Victorian Primary Care Partnerships

Submission to the Royal Commission into Family Violence

May 2015

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Purpose

This submission has been prepared to inform the Royal Commission about issues that relate to family violence response and prevention, as identified through a consultation process with Victoria's 28 Primary Care Partnerships.

Primary Care Partnerships (PCPs) are established networks of local health and human service organisations, They work together to find smarter ways to make the health system work better, so the health of their communities is improved. Since they were introduced by the Victorian Government in 2000, PCPs have become a vital component of the Victorian healthcare system.

In the 15 years of operation PCPs have grown significantly, in both size and reputation, as more and more health and social services and community groups join them in the quest to deliver better healthcare outcomes for Victorians. Today, PCPs facilitate partnerships with a wide range of health and social service providers and community groups; and they support collaboration and service integration. Most importantly, they play a key role to enhance the wellbeing of people within our local communities.

There are now 28 PCPs around Victoria that connect more than 800 organisations across many different sectors. This includes: hospitals, GPs, local government, universities, community health services, disability services, problem gambling services, women's health and family violence services, mental health services, sports groups, schools, police and many more.

These diverse organisations are working together to plan around the needs of the community, to share their skills and expertise, and align their efforts. In bringing these health and social service organisations together, PCPs find new ways to collaborate and share valuable learnings, research and information. When it comes to the health needs of the community PCPs also enable more effective integrated planning, and develop the service system through co-ordination and integrated care as well as by making better use of data, evidence-informed interventions and a common planning framework.

PCPs are delivering real results – particularly, better health and social outcomes for community members – at the local level. Indeed, a recent evaluation report[1] found that PCPs have:

- Improved integrated planning
- Improved service co-ordination
- Increased organisational capacity and learning for health promotion
- Delivered economic benefits and resource efficiencies
- Contributed to healthier communities

The Primary Care Partnership platform is used extensively by the Department of Health and Human Services to roll out new initiatives in the areas of service coordination, integration and chronic disease management. The platform is also pivotal in the delivery of prevention and

[1] Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010

health promotion work across Victoria. Accordingly, this submission has a primary focus in these areas.

This submission does not seek to duplicate the submissions of many other important PCP partners and stakeholders. In particular, we acknowledge and support the work and perspectives of women's health services and family violence services in Victoria, many of which are members of local PCPs. We also acknowledge and support the work of VCOSS, of which we are a member.

This submission does focus on systemic issues that relate to the ways in which individuals and communities access, or fail to access, appropriate services, particularly those in disadvantaged communities. It will also focus on barriers and enablers to effective prevention work, with particular emphasis on the leadership and partnership dimensions of prevention work. These are areas in which PCP staff has direct knowledge and expertise.

In preparation for this submission, staff from all 28 PCPs had an opportunity to contribute feedback via electronic survey regarding different areas of PCP practice and how they interface with service responses to, and prevention of, family violence. Some PCP experiences in these areas have been captured in this document but we also acknowledge the work of a number of individual PCPs that are making their own submissions.

Some key understandings that underpin our work

Victorian PCPs recognise that family violence is a serious, prevalent and preventable crime.

We acknowledge the gendered nature of this crime and the damaging consequences that it has on individuals, families and communities, particularly women and their children.

About language: in addition to using referring to "family violence", this submission uses the terminology of 'violence against women'. We do this in recognition of the gendered nature of family violence and the overwhelming use of violence by men towards women. The use of this terminology also places the emphasis on a community wide, systematic response that focuses on gender inequality as the root driver of men's violence against women.

PCPs acknowledge that as a result of processes of colonisation, dispossession and ongoing disadvantage, Aboriginal people experience a higher burden from family violence.

Service coordination

Key messages in this section:

Early intervention is crucial to minimising harm and ensuring a family's safety from family violence. Effective and widespread screening is a fundamental building block for earlier intervention.

At the current time, there are significant connectivity barriers to achieving more comprehensive screening.

Across PCPs there is a clear understanding that family violence services provide an essential specialist response. Our focus on improving service coordination is to ensure that those experiencing family violence will have an increased/improved support and referral pathways. Specialist family violence services are integral to providing a safe and specialised service for women & children experiencing violence and for men who use violence against their partners and children.

Most women and children who experience violence will come into contact with numerous health and community agencies rather than, or before they seek help from, family violence specialist agencies. To mitigate the risk these women and children face, mainstream health and community service providers need to be equipped to adequately identify and respond to family violence.

Effective partnerships are crucial to ensure that all people who experience family violence received the right care, in the right place at the right time.

PCPs are well placed to work with stakeholders to develop a more integrated service system and strive towards a more consistent, coordinated and timely response that result in increased safety for women and children who experience family violence.

PCPs recognise that the establishment of Family Violence Regional Integration Coordinators has been a positive step forward in building a more integrated family violence system.

Primary Care Partnerships have 15 years of expertise in service coordination having worked extensively in this area to ensure better access to services across a range of health and community services. Our experiences have taught us that improvements in service coordination practices are critical to reducing the harm of family violence in our community. Timely access to appropriate services is the key to ensuring the safety of women and children, and helping men recognise and change their violent behaviour.

The service coordination context

Service coordination stems from *Better Access to Services: A Policy and Operational Framework* (DHS, 2001). Implementation of service coordination is supported by policy, practice standards, training and other resources.

What is service coordination?

Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the services they need. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give consumers a seamless and integrated response.

What are the benefits of service coordination?

Service coordination can offer many benefits to consumers and service providers.

The benefits for consumers include the following:

- Provision of up-to-date information about local service availability and support options to contact the most appropriate service
- No wrong door – every door in the service system can be the right door for consumers to access services
- Clear entry points, plus transparent and consistent referral pathways and processes that are easy to navigate
- Improved and timely identification of needs through the initial needs identification process
- Improved response times to requests for information, referral and provision of service.
- Confidential transfer of information without collecting or storing client data for referral purposes in a way that does not require the consumer to repeat their information
- Improved access to assessment and coordinated shared care/case planning clarity regarding who is involved in service provision and what their responsibilities are to meet the consumer's goals
- Reduced duplication of assessments and services as well as identification of service gaps
- Increased knowledge of the local service system and access to resources that support service coordination, such as the National Health Services Directory (NHSD)
- Consistent service standards from each service provider through the use of regional protocols and memorandum of understandings between service providers.
- A positive experience of the service system that puts the consumer at the centre of care.

The benefits for service providers include the following:

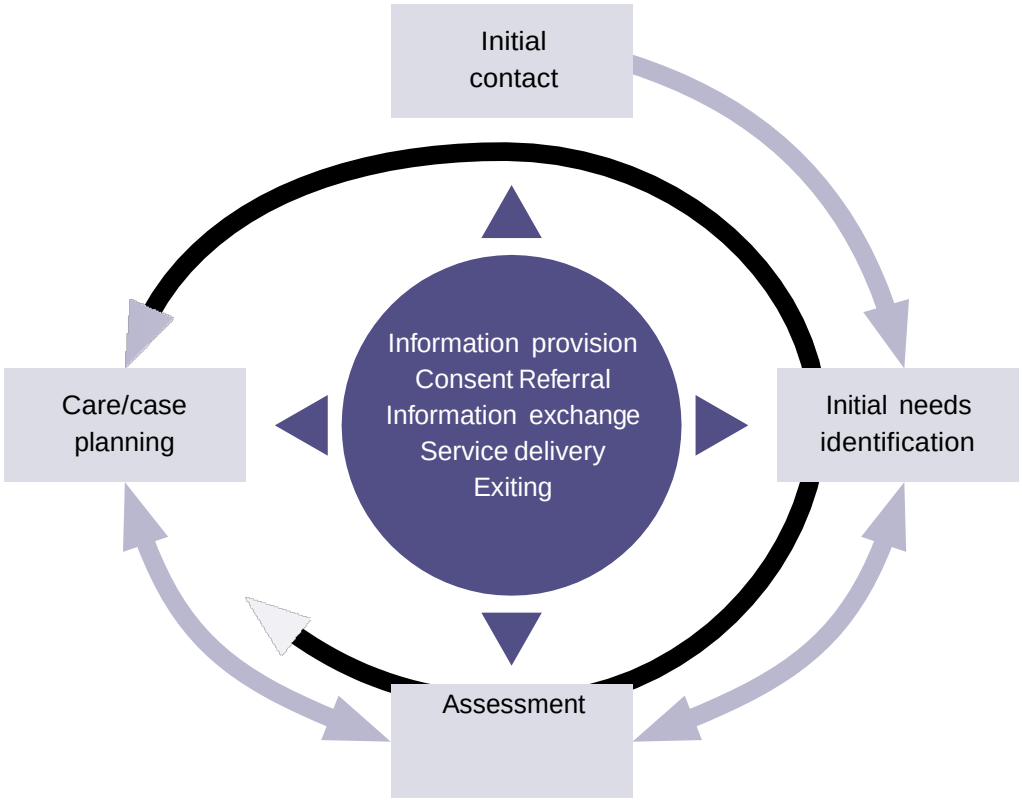
- Practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and inter-organisation practice, including continuous quality improvement strategies aligned with accreditation standards
- Documented practice standards for the elements of service coordination including; initial contact, initial needs identification and shared care/case planning, providing a common language between services
- Improved consistency and quality of consumer information through the use of common tools such as the Service Coordination Tool Templates which has increased efficiency by combining over 300 different versions of templates.

- More efficient use of resources through improved information and feedback from referrals, fewer inappropriate referrals and less duplication of services
- Streamlined services through the provision of a consistent, agreed, standardised way for practitioners within and across organisations to identify consumer needs, identify appropriate services, make referrals, provide feedback, communicate and coordinate care, leading to improved operational efficiency and a reduction in the demand on the service system through more effective client / consumer outcomes.

What is the Service Coordination Framework and what are the elements?

The operational elements of service coordination, as described in the *Better Access to Services: A Policy and Operational Framework* are depicted in the figure below. Initial contact, initial needs identification, assessment and care/case planning are the key service coordination elements. Additional processes such as information provision, consent to share information, referral, information exchange, service delivery and exiting can occur at any stage.

Service coordination elements are implemented in a range of ways according to the consumer, the service provider and context in which services are provided. For example, in some services, initial contact and initial needs identification are carried out by the same person and assessment is conducted by a different person; in other services, one person may conduct both initial needs identification and assessment processes at the same time.



A consultation process undertaken with staff employed in Service Coordination capacity building and advisory roles identified a number of issues with the way in which access to family violence support services and assistance were less than optimal.

Service Coordination in Victoria is documented in the *Victorian Service Coordination Practice Manual* (VSCPM). The manual and associated resources were designed for managers and service providers involved in the implementation of service coordination. We recommend this resource to the Commissioners. Initially developed in 2006 by the Statewide Primary Care Partnership (PCP) Chairs' Executive, with funding from the formally known Department of Health, the resources aim to provide an overarching service coordination framework applicable to a range of sectors and services including:

- Aboriginal community-controlled organisations (ACCO)
- Ambulance Victoria
- disability services
- family violence services
- general practice
- health
- housing
- mental health
- multicultural and ethno-specific services
- welfare and community services
- youth and family services

Representatives from each of these sectors were involved in the revision of the manual and associated documents. However, until now, implementation of the framework has not been strong across the family violence sector, although there is some variation between regions.

As part of this submission, a wide consultation process across all PCPs has been undertaken. This process has identified a number of issues with access to and coordination of family violence support and assistance.

This submission documents the findings from our consultation process according to the key service coordination processes outlined in the figure above.

Consultation responses from Victorian Primary Care Partnerships according to service coordination area of practice

Initial contact

Initial contact is the consumer's first contact with the service system. It is an important function of every service provider and usually includes the provision of accurate, comprehensive service information and facilitated access to initial needs identification. It may or may not include the completion of a family violence screening tool which some agencies will undertake at a later date.

Where initial contact is via the police there are clear mandated processes in place that result in referral for follow up support. At other times initial contact may be via a local agency where a person may present for family violence related support, or with issues that do not appear to be related to family violence where the presence of family violence is subsequently uncovered. In these cases, follow up is not mandated (except in cases involving children) and there is variability in the quality of information and follow up needs identification that is available.

Furthermore, the primary way that many agencies promote access to services is via telephone. People experiencing family violence may need to access services via other means including walk-in (during and outside of business hours), e-mail and on-line. There seems to be variability in standards that apply in this area which further contributes to the aforementioned variability.

This variability is also acutely felt in the area of connectivity. In some catchments, services are operating from electronic systems that enable the secure transmission of client information. However multiple systems exist, especially when agencies operate across more than one catchment, and this can hinder the willingness of agencies to move towards more secure and efficient electronic transmission of referral and other data.

Initial needs identification

Initial needs identification is a brief, broad, screening process to uncover underlying and presenting issues. Initial needs identification canvasses the consumer's needs as well as opportunities for intervention and information provision early in their contact with the service system. The service provider engages in a broad conversation to identify these needs. It is not a diagnostic process, but includes identification of the consumer's safety risk, eligibility and priority for service. Initial needs identification involves a whole-of-person, consumer-centred approach.

Initial needs identification is the stage at which many agencies will complete a family violence screen in completing the *Single page screener of health and social needs* (see Appendix 1). This screen asks the questions "Have you felt afraid of someone who controls or hurts you?" and recommends that if answered in the affirmative, the more comprehensive Accommodation and Safety Arrangements Tool be used (see appendices). These forms are both part of the Service Coordination Tool Templates.

The Service Coordination Tool Templates (SCTT) were developed to collect client information and undertake initial needs identification, referral and information sharing processes. These templates have been adopted by hundreds of agencies across the state replacing over 300 different screening and referral forms. This has led to greatly improved consistency in screening, referral and data collection. The templates have been regularly updated since they were first introduced. In 2012, a single page screener (which screens for family violence) was introduced. The hope of the inclusion of this question was that more cases of family violence would be identified earlier. However, as SCTT 2012 is still not consistently embedded across client management systems this results in the use of paper versions which can lead to subsequent difficulties in terms of timeliness of processing, usability, lack of data collection and storage. Other agencies continue to work with older versions of SCTT but in doing so, they miss key this screening question for family violence.

There is significant research which shows that women who experience violence access health services more than women who do not experience abuse[2]. Given this, it is advisable that health services systematically screen for family violence. Earlier identification of violence is critical to achieving better outcomes for abused women and children.

[2] Lesley Laing **Routine Screening for Domestic Violence in Health Services** **http://www.adfvc.unsw.edu.au/PDF%20files/screening_final.pdf**

Regardless of the tool being used, there is inconsistency in screening for family violence. Reasons for this are varied but often relate to staff knowledge, skills and comfort levels in asking women about their safety in the home. The decision whether to ask about safety is sometimes left to the discretion of the worker. This approach is laden with risk, as inexperienced practitioners outside the family violence sector may be influenced by unconscious bias and stereotypes regarding how people experiencing violence may present and therefore not ask all women. A small number of agencies report that a safety question is not part of their screening tool because they felt it was the responsibility of more specialised roles and services to ask this question. We need to support agencies so that all staff in health and associated services are trained to complete Initial Needs Identification, irrespective of which services their organisation will provide or which service the client may be referred to in order to access services.

Some member agencies reported that there were often no 'official' protocols/procedures for responding to family violence and that family violence training is not routinely offered as part of induction/professional development. Additionally, a small number PCP member agencies who responded to our survey reported that staff has low levels of knowledge in this area. When combined with a lack of organisational systems this has meant that clients have disclosed family violence issues and no follow up has then occurred. Further support for member agencies and their frontline staff to develop and embed these systems is recommended.

Assessment

Assessment is a decision-making methodology that collects and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering services. It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention. It is often service cpecific.

Consultation with PCPs revealed that inadequate staff training and poor understanding of local service systems impedes timely and effective assessment. Disclosure of family violence is unlikely if staff is not confident or are unable to articulate what will happen next. Key staff need to know how to conduct a comprehensive risk assessment and how to develop and implement a safety plan where required or have the ability and confidence to refer to someone that does. Clear guidelines around whose role it is to develop a safety plan with the client and whether this should occur during the initial needs identification or assessment phase would beneficial.

The family violence sector is now well versed in use of the Common Risk Assessment Framework (CRAF). The development of the CRAF, and associated training, is a significant step forward in increasing the safety of women and children experiencing family violence. However, there needs to be much wider roll out of training to those outside the family violence sector, including the schools / education sector.

The CRAF Framework is designed to assist professionals working with women, to identify risk factors associated with family violence and to respond appropriately.

It was developed:

- to better identify and respond to women and children who are victims of family violence
- for use by a range of professionals including family violence service providers, the police, the courts, and professionals in mainstream services who encounter and work with women and their children who experience family violence

The Framework aims to develop common standards and practices among service providers to ensure that the focus of any intervention and support remains on the safety of those experiencing violence.

A significant amount of training has been available to staff from outside the family violence sector. For example, level two CRAF training is targeted at workers who are not family violence specialists but who may encounter clients who are victims of family violence. It includes training on how to recognise and respond to family violence, assess the level of risk to the client, assist the client to develop a basic safety plan and provide the client with an appropriate referral. Unfortunately, training availability been insufficient to ensure a broad range of staff from health and community agencies is appropriately skilled in this area. As only a small proportion of women experiencing violence will enter the service system directly through a family violence agency, it is critical that staff in community health services, general practice, local council and family services is able to be able to respond effectively.

It must be noted that there are plenty of examples of good practice. For example, one police station within the North West metropolitan region (Darebin) has participated in professional Aboriginal cultural awareness training as part of a Koori family violence project. This training emphasised the importance of the integrated family violence sector being responsive to the needs of Aboriginal women experiencing family violence. Further rollout of this type of training to all Police stations in the State is recommended.

As with initial needs identification, electronic client management systems need to enable agencies to undertake comprehensive standard assessments. These systems should also have built in alerts to ensure that abusive partners are never able to access information about their partner (ie next appointment time, etc.). The ability to track family violence history or perpetrators of violence nationally would also be valuable. Training would need to accompany the implementation of such systems. This also needs to happen with Federally funded organisations outside the family violence sector including Centrelink who frequently send letters home to victims when changes are made to payments.

Care/case planning

Care/case planning is a dynamic process that incorporates assessment coordination, care/case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care/case planning may occur at an individual provider level and both within and across agencies.

Coordination of care is difficult for people presenting in family violence crisis. Often when a person needs to escape from a family violence situation they come into contact with multiple services including police, child protection, hospitals, specialist family violence services and

mainstream services. A system of case management that was shared in real time across agencies would provide a streamlined service so that a client is able to escape the situation in a timely and safe way is imperative. Clear communication and referral pathways would assist in this regard. Due to resource constraints the service system is limited in the case management and support it is able to provide to all but the most extreme cases of violence. A time poor, resource constrained workforce is more likely to experience poor understanding of local service systems outside of their own. In this context information remains fragmented and responses are less likely to be holistic and more likely to put women and children at risk.

A shortage of safe accommodation options is a major obstacle to effective care coordination. Without timely access to appropriate accommodation, families are more likely to find themselves moving areas creating discontinuity of care. Many services are constrained by regional boundaries and funding. Sometimes agencies are unable to continue to offer support to women and children who have moved to different towns or regions.

Care coordination can be greatly enhanced when there are high levels of IT connectivity which comply with the National E-Health Transition Authority(NEHTA) Standards. There are a number of electronic client management systems that enable better connectivity for supporting services. S2S and Connecting Care are the ones that are used by the majority of PCP member agencies in Victoria. S2S and Connecting Care enable secure messaging between agencies. s2s also has the capacity to have an interactive shared support plan between agencies supporting a consumer. Many family violence services are not yet working in this way instead using unsecure fax, unsecure email or post. This exposes agencies to risks in breeching confidentiality of client information. The use of these methods is not in line with best practise and contravene NEHTA standards as well as the orginisational polices of agencies. Likelihood of delays in delivery of fax or mail can result in slow referrals and inconsistent or no acknowledgement of referral which may result in women not being able to access services.

PCPs are well placed to assist Family Violence agencies to become e-referral literate.

When referrals are received by agencies this information has to be re-entered into Client Management Systems. The Department of Health and Human Services have been work around standardisation of the fields[3] within the SCTT so that data when received will self-populate into the receiving agencies CMS. This will reduce intake workloads, prevent data being overlooked and will improve the flow of referral. It is important to note that TCM already has some functionality with self population but this is limited and due to this it is frequently not utilised.

It is worth noting that all of the above processes are enhanced when there are close working relationships and partnerships between different agencies, Co-location of family violence specialists in community health settings could be particularly powerful in this regard. Foe example, the Neighbourhood Justice Centre (NJC) in the City of Yarra provides a model of service delivery that has been recognised as best practice. It holistically addresses the needs of applicants and respondents, and provides timely interventions in relation to family violence. Currently the NJC only accepts applicants from within the City of Yarra. However a broadening of the boundaries for service delivery across the Inner North West region would

[3] Using Client Document Architecture (CDA) and atomised data. Currently blob data is used.

enable greater utilisation of these services. This model sits in stark contrast to the Melbourne Magistrates court that does not currently have appropriate facilities to separate family violence intervention order applicants from respondents. This may increase the likelihood of intimidation and fear between the parties prior to orders being made, or prevent some applicants from attending court due to safety concerns.

Additional processes

Information provision

Providing information that is relevant to the consumer's needs may be undertaken at any and all stages of the service coordination process. When choosing the type and complexity of information to provide, service providers will be receptive to and guided by the consumer's needs, learning styles and their capacity to understand information (taking into account issues such as preferred language and visual or cognitive requirements). Service providers will check that consumers have understood and, importantly, are able to utilise the information that is being provided.

PCPs have identified that the availability of bi-lingual staff and CALD resources are critical in this respect. However, other factors such as health literacy must also be taken into account. People require information in safe, easily understood formats including through verbal, written and electronic means. Once again, IT limitations exist in this area with many web searches for information failing to bring up the range of services available, and many people not having access to computers and internet facilities that permit them to access information in this way. In the Northern Metropolitan Region, family violence help cards developed by Women's Health in the North provide an example of good practice for women requiring initial information but there is often a lack of funds to produce even such basic information in accessible formats.

The National Health Services Directory (NHSD) is a key resource within this area it has been expanded from the Victorian Human Services Directory and is now nationwide. It underpins directories such as Nurse on Call, the better health Channel and Connecting Care among others. It is on-line and is regularly updated by agencies. Despite this, due to lack of knowledge or understanding some agencies still choose to develop local directories. When they do this, it is often at the expense of populating and updating the NHSD. The Department of Health and Human Services encourages use of the NHSD but it would be helpful to issue stronger directives in this regard and provide funding and or incentives to make it more accessible and increase the functionality and develop this technology further

Consent to share consumer information

Privacy legislation requires the protection of an individual's personal information and their right to decide how the information is used, disclosed to or shared with others. Consumer consent is a compulsory part of the information exchange process. The primary purpose of information collection is the purpose for which the information was originally provided. The secondary purpose is any additional use that is not directly related to the consumer's original disclosure. Consumers must agree to the disclosure of information for secondary purposes.

In relation to family violence, often multiple services are involved in providing a response. Currently, outside of those agencies that have signed up to service coordination principles, there is no consistent approach to obtaining consent between providers. For example, some agencies accept verbal consent while others require written consent. Both forms of consent are acceptable under service coordination principles although written consent is preferred. Additionally, processes can become quite bureaucratic when multiple services are involved, especially new services, with a limited amount of trust and without consistent information sharing systems in place. Generally, PCP member agencies and their staff have good knowledge of consent and privacy issues. This is especially the case where they use SCTT because this system has high standards for compliance in this area. The family violence sector has been slow to uptake the SCTT. Therefore, it is important that all staff working with people who have experienced family violence has received training in Commonwealth and State privacy legislation.

IT systems also play an important role here. Not all IT systems can document electronic informed consent. For example, Titanium, which is used in community health dental services, has scope to record initial consent but not all of the informed consent that would need to be obtained if the dental service was to refer a client to a family violence service. This might seem unnecessary but could occur if a dentist became aware that they were treating dental injuries resulting from a family violence incident. Systems that deliver secure messaging need to be able to show that informed consent has been gained.

Referral

Referral may occur at or result from any stage of the service coordination process. Referral is the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision.

PCPs acknowledge the significant work and outcomes that have been achieved in relation to police protocols and the use of L17s following police attendance at family violence incidents. Generally, PCPs are not directly involved in this area but the feedback we have received from our agencies that are suggests this system is a very positive and important development in addressing family violence as this is often the first report that family violence is occurring. Agencies are currently however not given any funding to follow up on L17s and merely send a letter advising that help and support is available. Unfortunately often there is no response. Funding into this early intervention model could reduce family violence at the start rather than waiting until it is a crisis point. PCPs work focusses more on referrals from and between health, community services, mental health, drug and alcohol and other similar services, including family violence services. The following observations relate to referral pathways in these sectors rather than those between police and family violence services directly. However, the heavy reliance on fax within this system is problematic.

Ideally, interagency or service referral should occur via a secure messaging platform. It is acknowledged that secure messaging is currently limited by inconsistent uptake of systems that have this functionality. Interoperability issues between different agency referral systems is also a factor. There are two messaging platforms that are used by PCP agencies both of which enable secure transmission of client referrals, including consent.

Whilst it is not ideal that PCPs agencies are operating from two systems, it is preferable to the dozens of home grown systems that tend to appear in the absence of an overarching framework. PCPs are particularly concerned about the use of non-secured messaging and referral pathways, in particular post and unsecured email. Faxes continue to be widely used, and should be equally discouraged due to issue of acknowledgement in addition to fax messaging being unsecure and machines being in communal areas. This is doubly concerning given the inherent safety concerns present in cases of family violence.

The lack of good systems in this area compounds a problem with the acknowledgement of referrals. In some services, there is no consistent system set up to acknowledge the referral, confirm acceptance and documentation of the process. This increases the likelihood of clients getting "lost" between systems. Inadequate follow up on cases, and a failure within the system to ensure all relevant information is known to agencies involved, have been identified by previous inquiries as systemic failings that contribute to poor outcomes. For this reason, PCPs advocate for further work in this area in line with service coordination principles and the Statewide Service Coordination Practice Manual.

Information exchange

Information exchange is essential to provide consumers with a seamless, coordinated service delivery. Information exchange includes: acknowledgement that a referral has been received and the subsequent action to be taken, provision of summary information to other service providers at key points in the consumer's pathway, such as following assessment, care/case planning, review or change in service delivery, handover, transition, exiting, or at other points in the consumer's service delivery pathway as appropriate.

The barriers to effective information exchange are similar to those experienced with referrals. As highlighted earlier they include:

- use of non secured pathways for information exchange
- lack of interoperability between IT systems and platforms where secure messaging has not been mandated. (An effective solution here requires pressure from government on vendors for interoperability.)
- concerns regarding privacy and confidentiality
- inadequate processes for acknowledging referrals and providing feedback to the referring agency
- knowledge barriers among the existing workforce (A solution here might lie in education at university for practitioners on the service system and IT systems. New graduates could be well positioned to mentor older workers in this area.)

In addition, there may be difficulties obtaining client authorisation. Reasons for this can be varied: lack of trust and understanding on the part of the client which could due to insufficient effort/time/resources at practitioner level to adequately explain the value of sharing information as well as the sort of information that will be shared or who it will be shared with. It can be that client has genuine concerns about privacy or a multitude of other reasons. Referrals can still occur when a client declines to share information. However, this means that the client has to retell their story; which in the case of Family Violence and abuse can be harrowing. In some cases inadequate provision of information can mean that at times, one

agency will be working with a client without knowing that others are involved and the roles that they are taking. This inhibits effective care coordination and case management, leads to duplication of services and can result in poorer client outcomes. PCPs address these issues through partnership building and service coordination. Outcomes would be enhanced with greater levels of participation from family violence services.

Service delivery

Service delivery is generally undertaken in accordance with local protocols and in keeping with the needs of the consumer and the level of skill of the person providing the service. Within local PCPs, all work is underpinned by core service coordination principles as outlined in the Victorian Service Coordination Practice Manual[4]:

Central focus on consumers

- Service delivery is driven by the needs of consumers and the community rather than the needs of the system, or those who practice in it.

Partnerships and collaboration

- Service providers work together and take responsibility for the interests of consumers, not only within their own service but across the service system as a whole.

The social model of health and the social model of disability

- The social model of health is a distinct conceptual framework for thinking about health and wellbeing. This framework is concerned with addressing the social and environmental determinants of health and wellbeing, such as education and housing, as well as biological and medical factors. This includes the spiritual and family connections that contribute to wellbeing.
- The social model of disability adopts a human rights approach to disability and differentiates between physical impairment and the disabling effects of society.

Competent staff

- Elements of service coordination must be undertaken by staff that are appropriately skilled, qualified, experienced, supervised and supported.

Duty of care

- A duty to take reasonable care of a consumer. The duty of care extends to service coordination, where staff have a duty of care to provide accurate and timely information, and assist consumers with referrals.

Protection of consumer information

- All confidentiality and consumer information requirements are met. The brochure *Your information – It's private* and the SCTT *Consent to share information* template are designed to improve consumer outcomes, information flow and practice.

Engagement with a broad range of service sectors

- Service coordination embraces the broadest range of partnerships across sectors including non-government, government and private providers.

Consistency in practice standards

- Service coordination procedures and tools are developed to provide consistent, coordinated service delivery.

Unfortunately some sectors have not embraced service coordination principles and in some cases vulnerable clients have to repeat their "story" multiple times to get access to services.

[4] Victorian Service Coordination Practice Manual 2012, http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

The uptake of service coordination principles by all sectors would be beneficial. The directive to enable this to happen needs to come from government mandate.

This submission does not focus on service delivery as we expect that agencies working directly with consumers are in in the best position to do this. However, we do note that effective service delivery requires adequate resourcing. In particular, many of the systemic issues we have identified and the current limitations of our IT systems will not be addressed without additional resourcing, as well as stronger directives to agencies that they must operate from systems that interface effectively with other help service providers and health agencies.

Exiting

Exiting can occur at any stage of the service coordination process and is generally managed in accordance with local protocols.

Before exiting, a case closure plan should be put in place particularly in cases where support provided has been complex and extensive. Effective planning once again requires good communication to internal and external staff and agencies. It should be secure, timely and include processes to ensure all service providers are informed. The use of secure message delivery should be expanded across sectors to enable best practice in this area.

PCPs acknowledge that family violence can be such a complex and protracted issue that in many instances, clients who have “exited” will require further services in the future. Improved connectivity with client management systems and secure means of transferring client data will ultimately lead to more efficient and effective service delivery.

Other areas of feedback relating to Service Coordination

Barriers and enablers to engaging GPs in family violence responses

General practitioners are the gateway to health services for most of the population. For this reason, engaging GPs in this issue is crucial.

However, PCPs have identified that engaging GPs in partnership, sector development and training activities can be extremely difficult. This has been PCPs’ experience across multiple issues and many years of practice in this area. PCPs anticipate that greater engagement of GPs in family violence issues, whilst essential, will not be easy to achieve. The role of PCPs engaging directly with GPs is limited but with the introductions of newly funded Primary Health Networks at a federal level from 1 July 2015, there may be additional opportunities in this area.

The demands on GPs to see patients and lack of mechanisms to remunerate them for participation in any other activities has meant that often GPs are often unaware of the broader service system and are ill equipped to assess family violence risk. The Wagner Chronic Disease model did however, demonstrate that financial incentives work for GPs and lead to higher levels of GP participation. As with other non family violence health and community workers, GPs would benefit from Level 2 CRAF training delivered in a way that made it viable for GPs to attend. Similarly, the system would be strengthened if there was greater interoperability between GP referral and health service messaging platforms. At the present time, it can be difficult to communicate effectively with GPs about their referrals. It is

acknowledged that this situation is improving with new systems and technologies being currently introduced. Developing good relationships with GPs is also very important.

There were several other examples given by PCP member agencies of instances where GP responses did not reflect good practice. In one case raised as a result of our consultations concern was expressed about a situation where a GP from the same cultural group as a patient dismissed family violence that was disclosed as the norm for that culture. In other cases, there was concern about a lack of discharge planning by hospitals to GPs which meant that patients did not receive adequate follow up. There is scope here for improvement across the board as follow up is often suboptimal.

The importance of supportive funding and service agreements

Service agreements between agencies and government funding bodies present a real opportunity to embed better practice with regards to earlier identification of family violence. Improved connectivity through mandated use of secure messaging and strong guidelines and best practice measures around timelines for acknowledgement and referral processes on discharge would greatly benefit the family violence sector.

Better alignment between family violence crisis response services and mainstream service is critical but enablers for this must be embedded in all service agreements across all government sectors. Adequate IT platforms across sectors form a large part of this picture but other dimensions include the way agencies are required to meet and record target client hours / visits, data recording, and more widespread adoption of screening for family violence.

Across the State, PCP member agencies have service agreements with multiple government departments and statutory bodies including: Justice, Police, Housing, Education, Health and Human Services, Local Government, the Victorian Responsible Gambling Foundation, VicHealth, the Office of the Public Advocate, etc. **There is a major opportunity to improve alignment and achieve a whole of government and whole of community approach to responding to family violence but this will not occur without leadership at the highest levels**.

Recommendations – Service Access and Coordination

1. **Implement the Service Coordination framework across all funded agencies and resolve issues with connectivity to ensure secure and efficient practice in relation to all aspects of service coordination:**

- SCTT frameworks, guidelines and templates should be mandated for a broader range of agencies, especially agencies providing family violence services.
- The Department of Health and Human Services (DHHS) should work with software providers to ensure that all future upgrades to the SCTT tools are included in software products. Furthermore, future developments should occur in consultation with vendor providers' development teams to enable implementation of the upgrades in a timely manner.
- DHHS should complete the standardisation of the SCTT as a priority. Use of the single page screener should be mandated across all agencies and health funded services using the SCTT.
- Mandate use of secure messaging to ensure the safety and privacy of vulnerable women and children.
- Department of Health and Human Services should continue to work with message vendors to ensure interoperability between secure messaging platforms
- Continue to support the ongoing development of platforms to enable interoperability of CMS in future developments that align with NEHTA standards.

2. **Ensure a well trained and competent workforce**

- CRAF Level 2 training should be more broadly available across the non family violence sector.
- Implement minimum compulsory training standards for all existing staff in privacy and confidentiality and the transfer of client information. This should include information about secure messaging.
- All staff administering the SCTT should receive appropriate training to ensure they are comfortable asking about safety and skilled and knowledgeable about how to respond if violence is disclosed.
- Ensure that Service Co-ordination is included within the curriculum at university to all medical, health and social students with some detail about the secure messaging, privacy and systems.

3. **Invest sufficient resources to ensure that all agencies can meet best practice standards in relation to service coordination**

- Resource and strengthen existing partnerships and platforms. New initiatives should not be introduced independently of existing structures, as it can be counterproductive to create new partnerships, governance structures and organisations.
- Consider extending and enhancing co-location arrangements so that family violence specialist workers are working alongside non specialist staff in community health and other community settings.

A case study

The Identifying and Responding to Family Violence project is a Regional PCP initiative that aims to assist PCP member agencies in the North West Metropolitan Region to provide a more streamlined and coordinated service system response to the diversity of women and children experiencing family violence by:

- supporting the rollout of the SCTT 2012 single page screener and improving family violence screening practice and initial response
- developing a resource for PCP member agencies that will assist staff at all levels to identify and respond to family violence and make effective referrals, so the client is seen in the right place, at the right time and clients do not have to repeat their story

In 2012, the *Single Page Screener for Health and Social Needs* was introduced as part of an update to the SCTT suite (see Appendices). The purpose of the single page screener is to support service providers to screen consumers for risk in a number of health and social areas and determine whether there is a need for further action. One of the questions which feature on the single page screener aims to identify issues of family violence. "*Have you felt afraid of someone who controls or hurts you?"*

Since the release of the SCTT Single Page Screener, the North West Metropolitan Region (NWMR) PCPs have been exploring how they can best support member agency staff who screen for family violence. A family violence needs assessment survey was completed by 199 PCP member agency staff in the region in April 2014 and has provided some much needed evidence around staff confidence in identifying and responding to family violence.

The survey investigated the extent to which agencies had implemented the SCTT 2012 single page screener and how confident agency staff are at screening, assessing risk, responding, referring and developing a safety plan for clients accessing their services who are at risk or experiencing violence.

The needs assessment highlighted the following points:

- A large number PCP member agency staff feel they lack the necessary skills and confidence required when screening, assessing, responding, referring and developing a safety plan for victims of violence who access their services.
- The need to improve initial response services in mainstream organisations and improve family violence screening practice by providing a standardised comprehensive approach

The Identifying and Responding to Family Violence Project seeks to address some of these common needs. The project is particularly looking at how this can be achieved.

Prevention

Key messages in this section:

Violence against women is preventable

Evidence is clear that the drivers of men's violence against women include:

- Unequal distribution of power and resources
- An adherence to rigidly defined gender roles and stereotypes
- Gender inequality and masculine sense of entitlement

Effective prevention work needs to address these issues.

There are many existing partnerships and plans to prevent violence against women. These partnerships and plans have great potential to effect change if adequately resourced. Current resourcing in the prevention system is inadequate.

New initiatives should not be introduced independently of existing structures, as it can be counterproductive to create new partnerships, governance structures and organisations. Such approaches tend to drain funds and resources away from existing work and partnerships.

In addition to the above mentioned determinants of violence against women, there are a number of contributing factors including homelessness, alcohol and drug use, gambling etc. Where evidence is clear as to how government intervention can address these issues, steps should be taken to reduce the prevalence of contributing factors as part of a broader plan to prevent violence. Preventing problem gambling is an example of an area where stronger government intervention would be cost effective.

An introduction to prevention and integrated health promotion in PCPs

In Victoria, the term 'integrated health promotion' refers to:

> 'Agencies and organisations from a wide range of sectors and communities in a catchment (local area) working in collaboration using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.' [5]

In order to achieve effective integrated health promotion program delivery in the current Victorian context, PCPs apply the following elements:

- Effective partnerships
- A mix of interventions and common planning framework
- A broad range of sectors

In recent years, there has been a shift in language towards wider use of the term "prevention" to cover a broad range of health promotion activities intended to keep populations healthy. Sometimes language around "public health approaches" may also be used interchangeably as a public health approach denotes all organised measures (whether public or private) that might be undertaken to prevent disease, promote health, and prolong life among the population as a whole. This submission does not propose to enter into

[5] IHP Resource Kit (2012) Department of Health http://docs.health.vic.gov.au/docs/doc/Integrated-health-promotion-resource-kit--Entire-practice-guide

discussion relating to the aetiology and semantics of these different terms. In relation to preventing family violence they might all be used to refer to the range of activities and initiatives that are undertaken.

Documents relating to IHP can be found on the Department of Health/PCP website. In particular, the **Primary Care Partnerships: Integrated Health Promotion Report 2011** draws on findings from an evaluation conducted in 2008 on the impact of the PCP IHP strategy.

Each Primary Care Partnership is required to develop a three year Strategic Plan that covers the four domains of activity; Partnership development, Integrated Chronic Disease Management, Service Coordination and Integrated Health Promotion.

The PCP Strategic Plan is reviewed annually in March and updated as needed. Updated Plans are required to be submitted to the Regional Director, Health & Aged Care.

Within IHP, this overarching PCP Strategic Plan is supported by a '**IHP Catchment Plan'** and annual **IHP Implementation/Operational Plans** (per financial year)

Victorian Health Promotion Priorities

Each PCP's IHP Catchment Plan generally has between one to three health promotion priorities which align with the priorities of the Victorian Pubic Health and Well-Being Plan 2011-2015. The priorities are as follows:

1. increasing healthy eating
2. increasing physical activity
3. controlling tobacco use
4. improving oral health
5. reducing misuse of alcohol and drugs
6. promoting sexual and reproductive health
7. promoting mental health
8. preventing injury
9. preventing skin cancer.

The Department of Health and Human Services (DHHS) has specific requirements of PCPs for their planning activities and documents, which are linked to PCP funding and service agreements with DHHS. Total funding to PCPs across Victoria to undertake Integrated Health Promotion is modest and is in the vicinity of $2 million.

How are PCPs currently working to prevent violence against women?

In collaboration with regional women's health services PCPs are involved in partnership and capacity building and coordination activities to prevent family violence. PCPs consider women's health services to be key leaders in this area. Women's health services are also longstanding members of local PCPs, in many cases participating on boards or governance groups.

The work of PCPs to prevent family violence / violence against women falls into several categories:

1. **Participating in, and promoting, partnerships to prevent violence**

   Example 1: Prevention of violence against women (PVAW) has been the North East Primary Care Partnership's (NEPCP) Integrated Health Promotion (IHP) priority since 2012, under the mental health priority. Eight member agencies make up the NEPCP PVAW Collaborative: Banyule City Council; Banyule Community Health; Darebin City Council; Darebin Community Health; Neami National; Nillumbik Health; Nillumbik Shire Council; and, Women's Health in the North. Taking a multi-component or 'jigsaw' approach, the PVAW Collaborative has a shared vision with individual agencies implementing separate but complementary strategies guided by a regional strategy (Women's Health in the North's *Building a Respectful Community – Preventing Violence Against Women – A Strategy for the Northern Metropolitan Region of Melbourne 2011-2016*) and underpinned by VicHealth's *Preventing violence before it occurs: A framework and background paper* to guide the primary prevention of violence against women in Victoria. The PVAW Collaborative's vision is to build communities in the NEPCP catchment in which violence against women is unacceptable and where communities, cultures and organisations are non-violent and gender equitable. The August 2014 survey of the PVAW Collaborative Working Group members indicated that the NEPCP PVAW Collaborative approach has been valuable with 83% of respondents (5 out of 6) agreeing that being a member of the PVAW Collaborative added value to their PVAW work and inspired and motivated them. In addition, 100% of respondents agreed the PVAW Collaborative fostered respect, trust, inclusiveness and openness, combined the perspectives, resources and skills of partners, helped the partnership create and look at things differently; and, minimised barriers in partnership meetings and activities. To progress the work of the NEPCP PVAW Collaborative and address the challenges identified to date, the current NEPCP PVAW Operational Plan supports individual partners to implement their organisational specific plans and strategies, with the NEPCP also leading the development and implementation of additional strategies that will benefit all partners.

2. **Building the capacity of PCP member agencies to undertake prevention work**

   Example 2: The G21 PCP (Geelong) has developed a G21 region Health & Wellbeing plan which has identified the G21 regional family violence strategic plan development as a key priority. The G21 PCP will contribute to the project planning executive group to oversee the development of the plan. This project will deliver an integrated evidence based five year Strategic Plan for the G21 area that will have a strong focus on capacity building and provide consistent, evidence-based and effective approaches to the primary prevention, early intervention and response to violence against women and children. The following stakeholders are represented on the project planning executive group: Barwon Area Integrated Family Violence Committee, City of Greater Geelong, G21 Health and Wellbeing Pillar & Women's Health and Wellbeing Barwon South West. Partnerships and formal MOU's with agreed shared objectives in the G21 region have enabled a more coordinated approach and the platform to address service system change. In particular seeking shared projects with the Barwon Area Integrated Family Violence Committee (BAIFVC),which represents specialist services across the Barwon region has provided enablers to address reform and connections in the service system.

3. Developing and implementing evaluation strategies

Example 3: The INWPCP IHP Partnership is currently implementing the INCEPT (Inner North West Collaborative Evaluation) Project. The aim of the project is to develop an evaluation framework on Preventing Violence Against Women (PVAW) for the Inner North West catchment, including shared indicators, measurements tools and instruments, and apply this framework to evaluate the effectiveness of PVAW projects across the catchment. The framework will be completed by the end of 2015 and data will be collected on local PVAW projects in 2016-17. As part of the project, the INWPCP will develop a data management system for collecting and storing process and impact data on relevant projects. The INWPCP has engaged the University of Melbourne to provide expert advice and technical support for this project.

4. Participating in awareness raising work

Example 4: Members of the Lower Hume PCP have worked to establish a municipal based awareness program based on a small fiberglass elephant known as Elly who acts as a conversation starter. The response agency (nexus) then works with local sports clubs and other areas for support on their policy and leadership frameworks through a Philanthropic grant. Importantly, this is a multi level response which includes the service providers.

5. Supporting regional women's health services by promoting and participating in regional plans

Example 5: The Inner and Outer East PCP's have Prevention of Violence Against Women listed as on of their key prevention priorities. They have worked in a collaborative partnership with Women's Health East (WHE), Council and Community Health Services and other key stakeholders in the development, implementation and evaluation of the Together for Equality and Respect regional (TFER) action plan. THEF is a four year strategy developed by WHE and partners aimed at preventing violence against women in Melbourne's East 2013-2017. The Strategy provides partner organisations with the opportunity to work together to prioritise, coordinate and integrate our efforts to prevent men's violence against women across the EMR. Both PCPs sit on the leadership group and evaluation committees and are extensively involved in driving the work in the partnership with WHE. They have supported the strategy in developing tools and frameworks used in both the implementation and evaluation of the action plan and carried out evaluation activity to assess components of the plan as well as the regional partnership.

What enablers exist that facilitate effective prevention work?

PCPs have reported that the following existing factors support effective prevention work:

1. Strong regional leadership by women's health organisations.
2. The fact that violence against women is now widely recognised as a significant, prevalent and preventable public health issue and as a result has been prioritised in many organisational plans.
3. Commitment by many organisations to work in partnership to address violence against women.
4. A competent and committed health promotion workforce across a range of organisations that is able to plan and implement prevention activities, and

advocate for gender equity, non-violent social norms, and the prevention of violence against women.

5. The availability of an increasing number of evidence based frameworks that emphasise action on the determinants of violence against women to guide planning and implementation of primary prevention activities.

These are the features of the system that are currently working quite well to support prevention initiatives. These features are almost certainly the reason why many PCP member agencies have adopted preventing violence against women as a priority for work in the last few years. Not withstanding these enablers, there are significant issues when it comes to ensuring the effectiveness of all prevention work. Some of these are identified in the next section.

What barriers do PCPs encounter to effective prevention work?

The most significant challenge that PCPs have identified to more effective prevention work relates to limitations with statewide strategy to eliminate men's violence against women. Statewide leadership would help to ensure we are working to both respond to violence when it occurs but also putting resources into addressing the root causes of violence. The current approach is piecemeal and has resulted in a myriad of poorly funded and integrated initiatives. There are now hundreds of partnerships working to prevent violence which is a fantastic beginning but unfortunately many partners have limited human and financial resources to contribute to additional shared actions and strategies. There is no linking body or overarching campaign in this area. Furthermore, prevention of violence against women is not a listed priority in the Victorian Health and Well Being Plan. Many agencies funded to deliver health promotion under this plan select PVAW as a priority anyway and then attribute it to the Mental Health priority area. This is problematic for several reasons. Violence against women is much broader than just a mental health issue. It is the greatest contributor to burden of disease for women in the 15-44 age range as a result of the physical, emotional and psychological harm that it causes. Subsuming the PVAW priority under mental health denies the true extent of the issue and undermines the ability of agencies to devote sufficient time and resources to addressing the issue.

The Victorian Public Health and Well Being Plan should be amended to add preventing violence against women as one of its key priorities.

PCPs identified a number of additional barriers to more effective prevention work including:

- Duplication of partnership structures across the catchment and region – prevention work is taking place at local government, PCP catchment and regional levels via women's health services. In some cases, these different partnership structures draw on the same pool of professionals who then experience "partnership fatigue", being pulled into too many meetings and planning forums and finding little additional time to actually undertake much work. As one PCP respondent wrote, "too many meetings in relation to tiny available resources."
- Many survey respondents indicated challenges in maintaining the focus of member agencies on primary prevention activities, rather than being drawn to intervention and response activities.

- PCPs noted the complexity of undertaking work to change attitudes, behaviours and environments to promote gender equality and prevent violence against women.
- Anecdotally, partner organisations in areas where there are lower rates of family violence incidents (incidents reported to police) have found it more difficult to provide the rationale for their organisation committing resources to prevent violence against women (even though there is a huge under-reporting of FV). There is also a feeling that funding is not as available to areas with lower rates of FV incidents.
- Influencing stakeholders who are not in health promotion/prevention roles to understand and focus on the link between gender inequity/rigid gender roles and stereotypes and violence against women can be challenging.
- Policy responses were seen as particularly effective but difficult to achieve. Despite their widespread promotion as effective prevention tools, Workplace Family Violence Policies, a Client Services Family Violence Policies and Prevention of Violence Against Women organisational audits are not being as widely adopted as might be hoped due to constraints in resources and understanding of issues.
- Some PCPs identified challenges in working with Local Government due to approaches that operated in silos and difficulties getting broader catchment and / or regional agreement.

Most of the challenges identified related in some way to resourcing issues. Many professionals from within PCPs noted frustrations with lack of time allocation to follow through on prevention activities, lack of staff skill and knowledge in understanding how to tackle the determinants of violence against women and lack of resources that would enable follow through on prevention activities and ideas generated by partnerships.

What improvements could be made to maximise prevention benefit?

PCPs identified the following changes that could be made to maximise prevention efforts in Victoria:

- Ensure family violence stays on the 'agenda' in health promotion for partner agencies. Currently community health is not funded to be involved in family violence prevention activity and it can be hard to justify as it is not a Victorian Health and Well Being Priority. If this was changed, it would be easier for PCPs and Community Health in particular to work in this space.
- In line with appropriate framing in public health policy, planning and reporting guidelines for PCPs, Community Health and Women's Health should be structured to allow for appropriate prioritisation of VAW as a public health issue in its own right, with well established determinants and contributing factors.
- A strategic connection between Statewide PCPs and DHHS Family Violence Strategy is needed. Despite the fact that the Department of Health and the Department of Human Services have once again become one, the impact of this has not yet reached this area.
- Increase funding of primary prevention activities that specifically address the determinants of violence against women related to gender inequality, as identified in the evidence-base. This includes appropriately funding women's health services to lead and resource regional partnerships and primary prevention work, and supporting these local partnerships with statewide direction, similar to the regional implementation committees that focus on service delivery.

- There is strong evidence regarding local government (LG) and community health's (CH) unique and critical role in preventing violence against women. There has been a large investment to date in terms of capacity building and developing/supporting partnerships (e.g. VicHealth, WHIN, MAV, PCPs etc). However, these sectors are still an untapped resource, and there is still significant potential for them to play a more active role in preventing violence against women.
- Further investment could be made in local government and community health. Across Victoria these two sectors are among the most active members of PCPs. They have many strengths in relation to preventing violence against women Their role is both as large employers (org/workforce development), community settings with local employees and providing important services providers (often delivering Early Years, maternal and child health, HACC, health and family support programs, GPs, Youth Services, community & sporting facilities etc). Local government and community health are especially good places to invest in PVAW work because:
    - ✓ They know/understand their communities and can develop violence prevention strategies & initiatives to meet specific local needs and contexts (which we need to if we are to be effective).
    - ✓ They can address determinants – promote gender equity & equal and respectful relationships
    - ✓ They can influence contributing factors: for example employment, neighbourhood characteristics, social connections & cohesion - we know that addressing contributory factors is most likely to be successful in reducing violence against women when underlying gender issues are also taken into account.
    - ✓ They have influence/relationship with priority settings – for example sport, schools, media, workplaces
    - ✓ They have reach/ relationship with vulnerable groups (those vulnerable to experiencing FV and its impacts) – Aboriginal, CALD, young women, pregnant/new parents, women with disabilities, women in rural/remote areas, GLBTI and older people.
    - ✓ They can work across the continuum – prevention, early intervention and response.
    - ✓ They can take a multidisciplinary approach, bringing together professionals, organisations, individuals and communities from very different backgrounds and with many different skills and experiences.
    - ✓ They can provide leadership and want to lead / play an active role in PVAW.
    - ✓ If resourced & supported, they can drive whole of organisation / whole of community programs
- Appropriately address issues with data that would enable better measurement of the incidence of family violence and better evaluation of prevention activity. To this end:
    - ✓ Address gaps in data collection in regards to gender equity, such as population level gender equity statistics, to measure Victoria's progress in preventing men's violence against women.
    - ✓ Fund and support existing regional partnership platforms to collect and manage local data on gender equity and violence against women.
    - ✓ Promote mechanisms that support more effective sharing of data across a range of services to provide a more comprehensive insight into the prevalence of men's violence against women in Victoria.
    - ✓ Continue to fund critical data sets such as the Australian Census of Population and Housing and the VicHealth Community Attitudes Survey, to provide insight

into gender equity measures and attitudes towards violence against women in Victoria.

- Invest more resources in local media initiatives and capacity building for volunteers with a focus on improving and changing the entrenched attitudes related to 'gender equity'. PCPs strongly believe that there needs to be a greater focus on addressing the root causes of men's violence by making large scale structural changes to address gender inequities.

Recommendations – Preventing Violence Against Women

1. **Recognise and address the determinants of violence against women**
    - Ensure that all work to prevent violence adopts a gendered perspective and addresses gender inequality the key driven of men's violence towards women
    - Be explicit in use of language and name the things we need to change clearly and unambiguously – i.e. use language such as masculine sense of entitlement so that we can have more open discussion about how to address this and other determinants
2. **Invest more resources in prevention activities**
    - Adequately fund existing projects and initiatives
    - Recognise that investing in prevention is a long term strategy
    - Focus on children and young people as change may take place over a generation
3. **Build on existing plans and partnerships whilst strengthening statewide leadership**
    - Ensure that preventing violence against women is listed as a priority in the Victorian Health and Well Being Plan
    - Do not create new structures and partnerships when rolling out new initiatives
    - Build on the women's health platform for prevention of violence against women and "No to Violence" in relation to men's behaviour change

CASE STUDY Problem gambling and family violence – addressing contributing factors as a way to prevent violence and minimise harm

There is a significant and established co-morbidity between problem gambling and family violence. PCPs acknowledge that there are numerous other co-morbid issues. We are commenting particularly on this area because of PCP's long standing track record of working to reduce harm from gambling. When problem gambling contributes to family violence, PCPs consider this to be a major additional harm from gambling which should be actively prevented.

Since 2008, Victorian PCPs have been involved in work to prevent harm from gambling. Initially this work was funded by the Department of Justice under their 2008 Problem Gambling Prevention Strategy. When the Victorian Responsible Gambling Foundation (VRGF) was created on 1 July 2012, some PCPs continued to deliver innovative prevention activities under this umbrella. In 2014, the VRGF shifted the way in which it delivered prevention activities and announced a major new prevention grants program. This program has resulted in a $2.2 million investment in 15 prevention programs around the state including 4 which are directly led by PCPs and a number of others in which PCPs are active partners. Projects run by PCPs and with PCP involvement are identified in a table in the appendices.

There is an established link between family violence and problem gambling, with research revealing a prevalence of family violence of up to 52% among families with a member who is experiencing problem gambling. Such family violence is accompanied by high rates of physical harm towards children. In addition, a consistent accumulation of international evidence affirms that gambling is a contributing factor to intimate partner violence (IPV) and family violence more broadly.[6] Research indicates that people who have gambling problems are decisively more likely to be victims and perpetrators of family violence, than those without gambling problems.[7]

The most recent research is from the 2013 Australian arm of a large-scale study of the patterns and prevalence of co-occurrence of family violence and problem gambling in Australia, New Zealand and Hong Kong[8], which screened 120 help-seeking family members of problem gamblers in a range of clinical services for both family violence and problem gambling. The main results of this study showed that 52.5% reported some form of family

[6] Dowling, N., Suomi, A., Jackson, A., Lavis, T., Patford, J., Cockman, S., et al. (2014). *Problem Gambling and Intimate Partner Violence: A systematic review and Meta-Analysis*. Advance online publication. DOI: 10.1177/1524838014561269, retrieved from http://tva.sagepub.com/content/early/2014/12/02/1524838014561269.abstract,

[7] Dowling, N. (2014). *The impact of gambling problems on families*. AGRC Discussion Paper No. 1 – November 2014, retrieved from https://www3.aifs.gov.au/agrc/publications/impact-gambling-problems-families/what-are-impacts-gambling-problems-families

[8] Suomi, A., Jackson, A.C., Dowling, N.A., Lavis, T., Patford, J., Thomas, S.A., Harvey, P., Abbott, M., Bellringer, M.E., Koziol-McLain, J. & Cockman, S. (2013). *Problem gambling and family violence: family member reports of prevalence, family impacts and family coping*, *Asian Journal of Gambling Issues and Public Health,* Vol. 3, No. 13, pp. 1-15. August 2013, retrieved from http://www.responsiblegambling.vic.gov.au/information-and-resources/research/recent-research/problem-gambling-and-family-violence-family-member-reports-of-prevalence,-family-impacts-and-family-coping

violence in the past 12 months: 20.0% reported only victimisation, 10.8% reported only perpetration and 21.6% reported both victimisation and perpetration of family violence. They also noted that 'participants reported that problem gambling and family violence were related in over 70% of their problem gambling family members'.

According to a meta-analysis carried out by Nicki Dowling from Deakin University and her colleagues, over one-third of people with gambling problems report being the victims of physical IPV (38%) or the perpetrators of IPV (37%). Moreover, gambling-related problems are reported by 11% of the perpetrators of IPV and 56% of those who committed physical violence against their children. The researchers concluded that these findings 'highlight the need for public health and treatment services to routinely screen and assess for a range of issues, including gambling problems, family violence, alcohol and drug use problems and mental health issues, and provide treatments designed to manage this cluster of conditions.''[9] The researchers added that further work is required to investigate the nature of the relationship between problem gambling and IPV and the relationship between problem gambling and violence that extends into the family beyond intimate partners.

Addressing problem gambling should be a government priority as effective measures in this area are likely to result in lower rates of related family violence. Unlike some co-morbid issues that are inherently complex and difficult to manage, problem gambling is not an intractable issue. It usually results from addictive or problematic use of gambling products over which the government is able to exercise a significant level of control.

Electronic gambling machines (EGMs) hold particular relevance for this issue. More Victorians experience gambling problems through their use of EGMs (75-80% of problem gamblers) than through other form of gambling. EGMs in Victoria are predominantly high intensity, high risk machines.[10] One key way to reduce gambling-related family violence is to minimise the incidence of problem gambling by making the EGMs in Victoria safer.

The Productivity Commission undertook a major review on gambling in 2010 which resulted in the following observations[11]:

- While precision is impossible, various state surveys suggest that the number of Australians categorised as 'problem gamblers' ranges around 115 000, with people categorised as at 'moderate risk' ranging around 280 000.
- It is common to report prevalence as a proportion of the adult population, but this can be misleading for policy purposes, given that most people do not gamble regularly or on gambling forms that present significant difficulties.
- The risks of problem gambling are low for people who only play lotteries and scratchies, but rise steeply with the frequency of gambling on table games, wagering and, especially, gaming machines.
- Most policy interest centres on people playing regularly on the 'pokies'. Around 600,000 Australians (4 per cent of the adult population) play at least weekly.
- While survey results vary, around 15 per cent of these regular players (95 000) are 'problem gamblers'. And their share of total spending on machines is estimated to range around 40 per cent.

[9] Dowling, Op cit.

[10] http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Former_Committees/gamblingreform/completedinquires/2010-13/precommitmentscheme/report/output/b02

[11] Productivity Commission (2010) Productivity Commission Enquiry Report Gambling No. 50 26 Feb 2010

- The significant social cost of problem gambling - estimated to be at least $4.7 billion a year - means that even policy measures with modest efficacy in reducing harm will often be worthwhile.
- Recreational gamblers typically play at low intensity. But if machines are played at high intensity, it is easy to lose $1500 or more in an hour.

The Productivity Commission recommended that the following measures be implemented to reduce problem gambling related to EGM use:

- ✓ The amount of cash that players can feed into machines at any one time should be limited to $20 (currently up to $10 000).
- ✓ There are strong grounds to lower the bet limit to around $1 per 'button push', instead of the current $5–10. Accounting for adjustment costs and technology, this can be fully implemented within six years.
- ✓ Shutdown periods for gaming in hotels and clubs are too brief and mostly occur at the wrong times. They should commence earlier and be of longer duration.
- ✓ There should be a progressive move over the next six years to full 'pre-commitment' systems that allow players to set binding limits on their losses.
- ✓ Under a full system, there would be 'safe' default settings, with players able to choose other limits (including no limit).
- ✓ In the interim, a partial system with non-binding limits would still yield benefits, and provide lessons for implementing full pre-commitment.
- ✓ Better warnings and other information in venues would help. But school-based information programs could be having perverse effects and should not be extended without review.
- ✓ Relocating ATMs away from gaming floors and imposing a $250 daily cash withdrawal limit in gaming venues would help some gamblers. But the net benefits of removing ATMs entirely from venues are uncertain.
- ✓ Effective harm minimisation measures for gaming machines will inevitably reduce industry revenue, since problem gamblers lose so much. However, this would not occur overnight and the reductions may be offset by other market developments.

The Victorian Government estimates that the prevalence of problem gambling in the State is about 0.7%, with an additional 2.4% of people being classified as moderate risk gamblers.[12] The estimated population aged 18+ across Victoria, as at 2015 at would be 4,642,000.[13] The 0.7% prevalence would result in 32,494 problem gamblers, while the addition of 2.4% above (giving a total of 3.1%) would result in an estimate of 143,902 problem **or** moderate risk gamblers.

If the most recent research is accurate, then problem gambling may be contributing to approximately 16,900 cases of family violence. (that is, 52% of 32,494 problem gamblers) In light of the research finding that approximately four-fifths of problem gambling cases are linked to EGM use, it may be estimated that approximately 13,000 instances of family violence caused or aggravated by EGM gambling. Accordingly, enacting measures recommended by the Productivity Commission to make EGM use safer might prevent or reduce the severity of family violence in 12,000 cases.

Furthermore, addressing problem gambling as a contributing factor to family violence makes economic sense. Access Economics estimated that the average total lifetime cost of domestic violence was **$224,470 per victim** e in 2002–03 – the equivalent of $307,000 in

[12] Problem Gambling from a Public Health Perspective (2009) http://www.gamblingstudy.com.au/pdf/FactSheet_3_v2.PDF
[13] *Victoria in Future 2014*

2015 dollars.[14] These estimates signify that if family violence related to the use of EGMs could be eliminated, this might save $ 3.69 billion in associated costs (cost per victim x 12,000 cases). This figure dwarfs annual government taxation revenue from EGM problem gambling, of approximately$400 million annually (that is, 40% of $1billion).

Failure to act to prevent EGM problem gambling when the solutions are clear and able to be implemented (as per the Productivity Commission) is not only problematic in relation to the State failing to exercise its duty of care, it is creating an economic burden when this money could be better spent in other areas of prevention.

While the calculations presented here are based on some assumptions, it should be emphasised that a conservative approach has been taken in considering only problem gambling rates (0.7% prevalence) rather than the much higher prevalence of moderate risk gambling (2.4%), although it is likely that some moderate risk gambling is also associated with increased risks of violence. We urge further examination of these and other related data to provide a more refined insight into the scope of this problem and extent of the savings that might be accrued through more timely and expeditious action in this area.

Other issues relating to family violence and problem gambling that have been identified by PCPs include:

- Research into women experiencing problem gambling and isolation suggests that some women who are experiencing family violence use poker machine venues as a safe space away from home[15]. Some report that they then develop a problem with gambling as EGMs are designed to be addictive. Poker machines venues are not safe spaces for women who isolated are seeking refuge from family violence.
- Most quantitative research about this subject is non-gendered and therefore does not provide a complete picture of the problem of family violence in families in which there is gambling. Without this knowledge it is difficult to get a complete picture of the harm that women and children experience in these families.
- Whilst many health and human services sectors routinely screen for and address family violence in their service provision, the problem gambling sector does not routinely incorporate family violence into its work practices. Immediate steps should be put in place to ensure a comprehensive screening process in problem gambling services given such high rates of co-morbidity.
- There are currently limited response services for men who perpetrate violence. When the perpetration of violence by men against family members is not identified and addressed by problem gambling counsellors when they present for counselling, this is a missed opportunity for the men and their families. If counsellors are not provided with training on how to work with men who use violence, then they will not have the skills to address this issue in a safe and timely manner.

[14] The Cost of Domestic Violence to the Australian Economy (2004) Commonwealth of Australia, A report prepared for the Australian Government's Office of the Status of Women by Access Economics Pty Ltd, funded by the Australian Government under *Partnerships Against Domestic Violence*.

[15] Women's Information and Referral Exchange. (2008). *Opening doors to women.* Wire: Melbourne, retrieved from http://www.wire.org.au/wp-content/uploads/2010/08/OpeningDoors.pdf

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Appendices

Appendix 1 - SCTT Single page screener of health and social needs

Single page screener of health and social needs

Service provider administered

Purpose: to assist service providers to screen for consumer's needs.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Suggested introduction for consumers

The purpose of these questions is to help us get to know you and provide you with the best possible service.

Your participation in answering these questions is voluntary and we treat your information in the strictest confidence, in accordance with privacy legislation.

If you would like to proceed, we will read out several questions about the kinds of things that may be problems/issues for people.

Please answer 'yes' or 'no' to each question.

If you answer 'yes' to a question we will then ask you whether you would like to discuss it further.

Before we start the questions, may I ask you: what is the main reason you are seeking assistance today?

Questions	Is this an issue? Code: ☐	Would you like to discuss this? Code: ☐	If yes, consider completing optional SCTT templates as relevant including those listed below *For items marked with an asterisks (*) refer to SCTT 2012 User Guide for more information*
Do you have difficulty with daily tasks (such as getting dressed, showering or preparing meals)?			*Need for assistance with activities of daily living Care relationship, family and social network*
Have you been told by a doctor or other health professional that you have a health condition (eg breathing problems, a cancer, heart problems, chronic kidney disease, diabetes, high blood pressure, arthritis, osteoporosis or other condition)?			*Health and chronic conditions*
Have you recently had problems with your teeth, mouth, gums or dentures?			*Health and chronic conditions*
Are you concerned about your medications?			*Health and chronic conditions*
Are you concerned about your lack of physical activity?			*Health and chronic conditions*
Are you concerned about your weight?			*Health and chronic conditions*
Have you recently lost weight without trying?			*Health and chronic conditions*
Do currently smoke tobacco?			*ASSIST*
Have you quit smoking tobacco in the last 5 years?			*ASSIST*
Are you concerned about how much alcohol you drink?			*ASSIST*
Are you concerned about your use of drugs?			*ASSIST*
Are you concerned about your gambling?			*
Is your financial situation very difficult?			*
Do you often feel sad or depressed?			*Social and emotional wellbeing and care relationship, family and social network*
Do you often feel nervous or anxious?			*Social and emotional wellbeing*
Have you felt afraid of someone who controls or hurts you?			*Accommodation and safety arrangements Care relationship, family and social network*
Are you homeless or at risk of homelessness?			*Accommodation and safety arrangements Care relationship, family and social network*
Would you rate your health as poor?			*Health and chronic conditions*
Would you rate your life circumstances as poor?			*

Single page screener of health and social needs Service provider administered

Produced by the Victorian Department of Health, 2012

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Appendix 2 - SCTT Accommodation and safety arrangements screen

Accommodation and safety arrangements

Purpose: to screen for consumer's accommodation risk of homelessness and their safety needs, including family violence and personal emergency planning.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Accommodation

Accommodation Code: ☐

Comments on accommodation:

Is the consumer **homeless** (nowhere to stay tonight) Code: ☐

Is the consumer in housing/ accommodation that is:

At risk (for example eviction, behind in their rent

☐ Yes ☐ No ☐ Not stated/unknown

Unsafe (for example family violence, physical danger or other threats)

☐ Yes ☐ No ☐ Not stated/unknown

Insecure (for example, temporarily staying with friends/ family or using other temporary accommodation)

☐ Yes ☐ No ☐ Not stated/unknown

If yes to any of the above, refer the consumer to the homelessness support service in their area or specialist family violence service, via www.dhs.vic.gov.au/for-individuals/crisis-and-emergency/crisis-accommodation/homelessness-and-family-violence-getting-help

Is the consumer currently living in public/community housing (also known as social housing) and are:

☐ **At risk** (for example eviction, behind in their rent

☐ **Unsafe** (for example family violence, physical danger or other threats)

If yes to any of the above, refer to their local housing officer on www.housing.vic.gov.au/about-us/contact-us/local-housing-offices

Safety

Family violence

Is the consumer afraid of someone close to them who controls, hurts, insults or threatens them, or who prevents them from doing what they want?

☐ Yes ☐ No ☐ Not stated/unknown

***If yes**, proceed with the following questions:*

Who is the consumer afraid of? *(including the relationship to the consumer)* _____

What form does the abuse take? _____

Is the abuse becoming worse or happening more often or both?

☐ Yes ☐ No ☐ Not stated/unknown

Are any children involved experiencing the abuse or violence directly or by hearing or seeing it?

☐ Yes ☐ No ☐ Not stated/unknown

Is the consumer very scared for themselves or any children?

☐ Yes ☐ No ☐ Not stated/unknown

Has a safety plan been prepared with the consumer?

☐ Yes ☐ No ☐ Not stated/unknown

*For **women** experiencing family violence — refer to the Women's Domestic Violence Crisis Service on 1800 015 188.*

*For **men** experiencing family violence — refer to the Victims of Crime Helpline on 1800 819 817.*

*For **older people** experiencing elder abuse — contact Seniors Rights Victoria on 1300 368 821*

Living arrangements: Code: ☐

Comments on living arrangement:

Personal emergency planning

Does the consumer have a personal emergency plan in case of fire, heat wave or flood?

☐ Yes ☐ No ☐ Not stated/unknown

If no, encourage people living in high bushfire or other risk areas to develop personal emergency plans.

Does the consumer have a working smoke alarm in the house?

☐ Yes ☐ No ☐ Not stated/unknown

If no, and the person is unable to do this themselves, discuss options for assistance from families, friends, neighbours.

Other relevant information:

Produced by the Victorian Department of Health, 2012

This information collected by: AS pg 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Accommodation and safety arrangements

Appendix 3 - PCP and PCP partner projects to reduce harm from gambling

1. **ReSPIN – Gambling Awareness Speakers Bureau**

ReSPIN is a prevention project run by North East Primary Care Partnership made possible through a VRGF grant of $157,000. The project recruits, trains and supports a pool of volunteers to talk to community members, groups, media and professionals about their experiences with gambling. It aims to influence public discussions about problem gambling by increasing the number of consumer voices willing to talk about their experiences with gambling and reduce the stigma associated with problem gambling.

2. **Transforming Spin to Community Win**

Victorian Primary Care Partnerships and the Victorian Local Governance Association received a grant of $158,950 from the foundation to run the prevention project, Transforming Spin to Community Win. The project will focus on working with local councils to provide regular gamblers with alternative recreational activities to restore balance to how they spend their time. The project aims to improve the effectiveness of local government efforts to deliver and promote community-based activities that provide an alternative to gambling.

3. **Reducing Gambling Frequency CALD Project**

The HealthWest Partnership received a grant of $180,000 from the foundation to run the Reducing Gambling Frequency CALD project. This project will target social and seniors groups in CALD communities across 13 local government areas across four catchments.
The project will groups who frequently visit gaming venues and work with them to develop community-led actions to increase knowledge and understanding of the risks associated with EGM gambling.

4. **Chasing the Luck**

The Inner East Melbourne Medicare Local and the Inner East Primary Care Partnership (IEPCP) received a grant of $252,574 from the foundation to run the prevention project Chasing the Luck. This project will deliver a targeted information campaign to Chinese restaurant workers and their communities with the aim of reducing the prevalence of problem gambling. With research showing Asian immigrants are disproportionately affected by problem gambling, the project will address key determinants of problem gambling for this group.
These include the stigma associated with seeking help, the proximity of EGMs to work settings and a lack of culturally appropriate, convenient and timely alternative recreational activities.

In addition to these projects where PCPs have been directly funded to deliver activities to present harm from gambling, PCPs are active partners in other initiatives including:

5. **Increasing the Odds for Safety and Respect**

Women's Health in the North received a grant of $185,000 from the foundation to run the prevention project Increasing the Odds for Safety and Respect. This is a program tackling problem gambling relating to family violence by establishing problem gambling prevention officers in the women's health and family violence service system. The project will identify families entering the family violence system where harm from gambling is occurring or at risk of occurring and provide early and effective services to families to address and minimise the harm. The project will also focus on developing the skills and knowledge of workers in the family violence and problem gambling sectors and improve current practice. Women's Health in the North and Women's Health East are running this early intervention and prevention project where staff work with family violence and problem gambling service providers across the northern and eastern metropolitan regions to share knowledge about the link between family violence and problem gambling. The North East PCP and Inner East PCP are partners in this project.

6. **Putting the Health and Wealth back into Whittlesea**

Whittlesea Community Connections received a grant of $99,000 from the foundation to run the prevention project Putting the Health and Wealth back into Whittlesea.
A program focusing on community education to ensure Whittlesea residents are aware of the risks associated with frequent EGM use.
The project will also explore pathways to non gambling activities for frequent gamblers and members of vulnerable population groups and build partnerships with local council and community groups.
Hume Whittlesea PCP is a partner in this project.