal of Experimental Criminology*, vol. 3, issue 4, pp. 299-321

6.4 UK services for perpetrators

There has been some interest in the UK in providing services which work with individual perpetrators who are the (ex) partners of women referred to MARACs. In particular a pilot project to work with male (ex) partners was established in 2010/ 2011.[85] The project was called Fresh Start and was located in Buckinghamshire, with 3 MARACs making referrals to Fresh Start. The aim of the pilot was to establish whether perpetrators coming to the attention of MARACs were suitable for referral, and to investigate the issues associated with making successful referrals.

While the difficulty of engaging men who were trying to avoid accountability was recognised, it was considered that even modest success could give rise to substantial benefits, considering the risk of serious harm assessed.

There were 190 referrals to the 3 MARACs during the pilot period. Cases not suitable for referral to the planned Fresh Start intervention included:

- current involvement in a criminal justice process, or in prison
- mental health or substance abuse problem preventing effective involvement
- inability to travel to venue where intervention is provided (including whereabouts unknown)
- intervention may increase the risk to the victim

Of the 190 cases, there were 21 perpetrators who were deemed potentially suitable for referral to Fresh Start. Of these 11 men were successfully referred. The evaluation of the pilot noted differences in referrals from each of the 3 MARACs, and a wide variation in the skill of individual referring workers, resulting in differences between 'suitable' and 'successful' referrals.

The Pilot concluded that MARACs should be encouraged to consider identifying and referring suitable men to a domestic violence prevention program. It recommended that MARAC agencies should be capable of engaging and motivating suitable men to agree to a referral, and that training should be provided to achieve this end. Finally, suitable high risk men should referred from a range of sources, other than MARACs.

There is nevertheless some support for the concept of working more holistically with men who use violence. Salter (2012) asserts that initiatives to prevent re-offending are unlikely to be successful unless they are coupled with social welfare policies designed to address the housing, employment, health and other difficulties that are frequently prevalent in the lives of serious domestic violence offenders. Otherwise he notes that "the management of high-risk domestic violence offenders is likely to maintain the punitive flavour that contributes to the cycles of disadvantage, disempowerment and abuse that characterise serious domestic violence."

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[85] See Blacklock, N., Debbonaire, T. (2011) MARAC as a mechanism to engage perpetrators of domestic violence in behaviour change programmes,

7 Costs of domestic violence

Over the last 20 years or more, there have been a number of studies conducted on the costs of domestic and family violence. Laing (2001) summarised several Australian studies. These studies generally identified direct and indirect costs. Direct costs refer to the costs associated with the provision of a range of facilities, resources and services to a woman as a result of her being subject to domestic violence, and include the costs of crisis services, police responses, accommodation services, legal services and court costs, income support and health/medical services. Most studies found that the bulk of direct costs are borne by government.

Indirect costs include the cost of the pain, fear and suffering incurred by women and children who live with family violence, often resulting in loss of income and additional personal costs borne by the victim. This may include replacing damaged or lost household items, relocation costs, and additional security and protection costs. Most studies found that women bear the bulk of the indirect costs of domestic violence. Other studies note that loss of income and net impact on transfer payments represents a loss of Gross Domestic Product.

In 2004 Access Economics estimated the total annual cost of domestic violence to be about $8 billion per annum in Australia. The largest component was pain, suffering and premature mortality at $3.5 billion per annum. The largest cost burden (50% of total) is born by the victim.

Of particular relevance to strengthening risk management for high risk groups is a study recently undertaken by CAADA (2010). The *Saving Lives, Saving Money* report is a cost benefit analysis of responses to domestic violence in the UK, and in particular the Multi Agency Risk Assessment Committees (MARACs). CAADA estimates that for every 1 pound spent on MARACs, at least 6 pounds of public money can be saved annually on direct costs to agencies such as the police and health services. CAADA estimates are based on several sources of information including a large UK data base, and university studies (see Walby, 2009).

References

Access Economics (2004) *The costs of domestic violence to the Australian Economy*, a report prepared for the Australian Government's Office of the Status of Women.

Blacklock, N., Debbonaire, T. (2011) *MARAC as a mechanism to engage perpetrators of domestic violence in behaviour change programmes*, Respect, UK.

Brown, M. (2011) *Family Violence Risk Assessment Review of International Research*, New Zealand Police, Organisational Assurance Group, Wellington.

Buzawa, E. S. (2012) "The Evolving Police Response to Domestic Violence", ***Journal of Police Crisis Negotiations***, Vol. 12, 82-86.

CAADA (2012) *A place of greater safety*, Insights into domestic abuse No. 1.

CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.

CAADA (2010) 'The MARAC Guide 2010 – From Principles to Practice'. Bristol: CAADA.

Carswell, S. Atkin, S., Wilde, V., Lennan, M., and Kalapu, L. (2010) *Evaluation of the Family Violence Interagency Response System* (FVIARS), Summary of Findings, Centre for Social Research and Evaluation.

Campbell, J, Webster, D & Glass, N (2009). "The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide". ***Journal of Interpersonal Violence***, 24

Day, A., Chung, D., O'Leary, P., and Carson, E. (2009) "Programs for Men who Perpetrate Domestic Violence: An examination of the Issues Underlying the Effectiveness of Intervention Programs", ***Journal of Family Violence***, Vol. 24, 203-212.

Department for Child Protection (2011a) *The Western Australian family Violence Case Management and Coordination Services Governance and Operations Manual*, Perth, WA.

Department for Child Protection (2011b). *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, Perth, WA.

Government of British Columbia (2010) *Violence Against Women in Relationships Policy*, Victoria, BC.

Gondolf, EW. (2008) "Outcomes of Case Management for African-American Men in Batterer Counselling", ***Journal of Family Violence***, Vol. 23, 173-181.

Gondolf, EW. (2011) "The weak evidence for batterer program alternatives", ***Aggression and Violent Behaviour***, Vol. 16, No. 4, 347-353.

Klein, A. (2012) "Lethality Assessments and the Law Enforcement Response to Domestic Violence", ***Journal of Police Crisis Negotiations***, Vol. 12, 87-102.

Laing, L. (2001) 'Australian Studies of the Economic Costs of Domestic Violence', Australian Domestic and family Violence Clearinghouse.

NZ Family Violence Death Review Committee (FVDRC) (2013) Third Annual Report, December 2011 to December 2012, Health Quality and Safety Commission, NZ.

NSW Attorney General's Department (2012) The NSW Domestic Violence Justice Strategy, Improving the NSW Criminal Justice System's Response to Domestic Violence, 2013-2017.

NSW Government (2013) *It Stops Here*. Standing together to end domestic and family violence in NSW.

Marshall, J., Ziersch, E. and Hudson N. (2008) *Family Safety Framework, Final Evaluation Report*, Office of Crime Statistics and Research, South Australian Attorney General's Department, Adelaide.

Office of Crime Statistics and Research, South Australian Attorney General's Department (2008) *Family Safety Framework – Final Evaluation Report*, November.

Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation.

Robinson, A. (2005) Domestic Violence MARACS (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: Views from the Victims.

Robinson, A. (2009), 'Independent Domestic Violence Advisors: a process evaluation', Cardiff: Cardiff University.

Rosenfeld, D.L. (2012) "The High Risk Team Model and GPS Offender Monitoring: Stopping DV in its Tracks", ***Domestic Violence Report***, Vol. 17, No. 3.

Salter, M. (2012), 'Managing Recidivism Amongst High-Risk Violent Men', *Australian Family & Domestic Violence Clearinghouse Issues Series*, 23.

Sherman, L. (2007), 'The power few: experimental criminology and the reduction of harm', ***Journal of Experimental Criminology,*** vol. 3, issue 4, pp. 299-321.

South Australia, Office for Women (2013) *Family Safety Framework, Practice Manual*, Version 4, March, www.officeforwomen.sa.au

Uchida, C., C. Putnam, J. Mastrofski, and S. Solomon. (2001). *Evaluating a Multi-Disciplinary Response to Domestic Violence*: The DVERT Program in Colorado Springs, Final Report. Silver Spring, MD: 21st Century Solutions.

UK Home Office (2011) *Call to End Violence Against Women and Girls: Action Plan*, London.

Victoria Police (2009) *Living Free from Violence – Upholding the Right, Victoria Police Strategy to Reduce Violence Against Women and Children 2009 – 2014*, Melbourne.

Victorian Government (2012) *Victoria's Action Plan to Address Violence against women and children, 2012-2015*, Melbourne.

Walby, S. (2009) The cost of domestic violence: up date 2009, UNESCO Chair in Gender Research, Lancaster University. UK.

Walby, S., and Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British crime Survey*, Home Office Research Study 276.

Walsh, C., McIntyre, S-J., Brodie, L., Bugeja, L. & Hauge, S. 2012, *Victorian Systemic Review of Family Violence Deaths – First Report*, Coroners Court of Victoria, Melbourne, Victoria.

Westmarland, N., Kelly, L., Chalder-Mills, J. (2010) *Domestic Violence Perpetrator Programmes. What Counts as Success?*, Respect: London.

Appendix 3: Responding to women and children at high risk – comparison of selected model elements

Model element	SRMDP (Hume and Geelong)	MARACs (UK)	South Australia Family Safety Meetings	Women's Health West (WMR)	Victoria Police Northern (Darebin, Banyule, Whittlesea)
Target group	Women and children at high risk of serious harm and lethality	Women and children at high risk	Women and children at high risk	Women and children at imminent extreme risk of lethality/ intent to kill.	Recidivist and high risk perpetrators, and women and children at high risk
Membership of multi-agency panels	Women's family violence agency, Women's refuge, Victoria Police, Corrections, Child Protection, Child FIRST Mental health; D&a; hospital Centrelink; ooH Family support services Men's services Maternal and Child Health Others as required	Police IDVA Health Housing Children and Young People's services Probation	SAPOL Child Protection Women's dv service Health Education Corrections D&a Family support Victims of Crime	Victoria Police Women's dv service Men's fv services CHCs Other as required (Child Protection to be included)	Victoria Police Womens fv service Child Protection Corrections Men's service
Leadership	pilot agencies	Police in partnership	Office for Women and SAPOL	Victoria Police and WHW	Victoria Police
Coordination role	Women's fv pilot agencies	MARAC Coordinators	Statewide ngo – Victims Support Service	WHW women's fv service	Victoria Police
Chairing arrangements	1 chair independent (former manager of a CBO) 1 chair current senior manager in pilot agency	Police	SAPOL (Chair)	The referring agency (whichever) chairs	Victoria Police chair
Assessment tool	CRAF plus worker judgement is used. pilot agencies also rely on Victoria Police L17 forms, and other information	Mainly CAADA DASH (65% of MARACs), plus worker judgement	Weighted tool designed by SAPOL, used by SAPOL and women's services. Scoring system and tool has been modified.	CRAF plus 'Red flag' system, not scored. Terminology 'extreme risk'	Use a weighted tool based on CAADA-DASH
Main gatekeeper of referrals	SRM Coordinator/ RAMP	Police	SAPOL	Specialist fv agency Victoria Police	Victoria Police
Frequency of meetings	Monthly	Monthly but can be more frequent	Fortnightly	As needed (approx. 8 pa.)	Fortnightly
Average number of cases per meeting	1 - 6	5 - 20	2 - 5	1	16
Length of meetings	Up to 3 hours	Half day	2 – 3 hours	1 – 2 hours	All day

Responding to women and children at high risk – comparison of selected model elements

Model element	SRMDP (Hume and Geelong)	MARACs (UK)	South Australia Family Safety Meetings	Women's Health West (WMR)	Victoria Police Northern (Darebin, Banyule, Whittlesea)
Authorising environment	DHS funded pilot Limited involvement by IDC. Onus on pilot agencies to establish model, partnerships and agreements	Home Office MARACs are not statutory organisations	Ministerial/ Cabinet endorsement. Minister for the Status of Women championed the initiative. Govt driven and sponsored. All Deptl heads are 'on board'.	Collaborative locally driven model. Critical Reference Group is embedded in Western IFV network.	Victoria Police local initiative
Resources	Funding for Coordination role 1 EFT per pilot	The UK Home Office provides funding for Coordinator positions, IDVAs, administrator/ co-ordinator positions, training, and quality assurance.	Funding for Coordination role, from Victims of crime levy, by AG Dept. for ($100k) and SAPOL ($20k)	No additional funding	No additional funding
Guidelines etc.	Completed local MoUs and/ or protocol agreements. Not signed by all parties. SRM Guidelines not available	Detailed documentation, tools and Guidelines provided through CAADA	Guidelines and documentation provided		
Training strategy	CRAF training for a range of agencies	Funded training program	Joint training provided by SAPOL and Victims Support Service on FSMs; risk assessment tool		
Enhancements	Specific brokerage funds available Funds for case management positions High risk work integrated within agency fv team	Independent Domestic Violence Advisor (IDVA) positions	The single statewide agency contracted to undertake the coordination role promotes consistent admin practices, data collection, record keeping; identification of gaps, and barriers; statewide reporting Strong partnership between SAPOL, AG and family violence sector.	Strong local collaboration Women (AFMs) attend Integrated Coordinated Response Conferences Achieved within existing funding, and 'core business' of partner agencies	Initiated by Victoria Police. Strong collaboration and participation by partners. Frequency of meetings Access to Victoria Police Tasking and Coordination Unit strengthens responses to perpetrators Integrated with Victoria Police Family Violence Teams