



Northern Integrated Family Violence Services

A Report on the Northern Sub-Region Counselling and Group work Service Partnership Model for Women

**Prepared for Women's Health In The North
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Practice:

...includes the language, tools, documents, images, symbols, well-defined roles, specified criteria, codified procedures, regulations and contracts that various practices make explicit for a variety of purposes.

But it also includes all the implicit relations, tacit conventions, subtle cues, untold rules of thumb, recognizable intuitions, specific perceptions, well tuned sensitivities, embodied understandings, underlying assumptions, and shared world views. Most of these may never be articulated, yet they are unmistakable signs of membership of communities of practice and are crucial to success...

(Wenger 1998, p.47)

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1 Purpose

A new approach to improve the integration of family violence services has been effective since July 2005 as part of the whole-of-state government Integrated Family Violence (IFV) reform.(Office of Women's Policy 2005).

In 2008 the Department of Human Services (DHS), Office of Housing offered grants to the family violence and youth homelessness sectors to document effective integrated service models. Women's Health In the North (WHIN), as lead agency of the northern subregion's Family Violence Counselling and Support Services for women, proposed to document the service model that has been implemented in the northern subregion of the north west metropolitan region.

In its proposal for a Best Practice Grant, WHIN sought to document the development and implementation of integrated and collaborative work practices and systems involving mainstream and specialist services within a significant geographic area.

This project has provided an opportunity to reflect on the collaborative work that has been done so far and provides some direction for how and where the work needs to continue.

2 Methodology

A collaborative approach to the service model documentation was chosen, consistent with the process that has underpinned the implementation of the reform in the northern subregion.

The input of all participating service providers was sought. Individual discussions were held with representatives from the 12 agencies involved in delivering counselling and group workgroup work services.¹

The discussions focused on the agency's participation in the integrated service model, successful outcomes to date, gaps in the model, and identification of issues that need to be addressed to sustain the service model. Key themes arising from these discussions have formed the basis of this report.

Limited data analysis was possible. The available data included IRIS data, referral data collected by Berry St and limited Benchmark data.² At this stage the available data is neither consistent nor comprehensive. However, some insight into the progress of the integrated service model was gleaned.

The engagement of service users in the documentation was considered but not pursued because the model is at such an early stage and it would be difficult to identify service users who have accessed services through the service pathways. Also the complexity of receiving ethics approval within the timelines of such a small project was not practicable.

¹ See appendix 1 List of interviewees

² IRIS Integrated Reports and Information Systems, Department of Human Services Family services data collection system; Benchmark data specific purpose family violence data collection managed by Department of Planning and Community Development

3 The Northern Subregion Counselling and Group Work Model

3.1 Who is Involved

The northern subregion covers seven local government areas – Banyule, Darebin, Hume, Moreland, Nillumbik, Whittlesea and Yarra – and is home to nine community health services. It is part of the broader DHS north west region.

From the beginning, the approach to family violence service integration in the north aimed to involve local community health services in providing the counselling and support component of services for women and children.

The community health services are part of a partnership with Berry Street, Anglicare and WHIN, bringing the total number of organisations to 12: WHIN acting as lead agency and 11 service providers.

The numbers of community health services providing counselling and support has increased over the past three years. In the first year (2006–7), five community health services agreed to participate and provide services. By the second year (2007–8), all nine local community health services had joined the partnership.

These services are:

- North Richmond Community Health Service
- North Yarra Community Health Service
- Darebin Community Health Service
- Plenty Valley Community Health Service
- Nillumbik Community Health Service
- Banyule Community Health Service
- Moreland Community Health Service
- Dianella Community Health Service
- Sunbury Community Health Service

3.2 Level of Funded Service Provision – Organisational Roles

In 2008–9, nine community health services were provided with resources to offer individual counselling and group work services for women experiencing family violence. The level of resources is very limited and provides for counselling to eight women and one group involving eight women per year.

Berry Street and Anglicare were allocated resources to provide two groups each for women and provide secondary consultation for community health services. 'Secondary consultation' was described in the tender specifications as 'assisting generalist community service organisations and professionals in their work with women and children who have experienced violence'.

WHIN's role with respect to counselling and support services was identified as directing, leading and supporting the development and delivery of quality counselling and group work services. This included roles covering: legal responsibility for the DHS program and service agreement, monitoring the achievement of targets ; ensuring the implementation of relevant program initiatives such use of the Common Risk Assessment Framework; and supporting and resourcing staff involved in group work.

3.3 The Rationale for the Model

There are three key features that underpin the service model.

3.3.1 Local Champions, Localisation and Consistency

The service model built on many of the existing strengths of the subregion and its existing service landscape. The northern subregion has a strong structure of locally based family violence advocacy networks that have been active in some areas for nearly two decades.

The service model sought to extend, strengthen and coordinate those involved in advocating and responding to family violence issues by working with community health services.

3.3.2 Community Health Engagement

The engagement of community health services in the formal family violence reforms was considered a priority for a number of reasons.

Firstly, family violence is a key issue that needs mainstream attention. Through community health services there was great potential for supporting both existing and new local champions of family violence, thereby strengthening the voice and action around family violence issues.

Local community health services in the north provide comprehensive geographic service coverage. The partnership with community health services provides consistent service delivery across the whole subregion. The 2004 Health Costs of Violence report provided clear evidence that intimate partner violence is the highest contributor to the disease burden in Victorian women aged 15–44 years (VicHealth 2004).

Many women already present at local community health services for support in relation to family violence. Support available at community health services covers a broad and diverse range of services, which includes doctors and allied health staff in addition to specific family violence focused services. The services are well placed to respond to individuals and groups with a range of issues requiring specialist attention, for example, women with disabilities, women from culturally diverse backgrounds and women with complex needs.

Formal engagement with community health services recognised that women enter the service system at a range of entry points and that community health services are one of the important 'front doors' for family violence. The multiple access points for women as illustrated in the 'The House' diagram describes the need for the family violence service system to have multiple entry points (see appendix 2).

The model recognised the opportunity to improve the linkages between specialist family violence services and community health services and ensured that women have access to a more integrated service system.

Many of the community health services in the northern region have significant experience and history of participation in local family violence initiatives and as advocates around local family violence issues. The model provided an opportunity to formally bring all of these initiatives together.

The existing role and responses of community health services in relation to family violence meant that their inclusion was critical to the successful introduction of service coordination processes, for example Common Risk Assessment and comprehensive data collection processes.

There was a clear commitment to a gendered analysis and approach to family violence that was also shared by the specialist providers and community health services.

3.3.3 Focus on Group Work

The service delivery model for the north appears to highlight group work to a greater extent than other regions.³ Funds were committed to group work in order to support consistent localised coverage of the subregion and provide some capacity for innovative approaches. In addition some resources were committed to facilitating regional planning and training for group work. In 2007-8 a total of 11 groups for women experiencing family violence were funded with the IFV resources.

³ DHS regional offices were contacted to provide information about other regions service models. Three replies received.

4 The First Years: The Data Profile

Currently available statistical information regarding the demand for IFV funded counselling and support services in the northern subregion is reliant on a range of sources of non-matching data. The data is able to provide only an indicative picture of how the integrated service model is functioning.

The data sources are varied and include the following-:

- IRIS data
- Referral data from Berry Street to community health services
- Family Violence Benchmark project data
- SMART– NDCA – data collected at intake point from Berry Street

It should be noted that the IFV funded targets for each community health service do not in any way represent the extent of demand and responses that community health already provide on a daily basis.

The limitations of the available data include:

- The integrity of the data was not consistent as it was a new data collection system for many service providers and there were a number of implementation constraints.
- There is not a consistent collection period as service providers joined the service model incrementally.
- There have been hitches in the system implementation of the eleven providers uploading to a central regional bank.
- Some service providers reported only on funded targets while others included service provision beyond funded targets.

In addition only four of the nine community health services participated in the March 2008 Family Violence Benchmark data collection.⁴ The Family Violence Benchmark data collection project provides a mechanism for measuring and monitoring family violence reform as a whole and will be invaluable in the future for understanding the demand for family violence focused counselling and support services in the funded services in the north.⁵ More comprehensive participation of all community health services is intended for future data collections.

4.1 The Agreed Referral Process for Counselling Services

The community health services and Berry Street agreed to a referral process for the funded counselling services that would articulate and consolidate a service pathway from the specialist family violence service to the community health services. It was recognised that the referral process would contribute to building an integrated service model.

The referrals for the IFV funded counselling services provided by community health services are initiated by the specialist family violence intake service, Berry Street Victoria, Northern Region Family Violence Service.

⁴ Dianella, Moreland, Nillumbik and Sunbury community health services

⁵ Family violence Benchmark data: collecting 2 week snapshot from police, courts and family violence services (biannual collection)

4.2 The Emerging Picture

4.2.1 What Does it Say about Service Demand?

Table 1: Summary of Service Users: July 2007 to March 2008 (Females All Ages) by all Providers and LGA
Source: IRIS (Extracted 1 May 2008)

	Banyule	Darebin	Hume	Moreland	Nillumbik	Whittlesea	Yarra	Other LGA	TOTAL
Banyule CHS	11	3	3	37	16	1	1	2	74
Darebin CHS	1	31	0	3	1	1	0	1	38
Sunbury CHS	0	0	18	0	0	0	0	2	20
Moreland CHS	2	1	0	6	2	0	0	0	11
Nillumbik CHS	2	3	1	0	8	2	0	0	16
Plenty Valley	3	1	7	0	0	31	0	0	42
Nth Yarra CHS	0	2	0	1	0	0	28	27	58
Sub total	19	41	29	47	27	35	29	32	259
Anglicare Lalor	1	5	0	1	0	7	0	0	14
Anglicare Women's	0	1	8	5	0	0	0	1	15
Berry Street	15	12	4	3	4	8	1	3	50
Sub total	16	18	12	9	4	15	1	4	79
TOTAL	35	59	41	56	31	50	30	36	338

*Dianella and North Richmond Community Health services were not part of this data collection.

Table 2: Summary of Service Users of IFV funded counselling and group work by country of birth: July 2007 to March 2008 by 9 providers

Source: IRIS (Extracted 1 May 2008)

Service Provider	Australian born	Born outside Australia
Banyule CHS	62	Greece 2 Italy 2 not stated 8
Darebin CHS	23	Greece 2 Philippines 2 not stated 11
Sunbury CHS (males and females)	22	England 1
Moreland CHS	8	Italy 2 Albania 1
Nillumbik CHS	13	Germany 1 Poland 1 not stated 1
Plenty Valley CHS (males and females)	45	FYROM 2 not stated 5
North Yarra CHS (males and females)	45	Africa 3 China 2 Hong Kong 2 Jamaica 2 not stated 7
Anglicare	15	England 1 Turkey 9 not stated 5
Berry Street	86	Lebanon 2 not stated 3

- Note:
1. re inclusion of males
 2. High number of Turkish born women represents a Turkish specific group run at Anglicare Women's House

As indicated above in Table 1, IRIS data for the nine-month period, July 2007 to March 2008, recorded a total of **338** women as service users of family violence focused counselling and support services provided by ten of the 12 funded services⁶. Another significant issue illustrated by the available IRIS data in Table 2 is the under-representation of women from culturally diverse backgrounds in the local family violence service system.

Four of the nine community health services completed the Family Violence Benchmark Data Collection in March 2008. In that two week period a total of **98** women were recorded as being supported by the four northern region services who participated in the data collection with the provision of individual support, counselling and/or group work.

Berry Street referral data indicates that in the 12 month period from July 2007 to June 2008, 95 women were referred to community health services for counselling.

Key messages from the available data in relation to service demand are that:

- There is obviously significant and overwhelming demand from women experiencing violence and seeking support from local services. The currently funded IFV service levels of counselling for eight women and one group involving eight women are clearly inadequate to meet that demand.
- Women are entering the service system at a range of local and subregional entry points both for generalist and specialist services.
- There appears to be a significant under-representation of women born in countries other than Australia in the local service system.

4.2.2 What Does it Say about the Service System?

The data illustrates that there is a high level of commitment from the local service system to address family violence and support both victims and perpetrators. The data identifies a far greater number of women receiving a service than formally funded through the IFV service.

The agreement to trial a referral protocol is recognition by all participating service providers of the need for improved integration and referral pathways between local and subregional services. The development of a more formalised referral process and its ongoing refinement highlights the flexible and responsive working relationships which continue to evolve between the services.

Service providers' commitment to developing a more comprehensive understanding of the extent and nature of family violence is demonstrated in their willingness to participate in the extensive Benchmark data collection

⁶ Dianella and North Richmond data was not available

5 The Outcomes

The outcomes that have been identified reflect the beginnings of a new way for services to work together.

For many years women experiencing family violence accessed counselling support and groups through local community health services, family support services, local councils and victims of crime services. For the first time since 2006, IFV resources have specifically targeted counselling resources to women experiencing family violence. The process and resources provide capacity to formalise links between existing service providers.

The northern subregional partnership, established for counselling and support services, now forms part of a systemic response and commitment to address family violence.

The outcomes that have been identified are not necessarily consistent nor do they reflect all service providers' experiences. Diversity in the nature and extent of involvement in family violence and history of interagency relationships all impacted on how service providers perceived the outcomes of the model thus far.

The specific outcomes of the service coordination of group work are easier to identify. Prior to 2006 there was already a history of regional coordination around family violence focused group work. Coordination tasks were identified at a very early stage in the IFVS project and included a Regional Family Violence Group work calendar and facilitators' practice forums. Additional project resources were committed by WHIN to collaboratively develop a practice resource kit entitled *Collected Wisdom - Facilitated Family Violence Support Groups with Women in the Northern Subregion*.

The outcomes identified by service providers have been grouped into key themes and form the basis of this report. The key themes are:

- Engagement and ownership
- Advocacy
- Clarity
- Exchange
- Commitment and collaboration
- Confusion
- Gaps

5.1 Engagement and Ownership

A high level of engagement in the IFV service model was described in the discussions with service providers. All the organisations were engaged in the family violence reform in a number of ways with a range of staff involved. Participation in the subregional service model was an acknowledgement that 'it was work that we were doing anyway'. As all of the organisations were members of the funded subregional counselling and support services partnership they were formally involved in a range of initiatives regarding the IFV reform at a state-wide level, such as, policy launches, workshops, regional forward planning processes and piloting of the Common Risk Assessment Framework.

Formal administrative arrangements, such as the Memorandums of Understanding, outlined service levels, funding levels, reporting expectations, coordination mechanisms, expectations re participation in coordination mechanisms and referral processes.

Agreed referral protocols provided the incentive for the service providers to communicate and identify pathways for women moving between services. The agreed protocol for access to IFV funded counselling services was that referrals would come through the specialist family violence service, Berry Street, to the community health services. The protocol provided the initial means for service providers to clarify respective roles and improve their knowledge and understanding of the service systems including access issues, intake processes, practice models and service capacity.

A simple and very effective initiative that was agreed at the outset was the production of the Regional Family Violence Group work calendar for group work activities in the region. Its initial purpose was to encourage cross-municipal coordination for availability of groups and as a resource tool for referral.

It soon became apparent that the group work calendar was an important symbol to identify some of the initiatives of the IFV reform in the subregion and the part of the service system that was engaging these 12 organisations. The group work calendar has become a highly sought-after resource for service providers.

Innumerable meetings were held to engage organisations and establish the governance and planning and advocacy structures. While time consuming, the regular meetings in the first two years established interpersonal links across organisations. Different people in each organisation were engaged in different meetings which enabled the focus on family violence to be maintained at a number of levels within organisations. These meetings included:

- Community Health Centre Counselling Managers
- Group work facilitators Practice Forums
- One-off meetings, policy and project launches, workshops
- Subregional planning forums
- Local Family Violence Network activity

It is clear that at this stage, the involvement of 12 (including WHIN) agencies as service providers of family violence counselling and group work services has improved the relationships between generalist and specialist, local and regional organisations who previously had worked in independent, and at times unrelated, spheres. There is clear evidence of development of a partnership to contribute to the development of a more integrated model to address family violence.

5.2 Advocacy

For many years, a number of community health services in the north have been strong advocates around family violence and have led or significantly supported some of the local family violence initiatives. For others their participation in a subregional service model has strengthened their role as a family violence advocate. The service model has enabled the role of local services as advocates to be harnessed and achieve greater consistency across the subregion. As one service provider described, *'every one of us goes out and repeats the same story.'* There are more people to raise awareness in local settings, advocate for local policy initiatives, develop relationships with local police and courts, understand and utilise a common risk assessment framework, and communicate about new legislation.

In relation to family violence focused group work for women, the service model was described by some as restoring their capacity to advocate for recognition of the value of group work. As one worker said *'the subregional group work initiatives have enabled us to bring our voice back'*.

The subregional model has given a clear priority to group work. Initiatives that have included the group work calendar, practice forums and resource manual, have all contributed to strongly validating group work as a service option for women. Together, workers have been able to advocate for the need for recognition for groups to be well resourced and provided within a clear framework.

5.3 Clarity

The IFV reform has changed the landscape for potential service responses at a local level. The police, courts and locally based specialist family violence services all have new models of practice and protocols.

The environment is complex especially for generalist local services who are attempting to keep pace with change across a number of service systems. For example, along with family violence reform, community health services were engaged in a number of other systemic reforms including those in mental health (those with multiple and complex needs) and family support innovations such as Child First.

New Victoria Police protocols and more effective regional family violence intake services have changed local service pathways for women experiencing violence. Service providers described how the process of working together and building a more integrated model has enabled the role of each service to be clarified.

One local area identified that the local police needed to be more active in making formal referrals. In response to this need, a meeting was held involving the local police, the community health service and the subregional specialist provider. This meeting helped improve service responsiveness and clarify service pathways.

In a number of areas the role of specialist family violence service was not understood and the relationship between services was minimal. The development of a working relationship between service providers that clarified skills and roles that could be accessed in working with women was illustrated in a local workers' description of a case example where, *'none of us had the expertise that Berry Street had and with Berry Street involved we were able to hold the woman much better'*. The case example below demonstrates how service roles were clarified and better understood when a local service sought advice and support through the secondary consultation from Berry Street.

The service provider partnership and the referral protocol between service providers has enabled specialist service providers to understand more fully the generalist counselling response of community health services. An increased understanding of community health services including resource constraints, intake procedures, management of waiting lists and utilisation of a range of practice approaches, has enabled services to make more informed referrals.

Case Study: An example of secondary consultation

Brief Description of Case

Initial contact between service providers

Berry Street Northern Family Domestic Violence Service (NFDVS) was contacted by a worker from the local community health centre (CHC). The CHC worker was aware that her client had had previous involvement with NFDVS. On discussion it became clear that the woman was at high risk. There was a long term history of violence in the relationship of 15 years and a history of choking. The CHC worker had made a notification to child protection regarding a 14 year old child.

Options were discussed with the CHC worker. The worker stated that the woman wanted the violence to stop but was reluctant to involve the legal system as she had had bad experiences with the police in the past. The woman did not want to access refuge at this stage. It was agreed that the CHC worker would meet with the woman and advise the client that she could call Berry Street NFDVS and identify a good time to talk and review options.

Second contact between service providers

The CHC worker advised that the safe time for NFDVS to speak to the woman was between 7.30am and 9.30am the following day on her mobile. The woman advised that if a male answered, the worker should not continue the call. The CHC worker was anxious that she was not a family violence worker and wanted NFDVS to pick up this client immediately. However, the client had not engaged with NFDVS.

The NFDVS worker rang the woman at the prearranged time. Initially, there was no answer and then an angry male answered the phone. The worker hung up as previously agreed. The NFDVS worker informed the CHC worker of the outcome, and suggested a meeting between the CHC worker, the woman and NFDVS. A meeting was arranged where the NFDVS worker attended but the woman did not. It was agreed that the CHC worker would remain in contact with the NFDVS worker.

Third contact between service providers

The NFDVS worker remained in contact with the CHC worker. The NFDVS worker attended a second time to meet with woman, but the woman did not attend the appointment. The NFDVS worker discussed risk assessment, safety planning, intervention orders, engagement with the courts and police, and the cycle of

violence with the CHC worker. NFDVS forms regarding a safety plan and the cycle of violence were supplied to the CHC worker. It was agreed that the NFDVS worker would be available as required.

The woman attended NFDVS for a duty appointment. A further risk assessment was undertaken, a safety plan completed, and the following items were discussed: refuge, legal response, the cycle of violence and responses to the child. The NFDVS worker and the woman agreed that the CHC worker would remain the woman's primary point of contact given the accessible geographic location and level of engagement with that service.

Discussion

This client was an indigenous woman who would be regarded as difficult to engage. The CHC worker was situated in the woman's local community, had a positive engagement with her and had been involved with her for some time. It was clear that the woman had not engaged with NFDVS in the past. NFDVS provided a flexible service primarily to contain the CHC worker's anxiety around working with a woman who was at significant risk and to educate her regarding the options and process. The NFDVS worker shared knowledge demystifying the information and process and explaining what steps NFDVS would engage in if talking to the woman, including clarifying the woman's options. The woman had a one off contact with NFDVS. The primary role of NFDVS was in providing secondary consultation at a worker to worker level.

5.4 Exchange

The exchange of knowledge has been identified as a key concept in recent years in successful models of system changes (Best & Terpstra 2008). A number of examples relating to the theme of 'exchange' that emerged in the discussions with service providers are outlined below.

5.4.1 Practical Exchanges

- Workers were outposted to local services as a strategy to address staff shortages and to facilitate sharing of skills of local and regional services. Far greater understanding of how each service worked was achieved.
- Co-facilitation of family violence groups often involved workers from different organisations coming together to facilitate a group. The opportunity to exchange knowledge and expertise is invaluable to the service system.
- The service providers shared their knowledge of intake processes resulting in Berry Street implementing the Community Health Centre's Primary Care Partnership referral tools and software.
- Staff visited each other's agencies to meet staff, to learn about services provided and to see the environments in which people were working.

5.4.2 Improved Service Relationships and Knowledge of Services

The partnership has enabled services to extend their knowledge of service systems and improve the opportunities to work together. One service provider said *'before we did not know how to approach specialist services, I can remember when staff advised me that it was no use contacting Berry Street'*.

The model has provided an environment of learning and sharing of expertise as well as an opportunity to break down mutual agency stereotypes. The benefit of being able to access training in the pilot of the Common Risk Assessment Framework and work alongside specialist services was valued by service providers: *'we have learnt from the specialist services and gained a lot of confidence in what we are doing'*.

5.4.3 Focus on Practice

A range of issues relating to practice have been acknowledged and processes identified to collectively address them:

- The referral process has identified the question ‘what does it mean for women to be ready for counselling?’
- ‘What is gender focused practice?’ One service provider described how participation in the partnership has increased the awareness of the need for gender specific approaches.
- What are good models of practice for group work? In the northern region there has been a tradition over the last ten years of family violence group work facilitators meeting to support each other and share practice models and experience. Resources have been committed to the development of a resource manual in collaboration with local workers and practice forums for group work facilitators. The focus on group work practice was widely supported as validating the value of groups and maintaining the integrity of groups in the north. Important outcomes include increased consistency in practice and service access.

5.4.4 Intra-agency and Cross Sector Exchanges

Service providers described how their engagement in family violence issues had prompted closer attention being given to the other areas that they were working such as drug and alcohol, mental health and gambling. Increased attention has been given to the incidence of violence in work with families in these areas. Practice tools, such as risk assessment and safety planning; have been introduced to these staff teams and reassessment of gender focused approaches undertaken. One community health service has, upon reflection in this process, more overtly matched the gender of counsellor to client. The partnership with community health services has thus provided opportunities for integrating family violence within a multi disciplinary environment.

5.5 Commitment and Collaboration

The model that has been implemented over the past two years has strengthened the local service system and contributed to ‘cementing’ service provider relationships. There is clearly a significant commitment to working together to improve service responses for women experiencing family violence.

There are a number of examples that demonstrate the willingness of the twelve organisations to collaborate around service planning and development. For example, organisations have all agreed that there is a need for more effective data collection to provide a more accurate picture of demand in the service system from women experiencing violence. There is widespread commitment to coordinate current disparate data systems such as IRIS and Health Smart.

5.6 Confusion

As a whole of government reform, the IFV reform has driven widespread systemic changes including police practices, legal systems and support services. At a state level, 20 partnerships involving 70 organisations have formed to address family violence.

In the northern subregion the service landscape is complex. In the north alone the Women’s and Children’s partnership involves 14 organisations; the Men’s partnership involves three organisations and is in partnership with three western sub region agencies. In addition the region has additional indigenous services for men and women. Four of the ten Victoria Police Family Violence Advisors cross the northern suburbs. The seven local family violence networks are highly visible and active.

There is an array of governance and planning structures established on a regional (north and west) and subregional level to facilitate the partnerships. In addition, service providers are often asked to participate in

important state wide initiatives such as the implementation of Common Risk Assessment Framework and Family Violence Benchmark data collection.

Service providers, understandably, expressed varied levels of confusion:

‘There are endless committees what are they all about?’

‘We do not understand the roles of organisations.’

Adding to the confusion is the high mobility of the workforce and the continued need to induct people into the complex system. There is a significant challenge to maintain effective communication and engagement with an ever-changing workforce.

5.7 Gaps

A number of gaps in the reach of services were frequently identified by service providers. Two significant gaps are:

5.7.1 Culturally Diverse Communities

The northern subregion has a high proportion of women from culturally diverse backgrounds. The service model has not taken great account of the different access issues demonstrated by CALD communities and at times the high dependence of communities on culturally specific workers. One culturally specific worker highlighted the complexity of the service pathway for women in her community by the comment: *‘every party I go to there is a client so I take my cards to every party ... my mother brings home messages that her friends have asked her to pass on to her daughter’*. Women from culturally diverse backgrounds are clearly under-represented in the local support system and the need to address issues of trust and access for ethnic communities was consistently identified by service providers.

5.7.2 Older Women

The impact of family violence on older women was identified as needing more attention. Family violence spans a wide spectrum of populations. The service system needs to acknowledge that older women may have been subject to violence for many years and, with increasing vulnerability and dependency, may be subject to continued family violence as they age. The lack of clear service pathways and responses for older women needs to be addressed.

6 Sustainability

From the above discussion it is apparent that all the participating organisations are engaged in the model. Systems have been developed to facilitate the working relationship and improve the service pathways and service experience for women. Service providers were asked to identify issues that need to be addressed to sustain the model and their organisation's participation. A number of issues were identified.

6.1 Resources

It is universally acknowledged that the resources allocated through the IFV system for counselling and group work do not in any way match the level of work being undertaken by individual organisations. Organisations are committed to participation because family violence is a clear organisational priority and violence is a significant health issue for women. The limited resource base will continue to be a concern.

6.2 Family Violence as a Core Issue for Community Health

In order to sustain community health services' participation, family violence needs to remain a core issue. Strategies to maintain violence as a priority issue include advocating for state-wide work to be undertaken regarding community health services' role in family violence and recognition of the interrelationship between community priorities and municipal health plans. Ensuring that family violence is a priority issues in every local government health plan was identified as an important strategy.

6.3 Resource Intensive

The extent of participation expected in state-wide and subregional family violence activities was identified as a challenge for service providers. Smaller organisations where family violence responsibilities are held by one staff were particularly affected. The need to, if possible, rationalise or prioritise this participation was identified.

6.4 Improved Evidence

It was unanimously agreed that in order to sustain the service model there is a need to improve the evidence and develop an accurate picture of the level of demand being experienced by service providers and more effectively address gaps in service responses. The new community health services' data system, Health Smart, will enable a common data set to be collected across all nine community health services.

All service providers indicated a commitment to participate in the Family Violence Benchmark data collection in September 2008. Improved data regarding future need for services and current service demand will provide an important resource for agreement on indicators that could be used to guide the allocation of any new funds that may become available.

6.5 Coordination Tools

Current documents for the 12 counselling and support partnership partner organisations include a Memorandum of Understanding and a Referral Protocol which detail the service model, funding levels and expectations of participating organisations. A referral process has been agreed to and varies slightly according to the local systems in place. Where appropriate, Berry Street utilises the community health centres primary care referral system.

Subregional coordination meetings have involved extensive discussions of common approaches to data collection, organisations' capacity to accept referrals beyond the funded targets, intake processes, waiting list management, discussion of 'counselling readiness' and the role and scope of organisations providing 'secondary

consultation'. The need for a more detailed coordination manual was proposed. The manual would provide an accessible reference for all staff to understand the scope of the service model.

6.6 Staff Turnover

One of the complexities of having 12 participating organisations is the higher aggregated level of staff turnover. The referral system is very dependent on interagency staff relationships. Staff turnover creates a challenge in maintaining momentum and ensuring that referrals and participation do not stop when members of staff leave.

6.7 Focus on Practice

As outlined above, a significant amount of work has been undertaken in the subregion to document practice models in relation to family violence focused group work. The need for more opportunities to discuss counselling frameworks and improve understanding of different counselling models in use was identified. The recently released *Practice Guidelines for Family Violence Women's and Children's Counselling and Support Programs* could provide a starting point for these discussions. Attention could also be given to the extent of the service being provided and an attempt to identify any common patterns in service utilisation, such as how many counselling sessions were delivered for each woman.

6.8 Improved Communication

The need for more effective and accessible information regarding service availability was identified in the following situations.

6.8.1 For Service Users

There is a need for a consistent message in the community about what is available to those who are experiencing family violence. Specifically, there is a need to raise awareness and understanding of counselling. For many culturally diverse communities the concept of counselling is not understood or easily accepted.

6.8.2 For Service Providers

The information needs of service providers within the partnership have been outlined above (6.5, 6.7) Other local service providers who are working with families experiencing family violence such as local government councils and family support agencies need access to information about resources available and pathways to services. Obviously, information strategies need to be considered within the whole of reform and include all service components such as crisis response, outreach support, intensive case management and housing support.

6.9 System Linkages

From the outset the need for strong links between related service systems has been identified. At both a state-wide, regional and subregional level some work has already occurred to address the intersections between child protection, family support and family violence services. Many community health services are significantly involved in a number of service system reforms particularly in family support and Child FIRST, mental health services and drug and alcohol services.

The need to improve integration with family support services was highlighted by service providers.

In addition it was believed to be important to find ways to identify the incidence and impact of family violence on women and children who may be seeking support from these other service types.

7 Conclusion

The conversations with service providers that formed the basis for this report have been useful as a means to individually consult service providers, reconfirm service agreements, identify what needs to work better and highlight areas for future action.

It is clear that the foundations of the service model are in place. Resource availability has not driven the service model – rather it has been driven by the strong commitment from service providers to address family violence.

Service providers' relationships have been cemented as a result of strategies that have included formal service agreements, agreed referral processes, participation in state-wide initiatives such as Common Risk Assessment Framework (CRAF) and Benchmark Data Collection, and subregional practice focused workshops and resource development.

The service model design based on distribution of limited resources to a number of local service providers has resulted in the formal involvement of many staff members in local and subregional organisations. This widespread engagement has increased awareness and discussion of the impact of family violence across the service system.

There is a clear commitment from service providers to continue to be involved in and improve the evidence regarding the prevalence of family violence, the demand on local services and the consequent resource needs.

The subregional family violence counselling and group work service model has contributed to the development of a stronger platform and a more effective coordinated approach to addressing family violence in the north.

It is a work in progress with the foundations laid and the framework in place.

Appendix 1

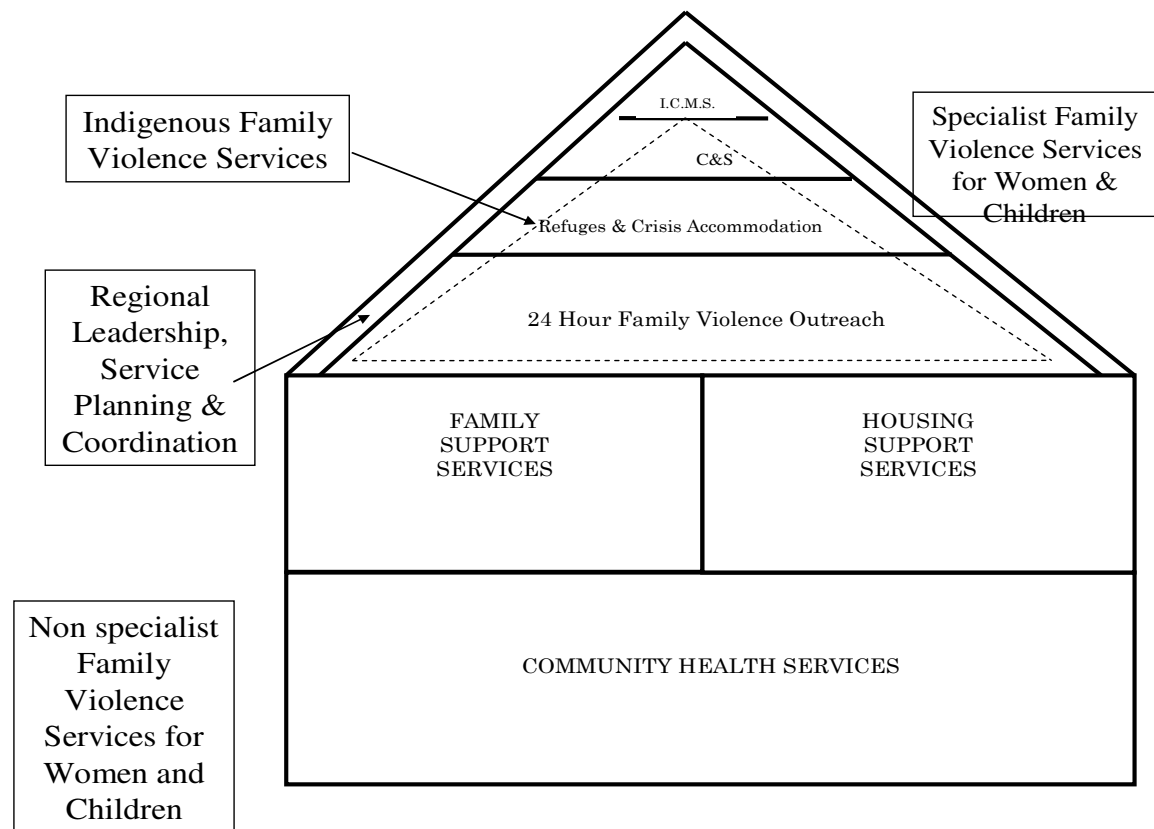
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Appendix 2

Framework for the IFVS model

Developed for the tender application: Northern subregion Women's and Children's consortium March 2006



Please note: I.C.M.S. refers to Intensive Case Management Support; C&S refers to Counselling and Support

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