Submission to the Family Violence Reform Implementation Monitor

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As Specialist Family Violence Advisors (SFVAs) for the alcohol and other drug (AOD) sector in the Western metropolitan region, we welcome the opportunity to contribute to the work of the Family Violence Reform Implementation Monitor. We commenced in the SFVA roles in September 2018 and provide capacity building support to all department funded AOD services in Western Melbourne and Brimbank Melton. Prior to our employment as SFVAs we both worked within the specialist family violence sector in victim survivor support services. This submission is informed by our experiences as specialist family violence practitioners and as SFVAs, in addition to feedback from local services that we support and collaborate with.

Specialist Family Violence Advisor Capacity Building Program

The state-wide Specialist Family Violence Advisor Capacity Building Program (SFVA CBP) was established in response to recommendations 98 and 99 from the Victorian Royal Commission into Family Violence. The Royal Commission emphasised the need to improve collaboration between health and human services to improve outcomes for people experiencing family violence. The Royal Commission recognised the unique position of AOD and mental health (MH) agencies to identify family violence and intervene early in collaboration with specialist services. The SFVA CBP provides an opportunity to share expertise across sectors, enhance identification of patterns of coercive control in relationships, address gaps in service provision and support professional development initiatives.

The SFVA CBP has been implemented in a staged approach:

1. Stage 1 was a 2-year initiative that placed Specialist Family Violence Advisors in auspice agencies across Victoria. Advisors were embedded within local specialist family violence services and worked with key MH services and AOD agencies in their area.
2. Stage 2 embeds Specialist Family Violence Advisors within MH services and AOD agencies. The advisor roles are ongoing positions designed to work with senior management to increase the capacity of services to collaboratively respond to family violence.

Although the program was implemented in a staged approach, the objectives have been consistent across each area of the SFVA CBP. The objectives of the SFVA CBP are to:

1. Strengthen networks and collaboration between agencies and across the three sectors
2. Enhance referral pathways to provide a more coordinated and collaborative health and human service system response to family violence
3. Increase capacity within the MH and AOD sectors through access to specialist family violence expertise and advice in identifying, recognising and responding to family violence

4. Facilitate earlier recognition of, and response to, family violence situations for patients/clients of MH and AOD services
5. Enhance quality and consistency of the service response to victims, survivors and perpetrators of family violence at whatever point they access the health and human services systems.

Changes since the royal commission

Since the Royal Commission into Family Violence in 2016, there have been a number of positive developments that we have observed. In particular, the capacity building work undertaken by local AOD services has resulted in a number of positive practices and outcomes.

First, the knowledge, confidence and skill of AOD clinicians in responding to family violence has increased since we commenced in our roles. Although there has always been family violence knowledge and expertise within the AOD sector, during the initial stages of our program many clinicians and teams had self-reported a lack of confidence to respond to family violence. Implementation of the reform agenda, in conjunction with the support provided by the SFVA CBP, has increased frontline clinicians' levels of knowledge and confidence. Although further capacity building work is still required, we note that clinicians now:

- Complete more in depth inquiry and screening in relation to use or experience of family violence.
- Are more aware of the breadth of family violence evidence based risk factors and more readily identify them in conversation with clients. In particular, identification of non-physical forms of violence and the associated evidence based risk factors, such as controlling behaviours or stalking, is occurring more frequently.
- Share risk relevant information with other services for the purposes of family violence risk management more frequently.
- Are more aware of invitations to collude with people using violence and the risks associated with this.

Additionally, we have observed several AOD services promoting an increased focus on perpetrator accountability and engagement in their responses to family violence. AOD services and clinicians within the Western region have begun to embrace the important role they play in monitoring family violence risk and keeping perpetrators of violence in view of the system. This is a critically important development, given that AOD services are likely to be working with people using violence more frequently than other sectors due to the gender composition of their client cohort. As such, AOD

services have an important opportunity to engage with men who would be unlikely to access support via other services and sectors. Some promising practices are beginning to emerge, including:

- Enhanced record keeping practices. For example, the use of family violence is now being recorded more explicitly on clinical review forms, assessments and referrals, for the purpose of flagging risk factors and behaviours which require further monitoring.
- Sharing information with other Information Sharing Entities (ISEs) about a client's use of violence, any escalation in identified risk and the quality of their engagement with AOD treatment; in recognition that AOD misuse is an evidence based risk factor which indicates a higher likelihood of the victim being killed or seriously harmed.
- Provision of Single Session Family Consultations to family members of clients who use violence. This allows clinicians to privately inquire about safety, provide safety planning support and offer relevant referrals to victim survivors.
- Greater connection with local specialist family violence perpetrator services, including via secondary consults and the provision of education sessions for local AOD clinicians.

Looking forward – what is still required in the family violence reforms

While there has been substantial progress since the Royal Commission into Family Violence, we would like to highlight the following areas which require further consideration:

Critical Changes Yet to Occur

1. Demand for specialist family violence services

Despite increased investment in the integrated family violence response system and the extraordinary efforts of specialist services, demand for family violence support remains greater than the capacity of the service system to respond. For example, long waitlists for specialist support remains a common experience for clients and referring practitioners. Additionally, while there has been an increased focus on perpetrator services since the Royal Commission, there remains a dearth of referral options for those that use violence. In particular, there are limited case management options for people who use family violence, in addition to high demand for behaviour change programs (No To Violence, 2020). There is a great level of need for case management services; particularly given the barriers clients with complex needs and those from diverse communities face in attending traditional behaviour change group programs. The availability of specialist case managers who are able to provide intensive and tailored support to people using violence greatly improves the ability of the service system to monitor risk and maintain perpetrator accountability. In

turn, this also produces additional pathways for information sharing between services to occur. AOD programs often hold considerable amounts of risk relevant information about perpetrators they are supporting, but do not always have a clear avenue to share this information in the absence of perpetrator service involvement.

The ability of family violence services to provide secondary consultations to other sectors is also impeded due to the overwhelming demand that they are required to manage. Because family violence practitioners are managing significant workloads, clinicians from other sectors can experience delays between requesting and receiving secondary consultations. Given that secondary consultations are a key mechanism for cross-sector collaboration as outlined in the Multi-Agency Risk Assessment and Management (MARAM) Framework, if family violence services are not appropriately resourced to fulfil this obligation, the efficacy of MARAM is undermined.

2. MARAM Practice Guidance

Although the full suite of MARAM practice resources, including perpetrator practice guidance, is not yet available, we believe that some elements of the existing victim survivor practice guides could be further developed. For example, MARAM practice guidance suggests that when victim survivors are assessed as at serious risk, a referral to specialist services or secondary consult with specialist services must occur (Family Safety Victoria, 2019, p. 26). Although this direction allows for the possibility that some cases of serious risk may be managed by non-specialist family violence services, detailed practice guidance around this is not provided. Some victim survivors do not want referrals to specialist services and as discussed above, the ability to access secondary consultations is sometimes limited. While the expertise of specialist services must be utilised, the AOD sector has an opportunity to provide support to victim survivors who would otherwise not have contact with the specialist service system. Resourcing the development of more detailed practice guidance around scenarios like this would be a useful addition to existing resources.

3. Support for victim survivors who use AOD

The barriers experienced by victim survivors who use substances must be recognised and addressed. The social stigma and discrimination experienced by substance users in the broader community is well documented, as is the connection between experiencing family violence and problematic substance use. Victim survivors of family violence may use substances to manage the trauma they have experienced, or as a safety related strategy (Domestic Violence Victoria, 2006, p. 19). Moreover, perpetrators often target a victim survivor's use of substances and utilise this to exert further power and control over them (Ibid, p. 19 – 20). Despite this being acknowledged, much of

the reform work being undertaken to ensure equitable responses for victim survivors with diverse needs has not considered the requirements of victim survivors who use substances. Because there has been limited capacity building work in this area, AOD services and clinicians continue to face difficulties finding family violence crisis accommodation which can support victim survivors with AOD issues. Victim survivors who use substances can face barriers accessing both communal refuge facilities and independent accommodation units; with some services requiring complete abstinence from all substances as a condition of support. We are concerned that victim survivors who are at serious risk and require immediate protection may not be able to access refuge due to their substance use. We recognise and appreciate that the review of the Code of Practice for Specialist Family Violence Services for Victim Survivors has been utilised to highlight and address this issue (Domestic Violence Victoria, 2020, p. 26, 30, 54). However, we would suggest that additional work is needed in this area to support sustainable practice change.

Lack of progress on this issue has additional consequences for other areas of family violence reform work, and in particular, the efficacy of the SFVA CBP. A collaborative health and human service system response to family violence is central to the reform agenda. However, cross-sector collaboration cannot occur without trust between services. If specialist services remain inaccessible to AOD clients, the ability to build cross-sector relationships is significantly impacted. In our experience, just as there is a need for AOD and mental health services to increase their family violence capability, family violence services also require support to be able to work better with clients affected by substance use issues. Without resourcing this component of work, the ability to build cross-sector collaboration is limited.

Improvements to the Implementation Approach of the Family Violence Reforms

Despite extraordinary levels of commitment to improving system responses to family violence, and the high quality of work that has been completed to date, some elements of reform implementation could be bolstered by enhancing project management processes.

1. MARAM and Information Sharing

MARAM and information sharing scheme alignment relies upon the availability of particular resources; including the organisational embedding guide, practice guidance, tools and training modules. However, the development and release of these resources have not been sequenced appropriately and has impacted the ability of services to align to MARAM and implement the information sharing schemes. Prescribed organisations had legislated responsibilities to begin aligning to MARAM and the information sharing schemes well before the MARAM organisational

embedding guidance was released, or information sharing training was widely available. Because alignment milestones and benchmarks were not communicated at the outset, alignment activities have been incomplete and inconsistent across the service system. Additionally, the availability of MARAM intermediate victim survivor training has been limited and this has further impeded the alignment process. It remains unclear whether services should begin embedding the available MARAM tools in practice, or whether this should be postponed until a majority of the workforce has been able to access training; which is likely some years away. Moreover, while there has been an expectation that organisations begin aligning to MARAM, there has been no compliance or review mechanism to ensure that appropriate amounts of progress have been made. This has meant that frontline collaborative practice has been impacted. For example, AOD clinicians have reported instances where they have requested information under the Family Violence Information Sharing Scheme from other ISEs, but were refused as the responding ISEs were not aware of their information sharing obligations. This suggests the level of alignment to MARAM and information sharing legislation is inconsistent across services, despite them being prescribed under the schemes at the same time.

Additionally, while MARAM victim survivor practice guidance and tools have been released, perpetrator resources are still in development. This results in additional risk and complexity for sectors such as AOD and mental health, who work with large numbers of people who use violence. As an example, work is being undertaken to align the state-wide AOD intake and assessment tools with MARAM by embedding relevant components of victim survivor practice guidance. This process will need to be repeated upon release of the perpetrator resources; creating additional burdens for organisations, as well as frontline clinicians, who will have to work through multiple iterations of the tools in a short time period. Additionally, by embedding the victim survivor practice resources without commensurate focus on best practice responses to perpetrators, we exacerbate the risk that clients who are using violence will be misidentified as victims. While AOD services and clinicians have made progress in their responses to people using violence, there are still instances where insufficient knowledge in this space results in risk being misidentified or collusion occurring; including cases where coercive control is mischaracterised as relationship conflict or as mutual violence. Although current victim survivor practice guidance and foundation knowledge guides provide valuable information regarding working with perpetrators, these resources have not been consistently utilised. We believe that this issue requires further attention to enable safe practice prior to the release of more comprehensive perpetrator practice tools and guidance.

2. SFVA CBP

Despite the initial successes achieved by the SFVA CBP within the Western metropolitan region, progress towards some of the program objectives, particularly those that relate to cross-sector collaboration and enhanced system responses, have been impacted by program governance issues. Stage 1 of the program established Area Based Implementation Committees (ABIC) to oversee and support the implementation of the program through local agency-level collaboration, as well as a State-wide Steering Committee to provide strategic direction and ensure alignment of the program with government policy and with the priorities of each sector. This governance mechanism was also endorsed in the stage 2 AOD SFVA CBP program guidelines. The ABICs and State-wide Steering Committee were designed to oversee the development and implementation of local action plans which advanced the SFVA CBP objectives. However, since commencing in our roles, the State-wide Steering Committee has not been operational. Without a state-wide committee providing an authorising environment for SFVA CBP work, many local ABICs have either ceased operating or been unable to progress key initiatives focused on enhancing collaborative practice and systems responses. Additionally, without a robust governance structure at both the local and state-wide levels, SFVAs have had limited connection to Family Safety Victoria or DHHS. Without this line of communication, SFVAs often do not receive timely updates or advice regarding key reform initiatives relevant to our roles. Moreover, this prevents SFVAs providing upward feedback which could benefit the work being done at a state-wide level. This seems to be a missed opportunity given that services engaged with the SFVA CBP are developing innovative practices which could assist with capacity building work being undertaken in other sectors across the state.

Impact of Covid-19 pandemic

The onset of the Covid-19 pandemic created significant challenges for organisations across the health and human service system. At the peak of the pandemic in Victoria, local services had to rapidly alter their primary mode of service delivery and transition staff to remote working. Understandably, during this time many organisations had to prioritise internal facing work which focused on core service delivery functions. However, as a consequence, progression of MARAM alignment activities and cross-sector collaboration initiatives were postponed in many cases. It was observed generally, that services adopted a focus on ‘core business’ and minimal cross-sector collaboration occurred during this time. Consequently, some frontline AOD clinicians expressed anxiety around holding family violence risk during this period and were concerned about whether there would be an ongoing ability to work in a collaborative manner with other services and sectors. We also note the increased demand for specialist family violence services which has resulted from the pandemic (Pfitzner, Fitz-Gibbon and True, 2020, p. 7) and the negative impact the pandemic has

had on the mental health and well-being of frontline practitioners (Ibid, p. 19) who have been tasked with managing increased risk while working independently from home. At the same time, we also wish to highlight the anecdotal feedback provided by AOD clinicians who have observed that remote service delivery via telehealth has resulted in higher levels of client attendance and engagement; particularly for the forensic client cohort. As such, the benefits of telehealth and its role in service delivery should be further explored post-pandemic.

References

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