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PROGRESSING RECOMMENDATION 31:

PHASE 1 PROJECT

FINAL REPORT

Prepared for DV Vic and CASA Forum

September 2020

CASA Forum
Victorian Centres Against Sexual Assault

DOMESTIC VIOLENCE VICTORIA

Contents

1. Executive Summary

Victoria's specialist family violence services and specialist sexual assault services are highly complementary and frequently interconnected. They provide different specialist services to a similar client group and, at times, the same client. There is a high level of respect for the specialist skills and expertise that each sector brings, and for the range of service elements provided by each sector. A high level of collaboration across sectors and a range of integrated approaches are in operation, and there is a willingness to explore further collaboration to improve outcomes for clients. These are key findings from this Project, funded by Family Safety Victoria (FSV), and jointly managed by CASA Forum and Domestic Violence Victoria, (DV Vic).

The Project is intended to inform possible ways forward for Recommendations 31 and 32, which focus on the potential for improving and increasing the collaboration between the sectors, as outlined in the 2016 Victorian Royal Commission into Family Violence Report.

Through interviews, focus groups and a workshop, the Project engaged 60 participants across the specialist services to examine the extent of collaboration between the sectors, in particular, in relation to levels of shared practice, secondary consultation pathways, and training and education.

The shared underpinning frameworks of feminist principles, a gendered understanding of family violence and sexual assault and a trauma-informed approach are the hallmark of both specialist sectors. They also share an understanding that people impacted by sexual assault may very often be victim survivors of family violence, and that a high percentage of women experiencing family violence will also have experienced sexual assault. Differences between the sectors is marked by their differing funding streams which dictate the different range of services they deliver. The suite of services offered by individual specialist sexual assault services (SSAS), specialist family violence services (SFVS) and integrated specialist sexual assault and family violence services (ISSAFVS) varies widely across the state.

Whilst using a range of similar terms in describing aspects of their work – such as trauma, risk, safety, therapeutic intervention and integration, practitioners within the sectors frequently demonstrate differing understandings or depth of understandings of those terms.

Collaborative practice is embedded with the specialist service system and the Project has found strong evidence of collaboration between the two specialist sectors. A set of essentials for collaboration has been identified including: respect; relationships, connection and trust; knowledge skills and confidence; leadership; and infrastructure.

A range of shared practice approaches have been identified and whilst not consistently in place or used across the state they demonstrate the capacity of the sector to work together in the best interest of victim survivors. They also identify where improvements can be made to shared practice. The growing awareness of the co-occurrence of family violence and sexual assault and its serious impact is emerging as the sectors respond to increasing client complexity and the need for them to work closer together.

Areas for improving the consistency of shared practice approaches includes the referral pathways into each specialist sector, expanding colocated approaches, and developing a framework to support joint client work – that is when practitioners from both sectors are supporting the same client. A number of integrated approaches provide a different model of service that brings together the expertise from both sectors into the one service to provide a holistic 'wrap around' service for clients. There is a desire to know more about integrated models and their impact for client outcomes. This is currently hampered by existing single stream funding models and data collection mechanisms, and inflexible targets.

The Project has identified a number of service gaps including the need for improved exchange of information across the specialist sectors about service offerings and access pathways; the lack of case management services in the SSAS funding model; and the design and documentation of service models that explicitly respond to the co-occurrence of family violence and sexual assault.

Increased professional development opportunities between the sectors on topics such as shared practice and understanding the terms and approaches of each sector is highly supported. There is also support for training for SFVS practitioners in responding to disclosures of sexual assault. Sector specific professional development must continue to support the learning and ongoing development of specialist practitioners.

This Project has examined the collaboration between a significant cross-section of the specialist sectors. However, to gain a full picture of the extent of collaboration across the specialist sectors, the areas out of scope of the Project, as designated by FSV, also require examination. This includes the collaborative effort between state-wide after-hours services, the Multidisciplinary Centre (MDC) and Orange Door models, and family violence therapeutic counselling services provided by the community health sector. Greater understanding is also required in relation to the impact of the co-occurrence of sexual assault and family violence and the most effective service responses.

This Project is intended as Phase 1 of longer-term work required to strengthen collaborative practice across the sectors. It has identified a range of opportunities to guide the focus of this longer-term work. The recommendations require considerable effort, time and resourcing in order to embed enduring collaborative practice that supports impactful benefits for clients. The suggested recommendations sit alongside the many other areas of priority work for both sectors.

The development of a strengthening collaborative practice implementation plan is suggested as a first step to assist in mapping out the complex long-term body of work required to strengthen and sustain collaboration between the sectors.

An environment of respect, goodwill, and eagerness to explore greater collaboration currently exists between the specialist sectors in Victoria. The driving force is a shared commitment to provide the best possible services, using trauma-informed, evidence-based approaches, and which can support victim survivors' healing, hope for the future and long-term recovery.

The Report makes the following recommendations, that:

Recognition

1. FSV continue to recognise and support each specialist sector in its own right, and support greater collaboration.

Common terms

2. DV Vic and CASA Forum work together to agree a shared understanding of common terms.

Essentials for collaborative practice

3. FSV, DV Vic and CASA Forum work together to ensure that the essentials for collaborative practice underpin programs and projects designed to enhance collaborative practice.

Collaborative practice approaches

4. CASA Forum and DV Vic work together to further examine referral pathways between the two sectors including the exploration of shared referral tools to improve referral pathways.
5. FSV consider funding colocated, or embedded practitioner approaches to support secondary consultation, increased knowledge, and confidence of practitioners.

6. FSV, DV Vic and CASA Forum work together to develop a framework to guide and support joint client work including terminology, principles, or protocols to guide practice, and flexibility of funding and targets.
7. FSV support research into outcomes for clients receiving integrated service responses.
8. FSV consider flexible funding arrangements to better support integrated service delivery models.

Identified service gaps

9. FSV support the specialist sectors to facilitate information exchange about their range of service offerings and access pathways through a range of communication channels.
10. FSV consider funding a case management function for SSAS.
11. FSV work with CASA Forum and DV Vic to design service models that explicitly respond to the co-occurrence of family violence and sexual assault.

Professional development

12. DV Vic and CASA Forum work with DVRCV to review the four-day core family violence training, and other relevant curricula, to ensure that they sufficiently address sexual assault including responding to disclosures and working collaboratively with SSAS.
13. CASA Forum and/or SSAS develop training for practitioners working in SFVS in relation to responding to disclosures of sexual assault.
14. DV Vic and CASA Forum identify training priorities for joint sector training. A priority for this training should be referral pathways and working with joint clients.
15. FSV work with CASA Forum and DV Vic to support the showcasing of highly integrated and collaborative ways of working such as ISSAFVS and MDCs.
16. FSV, DV Vic and CASA Forum ensure that training modules are suitable and available for delivery online and face to face.
17. SFVS and SSAS work together to deliver local community awareness and training about family violence and sexual assault.

Areas for further examination and research

18. FSV work with CASA Forum and DV Vic to examine the collaborative effort between the two statewide after-hours crisis services, the MDC and Orange Door models and the specialist sectors, and family violence therapeutic counselling services provided by the community health sector.
19. FSV support research to investigate effective service responses to the co-occurrence of sexual assault and family violence.

Additional resourcing

20. FSV fund DV Vic and CASA Forum to work together to develop a strengthening collaborative practice implementation plan that identifies actions, priorities, timeframes and the resourcing required for specific actions.

2. About the Project

2.1 Project Background

Chapter 12 of the Victorian Royal Commission into Family Violence 2016 Report explores the relationship between family violence and sexual assault with a particular focus on the relationship between the family violence and sexual assault sectors.

The Report suggested that *"In the short term, in order to provide a more integrated response to intra-familial sexual assault, there is a need for close partnership between the sexual assault and family violence sectors, and for both sectors to be working together."*[1]

The Report made two recommendations specific to the sexual assault and family violence sectors:

> *Recommendation 31:*
> The Victorian Government ensure funding of specialist family violence and sexual assault services to facilitate their collaboration [within two years] by:
> - Promoting and, if necessary, resourcing shared casework models
> - Establishing secondary consultation pathways
> - Participating in the recommended Support and Safety Hubs
> - Developing guidelines and protocols for facilitating information sharing
> - Participating in joint education and training.

> *Recommendation 32:*
> The Victorian Government review [within five years] family violence and sexual assault services to determine whether and, if so, how family violence and sexual assault responses should be unified.

DV Vic and CASA Forum have been working with FSV to determine how best to progress Recommendations 31 and 32.

In 2018, FSV engaged KPMG to undertake a series of consultations with specialist family violence and sexual assault services to produce a report to inform Recommendation 31. The subsequent KPMG report provides some direction for the Victorian Government to meet Recommendation 31, however it was recognised that further work was required to build the evidence and understandings about collaboration between the two specialist sectors.

2.2 Purpose

DV Vic and CASA Forum designed the Progressing Recommendation 31: Phase 1 Project (the Project) to gather and analyse information to facilitate evidence-based recommendations about possible ways forward for Recommendations 31 and 32. The Project is intended be the first phase to further explore progress towards Recommendation 31.

Specifically, the Project aims to:

- Describe and analyse:
  - Collaboration between the sectors
  - Similarities, differences and points of intersection and alignment by the two sectors

[1] Royal Commission into Family Violence: Report and Recommendations Volume II, (2016), p. 236

    - Level of shared practice approaches[2]
    - Current and evolving relationships between the two sectors
    - Training provided by both sectors.
- Consider and develop recommendations regarding the elements in Recommendation 31 that are not being addressed through other reform activities, specifically:
    - Shared practice approaches
    - Secondary consultation pathways
    - Joint education and training
    - Funding and resourcing required to support collaboration.
- Enhance sector and government understanding of how family violence and sexual assault sectors work together.
- Identify of cross-sector learning and development training opportunities.
- Consider and develop recommendations regarding how this report can inform the implementation of Recommendation 32.

2.3 Scope

Areas outside the scope of the Project include:

- Participation in the Orange Door - the interface/ referral pathways between family violence and sexual assault services and The Orange Door, and between The Orange Door and the Multidisciplinary Centres (MDCs).
- Specific consideration of collaboration between the two statewide after-hours services, that is, safe steps and the Sexual Assault Crisis Line (SACL).
- Sexual assault services provided by other than CASAs.
- Developing guidelines and protocols for facilitating information sharing – part of broader Multi-Agency Risk Assessment and Management (MARAM) and Information Sharing Reforms
- Training and professional development needs for the family violence and sexual assault sectors – being undertaken by The Centre for Workforce Excellence through the 2019 Family Violence Workforce Census and informed by the 10-year Industry Plan. The Project will identify opportunities for cross-sector training.
- Sexual assault that falls outside the definition of family violence as defined in the Family Violence Protection Act 2008. Note: this may be referenced as part of the service response continuum by sexual assault services but is not a focus of the Project.

2.4 Principles

The Project is underpinned by the following principles as outlined by DV Vic and CASA Forum in the Project brief:

Principles for our individual and joint sector work in this space include:

- *Service design and system architecture must be built around what is in the best interests of and will ensure best outcomes for clients. Safety, agency and recovery are goals of our work with clients.*
- *Victims should not have to repeat their story to multiple service providers.*[3]

2.5 Terminology

[2] Note: The Royal Commission Report uses the term shared case work models, the term shared practice approaches is preferred for this Project.
[3] *Progressing Recommendation 31: Phase 1 Project*, Project brief, DV Vic and CASA Forum.

The Report uses the following terms:

- **Specialist family violence services (SFVS)** refers to specialist services funded to provide a range of family violence support services.
- **Specialist sexual assault services (SSAS)** refers to CASAs funded to provide specialist sexual assault services (and specialist family violence counselling in some CASAs).
- **Integrated specialist sexual assault and family violence services (ISSAFVS)** refers to services funded to provide a full suite of specialist sexual assault and family violence services.
- **Participants** refers to people who participated in this Project via interviews, focus groups and a workshop.
- **Practitioners** refers to specialist professionals employed by specialist sexual assault and specialist family violence services.
- **Victim survivors** refers to adults, young people and children impacted by sexual assault and family violence. The term victim survivor is intended as a gender inclusive term except where participants specifically referred to their client group by gender.

Additionally, the following definitions of **key terms** was agreed by the governance group for use in the Project.

The purpose of these definitions was not to assess services and organisations against particular key criteria rather, to provide a simple definition to support conversation and discussion during the consultation period of the Project.

Whilst integrated service systems have been the mainstay to responding to family violence and sexual assault in Victoria for some years, there remains inconsistencies in the use and understandings of terms used to describe the way in which services work together to better respond to the needs of victim survivors of family violence and sexual assault. This includes terms such as co-ordination, collaboration, and integration. An Australian Domestic and Family Violence Clearinghouse paper in 2013 acknowledged that there is a '*fluid use of terminology in this field*'.[4] Similarly, a review of programs and evaluations conducted by ANROWS in 2015 noted that there is no standard definition of integration within the family violence and sexual assault sectors across Australia.[5]

TERM	DEFINITION
Coordination	Activity that supports practitioners, services or organisations to work well together in an organised way.
Collaboration	Activity where practitioners, services or organisations work together to establish common goals and achieve shared outcomes.
Co-location	Practitioners, services or organisations located within the same building or premises for the purpose of delivering, improving or expanding the services provided.
Integration	Integration can occur at various levels including: • Integrated service system responses involving cooperation and collaboration amongst all players within the service system to provide an effective system response. For example, regional integrated service systems involving specialist family violence and

[4] Healey, Lucy; and Humphreys, Cathy, *Governance and Interagency Responses: Improving Practice for Regional Governance – A Continuum Matrix. Topic Paper 21*, p. 2, Australian Domestic & Family Violence Clearing House, December 2013.
[5] Breckenridge, Jan; Rees, Susan; valentine, kylie; Murray, Samantha, *Meta-evaluation of existing interagency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: Key findings and future directions.* Australia's National Research Organisation for Women's Safety (ANROWS), 2016.

	sexual assault services, police, justice, health, community and housing services. • Integrated service delivery responses for clients where services come together to provide a unified response. For example, specialist family violence and sexual assault services working closely together to provide timely and effective service responses. Integration is an ongoing process that can occur on a continuum; supported by a shared gendered understanding of sexual assault and family violence, memorandums of understanding (MOUs) and protocols, joint planning, clear service and referral pathways, and regular review.
Shared practice approaches	An approach where specialist practitioners work together and use common frameworks to support an individual or family.

The terms above are not intended to be used in isolation from each other. For example, practitioners co-located in the same building may work together collaboratively and use a shared practice approach when working with some clients.

3. Context

3.1 Brief overview of relevant research

There is limited research in Australia on victim survivors' experience of the co-occurrence of family violence and sexual assault, on understandings of the intersection of family violence and sexual assault, and about highly collaborative practice approaches. There is also limited research on the co-ordination, collaboration and intersection between the two specialist family violence and sexual assault sectors, not-with-standing the inconsistencies of terminology as noted above. The following sections provide a brief overview of some relevant research in Australia.

Collaboration and integration

Whilst there is some documentation of multi-agency, or integrated approaches to family violence, few of these explicitly include the collaboration between the family violence and sexual assault sectors.

A meta-evaluation of interagency responses conducted by ANROWS in 2016 noted the lack of evidence regarding efficient and effective integrated models and the absence of a standard definition of integration (as indicated earlier). The meta-evaluation found few integrated responses focussed on sexual assault and only one integrated response focussed on service delivery of both family violence and sexual assault.[6]

In 2013, the Australian & Domestic Violence Clearinghouse developed a Regional Governance Continuum Matrix of Practice Tool to support regional or localised partnerships and integration between domestic and family violence services and sexual assault services.[7] The tool comprises eight indicators of Regional Governance Continuum Matrix for Partnerships:

1. Developing an integrated domestic and family violence and sexual assault service system
2. Strengthening community partnerships
3. Clarifying committee function and diversifying representation on the committee
4. Developing family violence sexual assault service pathways
5. Regularising joint review and planning
6. Supporting risk assessment and risk management
7. Developing professional practice across the system
8. Support evaluation and research.

The indicators are intended to guide services and professionals to develop effective local integrated partnerships that include a level of system accountability.

Co-occurrence of family violence and sexual assault

As is the case in relation to research regarding the collaboration between the sexual assault and family violence sectors, research about the co-occurrence of family violence and sexual assault is also limited.

Recent research by ANROWS aimed to inform the development of policy frameworks responsive to, and inclusive of sexual assault in the context of domestic and family violence.[8] This research synthesis uses the term intimate partner sexual violence (IPSV) which is described as a tactic of family violence, and that IPSV usually occurs alongside other tactics of domestic violence. The research identifies IPSV as a high-risk indicator of escalating frequency and severity of domestic violence. The research also

[6] ibid, p.4
[7] Healey, et al, op. cit., p.6
[8] Australia's National Research Organisation for Women's Safety. (2019). *Intimate partner sexual violence: Research synthesis* (2nd Ed.; ANROWS Insights, 08/2019). Sydney, NSW: ANROWS.

finds that experiencing IPSV has serious and long-lasting effects and is associated with increased severity of post-traumatic stress disorder (PTSD) symptoms.

The report notes that family violence and sexual assault services are often separate and underpinned by different mandates, goals, and practice frameworks. It noted that both types of services report IPSV as a challenging issue and one which increases the complexity of providing appropriate responses across the specialist services and the broader service system. The report makes a number of recommendations for policy and practice including calls for greater understanding and awareness of IPSV and resourcing for family violence and sexual assault services to facilitate cross-sector co-ordination and integrated care that responds to the specific contexts of IPSV.

An earlier report by ANROWS in 2015, examined the intersection between sexual assault and family violence, in particular the lived experience of two forms of concurrent victimisation.[9] Concurrent victimisation is described as including re-victimisation (when a woman, over her lifetime, experiences both sexual assault and domestic violence) and IPSV. The report found that women who experience child sexual abuse (CSA) are more likely to experience IPSV than women who have not experienced CSA, and are more likely to experience domestic violence, not limited to sexual assault, in their adult relationships.

In looking at responses to women affected by re-victimisation and co-occurrence, the report noted the limited evidence of effectiveness of service responses, and a potential gap in services that address co-occurrence specifically. It suggested that family violence and sexual assault services be resourced to enrich cross sector approaches, as well as with related services within the broader services system including mental health and drug and alcohol services.

It should be noted that this research focussed on the experience of adult victim survivors and does not consider the co-occurrence of family violence and sexual assault for young people and children.

3.2 Understanding the specialist service system in Victoria

Specialist family violence services

The DV Vic *Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors* (the Code)[10] describes the specialist family violence service sector as *"a group of service providers whose shared role is to work directly with victim-survivors providing dedicated resources and advocacy to promote their rights and respond to their safety and support needs"*.

It describes the main categories of specialist family violence services as:

- State-wide telephone services providing a 24-hour response to victim survivors of family violence.
- Local family violence support services located across the metropolitan, rural and regional parts of Victoria, and providing case management, risk assessment, safety planning, crisis responses, referrals, advocacy support and other specialised programs.
- Family violence accommodation services providing temporary alternative accommodation for victim-survivors who are unable to stay in their usual residence due to a serious level of risk posed by the perpetrator.

[9] Cox, Peta; *Sexual assault and domestic violence in the context of co-occurrence and re-victimisation: State of knowledge paper*, Australia's National Research Organisation for Women's Safety. 2015.
[10] Domestic Violence Victoria (2020). Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors. 2nd Edition. Melbourne: DV Vic.

- Family violence therapeutic programs including individual counselling and support groups for adults, children and young people who have experienced family violence.
- Targeted services or programs, either at the state-wide or local level, providing support for victim-survivors from specific communities, such as multicultural communities or ethno-specific groups, lesbian, gay, bi-sexual, transgender, intersex or queer (LGBTIQ) communities, older people, and people with disability.
- Family Safety Contact responses whereby practitioners provide support to current or former partners or other family members of a perpetrator involved in a behaviour change program.
- Aboriginal specialist family violence services located within Aboriginal Community Controlled Organisations, or programs in community health services or local family violence services.

Support provided by specialist family violence services outlined in the Code include case management activities (such as family violence risk assessment and risk management processes and safety planning), interventions including crisis responses, brief interventions and intermediate to longer term or intensive approaches, counselling and support group work, community outreach support, and advocacy for victim survivors' rights and access to resources and service entitlements.

Specialist family violence services provide secondary consultations and mobilise coordinated responses within the broader family violence system. They are also involved in researching and developing innovative responses to family violence and providing education about family violence to other sectors and the community.

DV Vic is the peak body for specialist family violence services for victim survivors in Victoria, with members representing over 100 organisations across the state. DV Vic is currently undergoing a merger with the Domestic Violence Resource Centre Victoria.

Specialist sexual assault services

The specialist sexual assault service sector in Victoria comprises fifteen CASAs, including the Victorian after-hours Sexual Assault Crisis Line (SACL), and a number of other funded sexual assault services and Sexually Abusive Behaviour Treatment Services (SABTS) program providers in Victoria.

Services provide a range of sexual assault therapeutic counselling, crisis, and support services to victim survivors of sexual assault, and their family members. SABTS providers work with children and young people who present with sexually harmful behaviours. Some CASAs are also funded to provide family violence therapeutic counselling.

CASAs work with all victims of sexual assault and sexual violence, including women, children, young people, men and people who identify as gender diverse. Many service users are women who have experienced sexual assault in an intimate partner relationship or were sexually abused as children; have experienced date rape; or sexual assault by a stranger or recent acquaintance; or sexual assault within an institutional setting.

Children and young people make up a large proportion of clients of services. They have most often been sexually abused by a family member or someone they know and trust.

Children and young people who receive services from the SABTS programs are frequently identified as having abused siblings or related family members. Up to 94 per cent of SABTS clients have also been found to be victims of family violence.

SSAS work collaboratively with professional colleagues including Victoria Police, Department of Health and Human Services (DHHS) Child Protection Services, the Victorian Institute of Forensic Medicine, the Victorian Forensic Paediatric Medical Service, SFVS and community support agencies.

In rural Victoria there are three ISSAFVS providing a full suite of specialist sexual assault and family violence services.

CASA Forum is the peak body for CASAs and SACL. In February 2020, CASA Forum expanded its membership to include all other funded SSAS in Victoria.

Multidisciplinary Centres and the Orange Door

It is important to note that Multidisciplinary Centres (MDCs) and the Orange Door form part of the specialist sexual assault and family violence service system, noting that collaboration between MDCs, the Orange Door and the SSAS and SFVS sectors was out of scope for this Project.

Seven CASAs operate within Multidisciplinary Centres (MDCs) where specialist police, child protection practitioners and a range of other specialist services are co-located in the one building to provide a victim centred, integrated and holistic response to victims of sexual assault and child abuse. MDCs provide coordinated access to specialist services to improve responses and outcomes for clients. Some MDCs also provide a range of specialist family violence services.

The Orange Door provides a colocated and coordinated intake pathway to victim survivor specialist family violence services, services for men who use violence and family services. The Orange Door keeps the whole family in view, with expert support tailored to each family member's needs. Some SFVS and ISSAFVS have teams of specialist family violence practitioners located at their local Orange Door.

Shared philosophy and practice approaches

In shaping the brief that informed this Project, CASA Forum and DV Vic, described the specialist sectors commonality in terms of vision and purpose, and philosophy and practice approaches as follows:

- Both support policy and practice approaches based on an intersectional, structuralist feminist analysis of all forms of violence against women including sexual assault.
- Both are committed to addressing the gender, cultural, social, economic and class inequalities which result in and enable the perpetration of violence against women and children.
- Both sectors operate to a Code or Standard of Practice model provided by their peak, and both place the rights of victim survivors at the centre of their practice.
- Both sectors' work is informed by the experiences of service users, who are predominantly, but not exclusively women and children affected by family violence.
- The family violence and sexual assault sector provide specialised and complementary service responses.[11]

[11] Ibid, p.3

4. Project Methodology

4.1 Governance

The Project was supported by the following governance mechanisms:

- Project Management Group (PMG): Comprising DV Vic and CASA Forum with responsibility for the management of the contract with the consultant, oversight and day to day liaison on the Project's progress, and provision of support for the consultant.
- Project Steering Group (PSG): Comprising FSV, DV Vic, and CASA Forum with responsibility for high level project oversight.
- Technical Advisory Group (TAG): Comprising members from the DV Vic and CASA Forum membership and providing technical support and assistance.

4.2 Project stages and approach

STAGE	APPROACH
Stage 1: Preparation **Aim:** To agree a Project Plan to guide the successful delivery of the Project	**Process** • Confirming PMG, PSC and TAG membership, roles and meeting points • Gathering relevant background material • Developing a Project Plan to guide the project, including identification of stakeholders for interview/focus groups, and other data sources • Drafting Consultation Plan **Deliverables:** Agreed Project Plan
Stage 2: Research and Analysis **Aim:** To agree definitions of key terms used in the Project to ensure clarity, and meaningful discussion and analysis.	**Process** • Analysing KPMG Report • Reviewing relevant literature • Drafting definitional document of key terms • Finalising Consultation Plan • Seeking TAG feedback on key terms **Deliverables:** Agreed definition of key terms
Stage 3: Engagement and consultation **Aim:** To engage and consult with stakeholders to gather information to inform the key Project questions.	**Process** • Implementing Consultation Plan, communicating with sectors and booking interviews, focus groups, etc. • Interviewing stakeholders • Conducting focus groups • Collecting examples of relevant documentation • Analysing qualitative data • Facilitating half day joint sector workshop **Deliverables:** Consultation
Stage 4: Analysis and resource development **Aim:** To document key findings and recommendations for the future.	**Process** • Agreeing structure and parameters of the Final Report • Analysing data in response to key project questions • Identifying opportunities and recommendations • Incorporating feedback into Final Report • Delivering Final Report

	Deliverables: Final Report

4.3 Impact of COVID 19 pandemic on project methodology

In November 2019, the PMG and PSC agreed the Project Plan to guide the delivery of the Project. The Project progressed accordingly, with most interviews completed in February and March 2020.

With the state of emergency declared in Victoria in mid-March in response to the COVID 19 pandemic, the Project was paused.

A Project Recommencement Plan was agreed in early June, and focus groups, a joint sector workshop and additional interviews were rescheduled. Timing for the delivery of the Final Report was renegotiated. The scope of the Project was also reconsidered, and it was agreed that the scope be expanded to capture the experience and learnings about the impact of the COVID 19 period on collaboration between the two sectors. Two focus groups were convened with this specific focus. The focus groups and joint sector workshop were conducted via the zoom online platform.

4.4 Consultation participation

Total number of participants: 60

Number of interviews: 19 (36 participants)

Number of focus groups: 4 (27 participants)

Number of workshops: 1 (12 participants[12])

Service type

SERVICE TYPE REPRESENTED	TOTAL	METRO	RURAL	STATEWIDE
SFVS	13	6	6	1
SSAS	7	4	3	
ISSAFVS	3		3	
MDC[13]	6	3	3	
Peak body	2			
Government agency	1			

A list of participants is provided at Appendix 1, and interview questions are provided at Appendix 2.

[12] Workshop participants were also involved in interviews/focus groups.
[13] Some integrated ISSAFVS and SSAS also operate within an MDC.

5. Findings

This chapter outlines the findings of the consultations and is grouped as follows:

- Similarities and differences
- Data
- Collaborative practice
- Benefits of collaborative practice
- Cautions about greater collaboration
- Specialisation
- Professional development
- Impact of COVID 19 on collaboration.

5.1 Similarities and differences

5.1.1 Similarities

Project participants reported a range of similarities between SSAS and SFVS. Key amongst the reported similarities was the understanding of the gendered nature of family violence and sexual assault and strong feminist principles, described as the underpinning ethos of all services represented in this Project. This shared understanding included the nature of family violence and sexual assault (also referred by many participants as working within a violence against women and children framework), understanding the prevalence and societal issues that underpin family violence and sexual assault.

Sharing a similar history from within the women's movement was also described by many participants as a key marker of similarities in shaping the evolution of the two sectors.

Participants across both sectors expressed an understanding that people impacted by sexual assault may very often be victim survivors of family violence, and that a high percentage of women supported in SFVS will have experienced sexual assault, most frequently in the context of family violence. They described an understanding that the impacts of sexual assault and family violence are similar. The specific and significant impacts for children and young people was most strongly reported from participants whose work has a focus on children.

> *"The experience may be different, but the impacts are similar."* [ISSAFVS, rural]

Participants acknowledged the complementary nature of services provided by both sectors. There was a recognition from participants that they provide different services to a similar, and at times, the same client group.

The majority of, but not all, participants described a sophisticated, whole-of-organisation understanding of trauma as their foundational approach. This involved the way in which their services were designed, planned and delivered; and the organisational infrastructure in place to support staff and clients for example, through recruitment, supervision, practice guidelines and standards, systems and processes, and professional development.

Resourcing women to understand the impact of trauma on children and equipping them to respond sensitively in the aftermath of trauma was reported as a key aspect of service delivery across SSAS and SFVS.

A small number of participants from SFVS stated that trauma was not their first consideration, and that considerations of risk and safety was their primary goal.

Participants across both sectors demonstrated a deep understanding about the immediacy of risk, and that both sectors played a key role in providing an immediate response post-incident. They reported that undertaking risk assessment and safety planning were key tasks of all practitioners and welcomed the use of consistent tools such as MARAM to do this. Both sectors described their approach as client-led.

Participants reported the depth of empathy and passion for the work demonstrated by practitioners across the sectors.

Working systemically and collaboratively within the broader system was reported as a strength of both sectors along with their ability to work together to influence, inform and shape policy, forums, and submissions to government, with each sector bringing its specialist expertise to the considerations at hand.

Each sector has a code or standard of practice and member organisations belong to the relevant peak bodies. A small number of specialist services are members of both peak bodies.

5.1.2 Differences

Participants across both sectors reported a range of differences between SFVS and SSAS.

Whilst this Project has not conducted an audit of the suite of services provided by SSAS, SFVS and ISSAFVS, the consultations revealed that delivering a different, though complementary, suite of services was the key difference reported by participants. The suite of services offered stemmed from the different funding and reporting models of each sector.

The range of services and way they are provided varied widely across the state. Across Victoria, there is a varying combination of service offerings provided by SSAS, SFVS and ISSAFVS. For example:

- Most SSAS, but not all deliver sexually abusive behaviours treatment services (SABTS).
- SFVS are funded to deliver case management services.
- SSAS are funded to provide therapeutic counselling and advocacy.
- Therapeutic family violence counselling is provided by some SSAS, some SFVS and some ISSAFVS, as well as a range of community health providers.
- After hours crisis services are provided by some SFVS, SSAS[14] and ISSAFVS.
- Some SSAS work within an MDC model, and some SFVS and ISSAFVS work in collaboration with the Orange Door in their local area.
- Therapeutic services for children and young people are provided by SSAS, in some refuge services provided in SFVS and in in adolescent family violence services.

Participants across both sectors reported that they believed that SFVS are highly skilled in responding to family violence but not so comfortable or skilled in discussing or responding to sexual assault. They stated that SFVS do not have a depth of understanding about sexual assault.

Participants across both sectors also reported that they believed that SFVS have a deeper understanding of risk, and that risk is at forefront of family violence work. They related that SSAS do not continually assess risk in the way in which SFVS do.

> *"Risk is the first lens in family violence work."* [SSAS, metropolitan]

Participants described differences in the nature of the work provided by both sectors. Participants from SSAS acknowledged that the work of SFVS is more immediate, faster paced, often crisis driven, and responds to higher demand with a greater number of referrals. The 'task-heavy' nature of early family

[14] Note all CASAs provide after hours crisis services

violence work in risk assessment and safety planning was described as a difference in the way in which the sectors worked.

Participants also noted that due to the different service models, SFVS mostly provide a shorter to medium term response, with SSAS being able to provide a longer-term intervention to support healing and recovery. Participants across sectors acknowledged that sexual assault did not always occur within the context of family violence. A further key difference reported by SFVS participants was that SSAS work with men and boys who are victim survivors of sexual assault and that SFVS did do not work with men[15].

Participants noted that different skill sets are required to deliver therapeutic counselling, largely provided by SSAS, and case management functions largely provided by SFVS, and that both functions were critical to provide a suite of services most likely to meet the needs of clients.

Participants noted differences in wage rates across the sectors which they felt impacted on the attraction and retention of workforce. They also noted that the SFVS sector is a much bigger sector than the SSAS sector with a larger number of services and practitioners across Victoria. Participants reported that family violence had a greater policy and funding influx as a consequence of the Victorian Royal Commission into Family Violence, and prior to that.

5.1.3 Varying viewpoints

Varying viewpoints across participants related largely to language and terminology. While some participants reported the language and terminology used by both sectors as similar, others reported it as quite different and often with differing understandings of the same terms. These participants reported that the sectors had differing understandings (or depth of understanding) in relation to trauma, risk, safety (not just physical safety), and used different terminology, for example, the use of affected family member, victim survivor, people experiencing family violence or sexual assault.

Some SSAS participants reported that SFVS did not have a depth of understanding in relation to trauma and that a trauma lens for children and young people was not as well developed in SFVS. Some SFVS participants reported that all the work they did was therapeutic, whereas SSAS demonstrated a deeper meaning in the provision of therapeutic interventions. Some participants reported an area of ongoing frustration in that the sectors did not always understand each other's language.

A second area where there were varying viewpoints was from ISSAFVS participants who expressed difficulty in distinguishing similarities and differences between the sectors. They describe their efforts as being much more focussed on an integrated way of working. They described their model as, in general, operating with specialist teams with specific functions, for example, integrated intake, integrated after hours crisis response, therapeutic counselling, case management, and Orange Door family violence practitioners teams (for those services working within an Orange Door catchment).

5.2 Data

SFVS and SSAS are required to report via two different data collection systems: SHIP and IRIS respectively. Participants reported a level of frustration in having two different reporting systems and the negative impact that this has in trying to work more collaboratively and to understand the co-occurrence of family violence and sexual assault.

[15] Note some SFVS provide services to male victim survivors.

Participants reported being unable to collect data on co-occurrence without conducting a labour-intensive manual investigation of the data held in either or both systems. They expressed a strong desire to access such data which they believed would be helpful in informing service design, planning, delivery, and ultimately influence improved client outcomes. Some participants reported that their services have attempted projects to try to collect such data, using social work students to conduct small projects, or have undertaken 'snap shot' data collection projects to estimate the level of co-occurrence to varying degrees of success. Participants felt that '*we should know more about this*'.

Participants who felt able to estimate the level of co-occurrence reported that upward of 80 per cent of adult women presenting for family violence had experienced sexual assault, and that more than 70 per cent of adults, young people and children presenting for sexual assault had experienced family violence.

> *"It is not often that we have a referral with no history of family violence."* [SSAS, metropolitan]

Participants reported that better data would assist in understanding the co-occurrence of family violence and sexual assault, what this means for models of service, or promising models of service and the impacts on clients' recovery and healing. They strongly advocated for an acknowledgement that the two issues frequently coexist and called for resources to explore this issue.

> *"More than numbers are needed. We need to understand the client's experience of the co-occurrence, what it has meant for them and what service interventions have been helpful. This needs to be captured in research."* [ISSAFVS, rural]

Participants from ISSAFVS reported the highest level of frustration with the limitations of the two data collection systems. They reported the lack of integrated data had impacts for expanding integrated responses due to not being able to readily demonstrate or report on outcomes from an integrated approach.

Participants also expressed a desire for greater work in measuring client outcomes and wanting a shared understanding of what could be regarded as a successful client outcome. Participants reported frustration in not being able to map the client pathway across the sectors, or to be able to map it to the extent they think would be beneficial to clients' longer-term recovery.

Some participants agreed that better data on the co-occurrence of family violence and sexual assault would be helpful but that it was not a priority. Better data on the understanding the impact of family violence and sexual assault for women with disabilities or clients identifying as LGBTIQ was a higher priority.

> *"There are so many areas for better data collection. (Data on co-occurrence) is not the priority."* [SFVS, Metropolitan]

5.3 Collaborative practice

In general, most participants reported a level of collaboration between SSAS and SFVS. The type and depth of collaboration varied widely across the state. The type of collaborative practice also reflects the main points of intersection between the specialist sectors and can be grouped as follows:

- Referral and assessment
- Colocated practitioners
- Joint clients
- Integrated approaches

- System-wide

5.3.1 Collaborative practice – referral and assessment

Many participants described frequently making warm referrals to either sector. These participants demonstrated a good knowledge of the range of services offered and referral systems used, and strong relationships between practitioners. The colocation or regular visiting of a specialist practitioner often facilitated and increased the timeliness of referrals and the sharing of assessment. ISSAFVS reported being much more easily able to refer clients across streams of speciality or service function according to client need.

> *"My work is family violence and risk focussed. It can be hard to get (my clients) into therapeutic services. When I do it's great because I can give my insights into the client's trauma presentations."* [SFVS, Metropolitan]

Service demand and the point at which the client presented in the system response depended on whether a referral might be made. SFVS participants frequently reported that the long waiting time for clients to receive services from SSAS impacted on the collaborative relationships between the services and the ability for clients to receive timely services. For some, this impacts on their likelihood of making a referral to SSAS. SSAS practitioners reported they frequently used their advocacy skills and relationships with individual SFVS practitioners to enable clients to receive case management services due to the large volume of clients accessing SFVS. Practitioners working in refuge mostly reported that the safety needs of the client may not be sufficiently managed which impacted on the client's suitability for therapeutic counselling. They would therefore be less likely to make a referral to SSAS.

Several SSAS participants reported developing new approaches to reduce waiting times and increasing access to services. The degree to which this is widely known across the local service system is unknown. However, some SFVS participants were largely unaware of these changes.

Some participants reported not knowing the staff in the specialist sector well or in really knowing the range of services they could offer. In this regard they tended not to make a referral. Some SFVS participants reported that their local SSAS preferred that women contacted the service themselves rather than via SFVS practitioners. One SSAS participant also reported that their local SFVS required women to contact the service directly. In these instances, the practitioner provided a phone number to the client without really knowing whether the client went on to contact the service. They expressed a degree of frustration with this response and concern that the woman would need to retell her story.

A small number of SFVS participants reported that they rarely made a referral to SSAS. They reported that they did not know the service well and that referral to a SSAS was not often identified as a priority for clients.

Some SSAS reported making infrequent referrals to SFVS unless it was to make an application for a Family Violence Flexible Support Package. SSAS participants reported that referrals to SFVS were largely related to the client's physical safety needs and required specialist assistance. Several reported that referral systems were 'clunky'.

Some participants reported that they would like to work more closely with SSAS beyond referral. These participants were unlikely to be involved in joint client approaches.

> *"It would be amazing to work closer together. The majority of women (we support) have experienced sexual assault. It would be good to work on more than a referral."* [SFVS, Statewide]

Participants from both sectors reported that the introduction of MARAM was an opportunity for improving referral pathways and assessment so that clients did not have to retell their story. SSAS participants commonly reported that they were currently in the process of aligning their assessment

procedures with MARAM. SFVS commonly reported MARAM was very similar to CRAF and not such a change of practice for them ad that they welcomed the introduction of MARAM for use by SSAS. Several participants reported that MARAM was still being embedded and that it was not yet resulting in shared, streamlined assessments.

5.3.2 Collaborative practice – colocated practitioners

Participants reported strong support for colocated models which provide secondary consultation, support, and advice to practitioners. For example, locating a SSAS practitioner within a SFVS, or locating a SFVS practitioner within a SSAS, or providing a 'visiting' service. Quicker referrals and better access to Flexible Support Packages were reported as benefits for clients. Colocated arrangements were seen to improve skills and confidence for practitioners.

In some cases, colocated arrangements were funded for a time limited period, and unable to continue once funding had expired. A strong preference for the colocation to continue was reported by participants impacted by the discontinuation of colocated approaches.

SSAS participants reported an increasing number of secondary consultations from SFVS regarding women they were working with who had revealed their experience of childhood sexual assault. This was most common where services had experienced colocation of practitioners.

ISSAFVS reported a high degree of peer support and incidental skill sharing due to having all practitioners located within the one service. They reported improved outcomes and stronger engagement for clients.

Several SFVS participants reported they had little or no collaboration or interaction with SSAS; and that they would appreciate more contact with them. These participants reported a growing awareness of sexual assault in the context of family violence and reported that they would appreciate and benefit from a visiting service or colocated practitioners.

5.3.3 Collaborative practice – joint clients

Participants reported that some clients required specialist therapeutic counselling and case management services to support their complex needs. They stressed that not all clients required this level of support.

Co-case management approaches such as those provided by some statewide services focussed on family violence and the connection with the SSAS was largely in relation to referral.

Participants who reported working collaboratively in relation to joint clients described this work using a variety of terms including dual work, collaborative work, the 'Jess and Jenny model'[16], and collaborative client-centred work. This practice most often involved a counsellor advocate providing therapeutic counselling and a case manager providing support and practical assistance to enhance safety to the same client. The services were reported in the most part, to not be provided concurrently. Rather, that one practitioner might 'step back' whilst the other practitioner worked with the client. Some participants reported that the case manager might work in the background and that the counsellor might be the key client-facing practitioner. Gaining the client's consent, having clear job roles, and good communication with the client were reported as essential for this model to work successfully.

Some participants described the challenge of practitioners 'staying in their own lane' when working with shared clients. They stressed the importance of practitioners being clear about their job role and

[16] The "Jess and Jenny model' was the term given by one service whereby Jess and Jenny denoted the pseudonyms of the two practitioners working concurrently with a client.

that unless practitioners communicated clearly and coordinated their services, the client might be provided with different and conflicting information and be left feeling confused and unsupported.

Participants from ISSAFVS described this approach as providing a wrap-around service and that it was easy to implement as the range of services could be accessed by the client under one roof. They also reported that clients often preferred to have separate practitioners that they could call on to suit their changing circumstances. A small number of practitioners from ISSAFVS reported that they provided both therapeutic counselling and case management functions as part of their job role. Some found this a challenging way to work.

Many participants reported working with other specialist services in care team meetings, developing shared care plans and joint risk assessments. This type of collaborative practice included working alongside other services such as child protection, schools, and mental health services and through their membership and participation in Risk Assessment and Management Panels (RAMP).

Many participants reported that collaborative client practice happened in an organic fashion and that the processes for sharing clients is not clear. No participants reported using protocols, guidelines, or such like to support this collaborative work, apart from MARAM.

> *"It [process of working with a shared client] is not a clear process at the moment."* [SFVS, rural]

Practitioners in the focus group reported that having a set of principles or guidelines - that were accessible, concise, and practical - to better support collaborative practice with joint clients would be beneficial.

5.3.4 Collaborative practice – integrated approaches

ISSAFVS. Participants from ISSAFVS described building a new integrated model of service from the merging of specialist sexual assault and family violence services. The model has evolved through careful consideration of how best to meet client's needs, making the best use of specialist skills and knowledge held by practitioners and the belief that an integrated approach could provide a clearer pathway towards healing and recovery for clients. They reported a high degree of satisfaction and job fulfilment from working within this model and being able to contribute to wrap-around service responses for clients.

> *"We should always put the client journey first. If we can make it better for them, why wouldn't we do it?"* [Integrated service, rural]

They reported working in specialist teams with specific functions including integrated intake, afterhours crisis response, therapeutic counselling, case management and Orange Door specialist family violence practitioner teams. Two of the ISSAFVS reported that collaborative practice was also embedded within the MDC in which they also belonged.

They reported that the funding model, reporting requirements and targets constrained the degree of integration and that the most practical approach in terms of administration is to keep service elements separate for ease of reporting. They reported that greater flexibility in funding and reporting mechanisms would allow them to evolve the integrated approach further.

After-hours crisis services. Whilst after-hours crisis responses to sexual assault and family violence varies widely across Victoria in the way in which it operates, there are a small number of integrated after-hours services. In these cases, integrated after-hours services are provided to victim survivors of sexual assault and family violence by a team of specialist on-call staff. Staff are trained in responding to family violence and sexual assault and are able to navigate the protocols and standards required by both systems, for example police, justice, and health protocols.

New collaborative projects. There are a range of new integrated or highly collaborative models and projects in development and funded through the Family Violence Therapeutic Interventions Program. These projects seek to work in new ways - a number with a focus on children, that are highly collaborative, require new partnership and governance arrangements, engage new staff and bring a more integrated delivery of services to clients. During interviews and focus groups there was a high level of excitement about the potential of such projects, and an acknowledgement of the planning required to support their successful implementation.

Most of these projects were stalled during the COVID 19 period, with participants expressing their disappointment in the delay in rolling out exciting new initiatives. They expressed a concern about the delay on the connections and trust that had been built in the planning of the projects.

5.3.5 Collaborative practice – systemwide integration

Local area integrated networks, RAMP participation, and attendance at joint training were all reported as areas of collaborative and integrated activity between SSAS and SFVS. SFVS participants reported that they found it useful to have input from SSAS at RAMP meetings.

Participants reported that funding models impacted on service design and levels of collaboration. Services reported being required to report on targets aligned to funding streams which impacted on their ability to deliver and report on more creative or collaborative ways of working.

Both sectors reported to be strong advocates for women, young people and children and frequently work together to raise the voice of women, young people and children. Participants described a real strength when the sectors worked together in this way.

Many participants reported that their priority in terms of collaborative work was not with their local specialist SSAS or SFVS but rather another service type – most commonly mental health services.

> *"We know they (SSAS) get it; we know they understand family violence. We have to focus our effort on working more with mental health services, that's where the need is."* [SFVS, metropolitan]

Most participants reported that they could see the need for, and benefit of increased integration and collaboration. They also reported that this would require additional resourcing and that the current system reforms required a level of consolidation before taking on anything else. Note that these comments were made prior to the COVID 19 period where indeed services did take on much, much more than they could ever have expected, and with great success in many cases.

5.4 Benefits of collaborative practice

Timely access to support, accurate provision of information, and a pathway to hope and long-term recovery were cited by project participants as benefits of collaborative practice for clients. Participants also reported that they benefited from collaborative practice in having increased confidence and skills through secondary consultation or through working with joint clients.

Participants from ISSAFVS described providing 'wrap-around' services for clients in a timely way which responded to client needs as they presented. They reported being able to easily access support from a specialist case manager or a specialist therapeutic counsellor, or to access secondary consultation about the best way to meet the needs of a client. Participants reported that clients often remarked how grateful they were not to have to seek out what they needed by presenting at a different service.

Participants reported benefits for individual clients and potentially reducing the time required for therapeutic counselling, if they could easily access skilled case management support. SSAS reported that many clients could benefit from specialist case management services regardless if family violence was a presenting issue. They expressed frustration that counsellor advocate time and skill was sometimes used to facilitate case management tasks rather than progressing therapeutic interventions with the client.

SFVS participants reported that where they could access specialist sexual assault advice and support, they were able to provide specialist support to clients while the client 'waited' to get access to therapeutic counselling.

5.5 Cautions about greater collaboration

Project participants were asked if they had any cautions or concerns about greater alignment and collaboration between the two sectors.

The greatest area of concern was related by SSAS participants in relation to the potential of 'sexual assault becoming lost' within collaborative approaches. They cited having to continually raise the issue of sexual assault at regional forums, RAMP discussions, in dialogue with policy makers and funding bodies. The assumption that family violence also included sexual assault had the effect of silencing or ignoring sexual assault even though this may not be the intention.

SSAS participants reported that they felt it was easier to talk about family violence than sexual assault, or child sexual assault. They reflected that child sexual assault was an area that SFVS found least comfortable to talk about.

Participants reported that it was important for clients to have the dignity of choice about what services they accessed and what information was shared. SSAS expressed a level of concern about the information shared in collaborative practice, particularly where a police investigation was underway.

Participants from ISSAFVS expressed the importance of maintaining specialist teams within the integrated model. They stressed the importance of ensuring that they could provide both specialist case management and specialist therapeutic counselling services to clients. Each specialist function was described as requiring a high level of skill and ongoing professional development to maintain contemporary evidence-based practice.

Participants expressed a caution in unintentionally undermining the work of each specialist team, or providing conflicting messages to clients but that shared, co-ordinated case plans and good communication were vital in providing successful integrated approaches for clients.

Participants reported that the differing pay rates and funding models presented challenges in expanding collaborative approaches.

> *"I worry about the potential of privileging one sector over another. This would set up further inequities, and elitism within the service system."* [SFVS, Metropolitan]

Participants cited organisational structures as a potential impediment in increasing the number of ISSAFVS. For example, SFVS participants reported that they would find it difficult to merge with a hospital-based CASA and felt that this would compromise their model of service. Likewise, hospital based SSAS expressed concern about the way an integrated model of service could work.

Whilst outside the remit of this Project, many participants expressed a level of caution and concern as to the location and intersection between specialist services and the Orange Door services, and the alignment between MDCs and the Orange Door.

5.6 Specialisation

Participants were asked about the value that specialisation brings to their work. The most common response across both sectors, was the underpinning feminist framework, gendered lens for understanding family violence and sexual assault and trauma-informed approach that shape and inform specialist practice approaches.

Participants stressed that specialisation should be preserved, respected and given credibility, and that it must not marginalised. They suggested that the impact of losing specialisation would result in a loss in a gender-based understanding of family violence and sexual assault which would have a subsequent detrimental impact on people seeking support from the specialist services.

Specialisation was reported to enable services to understand the structural impediments to violence against women and children which is key in making long term change.

Specialist support for clients was described as vital in supporting clients to get the best service that they need and what '*they are entitled to receive*'. Specialisation was reported to achieve better outcomes for clients. Specialist practitioners were described as confident and better informed in their work with clients and therefore more effective in the way they worked. Practitioners were able to holistically address clients' needs, especially when working collaboratively in managing risk and providing therapeutic work. This resulted in clients who are better engaged with the service, more empowered and less likely to be at risk. For clients, a specialist approach was reported to give them permission to disclose their experiences and the opportunity and where-with-all to restore their hope and recovery.

> *"Specialisation provides clinicians with the capacity to go places with clients where other people can't or won't go. Not going to such a place entrenches shame and guilt (that clients can experience)."* [SSAS, metropolitan]

Working daily in a specialist service was reported to bring a level of understanding, competency and confidence which defined specialist practice. Highly skilled practitioners mitigated risk and enhanced safety, and specialisation bought clarity around what modalities might suit individual clients.

Specialisation was described as bringing a depth of knowledge and understanding about the best way to approach clients, understanding that it can be difficult for people to seek help and that clients can easily disengage with the service. SSAS participants reported that trauma-informed approaches were key in supporting people to speak about sexual assault which was very difficult for most people.

> *"Often the question has not been asked before and the client has not been able to tell anyone. They have not had a path laid down for the recovery, for people to have been given hope to keep going."* [SSAS, metropolitan]

Participants reported that there was more potential for their voice to be heard in care team meetings if they were regarded as a specialist by other practitioners. Specialisation also allowed them to build capacity in the broader service system through secondary consultation and professional development.

> *"Working with another specialised service helps me to see thing from another perspective and helps me to inform how I work with clients. And we can help child protection practitioners with a family violence perspective and that assists in supporting the clients."* [SFVS, rural]

Most participants stressed their preference to have deep specialist knowledge about either sexual assault or family violence – a dominant lens or primary focus. They reported not wanting to be a Jack, or Jill of all trades. They considered that it would be difficult to keep up with current research across too many specialities – '*the area is constantly evolving*', and that best practice work, and job satisfaction for practitioners was improved if they had a clear area of specialisation.

Participants described the passion and desire that practitioners held in working in these specialist sectors. They described it as a difficult field to work in and that practitioners needed a level of resilience and a desire for the work.

5.7 Professional development

Participants reported strong support for shared training opportunities. At the time of the interviews (February 2020), practitioners across both sectors reported that they were looking forward to attending the DV Vic, CASA Forum and No To Violence (NTV) sponsored Responding to Serious Risk: Family Violence and Sexual Assault Practitioner Forum. The Forum was postponed due to COVID-19. Joint sector training such as the recent MARAM training was reported as a good opportunity for the two sectors to come together, to receive consistent messages and to share skills and learn together.

> *"Joint sector training is fantastic. It feels like finally there is something to bring the conversations together. It feels new and is very welcome."* [ISSAFVS, rural]

Participants also felt it is important that specific training such as therapeutic counselling modalities were more relevant and more beneficial to be delivered as sector specific training.

Participants from SFVS reported wanting to work more closely with SSAS in order to be better skilled in responding to disclosures of sexual assault. Several SFVS participants reported a growing awareness over the last year or so of the experience of sexual assault within the context of family violence. They also acknowledged the need for practitioners in SFVS to feel more confident in responding to clients' needs in relation to recent and historical sexual assault.

> *"I would like to have training from CASA about how to help women a bit more as part of my case management work."* [SFVS, Statewide]

Many participants expressed a desire to learn more about integrated models, including MDCs – how they operate and the benefits for clients. They wanted to know what was working well in that space.

Whilst several participants reported that their service delivered training, few reported delivering training as joint sectors. However, participants responded favourably to the idea of delivering training together and felt it could be a good way of working together and in improving local area understandings of the system response to family violence and sexual assault.

5.8 Impact of COVID 19 on collaboration

Two focus groups brought together senior practitioners to discuss the impact of the COVID 19 pandemic on collaboration between the sectors. Practitioners touched on the many changes that they have and are making to the way in which they deliver services, however this Project focused the conversation on the impact of collaboration.

5.8.1 Impacts on referral pathways and access to services

Focus group participants reported a range of impacts on the collaboration between SSAS and SFVS. This ranged from little to no change in the way in which they collaborated, focusing more on internal organisation systems and issues than on collaboration, to a significant increase in collaboration.

Participants who reported an increase in collaboration described actively using the COVID 19 period as an opportunity to collaborate more. The use of online platforms to quickly engage across services without the need to travel supported this increased collaboration.

> *"We have had more meaningful conversations, and positive experiences. We are working more closely together."* [SSAS, rural]

Many participants reported spending time 'looking inward' – considering the best way to provide the best possible services and refining internal processes. SSAS participants reported also spending this time considering their MARAM alignment, embedding MARAM and risk management processes and reviewing intake systems. Participants described this as having '*breathing space'* to review processes and policies and areas for improvement.

A small number of participants who reported having little or no collaboration between the sectors, indicated that this continued to be the case during the COVID period.

SFVS participants reported that collaboration was significantly impacted due to the reduction in the availability of SSAS in the initial COVID period. This resulted in clients remaining on waiting lists for a longer period, and for 'holding' clients they would normally have referred to SSAS. For clients this resulted in delays in accessing therapeutic counselling services. Participants also reported that referral processes were changing rapidly and that some clients' appointments were cancelled.

Some participants reported that in the initial period it was difficult to know which services were still operating, and if so, what type of service they were providing, for example whether face to face services were still available or whether clients could contact services via telephone or online.

At the time of the focus groups in June 2020, many participants reported significant changes to the suite of services they offered and they way in which these services were provided, for example, through a variety of online platforms.

Some SFVS participants reported that it was not easy to find the right person to call and that referral processes into SSAS were more complicated.

SFVS participants reported that they experienced an increase in secondary consultations with a range of services in the wider service system, and with families and friends of clients. They suggested this was due to SFVS being nominated by government as an essential service and as such, their service was the '*only one open for business*' in the early stages of the COVID 19 period. SFVS participants also reported increased collaboration with other sectors such as police who initiated new projects in some areas designed to monitor clients at high risk of experiencing family violence.

> *"They (police) were the only service providing face to face work and they helped us to monitor our most vulnerable clients."* [SFVS, rural]

Participants reported that many clients who did access services during this time were experiencing increased mental health and suicidality, and that they were seeing more significant injuries for children and young people. They reported that some clients were distressed about not have face to face contact for example with mental health worker, and that the situation was very isolating for vulnerable clients.

As services refined their service offerings and began to provide online services, some reported that they were able to reach a broader range of clients and to reach out to clients who may have struggled in the past to attend services face to face. Some SSAS also put in place new arrangements to counter extended

waiting lists including offering single session frameworks to improve accessibility for clients. The degree to which SFVS were aware of the use of these changes is not known.

Children and young people

Participants reported that this period, particularly in the early stages of the pandemic, had impacted negatively for many children and young people, and that a range of services and service modalities aimed at children and young people were paused. Some SFVS reported that referrals to SSAS for children and young people were difficult and lengthy, partly due to this pausing of services. This pausing occurred while SSAS shifted their service delivery focus to telephone and online services. For some SSAS the time needed to develop secure delivery systems and to ensure staff were adequately trained and supported in using these systems impacted on the pausing of some services. Some SFVS participants reported an increase in children presenting with sexually harmful behaviours which they would normally refer to their local SSAS. With SSAS providing limited services in the initial COVID period they found that they were '*holding cases we normally wouldn't*'.

Some participants reported that delivering online and telephone services was highly successful for some children and young people.

SSAS participants reported that while services worked hard to establish platforms suitable for working with children and young people, they were limited in what services they could provide for children. Instead their work focussed on risk assessment and working through the parent or carer.

As SSAS began to establish new platforms for service delivery, such as web-based referral systems, group programs and online systems, they expected that other services would begin to see an increase in availability of services for children and young people. Some SSAS participants reported that some services such as sexually abusive behaviours treatment services were best provided face to face which, in the COVID 19 environment, meant delays to referrals and a pausing of services.

SSAS participants reported that preventative and early intervention work with schools was put on hold.

Some SFVS participants expressed frustration with SSAS referral processes that changed during this period. They reported feeling confused about the lack of clear information about making referrals and needing to *'think about how we can work better to support the client'*.

5.8.2 Impacts on new collaborative initiatives and projects

As discussed earlier in this Report, several new highly collaborative projects are being planned and implemented across the State. The COVID 19 period has seen many of these projects paused. Participants reported being disappointed about the delay to the start up of the projects given the amount of work that had gone into the planning. For some practitioners recruited specifically in newly created roles, the pause in projects has limited the way in which they can work. For some practitioners this has meant focussing their effort on other ways or working to add value to the online work.

Some projects were now considering how online platforms might assist them to deliver the project. Of most concern was the ways in which these new programs and projects could be delivered safely for women and children.

> *"People are working hard to work out how to do it. The systems [across organisations] need to be secure. It's a different ball game about how to do a group online, considering safety and security, and the technical skills for staff."* [ISSAFVS, Rural]

Participants described partnership meetings beginning to start up again and that they were considering how such projects will operate to accommodate COVID 19 restrictions. Some participants reported that

work to finalise partnership agreements and MoUs (not necessarily between the two specialist sectors) had also been delayed and were taking longer that they normally would to be finalised.

> *"We have had to push ourselves to see things differently and see what is required. It's allowed us to think outside the box."* [SSAS, Rural]

5.8.3 Impacts on collaborative practice

Participants reported that care team meetings, a feature of collaborative practice, have continued during the COVID 19 period, and that in many instances these have become more frequent and easier to conduct due to online platforms. They also reported that one downside of this increased accessibility was the duration and frequency of online meetings. They reported that whilst there was a benefit in reduced travel times to attend such meetings, that travel time allows time for thinking and planning prior to the meeting.

Participants also reported that there was reduced opportunity for incidental supervision with peers - an important feature of collaborative work. Practitioners have worked to create different ways of connecting informally with colleagues online to reduce the isolation of working from home.

5.8.4 Impacts on induction and networking for recently recruited practitioners

In the focus groups, participants discussed the impact of the COVID period on the induction of practitioners recruited during or just prior to the COVID period, and the ability of new practitioners to understand the broader service system, in particular, the two specialist sectors.

Participants reported the difficulties for new practitioners in having a sense of being part of the specialist sector and connecting with the many colleagues working within it.

Services reported using online orientation processes, and online training to support induction of new workers. In some instances, participants reported deciding to not recruit to some roles for the time being.

Participants reported a level of concern for practitioners who had not met any of their colleagues face-to-face, let alone colleagues from other specialist services.

Some participants reported having to work harder in the initial starting period to engage with new practitioners and in thinking creatively to counter the impact of not being able to attend meetings in person as a way of understanding the wider service system and establishing relationships with colleagues across services. A participant described setting up 'zoom meet and greet' sessions with all agencies to assist in reducing isolation and increasing connection for new practitioners.

> *"If you have been around a long time, people know who you are. After doing 'zoom meet and greets' it helped because all the calls weren't coming through to me, they could go to our new staff too."* [SFVS, Rural]

Other examples conveyed by participants included setting up casual peer support online spaces, online meetings to discuss counselling practices, peer supervision groups, buddy systems and team meetings.

5.8.5 Impacts on professional development

Focus group participants reported very favourable outcomes from the increased access to training via online platforms and the increased time for training due to the initial slowing of referrals to service and the pausing of some services.

> *"Staff's ability to access good professional development has vastly increased. It's training we normally wouldn't be able to get to. I've seen an improvement in my staff's knowledge and skills*

due to our increased access to training. It's meant our new staff have been able to fast track their orientation." [SFVS, rural]

Participants from rural services reported benefits in being able to access valuable online training. They reported that it is often difficult for them to attend training, particularly half day (or less) training when coming from rural areas due to the travel time involved, and that staff often did not put their hand up to attend training due to the impact of being out of the office for an extended period (a whole day or longer required for a three hour training session).

Focus group participants were very supportive of online MARAM training that they and their colleagues attended during this period.

5.8.6 Learnings from COVID period

Focus group participants reported a range of learnings from the COVID 19 period. This included the ability to be flexible – at a staff level, at a client level and at an organisational level – and to be open to think about what might be possible.

Participants reported an increased appreciation for the potential of online platforms in delivering services. They described a growing understanding of which platforms might best suit which clients, and which online services might be unhelpful for some clients. They reported an ability to now offer a broader suite of service offerings and modalities alongside face to face services including via email, telephone, tele-health, and web services. Participants also related a key learning in the complexity of finding suitable online platforms, for example, to support the delivery of therapeutic group programs and working with joint clients.

"We have learnt to ask: How else can we do it? What is it that clients need? And we know now, we can do it!" [SSAS, Rural]

Understanding the impact of online service delivery for children and young people has been a significant area for learning. For example, understanding which therapeutic modalities were suitable to be delivered online, and which children and young people most suited online delivery. One participant described this as *'learning about the clinical indicators that help us to understand which children are most suited to online or telephone services.'* Focus group participants agreed that this was an area for greater learning and understanding.

6. Discussion

6.1 Essentials for collaborative practice

This Project has identified the following essentials to support collaborative practice:

- Respect
- Relationships, connection, and trust
- Knowledge, skills, and confidence
- Leadership
- Infrastructure

The essentials are interconnected and build on each other. It is the combined impact of the essentials that brings about impactful collaborative practice. The following section unpacks each essential component.

6.1.1 Respect

High levels of respect across both sectors is apparent from discussions with Project participants. There is a high level of respect for the skills and expertise each sector brings, and for the service elements that are mostly unique to each sector – in particular, the therapeutic support provided by SSAS and specialist case management skills provided by SFVS. A willingness, interest and need to learn from each other is also apparent. This respect encompasses when both sectors working together as well as delivering services independently.

There is a growing respect for the ISSAFVS, and a keenness to understand more about this model. There is an opportunity to demonstrate respect for ISSAFVS as a legitimate model and to support this approach via integrated funding streams and data collection, service model design, and protocols, standards, and codes of practice. There is an opportunity to nurture, refine and document this integrated approach and subsequent client outcomes.

It is important to create space for and acknowledge the legitimacy of each sector and specialty. This includes explicitly naming both areas of specialty and acknowledging the frequent interconnections between the sectors. In discussions about family violence, at a policy and practice level, it is important to also consider the implications for sexual assault services. Similarly, in policy and practice discussions about sexual assault it is important to consider the ramifications for family violence services.

6.1.2 Relationships, connection and trust

One of the strongest messages to come from Project participants was that good collaborative practice cannot happen without strong relationships, connection and trust between practitioners and services.

As services face ever increasing demand, and in the current COVID 19 climate, there are challenges in creating the time for practitioners to meet and connect. Practitioners from statewide services described the logistical difficulties in establishing good working relationships with practitioners across the state.

In some local areas in both metropolitan and rural areas, there remains minimal contact between the two sectors. There could be greater expectation by peak bodies and funding bodies for each local SSAS and SFVS to have effective working relationships built through clear referral pathways, protocols, policies, and procedures.

Shared practice approaches, joint training opportunities and participation in local integrated networks provide avenues for increasing connection and understanding between the sectors.

6.1.3 Knowledge, skills and confidence

The Project has found that deep knowledge about service offerings and in the way in which each sector works is patchy across the state. Specialist services who frequently work together tend to have a good knowledge of each other's services and a deep understanding of each other's roles. On the other hand, some services appear to have little to do with each other and have a limited understanding about what each sector provides for clients.

There is a growing awareness among SFVS practitioners that they need to build skills and confidence in responding to disclosures of sexual assault, and in understanding the impact of child sexual assault for adult women.

Some practitioners related that they have experienced an increase in the honesty of staff to discuss gaps in their knowledge. An increasing awareness of gaps in knowledge appears to relate to supportive work structures including strong supervision models, improved access to training opportunities, and a growing awareness of the importance of risk assessment in the SSAS sector and of sexual assault in the SFVS sector.

The intersection between sexual assault and family violence is an area where practitioners are interested to develop a greater understanding. They are interested to understand the co-occurrence of family violence and sexual assault, what this means for the way in which they work.

6.1.4 Leadership

Participants identified leadership as a key factor in the strength of their collaborative practice across the two sectors. Leadership related to individual practitioners and services, and also to peak bodies and funding bodies.

Encouragement to work collaboratively frequently stemmed from leadership within individual services. For example, practitioners were supported to 'spend extra time' in establishing good relationships with other specialist practitioners and to take the extra time needed to jointly work with another service in providing support for victim survivors.

Leadership by peak bodies in delivering joint training opportunities was welcomed and accompanied by a level of excitement. CASA Forum and DV Vic have an important role to play in demonstrating collaborative leadership; continuing to work together to inform policy and practice, and reviewing sector codes and standards to ensure that they adequately address the interconnection between sexual assault and family violence.

Both sectors expressed a desire to see leadership from funding bodies in understanding the complementary nature and the interconnections between the specialist sectors.

6.1.5 Infrastructure

Collaborative practice is currently restricted by the infrastructure underpinning service delivery such as funding models, data collection and practice tools. The introduction of MARAM is welcomed across both sectors, and whilst it is currently being embedded into service delivery it appears to be influencing and increased understanding of the complementary roles of the two sectors.

A more flexible approach to funding models and data collection systems, and additional resourcing to support collaborative practice, could create an environment for collaborative practice and collaborative service models to evolve further.

Practitioners have experienced a rapid expansion in skills and familiarity in using online systems during the COVID 19 period. They have welcomed the flexibility and ease the online environment provides in connecting with practitioners across the sectors. It is likely this will continue to grow as the COVID 19

period continues and platforms are developed to support collaborative service delivery such as therapeutic group programs. Practitioners have called for systems that could better support the sharing of information and risk assessments across the two sectors.

Participants stressed that it was important to also consider the limitations of online systems in relation to collaboration and the need to develop a more nuanced understanding of where the strengths of online systems lay.

6.2 Communication, clarity of job function, and service gaps

Overall, the consultation found consistent understandings of job functions, for example, therapeutic counselling, case management, intake, risk assessment and management. These job functions appear to be well understood across participants from both sectors.

The range of service offerings provided by each sector was less well known with many participants showing a limited knowledge of the range of services provided by specialist services in their local area. Several participants reported, *'we know what they provide but they don't know what we provide'*. The dynamic nature of services and their ability to quickly adapt service elements in responding to client need along with the rapid introduction of new service offerings is likely contributing to practitioners' sense of not keeping up with 'what is on offer' for clients. The ongoing demand for services across both sectors may also mean that less attention is paid to communicating service changes.

The increasing range of service offerings and changing service pathways has been exacerbated in the COVID 19 period where many new ways of working are being implemented. It is unclear from this Project the extent to which information about new service offerings is being shared between the specialist sectors.

An increasing complexity in relation to client need, as reported by participants, has raised awareness about the best way to respond and often the dual need for clients to access both therapeutic counselling and case management services. A level of frustration about access to case management services is apparent across both sectors.

SSAS are not funded to provide case management services for sexual assault clients. However, SSAS practitioners reported that many clients may require case management support, not always in response to family violence matters. SSAS participants reported frustration with 'clunky' and time-consuming referral processes to assist a client to access specialist family violence case management services. They also reported having to use valuable therapeutic counselling time to undertake case management tasks, particularly where they were unable to secure such case management support. Being able to access Family Violence Flexible Support Packages for sexual assault clients assisted with case management needs in some cases.

Additionally, several participants reported confusion between the functions of advocacy – a common and funded function provided by SSAS, and case management – a common and funded function delivered by SFVS. Some participants reported that practitioners from services within the broader service system were also confused by the different terminology and functions, and that funding bodies did not fully understand the difference. In general, SSAS practitioners were much clearer about the distinction between the functions.

> *"Our role in advocacy is to get that service in, to enhance her safety. We might advocate to [SFVS] for her to have a flexible support package, or to get case management, but we are not*

case managing provision of those services. Our role is to work therapeutically on the impact of the trauma of family violence." [SSAS metropolitan]

This issue points to a potential service gap in the provision of case management for sexual assault clients.

Some SSAS also reported responding to a high demand for specialist family violence counselling even though they did not receive funding to do so. They reported that in the process of providing therapeutic sexual assault counselling, issues of family violence become apparent and the focus of counselling changes accordingly. A growing awareness about the impact of sexual assault, including childhood sexual assault, for clients accessing SFVS was reported by SFVS participants. This highlights an emerging recognition of the impact of co-occurrence and the need for more responsive service models.

6.3 Opportunities for collaborative practice

6.3.1 Shared practice approaches

It is clear from this Project that shared practice, or collaborative practice approaches are an important element of the service system and that there is significant variation in their deployment.

Two areas for improved and more consistent collaborative practice approaches are referral pathways and working with joint clients.

There is an opportunity to enhance the referral pathways between the two specialist sectors. This is an area where the greatest level of inconsistency across the state was identified. A clearer and more consistent referral pathway across services is hampered by the level of demand on services, practitioner knowledge of both specialist systems, and the relationships between practitioners. Practitioners from both sectors describe the importance of clients not having to retell their story as a key component of their trauma-informed approach. However, inconsistent referral pathways mean that for many clients they will in fact need to retell their story. Some SFVS practitioners feel discouraged from making a referral to SSAS as their local SSAS prefers that clients contact the service themselves rather than through the support of a SFVS practitioner.

Further work is required to more fully investigate the referral pathways between the specialist sectors. This includes understanding the identified need that might trigger a referral, and the processes for prioritising referrals.

As MARAM becomes embedded within the specialist sectors it will provide the opportunity for more joint risk assessments and potentially improved referral pathways. A shared referral tool might also provide a more effective referral pathway and the opportunities for fast tracking clients into the services that best meet their needs.

"We still have a paper-based referral system. Surely, we can have a better process that doesn't require us to share bits of paper. [SFVS, rural]

A number of services are actively working with joint clients. This practice largely occurs where there are good working relationships between the specialist services at a local level and in particular, where practitioners are colocated, or where an integrated approach is the foundation of the service, such as that in ISSAFVS. There is an opportunity to shift this practice from one that is currently organic to one that is a formal service offering and is supported by principles or guidelines.

"Having something like principles for shared client work would help to keep services accountable but also to keep us as counsellors accountable to clients." [SSAS, Metropolitan]

Integrated approaches such as those offered by ISSAFVS provide an insight into an approach that is informed by an understanding about the co-occurrence of family violence and sexual assault. This approach has evolved over several years and ISSAFVS are well placed to document the model and the impact on outcomes for clients.

6.3.2 Secondary consultation pathways

A growing awareness about sexual assault among SFVS practitioners is likely to result in greater connections between SSAS and SFVS practitioners and the need to support increased secondary consultation pathways. There is an opportunity to increase colocated, or embedded practitioner models whereby a specialist practitioner is colocated within a complementary specialist service. This model was widely supported by project participants. This approach can strengthen relationships between practitioners and increase the knowledge, skills and confidence of practitioners. This along with improved referral pathways could have a significant impact on supporting clients experiencing the co-occurrence of sexual assault and family violence.

An increase in secondary consultations across the sectors is likely to be impacted by demand for services. Consideration is needed of the impact on service capacity and funding in providing secondary consultation.

6.3.3 Joint education and training

There is a strong appetite from consultation participants for joint sector professional development opportunities. Areas that lend themselves to joint training are shared practice approaches, increased understanding of service offerings and ways of working, and the co-occurrence of family violence and sexual assault.

Participants across both sectors identified a need for SFVS practitioners to have a greater level of understanding about sexual assault, its impacts, ways of responding to disclosures and options available to victim survivors. SFVS participants expressed a desire to feel more confident in responding to disclosures of sexual assault without having to become 'experts on sexual assault' which they saw as they role of SSAS.

There is an opportunity to review the DVRCV core family violence training for new practitioners to ensure it sufficiently covers sexual assault including the impact for children and young people. This could include training elements as suggested in the ANROWS Report on intimate partner sexual violence:

- Myths and dynamics of sexual violence within relationships
- Guidance on 'how to ask' and building trust
- Effects and health consequences
- Managing victim survivor safety
- Cultural considerations
- Legal options and evidence requirements.[17]

The ANROWS Report provides guidance regarding training elements in relation to adults. Additional training elements are required to ensure the training also covers the impact of sexual assault for children and young people.

There is also an opportunity for SSAS to deliver training about responding to disclosures of sexual assault for the SFVS.

[17] ANROWS, op. cit., p.7

It is likely that greater exposure to each sector through shared training opportunities will also have a positive impact on deepening the understanding of the approaches of each sector.

It is important that sector specific training continues to be available to maintain and extend the specific specialist professional development needs of practitioners.

Whilst not all specialist services deliver local community education training, for those that do, jointly delivering this training, using an intersectional feminist framework, is another area of opportunity for the two sectors to work together. Joint training of this sort would provide the community with a broader understanding of the service system, and increased recognition of the complementary nature of the two sectors and of the co-occurrence of sexual assault and family violence.

6.3.4 Resourcing collaborative practice

The terminology and understandings of the terms collaboration and integration are not shared or agreed between services, peak bodies and funding bodies.

There are also differing beliefs about the potential consequences for greater integration. For some participants there is a fear of specialisation being lost if 'pushed' towards integration. For other participants, a move to integrated practice has seen innovative approaches that participants report brings improved outcomes for clients.

Providing opportunities for the sectors to discus and share their experiences and understandings of collaborative practice could support the development of shared language and increased knowledge.

The call for better data in relation to the co-occurrence of sexual assault and family violence has been made strongly by participants and is echoed in recent research. The specialist sectors are keen to understand more about co-occurrence and the most effective service responses. The current dual data collection systems are unhelpful in progressing such understandings.

There is also a lack of documentation of the ISSAFVS approach and benefits for clients.

There are some frameworks that can guide further collaborative work such as the eight indicators set out in the Australian & Domestic Violence Clearinghouse Regional Governance Continuum Matrix of Practice Tool[18]. However, this tool lacks the inclusion of joint client work. Codes and standards of practice also lack explicit description of standards for joint client work and for responding to the co-occurrence of sexual assault and family violence. There is an opportunity to include specific reference to sexual assault in the specialist family violence service model project and supporting protocols and policies currently under development.

Greater flexibility of funding models would provide much needed support for integrated models of practice. This would not only validate these models but also provide a more relevant tool and incentive for supporting such practice.

6.4 Areas for further examination and research

While this Project has examined collaboration between a significant cross section of the specialist sexual assault and family violence services, there are a number of areas that have not been examined. These include: intersection with the Orange Door, collaboration between the two statewide after-hours crisis services and between the two specialist sectors, collaboration between the MDC and Orange Door models, collaboration between the specialist sectors and family violence therapeutic counselling

[18] Healey, et al, op. cit., p.6.

services provided by the community health sector. These are significant omissions in giving a full picture of the level of collaboration between the two specialist sectors. The out of scope areas do however provide an opportunity for further investigation.

The Project has also not examined collaboration of other service sectors responding to family violence and sexual assault, for instance police, justice, health, and mental health. This again is an area for greater understanding and investigation.

In some way it appears unusual to examine greater collaboration between the sexual assault and family violence sectors without also examining this interaction across the broader service system. Several participants reported that the priority for greater collaboration was not with either specialist sector but with the broader service system, for example with mental health providers.

A priority for greater understanding is the growing area of co-occurrence of sexual assault and family violence. Participants reported that they were increasingly seeing this issue presenting in the complexity of clients' needs but feel under-resourced to respond in an evidence-informed way.

7. Conclusions and Recommendations

This Project finds that the specialist family violence and sexual assault sectors are highly complementary and frequently interconnected.

There is strong evidence, from the project consultations and contemporary research, that collaborative practice is embedded within the specialist system response. There is also strong evidence that there is effective collaborative practice between the two specialist sectors and that there is variation in the depth and extent of that collaboration across the state. There is an enthusiasm across the sectors for greater connection and collaboration with an awareness that this is essential in responding to a growing complexity in the needs of victim survivors of sexual assault and family violence.

The Project has identified that the two specialist sectors have much in common including the underpinning frameworks of feminist principles, a gendered understanding of family violence and sexual assault, and a trauma-informed approach. There is also a shared understanding that women, children and young people impacted by sexual assault may very often be victim survivors of family violence, and that a high percentage of women experiencing family violence will have also experienced sexual assault. There is an acknowledgement that the sectors provide different services to a similar, and at times the same client group.

The Project has also found that there are differences between the sectors including significant differences in the size of the sectors - the SFVS being much larger than the SSAS sector - and the range of services offered, often dictated by the different funding models of each sector.

Both sectors require continued recognition and government attention in their own right, along with support for greater collaboration. Attention to greater collaboration should not be at the expense of a lessening of attention to the demand for services and service innovation essential for each sector.

The Project finds that it is not sufficient to consider that sexual assault is encompassed within an understanding of family violence. This does not mean that sexual assault should not be considered an element of family violence, rather that without explicit reference to sexual assault it is likely to be lost or minimised.

It is critical that both arms of specialisation are 'seen', respected, and considered in practice, policy and funding. This recognition is vital because this is the reality of many clients. To not do so is a disservice to clients.

It is recommended that:

1. FSV continue to recognise and support each specialist sector in its own right, and support greater collaboration.

There are a range of terms used by both sectors that have a different meanings and understandings. These terms include trauma, risk, safety and integration. There is also a range of understanding about what constituted a therapeutic intervention. The introduction of shared tools such as MARAM are helpful in creating shared understandings of these terms. Further work between the peak bodies to align language and develop a shared understanding of common terms would be beneficial.

It is recommended that:

2. DV Vic and CASA Forum work together to agree a shared understanding of common terms.

The Project has found a high level of support for collaborative practice. Participants described collaborative practice as essential to their work. Collaborative practice between the two specialist

sectors varies across the state with some services working closely together and other services reporting that they rarely had contact.

The Project has identified a set of essentials for collaborative practice:

- Respect: respecting the skills and expertise that each sector brings, and respecting newer integrated models of practice.
- Relationships, connection, and trust: to create meaningful, reliable interactions between specialist practitioners, and facilitating client access to services that best support their needs.
- Knowledge, skills, and confidence: gained through the sharing of skills and the explicit inclusion of family violence and sexual assault into training modules.
- Leadership: to enable, guide and promote collaborative effort.
- Infrastructure: flexible funding models and data collection and further research to support, nurture and encourage innovative collaborative practice.

It is recommended that:

3. FSV, DV Vic and CASA Forum work together to ensure that the essentials for collaborative practice underpin programs and projects designed to enhance collaborative practice.

The Project has identified the need to improve referral pathways and work with joint clients. While both sectors share a common goal for clients to not have to repeat their story, the current arrangement of unclear and inconsistent referral pathways between the specialist sectors means that some clients are likely having to repeat their story. Strong practitioner relationships, colocated services, and ISSAFVS enhance the likelihood of effective referral pathways. Shared referral tools may also improve referral pathways.

The colocation of specialist practitioners within a complementary specialist service has received a high level of support from participants including those currently involved in colocation, those experiencing colocation in the past and those with limited interaction between the sectors. The benefits of colocated, or embedded practitioner models include improved knowledge and confidence for practitioners, greater secondary consultation between the sectors, and improved referral pathways for clients.

The Project acknowledges the joint client work occurring between a number of SSAS and SFVS, and the growing awareness amongst practitioners that this approach can have significant positive outcomes for clients with complex needs and in particular clients experiencing the co-occurrence of sexual assault and family violence. In the absence of service models and practice guidance, joint work was described as organic and dependent on good working relationships between practitioners. Practitioners expressed support for principles or protocols to guide joint client approaches.

Integrated approaches as demonstrated by ISSAFVS, integrated after-hours crisis responses, and recently funded integrated projects provide new models for bringing the expertise of both sectors together to improve service responses and facilitate improved outcomes for clients. There is a high level of interest across both sectors to learn more about these integrated approaches and the benefits to clients.

The inflexibility of funding models and data systems does not support integrated effort. While participants working in integrated models report significant benefits for clients, the inflexibility of system infrastructure is an impediment to demonstrating the impact on outcomes for clients. It is difficult to suggest increasing integrated approaches without a subsequent integration of funding and data mechanisms, or at the least more flexible approaches to funding and data collection.

In relation to improving collaborative practice approaches, it is recommended that:

4. CASA Forum and DV Vic work together to further examine referral pathways between the two sectors including the exploration of shared referral tools to improve referral pathways.
5. FSV consider funding colocated, or embedded practitioner, approaches to support secondary consultation, increased knowledge. and confidence of practitioners.
6. FSV, DV Vic and CASA Forum work together to develop a framework to guide and support joint client work including terminology, principles, or protocols to guide practice, and flexibility of funding and targets.
7. FSV support research into outcomes for clients receiving integrated service responses.
8. FSV consider flexible funding arrangements to better support integrated service delivery models.

The Project finds that there is confusion from both sectors about the range of services each offers and the access pathways for those services. New streams of funding have seen an increase in service offerings, along with services offering more innovative approaches born of a desire to respond to the complexity of client need. This creates a dynamic and changing service system that relies on a range of communicating channels to inform services, and the community, about what sorts of support is available for clients and how they can access those supports.

In responding to the increasing complexity of client need participants reported limited access to specialist case management services, in particular, for clients accessing SSAS. As case management is not a funded component of the sexual assault services model, practitioners are finding that they are using therapeutic counselling time and skills to respond to the case management needs of clients. Clunky referral systems and high demand for SFVS case management is resulting in limited access for clients from SSAS. This is much less of an issue in ISSAFVS as practitioners are much more easily able to access case management support from practitioners working alongside counsellor advocates in the same building.

There is growing evidence and awareness of the serious impacts of the co-occurrence of sexual assault and family violence. While there is much to learn and understand, participants across both sectors expressed a strong desire to learn more about this issue and the implications for service delivery models. In the absence of effective data collection systems to support an increase in knowledge about co-occurrence, the practice wisdom of practitioners can be harnessed to document, develop and share effective service responses.

In relation to identified service gaps, it is recommended that:

9. FSV support the specialist sectors to facilitate information exchange about their range of service offerings and access pathways through a range of communication channels.
10. FSV consider funding a case management function for SSAS.
11. FSV work with CASA Forum and DV Vic to design service models that explicitly respond to the co-occurrence of family violence and sexual assault.

The Project has identified a range of opportunities for strengthening professional development between the sectors. The notion of joint training was widely supported during consultations, while also noting that it must not be at the expense of sector specific specialist training. A growing awareness of the impact of sexual assault, and a need for greater knowledge and confidence in responding to sexual assault among SFVS practitioners has also been identified.

In relation to professional development is recommended that:

12. DV Vic and CASA Forum work with DVRCV to review the four-day core family violence training, and other relevant curricula, to ensure that they sufficiently address sexual assault including responding to disclosures and working collaboratively with SSAS.

13. CASA Forum and/or SSAS develop training for practitioners working in SFVS in relation to responding to disclosures of sexual assault.
14. DV Vic and CASA Forum identify training priorities for joint sector training. A priority for this training should be referral pathways and working with joint clients.
15. FSV work with CASA Forum and DV Vic to support the showcasing of highly integrated and collaborative ways of working such as ISSAFVS and MDCs.
16. FSV, CASA Forum and DV Vic ensure that training modules are suitable and available for delivery online and face to face
17. SFVS and SSAS work together to deliver local community awareness and training about family violence and sexual assault.

The Project has also identified areas for further examination and research in relation to increased collaborative effort including specialist sector elements out of scope of the Project, and collaboration between the specialist sectors and other areas of the service system. There is also a growing need for increased understanding about the co-occurrence of sexual assault and family violence. ISSAFVS are well placed to provide insights and learnings into effective responses to the co-occurrence of sexual assault and family violence.

Investing in areas for further examination and research will provide a fuller picture of collaboration across the entire specialist sexual assault and family violence sectors and support the service system to be more responsive to emerging issues. It is recommended that:

18. FSV work with CASA Forum and DV Vic to examine the collaborative effort between the two statewide after-hours crisis services, the MDC and Orange Door models and the specialist sectors, and family violence therapeutic counselling services provided by the community health sector.
19. FSV support research to investigate effective service responses to the co-occurrence of sexual assault and family violence.

This Project is intended as Phase 1 of longer-term work required to strengthen collaborative practice across the sectors. It has identified a range of opportunities to guide the focus of this longer-term work. Indeed, many of the recommendations require considerable effort and time to implement and sit alongside the many other areas of priority work for both sectors.

The recommendations also require an investment of resources to support their further development and implementation. Recommendation 31 of the Royal Commission's Report alluded to the fact that funding would be required to facilitate greater collaboration between the two specialist sectors.

Additional resourcing is required to implement specific recommendations as indicated such as in relation to service gaps and further research. Additional funding is also required to support the peak bodies to lead and promote further collaborative effort, to develop frameworks and guidance to support and strengthen collaborative practice, and to enable sector participation in collaborative practice activities. As a first step, an action or implementation plan might assist in mapping out the complex body of work required to strengthen and sustain collaboration between the sectors. The plan could identify actions that can be readily included in work already in progress, priority actions and timeframes and areas where additional resourcing will be required. Funding would be required to support the peaks to develop such a plan.

20. FSV fund DV Vic and CASA Forum to work together to develop a strengthening collaborative practice implementation plan that identifies actions, priorities, timeframes and the resourcing required for specific actions.

A more sophisticated understanding of the way in which the 'two sectors' operate is one that recognises and values the shared underpinnings and frameworks that guide the work - the hallmark of what makes them specialist, that sees them as complementary and frequently interconnected, and which perhaps, down the track, might consider them to be one sector with two specialist branches.

The Project finds an environment of goodwill and eagerness in exploring opportunities for greater collaboration between the sectors. The driving force is a shared commitment to provide the best possible services, using specialist trauma-informed approaches, and which can support victim survivors' healing, hope for the future and long-term recovery.

Appendix 1: List of participants

Name	Position/Organisation (at the time of interview)
Megan Andison	Senior Project Officer, Family Violence Sexual Assault Policy & Programs, FSV
Sylvia Andrew	Team Leader Adults, CASA Central Victoria (CASACV)
Gemma Beavis	Program Leader Healthy Relationships, Grampians Community Health
John Blomfield	Team Leader/Counsellor Advocate, The Sexual Assault and Family Violence Centre (The SAFV Centre)
Helen Bolton	CEO, The SAFV Centre
Janet Bonython	Team Leader Intake, Mallee Sexual Assault Unit – Mallee Domestic Violence Services (MSAU-MDVS)
Sarah Brittian	Coordinator Intake and RAMP, Emma House Domestic Violence Services
Kerry Burns	CEO, Centre Against Violence (CAV)
Kate Cannon	Acting Senior Manager, Northern Specialist Family Violence Service, Berry Street
Heather Clarke	Manager, Northern CASA
Laura Clements	Specialist Family Violence Practitioner, WAYSS
Alex Crocker	Team Leader Children, Young People and Families, CASACV
Maria da Palma	Team Leader Swan Hill/Counsellor Advocate, MSAU-MDVS
Erin Davis	Senior Practice Development Advisor, DV Vic
Katherine Dowson	Director, South East CASA (SECASA)
Robyn Durling	Senior Program Manager, Family Violence Gippsland and Orana Gunyah, Victorian Aboriginal Child Care Agency (VACCA)
Lauren Famulari	Strategy and Reform Advisor, The SAFV Centre
Ruth Fox	Executive Manager Client Services, InTouch
Susan Geraghty	Clinical Services Manager, West CASA
Rachel Green	Director Risk Management and Information Sharing/Acting Manager Workforce Development, FSV
Robyn Gregory	CEO, Women's Health West (WHW)
Gabrielle Hitch	Program Manager Assessment & Response Relationship Lead Outer East, Assessment & Response, Eastern Domestic Violence Service (EDVOS)
Karen Hogan	CASA Forum Convenor, Manager Gatehouse Centre
Susie Huynh	Senior Specialist Family Violence Counsellor, Berry Street
Ruth Isbel	Executive Officer, Emma House Domestic Violence Services Inc
Libby Jewson	Executive Officer, WRISC
Helen Kambouridis	Research and Education Program Manager, Gatehouse Centre
Gina Kennard	Program Manager, Case Management Team, Relationship Lead Inner East, EDVOS
Hamsa Kunaratnum	Case Manager, InTouch
Kathy Lane	Senior Counsellor, Goulbourn Valley Health CASA
Ali La Rocca	Clinical Lead, SECASA
San Leenstra	Therapeutic Services Co-ordinator, CASA Central Victoria
Alison Macdonald	A/CEO, DV Vic
Sheri McDonald	Senior Clinician, Gippsland CASA
Michelle McGoldrick	RAMP Co-ordinator, Centre for Non-Violence
Sarah McGregor	Manager of Projects and Innovation, SECASA
Robyn McIvor	CEO, West CASA
Suzanne Meharry	Team Leader, Specialist Family Violence Service, Berry Street
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Appendix 2: Consultation questions

SIMILARITIES, DIFFERENCES, COLLABORATION AND POINTS OF INTERSECTION AND ALIGNMENT

1. What are the greatest areas of similarities and differences between the sectors?

2. Where do the sectors mainly intersect or align? Statewide? Local area/region?

3. What would you say is the current level of collaboration between the two sectors across the state, and locally? Has this changed in last few years? What does this collaboration look like?

4. Are there opportunities for greater intersection and collaboration? What might this look like?

5. What would be required to make this happen?

6. What would be the benefits? (clients, staff, organisations, sector influence)

7. What cautions do you have about greater alignment and or collaboration between the sectors?

SHARED PRACTICE APPROACHES

8. Are there opportunities for greater shared practice approaches? (for adults, for children)

9. What benefit do you see in increased shared practice approaches? (clients, staff, organisations, sector influence)

10. What cautions do you have about increased shared practice approaches?

11. What policies, procedures are in place to support shared practice approaches?

INTEGRATED MODELS

12. Are there any integrated models existing or emerging delivering integrated across FV and SA?

13. What changes did you need to make to create integrated services?

14. Are there opportunities for greater integration? And What would support further integration?

15. What benefits would there be? (clients, staff, organisations, sector influence)

16. What cautions do you have about integration between the sectors?

DATA

17. How well do existing data collection systems assist our understanding of the co-occurrence of family violence and sexual assault?

18. What else is needed?

TRAINING

19. What are the benefits of attending and/or delivering training jointly? (training participants, staff, organisations, sector influence) What would be needed to make this happen?

SPECIALISATION

20. What value does specialisation brings to the work?

FUTURE PLANS

21. What future plans to you have in relation to working between the SA/FV sectors, e.g. further collaboration, protocols or integration?

ANYTHING ELSE

22. Is there anything else you would like to say about the potential for further collaboration/integration between the sectors?

Appendix 3: Bibliography

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