Submission to the Royal Commission into Family Violence 2015

Latrobe Community Health Service (LCHS) is an independent community health service located in and providing services to the Gippsland community.

We provide primary health services such as GP, nursing, dental and allied health services in the Latrobe City local government area as well as a large range of psycho social support, aged and disability services on a regional and subregional basis.

We provide counselling services (not crisis) for women and children impacted by family violence in Latrobe City and deliver the Men's Behaviour Change Program (MBCP) in three local government areas including a group for Aboriginal men and a case management program for Aboriginal men who use violence. These services are funded by DHHS.

LCHS is a full member of the Gippsland Integrated Family Violence Service Reform Steering Committee and we endorse the recommendations made in its submission to the Royal Commission.

The following points are made with respect to LCHS role as a provider of family violence services and community health services.

1) MBCP

We are committed to the MBCP and support the lead that No To Violence (NTV) takes with respect to the standards around the program delivery. LCHS has led the way in the development of the 'Choices' culturally specific MBCP for Aboriginal men.

We are significantly resource constrained in the provision of MBCP.

Factors:

- Insufficient funding to meet demand. Our target for our MBCP is 61 men assessed as suitable to attend. For five years we have reached between 400%-800% of our referral target for the program.
- Lack of workforce deemed qualified to deliver the program. The NTV minimum standards provide clear instruction regarding the qualifications for facilitators as below:

  Level Three Facilitator (a) meet all of the following criteria:

  - *Has a Graduate Certificate of Social Science (Male Family Violence – Group Facilitation);* ***AND****,*
  - *Has at least 100 hours of experience facilitating men's behaviour change groups;* ***AND****,*
  - *Has a demonstrated understanding of the men's behaviour change process and the gendered nature of male family violence.*

  OR

  Level Three Facilitator (b) meet all of the following criteria:

  - *Has a four year degree from a recognised tertiary institution in a relevant discipline (e.g.: Social Work, Psychology, Psychiatry, Community Welfare, Behavioural Science or Medicine);* ***AND****,*
  - *Has at least three years professional experience in counselling;* ***AND****,*

- *Has at least two years experience facilitating relevant group work;* ***AND****,*
- *Has at least 100 hours of experience facilitating men's behaviour change groups;* ***AND****,*

  Has a demonstrated understanding of the men's behaviour change process and the gendered nature of male family violence.

Level Two Facilitators meet all of the following criteria:

- *Has a demonstrated understanding of the men's behaviour change process and the gendered nature of male family violence;* ***AND****,*
- *Has at least 80 hours of experience facilitating relevant group work;* ***AND****,*
- *Has observed a minimum of ten men's behaviour change group sessions;* ***AND****,*
- *Has at least two years experience in direct service provision with women in the context of family violence;* ***OR****,*
- *Has at least two years experience in a program that adheres to NTV minimum standards (or an equivalent for Men's Behaviour Change).*

Minimum Standards and Quality Practice Guidelines of the Men's Behaviour Change Program, as stipulated by No To Violence;

For every MBCP group session:

a) At least 1 facilitator is a Level 3 Facilitator
b) A 2nd Facilitator is at least a Level 2 Facilitator
c) 3rd and subsequent Facilitators are at least Level

There are a number of issues this presents:

- The graduate certificate is costly and lengthy to obtain. As it is program specific, there are few candidates who present at interview already qualified which means a lengthy delay in getting staff actively delivering MBCP. While some availability of funding for course costs is a positive, staff move on to non MBCP roles and the investment is lost.
- With the program resource constrained, there are limited opportunities for staff to observe the required number of MBCP programs. The observation component is resource intensive and restricts the opportunity to build workforce capacity from within current workforce.
- With no timely flow of newly qualified facilitators, current facilitators risk burn out and move on.
- There is only one provider of the Graduate Certificate, Certificate of Social Science (Male Family Violence group Facilitation). This makes completion challenging and onerous for regional service providers and staff. They incur significant time and cost penalties for completion in terms of out of pocket expenses and time lost to productivity in the staff member's 'home' program, which is unlikely to be MBCP.
- People interested in working the program have observed, 'you can't get qualified in MBCP if you don't work in it and you can't work in it if you aren't qualified'.

- Engaging and training facilitators from an Aboriginal or CALD background is incredibly difficult under the current arrangements.
- We engage tertiary qualified counsellors and registered psychologists in other programs; the option to up skill with a series of MBCP modules or recognition of prior learning/experience would be a pathway to building workforce capacity for delivery.
- There is no non Aboriginal equivalent of the Case Management for Aboriginal Men Who Use Violence which includes a brokerage component to support men in their behaviour change journey. In our experience, case management has proven to be successful in maintaining engagement of clients and the brokerage component has been crucial in stabilising these men, and gaining positive outcomes. We see this as a service gap.

***Recommendations**:*

1.1 That the targets and funding for MBCP be reviewed and increased as a priority.
1.2 That the qualification requirements to facilitate MBCP be reviewed as a priority and qualification pathways be expanded to ensure a workforce capable of MBCP delivery is available.
1.3 That case management and brokerage programs for men be evaluated with a view to determining effectiveness and applicability for all men who engage with the MBCP.

2. Counselling for Women and Children.

This service is funded by DHHS. It is not a crisis service and provides counselling services to women and children who have experienced family violence and/or are at risk of being unsafe in the family environment. We receive funding for 1.0 EFT counsellor. Our target is 67 clients per annum. We consistently receive over 120 referrals annually to this program.

***Recommendation**:*

2.1 That the targets and funding for this program be reviewed and increased as a priority.

3. Community Health Services.

Our internal consultation with program staff and managers at LCHS reveals that there is a distinct lack of awareness of family violence as a possible contributor to presentation for services. Staff talked about flags that might raise questions about the presence of family violence in the client/patients life and that even in this case, they would not know how or whether to address the issue. The following example was given by one of our dentists.

Children who have had a fall or accident generally present for dental treatment straight away; some children present clearly much later after the damage occurred. This might raise a question in the clinician's mind about a family violence incident as a cause however, this raises the following questions; how would a dentist approach this, should they, what is the referral pathway?

There was a stated willingness to identify and act however; staff across programs indicated a feeling of helplessness at what to do or where to go.

Our Director of Medical Services indicated that our General Practitioners are aware that they can contact crisis services locally and have had very responsive service for women

presenting at appointments who are clearly unsafe. The GPs see women in the most serious situations and in which the Police are already involved. They do identify women who they speculate may be in an abusive relationship; they have experienced reticence from women to access services when they mistakenly believe that support must be accompanied by a report to Police. A key piece of feedback from our GPs is that they experience frustration with the constantly changing service system environment where programs exist short term and disappear or change names. For busy GPs, the key is continuity of services and maintaining service system knowledge and connection.

Staff in our aged and disability services did not report a high awareness of the presence of family violence in their clients' lives. We deliver services to a number of people in these programs.

Anecdotally our Drug Treatment Services team reported some observance of controlling behaviours in families they engage with but no significant feedback about family violence being a feature in the lives of their clients.

Our Settlement Services staff work with people from CALD backgrounds who have been here less than five years. They report that approaching topics like family violence in these communities must be managed carefully and sensitively. We are aware of resources available to skill our workforce in this regard such as the services of 'In Touch'.

What is striking about this feedback overall is that talk of family violence as a factor in primary and community health service provision here at LCHS appears conspicuous by its absence. This raises questions about whether we are aware enough to notice it when it does present and confident enough to know what to do about it. Is there a siloed approach to family violence that leads program staff to opt out and leave it to the 'experts', hoping that someone else will pick it up and offer the appropriate options or support to the woman?

In summary, the family violence statistics in our region and in particular Latrobe City, indicate that as a large services provider with many programs, we are meeting many women and children directly impacted by family violence and missing the opportunity to link them with appropriate services and supports.

Recommendations:

3.1 That primary and community health including aged and disability services become a target audience for a family violence awareness raising campaign which includes training, detail about referral pathways and suitable material to provide women.

3.2 That a campaign be designed to make community health services places where it is safe for women to disclose their experience of family violence to any practitioner and equip the practitioner to deal with the disclosure.

3.3 That family violence awareness raising and prevention projects adopt a systems approach and become integrated in workplaces.

In conclusion, LCHS supports the recommendations of the Gippsland Integrated Family Violence Service Reform Steering Committee and submits our additional recommendations in support thereof.