

ATTACHMENT [JH-1]

This is the attachment marked "[JH-1]" referred to in the witness statement of Jeremy Luke Hearne dated 5 August 2015.

Submission to the Royal Commission into Family Violence

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Key Messages

1. Introduction to cohealth

1.1 People with lived experience of family violence have the expertise to help improve services and systems. The best way to bring about effective improvements to the prevention and response systems for family violence is to include people who have experience using them. This co-design approach both empowers service users and enhances the likelihood of successful program and system improvements.

1.2 Language is important. Not everyone feels included in the term “family”, and not everyone who is experiencing abusive, threatening or controlling behaviours within a relationship recognises this as “violence”. It is a significant challenge to develop understanding within both services and communities of key concepts, including what family violence is; and how it is linked to broad social and cultural gender inequities.

2. Act on gender inequity

2.1 The root cause of family violence is gender inequity. Actions that remedy gender inequity are required at all levels of government and community. Strategic initiatives which address gender inequities and gender stereotypes are foundation components of a long term approach to eradicating family violence.

3. Work with communities to prevent family violence

3.1 There are useful high-level policies and strategies already in place. The VicHealth *Preventing Violence Before It Occurs* framework is a comprehensive guide to primary prevention of family violence. Investment is required to support its implementation and evaluation of the work which flows from it.

3.2 The good prevention work done to date needs further enhancement and expansion. Effective primary prevention requires sustained, secure funding which enables long-term engagement and capacity building with communities. This work needs rigorous evaluation of effectiveness.

3.3 Primary prevention work needs to be tailored and targeted. Population-wide awareness campaigns may be visible and relatively fast, but changes in attitudes and behaviours are unlikely to follow in the absence of targeted, tailored approaches. Different communities, including those defined by language, culture, and identity require different approaches. All communities require long-term engagement to build relationships and trust, and to ensure that approaches work with existing community strengths and structures.

4. Family violence is a health issue

4.1 Family violence is a health issue. All experiences of family violence have detrimental impacts on health. There is an important role for health services in recognising and responding to women and others who experience violence. This is in addition to the role of the legal system in responding to criminal offences. Conceptualising family violence as a health issue provides a

useful framework for thinking about prevention, early intervention, system navigation and service coordination.

4.2 Freedom from violence is a right. Women and others have a right to personal safety and not to be subjected to harassment, abuse, control or violence “likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Article 1, UN Declaration on the Elimination of Violence Against Women, 1993).

4.3 Lack of integration and coordination is a major problem for service users. The response system is complex and difficult to navigate. Interactions with services in the legal system, the social service sector and the health system should not compound the difficulties faced by women affected by family violence. Women and others who enter a system which cannot support them can be placed at additional risk by seeking such assistance.

4.4 Building the capacity of the health system to respond involves a comprehensive approach. This must include investment to improve data collection systems, workforce capacity, referral systems and organisational cultures.

5. Improve response systems

5.1 Response systems are chronically under-resourced. Increased attention to family violence issues is likely to place further pressure on already-stretched response services. Significant additional investment is required.

5.2 What’s happening in other sectors impacts on the risk of violence and womens’ capacity to be safe. Most crucially, the availability of affordable housing impacts on a woman’s ability to reduce her risk of experiencing violence. The policies and conditions in the refugee and migrant sector (including mandatory detention and settlement support), and the legal system, have significant impacts on women’s safety.

5.3 Flexible service responses are important. Brokerage funds allow flexible, appropriate and timely responses to women and others experiencing family violence.

Recommendations

1. Co-design system improvements

Recommendation 1: Use a co-design approach to improve prevention and response.

The Government should utilise co-design processes and approaches with women and others who have experienced violence to improve prevention strategies as well as the service response for women and others experiencing violence.

2. Act on gender inequity

Recommendation 2: A Victorian Gender Equity Strategy

The Government should develop and implement a whole-of-Government Gender Equity Strategy that:

- a) establishes high level goals and benchmarks to be achieved in the short, medium and long term, including a reduction in prevalence of family violence;
- b) requires each government department, agency, government-owned business, local government and organisation that delivers services funded by the Victorian Government to develop a Gender Equity Strategy that supports the direction, goals and targets of the Victorian Gender Equity Strategy;
- c) requires each government department to review all policies, regulation and legislation with a view to ensuring that they promote gender equity;
- d) establishes new procurement guidelines to support agencies and funding bodies to assess procurement decisions from a gender equity perspective;
- e) assesses inter-governmental agreements, national partnership agreements and contracts of the Victorian Government, and approves only if they promote gender equity;
- f) supports creation of workplace standards and environments that uphold commitment to gender equity in the workplace as a determinant of violence against women; standards would include implementing flexible work options and workplace family violence policy and leave.

Recommendation 3: Parenting policies to promote gender equity

The Government should:

- a) promote through the Council of Australian Governments parenting leave policies that:
 - i. provide paid leave universally with modest eligibility restrictions
 - ii. include minimum non-transferable leave for each parent
 - iii. enable the liability for making these payments to be shared, so that an individual employer is not fully liable and possibly deterred from recruiting women
 - iv. flexibility to schedule leave
- b) resource training and education pathways that provide opportunities for increased economic participation for women, particularly women from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds and other communities who face increased risk of violence;
- c) work through the Victorian Department of Health and Human Services to ensure that health services also focus on the role of fathers, and deliver services aimed at both new mothers and fathers;
- d) fund university courses for health professionals to understand how to engage fathers and promote their role as parents; and
- e) promote child and whole family (or parental) services rather than just child and maternal services.

3. Work with communities to prevent family violence

Recommendation 4: Some parts of the community require additional focus for prevention activities

The Government, in developing funding approaches for prevention, should give particular consideration to:

- a) programs that address the specific needs of women and children from culturally and linguistically diverse backgrounds and target the broader determinants of health that make these communities more vulnerable to family violence and less able to access support services;
- b) initiatives that actively engage and encourage men and boys in the primary prevention of violence against women that address cultural norms across the life stage. This includes a continuum from early education with boys and young men through to adult institutions such as workplaces and sporting clubs where cultural norms are embedded and perpetuated.
- c) initiatives which engage with lesbian, gay, bisexual, transgender and queer communities and other communities for whom the language of family violence may be exclusionary.

Recommendation 5: Endorse and adopt the VicHealth Framework: Preventing violence before it occurs

The Government should use the VicHealth Framework: *Preventing violence before it occurs* to guide effort and funding for primary prevention effort across the state.

Recommendation 6: A Safer Communities Sovereign Wealth Fund

The Government should:

- a) establish a Safer Communities Sovereign Wealth Fund, to provide a long term funding stream for primary prevention and research activities related to family violence;
- b) appoint a Safer Communities Advisory Council of women and others who have experienced violence, academic and service delivery agencies and prevention partners to make recommendations to the Governor-in-Council (on advice of the Premier) as to strategies, approaches and projects to be funded;
- c) make it a condition of funding that any intellectual property from initiatives funded by the Safer Communities Fund be subject to open access principles and be available to better inform community prevention efforts; and
- d) agree that primary prevention activities have a minimum three year funding cycle and be evaluated against principles or frameworks in line with the developmental work already occurring.

4. Family violence is a health issue

Recommendation 7: Recognise family violence in key health policies

The Government should specifically identify and focus on family violence as a health issue within overarching primary health frameworks such as the Victorian Public Health and Wellbeing Plan.

Recommendation 8: Use health literacy approaches to improve services

The Commission should convene co-design forums with women who have experienced violence and representatives of service providers representing the specialist and mainstream response service systems to:

- a) develop information resources and system navigation tools that will support better understanding of the range of supports available to women and others requiring support; and
- b) assist disparate elements of non-specialist response services (for example income support, courts, child care, housing, child support, employment networks) to understand that they are all elements of a family violence service response system in order to improve services, information and access points.

Recommendation 9: Increased resources for system navigation

The Government should increase funding to case management functions and engage system navigation aides for women and others experiencing violence, to advise about available support or link them with key liaison officers in various service agencies.

Recommendation 10: Workforce capacity building

The Government should:

- a) fund capacity building across the health and human services systems to prepare and resource organisations delivering services to provide safety, skills and environments that support early identification and disclosure as well as appropriate referral and support to women and others experiencing violence.
- b) work with universities, professional accreditation agencies and other training bodies for the health, human services, justice and education workforces to embed family violence training in entry-level qualifications.
- c) require as a condition of accreditation that all agencies receiving Victorian Government funding be required to meet specific accreditation standards that promote improved service response for women and others experiencing family violence.

Recommendation 11: Act on elder abuse:

The Government should implement recommendations of the submission on elder abuse by Justice Connect Seniors Law.

Recommendation 12: Improved data collection

As recommended by the Preventing Violence Together Partnership (PVT) the Victorian Government should:

- a) establish a minimum data set for health and human services agencies to collect which can contribute to understanding of prevalence of violence and impact of prevention activities;
- a) support the 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;
- b) 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; and
- c) 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.

5. Improve response systems**Recommendation 13: Support regional networks**

The Government should support regional networks to undertake service integration and coordination work by funding Primary Care Partnerships / regional family violence service providers to participate in and resource network activities, and by providing funding to organisations who without such support would not participate.

Recommendation 14: Increased level and certainty of resources for response services

The Government should:

- a) increase crisis and specialist service response funding in line with the increase in reporting to police that has occurred from 2009-10 to 2015-16, and each year of the forward estimates and ultimately continue to grow funding to this sector in line with better understanding of prevalence based on improved data collection;
- b) relocate the management of services and funding associated with the response to family violence to a new statutory agency reporting to the Minister for the Prevention of Family

Violence which is overseen by a Board consisting of the Secretaries of the Departments of Health and Human Services, Police, Justice, Education and Early Childhood

- c) negotiate with the Federal Government for a National Partnership Agreement to End Family Violence instead of funding services for family violence under the National Partnership on Homelessness.

Recommendation 15 Increase the availability of flexible funds

The Government should:

- a) extend the availability of brokerage to women and others experiencing violence beyond housing and the Victims Assistance Program; and
- b) increase the capacity of the Victims Assistance Program to support more women and others who have experienced violence by allocating a specific additional funding increase for this group of service users.

Recommendation 16: Increased resources for counseling services

The Government should increase the funding support for specialist family violence counseling to ensure that women and others experiencing violence can access counseling support at any stage of their experience or recovery from violence.

Recommendation 17: Support sector collaboration

The Government should consider funding processes for family violence response services that encourage collaboration and service integration between agencies.

Recommendation 18: Increased investment in whole family approaches

The Government should:

- a) increase investment in counseling for children who directly or indirectly experience the effects of family violence;
- b) support development of programs promoting whole of family interventions that are not reliant on the decision of a woman or other person experiencing violence to leave the relationship. (based on international practice, such as the Caledonian System)

Recommendation 19: Advocate for changes to asylum seeker policy

The Government, as a matter of urgency, should communicate with the Commonwealth Government in the strongest possible way to seek changes to the policy and program design which is exacerbating the risk that asylum seekers will be subject to violence and abuse.

Recommendation 20: Mandatory use of trained interpreters

The Government should mandate the use of NAATI accredited interpreters (where available) for the delivery of services funded by the Victorian Government

Recommendation 21: Addressing housing needs

As recommended by the joint submission of housing, homelessness, community, family violence and legal sectors, the Victorian Government should :

- a) improve **measures to sustain tenancies and prevent homelessness** for women who can safely stay in their housing, including strengthened programs such as Safe @ Home responses, the Social Housing Advocacy and Support Program, legal representation for women facing eviction, and private rental brokerage schemes. \$13.4 million per year could assist an additional 3800 families;
- b) establish a **rapid rehousing** program to assist women and children escaping family violence to be quickly rehoused with appropriate supports in place. \$10 million per year could assist over 1000 women and their children;

- c) improve **affordable housing pathways for perpetrators** of family violence to ensure they remain engaged with relevant supports to help prevent the risk of further violence;
- d) develop a **long-term affordable housing strategy** to address the soaring public housing waitlist and increasing unaffordability of private rental for low-income Victorians. An affordable housing growth fund of \$200 million per year could build a minimum of 800 homes.

1. Introduction to cohealth

cohealth is a not-for-profit registered community health service operating across the north and western metropolitan regions of Melbourne. cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. Over 110,000 people a year use our services, which operate from 44 sites across 14 local government areas in the north and west of Melbourne. We prioritise those who are disadvantaged or marginalized because we know that these groups experience the poorest health. This includes people who are homeless or at risk of homelessness, Aboriginal and Torres Strait Islanders, refugees and asylum seekers and people who use illicit drugs.

cohealth was formed on 1 May 2014 as a result of the merger of Doutta Galla Community Health, North Yarra Community Health and Western Region Health Centre; three agencies with a history of working with disadvantaged population groups and delivering services that are shaped and tailored in partnership with service users and communities.

cohealth's approach is based on human rights, co-design, and a social model of health. Co-design is about engaging consumers and users of products and services in the design process, with the idea that this will ultimately lead to improvements and innovation¹ (Burkett, 2014). Our co-design approach means that we work in partnership with consumers, clients, carers and the community. We create opportunities for active and meaningful participation in decisions about people's own health and health care, as well as how cohealth's services are designed and delivered. Our experience shows that people with lived experience have the expertise to inform effective improvements to programs, services and systems. A co-design approach both empowers service users as well as enhancing the likelihood of successful improvements.

Building on our shared legacy of speaking out for social justice, human rights and better health care, we engage with clients and communities to be a vigorous advocate with and for people whose voice is so often missing from community and political debate.

We have both broad and deep experience in the field of family violence prevention and response. We provide specialist response programs such as family violence counselling (over 200 clients a year) and the Victims Assistance Program (over 500 clients a year). We have undertaken extensive family violence primary prevention activities with culturally and linguistically diverse communities and place based initiatives, with a particular focus on using peer facilitators. (See Appenices 1 and 3)

cohealth is an active partner in a range of other primary prevention programs and strategies, including for example Preventing Violence Together: The western region action plan to prevent violence against women, the UNITED project, respectful relationship programs, White Ribbon Day, 16 Days of Activism, the Western Region Crime Prevention Advisory Committee and others.

As a mainstream health service working with groups and communities who are often regarded as hard to reach, cohealth and its predecessor agencies have experience developing the capacity of our workforce to be responsive to the needs of the individuals and groups who use our services, or who might be in need of tailored engagement approaches to improve access to services. This has been achieved through a strong commitment to workforce capacity building, reinforced by leadership and supporting cultural change at personal and organisational levels. This ensures responsive, appropriate and culturally safe service delivery that is sensitive to the needs of diverse

¹ Burkett, I. (2014, October). *An Introduction to Co-design*. Retrieved May 15, 2015, from www.knode.com.au:

service users. This submission draws on our experience of capacity building and understanding of the architecture required to achieve lasting change and commitment.

cohealth and its predecessor agencies have also developed significant expertise in the use of approaches that reach outside the service delivery systems to give opportunities for access for individuals and groups whose experience of marginalisation and exclusion is isolating and detrimental to good health. Whether it is the work of cohealth Arts Generator, Billabong BBQ or the Western Storm Football Club, this approach to outreach and engagement is, cohealth believes, necessary for a complete and competent approach to broad-based community engagement to reduce and ultimately eradicate family violence.

A note on language

The language used to describe family violence is important. Firstly, not everyone feels included in the term "family", particularly those in relationships with carers, as well as sexually and gender diverse communities.

Secondly, not everyone who is experiencing abusive, threatening or controlling behaviours within a relationship recognises this as "violence".



It is a major challenge to develop understanding within both services and communities of key concepts, including what family violence is; and how it is linked to broad social and cultural gender inequity. Our experience in primary prevention projects is that some communities find it easier to engage in primary prevention work when it is framed in positive terms, for example building respectful relationships.

In undertaking population wide work to prevent and respond to family violence, care needs to be taken to ensure that different approaches in different communities of identity best support engagement with these communities to understand, prevent and respond to family violence.

Co-design process for developing this submission

In developing this submission, we have used a co-design approach which draws on the expertise of staff within cohealth and beyond, as well as users of our services and participants in our primary prevention programs. Overseen by a Working Group comprised of cohealth staff with expertise in family violence response and prevention, community engagement and policy development, processes used in the development of the submission have included:

- Focus groups with service users with graphical notes summarising the conversation (see Appendix 1);
- Focus groups with peer facilitators in prevention activities with graphical notes summarising the conversation (see Appendix 2);
- Consultations with staff with particular practice knowledge and experience in response or prevention;
- Participation in consultations through networks / forums with partners and alliances.

In addition to the production of a written submission for the Commission, we are also reflecting on the learnings of this process and the implications for changes we can make to our own services, programs, and approaches.

Recommendation 1: Use a co-design approach to improve prevention and response.

The Government should utilise co-design processes and approaches with women and others who

have experienced violence to improve prevention strategies as well as the service response for women and others experiencing violence.

2. Act on gender inequity

The root cause of family violence is gender inequity. If we wish to prevent family violence then we must act at all levels of community and government to remedy gender inequity. This refers to “the unequal distribution of power and resources between men and women and adherence to rigidly defined gender roles”² It is evident in labour force participation rates, wages, contributions to child care and domestic duties, and other aspects.

Change will not happen easily. This must be recognised for what it is: a transfer of power a transfer of resources and an expansion of roles. There are those who will be threatened by this.

Preventing and responding to family violence requires strong leadership, and multiple actions at different levels from the national and state governments, through to our local communities of place and identity – the places and the people with whom we live our lives. The scale of the work required as well as the changes that are sought require that the efforts at all levels need to be mutually reinforcing. This will require sustained effort in a variety of areas and sectors, requiring consideration of issues that may not immediately appear related to family violence.

The Victorian Government is to be commended for establishing the Royal Commission. We propose that the Government can further place the state in a stronger position to stop family violence over the longer term through the development of a Gender Equity Strategy for Victoria. The Strategy should include high level goals and benchmarks, and include specific actions for government departments, agencies, government-owned businesses and organisations that deliver government-funded services.

The Gender Equity Strategy should require a systematic audit of policy, regulation, legislation, administrative frameworks, inter-governmental agreements, national partnership agreements, and all contracts signed by the Victorian Government. This audit should assess whether these instruments promote gender equity, and identify elements that *fail to promote gender equity*. This is a higher standard than addressing only those elements which are barriers to gender equity.

Recommendation 2: A Victorian Gender Equity Strategy

The Government should develop and implement a whole-of-Government Gender Equity Strategy that:

- a) establishes high level goals and benchmarks to be achieved in the short, medium and long term, including a reduction in prevalence of family violence;
- b) requires each government department, agency, government-owned business, local government and organisation that delivers services funded by the Victorian Government to develop a Gender Equity Strategy that supports the direction, goals and targets of the Victorian Gender Equity Strategy;
- c) requires each government department to review all policies, regulation and legislation with a view to ensuring that they promote gender equity;
- d) establishes new procurement guidelines to support agencies and funding bodies to assess procurement decisions from a gender equity perspective;
- e) assesses inter-governmental agreements, national partnership agreements and contracts of the Victorian Government, and approves only if they promote gender equity;
- f) supports creation of workplace standards and environments that uphold commitment to gender equity in the workplace as a determinant of violence against women; standards would include implementing flexible work options and workplace family violence policy and leave.

² VicHealth. (2007). Preventing violence before it occurs. Melbourne: Victorian Health Promotion Foundation.

Gender equity and female labour participation

Every year the World Economic Forum ranks countries according to gender equity. They consider labour force participation, wage equity, earned income, numbers of women in senior positions in various sectors, numbers of women in multiple professions, and various other education and health indicators. In 2014, Australia was ranked 24th in the world,³ down from 15th in 2006.

The areas in which Australia ranks poorly are all related to women and employment:

- Wage Equity = 63rd
- Professional and technical workers = 57th
- Labour force participation = 51st
- Legislators, senior officials and managers = 40th

In Victoria, the gender pay gap worsened from 14.1% in November 2012 to 15.7% in November 2013⁴.

The European Commission has highlighted the predominance of women providing care at home as a leading reason for wage and labour force inequity. In the European Union, 65.8% of women with young children are working compared to 89.1% of men⁵, and European countries are often performing better than Australia in the World Economic Forum rankings.

Research into gender differences amongst top earners between 1981 and 2012 found that “career interruptions for family reasons explain a substantial portion of the top earnings gender gap”⁶. The researchers discuss the theme of “paper floors” where, even if women can attain senior positions, they often lose them because of leaving work for family reasons and returning at a lower level. In Australia, women returning to work after one year experience a wage reduction of 5% on average, and nearly 15% on average after 3 years⁷.

Sweden has one of the most progressive systems of parental leave and is ranked 4th overall by the World Economic Forum. In 1995, Sweden introduced days off work that fathers must use or lose, which is paid at almost full wage, and this led to a 50% increase in time taken by fathers to care for their offspring. A second month off was added in 2002 to total 60 days⁸. A Swedish study showed that fathers' use of parental leave had a direct positive impact on their partners' earnings. With each month the father stayed on leave, his partner received a 6.7% growth in earnings⁹.

A review of parental leave policies in 21 countries identified four countries with policies that are strongest on both generosity of parental leave and gender equity - Finland, Norway, Sweden and Greece¹⁰. The parallels with gender equity are clear - Finland is ranked second, Norway third and Sweden fourth by the World Economic Forum.

³ World Economic Forum, 2014. <http://reports.weforum.org/global-gender-gap-report-2014/rankings/> Viewed at 10:20am, 15/05/2015.

⁴ Workplace Gender Equity Agency (March 2014), *Gender Pay Gap Statistics*: https://www.wgea.gov.au/sites/default/files/2014-03-04-Gender_Pay_Gap_factsheet_website.pdf Viewed at 11:13am, 15/05/15

⁵ The European Commission: http://ec.europa.eu/justice/gender-equity/gender-pay-gap/causes/index_en.htm Viewed at 11:50am, 15/05/15

⁶ Guvenen, F., Kaplan, G., Song, J. (2014), *The Glass Ceiling and the Paper Floor: Gender Differences among Top Earners, 1981 – 2012*.

⁷ Workplace Gender Equity Agency, *Behind the gender pay gap*. https://www.wgea.gov.au/sites/default/files/behind_the_gender_pay_gap_branded.pdf Viewed at 11:17am, 15/05/15

⁸ Fletcher, R. (2015), 'Why paternity leave along won't close the gender gap', <https://agenda.weforum.org/2015/04/why-paternity-leave-alone-wont-close-the-gender-gap/> Viewed 11am, 15/05/2015

⁹ Johansson, E.A. (2010), *The effect of own and spousal parental leave on earnings*, IFAU Working Paper 2010:4. IFAU – Institute for Labour Market Policy Evaluation, Swedish Ministry of Employment. Uppsala, Sweden

¹⁰ Ray, R. Gornic, J. & Schmitt, J. (2009), *Parental Leave Policies in 21 Countries: Assessing Generosity and Gender Equity*. Centre for Economic and Policy Research. http://www.cite.gov.pt/asstscite/images/grafs11/Parent_Leave_Policies_21.pdf Viewed at 11:44am, 15/05/15

The researchers found that there were five practices that are key to creating gender equity:

1. Generous paid leave
2. Non-transferable quotas of leave for each parent
3. Universal coverage combined with modest eligibility restrictions
4. Enable the liability for making these payments to be shared, so that an individual employer is not fully liable and possibly deterred from recruiting women
5. Scheduling flexibility

Of these 21 countries, the average unpaid parental leave offered is 72 weeks, greater than Australia's 52. The average full-time equivalent paid leave is 22.5 weeks, whereas Australia does not offer any weeks paid at full-time equivalent, only providing 18 weeks paid at the national minimum wage. Researchers found that it is important to have non-transferable leave as traditional expectations of mothers to provide care combined with commonly earning less will result in the vast majority of leave being taken solely by women. Current parental leave policy approaches reinforce factors excluding men from child care and promote gender stereotypes and inequity. Non-transferable paternal leave policies, as delivered in Sweden, would start to reverse this approach.

Enabling men to spend more time parenting

Measures to include fathers in parenting are not only beneficial to gender equity but are also crucial to prevention of violence against women at a time of high risk, as well as the health and development of children¹¹.

An Australian survey of new mothers found that 29 per cent of mothers reported partner abuse in the first 4 years after birth¹² and VicHealth has highlighted this stage in a woman's life as being a point where they are greater risk of intimate partner violence¹³.

To reduce violence against women, and benefit children's health simultaneously, we need to make changes to health services to enable men to be active parents. Male participation can be limited by fathers' perceptions of maternal bias in service delivery¹⁴, illustrated by the common name of Child and Maternal Health Services, which can reinforce stereotypes about mothers being the primary care giver and exclude fathers from consideration and often from conversations. Whilst mothers have particular health needs and risks, Victoria could follow South Australia's lead by changing the name of the program to Child and Family Health services.

Undergraduate or preparatory courses in health have little focus on preparing for working with fathers, and there needs to be more courses such as the postgraduate courses at the University of Newcastle - *Father-Infant Attachment and Coparenting* and *Working with Fathers in Vulnerable Families*. Practices need to be aligned to be father inclusive as well.

The *Caring Dads* program in Canada targets men who have exposed their children to intimate partner violence. It is a 17 week group parents intervention that also includes support for mothers to ensure safety and the referral to/inclusion of other professionals. This had an impact on male

¹¹ Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. (2014). *Engaging fathers: Evidence review*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

¹² Gartland D., Hemphill S. A. Hegarty K. and Brown S. J. 2011. Intimate partner violence during pregnancy and the first year postpartum in an Australian pregnancy cohort study. *Maternal and child health journal*, 15,570-578.

¹³ VicHealth (2007), *Preventing violence before it occurs*

¹⁴ Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. (2014). *Engaging fathers: Evidence review*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

aggression and rates of coparenting¹⁵. Becoming better fathers or parents seems to be one of the keys to building motivation to stop partner violence/abuse¹⁶.

Recommendation 3: Parenting policies to promote gender equity

The Government should:

1. promote through the Council of Australian Governments parenting leave policies that:
 - i. provide paid leave universally with modest eligibility restrictions
 - ii. include minimum non-transferable leave for each parent
 - iii. enable the liability for making these payments to be shared, so that an individual employer is not fully liable and possibly deterred from recruiting women
 - iv. flexibility to schedule leave
2. resource training and education pathways that provide opportunities for increased economic participation for women, particularly women from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds and other communities who face increased risk of violence;
3. work through the Victorian Department of Health and Human Services to ensure that health services also focus on the role of fathers, and deliver services aimed at both new mothers and fathers;
4. fund university courses for health professionals to understand how to engage fathers and promote their role as parents; and
5. promote child and whole family (or parental) services rather than just child and maternal services.

3. Work with communities to prevent family violence

The VicHealth Framework *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*¹⁷ is regarded highly and could be used to support Commission recommendations about prevention. The framework is ready to be implemented, and simply requires appropriate governance and resources.

Similarly, the *National Plan to Reduce Violence Against Women and their Children 2010-2022* and *Victoria's Action Plan to Address Violence against Women and Children* provide important policy foundations for a comprehensive approach to family violence prevention and response.

"Primary prevention" refers to work to prevent family violence through community based work. While there is significant current activity in this field, it is fragmented, disjointed and severely under-resourced. Most funding streams are short term, relatively small and administered in isolation without capacity to understand their contribution to the community wide effort to reduce family violence. This prevention work is also undertaken in the absence of an evidence-based evaluation framework that can support learning and inform better targeted approaches to work at the community level to prevent violence before it starts or to reduce its impact through earlier recognition of it.¹⁸

The Commonwealth Government has dedicated funds in the 2015 budget to a national awareness campaign regarding prevention of violence against women. cohealth respectfully suggests that the Commission **does not** recommend to the State Government that they fund an awareness campaign

¹⁵ Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. (2014). *Engaging fathers: Evidence review*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

¹⁶ Bunston, W. (2013). What about the fathers?' Bringing 'Dads on Board™' with their infants and toddlers following violence. *Journal of Family Studies*, 19 (1), 70-79.

¹⁷ VicHealth. (2007) *Preventing violence before it occurs*. Melbourne: Victorian Health Promotion Foundation.

¹⁸ Heise, L. L. (2011) *What works to prevent partner violence: An evidence overview*. London: STRIVE Research Consortium.

about this issue. Untargetted awareness campaigns mean that the people most at risk of becoming perpetrators are not reached. Campaigns which raise awareness may have little impact on knowledge or attitudes, and even if there is increased knowledge or a change in attitudes, behavior may not change as a result. Even the best planned, targeted and funded campaigns can have very little impact, as the below example shows.

The England Health Education Authority ran a three year campaign to encourage people to increase knowledge of and acceptability of adults doing moderate intense physical activity, and secondly to contribute to increased participation of moderate intense physical activity¹⁹. The campaign used television and others forms of media costing millions of dollars but only 38% of surveyed participants were **aware** of the campaign, and only 5.5% could recall key messages of the campaign. Those most likely to recall the campaign were people already physically active at intense levels.

There was a slight increase in the **knowledge** about the moderate physical recommendations but only from 14.7% of the pre campaign survey to 18.4% at the end. In terms of **attitude**, there was no change in terms of being ready to become active or not. In terms of **behavior**, there were fewer people physical active at the end of the campaign than at the start.

The same has been experienced in Australia regarding walking. After a mass media campaign, there were some positive changes although the study could not attribute changes to the campaign and when the campaign was repeated one year later, differences in walking were not sustained²⁰.

Awareness campaigns have been successful when being focused and combined with face-to-face community level work, as shown by a suicide prevention campaign in Nuremberg, Germany. The public awareness campaign was done in cooperation with various community members and relevant professionals e.g. teachers, GPs, police. There was a 20% reduction in attempted or completed suicides compared with a city that was not exposed to the program²¹.

Family violence affects communities throughout Australia but we do know those communities where risk is higher. We have the opportunity to work with these communities to change beliefs, attitudes and behavior that will reduce the incidence of family violence but we need to understand the scale of investment in time, people and resources that this will take. We give the example below to indicate what it takes to change attitudes in a community.

cohealth currently works as part of the 360 Turn Around Project in Flemington Community Estate. In 2014, we led a project to change gender attitudes in that community. Nine young people (males and females) from East African heritage were recruited to take part in a leadership course. This developed their community engagement skills and increased their knowledge of preventing violence against women and gender equity.

The community engagement focused on promoting two events, a 'You the Man' (YTM) theatre performance and after show discussion, addressing bystander intervention to violence against women, and an accompanying warm up event, with the theme of discrimination, both held at Flemington Community Centre. The Youth Leaders were successful in encouraging their peers to participate, with a total of 156 young people attending the two events.

¹⁹ Hillsdon, M., Cavill, N. et al (2001). *National level promotion of physical activity: results from England's ACTIVE for LIFE campaign*. *Journal of Epidemiol Community Health* 55: 755 - 761

²⁰ Owen, N., Baumann, A, Booth, M et al (1995). *Serial mass-media campaigns: reinforcing or redundant*. *American Journal of Public Health* 85:244-8

²¹ Dumesnil, H, Verger, P. (2009). *Public Awareness Campaigns about Depression and Suicide: a Review*. *Psychiatric Services* Volume 60, Issue 9.

Comparing pre and post survey results, there were increases in the number of people who felt able to take action if they witnessed gender discrimination, and 87.5% of the attendees felt that witnessing the *You The Man* performance increased their confidence to take action on behalf of someone else. Exit interviews and an evaluation session with the Youth Leaders indicated that seven of the group wish to be involved with future cohealth work in this area, and that all nine members were 'satisfied' or 'very satisfied' with the results achieved by the project.

Key to the success of the project was the involvement of people from the community. It was the Youth Leaders who were able to get people from the community to attend the events. One of the older Youth Leaders acted as a good role model to younger men encouraging them to voice their thoughts and opinions about this sensitive subject.

This approach was successful, but it is important to understand what level of commitment and resources this takes. A cohealth staff member worked 3 days a week during the four months of this project, with additional staff and resources from Flemington Neighbourhood Renewal, Women's Health West, Deakin University and Flemington Theatre Group being involved. This project was only possible because of prior long term investment in building relationships.

Community level work requires long-term commitment to building relationships but can be effective given sufficient investment. Investing in public awareness campaigns is easy but changing attitudes is not. Public campaigns are quickly visible, but changes in attitudes or behavior because of them is not.

cohealth's experience suggests that a \$100,000 a year commitment for a three year period would support a project to enable engagement and processes to support behaviour change and sustainability in a community. Based on this, a rolling program of \$20m recurrently would support work in 85 communities with identified risk factors, with \$3m provided for work in communities of identity supporting an additional 15 projects. The length and shape of these projects would be based on working with communities to identify need.

Different communities need different approaches

cohealth has a long history of primary prevention work undertaken in partnership with culturally and linguistically diverse communities, and place based initiatives that engage deeply with local communities. These include:

- STAMP (Supporting Traditional African Mediators Program) with African communities across the West of Melbourne
- UPSCALE (UP Skilling Community and Legal Education) with ethnic-Burmese communities in Wyndham and Brimbank
- SHIFT (Supporting Harmonious Indian Families Together) with the Jagriti Forum and Indian communities in Wyndham and Brimbank
- Living in Harmony Project with culturally and linguistically diverse communities living in the Collingwood high rise estates
- 360 degree turnaround project in partnership with Flemington Neighbourhood Renewal.

All of the projects listed above used a peer facilitators approach. Further information about these projects is provided in Appendix 3. Our experience shows that success is dependent on working in partnership with communities. Such partnerships with communities, including communities of place, identity or in a setting such as a school or workplace, require strong relationships which are robust and underpinned by trust. To develop relationships of this quality takes time, and requires understanding that this part of the process, and one that will have a significant influence on the projects success.

The time and commitment required to develop relationships and trust goes unrecognised and is almost always unfunded. Funding applications require a description of the project, milestones, benchmarks, evaluation plans and the like, all of which need to be built on unfunded activity of engagement, relationship development and shared understanding with communities.

As in the project described above, cohealth finds that engaging community members as peer facilitators is an effective way to support change at an individual level through opportunities for learning and personal reflection, and creating a powerful agent of change within their communities. Recruiting and building the capacity of peer facilitators takes time and dedicated staff members with long term funding support.

Every community – regardless of how it defines itself - has different understandings of issues it experiences and requires different approaches to solving problems. Every community has strengths that can be built upon to bring solutions to deeply embedded problems such as the prevalence of family violence. This allows for project design with multiple activities that leverage of these strengths and understand the communities' readiness to engage in discussion around issues of gender equity, power relations and equal access to resources that may support positive engagement to achieve and sustain long lasting change.

In this section we have focused on communities from different cultures, but other groups of people such as boys and young men are also in need of specifically targeted approaches. The Department for Education and Early Childhood Development have produced excellent resources called *Building Respectful Relationships* (2014) however they require a lot of investment of time from schools meaning that not many schools are using the curriculum. Schools need to be supported to implement such programs and alternative programs need to be developed, such as cohealth's *Sisters and Brothers* program which successfully reduces intolerance and discrimination in primary schools.

cohealth has another project, partnering with Women's Health West, in specialist schools aiming to create respectful relationships called *Girls Talk, Guys Talk*. People with disabilities is another group of people of particular concern and we are also running Living Safer Sexual Lives, Respectful Relationships with adults who have intellectual disabilities, using a peer led model.

It is clear that to be effective in primary prevention, long term funding streams are required which allow deep engagement tailored to specific communities to occur and change to be sustained.

Recommendation 4: Some parts of the community require additional focus for prevention activities

The Government, in developing funding approaches for prevention, should give particular consideration to:

- a) programs that address the specific needs of women and children from culturally and linguistically diverse backgrounds and target the broader determinants of health that make these communities more vulnerable to family violence and less able to access support services;
- b) initiatives that actively engage and encourage men and boys in the primary prevention of violence against women that address cultural norms across the life stage. This includes a continuum from early education with boys and young men through to adult institutions such as workplaces and sporting clubs where cultural norms are embedded and perpetuated.
- c) initiatives which engage with lesbian, gay, bisexual, transgender and queer communities and other communities for whom the language of family violence may be exclusionary.

Evaluation and understanding of impact of primary prevention activities

Evidence of the impact of primary prevention work in family violence is limited. Documenting and disseminating such evidence is challenging for a number of reasons, including inherent difficulties in showing effectiveness of all types of primary prevention work, capacity to conduct outcome evaluations of time-limited projects, and barriers to sharing of information.

The Inner North West Primary Care Partnership (INWPCP) Integrated Health Promotion Partnership is currently implementing the INCEPT (Inner North West Collaborative Evaluation) Project. The aims of the project are 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 to 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.

There are varying levels of organisational capacity to undertake quality evaluation work. Publicly funded prevention activities should be required to evaluate their services and programs and make their evaluation and learning publicly available. The funding of prevention activities can support a culture of organisations and businesses copywriting their programs which renders them less accessible. This can limit learning and the ability to replicate success. Where intellectual property is generated through a project predominantly funded by public money, open access principles should be applied to ensure that successful approaches can be adopted and adapted to work in different communities, where appropriate.

Recommendation 5: Endorse and adopt the VicHealth Framework: *Preventing violence before it occurs*

The Government should use the VicHealth Framework: *Preventing violence before it occurs* to guide effort and funding for primary prevention effort across the state.

Recommendation 6: A Safer Communities Sovereign Wealth Fund

The Government should:

- a) establish a Safer Communities Sovereign Wealth Fund, to provide a long term funding stream for primary prevention and research activities related to family violence;
- b) appoint a Safer Communities Advisory Council of women and others who have experienced violence, academic and service delivery agencies and prevention partners to make recommendations to the Governor-in-Council (on advice of the Premier) as to strategies, approaches and projects to be funded;
- c) make it a condition of funding that any intellectual property from initiatives funded by the Safer Communities Fund be subject to open access principles and be available to better inform community prevention efforts; and
- d) agree that primary prevention activities have a minimum three year funding cycle and be evaluated against principles or frameworks in line with the developmental work already occurring.

4. Family violence is a health issue

All experiences of family violence have detrimental impacts on health. As such, family violence can be understood as part of a web of the social determinants of health. cohealth service delivery, prevention work and advocacy are based on the social model of health. This approach “recognises that services that aim to improve health and wellbeing and to reduce and prevent disease need to be concerned not only with the individual, but also with the broader areas of public policy, environmental influences, group and family influences and the community context.” (Victorian Department of Health and Community Services, 1991,)²². While primary prevention of family violence is built on a broad understanding of the social model of health, many health policies, strategies and programs do not incorporate an understanding of family violence as a health issue. This approach also highlights the interaction between family violence and a range of political, social and cultural factors. In section 5 we discuss the impact of a range of public policy and social factors that impact on the health and safety of women and others experiencing violence, including legal system processes, refugee and asylum seeker policies, and housing.

Recommendation 7: Recognise family violence in key health policies

The Government should specifically identify and focus on family violence as a health issue within overarching primary health frameworks such as the Victorian Public Health and Wellbeing Plan.

Framing family violence as a health issue does not negate the right to freedom from violence. Women and others have a right to personal safety and not to be subjected to harassment, abuse, control or violence “likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Article 1, UN Declaration on the Elimination of Violence Against Women, 1993). Where violence is of particular form and intensity, a criminal justice system response is necessary.

Conceptualising family violence as a health issue highlights two important things. First, there is an important role for health services in recognising and responding to women and others who experience violence. This is in addition to the role of the legal system in responding to criminal offences. The health system is a key point of contact for both identifying family violence, and for intervening to support women and children to reduce their risk of violence. More specifically, community health services, which offer comprehensive primary health care and operate on a social model of health, have an opportunity to identify experiences of violence or risk of violence as part of their routine screening and assessment practice, regardless of whether a client presents for a broken tooth, gynaecological issues, chronic pain, or anxiety and depression. For many women it is less confronting and more acceptable to access (and to be seen to access) primary health services rather than specialist family violence services, especially as a first step.

Improving identification of family violence among clients of generalist health services is not a simple matter of adding a tick-box to a screening or initial needs assessment tool. A capacity building approach is required which incorporates a range of elements including: changes to screening and assessment practices and tools; changes to data collection systems; ensuring the referral pathways are in place; and training for staff in “asking the question” and in making referrals to appropriate services. Capacity building and data collection is further discussed in subsequent sections below.

A second key implication which flows from recognition that family violence is a health issue, is that important concepts from the health sector are useful to apply when thinking about family violence. These include: the continuum from primary prevention, through early intervention, to response; and

²² Cited from <http://www.wchm.org.au/social-determinants-model-of-health> accessed on 29 April 2015

system issues such as system navigation and service coordination; and the concept of person-centred services.

A public health framework for prevention, early intervention and service response supports a broader range of approaches that can deliver better outcomes through more appropriate interventions in a more timely manner. The focus of primary health care is to move the emphasis of the service system from that of response to crisis to that of earlier engagement and preventing harm before it might occur.

The manner of engagement and participation within the health system is different in nature to that of the justice system. Both systems have administrators who to a varying extent direct, guide, engage or assist with navigation through different services operating independently. The health system is designed for both long term engagement to improve health and wellbeing, as well as more isolated episodes of care.

The justice system appears designed for a more transactional response, to resolve criminal, civil or administrative matters. The health system has developed a significant body of expertise in navigating complex systems, assisting people to 'find their way' across multiple services. Concepts such as care coordination, and health literacy are useful to consider as tools that can be readily applied to support women and others experiencing violence access a diverse range of services. These could include specialist response services, refuges, courts, Police, Victims of Crime Assistance Tribunal, the Family Court, and more generalist services such as health and support services, public and private housing, child protection, income support, child support, child care, schools, taxation, counselling, employment, legal aid or private legal support.

Consultations highlighted the difficulty that women and others who experience family violence find the extent of the service system that they need to negotiate across jurisdictions incredibly complex and difficult at a time when they are highly focused on their own safety and often that of their children. A case study, showing one woman's journey, is provided on the following pages.



Case study: A journey through the service system

"Lily" is a Serbian speaking woman who was 49 years old when she was referred to the Integrated Family Violence Service. She and her 10 year old daughter ("Natalie") were living in significant fear of Lily's ex-partner. Lily had acquired an Intervention Order but her ex-husband was breaching the order on a regular basis. He had broken into the family home and stolen important documents. Lily's ex-partner was an alcoholic and had made little financial contribution to the household. He left her with debts for furniture, which he had taken with him, and a car, for which she had no driver's licence and could not use. There was a mortgage on the family home, which was for sale when Lily first attended the service. Lily was seeing a Serbian speaking solicitor who was assisting her with a property settlement.

Lily was seen at a duty appointment, allocated for case management, and placed on the waiting list for counselling. She requested counselling for Natalie as she was very fearful. Natalie spoke English and was often called upon to interpret for her mother (not by cohealth, but elsewhere). As a result she had become somewhat 'parentified'. She also had to see her father when she went to a Croatia club for her regular dancing lessons. Counselling sessions with a specialist children's counsellor for Lily's daughter were paid for using cohealth's Victims Assistance Program (VAP) brokerage funds.

Living with fear was having a physical as well as emotional impact on Lily and her daughter. Lily was referred back to the Magistrates Court with a support letter to apply for a variation of the conditions of the Intervention Order so that Natalie could attend her dancing classes without fear.

The house was sold and Lily needed to find a private rental property for herself and Natalie. She was referred to a housing service and linked in with a Serbian speaking real estate agent in the area where she hoped to live. Within a short time she had located a property, and was provided with some money towards rent in advance by the VAP. The real estate agent referred Lily to the Office of Housing for assistance with a bond loan. Lily often called the VAP (with assistance from an interpreter) when she was unsure as to what to do. As a result of her limited English she was often confused as to what she was being advised when an interpreter was not used by other services. During this time the VAP liaised with the real estate agent and the Office of Housing on her behalf.

When Lily was informed about making an application to Victims of Crime Assistance Tribunal (VOCAT) she was provided with a list of solicitors who could assist her. The Serbian speaking solicitor who was representing Lily for the property settlement was on the list for VOCAT applications, so Lily decided to seek assistance from him with her VOCAT claim. When she needed assistance with funds for removal expenses, the VAP informed her that an application for an interim award could be made to VOCAT for this. The VAP contacted her solicitor to facilitate this. He agreed to lodge an application on Lily's behalf. The VAP organised a quote for the removalist and faxed it, to send with the application. The solicitor contacted within a couple of days to say that VOCAT had denied the application. The solicitor agreed to fax a copy of the support letter as the VAP worker was unsure as to why the request had been declined. Upon receipt of a copy of the letter from the solicitor it was clear that very little information had been supplied about Lily's circumstances. An appeal was lodged and the VAP worker provided a support letter to accompany the application. VOCAT reversed its decision.

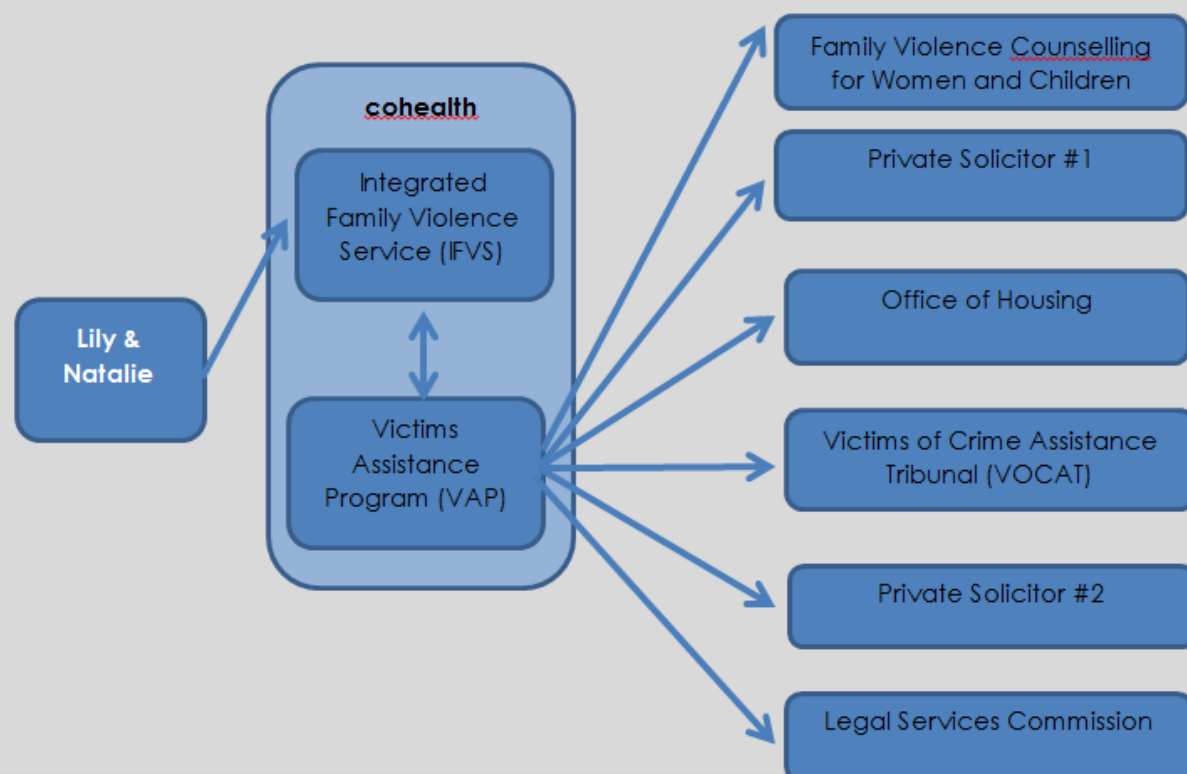
Lily became more upset with her solicitor as time went on. She called him regularly to check on the progress of the property settlement, but he would not answer her calls. When he did see her and she asked him to explain things, he either dismissed her concerns, or on one occasion told her that she should get Natalie to explain it to her. The VAP case manager called the solicitor several times to seek clarification of the situation to allay Lily's concerns, as she would often call in a distressed state, but he did not return the calls, or respond to the fax sent to say the calls were not being returned.

Lily was by this time having counselling with the Integrated Family Violence Service at cohealth. The IFVS worker was assisting both Lily and her daughter. She was hearing the stories of Lily's difficulties with the solicitor and made a call to Legal Aid to ascertain what could be done to assist and was told to contact the Legal Services Commission. This information was passed on to the VAP case manager, who contacted the LSC on Lily's behalf. An appointment with another Serbian speaking solicitor who was a family law specialist was made, the solicitor agreed to see Lily for a half hour consultation, and the VAP worker drove Lily to the appointment. The solicitor consulted with her for over an hour, and agreed to take on her case as she could not understand why it had not been resolved already. She offered to do the work "pro bono" and had the matter resolved successfully in one month, which the other solicitor had not done in over 6 months.

As Lily started to feel supported with her practical and legal issues by the VAP case worker, a shift was possible in the counselling, allowing Lily to focus on addressing the effects of the violence on her emotional state, to explore ways to support herself so she could in turn support her daughter Natalie, who had been carrying so much responsibility. A safety plan was put in place and by the end of the counselling, both had made significant progress in relation to the impact of violence on their well-being. Lily wanted to make a complaint to the LSC, and was assisted by the VAP case manager to do this. It took many hours of writing as Lily could not write the complaint herself, or respond to the letter the LSC received from the solicitor who was the subject of the complaint.

Lily subsequently received her property settlement and booked a trip for herself and Natalie to visit her adult children in Serbia and attend two of their weddings.

When the IFVS counsellor and VAP case manager did a joint session just prior to Lily's trip to Serbia, both Lily and Natalie were happy, not feeling stressed or scared any more, and looking forward to their future. The complaint with the LSC was resolved upon Lily's return from her trip. The solicitor's name was removed from the list provided to VAP clients.



System navigation was raised consistently during the focus groups as an issue causing great difficulties. Each system that is interacted with – whether it is the court, police and justice systems, the child protection, crisis response, housing and health systems, income support and family court- each can require an understanding of a specialist nature in order to understand your rights, but also understand how the system operates.

During the focus group with service users, the need for some support or advice about where they should go next or who they could talk to, was highlighted. This could include how to work with different elements of the broader service and support system that they had suddenly become more reliant upon, including but not limited to the income support system, child support, or housing assistance. This was a point reiterated by service providers, who relayed the experience of service users who often didn't know where to turn if they encountered issues or a decision had been made within one part of the service system which they felt placed their safety at further risk.

It became clear that there is a gap within the service system to support navigation, to provide a system wide perspective and advice and to place service users in contact with those people within each service that can assist with problem solving or removing barriers, that little bit of direction that can make all the difference.

In the case of Lily, there were many hours spent between the VAP case manager and the IFVS counsellor. However, by the end of our work she had an Intervention Order she was happy with, was successfully re-housed, and had her property settlement, and the claim against the solicitor resolved satisfactorily. Lily and her child were settled and on the path to recovery from the violence they had experienced. and support can make all the difference when undertaking a difficult journey.

Lily's case is a clear illustration of the importance of system navigation. It is in this context that health literacy as a concept to be applied across the response system could reduce the complexity and lack of coordination that women experience. The Australian Commission on Safety and Quality in Health Care separates health literacy into two components: individual health literacy and the health literacy environment²³.

Individual health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action

Health literacy environment is the infrastructure, policies, processes, materials people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services.

The health literacy approach suggests that while individuals within the response system can be supported to better understand how services work, the rules of access and opportunities for entry and engagement; the elements that make up the response system can also play their part in improving how women and others experiencing violence navigate the system and have their rights protected, their situation respected and not have different elements of the service system continue to be used against them as tools of abuse.

Women such as Lily, and those who participated in our consultation, who have used the services and systems to try and escape family violence and deal with its effects, are experts in what works and what doesn't. They have a great deal to offer in the re-design and improvement of response services so that they work better for the people that they are intended to help.

²³

There is a clear need for community education programs that are co-designed with women and others who experience violence a community education program to support understanding of the many and varied forms that family violence can take and promote understanding of the range of services that are available in support and how this support can be accessed.

Recommendation 8: Use health literacy approaches to improve services

The Commission should convene co-design forums with women who have experienced violence and representatives of service providers representing the specialist and mainstream response service systems to:

- c) develop information resources and system navigation tools that will support better understanding of the range of supports available to women and others requiring support; and
- d) assist disparate elements of non-specialist response services (for example income support, courts, child care, housing, child support, employment networks) to understand that they are all elements of a family violence service response system in order to improve services, information and access points.

Recommendation 9: Increased resources for system navigation

The Government should increase funding to case management functions and engage system navigation aides for women and others experiencing violence, to advise about available support or link them with key liaison officers in various service agencies.

Capacity building in mainstream service system

Given the prevalence of family violence, there is a vital role for the services that operate within the mainstream health system to be able to improve capacity to provide safe and culturally appropriate services that support early identification of the impacts of violence and improve referral to appropriate services at the earliest opportunity to reduce the impact that violence is having.

The principle is that women or others experiencing violence should be able to begin the journey to recovery and safety regardless of where they are accessing services – that in the health and human services support system there is ‘no wrong door’ through which they can walk which will allow safe disclosure and appropriate referral to support and services which best suit their needs at that point in time.

There have been many different approaches to workforce capacity building across issues, illnesses and populations groups. It is clear that capacity building that opens access and improves service system responsiveness is not achieved through a one off training program. Quality capacity building that impacts on service delivery and alters the practice of service providers requires a long term strategy with funding attached to support cultural change as well as leadership at the community and organisational level in order to support the embedding of change and enhanced capacity at the service level.

A model of capacity development which was promoted during consultations was that of the Aboriginal Health Promotion and Chronic Care (AHPACC) partnership initiative. This program was designed to support both “Aboriginal community-controlled health organisations (ACCHOs) and community health services to work in partnership to develop and deliver local services and programs that prevent and manage the high prevalence of chronic disease within Aboriginal communities.”²⁴ The program was rolled out in mainstream community health services with funding attached to employ an Aboriginal worker to promote engagement with local Aboriginal communities, which was then supported at cohealth predecessor agencies by a program of professional development

²⁴ <http://www.health.vic.gov.au/aboriginalhealth/access/ahpacc.htm> accessed 28 May 2015

activities to support more appropriate and culturally sensitive health care provision. The success of the program was further supported by the identification of champions to promote the importance of the work and reiterated by leadership across management and by CEOs that this work was an organisational priority.

The success of this capacity building initiative relied on each of these elements being present: funding for workers with particular skills and experiences who were available for consultation and secondary consultation with service providers; a tailored program of professional development for all staff within the organisation; the presence and empowerment of champions to promote the importance of the work; leadership from the CEO and management.

An important element of improving the capacity of mainstream health and human service systems to respond to the needs of women and others experiencing violence is to improve the training of the workforce. Professionals working in the health, human services, justice and education workforces should have an understanding of the cultural and gender context of violence against women, its prevalence and impact. Family violence training should be a mandatory component of entry-level training programs for health and human service professionals.

To further support improved responsiveness, the Victorian Government could require as a condition of accreditation that all agencies receiving Victorian Government funding be required to meet specific accreditation standards that promote improved service response for women and others experiencing family violence.

Recommendation 10: Workforce capacity building

The Government should:

- a) fund capacity building across the health and human services systems to prepare and resource organisations delivering services to provide safety, skills and environments that support early identification and disclosure as well as appropriate referral and support to women and others experiencing violence.
- b) work with universities, professional accreditation agencies and other training bodies for the health, human services, justice and education workforces to embed family violence training in entry-level qualifications.
- c) require as a condition of accreditation that all agencies receiving Victorian Government funding be required to meet specific accreditation standards that promote improved service response for women and others experiencing family violence.

Elder Abuse

cohealth is currently delivering a Seniors Law clinic at our Footscray First Response clinic, in partnership with Justice Connect. First Response is a walk-in clinic with no appointments for people requiring multiple services and experiencing homelessness or at risk of homelessness. This partnership developed as a result of a significant increase in older people presenting at First Response who were experiencing abuse by family members. There is significant need for services that support improved response to support people experiencing elder abuse as well as primary prevention programs about elder abuse.

Recommendation 11: Act on elder abuse:

The Government should implement recommendations of the submission on elder abuse by Justice Connect Seniors Law.

Data collection through service-user information systems across Government agencies

Data collection and use is a significant challenge for understanding prevalence of family violence, its impacts and determinants. Information about the experience of violence is often not routinely sought by health professionals. Even where it is, the client information system may not support recording of data in a field which can then be readily extracted and analysed. For example, in TrakCare (which until 2014 was the mandated CIMS for community health services in Victoria) this information could be recorded in the notes section of a client record which would require file audit to extract.

There is significant opportunity to improve data collection practices across the health and human services system. A minimum standard set of indicators that should be routinely collected by agencies should be developed by service providers, working with academics and service users. This is particularly important where current prevalence measures rely on police statistics which are likely to significantly understate actual prevalence.

It is important to note that it is not sufficient to mandate that various pieces of data are collected by service providers. Such a change needs to be embedded in a program of capacity building work to ensure that, in asking questions to gather information, the service provider can support the service user if a need is identified. There needs to be clarity about how the data collected through such processes will be used, though it is clear that improved information about the experience of family violence is useful for planning health service delivery as well as identifying relevant workforce capacity building requirements. The proposed index of the Victorian Government will also be dependent on valid, reliable datasets.

In addition to service level data it is vital that continued effort is applied to collecting data at the population level on gender equity measures, community attitudes towards women and family violence (using the broad definition of family violence adopted by the Commission). As such cohealth supports the recommendations of the Preventing Violence Together Partnership (PVT) in relation to data.

Recommendation 12: Improved data collection

As recommended by the Preventing Violence Together Partnership (PVT) the Victorian Government should:

- a) establish a minimum data set for health and human services agencies to collect which can contribute to understanding of prevalence of violence and impact of prevention activities;
- b) support the 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;
- c) 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; and
- d) 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.

5. Improve response systems

From the case study presented it is clear that the system of response can be complex and extend beyond the family violence system that is funded by the Victorian Government.

cohealth notes that there has been very good work done at a regional level to bring together diverse service providers such as through the Western Integrated Family Violence Committee, to improve response and build relationships across sectors for a more integrated response. These networks could be better supported by funding both the coordination and support work as well as the participation of organisations. The decision to participate in such networks for many organisations is often a choice between core service delivery, in the context of high demand and growing waiting lists, and network participation which may yield benefit over time, but will result in lower service activities in the interim.

The work of Primary Care Partnerships in service integration and coordination is a model for an approach that has yielded significant benefits for service users, service providers and communities through the realisation of more accessible and readily navigated services that are able to collaborate around the health and support of individuals, particularly those who require for a complex service response

Recommendation 13: Support regional networks

The Government should support regional networks to undertake service integration and coordination work by funding Primary Care Partnerships / regional family violence service providers to participate in and resource network activities, and by providing funding to organisations who without such support would not participate.

Notwithstanding the good work that has been occurring at regional levels, it became clear through consultations that the notion of a family violence response “system” is a misnomer. There are specialist services to support women experiencing violence – refuges, family violence services that undertake outreach, crisis response, case management and intake, family violence counseling services. There are Victims Assistance Programs which support significant numbers of women and small numbers of men who have experienced violence, but whose service remit is broader. There are Courts and Police as part of the legal system.

The services providing both the immediate crisis-based response as well as improving early response are severely under-resourced and therefore target their work at those who face the greatest risk. This means that many experiencing violence are not able to access the necessary supports at the time they are required to enable and empower them to make the best decisions about their life. This may place them at greater risk.

When police refer women to a family violence service a triage process occurs which results in only those assessed as having highest risk are followed up – triage processes are not perfect assessments of risk. During consultations, the advice cohealth received was that once police referred to a family violence service there was no follow up to determine whether contact had been made with the women who had been referred. Further to this there was no advice back to police where no contact had been made. This creates a problematic gap in the service system where women and others experiencing violence may be expecting contact and support, but do not receive it.

A healthy system that is supporting women and others experiencing family violence would be built on a culture of collaboration, where partnerships develop in response to expressed need and referrals occur because the needs of women and others experiencing violence are paramount. This is unfortunately not always the case. One of the side effects of competitive tendering and recommissioning processes is that it stresses and sometimes fractures collaborative relationships that

often underpin the smooth movement and navigation of service users across different service types in response to needs that are present at any given time.

The response that is actually needed for women and others experiencing violence includes a disparate and large number of services which may be required to meet personal, financial, housing and health needs.

Responses should be tailored to the needs of the individual. The unrelated nature of each element of this system (whether it be child support, income support, housing, child protection, Home and Community Care, child care, schooling, hospitals, general practice, counseling, employment support) and the lack of identification of each service as part of a system in and of itself makes the journey across and into it much more problematic for women and others experiencing violence.

Flexible service responses are a particularly important mechanism to enable meeting individual needs, as the case study of Lily illustrated. Brokerage funds, such as those available to the Victims Assistance Program, allow flexible, appropriate and timely responses to women and others experiencing family violence.

The concept of client-centred care or the 'person at the centre of the system', which is well understood in the health sector, is a useful one to bring to family violence response, to support improved navigation and simpler service access. Much work is required within each element of the response system to develop responsive and accessible services to women and others experiencing violence. Through this thinking cohealth proposes to understand the broad range of government services that are required to respond as a system which belongs to women and others experiencing violence, not as a set of self-contained and unrelated services which women and others experiencing violence may require.

Recommendation 14: Increased level and certainty of resources for response services

The Government should:

- a. increase crisis and specialist service response funding in line with the increase in reporting to police that has occurred from 2009-10 to 2015-16, and each year of the forward estimates and ultimately continue to grow funding to this sector in line with better understanding of prevalence based on improved data collection;
- b. relocate the management of services and funding associated with the response to family violence to a new statutory agency reporting to the Minister for the Prevention of Family Violence which is overseen by a Board consisting of the Secretaries of the Departments of Health and Human Services, Police, Justice, Education and Early Childhood
- c. negotiate with the Federal Government for a National Partnership Agreement to End Family Violence instead of funding services for family violence under the National Partnership on Homelessness.

Recommendation 15 Increase the availability of flexible funds

The Government should:

- a. extend the availability of brokerage to women and others experiencing violence beyond housing and the Victims Assistance Program; and
- b. increase the capacity of the Victims Assistance Program to support more women and others who have experienced violence by allocating a specific additional funding increase for this group of service users.

Recommendation 16: Increased resources for counseling services

The Government should increase the funding support for specialist family violence counseling to ensure that women and others experiencing violence can access counseling support at any stage of their experience or recovery from violence.

Recommendation 17: Support sector collaboration

The Government should consider funding processes for family violence response services that encourage collaboration and service integration between agencies.

Whole Family Approaches for prevention and response

There is strong evidence that one of the most effective ways to prevent people from becoming perpetrators in adulthood is by working with children who are witnesses to or victims of family violence²⁵. By investing in services that target the children of victims of family violence, and also create services that work with the whole family, we may see a reduction in violent behaviours from this cohort in future years.

A whole family approach used in Scotland, called the Caledonian System, is an integrated approach to address men's violence and to improve the lives of women, children and men.

For many women, the decision to leave an abusive or violent partner does not occur immediately upon recognition of violent behaviour. In these cases, the Scottish Government consider working with men in isolation is potentially dangerous as it may raise the risk of harm to women partners. The Caledonian System has three main elements:

- The Men's Service - which provides a programme of work with men lasting at least two years, comprising preparation and motivation sessions; a group-work programme of twenty-five sessions and post group work.
- The Women's Service - which provides a safety planning, information, advice and emotional support to women partners and ex-partners.
- The Children's Service - which ensures that the needs of the children whose parents are involved with the Caledonian are met and their rights upheld.

The Caledonian men's program uses a person centred approach coupled with cognitive behavioural techniques in order to encourage men to recognise their abuse and take responsibility for themselves and their relationship with their ex/partners and children. The man's risk of future domestic abuse is the focus of the men's programme.

The programme covers the main areas of behaviour, thinking, feeling, attitudes and beliefs which research and practice have identified as central to change in men who have abused women partners. The pre-group work also begins to provide men with the skills they will need for the next stage of the programme, and consequently the early stages of change can occur in some men.

The group work cover the key areas of promoting lifelong change; responsibility for and to self; responsibility within relationships; sexual respect; men and women; and children and fathering. The group work part of the programme is designed to operate on a carousel model, whereby members can enter and leave at many points enabling men to join when they are ready as opposed to having to wait for a new 'closed' group to begin, enabling the group to function at an enhanced level.

²⁵ Carter, J. (2000). *Report of the Community Care Review*, Deakin Human Services Australia, Deakin University

The Caledonian System women's service offers emotional and practical support to women and children improving mental and emotional wellbeing, advice on safety planning and understanding potential future risks, current risk assessment, participating in community responses to family violence and advocacy. Women whose partners are assessed as unsuitable for the intervention are also offered a limited service to do some safety planning and, if appropriate, to make referrals to alternative services.

The children's service promotes and protects the rights of the child and ensures that their needs are met. Each child has a designated lead professional who plans, monitors and coordinates the appropriate support and resources to meet the child's needs. An aim is to keep the child safe and repair the harm caused by domestic abuse.

Success is not being measured simply in terms of recidivism amongst men but against six criteria:

- Changes in respectful communication
- Expanded space/freedom to act
- Safety and freedom from abuse/violence
- Positive and shared parenting
- The male's awareness and understanding of the impact of violence on the partner and child
- Safer, healthier childhoods

Recommendation 18: Increased investment in whole family approaches

The Government should:

- a) increase investment in counseling for children who directly or indirectly experience the effects of family violence;
- b) support development of programs promoting whole of family interventions that are not reliant on the decision of a woman or other person experiencing violence to leave the relationship. (based on international practice, such as the Caledonian System)

Policy and practice in other systems impacts the health and safety of women and others experiencing violence

Justice System

While cohealth is not part of the legal system, during consultations it became clear that there are numerous issues with the operations of the legal system that create barriers and problems for women and others experiencing violence. cohealth understands that participants within the legal system will make specific submissions covering the operations of the legal and justice systems, we note the following issues that were specifically mentioned during consultations:

- The relationship between intervention orders and family court orders at times is clearly antagonistic to the safety, health and wellbeing of women and others experiencing violence
- The legal system can and is used to perpetuate abuse and impair the safety and agency of women and others experiencing violence
- The person experiencing violence is expected to maintain their own safety, to monitor breaches of orders and where required pursue these through the Courts. An overall lack of system resources – whether at the police, legal support or Court functioning, is used to justify inaction or failure to hold the perpetrator to account for their behaviours.
- Women and others experiencing violence are often inhibited by the privacy rights of the perpetrator in their ability to determine whether they are at risk. The perpetrator's right to privacy seems to be given precedence over the rights and safety and women and children experiencing violence.

Settlement Services: Humanitarian Program - Refugees

cohealth works closely with newly arrived refugees and asylum seekers through the delivery of the Refugee Health Program in the cities of Maribyrnong, Moonee Valley and Yarra as well as through the auspice of the coordination role for the Statewide Refugee Health Program. During consultations it was made clear that changed approaches to on-arrival placement and initial settlement practice has had the impact of increasing the isolation of newly arrived refugee women. This when combined with reduced case worker support, particularly for those seeking asylum in Australia, has reduced access to information about health and other services, which places women and others experiencing violence at greater risk of not being able to access support when they experience violence.

The impact of this isolation and lack of knowledge of available resources and supports is exacerbated when services are not funded to provide, or choose not to use, accredited interpreters. The use of family members, particularly husbands and older male children can mean that a woman experiencing violence cannot disclose that violence as the perpetrator of the violence is being used as the interpreter. This is a clear violation of the rights of women who do not speak a language other than English and must as a matter of urgency be remedied by the State and Commonwealth Governments

Settlement Services: Humanitarian Program – Asylum seekers

The experience of asylum seekers being released from detention, being held in community based detention, or being based in the community at various stages of the determination process for their application for asylum in Australia cannot by any definition be considered to be within the definition of 'humanitarian'.

Service providers advised during consultations that experience of women asylum seekers is almost a 'perfect storm' of factors that increase their risks of being subjected to violence, with little or no access to information, support or services that can protect them from that violence, and little to no capacity to be removed from the situation of that violence.

These increased risk factors include:

- the practice of settling asylum seeker families in relative isolation from each other and other members of the community who speak their language;
- the lack of income support, indeed the absolute poverty that asylum seekers experience as a result of current policy and program design;
- the absolute lack of security about their future that asylum seekers have. Again this is an explicit intention of policy and program design;
- the lack of information and support that is provided independent of those who are perpetrating violence;
- the lack of interpreter support for services to asylum seekers and the use of family members as interpreters in service delivery (outside of GP and community health services access to interpreters);
- the loss of status experienced by husbands, partners or older male children who are unable to provide for their families, have no financial security, are denied the opportunity to plan a secure future, have limited to no employment opportunities and have often experienced trauma associated with the journey to seek asylum and detention experiences.
- depression and post traumatic stress as a result of detention and the asylum seeking journey;
- the deterioration of the health of children and the fracturing of familial relationships that occur as a result of detention.

The approach to asylum seekers is an example how policy and program design can exacerbate the risk of being subjected to violence, as well as reduce the ability to escape violence and become safe. The design and implementation of these policies displays either ignorance of factors that increase the risk of abuse or callous disregard for its impact.

While settlement policy is outside the remit of the Commission, cohealth considers that the damage of the policy and the risks it poses require action not silence. The strongest possible advocacy is required to ensure that women and others seeking asylum are not condemned to silent and invisible suffering because of a system which is designed to be blind to their situation.

Recommendation 19: Advocate for changes to asylum seeker policy

The Government, as a matter of urgency, should communicate with the Commonwealth Government in the strongest possible way to seek changes to the policy and program design which is exacerbating the risk that asylum seekers will be subject to violence and abuse.

Recommendation 20: Mandatory use of trained interpreters

The Government should mandate the use of NAATI accredited interpreters (where available) for the delivery of services funded by the Victorian Government

Housing

Time and again through consultations it became clear that without access to safe, secure, affordable and accessible housing in the short, medium and long term, the capacity for the family violence response system to achieve sustainable outcomes is limited. Safe, secure, affordable and accessible housing is the platform from which thriving lives can be built. Cohealth endorses the joint submission of housing, homelessness, community, family violence and legal sectors that lack of appropriate housing options:

1. deters victims from leaving violent relationships;²⁶
2. pushes victims into homelessness;²⁷
3. can make perpetrators more isolated and increase the risk of repeated or escalated violence;²⁸

A suite of solutions is required to break these links between family violence, housing and homelessness in Victoria. We collectively call on the Government to invest in these solutions.

Recommendation 21: Addressing housing needs

As recommended by the joint submission of housing, homelessness, community, family violence and legal sectors, the Victorian Government should :

- a) improve **measures to sustain tenancies and prevent homelessness** for women who can safely stay in their housing, including strengthened programs such as Safe @ Home responses, the Social Housing Advocacy and Support Program, legal representation for women facing

²⁶ Just three in 100 two-bedroom rental lettings in the December 2014 quarter were affordable to a single parent reliant on Centrelink: Department of Health and Human Services, Rental Report December Quarter 2014. On 11–12 April 2015, less than 0.1% of private rental properties in metropolitan Melbourne were affordable and appropriate for a single mother of two children who relies on a parenting pension: Anglicare Australia, Anglicare Australia Rental Affordability Snapshot (2015), 88. There are currently 33,933 people on the Victorian public housing waiting list; 9,556 are eligible for 'early housing' due to urgent needs including unsafe housing as a result of family violence: Department of Health and Human Services, Public Housing Waiting and Transfer List March 2015.

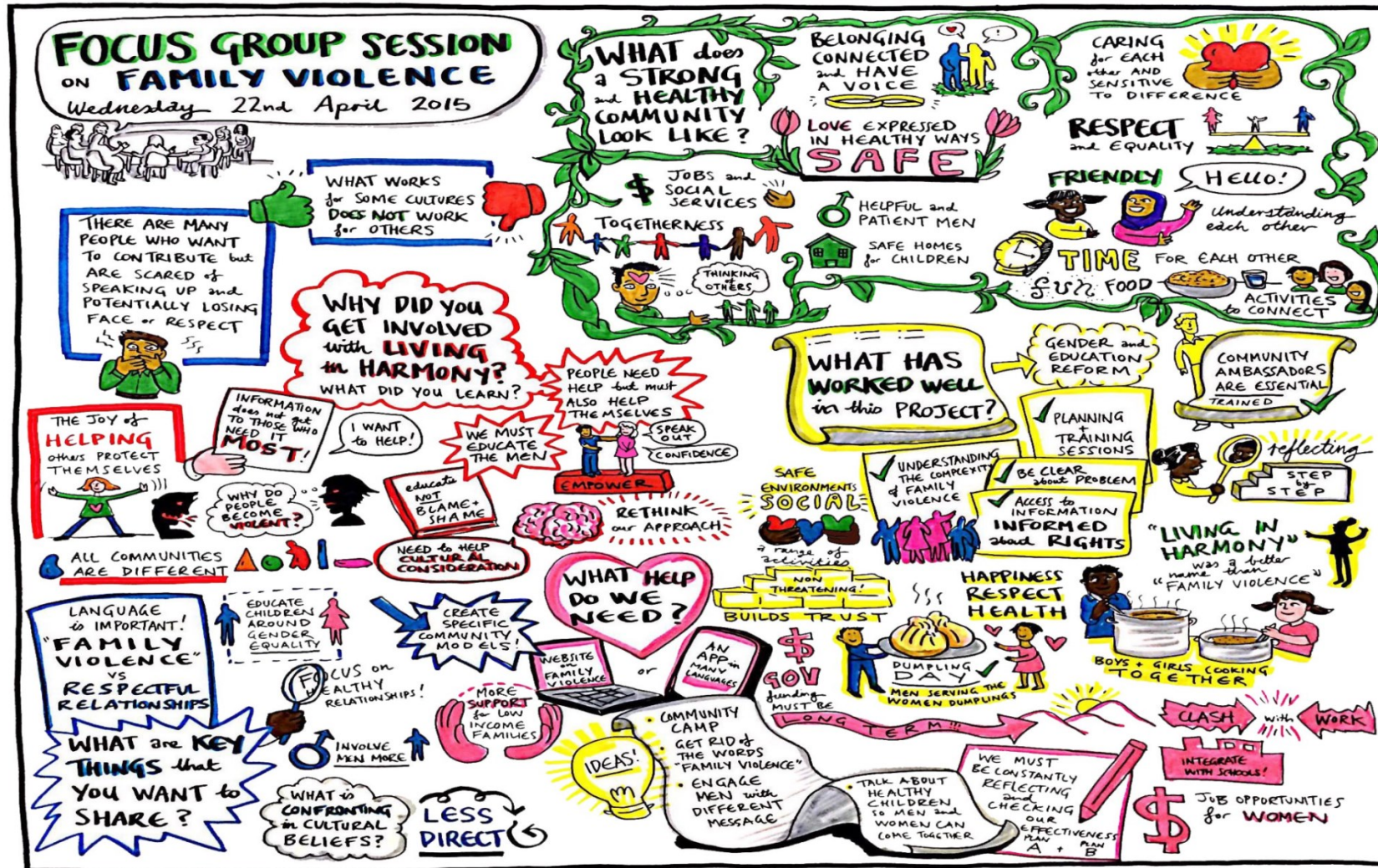
²⁷ 99,892 people sought assistance from specialist homelessness services in Victoria 2013–14. 28% of these people cited domestic or family violence as the main reason they needed assistance: 25,104 people in total; 2,892 male; 27,655 female. See Australian Institute of Health and Welfare, Specialist Homelessness Services: 2013–2014 (2014), 'Table VIC2.14: Clients, by main reasons for seeking assistance, 2013–14, adjusted for non-response'.

²⁸ See, eg, Centre for Innovative Justice, Opportunities for Early Intervention: Bringing perpetrators of family violence into view (2015) 50: The report identifies that availability of housing for men excluded through the intervention order process is a key aspect of engaging with these men to address their issues and prevent further violence from occurring.

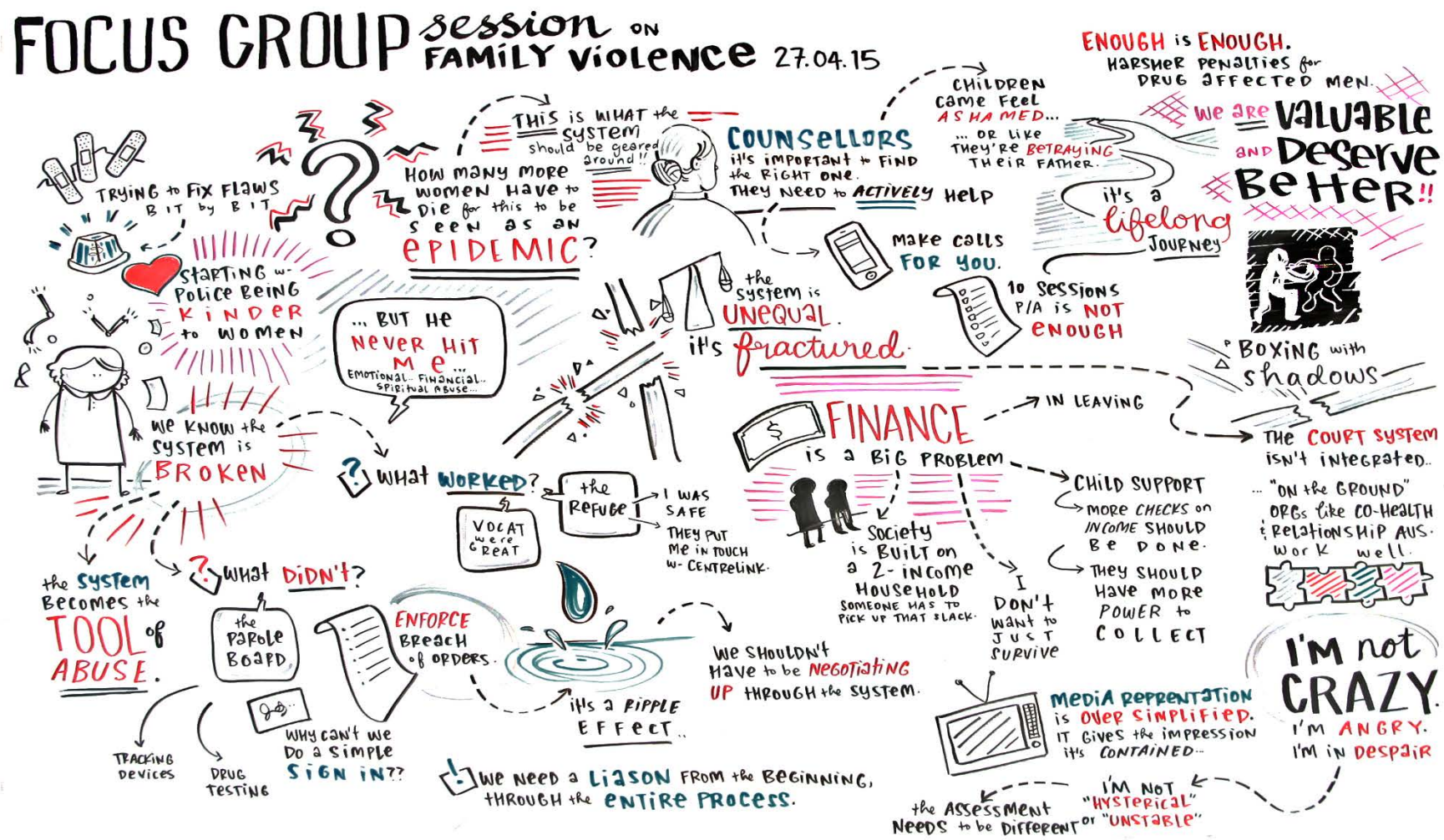
eviction, and private rental brokerage schemes. \$13.4 million per year could assist an additional 3800 families;

- b) establish a **rapid rehousing** program to assist women and children escaping family violence to be quickly rehoused with appropriate supports in place. \$10 million per year could assist over 1000 women and their children;
- c) improve **affordable housing pathways for perpetrators** of family violence to ensure they remain engaged with relevant supports to help prevent the risk of further violence;
- d) develop a **long-term affordable housing strategy** to address the soaring public housing waitlist and increasing unaffordability of private rental for low-income Victorians. An affordable housing growth fund of \$200 million per year could build a minimum of 800 homes.

Appendix 1: Peer Facilitators Focus Group (April 22 2015)



Appendix 2: Women who experienced violence focus group (April 27 2015)



Appendix 3: cohealth primary prevention projects – methodology and evaluation outcomes

Collingwood Living in Harmony Project*

Project Overview

This was the first place-based primary prevention project on the Collingwood public housing estate seeking to address the family violence by addressing the underlying determinants of violence. There was increased support and activity within the community to take a united stand against family violence thus creating a healthier community

Partnership Model

Cohealth (North Yarra Community Health) auspiced the project. There was an 11-member steering committee made of project partners: Women's Health in the North, Vichealth, City of Yarra, Collingwood Neighbourhood Justice Centre, Fitzroy Legal Aid, Berry Street, Victoria Police, DHHS (Office of Housing and Office of Women's Affairs), inTouch, Collingwood residents, the Wellington

Target Group/Setting

Culturally and linguistically diverse communities, particularly the Vietnamese, Chinese and Horn of Africa communities (Sudanese, Oromo, Ethiopian, Somali, Eritrean) living on the Collingwood public housing estate

Project Outcomes

Sixteen bilingual facilitators were trained in part of the *Certificate IV Community Development* course by Victoria University and the Domestic Violence Resource Centre. This enabled them to deliver 23 activities to over 800 residents of the three estates from 2011 to 2014.

Key outcomes include increased awareness, as well as the significant personal and professional development of the facilitators, who supported increased knowledge of the communities about family violence.

There were significant benefits for the communities:

- an increased understanding of their rights;
- more open and willing to discuss issues around family violence, including referring people to appropriate support services
- actively spreading the word about the *Living in Harmony* project, gender equality and respectful relationships, and encouraging people to become involved
- been attitude change in the community, with greater knowledge about where to go for support and understanding of family violence.
- Higher attendance at activities to understand how "to live in harmony and respect each other" helped build self confidence and an expressed belief that it is good for the family to know their rights.
- greater knowledge about where to go for support and protection about family violence attending activities and learning how "to live in harmony and respect each other" and expressed belief that it is good for families to know their rights.

*The peer facilitators who participated in the focus group referred to in Appendix 1 were drawn from this project.

The model used for this primary prevention in a place-based setting can be replicated to other CALD communities and/or locations / settings and the project has contributed to the national evidence and evaluation base for primary prevention activities in CALD communities.

Key learnings

- Increasing awareness of impacts of family violence and human rights and gender equality concepts is achievable when you work in partnership with communities;
- It is important to work with CALD communities to identify activities that will work best
- Building the capacity of community based peer facilitators increases the capacity of the community;
- Partnerships with allies in the are important to support primary prevention initiatives

Recommendations

- Continue to have a dedicated and supportive steering committee or reference group to work with the project team.
- Support and guide facilitators to reflect on and record their strategies, challenges and successes in engaging particular cultural groups throughout the project;
- Produce a concise report to share the learnings of the project with other CALD communities and public housing estates where similar place-based primary prevention projects could be implemented in future; this could include a “tool kit” of guidelines for effective facilitator training and community activities.;
- Develop a comprehensive community engagement strategy that addresses target communities and support implementation of likely projects on the other public housing estates;
- Support facilitators to plan and implement further activities that will continue to build the Collingwood housing estate community’s understanding of respectful relationships, gender equity and prevention of violence against women;
- While all funding is welcome, needing to repeatedly apply and advocate for small pieces of funding to keep a large prevention project going, takes resources away from the project.

Funding Model

\$270,000 was received over the course of three years from different sources: - Collingwood Neighbourhood Justice Centre, City of Yarra (2 funding streams), Office of Housing and Office of Womens Affairs (now DHHS), Ian Potter Foundation, Women's Health in the North, Inner North West PCP, Ethnic Communities Council, Rotary, Victorian Multicultural Commission.

STAMP (Supporting Traditional African Mediators Project)

Training program for community mediators targeting community leaders and elders to increase understanding of their role, refugee experience and impact on family life, gender inequality and its impact on family violence, values underpinning family law act and intervention orders, what constitutes family violence, mediation skills and self-care strategies. The goal of the project was to enhance the wellbeing of families by reducing family violence in a local community.

Partnership Model - Western Region Health Centre, Marula and Victorian Legal Services Board

Target Group/Setting - Work with African community in the west

Project Outcomes

- Eighty leaders and elders completed training between 2009 and 2012.
- Positive attitudinal change about gender roles and an increased knowledge of the Australian legal system.
- Mediators continued to meet to increase their understanding of family violence and to talk about their work and their communities.
- The development of relationships both within the Australian/African community and with various service providers especially the justice system.
- Paper published (available upon request)

Key learning

- Five years was spent developing relationships with African/Australian community leaders and designing the project, which was collaboratively developed by African community leaders, WRHC and other key stakeholders. Trust and relationship building were key components of its success.
- It was only when project workers immersed themselves in and sought to fully understand community leaders' cultural point of view that change was able to occur. This happened when project workers took a non-judging stance and accommodated the differences in culture
- The training program for traditional African mediators has been an effective method of engaging community members in family violence prevention.

Recommendation: That the relationship development and codesign elements of the program be recognised as vital to its success and funded in future approaches with culturally and linguistically diverse communities.

Funding: 2 year project funded by Legal Services Board \$104,000 each year.

SHIFT – Supporting Harmonious Indian Families Together (funded February to December 2015))

Project Overview

This project in partnership with the Indian Community builds in learning and experience developed through the STAMP / UPSCALE / Collingwood Living projects.

- Developing partnerships with and engaging community members and organisations in all project stages;
- A focus on building the capacity of community leaders to undertake Preventing Violence Against Women Community activities by engaging them in culturally relevant and appropriate education focusing on respectful relationships, family violence and relevant services;
- Project management and health promotion techniques; and
- Supporting community leaders to plan, conduct and implement PVAW activities in their wider community, and to support community members.

Project Aims

- Increase awareness of both universal and community-specific factors contributing to violence against women and their children in the Indian community;
- Identify violence prevention strategies that are supported by the community;
- Build the capacity of the Indian community to undertake and promote primary prevention activities;
- Develop a range of local and community service sector partnerships to support ongoing implementation of primary prevention initiatives;
- Build an evidence-based primary prevention model or toolkit, including engagement approaches, guides and resources, for replication with other CALD communities;
- Contribute to the national evidence and evaluation base for primary prevention activities in CALD communities; and
- Integrate violence prevention activities into existing programs that support community and cultural diversity.

Partnership Model

cohealth, Our Watch and Jagriti Forum (Indian community organization)

Target Group/Setting

Wyndham and Brimbank residents of Indian cultural background

Learnings from the consultation with community leaders and members to shape the project (The following recommendations sit outside the scope of the project funded by Our Watch however may be support future approaches.)

- There is a need for more psychologists of Indian background (or people who have knowledge of Indian culture) who are trained to support women and others experiencing violence
- More guided and specific support to the Indian community requires research ,to understand the incidence of family violence and the factors that may increase or mitigate risk.
- Support and assistance for community leaders as they informally advise members of the community who approach them for support and advice around family violence issues .
- Employ social/welfare worker from Indian background to work within important community institutions, such as temples. Instead of relying on informal and voluntary welfare committees.

Funding Model

11 month funded project by Our Watch

360 degree turnaround

Project Overview

The project utilised Deakin Universities 'You The Man' (YTM) theatre event as an intervention to promote non-violent norms and positive relationships through bystander intervention. Key project objectives included recruiting and training a group of youth leaders, empowering them to engage with other young people around preventing violence against women to improve gender equality, identify barriers to service access and to develop strategies to reduce them. cohealth led the youth component of the 360 turnaround project, a Flemington Neighbourhood Renewal (FNR) led partnership initiative responding to violence against women on the Flemington Housing Estate.

Partnership Model

Project leadership by Flemington Neighbourhood Renewal with the youth component led by cohealth. Other partners included Moonee Valley City Council (MVCC), New Hope Foundation, Women's Health West, Victoria Police, Moonee Valley Legal Service and Jesuit Social Services

Target Group/Setting

CALD communities who live on the Flemington housing estate - cohealth focus specifically on young people within this population group

Project Outcomes

- The Youth Leaders were successful in encouraging their peers to participate, with 156 young people attending the two events.
- Attendance was high at the youth training sessions with average 90% attendance rate. YTM Survey results indicated that attendees felt that they had the resources to take bystander action after witnessing the play (57% pre vs. 76% post).
- 75% of respondents for both pre and post surveys found local service providers at least 'more than a little bit helpful', showing some trust in local agencies.

Key learnings

- Peer involvement was vital in engaging the target audience in a very short time.
- Partnership model was important and supported the identification of the most appropriate youth peer engagement workers.

Recommendations

The peer led model was successful in engaging a broad range of young people from the Estate, and it is recommended that this should be used in future youth program planning. The leader payment model is not sustainable in its current form due to budgetary limitations, although it could perhaps still be employed for a smaller group that meet less frequently.

The theatre group workshops conducted by FTG provided a strong example of asset based community development, and cohealth recommends that FCC should incorporate these workshops into their suite of weekly youth focussed activities.

Involving local youth directly in the planning of the program activities and events worked very well, and this participatory approach should be utilized in the next phase of the project which will aim to encourage community members to draw on their own strengths and assets when working towards positive health outcomes for their community.

Funding Model

Total project funding with in-kind contributions \$155,000: with MVCC (\$60,000 over 2 years) and Department of Human Services (\$25,000 over 2 years) and the youth component received Inner North West Primary Care Partnership (total \$5,000 for 1 year), plus in-kind contributions (cohealth value total \$65,000 over 2 years).

Youth Advocates against family violence

Project Overview

A project to address and prevent family violence in the inner North-West region of Melbourne by educating young people about family violence in the local secondary school setting. This supported young people to build capacity and increase willingness to be gatekeepers / sources of information about family violence, understand and develop respectful relationships, and further their awareness of family violence support services.

The project sought to develop, pilot and share a model of community legal education for young people in Victoria through the secondary school system that addresses both response and prevention aspects of family violence.

Partnership Model

cohealth (Doutta Galla Community Health Service) and Inner Melbourne Community Legal Service were lead partners with support from the Victorian Law Foundation, St Aloysius College, Kensington Community High School, University High School, Simonds Catholic School, Partners in Prevention Network and the City of Melbourne.

Target Group/Setting

Young people attending secondary school in Inner North-West Melbourne. (98% in year 9 or 10)

Project Outcomes

More than 200 young people participated in the program. Participants were better equipped to identify, respond and advocate about the issue of family violence.

Respondents were readily able to identify the various forms of family violence including physical, sexual, emotional and financial abuse and also able to identify the attributes that determined healthy and unhealthy relationships, and placed value on pursuing and promoting respectful relationships.

- 66.1% of respondents indicated that they would know where to go to get help if they or someone they knew were experiencing family violence;
- 52.2% of respondents indicated that they felt more confident in responding to a family violence situation since attending the program; and

Key learnings

The target audience of Year 9 students was appropriate for the session content. The material also appeared suitable for the older audience of VCAL students. Future programs would ideally be directed at students in year 9 upwards, and consider including re-visited programs at Year 11 to further reinforce the key messages.

- While a significant amount of material was covered in the two project sessions, presenters believe that students would be better engaged with more nuanced and detailed program content. Further, messages and learnings have the best chance of being consolidated through intensive long-term program delivery¹².
- Having sessions facilitated by both male and female facilitators was important. As the program content devised sought to address the gender and social determinants of family violence through a feminist framework, it was particularly important that these messages were reinforced by a female and male facilitators.
- Having a youth worker in the project sessions enabled a clear pathway for students to seek assistance in the event that the project content caused students to disclose victimisation and/or perpetration of family violence. The project also sought to integrate with each

school's student welfare/wellbeing structures, to ensure that students had appropriate support pathways outside of the sessions.

Recommendations

- The program agencies should continue to pursue a youth-focused primary prevention program dealing with family violence. The establishment of partnerships with local high schools, and the buy-in from those schools should be consolidated in 2014, to ensure that the successes of the pilot program are not lost and the concept of violence prevention can be embedded in the curriculum of each school.
- More protracted programs; potentially of up to 5-10 sessions across a 12-24 month period, should be explored.
- Future programs should be confident to share direct stories about family violence to young people to engage them in the serious reality of the issues. Programs should endeavour to utilise a broad range of delivery mediums and activities to ensure maximum engagement with young people.
- Implementation of a professional development/training module for teaching staff should be explored. The objective of this would be to equip teachers to confidently respond to family violence issues among students, and to ensure sustainability of the program within schools across all year levels.
- Exploring expanding the program into community based settings as well as school settings, as was trialled with the Doutta Galla Youth Leadership Group. This has potential to engage a great cross-section of young people from various backgrounds, and may also have application for young adults and families.
- Any future program should build in evaluation of a longitudinal nature, so that practice changes among students and school environments can be measured in a multi-year way¹³. This would provide greater clarity as to the usefulness and success of programs like YAAFV, and provide an opportunity to consolidate and reinforce programs beyond the generally short life of a program.

Funding Model

Victorian Law Foundation

Literature Review - CALD communities

Project sought to clarify:

- What are the prevention of violence against women (PVAW) initiatives happening with culturally and linguistically diverse and broader diversity communities around the western region of Melbourne?
- What is working, how do we know and what are the gaps to begin to work in? To begin to answer these questions for Cohealth, discussions were held with key personnel working across the Western Metropolitan Region in PVAW aligned activities across three weeks in May and June 2014. In addition a literature search was conducted.

Learnings:

There is a lot of Australian and Victorian specific literature on family violence, interventions, programs, and the many dimensions of family violence and its dynamics across a wide range of diversity including cultural, linguistic and faith. The Australian Domestic Violence Clearing House has had its repository and collection functions for over ten years and has special collections to address the unique dynamics within different communities.

What is of particular interest is what isn't available. There is little explicitly on community based PVAW initiatives, let alone PVAW within diverse communities or focussed on particular areas of primary prevention. How to evaluate community based PVAW is a key issue as is questioning how we capture what works. Practice dilemmas include how to evaluate and how to link actions to outcomes.

Research suggests that best practice strategies in PVAW need to:

- Be comprehensive: Embedding the program within the community setting
- Contain quality program logic: Connecting theory and action, addressing structural factors and incorporating a change theory that clearly theorizes rationales for the particular prevention activities
- Demonstrate relevant and socially inclusive practice
- Demonstrate effective delivery through contextualized programming, addressing structural factors and incorporating health and strengths promotion and
- Contain Impact evaluation, for multiple-levels and with sophisticated indicators

Discussions with some staff highlighted the following issues:

- Definitions of violence needed to be encompassing of all women's experiences and broad enough to account for institutional, social and cultural forms of violence and cumulative violence
- Definitions of woman needed to be fluid to encompass anyone who identifies with the female gender
- Definitions of prevention needed to be clearer, with much more clarity on exactly what the indicators of success are for a program/initiative and who the audiences for the initiative and evaluation are.
- Time and resource constraints didn't always allow for comprehensive program evaluation or for consideration of scope, scale and sustainability.
- When evaluated, programs evaluations at times were not designed in a way to be used for speaking to diverse audiences such as program management and staff, participants, community members, public officials and funders
- When evaluated, program evaluations at times were not designed in a way to be used for different purposes such as for programming decisions, day-to-day operations or decisions about continuing participation, decisions about commitment and support, to improve

knowledge about the utility and feasibility of the program approach or to improve future grant making efforts.

- Politics between agencies and advisory groups of programs, effected partnership quality and sustainability

PVAW Initiatives that worked well included those that had;

- developed longer term relationships with community members and groups,
- had some form of evaluation conducted and shared,
- were flexible and evolving and often had dedicated ongoing staff time
- worked in partnerships with other agencies with different skills, including academic institutions and
- had developed some clarity around sustainability strategies – such as securing ongoing funding, becoming self-funding or institutionalising the program into the core business of agencies or systems.

Literature Review - ATSI communities

What are prevention of violence against women (PVAW) initiatives happening across aboriginal and non-aboriginal organisational partnerships in the western region of Melbourne? What is working, how do we know and what are the gaps to begin to work in?

A brief literature search was conducted and local program initiatives explored in early 2015, to begin to answer these questions for Cohealth. In addition, discussions were held with key personnel working across the Western Metropolitan Region in PVAW aligned activities.

Good practice elements for Aboriginal and Torres Strait islander driven programs and groups include having:

- cultural grounding
- community grounding
- engagement of men
- the addressing of colonial experiences and impacts
- use of partnerships and networks
- the incorporation of information dissemination
- training and skills acquisition
- flexibility of project design
- secure long-term funding
- employ strategies for integrated outcomes
- finding capable staff able to deal with the difficulty of the task and address issues of organisational performance and accountability .

Additional structural supports to support prevention include:

- the use of national Indigenous role models;
- strong cultural grounding of projects;
- holistic approaches in communities across genders and generations;
- networking and partnerships;
- information collection and dissemination on family violence; culturally-adapted good practices;
- provision of mentoring services for Indigenous Services and
- cross-cultural training for workers and service providers.

Appendix 4: cohealth funded services in response to family violence

It is well understood that all cohealth services will support people who experience family violence. Following are the services which are specifically funded through different funding bodies with responsibility for the response system.

Counselling

The Western counselling team offers generalist counselling and specialised family violence counselling for women as a funded service with the Integrated Family Violence Women's and Children's Partnership in the west. More than 150 women experiencing family violence are assisted with Counselling support in the west every year. Family Violence counselling in the City of Yarra is funded for 8 counselling clients and one group per year, so all up about 24 funded family violence clients are seen per year.

The following services are provided:

- Specialist counselling intake providing information, referral, risk assessment and safety planning and initial session to clients.
- Specialist family violence counselling for women offered at Footscray, Braybrook and Werribee.
- Werribee outpost located at New Hope Foundation with a focus on CALD women experiencing family violence.
- Family violence secondary consultation (internal and external).
- *Connections* group for women recovering from family violence which runs twice per year
- PARKAS (Parents Accepting Responsibility Kids are Safe) group for carers and children impacted by family violence
- In the City of Yarra one family violence group per year for women which has a focus on Parenting After Violence
- A Casework Counsellor position at the Neighbourhood Justice Centre works alongside a team from other funded agencies. This and has a key role in triaging both applicants and respondents who present for family violence at the Centre.

The Victims Assistance Program (VAP) (funded by DOJ)

The VAP is a case management service provided for victims of crime living or working in the west. Services assist victims of crime recover from and navigate the criminal justice system. As part of this program clients are often assisted with brokerage to assist recover from the crime such as counselling, security and assistance with accommodation.

The services are offered in Footscray at cohealth service sites through colocation arrangements at the Melton and Werribee Police Station. In 2012-2013, three hundred and thirty six women who had experienced family violence were assisted in this program. In 2013 -2014, three hundred and ninety nine women were assisted.

The type of crimes reported to the police included rape, sexual assault, assault, breaches of intervention orders, threats to kill and homicide.

In 2012 – 2013, twenty five related victims of family violence were assisted by the VAP – that is family members bereaved by a family violence homicide. This includes men, women and children. In 2013 -2014, twenty seven related victims of family violence were assisted by the VAP. The overall numbers of CALD victims of crime in the west is high. Overall for the VAP program in 2013 -2014, three hundred and sixty four clients were from CALD backgrounds. The number of ATSI clients for the same period was twenty two.

Youth services

Youth workers attend a young women's health program at River Nile Learning Centre in Term 2, which incorporates some FV material,.

Generalist counselling

Counsellors undertaking work funded through this funding also work with women and others experiencing family violence

Counsellors have been key members of the PVAW (Preventing Violence against Women) Steering Group since it began. The group conducts and oversees training and conducts campaigns to raise awareness about Family Violence. The counsellors have created information resources for the (DG) organisation and provided presentations and workshops to follow up the CRAF (Common Risk Assessment Framework) Training.

Appendix 5: cohealth Royal Commission Working Group Membership

Catherine Joyce, Senior Manager Policy Research and Service Innovation (Chair)

Robin Gregory, Senior Manager Refugee Health, Family Violence and Inner West Programs

Gordon Conochie, Senior Manager Prevention and Population Health Planning

Mercedes Martinez-Cruz, Team Leader Generalist and Family Violence Counselling (West)

Anne Dillon, Case Manager/Social worker Victims Assistance Program

Bichhoa Ha, Manager Community Partnerships & Programs North & Inner North

Merryn Wheeler, Manager Prevention North and Inner North

Jeremy Hearne, A/g Manager Prevention North and Inner North

Mark Noonan, Manager Community Partnerships and Programs (West)

Jessie Lees, Senior Manager, Community Partnerships, Programs and Strategy

Jeremy Miller, Senior Manager, Communications and Media Relations

Stuart Beswick, Manager Policy

Faith Hawthorne, Lawyer, Seniors Law, Justice Connect

Executive Sponsor: Jason Rostant, Director Advocacy and Partnerships