IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF VARUGHESE PRADEEP PHILIP

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Filed on behalf of: State of Victoria
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

I, VARUGHESE PRADEEP PHILIP, Secretary, Department of Health and Human Services, SAY AS FOLLOWS:

1. The Department of Health and Human Services (**Department**) was established on 1 January 2015. The establishment of the Department brought together the former Department of Health, the former Department of Human Services, and Sport and Recreation Victoria. Prior to 1 January 2015, I was the Secretary of the Department of Health. Before my appointment as Secretary, I held the role of Deputy Secretary, Policy and Cabinet Group at the Department of Premier and Cabinet. Prior to this position, I held senior roles in the Queensland Public Service and the Prime Minister's Office.

2. I hold a Bachelor of Economics and a Doctor of Philosophy in Economics, both from the University of Queensland.

3. In my current role as the Secretary of the Department, I have functions and powers under various pieces of legislation, including the *Public Administration Act 2004* (Vic.), the *Children, Youth and Families Act 2005* (Vic.) (**CYF Act**), the *Health Services Act 1988* (Vic.), and the *Public Health and Wellbeing Act 2008* (Vic.). I am also responsible for advising relevant Ministers on the operation of legislation within their portfolios. I am responsible for the general conduct and the effective, efficient and economical management of the functions and activities of the Department.

4. I oversee the administration and provision of health, disability, housing and homelessness, mental health, child protection, out of home care, youth justice, drug and alcohol, family violence, youth, medical research, and sports and recreation services in Victoria.

SCOPE OF STATEMENT

5. I have received a notice from the Royal Commission into Family Violence pursuant to s 17(1)(d) of the *Inquiries Act 2014* (Vic.) requiring me to attend to give evidence at the Royal Commission and to provide a witness statement.

6. In this statement, I respond to a request by the Royal Commission for information regarding Module 19 (Integrating Services from the victim's perspective). I understand the Royal Commission is interested in recent efforts and initiatives relating to integration of services including 'Services Connect' and other initiatives.

7. Integration of services can mean different things, can aim to accomplish different goals, and can be accomplished at different levels, using different means.

8. In order to understand the scope for, and desirability of, integration of health and human services to address family violence, it is necessary to consider:

    8.1 the existing service system and, in particular, access to and the service response of that system;

    8.2 known issues in respect of the existing service system; and

    8.3 areas of ongoing and potential work in respect of addressing these issues, including examples of existing work to improve integration of services to address family violence.

9. This statement is structured to address these three points.

10. I am aware that the Royal Commission has heard, or will hear, evidence from other witnesses from the Department in relation to topics that also have relevance to Module 19, as they relate to integrated service provision. I therefore do not provide, in this statement, detailed evidence about matters to which other Departmental witnesses have referred in their evidence to the Royal Commission. In particular:

    10.1 Ms Beth Allen has given evidence in relation to Module 3 (Children: Intervention and Response);

    10.2 Ms Judith Abbott has given evidence in relation to Module 5 (Alcohol and Drugs);

10.3 Mr Arthur Rogers has given evidence in relation to Module 7 (Housing and Homelessness);

10.4 Dr Mark Oakley Browne has given evidence in relation to Module 8 (Mental Health);

10.5 Mr Scott Widmer has given evidence in relation to Module 9 (Risk Assessment and Risk Management) and will also give evidence in relation to Module 20 (Information Sharing);

10.6 Ms Leeanne Miller has given evidence in relation to Module 15 (Intersection with Family Law and Child Protection Laws);

10.7 Mr Rocco Fonzi will give evidence in relation to Module 17 (Diversity of Experience, Community Attitudes and Structural Impediments); and

10.8 Ms Frances Diver will give evidence in relation to Module 18 (The Role of the Health System).

11. This statement should be read together with the above statements and other information filed by the Department with the Royal Commission.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

12. As I have stated above, the Department was established on 1 January 2015, bringing together the functions of health, human services and sports and recreation.

13. The Department's vision is to optimise the wellbeing of all Victorians and deliver policies, programs and services that improve social and economic outcomes across the population.

14. The health and human services funded by the Department provide a combination of universal services (such as basic hospital care for all) and targeted services that generally assist members of the community who are vulnerable or experiencing disadvantage.

15. A range of these services also play an important role in building cohesive and supportive communities that offer opportunities for participation. The Department also helps to maximise the health, social and economic benefits provided to all Victorians by the sport and recreation sector.

16. The combined efforts of health and human services working together can drive positive long-term change for individuals and families, particularly those with multiple and complex needs that span issues such as family violence, mental health, homelessness, drug and alcohol misuse, chronic health conditions and disability.

17. The Department supports the Ministerial portfolios of:

17.1 Health;

17.2 Ambulance Services;

17.3 Families and Children;

17.4 Youth Affairs;

17.5 Housing, Disability and Ageing;

17.6 Mental Health; and

17.7 Sport.

18. The Department's 2015-16 budget totals $20.05 billion, representing a 6.2 per cent increase in overall funding from 2014-15 (Victorian Budget Paper 3: 2015-16, page 222). The Department is also responsible for statewide planning for, and management of, the portfolio asset base of around $40 billion, which includes social housing assets which are the responsibility of the Director of Housing.

19. As shown in the table below, the Department funds and delivers services through 14 key budget output groups.

Department of Health and Human Services output summary

Output Group	2015-16 Budget ($) million
Acute health services	10,967.1
Ambulance services	736.6
Mental health	1,309.0
Ageing, aged and home care	1,288.6

Primary, community and dental health	452.3
Small rural services	578.7
Public health	339.3
Drug services	181.3
Disability services	1,780.0
Child protection and family services	990.8
Youth service and youth justice	155.7
Concessions to pensioners and beneficiaries	711.2
Housing assistance[#]	420.8
Empowering individuals and communities	137.5

Source: 2015-16 Victorian Budget Paper 3, page 222

[#] In addition to the output funding in the table, there are additional sources of revenue for housing assistance. These additional sources of revenue include rents and charges paid by tenants.

20. The Department is responsible for system planning, policy, funding, regulation and strategic priorities. The Department is also responsible for directly delivering some services.

21. The Department directly employs around 13,000 staff across Victoria.

FAMILY VIOLENCE: THE HEALTH AND HUMAN SERVICE SYSTEM RESPONSE

22. Victims and perpetrators of family violence might require a range of health and human services to meet their needs at two levels. The first is to keep them safe and assess and manage risks to their safety. The second is to support recovery from family violence and to help in the rehabilitation of perpetrators.

23. Consideration of the system and service response to family violence is complicated by three key issues:

    23.1 victims and perpetrators of family violence may often come in contact with health and human services for reasons other than their involvement in family violence;

    23.2 the support needs of victims will often include both services to assess and manage safety, as well as services that promote recovery from family violence that can address the short, medium and longer term impact of

violence and trauma and co-existing issues of disadvantage or vulnerability; for perpetrators, health and human services can help to prevent potential family violence and rehabilitate them; and

23.3 managing safety requires health and human services to coordinate and operate in cohesion with justice responses, such as police, corrections and courts.

24. As such, the service response in respect of family violence may involve:

24.1 multiple services being delivered;

24.2 services being delivered to persons other than the person who first comes in contact with the service system; and

24.3 services that cannot always narrowly be identified as 'family violence' services.

25. Figure 1 (under paragraph 26 below) provides a stylised representation of pathways through government delivered or funded services relevant to family violence. The figure acknowledges Commonwealth Government services. The Commonwealth Government funds a wide range of relevant services, including primary care provided by general practitioners, as well as income support and employment programs, which might assist people in the context of family violence.

26. Figure 1:

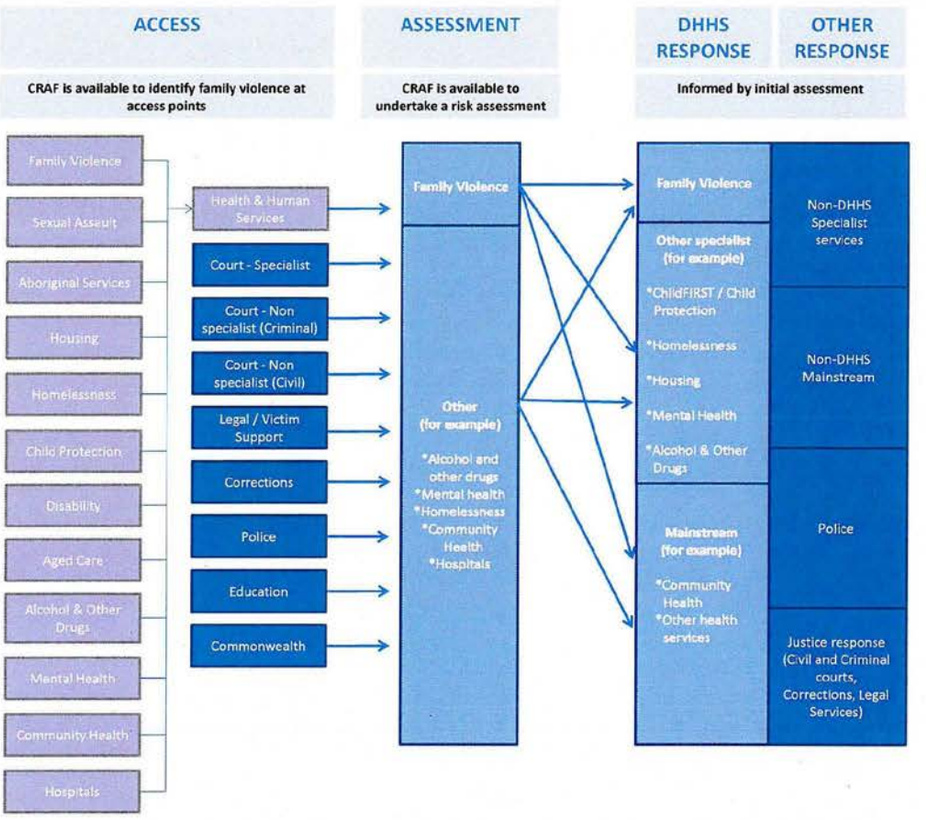
26.1 demonstrates how someone might **access** services;

26.2 details some of the **assessment** that might occur to determine the needs of individuals and families; and

26.3 refers to the potential **responses** that might address these needs.

Access, assessment and responses, as they relate to family violence, are discussed further in the following section of this statement.

Figure 1: Stylised representation of pathways through government delivered or funded services for people experiencing or perpetrating family violence



Access

27. From an individual's perspective, access involves contact with a service. Figure 1 demonstrates that a person experiencing family violence might access a number of government delivered or funded services, including a health service or a human service. A person might make contact with a service directly or, as depicted in Figure 1, a government agency, such as the police, might be the first point of contact for a victim or perpetrator of family violence. This person might then be referred by police to a relevant health or human service.

28. Figure 1 is consistent with observations in the Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3 (the 'Common Risk Assessment Framework' or the **CRAF**). At page 7 of the CRAF, it is noted that victims and perpetrators of family violence seek services in a range of ways. In summary, entry into the system can be through:

28.1 a specialist family violence service;

28.2 a justice or statutory body, such as police, courts, correctional services or Child Protection;

28.3 a universal or mainstream service, such as a hospital; or

28.4 other targeted services, such as a mental health service or Child FIRST, which is the intake arm for integrated family services.

29. Figure 1 and CRAF recognise that there are many ways in which victims and perpetrators of family violence access services. The access point is the first point at which connections between services need to be established at a systematic and local level.

Assessment

30. As demonstrated by Figure 1, there are multiple ways in which a person who accesses services may have their needs assessed. The assessment mechanism will depend, in part, on which access point the individual comes into contact with.

31. Assessment is based on information about the person and their circumstances. Information is gathered to understand the nature and extent of a person's need for a service. Initial assessments are often used to establish whether a person's circumstances meet eligibility requirements for a service, while further assessments can be undertaken to establish more detailed needs or their changing needs over time.

32. Assessment in the context of family violence might occur at two levels: a risk assessment to establish the response required in relation to safety issues and an assessment of other health and wellbeing needs to support recovery.

33. As demonstrated by Figure 1, family violence risk assessment first relies on family violence being identified by the professional who comes in contact with the person

at the access point. A common identification and assessment framework has been established in Victoria through the CRAF. The witness statement of Mr Scott Widmer, dealing with risk assessment and risk management (Module 9), describes the way in which family violence risk is identified, assessed and managed. Mr Widmer's statement and evidence included detailed information about the CRAF and its use. Family violence services tend to be the main health and human services that use the CRAF consistently to assess and manage risks of family violence.

34. In relation to assessing broader health and wellbeing issues and determining what a person needs, I refer to the statements and other evidence of other Departmental witnesses identified in paragraph 10 above and, in particular, the evidence of Ms Beth Allen, Ms Judith Abbott, Mr Arthur Rogers, Ms Frances Diver, Mr Rocco Fonzi and Dr Mark Oakley Browne.

35. The statements of my colleagues highlight that services have a suite of assessment tools that they use. They also describe the main objectives of assessment in each of these services and demonstrate that these assessments, to a varying degree, currently incorporate screening and risk assessment for family violence.

36. The myriad of assessments is another point at which services need to connect, as far as possible, through the use of common language and purpose.

Responses available for victims and perpetrators

37. As represented in Figure 1 and described in the statement of Mr Scott Widmer dealing with information sharing (Module 20), a person experiencing or perpetrating family violence may receive a wide range of government funded or delivered services.

38. The services provided may include numerous services provided or funded by the Department. Services funded or provided by the Department that might be provided to victims or perpetrators of family violence include:

    38.1 specific family violence services;

    38.2 Child Protection or Child FIRST and integrated family services;

    38.3 mental health services;

38.4 alcohol and drug treatment services;

38.5 housing and homelessness services;

38.6 healthcare services through hospitals, community health or a range of other health services;

38.7 sexual assault support services; and

38.8 disability services.

39. In addition to receiving health and human services, a victim or perpetrator of family violence may interact with police, the courts and legal services. This means that providers of health and human services might also interact with these agencies.

40. A brief description of the way in which each of these service responses operate in the context of family violence is outlined below.

Specific family violence services

41. In 2014-15, the Department funded 122 community service organisations an estimated $64.7 million to deliver discrete family violence services through two output groups – housing assistance and child protection and family services. A full list of these services is at **Attachment PP-1**. In summary, these include services to:

41.1 **respond to the immediate accommodation and housing needs** of women and children, including:

(a) women's refuges;

(b) the safe at home program;

(c) crisis accommodation and transport; and

(d) private rental brokerage services;

41.2 **support the recovery of victims from the consequences of family violence, and the rehabilitation of perpetrators,** including:

(a) the statewide crisis response – Safe Steps;

(b) case management support and outreach;

(c) intensive case management for women with complex needs, including women with a disability;

(d) counselling and support for women and children;

(e) men's referral services and intake services and behaviour change programs; and

(f) men's case management and intensive case management services;

41.3 **respond to the needs of Aboriginal families** who experience violence, including:

(a) three Aboriginal specific refuges in rural, regional and metropolitan areas;

(b) intensive case management and legal assistance for Aboriginal women and children;

(c) healing and time out services; and

(d) specific men's case management services;

41.4 **intervene early,** including through:

(a) the Families at Home program, which is identifying family violence early and seeking to prevent homelessness in the northern suburbs of Melbourne; and

(b) the Adolescent Family Violence program for adolescents who use violence against family members; and

41.5 **assess and manage risk** through the CRAF, which trains and guides a wide range of professionals to identify family violence, assess risk and manage safety.

42. In addition, the Department funds the following family violence services or family violence service infrastructure through other Departmental output groups.

43. Through the disability services output group, the Department provided $290,000 in 2014-15 for a disability crisis initiative that supports women and children with a disability when they are in crisis due to family violence to immediately access disability supports and family violence services. Further information on this initiative is available in the statement of Mr Rocco Fonzi for Module 17.

44. Through the ageing, aged and home care and senior programs and participation output groups, three programs were funded $1.54 million in 2014-15 to address elder abuse. Funded activities included:

    44.1 elder abuse prevention activities, such as an online training course;

    44.2 elder abuse community awareness raising initiatives across culturally and linguistically diverse communities; and

    44.3 elder abuse crisis and post-crisis response initiatives, such as funding for Senior Rights.

45. Through the acute health services output group, the *Strengthening Hospital Responses to Family Violence* initiative was funded $500,000 over two years in 2014-15 and aims to develop and trial an early intervention and response approach to family violence. This includes enhancing links between hospitals and specialist family violence services to improve services to victims. Further information on this initiative forms part of Ms Frances Diver's statement for Module 18.

46. Through the primary, community and dental health output group, funding of $87,000 was provided in 2014-15 to the Inner North West Primary Care Partnership to undertake a 12-month pilot project to assist member agencies to develop a more streamlined, coordinated and integrated response to women and children experiencing family violence. Further information on this initiative also forms part of Ms Diver's statement for Module 18 (at paragraph 152).

47. The Department funds three statewide and eight regional women's health services as part of the Victorian Women's Health Program. This program aims to improve the health and wellbeing of Victorian women, with an emphasis on those most vulnerable. The Victorian Women's Health Program operates from a social model of health and acknowledges gender as a key determinant of health. All services undertake program activities aimed at preventing violence against women, including addressing gender inequity.

48. The Department is also commencing two new services to respond to family violence to address the multiple needs of family violence victims. These new services will encourage multi-agency responses and support a broader range of outcomes to be achieved for victims of family violence. These services are the Strengthening Risk Management program (Risk Assessment and Management Panels) and flexible packages of support for family violence victims.

49. The Strengthening Risk Management program (Risk Assessment and Management Panels) is being implemented in all 17 Departmental areas across Victoria to improve safety and outcomes for women and children at imminent and serious risk from family violence. This occurs through multiple agencies working together to assess and manage serious and imminent risks to women and children. A large part of work undertaken by the Risk Assessment and Management Panels involves health and human services funded or directly delivered by the Department, including family violence services, Child Protection, Child FIRST and integrated family services, and housing, mental health and drug and alcohol services. These services work together to assess and manage high risk. Mr Scott Widmer has provided information on the Strengthening Risk Management program in his statement for Module 9 and in his statement for Module 20.

50. The Department also provides flexible packages of support to obtain outcomes for women and children by providing flexible funding to resolve crisis situations. Services are to be delivered in line with a family's own goals in life. The outcomes sought for women and children from these packages include:

50.1 safety and freedom from violence;

50.2 safe and stable housing;

50.3 financial stability;

50.4 family health and wellbeing;

50.5 economic, social and community participation; and

50.6 independence.

Other health and human services that support victims or perpetrators of family violence

51. As noted above, and as demonstrated by Figure 1, in addition to family violence specific services, the Department funds or delivers services that support recovery from family violence. These services can support people for a short time and also when they are in crisis, over the medium term or for a longer period of time. Arrangements will depend on the needs of the person and the service they receive. Some people may have a single encounter with a service and have their support needs simply and quickly met. People with more complex needs may require multiple interactions or services in order for their needs to be met.

52. More detailed information about these services is contained in the evidence of Ms Beth Allen, Ms Judith Abbott, Mr Arthur Rogers, Ms Frances Diver, Mr Rocco Fonzi and Dr Mark Oakley Browne.

53. Health and human services include child, adult and whole-family focussed services that have the express aims of keeping people or children safe; supporting recovery from a crisis; or improving health and wellbeing. The main health and human services operating in the context of family violence, and the ways in which these services might interact, are discussed below.

54. Children's services, such as Child Protection and Child FIRST and integrated family services, play a key role in responding to family violence and keeping children safe. According to Victoria Police statistics, children were present in 34 per cent of all police attendances for family violence in 2013-14. As depicted in Figure 1, referrals or reports to Child Protection or Child FIRST might be made through other agencies, such as police. Referrals and interactions occur between these child-focussed services and adult-focussed health or human services, such as specific family violence services, mental health services or drug and alcohol treatment services.

55. Mental health services might support people who experience, witness or perpetrate family violence, as many people using mental health services have experiences of trauma (including family violence) at greater rates than the rest of the population (see, for example, the statement of Dr Mark Oakley Browne). In addition to mental health services funded by the Department, there are also specific family violence counselling services that deal with the psycho-social needs of women and children who experience family violence.

56. Alcohol and drug treatment services support people who are experiencing problems with alcohol and drugs, including victims and perpetrators of family violence. Treating these issues can help to address violent behaviour or support recovery from family violence. These services might interact with other health and human services, such as children's services and family violence services.

57. Housing and homelessness services are available to assist Victorians who are homeless, at risk of homelessness or in need of affordable and stable long-term housing. This includes victims and perpetrators of family violence. Supporting people who experience or perpetrate family violence to keep a home can require housing and homelessness services to connect with other health and human services.

58. Health services, including community health services and hospitals, can be an initial point of contact for people who are experiencing family violence. A community health service will typically design a response that draws together the range of services and supports that a person requires. Addressing a family violence victim's health-related needs is important in terms of recovery for that individual. A number of community health services also provide family violence services or other health and human services. In this way, these services can address needs beyond those that might be strictly health-related.

59. Sexual assault support services are funded to provide counselling support for victim survivors of sexual assault. Victims who experience family violence may also experience sexual assault, and family violence and sexual assault services work closely together to support victim survivors as required. Some sexual assault support service providers also deliver family violence services.

60. Disability services include individualised supports that are flexible and directed by the person. Some people with a disability who currently receive disability services may also be experiencing family violence.

61. These services interact together when the identified needs of clients require multiple services. In the context of family violence, service coordination through to integration occurs in a number of ways and can involve:

    61.1 the use of common assessment and screening tools, such as the CRAF;

61.2 the establishment of referral pathways and protocols, some of which are outlined in the statement of Mr Scott Widmer for Module 20;

61.3 partnerships and collaboration such as the Risk Assessment and Management Panels;

61.4 the co-location of services; and

61.5 training that builds the capacity of different service sectors to interact with each other and understand each other's mission and functions.

62. Further, some health and human services funded community service organisations might deliver one or more of the kinds of services outlined above. A community health service or another community service organisation might receive funding for a range of activities that span health, human services, justice and other portfolios.

63. For example, some community health services are funded to provide family violence services, drug treatment, mental health services and a range of other State and Commonwealth funded programs. The State has also worked to foster service coordination between State and Commonwealth funded services. This includes a particular focus on the primary care interface through Primary Care Partnerships and their work with Primary Health Networks (formerly Medicare Locals) to foster population health, early intervention and service integration.

64. This allows these services to provide integrated services to individual clients, as they can meet a range of their needs within the same service. For example, an agency that is a Child FIRST and integrated family service provider might also deliver family violence and homelessness services. In this way, victims or perpetrators who access these services may be able to have multiple needs met by the one service.

KNOWN CHALLENGES

65. As I have observed above, others in the Department have given evidence to the Royal Commission about various aspects of the service systems that support victims of family violence or work with perpetrators. , Bearing that evidence in mind, I consider that there are five key challenges in delivering services to family violence victims and perpetrators.

66. These challenges create disconnections in access, assessment and response arrangements that I have detailed in the previous section of my statement. These issues may impact on whether victims of family violence receive a quality service at the right time. The major challenges that impact on the ability to obtain good outcomes for people are as follows:

66.1 Service demand and supply imbalances can prevent the delivery of the right service at the right time. Demand pressures might impact on the length of a service and they can drive responses to be 'crisis' focussed because they reduce the ability of services to intervene early in the cycle of family violence.

66.2 The myriad of health and human service access arrangements make it difficult to support consistent identification, assessment and management of family violence. The current arrangements require additional coordination efforts, particularly between universal and targeted settings.

66.3 A disconnect can occur between adult and child-focussed services that can reduce service quality and appropriate risk assessment and management.

66.4 There is a lack of systemic funding arrangements focussed on outcomes generated for victims and perpetrators across service streams. Funding arrangements could do more to empower people to make their own choices about their lives.

66.5 Further work is required to put in place information and accountability regimes that promote and encourage service improvement through feedback loops.

67. I summarise below how these challenges impact upon delivery of services across health and human services in the context of family violence.

Demand for services exceeds supply and is continuing to grow

68. Service demand and supply imbalances impact on the ability to deliver the right service at the right time for both victims and perpetrators. They also reduce the ability to intervene early in the cycle of family violence. Budgets typically provide for capped funding which, by definition, means that demand will be regulated through a 'rationing' model.

69. Across the family violence services outlined at **Attachment PP-1** and paragraphs 41 to 49 above, as well as the health and human services I have described at paragraphs 52 to 60 above, I am aware of some specific supply and demand challenges. These challenges mean people might not get the supports they need, or they may not get the supports at the right time, or they may have to wait for them. A lack of available services, for example supports to remain safely at home or at an alternative house, or indeed the provision of a house that does not meet the requirements of family composition, might impact on how victims respond to family violence and influence the ability to rehabilitate perpetrators.

70. Targets for family violence service support programs have not kept pace with growing police reports of family violence. Reports of family violence to the police increased by 83 per cent between 2009-10 and 2013-14 and totalled 65,393 incidents in 2013-14. During the same period, Departmental funded targets for dedicated support for family violence victims through outreach or case management, increased by around 30 per cent to 5,690 targets in 2013-14, compared with 4,285 targets in 2009-10.

71. In 2013-14, 37,820 episodes of support were provided by outreach services according to the Australian Institute of Health and Welfare National Homelessness Data Collection Agency reports, 2013-14. These services included access and assessment services, including risk assessments, as well as case management services. Outreach services are not funded to provide a specific intake service and are funded to deliver case management.

72. I am aware that increasing referrals from police mean outreach services spend more time on access and assessment. This limits the number of women and children who can receive 'case managed' support. Case management support coordinates and integrates service delivery for victims and helps them navigate and receive other services that might be essential for them to recover from family violence.

73. More broadly, demand for health and human services is expected to increase over time. The anticipated growth in demand is underpinned by demographic changes, particularly the ageing of the population. Demand is also influenced by the broader economic conditions. The 2014 Household, Income and Labour Dynamics in Australia (HILDA) survey suggests that, despite a growth in mean Australian household incomes since 2001, poverty rates are not reducing.

74. The location of demand is also likely to intensify in rural and regional areas, reflecting higher concentrations of people experiencing disadvantage. The 'Dropping off the Edge 2015' report revealed that, of Victoria's 40 most disadvantaged postcodes, 70 per cent (28 postcodes) are in regional or rural areas. These areas tend to have poor results on indicators of disadvantage, such as unemployment, long-term unemployment, rent assistance, juvenile corrections and criminal convictions.

75. Specifically, there are known demand pressures on some of the services that are outlined at paragraphs 52 to 60 above. For example the witness statement of Mr Arthur Rogers describes pressures on housing and homelessness services at paragraphs 171 to 188. The witness statement of Ms Beth Allen describes demand increases in Child FIRST and integrated family services at paragraphs 33 to 39. Mr Rocco Fonzi's statement for Module 17 discusses increasing demand for the Disability Crisis Initiative at paragraph 36.

76. These pressures might reduce the ability for health and human services to provide comprehensive and timely responses to victims and perpetrators. Demand exceeding supply can be a reason why disconnection in the service system might occur. This is because agencies might seek to ration services or not 'on-refer' to services that they are aware are not available because of excess demand.

77. Further, system capacity issues can impact on services working early to prevent a crisis from occurring in the first place. For example, in a busy emergency department, where there are pressures on hospital beds, the ability of health care staff to identify and make a risk assessment around family violence might be compromised from time to time. While health services are obliged to look at a person's entire set of needs, demand pressures can increase wait times and may impact on the quality of services.

78. In addition to demand pressures that may result in people who experience family violence potentially missing out on the right service, family violence, as an issue, is also a significant driver of demand across some health and human services. For example:

    78.1 Family violence is a driver of demand for services provided by Child Protection and Child FIRST and integrated family services. In 2014-15 91,348 reports were made to child protection, representing an increase of

approximately 11 per cent since 2013-14 when 82,101 reports were made. Family violence is a prevalent factor in this growth and in 2013-14, 14,037 reports to child protection were from Victoria Police L17 referrals. In 2013-14, family violence was identified as an issue for around 37 per cent of families provided with support by Child FIRST and integrated family services.

78.2 Family violence was cited as a factor among 35 per cent of clients who sought homelessness services in 2013-14, according to the Australian Institute of Health and Welfare's Specialist Homelessness Data Collection 2013-14.

79. Family violence as a driver of health and human services demand sets up a further challenge as to how this issue is addressed.

Multiple and inconsistent access and assessment arrangements

80. As I have observed above, victims and perpetrators of family violence may often come in contact with health and human services for reasons other than their involvement in family violence. Even when a family violence victim comes to the attention of health and human services due solely to family violence, there are multiple ways they may enter these services.

81. The multiplicity of access and assessment arrangements can impact on the following two matters:

81.1 the identification of and subsequent risk assessment for family violence; and

81.2 the ability of a person to receive the right service at the right time.

82. These issues can be compounded by limits in the availability of services, as I have observed at paragraphs 68 to 79 above.

83. Services need to be able to identify family violence using a common language and tool and, in this regard, the CRAF provides a strong foundation. However, health and human services that identify family violence might also be focussing on triaging a patient who is in a critical condition, or planning with someone who has a disability, or assessing someone's alcohol and drug treatment needs. The need for services to deal with their core assessment and service function is paramount in

meeting all the needs of a person and, in particular, responding to the core reason as to why the person has contacted the service.

84. The challenge across health and human services is to improve the identification and assessment of family violence. Every health and human service has its own core service objective. The identification and assessment of family violence must complement assessments for each of these core objectives. For example, if assessing a person's need for disability support services, assessment must be focussed on the need for disability supports, as well as efficiently identifying and screening for family violence. Assessments must also not be so onerous as to render them unworkable in what can often be fast-paced and demand-pressured working environments.

85. The bringing together of risk information can be hampered by the multiple access and services arrangements that are involved in various assessments. This might mean critical information to inform a risk assessment might not be shared, due to a range of factors that are outlined in Mr Widmer's statement for Module 20. This can impact on the safety of victims of family violence.

There is a disconnect between adult and child focussed services

86. A known challenge within the current arrangements is disconnection that can occur between adult and child-focussed services. This can reduce service quality to an entire family unit and compromise appropriate risk assessment and risk management.

87. More than half of the women who experience partner violence in their life time will be caring for children during the time they are in the relationship (Australian Bureau of Statistics, Australian Personal Safety Survey 2006). The co-existence of family violence with other parental concerns such as homelessness, substance abuse and mental health problems means that adult service providers should be able to 'think child' and appropriately identify and respond to the needs of children.

88. Service coordination and integration between adult and child services remains variable. Routine and systematic coordination does not occur between child focussed services, such as Child Protection, and adult-focussed services such as family violence and homelessness services. For example, adult services might be reluctant to refer or make reports to children's services for fear of losing trust from the adult they are servicing. Further, there is scope to focus on improving

outcomes for children who are exposed to family violence and who are also serviced by adult services.

Funding arrangements that focus on outcomes and choice

89. Another challenge that I have identified with current arrangements is the lack of funding arrangements that focus on outcomes for victims and perpetrators. There are also few funding arrangements that empower people to make choices about their own lives or the services they receive.

90. Government funding for services is provided through a number of defined programs that typically focus on the delivery of units of service (or 'outputs'). This approach means that funding must be applied by a service for a defined activity. If a person's support needs do not fit within a defined activity, the service might not be funded to deliver a program to the person. This can limit the flexibility of front-line workers to tailor interventions and responses to the specific needs of a person or family.

91. The activity-focused funding approach is intended to provide a strong mechanism that ensures funding provided to services is used for a specific purpose. However, this approach also limits flexibility for service providers in the way they can respond to each individual person's needs. Even when providers are funded for multiple services, they are often required to acquit and account for their service delivery based on particular programs and outputs. This approach may not reflect, or be connected to, the outcomes sought to be achieved for the person receiving the service.

92. For example, a service provider who operates family violence services, Child FIRST and integrated family services and a drug and alcohol treatment program, would provide services according to the activities they receive funding for. This might mean a person may receive multiple services from the one provider through different workers and funding programs and not a single point of contact within the one agency. This can make services difficult to navigate for people, including in the context of family violence.

Need for accountability regimes promoting improvement through feedback

93. As services are funded to deliver specific outputs, rather than outcomes, information collected for the purposes of monitoring service delivery performance

does not include a systemic measurement of the outcomes achieved by people who are accessing services.

94. In the case of family violence, there is limited systematic information that is available about the effects of service provision on client safety. There is also limited evidence on how well the available service responses meet people's support needs.

95. There is currently no comprehensive or systemic approach to collecting information on the needs, services received or outcomes of victims of family violence and their families, or of perpetrators in addressing offending behaviour.

96. Without this information it is difficult to confidently and systematically promote and encourage service improvement. Further information on some of the barriers to obtaining such data is outlined in Mr Scott Widmer's statement for Module 20.

97. Further, there are limited feedback loops that allow policy and program makers within the Department to accurately and confidently assess whether services are working from the perspective of the person receiving them. This is particularly difficult in relation to feedback from services that are indirectly delivered through community service organisations. While evaluation and reviews do occur, as do surveys of clients, there is not a regular source of this information, and often complaints are used as a proxy for feedback.

CURRENT AND FUTURE WORK: IMPROVING SERVICE INTEGRATION TO RESPOND TO FAMILY VIOLENCE

Integration of services in respect of family violence

98. As I have observed above, the response of the health and human service systems to family violence is complicated by:

98.1 the often complex and time-sensitive needs of victims and perpetrators of family violence;

98.2 the breadth and multitude of service streams necessary to meet those needs, which often involve delivery of services by multiple providers;

98.3 the multiple entry points and varied ways in which victims and perpetrators come in contact with the health and human service systems; and

98.4 variable levels of consistency, capability and infrastructure in respect of family violence-related matters across these multiple entry points and service providers.

99. The challenges of complexity, urgency and variability can manifest as fragmentation and a narrowing of focus in respect of service response. The service response can focus on urgent but potentially disconnected 'episodes' of service delivery. As a result, service delivery can be less effective in meeting the actual needs of victims and perpetrators of family violence.

100. Integration of services in respect of family violence essentially involves overcoming these complexities. It also necessitates a more appropriate matching of supply with demand for services through:

100.1 a more holistic up-front assessment of the needs of individuals and families (whether in the short, medium or longer term) when they come in contact with the service system; and

100.2 more robust mechanisms to place people on service pathways through the range of services and providers necessary to meet their holistically defined needs in an effective fashion.

101. In this way, the actual needs of individuals and families can become the organising principle around which pathways through services and providers are organised and integrated. The ultimate goal when delivering services in response to family violence is prompt recovery for victims, and the rehabilitation of perpetrators, of family violence wherever possible.

102. This is the kind of integration we are working towards in the health and human service systems. This kind of integration requires action to be taken across a range of aspects of the service systems to address some of the known challenges set out above.

103. Our current efforts to integrate services to improve the lives of people include:

103.1 introducing new services and arrangements that focus on multi-agency exchanges and co-location, as well as responding to key demand pressures;

103.2 establishing clearer and more consistent networks of services to achieve service coordination; and

103.3 improving the consistency of the identification and assessment of family violence.

In the paragraphs below I set out some of the Department's current and planned work and the directions being pursued (which we are refining in line with emerging evidence) against each of the key challenges identified above.

Addressing demand and supply challenges

104. As I have observed above, capped budgeting and rationing of services in a context of high demand can lead to timeliness and quality complications in respect of service delivery. This reduces the effectiveness of services in meeting the actual needs of victims and perpetrators of family violence.

105. In response to escalating demand, health and human services funding is budgeted to increase by 6.2 per cent between 2014-15 and 2015-16. As part of this overall increase, investment in the specific family violence services that are outlined at paragraph 41 above is expected to increase by around 28 per cent between 2014-15 and 2015-16, to address key demand pressures.

106. This new investment means that more people who experience family violence will have more access to services that support their safety and wellbeing. For example:

106.1 An additional $2 million is being provided to outreach and case management services in 2015-16 to respond to the increasing police referrals made to these services. This will provide over 800 more outreach and case management supports that help to integrate services for victims of family violence.

106.2 An additional $600,000 will be specifically allocated for case management services for Aboriginal women and children.

106.3 An additional $3.5 million is being provided over two years from 2014-15 for additional crisis accommodation and transport for victims of family violence. Funding will also be used to secure more long-term housing opportunities for women and children in the private rental market to prevent

the disruption that homelessness causes in the lives of women and children.

106.4 An additional $3.5 million is being provided over two years from 2014-15 for counselling services for women and children to help deal with the trauma of family violence.

106.5 An additional $1 million in 2015-16 will support additional services for male perpetrators to improve their accountability and help to change their behaviour.

107. In addition to these initiatives, new family violence services have been specifically designed to promote collaboration and integration around the needs of people who require services. These innovations are outlined at paragraphs 48 to 50 above and include Risk Assessment and Management Panels and flexible packages of supports for victims.

108. Other increases in funding for health and human services include additional funding for Child FIRST and integrated family services and Child Protection, as well as additional funding for alcohol and drug treatment services and health services. This will provide additional capacity to respond to victims and perpetrators of family violence.

Potential future directions

109. Going forward, there are opportunities across a range of settings to reduce family violence and prevent it from occurring in the first place. This would prevent dislocation in the lives of victims of family violence. I consider prevention as an important and, ultimately, long-term approach to managing demand. Locational rates of family violence and the demographics of communities are important determinants of prevention approaches.

110. In the meantime, there is potential to consider factors in society that lead to instances of family violence. These factors can be used to guide the Department in building a comprehensive early intervention agenda. To date, dealing with the immediacy of demand, at the crisis end, has dominated the work of organisations involved in this field. The Department has commenced a review into early intervention, as part of a reform project to shape the support service system for vulnerable children and families. This review provides an opportunity to consider the

points at which the systems I describe above can connect better to prevent children and their families falling into crisis situations, particularly as a result of family violence.

More consistent access and assessment arrangements to improve services for people

111. As I have observed above, a key challenge is to improve the early identification and assessment of family violence, across universal and targeted health and human service settings. This is so people can have their needs met as quickly and effectively as possible without having to move between multiple access points before action is taken to improve their wellbeing. This requires identification and screening for family violence to be – as much as possible – embedded in each service provider's assessment and screening tools, supported by necessary capability development of provider workforces.

112. The *Strengthening Hospital Responses to Family Violence* initiative, which is described in Ms Frances Diver's statement for Module 18, offers an opportunity to improve the identification and assessment of family violence in hospital settings. The project examines key systems and tools that can be transferred to other hospital settings and also focuses on the capacity building of staff and integrating hospital services and family violence services through strengthened relationships.

113. The Department is also working on improving the identification of elder abuse and the response to it in universal settings. The Initiatives outlined at paragraph 44 above, and further described in the statement of Ms Frances Diver, promote the effective identification of this type of abuse.

114. Improving access arrangements for people seeking housing is a key priority for the Department, as well as linking people seeking housing with the other supports they require. As far as possible, these access arrangements ought to make it easy for people to get the services they need. The statement of Mr Arthur Rogers refers to this future direction at paragraphs 224 and 225.

Potential future directions

115. Underpinning the discrete improvements in access and assessment arrangements that I have listed above is the planned review of the CRAF that is referred to in the statement of Mr Scott Widmer for Module 9 on risk assessment and risk management. This review provides the opportunity to strengthen the identification

of family violence in universal settings and the subsequent interaction with and between targeted services, like family violence services.

116. A review of the CRAF should also strengthen the identification and assessment of all forms of family violence, including adolescent family violence and elder abuse. It should promote assessment that is tailored to the needs of diverse communities.

117. There are opportunities to consider multi-agency or co-located models, such as those deployed in other jurisdictions. Mr Scott Widmer's statement for Module 20 on information sharing outlines, at paragraphs 74 to 76, one model to integrate at the access and assessment points. Models could be explored to embed some health and human services with justice responses to improve the exchange of information to manage safety risks and foster service integration for victims. Through better risk assessment and risk management, these models represent an additional approach to the prevention of further harm.

118. Further, within health and human services, there are opportunities to consider how information might be shared to improve risk management for families experiencing violence. For example, information about a perpetrator's mental health (if it relates to their violence) might be relevant to a family violence risk assessment. Current assessment processes assess the victim and perpetrator separately. Information gathered in these assessments is not necessarily routinely connected. Future work could explore more robust sharing in this context.

Increasing connections between adult and child focussed services

119. Effective responses to family violence should consider the needs of the victim and any children, as well as aim to keep the perpetrator accountable and in view. This requires a close working relationship between child focussed and adult focussed health and human services. I am aware that adult focussed health and human services have introduced a range of services and strategies to increase the focus on children and families. These include a number of initiatives that are set out below.

120. The 'Assessing children and young people experiencing family violence practice guide' was introduced in 2013 (attached to Mr Scott Widmer's statement for Module as Attachment SW-6). This guide incorporates comprehensive assessment practice specific to children and young people experiencing family violence. The intent of this guide is to assist family violence services that also work with children

to better understand children's needs and be more attuned to meeting their needs. This guide was distributed by the Department to all 'adult focussed' family violence services.

121. Drug and alcohol support services have embedded a family focus in their service planning and delivery. The statement of Ms Judith Abbott for Module 5 details these approaches and notes at paragraph 78 that:

> *... the Department has been progressing a range of work to ensure that family members (including dependent children) affected by another's drug use are considered, and safety and other concerns acted upon. It is also recognised that family members can be integral to supporting people with problematic alcohol and drug use into treatment and through their recovery.*

122. Children's Resource Worker positions within homelessness services aim to improve the coordination of adult and children's services to ensure children's developmental needs are taken into account when they are experiencing homelessness. Statewide coverage of this program is achieved through ten Department funded worker positions.

123. Specialist Children's Response programs were introduced under the National Partnership Agreement on Homelessness. There are four programs located across the State that provide support and assistance to children who are experiencing homelessness through three service streams: assessment and case planning, intensive case management and group work. The programs provide practical assistance to support children's development, for example in relation to their schooling. Many of the children who are helped by this program have experienced family violence. The programs are delivered by four services located in North and West Melbourne, Southern Melbourne, Wodonga and Geelong.

124. The Department is also implementing an initiative to co-locate family violence workers within Child Protection investigation teams and in the after-hours Child Protection service. This will improve the relationship and operation of adult and child-focussed services to provide a better service for victims of family violence and their children. Further information on this initiative is outlined in Ms Beth Allen's statement at paragraphs 190 to 192.

125. The purpose of the initiative is to strengthen child protection practice, enable joint assessments, assist Child Protection to navigate the family violence system and strengthen opportunities to divert children away from statutory responses. The initiative will be rolled out in 2015-16.

Potential future directions

126. There are opportunities to take a more systemic approach to adult services requiring a focus on children, particularly family violence services. Among other things, there are opportunities for the Department to introduce consistent child-centred practice in refuges.

127. Other options include developing more formal partnerships and networks between discrete adult services and Child FIRST and integrated family services. This includes enhancing the capability of Child FIRST and integrated family services to work with families impacted by family violence, including when perpetrators remain in the home.

128. In addition, the education needs of children experiencing family violence require careful consideration and attention from service providers, as well as formal pathways and linkages with education settings.

Improving funding arrangements to focus on outcomes and choice

129. A number of initiatives are being trialled to better address the needs of people (including those who experience family violence) through greater integration of services.

130. Services Connect is a small-scale trial of a model for integrated services in Victoria, designed to connect people with the right support, address the whole range of a person's or family's needs, and help people build their capabilities to improve their lives. Services Connect Partnerships are operating in eight external sites within the community services sector. Further information about Services Connect is contained in **Attachment PP-2**.

131. The eight Services Connect Partnerships will continue until October 2016. They bring together groups of community service providers to deliver integrated child and family support, mental health, alcohol and drug treatment, family violence, homelessness, housing, disability and Aboriginal-specific services.

132. Flexible support packages for family violence victims are being rolled out with a focus on providers generating client outcomes across a range of domains as set out at paragraph 50 above. Importantly these packages seek to drive a focus on the person and a 'do what it takes' attitude among workers who support them to achieve good results for families.

133. As Mr Arthur Rogers observed in his statement for Module 7, an innovation action project called Families at Home has tested a client outcome driven approach to intervening in family violence situations to prevent homelessness among women and children. This program is showing promising results. This program is based on services working together to address the needs of victims of family violence and outcomes for clients are measured.

Potential future directions

134. There is scope to maximise people's wellbeing by introducing more flexible funding arrangements in some health and human services to enable a 'do what it takes to get it right for people' approach among the workforce. These arrangements could include scaling up the availability of flexible packages of support and should be based on providing services that enable families and children to flourish and thrive. As far as possible, such an agenda should promote the empowerment of people who use services. Services should be delivered in a way that makes sense for the person and offers them as much choice as possible over the future course of their life.

Improving accountability through feedback

135. The Department is establishing some systems to encourage better service delivery. An 'Interim Platform' is being used in the Services Connect Partnerships test sites to track client outcomes and client goal-focused planning. The Interim Platform is an information management system that records client and service provision data. Use of this platform commenced in February 2015. It includes a number of specific data fields relating to family violence, including:

135.1 a specific alert category and type that is inclusive of the victim, child and perpetrator;

135.2 a services category, which includes the services being provided such as men's behaviour change interventions;

135.3 a category which captures court orders such as intervention orders and family law orders.

136. The platform enables the alignment of an individual's needs and goals as they relate to relevant family violence outcomes. The platform creates an individual or family plan that captures all the needs and actions for an individual or family in one place and measures outcomes achieved throughout the support provided. The platform links outcomes for individuals and families, including family violence specific outcomes, with performance monitoring and accountability. This approach enables funding and accountability to be directly monitored against outcomes for victims, perpetrators and children.

137. This system is currently in the testing phase but offers a promising model for outcomes-based funding and service delivery. Further information about the Interim Platform is contained in the document attached to this statement at **Attachment PP-2**. Work is occurring to link policy priorities with accountability arrangements. An example of this is referenced in Ms Frances Diver's statement - the 2015-16 Statement of Priorities includes a mandatory criterion that requires health services to address family violence.

Potential future directions

138. At a system level there is potential to consider common performance or outcome measures between health and human services around family violence.

139. For all funded health and human services there is a need to improve the nature and quality of information routinely collected, and to ensure that this information is routinely analysed and reported on to inform practice locally, but also to determine system wide priorities going forward.

140. Systematic improvement in services requires the creation of regular feedback from people who use our services. For services to be truly effective, they need to consider how people journey through them and make contact with them and the development of data collections should include indicators of people's satisfaction with services and the quality of services.

Conclusion

141. Fundamentally, the integration of services for people requires that new mechanisms draw together the diverse and varied providers and services around pathways that meet the *actual* needs of *real* people affected by family violence.

142. I am conscious of the importance that improvements in the Department's services can have on the lives and wellbeing of many people in Victoria. Placing people at the heart of the health and human service systems is core to the mission of the newly-established Department and to my agenda as Secretary.

143. There are significant opportunities to improve the effectiveness of the response to the scourge of family violence – and its devastating effects on the lives of Victorians. Taking those opportunities will require the Department to engage in inclusive policy development and on-going dialogue with providers, users and workforces. I look forward to the findings and recommendations of the Royal Commission and its insights into how the lives of people who experience family violence might be improved.

Signed by **VARUGHESE PRADEEP PHILIP**)

at Melbourne)

this 10th day of August 2015)

VARUGHESE PRADEEP PHILIP
SECRETARY, DEPARTMENT
OF HEALTH AND HUMAN SERVICES

Before me

[redacted]

[redacted]

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