SAFE+EQUAL

Standing strong against family violence

# Measuring Family Violence Service Demand Project

## Phase One Outcomes Report

## March 2022

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

# Acknowledgement of Traditional Owners

**Acknowledgement of Aboriginal and Torres Strait Islander peoples**

Safe and Equal acknowledges Aboriginal and Torres Strait Islander peoples as the traditional and ongoing custodians of the lands on which we live and work. We pay respects to Elders past and present. We acknowledge that sovereignty has never been ceded and recognise First Nations peoples' rights to self-determination and continuing connections to land, waters, community and culture.



**Key Author:**
Dr Kristin Diemer, Associate Professor, The University of Melbourne

**Contributing Authors, The University of Melbourne:**
Dr Anneliese Spiteri-Staines, Research Fellow
Jasmin Isobe, Research Assistant

**Contributing Authors, Safe and Equal:**
Tania Farha, CEO
Louise Simms, Executive Director, Policy, Communications and Engagement
Emma Morgan, Manager, Strategic Projects and Engagement
Ella Longhurst, Data Analyst

**Key Contact:**
Tania Farha, CEO, Safe and Equal - taniafarha@safeandequal.org.au

# About Safe and Equal

Safe and Equal is the peak body for specialist family violence services that provide support to victim survivors in Victoria. The interests of people experiencing, recovering from, or at risk of, family violence is at the heart of everything we do. Our vision is a world beyond family and gender-based violence, where women, children and people from marginalised communities are safe, thriving, and respected. We recognise the gendered nature of violence in our society, and the multiple intersecting forms of power and oppression which can compound the impacts of violence and limit people's access to services, support, and safety. We work closely and collaboratively with other organisations and support the leadership of victim survivors to amplify their voices and create change.

We provide specialist expertise across primary prevention, early intervention, response and recovery approaches and the inter-connections between them. Our work is focused on developing and advancing specialist practice for responding to victim survivors, building the capability of specialist family violence services and allied workforces, organisations and sectors that come into contact with victim-survivors; building the capabilities of workforces focused on primary prevention; and leading and contributing to the translation of evidence and research, practice expertise, and lived experience into safe and effective policy, system design and law reform.

**We develop family violence practice and support workforces** to ensure that victim survivors are safe, their rights are upheld, and their needs are met. The prevalence and impact of family and gender-based violence will be reduced because we are building a strong and effective workforce responding to victim survivors that can meet the needs of the community we serve, while also having a growing and impactful workforce working to prevent violence.

**We work to strengthen and connect organisations, sectors, and systems** to achieve safe and just outcomes for victim survivors irrespective of entry point, jurisdiction and individual circumstances. Joining efforts across prevention, response, and recovery we work to ensure the family violence system is informed and supported by a well-resourced and sustainable specialist sector. Our contributions to primary prevention workforces, initiatives and alliances contribute to social change for a safer and more respectful community.

**We are building momentum for social change** that drives meaningful action across institutions, settings, and systems for a safer and more equal society. Our workforce and practice development efforts are coupled with a partnership approach that builds community awareness and commitment to change. Our expertise and efforts enable citizens across the community to recognise and respond to family and gendered violence, hold perpetrators to account and support the ongoing recovery and empowerment of victim survivors.

**We are a strong peak organisation** providing sustainable and influential leadership to achieve our vision. The work we do and the way we work are integrated and align with our values. This is achieved through inclusive culture, and a safe and accessible workplace supported by robust systems and processes.

# Contents

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

# List of Tables

# List of Figures

# Foreword

The data insights gained through phase one of the Estimating Family Violence Service Demand Project are enabling us, for the first time, to begin to truly understand the demand and complexity of the support being provided by specialist family violence services. Given the unprecedented transformation and expansion of the Victorian family violence system since 2016, there has never been a more critical time for us to have a whole of system picture to ensure safe and just outcomes for victim survivors.

The data collected through this project during 2021 provide insights into system demand that we have previously been unable to document, including a robust snapshot of case management service provision among specialist family violence services. Safe and Equal is encouraged by the results to support the sector to move towards more reliable, meaningful data collection and analysis.

The insights gained through this project to date paint a picture of the complexity of both client need and specialist service response. This picture of service response is much more finely detailed and nuanced than the picture that the data currently available provides. It allows us to see how complexity plays out in the specialist service system and where the pressure points put further strain and stress on an overworked and under-resourced specialist family violence sector. It also begins to identify where we should focus effort and investment to remedy this.

We are so grateful to those Safe and Equal member organisations who contributed to this important work. It was a heavy lift for services and practitioners, particularly during this point in the Covid-19 pandemic, and yet so many practitioners chose to contribute because they recognised the critical need for our sector to better understand the demands on our services.

We are also very grateful to our colleagues within the Victorian Government who have supported us in this endeavour, and contributed data, expertise, and insights as we navigated through the complexity of family violence data sets. We look forward to continuing to collaborate with our members and partners in government as our sector moves toward the collection of data driven by a whole of system view that can show us whether we are providing and achieving safe and just outcomes to victim survivors and holding perpetrators to account.

Tania Farha
CEO, Safe and Equal

## Audience, Focus and Approach

This report's primary audience are the Victorian specialist family violence services, government funders and decision makers, and other key stakeholders that engage in systems change. Phase one of the Estimating Family Violence Service Demand Project sought to identify and develop data indicators for specialist family violence services (SFVSs) to estimate unmet service demand. This report outlines the methodology for developing and piloting a demand indicators data framework, and the findings from this pilot. Against each of the five identified indicator domains, it discusses where we were able to gain insights, where we were not able to gain insights and makes recommendations about next steps for creating a robust demand measurement approach for the sector moving forward.

# Executive Summary

Phase one of the Estimating Family Violence Service Demand Project sought to **identify and develop data indicators for specialist family violence services (SFVSs) to estimate unmet service demand.** This report outlines the methodology for developing and piloting a demand indicators data framework, and the findings from this first phase. Against each of the five identified indicator domains, it discusses where we were able to gain insights, where we were not able to gain insights and makes recommendations about next steps for creating a robust demand measurement approach for the sector moving forward.

**Demand is an important measure for understanding whether victim survivors are receiving the support they need when they need it.** To understand demand, we need to understand which services are requested by whom and the services delivered to them. This project sought to estimate demand for case management from specialist family violence services - both in terms of **the volume of people accessing services and how services are working to meet client support needs.**

**In Victoria, a complete state-wide data set inclusive of all family violence cases and clients does not exist.** The information required to measure demand is partially collected in service provider administrative data sets. These data sets are mapped against funding allocations and therefore tend to be constrained to information about services delivered rather than services requested. This means **we currently have no consistent measure of unmet need.**

Throughout our work on this project, we heard from Safe and Equal members that within the current funding model they are frequently **unable to respond to the complex needs of victim survivors in a timely way.** This was borne out in the data, which showed services are consistently providing services above their funded targets, there are wait times for clients to be allocated case management support and this places them at increased risk, case managers are only able to work with those clients at the highest level of risk and only for short periods of support, and these pressures are having a corrosive impact on practitioners and services.

Importantly, these insights have underscored what we already knew - **that there is a lack of cohesive data reporting on agreed key indicators across the service sector**. This gap means that the service sector as a whole cannot clearly see how clients come into the system, how they move around and where the blockages are. Our efforts to date are helping us to identify and action opportunities to **strengthen a joined up whole of system data picture within existing frameworks and structures, and progress action toward addressing outstanding gaps into the future.**

# Snapshot of Insights

## The Demand Indicators Data Measurement Framework

Developed in consultation with Safe and Equal member organisations and key government stakeholders, the following indicators were piloted across five thematic areas:

- Case complexity
- Identifying and managing risk
- Meeting children's needs
- Crisis accommodation
- Identifying unallocated cases

### Participation and data sources

- Participation in the project was voluntary for services and case managers.
- Data collected included a sample from urban, regional and remote areas.
- This resulted in 6,029 records of case management activities across 28 services, and service level data from 20 services over two x two-week periods in October and November 2021.
    - Data Capture One: 18.10.21 - 31.10.21
    - Data Capture Two: 15.11.21 – 28.11.21
- To compliment the primary data, extracts of data over the same period were received from The Orange Door, the Homelessness Data Collection Tool (otherwise known as SHIP) and Safe Steps.
- A Team Leader Insights Workshop was used to explore some of the preliminary findings before final analysis.
- Preliminary results were shared with the Specialist Family Violence Leadership Group.

## Key data insights

### Exceeding Funded Targets:

- **During the data collection periods services provided case management to an average of 7 clients above their target allocation, with a range of 2-14**. The analysis shows that most services were working with caseloads notably higher than their target allocation during the data collection period.

### Staffing Levels:

- **Two-thirds of the services (13 of 20) were operating with case management staff vacancies during the data collection periods**. Of these, **one third had only 50-65% of case management positions filled**.
- Overall, only a quarter of services were operating with 76% or higher staffing levels including vacancies and people on leave.

**Service Demand and new CM Clients:**

- **Only a fifth (20%) of clients (de-duplicated) were identified as new case management clients across the two data collection periods** (12% new clients and 8% with a new support period for an existing client).
- Identifying new cases was found to be a complex process. The low proportion of new case management clients prompted further investigation about the referral pathways of new clients and raised questions about why there were so few when it was widely reported that there was a backlog of support requests unable to be filled. This was unable to be resolved in the current data collection.
- **During each two-week data collection period services were full, or not taking additional clients, for an average of 7 days.** More than one third were full for 12 days or more, nearly the entire data collection period; one third were full from one to eleven days. Less than one third were not full for any time during the data collection period.

**Intake and allocation:**

- **Nearly two-thirds of services reported having some form of a waitlist or were actively holding cases before allocation to case management.** If case managers report that only 12% of their case activities over four weeks were with new clients, this suggests that clients are 'waiting' to receive a service and not yet allocated to case management.
- Active holding and waitlists illustrate a high level of demand and service provision that **appears largely uncounted and unfunded.**
- The data capture revealed that one third of activities took place in a service where a wait list was not available (31%). Another third (30%) were seen in services using active holding and provided some service while waiting for case management. In another third the client was seen immediately without a need to wait (34%). When a service offered a waitlist 42% of their clients waited 21 days or longer to be allocated to case management. A fifth (19%) were allocated within one to two days and another quarter within a week (23%). When a service was able to be provided to clients being held they had longer waiting times (average of 21 days) compared to clients being held but without any service being provided (average of 7 days). This demonstrates invisible service provision that will not be counted and is therefore largely unfunded.
- **The Orange Door reports that the average length of time from screening to case closure was over 30 days and includes all clients referred into the system, regardless of whether they have asked to be referred** (Figure 20). For example, L17 referrals to The Orange Door are triaged and then assigned to a practioner for assessment. It may take some time for The Orange Door to establish contact with the potential client and determine their needs before either referring onwards or closing the case.
    - Data provided by Family Safety Victoria for The Orange Door sites shows that there was a high level of demand in The Orange Door sites during October and November, with over 16,000 screened and 12,000 persons moved to a case between 18 to 31 October and 15 to 28 November respectively.

- Of these screened persons, 70% were given a service from The Orange Door. Data also showed the average length of time from referral to case closure was over 30 days.
- **Due to the short follow-up time between the reporting periods and the data extraction, the data systems were not able to tell us the precise number of allocations from The Orange Door to specialist family violence services and whether cases were being managed by The Orange Door for that period of time due to specialist family violence services being at full capacity.**

**Referral Pathways into the SFVS:**

- 29% of referrals were made by direct contact from client
- 23% were The Orange Door
- 21% were from another specialist family violence service
- 14% were made by police

**Client characteristics:**

In understanding the complexity of the specialist family violence services response, **it is important to understand both the layered and tailored range of activities provided by services** in response to the complex needs and characteristics of victim survivors seeking support.

- **Nearly all clients were female** (98%, N= 1,714). There were 37 males and 5 non-binary persons
- The average age of **adults was 36 years** and **9 years for people under 18**. Information was recorded on twenty client characteristics. The **most common characteristics included having protection orders in place, having younger children in their care, and being of a culturally, linguistically, or faith diverse background.**

**Type of case management activity:**

- Analysis of the most common activities (excluding case notes and generic case management) showed that **emotional support was clearly the most common (42%),** followed by **general enquiries (26%), safety plans (20%)** and **referral follow-ups (19%)**
- The more characteristics, the more likely a case could be complex and may require more time and experience to manage. **Nearly two-fifths of the case manager activity on any given day involved three to four activities (39%).**

**Risk Assessment:**

- **One fifth of the case management activities involved risk assessment.** The times taken to complete risk assessment activities were, on average:
  - 59 minutes to complete a comprehensive risk assessment
  - 32 minutes to conduct a screening / intermediate / brief assessment
  - 29 minutes to update or monitor the risk assessment

## Summary of indicator outcomes and recommendations

### Case complexity

This project sought to capture the work that practitioners perform when undertaking case management activities to meet the needs of clients in terms of diversity of tasks, complexity of cases and time required to support safety. **This information is not recorded anywhere in the service system and therefore so much of the work done by the specialist family violence services is currently invisible.**

Case complexity was identified as a key indicator of demand as it is likely that greater time may be required for case management when cases are complex. Complexity was defined through pre-data collection consultations with the leadership team / service sector and client characteristics identified through the Multi-Agency Risk Management Framework (MARAM).

Complexity was measured with diversity of client characteristics that may indicate additional support needs (for example, disability, age of children, whether the client was a child themselves, as well as involvement in family law or criminal matters), number of activities and whether a secondary consultation was required.

As an indicator several promising measures emerged. Cases with five or more activities took significantly longer that cases involving four or fewer activities. Client diversity was less revealing as an indicator than as many common characteristics clustered together. Combining characteristics with type and number of activities created a proxy measure of complexity that showed the following client characteristics required a greater amount of time:

- having a protection order in place
- having younger children in the adult client's care
- clients of diverse cultural and inter-faith background
- clients requiring support for legal or criminal issues other than family violence

All of these client groups generally required a greater number of case management activities, which resulted in taking a greater amount of case management time. Nevertheless, most case managers were optimistic that they could meet client needs.

**Recommendation:** The indicator can be improved by distilling distinguishing features of cases that might specify complexity more precisely than the data that was able to be collected in this project. More qualitative research could assist to scope the characteristics which case managers believe make cases more complex.

### Identifying and managing risk

Identifying and managing risk is central to the whole of system response to family violence in Victoria. It is commonly reported that clients with higher risk profiles are likely to be allocated to case management more quickly than those with a lower risk profile. It is also estimated that the greater amount of risk a client faces, the likelihood that case management will require more time and may be more complex.

It was identified from the data that risk assessment activities and safety planning take a notable amount of time – ranging from one hour for conducting a comprehensive risk

assessment, or creating a new safety plan, to 30 minutes when reviewing or monitoring risk and safety.

It was also identified that the small proportion of activities involving the more serious risk and need for immediate protection also took proportionally longer (45-50 minutes) than lower risk clients (30 minutes).

**A concerning gap in data on risk management was the monitoring of change in risk for clients on a waiting list.** Risk may change whilst waiting for allocation or referral to another service, both increasing and /or decreasing. Case managers reported that risk did increase for 30% of clients while on a waiting list.

**Recommendation:** This indicator may be improved with better information about clients on waitlists, including risk monitoring and supports to prevent clients from dropping off the waitlists before receiving a service along with understanding where they went and why they left before receiving a service.

### Meeting children's needs

Family violence risk management is most often focused on the adult client - often leaving children's needs invisible. The support system has evolved from a model of meeting the needs of the parent and providing safety so they can support their children. Although contemporary practice has changed and recognition of family violence impact on children has improved, **the support system response has not improved to consistently recognise children as clients in their own right and able to accommodate their specific needs.**

Comparatively few children appeared in the data generated for this project. This is thought to be a result of current data system design, which makes it difficult to add children as clients without expanding caseloads significantly. Because of this, an indicator for this measure was not able to be identified.

**Recommendation:** Better data needs to be collected on the number of children accessing services (or requiring access to services) in SFVS as clients in their own right, their support needs and associated risk management activities. An opportunity exists to explore possibilities for adapting existing data collection tools so that children can more easily be recorded as clients in their own right without additional administrative burden on case managers.

### Crisis accommodation

**A knowledge gap exists in tracking the ability to meet accommodation demand alongside occupancy rates of available appropriate accommodation.** In addition, there needs to be better insight into instances where unmet demand for crisis accommodation in the family violence sector flows through to cross-sector referrals, for example referring into the homelessness sector or vice versa.

Affordability was identified as the primary barrier to obtaining suitable accommodation, both short and long-term. This suggests that either clients did not qualify for public housing, public housing was not available, or the public housing that was available was not suitable, and therefore the client was looking for other, more permanent options.

Analysis of risk profile and accommodation demand did show that clients with higher risk profiles were more likely to obtain crisis accommodation such as refuge and/or other short-term accommodation, and case managers may be spending more time locating accommodation for low or medium risk clients. Two indicators to estimate demand were identified as:

- affordability as a significant barrier to suitable accommodation
- risk profile among clients seeking accommodation to estimate resources required to meet needs

**Recommendation:** Some work could be done with the crisis accommodation services to better understand the pressures which impact their occupancy rates. An opportunity exists to collaborate with the homelessness sector to better record and report on housing support needs of family violence clients.

### Identifying unallocated cases

**There is limited understanding about which clients 'get stuck' waiting for service and where those bottle necks are.** Unallocated cases may be clients who have requested a service and are waiting for a referral, or clients who have been processed through intake and not yet allocated to case management. Depending on 'where' a client is waiting they may or may not be receiving some form of service.

Recent changes to the family violence system mean that The Orange Door network will receive, triage, assess and allocate an increasing number of individuals and families , **without a commensurate increase in capacity for SFVS case management services.**. It was described in one workshop as though **the door to a house has gotten bigger, but the house remains the same size.** Services with a waiting list or 'active holding' can see the pipeline of clients on their list, but services cannot readily see the pipeline from The Orange Door unless through formal allocation meetings.

The number of staff in a service is central to meeting demand and caseload against staffing capacity is a key measure of ability to meet target caseloads. However, staffing levels do not consider periods of leave, staff experience and vacant positions. Organisations may look like they have more capacity to meet demand than they do at given points in time.

Case managers and team leaders speak of working above caseload targets and finding innovative ways to support clients beyond their caseloads. **As case managers find 'work around' solutions, there is invisible service provision here which would assist to measure demand.**

Several strong indicators to estimate demand through unallocated cases were identified. The number of clients being actively held by services before being allocated to case management provides a good picture of the excess demand cases.

Additionally, estimates of service provision above targets and staffing shortages provided measures of services struggling to meet demand. The qualitative data provided a rich understanding of the impact of excess demand including pressure on staff well-being, and reasons for staff vacancy and turn-over.

The data collected for this trial indicator identified:

- There is significant excess of demand beyond target allocations
- Services are facing notable staff shortages which impedes their ability to deliver services efficiently.
- Due to the high demand for service and high staff turn-over, risk may not be efficiently managed which may, in turn, over burden all areas of the system.

**Recommendation:** Explore opportunities to link data between The Orange Door and specialist family violence services. Continue to collaborate with government partners to explore ways to record how long clients are waiting and changes to risk profile while waiting for allocation.

# Building and Testing a Family Violence Service Demand Framework

Phase one of the Measuring Family Violence Services Demand Project sought to identify and develop data indicators for specialist family violence services to estimate unmet service demand in order to measure gaps in funding associated with meeting current service demand in Victoria.

### Objectives

1. To identify potential key indicators of service demand and unmet need, in discussion with Safe and Equal, Family Safety Victoria and the specialist family violence service sector
2. To develop and trial a data collection tool to measure the proposed indicators and assess viability

### Deliverables

- Draft key indicators to estimate specialist family violence service demand
- Suggested approach and methodology to trial data collection on the key indicators
- Analysis report of the trial indicators and recommended next steps to develop the demand model

## Defining service demand indicators

It is useful to define some of the key terminology and components of the project to clarify the parameters and limitations. "Demand" for service is often used interchangeably with "need" for service. While estimating both the need and demand for specialist family violence service is necessary, it is also extremely challenging. Borrowing from a working paper estimating need and demand for alcohol and drug treatment, the two central concepts can be defined as follows (Ritter et al 2013, p.2):

- "Unmet need" is the proportion of people who meet the definition of experiencing domestic or family violence but who have not sought assistance.
- "Met need" is the proportion of people who meet the definition of experiencing domestic or family violence and who have received assistance that reduces their need.
- "Unmet demand" is the proportion of people who sought a service but were unable to access it.
- "Met demand" is the proportion of people who sought a service and were able to access it.

Both need and demand are important estimates for service planning, this project focusses primarily on estimating the latter, demand from clients who sought a service.

### Estimating demand

Demand is an important measure for understanding sufficiency of service and responses among those who have successfully and unsuccessfully sought a service. This includes people who have had their needs partially met. There are three possible ways of measuring demand: current service utilisation; intention to seek a service; and analysis of waiting lists (Ritter et al 2013).

- **Current service utilisation measures met demand.** It relies on accurate administrative data recording both the services requested, and service delivered. Examination of services requested that were unable to be met can provide a limited proxy measure of unmet demand. Service providers may not record requests that they deem inappropriate or unavailable at their service. Data collection tools are usually limited in listing all services and often record only the 'main' issues. Service providers are generally time poor and accuracy of data recording is low.
- **Surveys asking people about their intention to seek a service and review of service response post service delivery can be useful in estimating demand.** In general, however, very few people self-identify as needing a service before they engage in discussion with a service provider and through discussion recognise their needs. The conversation will also be influenced by the service provider questions and direction.
- **Waiting lists can measure unmet demand however there is not a systematic approach to the collection of data about waiting times**. Length of waiting time needs to be assessed in relation to needs, risk and services being requested. In addition, awareness of a waiting period may discourage clients from contacting a service; prospective clients on the waiting list may find service elsewhere but remain on a list; a proportion of people on waiting lists never enter the service, or may be uncontactable; and fundamentally, a waiting list only exists in relation to an actual service – there may be demand however no services and hence no waiting lists.

A simple measure of demand is limited in usefulness unless matched with different service responses, risk and timeliness. Not everyone experiencing family violence requires the full array of available interventions within the same time frame. Therefore, this project seeks to develop a range of indicators that can accommodate variations in client characteristics, need, demand and available responses. **This moves us beyond simple estimates of demand and considers demand for whom and for what type of client or service.** Additionally, understanding demand cannot be divorced from the features of services such as accessibility, geography, stigma and reputation etc.

## Service utilisation data

**While state and federal funding requires regular data collection and reporting in relation to funding received, that reporting is designed for administrative purposes in relation to monitoring funded programs. It is not suitable for measuring the full range of met and unmet demand.** Current administrative reporting usually consists of a crude summary of the number of services delivered against target funding allocations. It excludes the rich and full story about demand not clearly linked to a funding target. It does not usually measure:

- the tasks involved in meeting demand (time, range of activities undertaken, resources used)
- information about the challenges in locating and securing services
- information about unique client characteristics that may delay uptake of a service or support
- client reliance on case managers for emotional support both during and post case management
- creative methods to meet client needs when allocated funds are exhausted

Much time and activity involved in meeting demand is invisible in data recording tools yet significantly impacts on the length of time required to manage cases safely.

A single data set for all family violence service records does not exist in Victoria. Family violence is recorded across a range of reporting systems and while centralised, services may use one or more for each client depending on funding source. **Therefore, family violence related information for a service, and each client, may be included in multiple data systems which are often unlinked.**

## Methodology for building the Framework

Developing a framework of key indicators to estimate demand for specialist family violence services is challenging due to the variation in services provided, data collection practices, systems and tools. Pre-existing demand indicators for family violence services were not located through a brief literature search prior to this project and therefore a combined grounded theory[1] and participatory approach[2] was used to allow the data to inform the indicators, framework and methodology.

The framework was developed in consultation with family violence specialists at all levels from the Safe and Equal Specialist Family Violence Leadership Group, team leaders, case managers and government partners. The key thematic areas for the framework included:

1. Case complexity
2. Identifying and managing risk
3. Identifying and managing children's needs
4. Access to crisis accommodation
5. Monitoring unallocated cases

Stakeholders and partners identified the following areas for defining demand indicators:

- Client characteristics
- The invisible data about the range of tasks and time spent on meeting measured demand
- The range of activities involved in case management on a day-to-day basis
- The demand needs that can be met and not met
- The amount of time spent in meetings and type of meetings
- Secondary consultations and information sharing activities
- Client characteristics or needs that are unexpected or not generally recorded
- Staffing vacancies and well-being issues impacting on meeting service demand
- The length of time clients wait to be allocated to case management

### Data collection methodology

There were three data collection options proposed and workshopped with the Safe and Equal Specialist Family Violence Leadership Group to determine best data collection, with

[1] The theory is "grounded" in actual data, which means the analysis and development of theories happens after data is collected (Glaser & Strauss 1967). Data analysis occurs at the same time as data collection and continues to inform the research if the data uncovers a new potential direction. While originally developed for qualitative research it is applicable to all forms of data collection.

[2] Participatory Research is a research-to-action approach that emphasizes direct engagement of local priorities and perspectives (Cornwall & Jewkes, 1995). Participatory research uses systematic inquiry in direct collaboration with those affected by the issue being studied (Cargo & Mercer, 2008) and prioritizes co-constructing the research through partnerships between researchers and stakeholders, community members, or others with insider knowledge and lived expertise (Jagosh et al., 2012).

least resistance and least service disruption. The options considered included collecting data:

- One day per month for 6 months (total 6 days)
- Over a two-week period in two different months (total 14 days x 2)
- A single point in time

The preferred model was to collect data over a two-week period in two different months. It was thought this would provide a good representation of the work that's done over time.

- A data collection tool was piloted and reviewed to ensure sufficient data capture without being onerous on the staff
- Once finalised, data collection Time 1 commenced.
- Preliminary results and indicators were reviewed with research partners and changes made to the data collection tool
- Once finalised, data collection Time 2 commenced

The final design for data capture included two separate data inputs at the case manager and service level.

- **Case Manager data:** staff from specialist family violence services (SFVS) who work in case management and other staff who perform case management tasks recorded their workload and the demand on their time to meet client needs. Case managers entered data for each client they worked with, every day, for the data collection period.
- **Service data:** SFVS provided service level information about case management target allocation, as well as case management clients above target allocations and how waiting lists were managed during the collection period.

Data was collected over two separate data collection periods.

- Time 1: October 18 - October 31
- Time 2: November 15 - November 28

In addition, data extracts from the Homelessness Data Collection Tool (otherwise known as SHIP) and The Orange Door (TOD) databases for the same data collection period were requested from Family Safety Victoria.

Data was also requested from Safe Steps to provide a snapshot of emergency accommodation demand during the data collection period.

These additional data extracts are referred to throughout the report and are included in the Appendices.

### Participatory approach to data collection, feedback, and analysis

Consultation with Specialist Family Violence Leadership Group and team leaders occurred at multiple points during the research:

- Consultation with Specialist Family Violence Leadership Group to shape the demand framework and proposed indicators
- Preliminary analysis of data capture 1 and data capture 2

- Focus group with team leaders to discussion initial findings and clarify some uncertainties apparent in the data
- Final reflection workshop on data collection tools and the process
- Preliminary results presented and discussed with stakeholders and partners
- Final analysis to test and shape the proposed indicators

### Team Leader insights workshop

The insights workshop included 22 attendees representing 15 specialist family violence services. The purpose was to share the preliminary findings and engage on some of the uncertainties in the initial results. Insights from team leaders assisted to further understand what the data is telling us and to support future planning for this work.

Discussion topics included:

- Unallocated clients & small number of new clients
- Intake management processes and risk triaging
- Access to appropriate accommodation (crisis and short-term) & intersection with homelessness sector
- Understanding what emotional support in case management service provision entails
- Staff well-being & capacity issues

A summary report of this workshop is included in Appendix 3

## Challenges and limitations

### Dedicated data collection for this analysis

Due to the voluntary nature of the methodology for this data collection and heavy workload across the sector, many services did not participate. In addition, there was some mistrust that the data could be used to monitor individual case manages and a few services chose not to participate for this reason.

The data collection tool needed to be simple and brief to keep case managers and services involved in data collection for the duration of the project, especially leading up to end of year and during a period of upheaval as The Orange Door networks were rolling out in some areas. Limitations of the data tool were that it did not support tracking of activities for the same client, nor did it collect all the detail to fully understand client needs or the unique issues of each client's situation.

However, the services that did participate provided an expansive data set of more than 6,000 activities from a large range of services (n=28) and it is likely that common issues have been identified. The results are sufficient to test the identified indicators and to recognize areas which need more exploration with the leadership team and case managers.

Therefore, while this data is indicative and exploratory, it provides a solid pilot testing of proposed indicators.

Some specific limitations are listed here.

- **Defining a new client or support period**: The way cases are managed before a client is allocated into case management is different between services. This caused some

confusion for identifying new clients and support periods. If a client receives a service prior to case management allocation the case manager may not consider the client a new client or receiving a new support period. Therefore, measures of new clients and new support periods were significantly undercounted.

- **Privacy**: To maintain privacy of the person entering data, computer identification was not saved into the data record. This meant that the person entering data could not save a record and return to it later. It is therefore likely that some records were lost when people could not complete data entry in one session.
- **Mandatory data fields**: To assist with efficiency of data entry, none of the data fields were mandatory. This means that people may skip questions instead of responding. Most often people skip questions when they are not applicable, or the answer is unknown. However, we cannot know why questions have been skipped.
- **Measuring estimated time conducting activities**: There was a lack of specific instruction in the first-round questionnaire when asked to estimate time taken to conduct an activity. This was updated prior to data collection 2.

**Comparative centralised data extracts (Safe Steps, The Orange Door (TOD), Customer Relationship Management (CRM) and Homelessness Data Collection Tool (otherwise known as SHIP)**

Data extracts were sought from centralised data bases for the following primary purposes:

1) to assist in filling in some of the data gaps;

2) to review the data that is available and whether it can be used to measure some of the indicators; and

3) assess long-term viability of adapting current data collection tools to estimate demand rather than request services to provide additional data on an on-going basis.

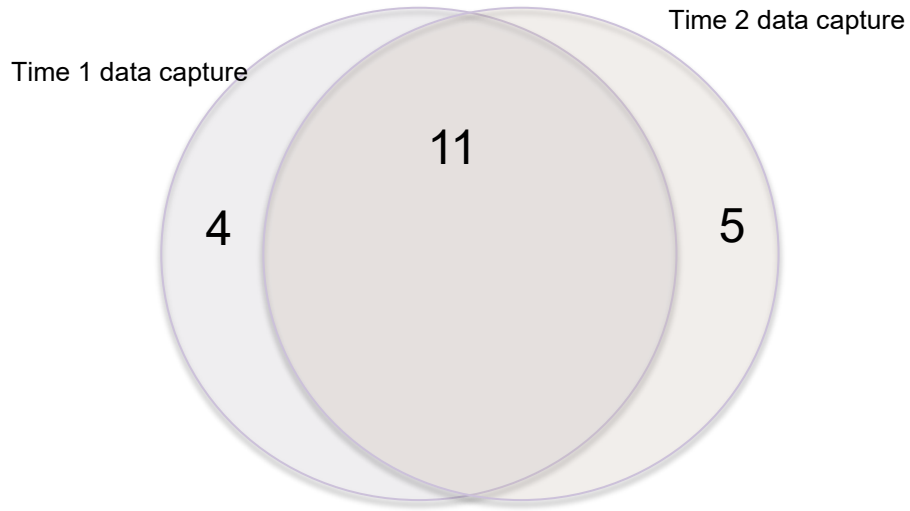
The limitations of these data requests were that we could not access the raw data and were reliant on aggregate extracts; The Orange Door data system is new and still evolving; and we did not always know the quality of the data or limitations of the data fields requested until the data was supplied.

Sharing and reviewing the current data bases is an area of opportunity for ongoing work with data holders to assess opportunities for including indicators of demand.

## Services data

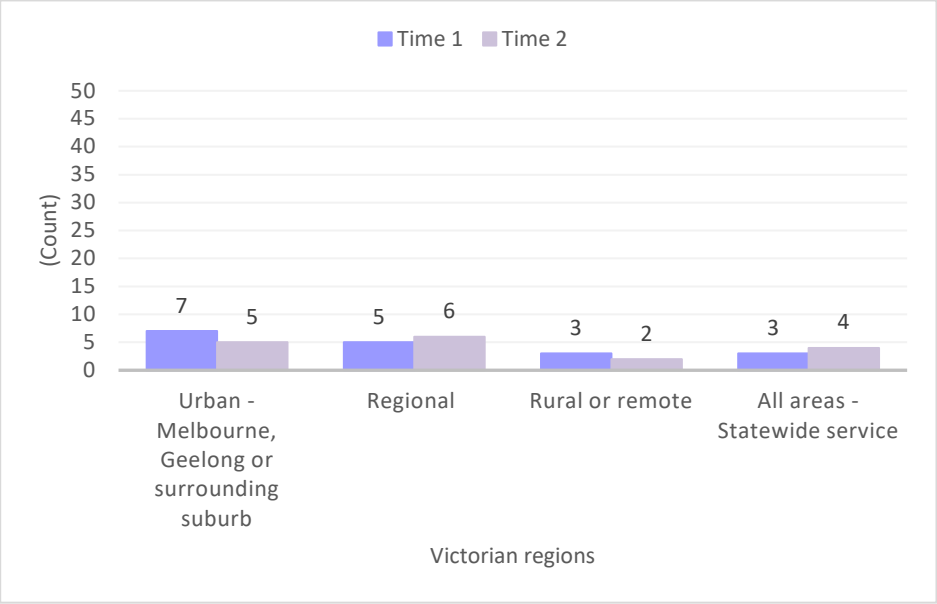
A total of 31 responses were received from 20 services during the two time periods. Fifteen services provided service level data at Time 1 and 16 services at Time 2 (Figure 1). Eleven services provided data in both data capture periods.

**Figure 1: Number of services participating in the services data capture component (N=20)**




Services joining the data capture provided specialist family violence support to clients from metropolitan, regional, and rural geographic areas – a similar proportion of geographic regions were represented in both data collection periods (Figure 2). Four of the five services working across rural and remote areas also serviced a regional area.

**Figure 2: Services participating in the services data capture by region where they provide service (N=20 services)**




## Case Managers meeting demand

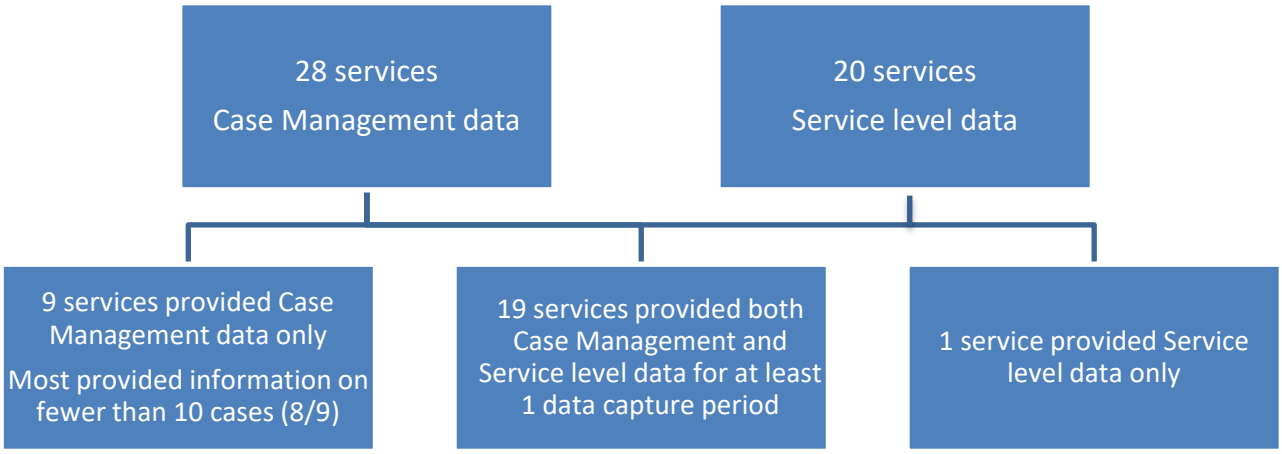
A summary of clients and activities included in the data set is presented in this section with further detail locate in Appendix 1.

## Overview of the case / client data

Twenty-eight services entered data on at least one case (Figure 3); eight of which provided only a few case management activities, most likely to trial the data collection process, but did not continue to provide data throughout the data capture period. Nineteen of the twenty services providing full case management data for at least one data capture period also entered service level data. One service provided case management data but not service level data and one service completed the service level data for both data capture periods but did not provide case management data.

Therefore, the service level data and case management data are mostly linked.

**Figure 3: Overlap of services providing Case Management and Service level data**




The purpose of case management data capture was to understand the nature of client /case demand, complexity of cases and estimates of the time taken to perform activities to meet demand.

Case managers were asked to enter data for every case management related activity each day during the two data capture periods. This means that when working with clients over multiple days they would have entered information about the same client multiple times. Some clients may be included in both data capture periods. For this data project it was not within scope to link cases between data captures or to include each only once in data collection period.

## Managing multiple activities for the same client

This project has focussed on analysis of types and number of activities and time taken to undertake those activities. For most analysis in this project, it is irrelevant whether activities are for the same client on either the same day or a different day. For example, a risk assessment may be undertaken over several days rather than in one sitting and it's important to count all the activities and time taken to conduct the risk assessment.

The scope of this project was to examine case management activity, service demand, impact on case manager time, and impact on service target allocations.

Analysis of case management of clients with multiple activities on different days compared with clients receiving a single service during the data collection period may not be appropriate for several reasons:

- Case managers may provide the first activity for a client at the end of the data collection period and may go on to provide significant activity and time that is not represented in the data collection period.
- Case managers may provide the last activity for a client at the beginning of the data collection period and there is no record of the activity and time prior to the data collection period.
- Clients may not reveal all their characteristics or circumstances during their first meeting with a case manager, and therefore analysis of characteristics for a single record of service may not be accurate.

Therefore, comparative analysis has been undertaken conservatively. The two groups may be indicative of client characteristics where more or less activity is required, but likely to be an underreport of clients in need of multiple service points over time.

For ease of reporting, clients where data was recorded for activities on the second or subsequent service were referred to as duplicate cases. Non-duplicate cases include both those who were recorded only once in the data file as well as the first data entry point of for clients where a case manager may enter additional data on subsequent data collection dates. It is purely descriptive.

A more extensive project could be framed to identify where a client is in the cycle of service and if feasible, connect services for the same case. This would require a significantly more complex data capture.

## Descriptive summary of case management activity

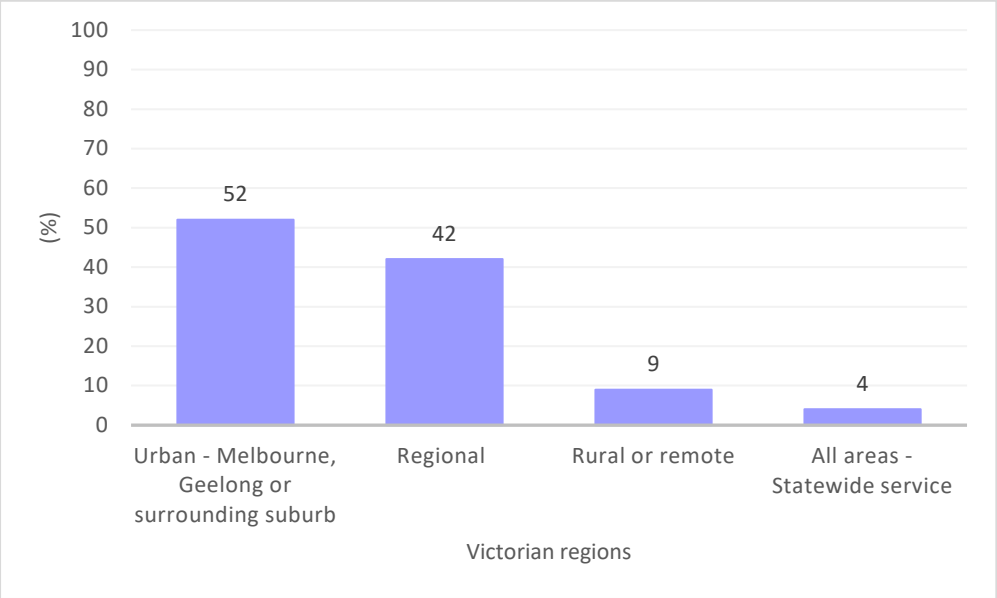
A total of 6,029 case management reports were entered during the two points of data capture (3,620 Time 1 and 2,409 Time 2). Just over one thousand (1,195) entered preliminary information but did not proceed to case management activity questions. Most of these cases (1,033) were reporting on time spent participating in meetings. Analysis of meetings can be found in Appendix 2.

Nearly five thousand case management activities (4,834)[3] were recorded with enough detail to include them in our measures to estimate demand.[4]

### Service location

Half of the activities reported on were from urban services (52%) and half from regional (42%) or rural / remote areas (9%) (Figure 4). Service participation was voluntary and therefore state distribution was random. A small proportion (4%) were from services providing a state-wide response.

**Figure 4: Recorded Case Management activity by region serviced (N=4,828)**

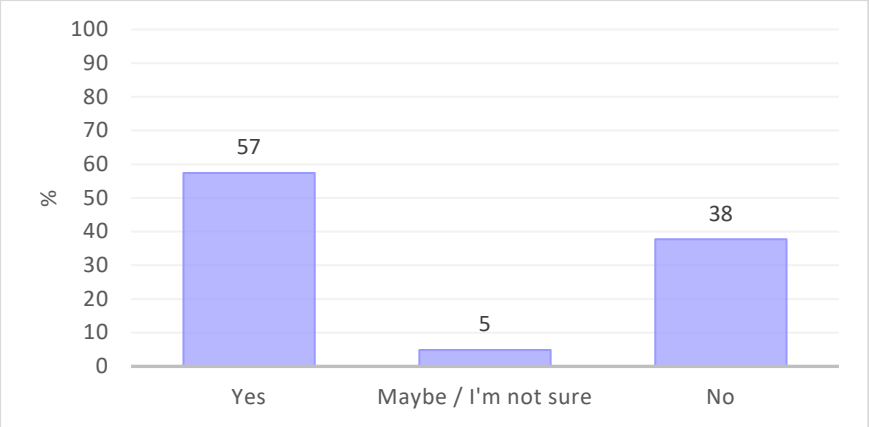



### Multiple services for the same client (Duplicate cases)

Duplicate cases were identified by asking case managers whether they had previously entered data about this client during the data capture period. Over one third (38%) of activities were reported for clients recorded in the data capture once (Figure 5).

[3] Note that not all questions were answered for all activities and therefore the sample size referred to in graphs and tables through the report will vary.
[4] Note that information provided during the first data capture informed changes to the questionnaire for the second data capture. Therefore, not all case management activities were included for all questions.

**Figure 5: Has case manager previously entered information about this client during the data collection period? (N=4,844)**




## Gender of clients

Not surprisingly, when gender was recorded, nearly all activities were reported for female clients (98%, N= 4,646). There were 64 activities reported for males and 13 for non-binary persons (Table 3 in Appendix 2).

Male clients were represented in all geographic areas serviced and non-binary clients were serviced by urban and regional agencies.[5]

## Age of clients

Where age was recorded,[6] clients spanned from less than a year to 79 years with the majority of activities for clients aged 18 and older (96%, n =2,782;

| What is the gender of this client? | Duplicate client | | Non-duplicate client | | Total | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| Female | 2,932 | 99% | 1,714 | 98% | 4,646 | 98% |
| Male | 27 | 1% | 37 | 2% | 64 | 1% |
| Non-binary or gender diverse | 8 | 0% | 5 | 0% | 13 | 0% |
| Total | 2,967 | 100% | 1,756 | 100% | 4,723 | 100% |

Table 4 Table 4 in Appendix 2). The mean and median age of adults was 35 years; the mean age for young people was 9 years with a median age of 8.

## Client characteristics

Following the MARAM, information was recorded on twenty client characteristics for each case management activity (Figure 40 in Appendix 2). The most common characteristics included clients having protection orders in place, having younger children in their care, and being of a diverse background (culturally, linguistically, or inter-faith).

[5] Due to the small numbers of male and non-binary clients, analysis is limited to protect their identity.
[6] Note that half of the activity data did not have client age recorded.

# Outcomes from the Pilot: The Indicators

## 1. Case Complexity

Case complexity was identified as a key indicator of demand as it is likely that a greater amount of time may be required for case management activities when cases are complex.

Case complexity may be related to characteristics of the survivor, children, the partner, and/ or the nature and circumstances of the abuse. It may also be due to external circumstances such as being on a bridging visa or studying full-time.

A suitable complex needs assessment tool, of appropriate length, was not identified prior data collection. Therefore, proxy measures of complexity were trialled including:

**Proposed Indicator: diverse client characteristics**

Client characteristics as included on the MARAM including characteristics of diversity, disability, age of children, whether the client was a child themselves, as well as family law or criminal matters.[7]

**Proposed Indicator: complexity of activities**

- The more activities and the length of time taken to do them may indicate case complexity.
- Some characteristics will generate related activities and therefore we propose analysis of the number and type of characteristics by the activity type and time taken to address the related needs.
- Secondary consultations may indicate a case was complex
- Ongoing activities or needs that are unable to be met may illustrate ongoing risk and an inability to transition a client out from a SFVS.

### Client characteristics

Similar proportions of clients were identified with between 1, 2, 3 or 4+ characteristics.

More than one quarter of all case management activities involved clients with 4+ characteristics (29%, see Figure 32 in Appendix 1) and these included:

- caring for children and young people (Table 9 in Appendix 2);
- cultural, or language diversity, or were on bridging visas (Table 10 in Appendix 2)
- reporting protection orders, family law matters or other legal issues (Table 11 in Appendix 2).

**Client characteristics by case activity**

Case complexity may be marked by the type and number of case management activities that need to be undertaken. The greater number of activities required (3, 4 or 5+) corresponded with complexity characteristics such as having a protection order in place, younger children

[7] Information recorded in the MARAM tools could be used to construct a measure of case complexity. This data was requested from FSV but was not able to be provided within the data collection period.

in care of the survivor and/ or being culturally, linguistically and/or inter-faith diverse (**Table 1**).

**Table 1: Client characteristics by number of activities (three or more, n=2,678)**

| | Number of activities | | | | Total | |
|---|---|---|---|---|---|---|
| *Client characteristics* | 3 to 4 | | 5 or more | | | |
| | Count | Column N % | Count | Column N % | Count | Column N % |
| **Protection order in place** | 864 | 50% | 476 | 50% | 1340 | 50 |
| **Client has young children aged 5 years or younger** | 640 | 37% | 366 | 38% | 1006 | 38 |
| **Client has children aged 6-11** | 595 | 34% | 337 | 35% | 932 | 35 |
| **Culturally, linguistically and/or inter-faith diverse** | 474 | 27% | 220 | 23% | 694 | 26 |
| **Client has children aged 12-17** | 419 | 24% | 231 | 24% | 650 | 24 |
| **Family law matters** | 306 | 18% | 192 | 20% | 498 | 19 |
| **Language other than English as primary language** | 363 | 21% | 150 | 16% | 513 | 19 |
| **Other legal or criminal issue** | 242 | 14% | 182 | 19% | 424 | 16 |
| **Located in rural or remote areas** | 192 | 11% | 90 | 9% | 282 | 11 |
| **Aboriginal and/or Torres Strait Islander** | 156 | 9% | 79 | 8% | 235 | 9% |
| **Identified disability and in need of support such as modified housing, mobility aids, carer support.** | 155 | 9% | 89 | 9% | 244 | 9% |
| **Client has an infant less than one year** | 122 | 7% | 66 | 7% | 188 | 7% |
| **On bridging or temporary visa** | 128 | 7% | 57 | 6% | 185 | 7% |
| **Client is a young person aged 18-25** | 61 | 4% | 40 | 4% | 101 | 4% |
| **Client is pregnant** | 37 | 2% | 38 | 4% | 75 | 3% |
| **LGBTIQ** | 41 | 2% | 31 | 3% | 72 | 3% |
| **Older person** | 61 | 4% | 23 | 2% | 84 | 3% |
| **Client is a child - aged 11 or younger** | 51 | 3% | 15 | 2% | 66 | 2% |
| **Client is a young person aged 12-17** | 29 | 2% | 18 | 2% | 47 | 2% |
| **Client is an infant** | 6 | 0% | 2 | 0% | 8 | 0% |
| **Total** | 1727 | 100% | 951 | 100% | 2678 | 100% |

## Case management activities

### Time taken for activities

The average time taken for case management activities was just under 1 hour (59 minutes, median 45 minutes). Time did not vary by whether the case management activity was the first / only activity, or duplicate client with case management (Table 8).

The range of time spent was between about 5 minutes through to 2 hours (Std Dev 53 minutes). The amount of time spent increased with the number of activities performed (Figure 6). Therefore, the greater the number of activities required; the more likely case management will take more time.

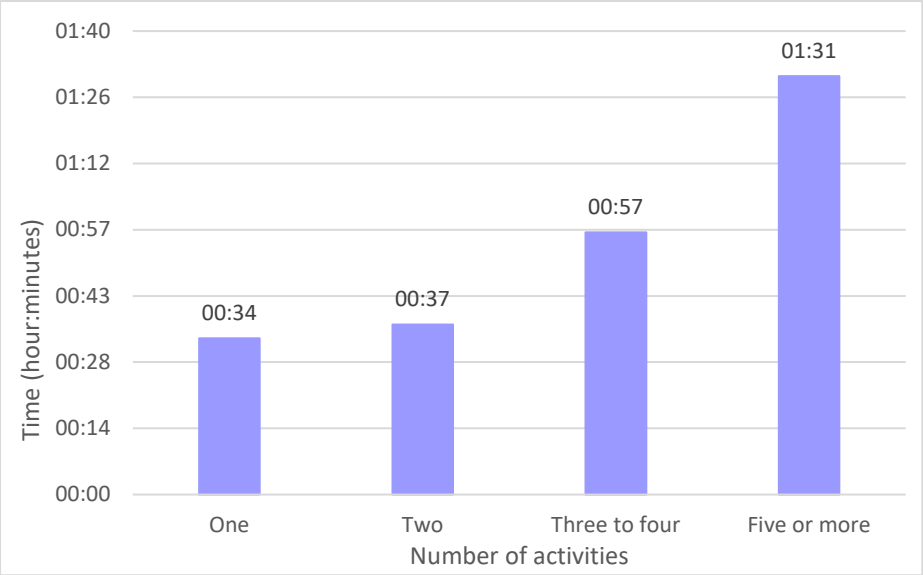
Activities which took less than 30 minutes were mostly updating case notes and general administration, or follow-up activities. Activities which took greater amounts of time included: client allocation meetings (2.5 hours), followed by different assessments and safety plans, counselling /crisis support, or opening a case file (Table 2).

Risk assessment and safety planning activities will be discussed further under indicator 2 (identifying and managing risk).

**Table 2: Average amount of time for activities by activity type**

| 30 minutes or less | 1 hour | 1.5 hours | Two hours or more |
|---|---|---|---|
| • Updating case notes<br>• General administration<br>• On-going case management | • Secondary consultations<br>• Application for support package<br>• Initial consultation<br>• Referral follow-up<br>• Outreach support<br>• Information sharing | • Opening a case file or Intake<br>• Child assessment<br>• Risk assessment<br>• Safety plan<br>• Counselling or therapeutic support<br>• Crisis support<br>• Accommodation support<br>• Court support | • Client allocation |

**Figure 6: Average time taken for case management activities by number of activities (all clients and activities N=4,734)**




## Secondary consultations

In preparation for this project, it was proposed that complex cases might require secondary consultations, and that secondary consultations might take a disproportionate amount of time. Secondary consultations may be another proxy measure to indicate case complexity.

*Vicpol [Victoria Police] requesting secondary consult and advocacy with client (Survey case ID 2898)*

*Secondary consultation provided to external agency re family violence risk management and support and safety (Survey case ID 1488)*

*Secondary consult with Therapeutic team within our service (Survey case ID 91)*

*Young person self-referred into specialist young person program requesting to be linked in with housing supports and potential referral for therapeutic supports. Further risk assessment and safety planning required. (Survey case ID 1489)*

Secondary consultations were identified in a third of all activities during the data capture (n = 1,679). An unexpected finding was that more than three quarters (78%) of secondary consultations were internal to the organisation a quarter external (22%). There were no differences comparing duplicate and non-duplicate clients. When discussing this in the focus group with team leaders we identified that a majority of the internal secondary consultations were likely to be indicative of new or inexperience case management staff who needed to consult with another staff member regarding the best course of action.

*Being a senior, we've had some graduate new workers so it's training them up at the same time, their [sic] green and they haven't worked in the sector and that increases the workload on myself, you know I am doing a lot of my secondary consults that were around them needing support with the clients and telling them what they need to do and where to go. (Team leader focus group discussion)*

The average length of time spent on secondary consultations was 34 minutes (Figure 7). Internal consultations tended to be a bit longer (average of 36 minutes) as compared with external consultations (average of 29 minutes).

Most activities involved only one secondary consultation (66%) and one quarter (23%) involved two consultations (Figure 8). A small portion of activities required three or more secondary consultations, and this small group of clients required significantly more time for case management. The average time taken increased along with the number of secondary consultations. While one or two secondary consultations took about 30 minutes, three or more consultations took between 1-1.5 hours on average (Figure 9).

There was a pattern of common client characteristics corresponding to an increased number of secondary consultations. The most common characteristics, regardless of the number of consultations included having a protection order in place and children aged 11 or younger in the survivor's care. As the number of secondary consultations increased, there was more likelihood of corresponding with characteristics including caring for children aged between 12-17 years, needing support with other legal or criminal issues, and disability support needs.

**Figure 7: Average time taken for secondary consultation (all clients and activities, n=1,679)**

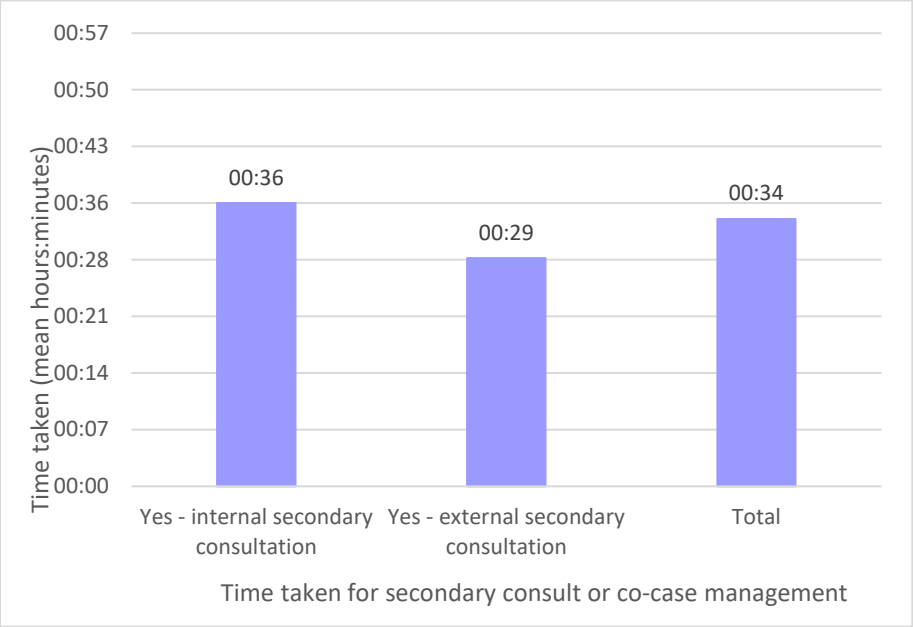



**Figure 8: Number of secondary consultation (all clients and activities, n=1,634)**

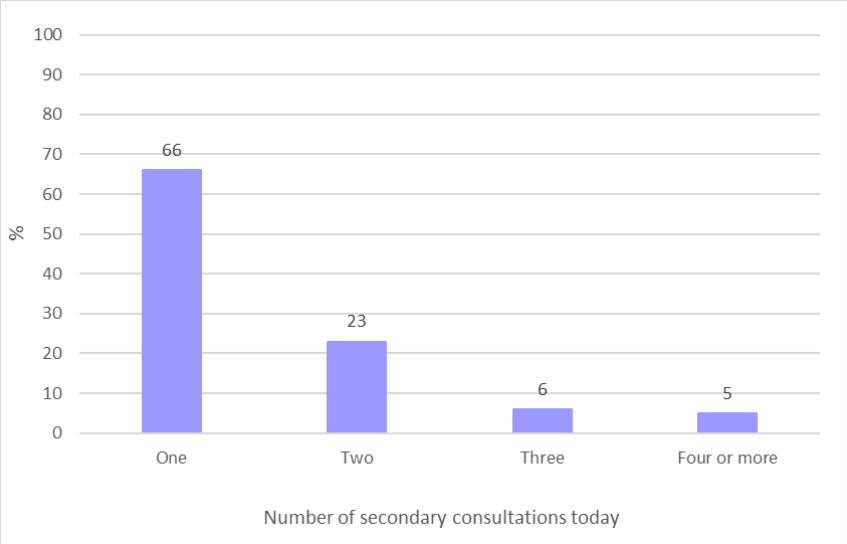
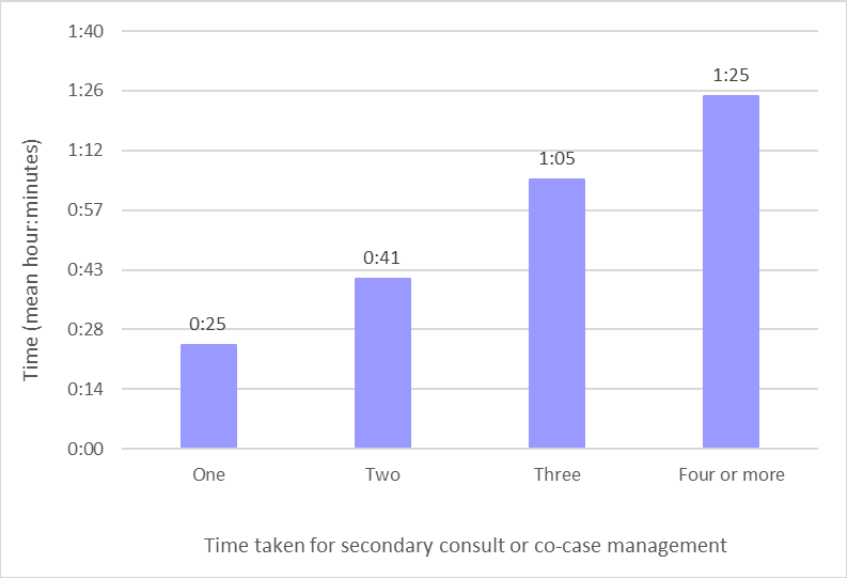


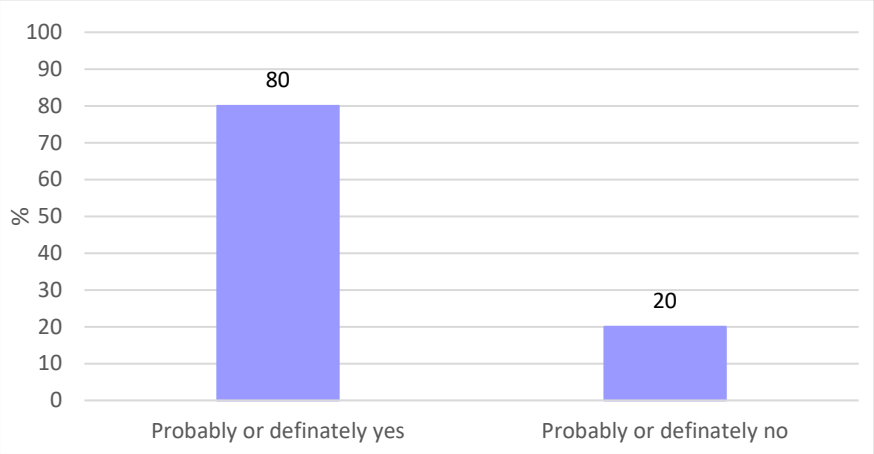
**Figure 9: Average time taken for secondary consultation by number of secondary consultations (all clients and activities, n=1,679)**




## Case management activities – needs met

Most case managers (80%) believed that their clients would have their needs met during the activities performed on that day (Figure 10).

**Figure 10: Estimate that client will have her needs met (all clients and activities, n=1,046)**




Even when there was a lower expectation of meeting needs, it was believed that more than half would have their needs met.

Clients with the lowest likelihood of having their needs met on the day corresponded with characteristics that suggest increased case complexity. They were also among the least likely client characteristics to appear in the data capture including:

- LGBTIQA+ clients (n=44, 61%)
- Clients with identified disability and in need of support such as modified housing, mobility aids, carer support (n=162, 66%)
- Clients on bridging or temporary visa (n=83, 67% likely needs met)
- Client being a young person aged 18-25 (n=41, 68%) or 12-17 (n=35, 54%)

Case managers also identified a slightly lower rates of ability to meet client needs among culturally, linguistically and faith diverse clients, those who were pregnant, or those with other legal issues:

- Culturally, Linguistically and/or Inter-Faith Diverse clients (n=363, 75% likely needs met)
- Clients with a language other than English as primary language (n=272, 74% likely needs met)
- Case management activities involving other legal or criminal issues (n=248, 75% likely needs met)
- Pregnant clients (n = 55, 75% likely needs met)

**Case complexity: Discussion**

As would be expected, the following was shown to be true in this data set:

- Some client characteristics could be associated with case complexity
- The more complex the case, the greater number of case management activities are likely to be required
- The greater the number of case management activities, the likelihood that case management will take a longer amount of time
- Some case management activities take more time to conduct (on average)
- The greater the time required for case management activities, then the fewer cases the specialist family violence services will be able to take on

Case complexity may be used as an indicator for estimating the amount of time it might take to work with clients and estimating periods of workload intensity. In this data there was a correlation between the characteristics which are likely to lead to complex case management and an increased number of activities required.

To fully understand case complexity a more significant amount of detailed information would need to be collected about each case, as compared with what could be collected for this project. The proxy measures used in this project (client characteristics, type and number of activities) identified patterns where greater amount of case management time was required.

Common characteristics of these clients included:

- Having a protection order in place
- Having younger children in the survivor's care
- Clients of diverse background
- Clients requiring support for legal or criminal issues other than family violence

All of these client groups generally required a greater number of case management activities, which resulted in taking a greater amount of case management time. Nevertheless, most case managers were optimistic that they could meet client needs.

Particular client groups appeared in small numbers and were identified as the most difficult to meet their needs:

- Clients on bridging or temporary visas;
- Those with identified disabilities related to their support needs;
- Younger clients; or

- LGBTIQA+ clients.

Client and case characteristics are likely to be useful demand indicators for monitoring case complexity. This indicator may be useful to assist services to plan their workload across staff allocations (perhaps assigning more complex cases to more experienced staff) and to anticipate when the service may be above target allocations.

**Recommendation to improve the indicators:**

- Using the information gathered in this project, conduct qualitative research with case managers to identify the characteristics and activities that determine whether a case is considered complex and how decisions are made in relation to managing needs for those cases.
- Identify a suitable tool for measuring case complexity

## 2. Identifying and Managing Risk

Identifying and managing risk is central to the whole of system response in Victoria. It is commonly reported that clients with higher risk profiles are likely to be allocated to case management more quickly than those with a lower risk profile. It is estimated that the greater amount of risk a client faces, the likelihood that case management will require more time. It is therefore estimated that a significant proportion of case management time will be spent on managing risk. An indicator to estimate demand may be generated from the length of time to manage risk and change in risk over time.

Currently there is no agreed model for monitoring risk and identifying key points of intervention for maximum impact and benefit. The ability to measure risk alongside case management response may provide insights into interventions that reduce risk over the long term, reduce service demand, and suggest benefits of early intervention.

**Proposed Indicator: Length of time required to conduct risk assessment or safety plan**

- The risk profile of clients in the service during data collection.
- The amount of time case manager spends on risk assessment, risk management and safety plans by estimated level of risk.

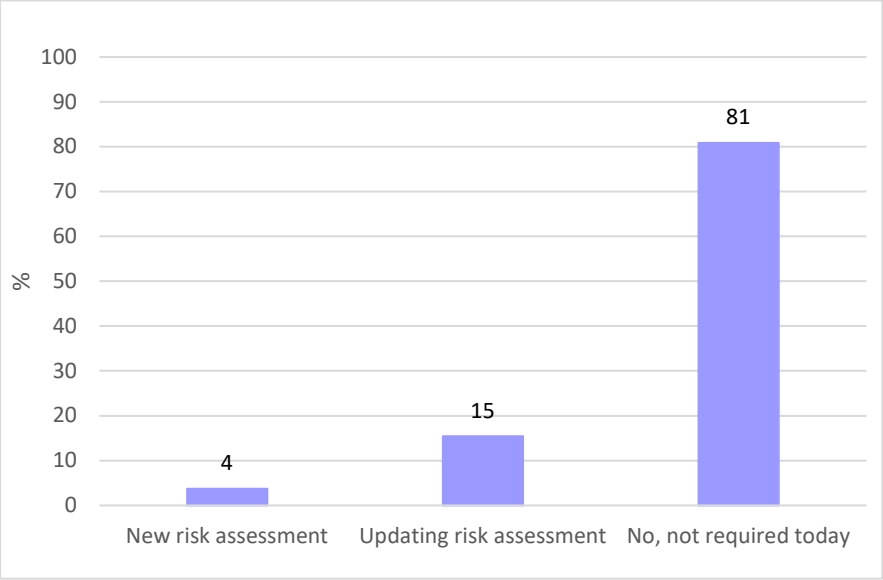
**Proposed Indicator: Changes in risk for client over time**

- Apart from recording immediate risk reduction activities such as police intervention, placement of survivors into refuge, or implementing court orders, there is limited documented evidence of risk reduction relative to service provision, wait time and exit from the system.

**Risk assessment**

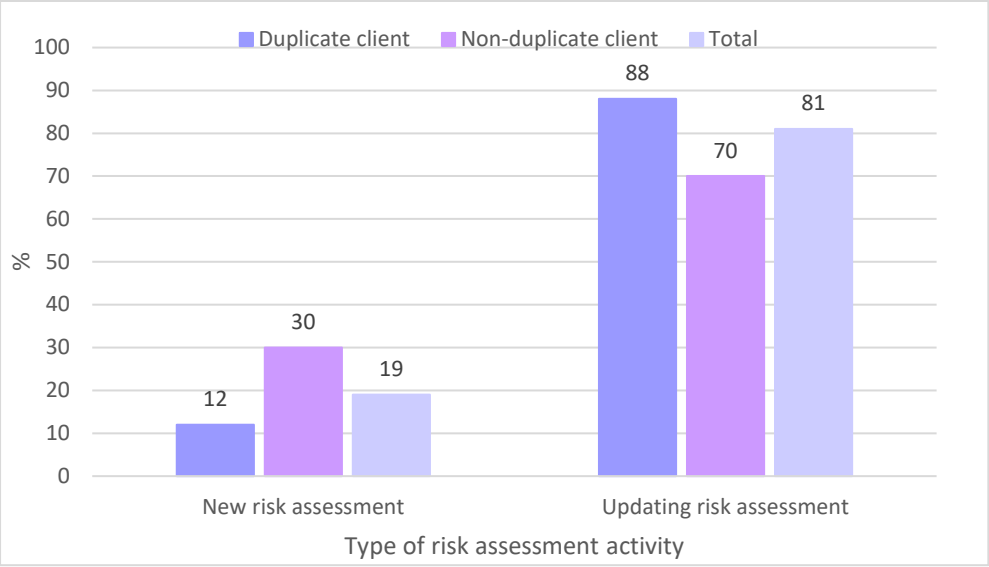
One fifth of the case management activities involved risk assessment (19%, n=912, Figure 11).

**Figure 11: Risk assessment activity (all clients and activities n=4,763)**



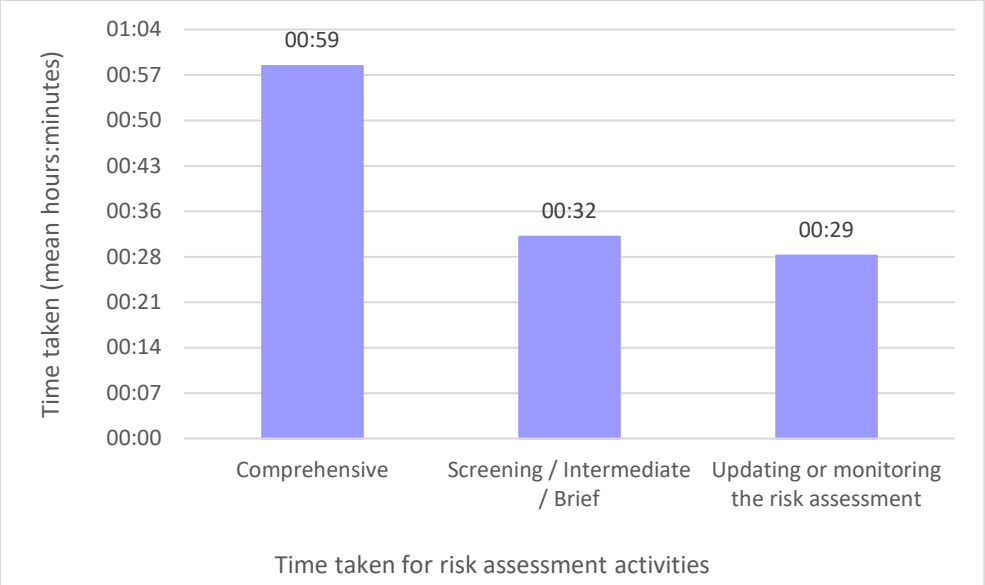

A new risk assessment was recorded for one in three non-duplicate clients (30%) compared with one in ten (12%) duplicated clients (Figure 12), thereby signalling that non-duplicate clients are likely to be representative of 'new' case management clients or attending their initial case management service.

**Figure 12: New risk assessment by duplicate or non-duplicate client (all clients where risk assessment activities undertaken n=912)**




As would be expected, comprehensive risk assessments took, on average, the longest amount of time – around 1 hour (Figure 13) followed by risk screening, brief or intermediate assessments and general updating or reviewing the risk assessment, an average of 30 minutes. There was no difference between duplicate and non-duplicate clients.

**Figure 13: Average time taken for risk assessment activities by type of risk assessment (all clients where risk assessment activities undertaken n=913)**




Less than one in ten clients (7%) where risk assessment activities were undertaken were deemed to require immediate protection and one in twenty considered at serious risk (20%). Most clients (66%) were estimated to be at risk or elevated risk. There was no discernible difference between duplicate and non-duplicate clients (Figure 14).

The average length of time it took to conduct risk assessment activities corresponded directly with the level of estimated risk. That is, the greater the estimated level of risk, the more time was spent on assessing risk assessment (Figure 15).

The information collected through this data capture cannot inform us as to whether case managers first estimated client risk and then selected the most appropriate risk assessment activities, or whether case managers routinely conducted the most appropriate risk assessment activity and through that process identified the level of risk. It is likely that both approaches have been applied.

What is clear is that the greater the estimated risk, the more time is spent on risk assessment activities.

**Figure 14: Estimated risk level (all clients where risk assessment activities undertaken n=907)**

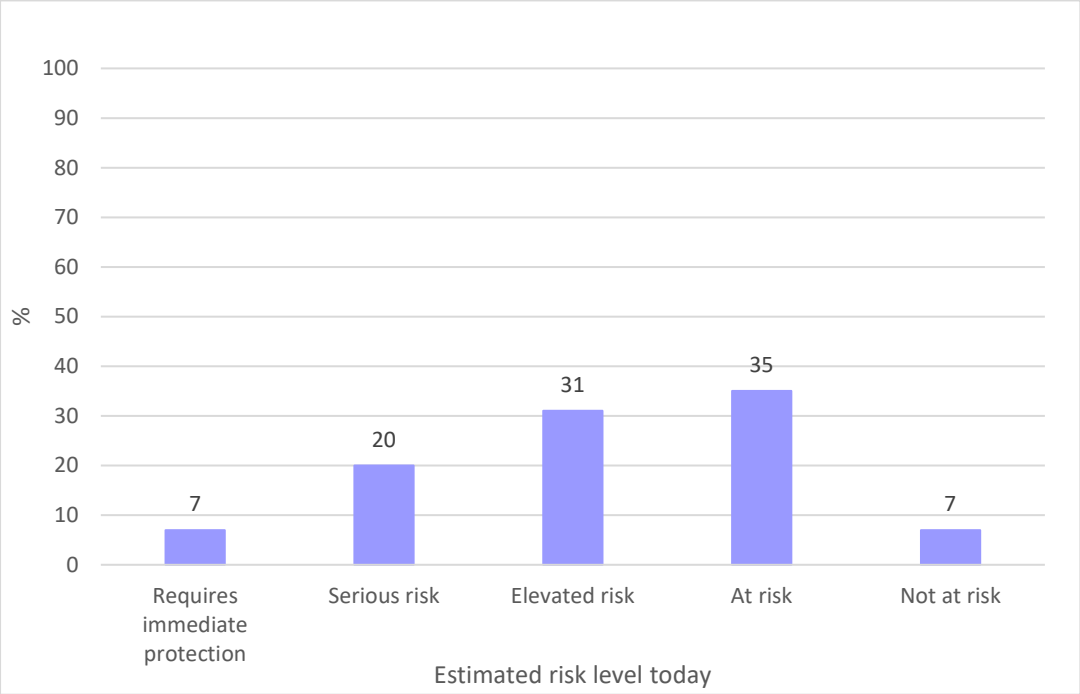
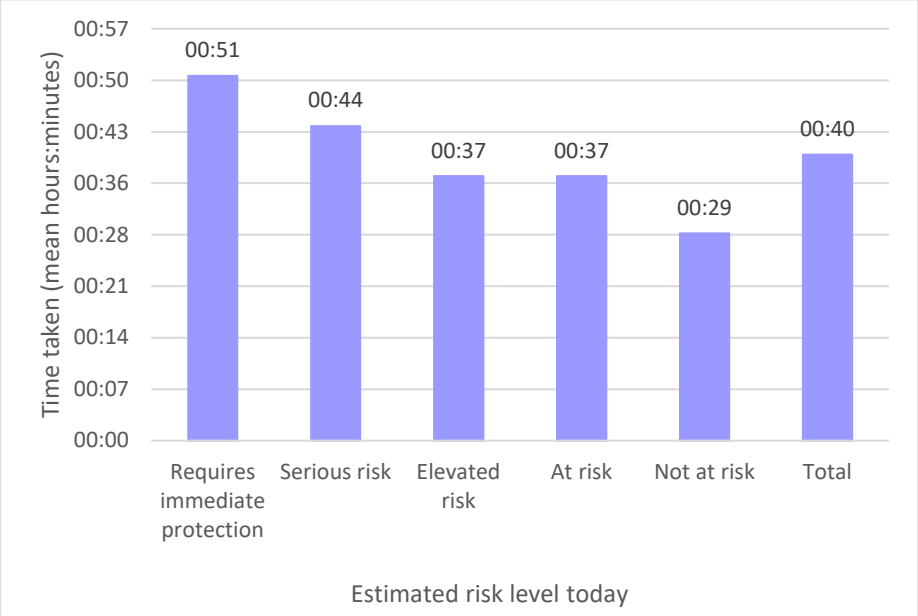



**Figure 15: Average time taken for risk assessment activities by Estimated risk level (all clients where risk assessment activities undertaken n=907)**




## Managing risk & safety planning

One quarter of the case management activities involved safety planning (25%) and most of that activity was for reviewing and updating the safety plan (Figure 16). Only 4% of the activities involved creating a new safety plan. Time taken to create a safety plan was half as long for non-duplicate clients (30 minutes) as compared with duplicated clients (1 hour) (Figure 23).

**Figure 16: Was any safety planning activity conducted today (all clients and activities n=4,732)**

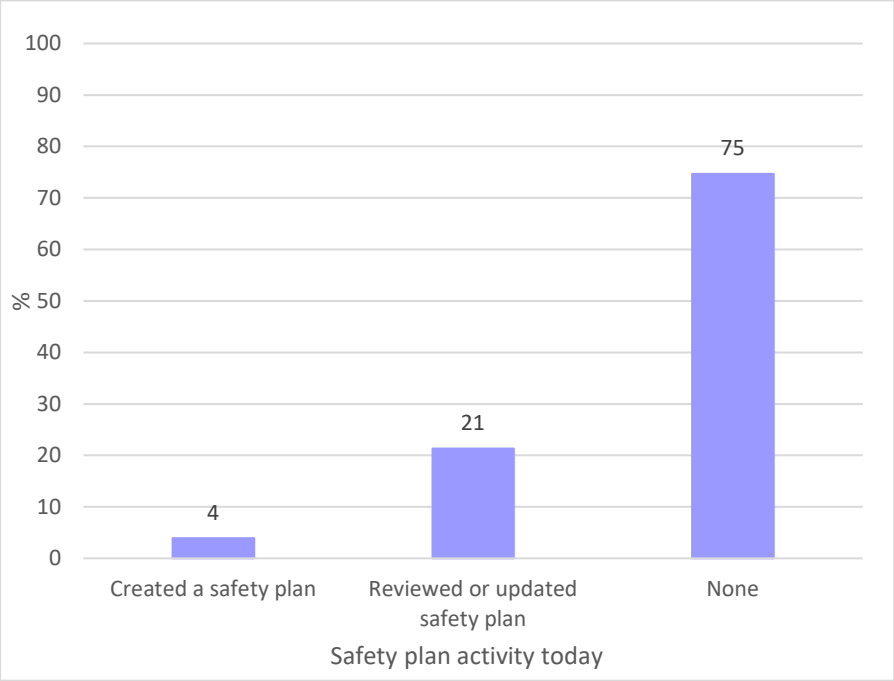



**Figure 17: Average time taken for safety plan activities (all clients where safety plan activities undertaken n=1,195)**


## Risk and intake, waitlists and active holding

When considering the risk profile of clients and how it might impact demand, it's useful to understand the risk for both clients allocated to receive case management as well as those who may be on a waiting list for case management. It is likely that those being held on a waitlist have a comparatively lower risk profile, but we do not have systematic and consistent

ways of measuring change in risk, how long clients are on a waitlist, and loss of contact with clients waiting for case management.

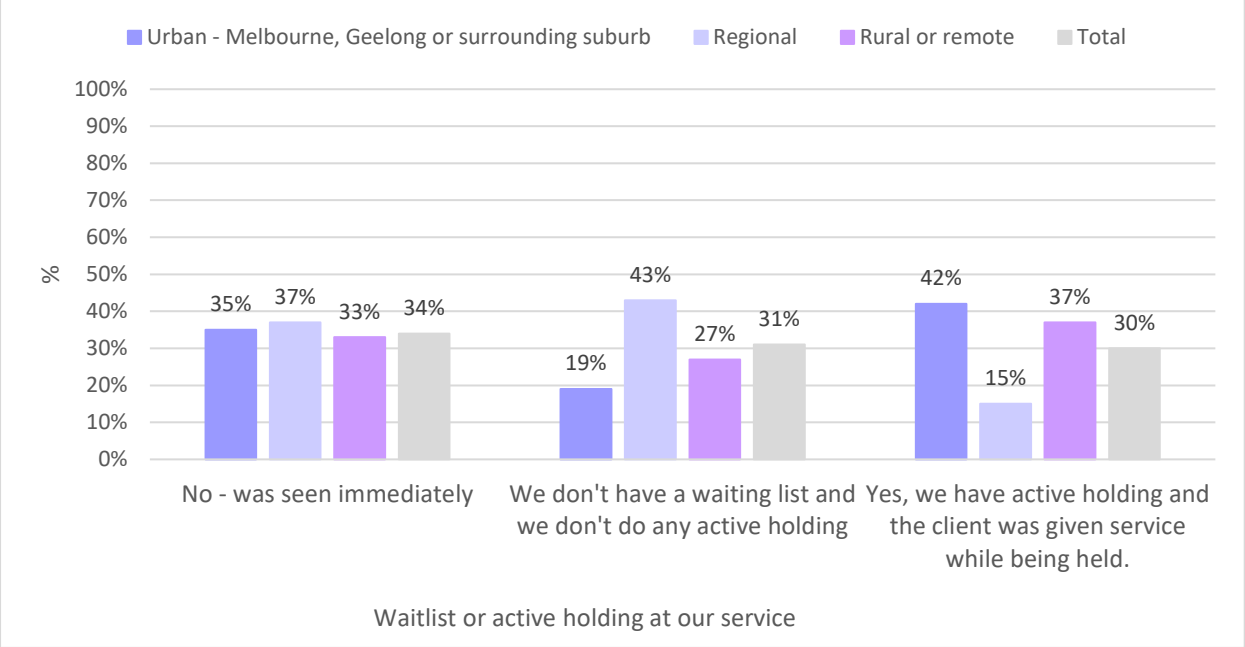
To obtain insight into this process, we asked case managers to report on whether the client they were working with had been on a waitlist both at their own service or another service.

- Some services have a waitlist and self-manage that list.
- Some services do not have waitlists and will not accept new clients until they have an available case manager. In these cases, clients are likely to remain managed by The Orange Door or another service.
- Some services use a combination of intake and outreach to support a group of clients in between intake and case management. This is often called 'active holding'. A client goes through intake and the most urgent needs may be met through outreach, but case management service is put on hold until a place opens.

One third of the activities took place in a service where a wait list was not available (31%); another third (30%) were seen in services using active holding while waiting for case management. In another third of activities the client was seen immediately without a need to wait (34%) (Figure 18). Urban services were more likely to have active holding (42%) compared with regional services (15%).

The average number of days for a client to be held was 21 days in services where clients were actively managed while waiting, and 7 days where they were held but without receiving a service.

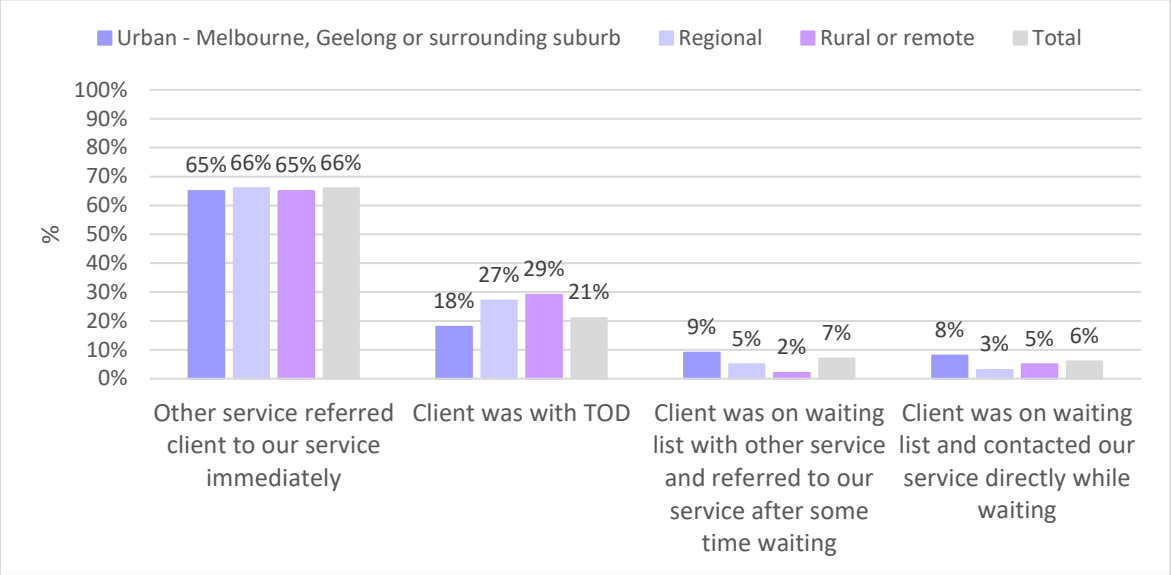
**Figure 18: Whether client was on a waitlist or being actively held by the SFVS before case management allocation (all clients and activities where information was recorded, n=1,788)**




A small group of case managers were able to report on whether a client had been on a waitlist at another service before coming to the specialist family violence service (Figure 19). With the information available to the case managers, two thirds (66%) were referred directly

to the service without waiting and one fifth (21%) were being handled by The Orange Door. Clients located in urban metro areas were less likely to be managed by The Orange Door (18%) compared with regional clients (27%) and rural / remote clients (29%).

**Figure 19: How was client being managed prior to referral to this agency (case manager reported all clients and activities, n=921)**

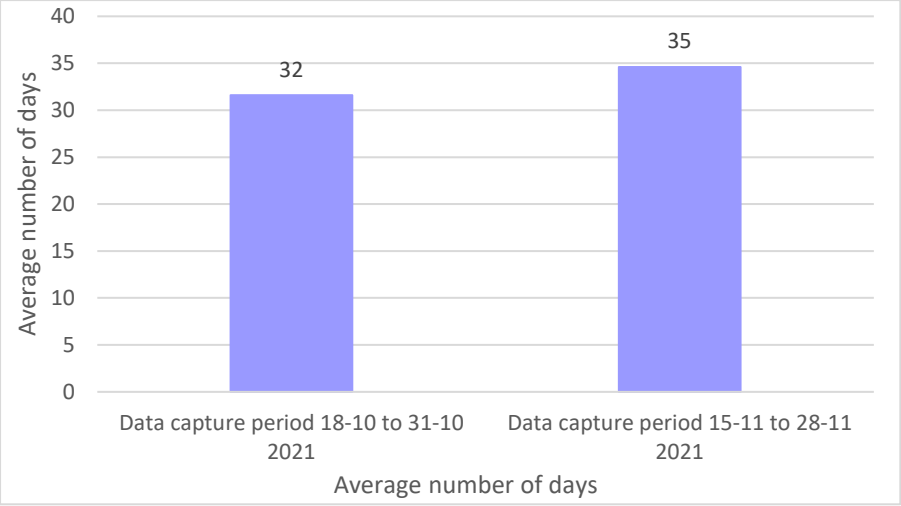



Case managers reported that **clients assessed by** The Orange Door **waited an average of 13 days before intake at a specialist family violence service**. During the period before intake, **case managers estimated that risk changed for two in five clients, a third of whom experienced increased risk.**

Data provided by Family Safety Victoria for The Orange Door sites shows that there was a high level of demand in The Orange Door sites during October and November, with over 16,000 persons screened and 12,000 moved to case between 18 to 31 October and 15 to 28 November. Of these screened persons, 70% were given a service from The Orange Door.

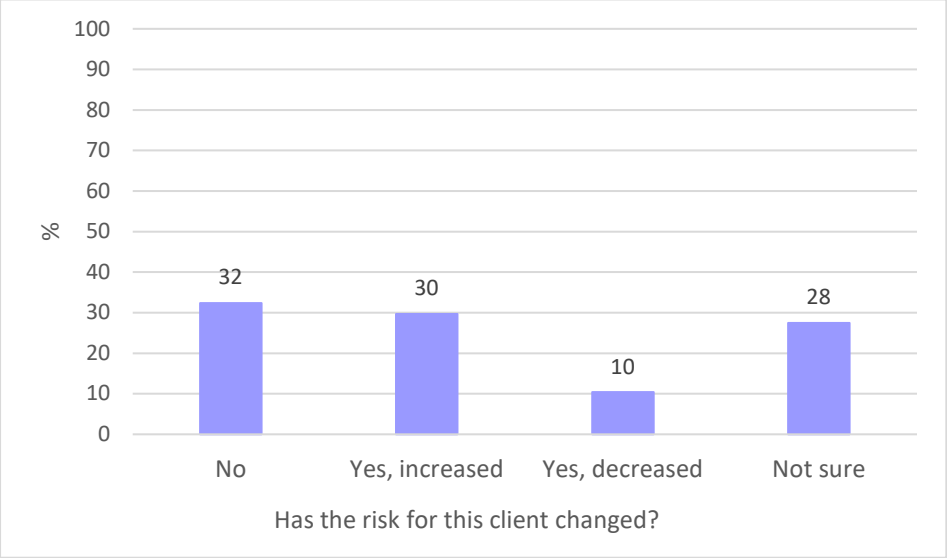
At The Orange Door, the average length of time from screening to case closure was over 30 days and includes all clients referred into the system, regardless of whether they have asked to be referred (Figure 20). For example, L17 referrals to The Orange Door will be triaged and then assigned to a practioner for assessment. It may take some time for The Orange Door to establish contact with the potential client and determine their needs before either referring onwards or closing the case.

**Figure 20: The Orange Door: average number of days between screening and case closure (all family violence clients, data capture 1 N=3,551 and data capture 2 N=4,217)**




Source: Client Relationship Management data for The Orange Door

**Figure 21: Has the risk for this client changed while waiting for case management? (all clients and activities, N=1,911)**




During the wait period, case managers estimated that risk changed for two in five clients. For 30% the risk is likely to have increased and stayed the same for another 10%.

*"Intake is now subject to referrals coming through from the Orange Door which has impacted complexities and risk of clients (both higher) . . . There is always a 'bottle neck' coming from The Orange Door and it seems that the low-medium risk clients (who could easily become high risk) don't get through to case management.Shared allocations with The Orange Door and case management agencies is overall working well in [this region]" (Service ID 14)*

This perception may be illustrative of the lack of information available to case managers as to why clients have not been allocated.

**Risk management: Discussion**

It was clear from the data that risk assessment activities and safety planning take a notable amount of time – ranging from one hour for conducting a comprehensive risk assessment, or creating a new safety plan, to 30 minutes when reviewing or monitoring risk and safety.

It was also clear that the small proportion of activities involving the more serious risk and need for immediate protection also took proportionally longer (45-50 minutes) than lower risk clients (30 minutes).

Safety planning seemed to take more time for clients that were seen more than once during the data collection period (duplicated clients). This suggests that their safety plan may have been more complex or require more attention to ensure it was effective.

Risk assessment and safety planning activities were only recorded for a fifth to a quarter of activities each, but together they make up nearly half of the activities recorded. In a state like Victoria where risk assessment and safety planning are a primary focus across specialist family violence services, this is not surprising.

A notable portion of clients could not be allocated to case management when first referred. Regardless of whether they were placed on a waiting list for the local specialist family violence service or a universal service or were being screened and serviced by The Orange Door, the longer a client waits for case management, the more likely their risk profile will change. For some, risk will reduce, and they may no longer need a service, for others risk may increase. If risk is not monitored as part of the waiting and intake process it could be dangerous.

We were unable to locate data collections where change in risk while waiting for a service, or systematic recording of clients whom services lost contact with was recorded. The information is likely held in individual case files but appears to be largely absent from data reporting software.

With services working to full capacity most of the time, it will be difficult to allocate sufficient time and funds to adequately monitor waitlisted clients.

**Recommendation to improve the indicators:**

- Recording better information about clients on waitlists, including risk monitoring and supports to prevent survivors from dropping off the lists without the service understanding where they went and why they left.

## 3. Children's Needs

With a default focus of family violence risk management most often placed on monitoring the adult victim survivor and the perpetrator of violence, the needs of child victim survivors are often invisible. The support system has evolved from a model of meeting the needs of the adult/parent victim survivor and providing safety so they can support their children. Although our thinking has changed and identifying the presence of children in family violence incidents has improved, the support system has not improved to accommodate children's needs.

A system that is focused on individual case targets and allocations deters service providers from identifying children as clients in their own right for a few reasons:

- Recording multiple family members would rapidly fill caseloads
- Service provision resourcing does not increase with the number of children and their needs identified in a family
- Child oriented risk assessments are not commonly used
- There are limited services available for children

Without documenting children's needs they remain invisible to the service system, and this perpetuates a cycle of underfunding demand for children's needs. The need and demand for service is present, but the capacity to deliver is not available in the service system.

Having an indicator of demand for children's needs would assist in visibility of their need and demonstration of the service gap.

**Proposed Indicator: Numbers and ages of children with family violence related support needs**

- Being able to count the ages and numbers of children impacted by family violence would be a good first step toward recognising the scale of the problem.

**Proposed Indicator: Number of case management records and files for children and young people**

- Separate case files for children and young people provides visibility of them and their needs.

**Proposed Indicator: Met demand of child clients**

- Once there is documented evidence and reporting of children's needs, the demand can be estimated, and service gaps mapped.

The specialist family violence services data identified that nearly half (48%) of activities were for adult clients who had children aged 17 years and younger. Children and young people were infrequently recorded as case management clients. Only 4% of activities were for clients aged 17 or younger

| Age: adult or child | Duplicate client | | Non-duplicate client | | Total | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| 1-17 years | 53 | 3% | 66 | 6% | 119 | 4% |
| 18 years and older | 1,743 | 97% | 1,039 | 94% | 2,782 | 96% |
| Total | 1,796 | 100% | 1,105 | 100% | 2,901 | 100% |

Table 5 in Appendix 1)

When asked how children's needs were being met, case managers mostly reported that either they were managed through the mother's support plan, partnered with another agency such as child protection or maternal child health services, or provided very simple support themselves. A lack of availability of services was mentioned frequently.

Refuge services were the exception with services more often provided to children while they were in refuge accommodation. Refuge provides staff visibility and time with the children so that their needs are better assessed and support for children is often part of the refuge case management program. During the team leader discussion, staff who have worked in both SFVS without accommodation and in refuges mentioned this point of difference.

*"I think that's a significant point of difference for us when we looked at the different case management roles.* ***In refuge, children dominate … because the children's behaviour was so obvious*** *and we could work around them and their case plan goals around education, inclusion in activities, understanding behavioural needs, could get them into support in terms of external providers sometimes quicker than mum. So, we had some really good outcomes. However, some of the* ***other case management with other outreach teams, it was really hard, [especially] through covid where they were rarely seeing children, it's hard to ask about the needs of the children over the phone without the parent feeling it was an inquisition for a child protection questionnaire****." (Team Leader focus group discussion)*

*"At our larger* ***refuge****, it is difficult with higher numbers of children referred into the service,* ***we provide each child with individual case plans, their own case manager, safety plan, risk assessment and in our new core and cluster refuge we can have up to 35 children on site which is stretching our part time team to capacity****. We believe hugely in supporting children as clients and victim survivors of family violence in their own rights, extra funding to support larger families is critical!" (Service questionnaire, ID 7)*

- Working with children is intense and demanding specialist work. Specialist family violence case managers do not have the time, skills or adequate resources to meet their needs.
- If children were listed as clients in case management allocations, then case managers would have a full case load with only 1-2 families.

## The Orange Door, Homelessness Data Collection Tool (otherwise known as SHIP) data, & Safe Steps[8]

Family violence support periods recorded in the Homelessness Data Collection Tool (otherwise known as SHIP), The Orange Door (TOD) and Safe Steps during comparable data collection periods identified:

[8] See

Appendix 3: Comparative data analysis Family Services Victoria, The Orange Door and Safe Steps on page 50.

- **Homelessness Data Collection Tool (otherwise known as SHIP)**: One quarter (28%) of the support periods recorded were for people aged 17 and younger; 72% aged 18 and older (see Table 23 and Table 24 In appendix 3.
- More than a third of young people were aged 10 years and younger (68%).
- **The Orange Door (TOD)**: More than two-thirds (39%) of the cases created in the data collection periods were for young people aged 17 years and younger (Table 34 and Table 37 in Appendix 3).
- More than half of the young people were less than 10 years old (57%) (Table 36 in Appendix 3).
- **Safe Steps**: Two thirds (60%) of accommodation places during October and November 2021. included children and young people aged 14 years and younger (Table 38 in Appendix 3).

Homelessness Data Collection Tool (otherwise known as SHIP), TOD and Safe Steps all collect a notable record of children's needs in their data sets, but this data is not easily accessible for reporting purposes. The Homelessness data collection has provided information on whether or not identified children's needs were met across broad categories (Table 27 and Table 28). Comments from the team leaders, case managers and service providers in the data collection identify some of the challenges for measuring this indicator.

*Working with children is really dynamic and its really difficult because children have many different needs both emotionally and developmentally and getting workers to understand that...* ***I think we need more resources to do it well...it means bringing in more staff and staff with specialist skills around children and looking at whether we do it therapeutically or as case management****...it needs a much bigger focus and resourcing. (Team Leader focus group discussion)*

*We had a worker here recently who was working with a mother who had 9 children,* ***if you count each of those children as a client, she's [case manager] got a full caseload****. (Team Leader focus group discussion)*

*(on managing children's needs) I would say probably not [doing] that well...if I'm entirely honest…you know when you have* ***new workers*** *coming through that are fresh out of their social work degree that have a very basic understanding of family violence and actually no experience in what that means practically and* ***they're trying to learn how to work with women and then also trying to understand that work around children you know is really difficult.*** *(Team Leader focus group discussion)*

*It's also about the relational stuff you know because you can work with mum you can work with the kids but unless you do that relational work…what's the point? ... I think the work with children is so complicated and complex and really needs to be looked at. Because it's one thing to do direct service with children but* ***you cannot miss that relational work. For me, that's the key in the long term is sustaining wellbeing for children.*** *(Team Leader focus group discussion)*

It is clear from the comparative data sets that there are many more children in the family violence service system than were recorded in the specialist family violence service indicator data template. During the team leader insight discussion children's needs were identified as very much hidden. Specialist family violence case managers are unlikely to record the

children of their adult clients as separate clients unless there are particular needs. This is due to multiple factors:

- Adding all children as clients would quickly supersede the case manager and service target case allocations;
- There is significant administrative burden when opening case management support periods and few dedicated services that can be offered to children so there was questionable value in opening support periods; and the work with children is complex and often not sustainable during crisis support.

**Children's needs: Discussion**

Comparatively few children appeared in the data generated for this project. This is thought to be a result of the way that the system is designed which makes it difficult to add children as clients in their own right. Due to the way the system measures target allocations and caseloads, case managers often try to meet the needs of multiple family members but recorded as service provision to a single client, usually the mother.

Qualitative responses from CMS and team leaders illustrated how important they thought the work was with children. In respect of that, they were very clear that the work was challenging and required more resources than they had available in their current roles to support children.

**Recommendation to improve the indicator:**

The data collected for this trial of indicators cannot provide a robust measurement of children's needs.
That a data item be included in specialist family violence services data systems that indicates:

- What children's needs are.
- Whether the needs can be met; and
- If they cannot be met, why not.

## 4. Crisis Accommodation

A knowledge gap exists in tracking the occupancy rate of available accommodation in the context of appropriateness to meet client needs. There also is a need to understand when unmet demand for crisis accommodation in the family violence sector flows through to cross-sector referrals, for example referring into the homelessness sector.

In addition, crisis accommodation reporting can sometimes appear as though facilities are below target while there is unmet demand for accommodation. There are appropriate reasons for under occupancy such as staffing shortages, or housed clients with higher needs which may reduce the appropriateness of increased capacity. At times beds may need to be closed for the accommodation to be appropriate for the clients who are being housed. The way that housing and accommodation need data is currently reported does not include information to assist understanding why targets may not be met in the face of unmet demand.

**Proposed Indicator: Number of clients unable to be accommodated and why**

- Understanding who can be accommodated and who is not able to be accommodated would assist in understanding and mapping accommodation demand.
- Measuring the amount time case management staff spend locating suitable accommodation by client characteristics and risk may assist in estimating demand across the sector.
- Understanding why crisis accommodation is not available.

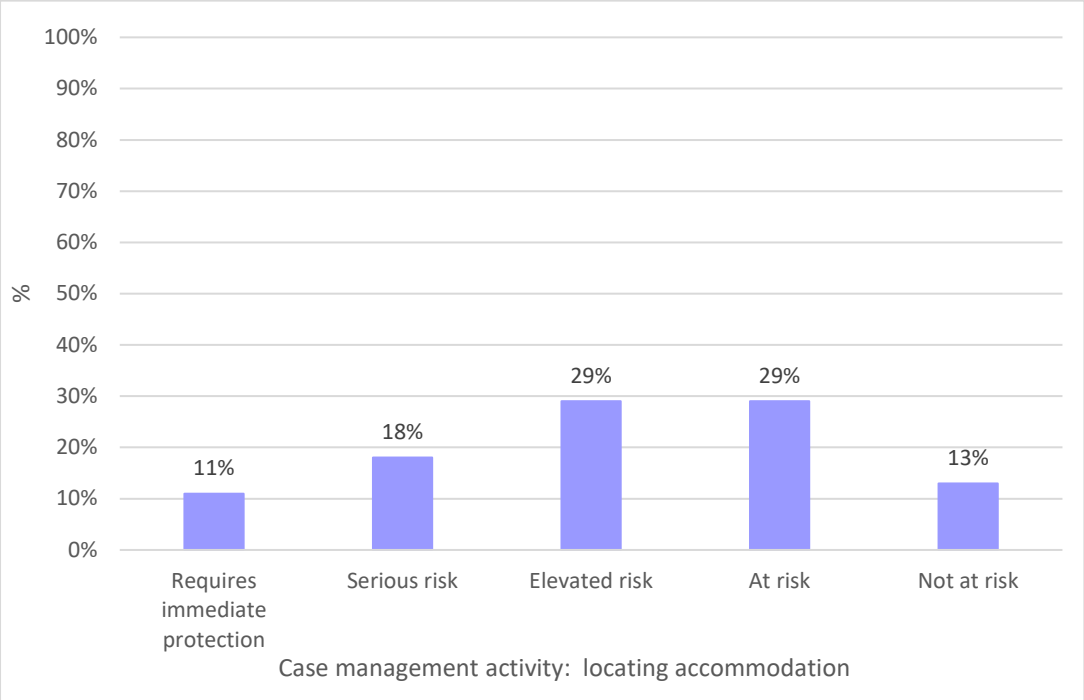
**Proposed Indicator: Number of cross referrals to housing sector and why**

When housing is not available in the family violence sector clients are sometimes referred to the homelessness sector and they then become invisible to the family violence sector. This can lead to under estimating housing demand.

Upon examination of all 26 identified case management activities provided by SFVS (excluding case notes and ongoing case management), activities to locate client accommodation was the 7th most listed activity (13%, n=3,713) and took an average of 1 hour 26 minutes. These clients were generally of mid-range risk profile (Figure 22).

Client characteristics associated with accommodation demand included having a protection order in place (44%, Table 15 in Appendix 2), children aged 5 and under (40%), and culturally, linguistically and faith diverse (19%).

**Figure 22: Case management activity to locate accommodation by risk profile (n= 341)**




Case management Time 1 data did not collect adequate information about accommodation needs so additional questions were added into the Time 2 questionnaire. The remaining accommodation data reported on here refers to Time 2 data collection only (N=2,409 activities).

While accommodation demand was projected to be one of the most frequent and time-consuming activities it was not identified as an issue in the majority case management activities.

(**Table 14 Case management activity to locate accommodation by risk profile**

| What do you believe is the risk level for this client today? | Accommodation request / locating accommodation | |
|---|---|---|
| | Count | Column N % |
| Requires immediate protection | 53 | 12% |
| Serious risk | 101 | 22% |
| Elevated risk | 125 | 27% |
| At risk | 143 | 31% |
| Not at risk | 38 | 8% |
| Total | 460 | 100% |

**Table 15 Case management activity to locate accommodation by client characteristics**

| Client characteristics | Accommodation request / locating accommodation | |
|---|---|---|
| | Count | Column N % |
| Protection order in place | 192 | 44% |
| Client has young children aged 5 years or younger | 178 | 40% |
| Client has children aged 6-11 | 166 | 38% |
| Client has children aged 12-17 | 97 | 22% |
| Culturally, Linguistically and/or Inter-Faith Diverse | 85 | 19% |
| Language other than English as primary language | 67 | 15% |
| Other legal or criminal issue | 56 | 13% |
| Family law matters | 54 | 12% |
| Client has an infant less than one year | 37 | 8% |
| Located in rural or remote area that might have less access to services | 37 | 8% |
| Aboriginal and/or Torres Strait Islander | 32 | 7% |
| Identified disability and in need of support such as modified housing, mobility aids, carer support. | 31 | 7% |
| Client is pregnant | 23 | 5% |
| Older person | 16 | 4% |
| LGBTIQ | 8 | 2% |
| On bridging or temporary visa | 10 | 2% |
| Client is a young person aged 12-17 | 7 | 2% |
| Client is a young person aged 18-25 | 11 | 2% |
| Client is a child - aged 11 or younger | 6 | 1% |

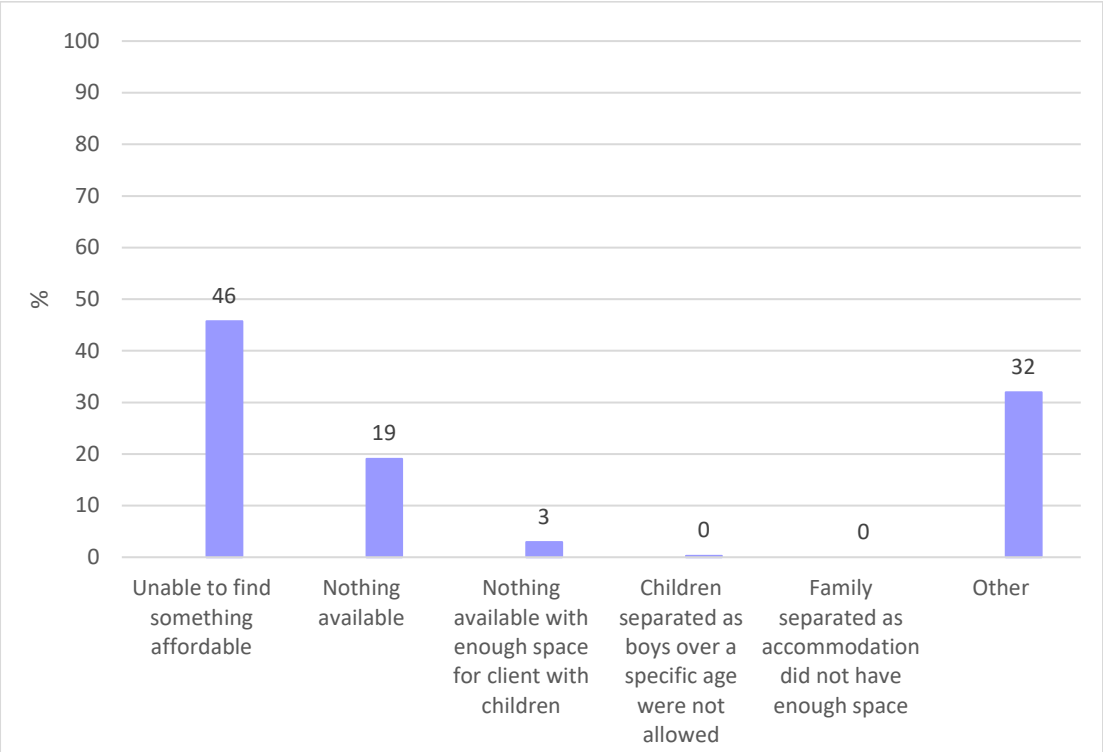
| | | |
|---|---|---|
| Client is an infant | 1 | 0% |
| Total | 441 | 100% |

Table 16 in Appendix 2) and half of these clients were living in crisis or short-term accommodation (Table 17 in Appendix 2). The main barrier to finding suitable long-term accommodation was affordability and not having a rental history, or a problematic rental history (included in the 'Other' category Figure 23) as well as accessibility for disabilities, inappropriate location, and accommodation being too small.

*Homelessness is ongoing with nothing affordable and safe. And other service expectations for accommodation which funding for this is limited and housing services are at capacity.* (Team leader focus group discussion)

Families being forced to separate in order to access accommodation was rarely identified (Figure 23). Clients were instead being supported to find accommodation sufficient for the size and makeup of the family, which in turn made identifying suitable accommodation more challenging.

**Figure 23: Barriers to accessing suitable accommodation (activities identified with clients living in crisis or temporary accommodation, n= 341)**

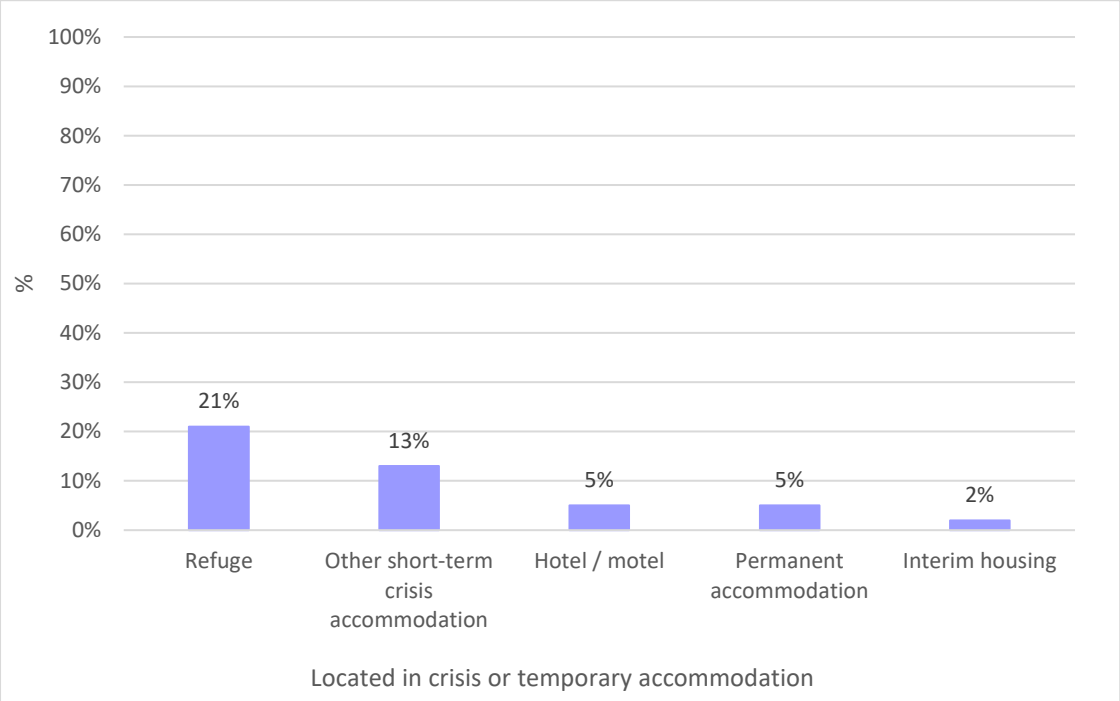



While we were unable to count the number of children for which a lack of suitable accommodation was an issue, 16% of activities (n=178) where the client had children (n=1,113) also reported accommodation issues. And, as reported in the previous indicator measuring children's estimated demand, data from Safe Steps revealed that two-thirds (60%) of emergency accommodation places during the data collection period included children and young people aged 14 years and younger (Table 38 in Appendix 3).

## Accommodation needs and risk

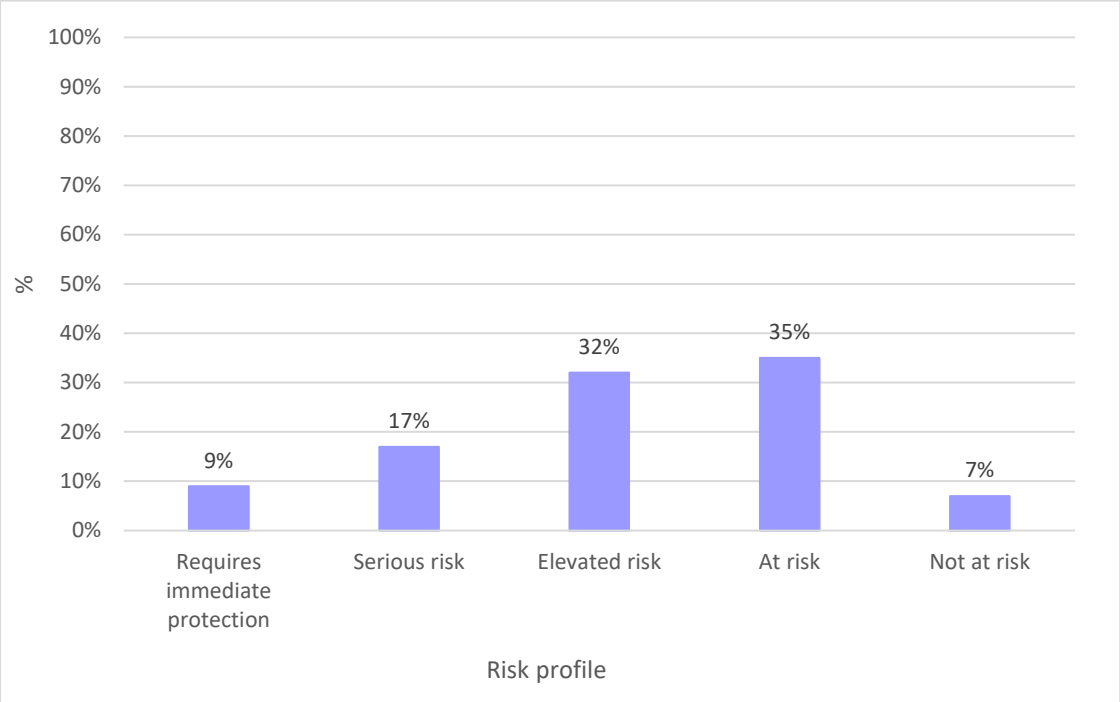
Clients located in crisis or temporary accommodation were distributed across risk profiles (Table 20 in Appendix 2), however a larger portion of women in refuge, compared with other types of accommodation, required immediate protection (Figure 24). This suggests that clients requiring immediate protection were more likely to obtain crisis accommodation.

**Figure 24: Clients located in crisis or temporary accommodation by require immediate protection (n= 581)**




Among the group who had problems accessing suitable accommodation, only 9% required immediate protection (Figure 25). As risk reduced more clients experienced problems accessing suitable accommodation, thereby suggesting that appropriate accommodation was easier to obtain when risk profile was higher.

**Figure 25: Clients who had problems accessing suitable accommodation by risk profile (n= 582)**



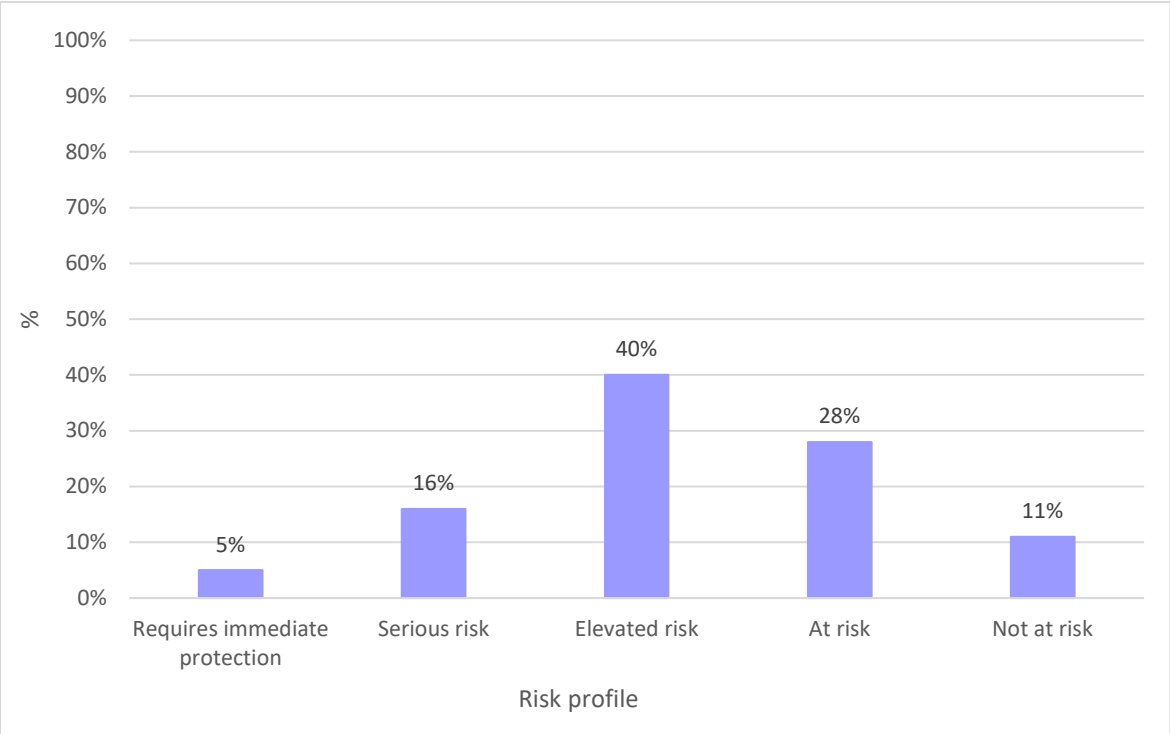

## Cross-referrals into the homelessness sector due to the inability to meet housing demand

Among the CMs and team leaders there had been discussion of the likelihood that specialist family violence service clients were often referred over to the homelessness sector when accommodation needs could not be met. Concern was raised that moving these clients means that the unmet demand through specialist family violence services becomes invisible.

During the 2-week data collection in Time 2, there were 130 activities where the clients were referred to the homelessness sector. This is only 5% of the whole data capture, but accounts for more than two-fifths of the activities facing accommodation issues (44%, 130 out of 294).

Review of risk profile shows that clients deemed to be at greater risk of violence were less likely to be referred into the homelessness sector for accommodation needs. One in five clients requiring immediate protection (21%) were referred into the homelessness sector compared with one in three identified at serious risk (38%) and half at elevated risk (49%, Figure 26).

**Figure 26: Referral to homelessness sector to meet housing needs by risk profile (n= 315)**




## Comparative data provided by Safe Steps

None of the DFV data provided by comparative data providers included information about the number and family type of clients who were unable to be accommodated, reasons why and information about their current accommodation situation. Information about accommodation was limited and the information needed to estimate demand is invisible.

Data from Safe Steps does provide comprehensive monthly data on accommodation provided as well as exit information from supported places. Information includes the type and length of accommodation provided during the data collection period.

- Average of 80 victim-survivors in crisis accommodation on any given night in October 2021 and 109 in November 2021.
- More than 300 housed in motels for each month of the data collection (October n = 318; November n = 377)
- Between the two data collection periods, clients stayed in emergency accommodation longer (17% of clients stayed for more than 10 nights in October 2021 compared to 22% in November 2021).

Safe Steps information about where clients go when exiting emergency accommodation provides insight toward understanding the implications of limited affordable and appropriate accommodation options (Figure 27).

- Less than one in ten survivors exited emergency accommodation into private rental (6% in October 2021 and 3% in November 2021).
- One in ten (11%) exited to stay with family and friends
- One in six exited through a Safe@Home plan (15% in October 2021 and 18% in November 2021).

- Roughly a quarter to one third moved into public housing

**Figure 27: Safe Steps accommodation exit pathways (October and November 2021)**



## Crisis accommodation needs: Discussion

While the data collection did not identify a significant number of adults and children with demand for accommodation, this activity was within the ten most frequently listed activities under case management. Affordability was identified as the primary barrier to obtaining suitable accommodation, which suggests that either clients did not qualify for public housing, public housing was not available, or the public housing that was available was not suitable and therefore the client was looking for other, more permanent options.

Analysis of risk profile across accommodation demand activity did show that clients with higher risk profiles were more likely to obtain crisis accommodation such as refuge and/or other short-term accommodation, and case managers may be spending their time locating accommodation for low or medium risk clients.

Like children's needs, the data identified accommodation as another notable support need that is often not able to be met by specialist family violence services and may not be duly recorded.

- The data collected for this trial identified two potential indicators:
- Affordability as a significant barrier to suitable accommodation
- Risk profile among clients seeking accommodation to estimate resources required to meet needs.

## Recommendation to improve the indicators:

- To further develop this indicator, additional qualitative research with crisis accommodation providers may increase understanding of unmet demand and what is reasonable to measure at the specialist family violence services case management level.

# 5. Unallocated Cases for Case Management

There is limited understanding about which clients 'get stuck' waiting for service and where those bottle necks are. Unallocated cases may be clients who have requested a service and are waiting for a referral, or clients who have been processed through intake and not yet

allocated to case management. Depending on 'where' a client is waiting they may or may not be receiving some form of service.

Services with a waiting list or 'active holding' can see the pipeline of clients on their list, but services cannot readily see the pipeline from The Orange Door unless through formal allocation meetings held between TOD and the SFVS services. Changes to the Victorian family violence system mean that referrals will be increasingly collected and distributed by The Orange Door, but capacity at the service level **has not increased commensurately.**

The number of staff in a service is central to meeting demand. Caseload against staffing capacity is a key measure of ability to meet target caseloads. However, staffing levels do not consider periods of leave, staff experience and vacant positions. Organisations may look like they have more capacity to meet demand than they do.

Case managers and team leaders speak of working above caseload targets and finding innovative ways to support clients beyond their allocation. As CMs find 'work around' solutions, there is invisible data here which would assist to measure demand.

**Proposed Indicator: waiting for case management allocation**

- Wait time for referral from The Orange Door into the local specialist family violence service
- Length of time between intake and case management

**Proposed Indicator: Number of clients exceeding targets**

- Number of clients exceeding targets at the service level

**Proposed indicator: Service staffing levels**

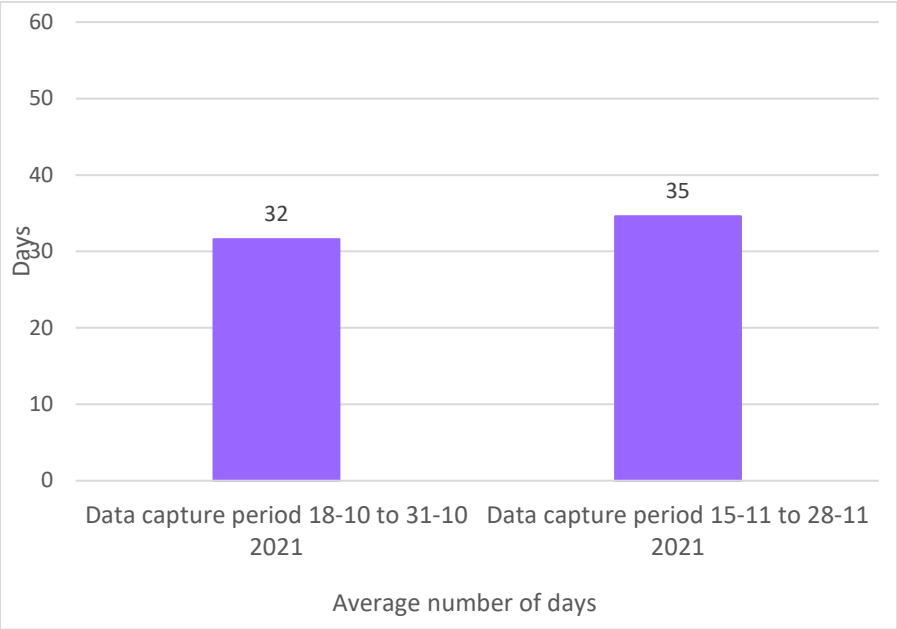
- % of staffing and length of time not fully staffed
- Length of time to fill a position
- Staff experience

## Intake, referrals and case management allocation

### The Orange Door referrals

As more Orange Door hubs open across the state, this referral pathway is likely to increase and put additional pressure on specialist family violence services. The Orange Door data shows that the time between screening and case closure was an average of 33 days (Figure 36). Specialist family violence services case management staff estimated their clients who were on a waitlist with an external service waited an average of 13 days before being allocated to case management.

**Figure 28: Average number of days from screening to case closure in TOD (N=7,768 cases)**




1. Cases closed within the reporting periods were matched with referrals data.
2. Invalid cases and clients identified as perpetrators excluded.

Examination of The Orange Door case outcomes (reason for case closures) show that approximately 50% of the cases coming through The Orange Door have their needs met either by The Orange Door (25%) or by engaging with the service system (27%, see Table 37). Most of the remaining cases could not be contacted, declined the service offer or disengaged.

*I know in some regions, places like the Orange Door hold a lot of unallocated cases because [specialist family violence] case management lists would close. Therefore, they were holding a lot of those case management unallocated clients for significant periods of time. (Team leader focus group discussion)*

*We don't run a waitlist or active hold list, because we don't have capacity to pick up cases from The Orange Door but that's becoming hard… I think we will probably move to…develop up an active hold list…because there's obviously KPIs we need to meet. (Team leader focus group discussion)*

## Time between intake and case management

Sixty percent of the services had some form of wait list between intake and case management, however the waiting time was short, an average of 1 day (std dev .6).

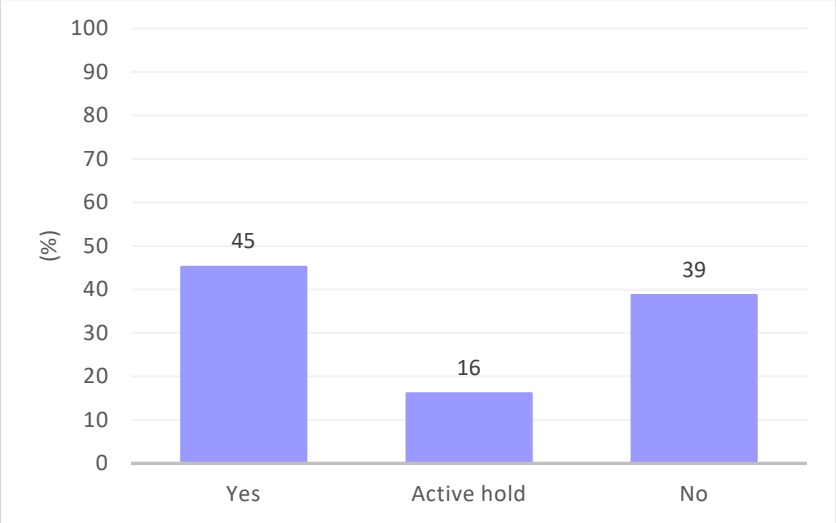
One in ten services (16%) performed 'active' holding, meaning that clients on the waiting list received a form of outreach support such as regular calls from staff and referrals to resources (Figure 29).

*When understaffed and/or a high number of formal/informal referrals and self-referrals, high number of secondary consultation or information requests, our intake demand management*

*data sheet will reflect the need of activating the wait list/active hold list. This impacts our service delivery including longer wait time to receive intake assessment and case allocation, more co-case management is needed in the interim to ensure client safety, and more resources are required to support staff wellbeing. (Service ID 26)*

Five of the thirty-one services reported that they see case management clients the same day as intake; of the remaining services, two did not provide an estimate of the time between intake and case management allocation.

**Figure 29: Does the service have a wait list (N=31 services)**




Other reasons given for clients to be waiting for case management:

*During the [data collection period] cases are on the waitlist due to client readiness concerns as well as some goals that can be addressed in an interim support capacity. (Service ID 15)*

*New workers need to go through induction and training before providing client work. (Service ID 27)*

*We do not generally hold clients on an outreach waitlist, unless their risk is deemed low (no recent separation, no high-risk factors, not living with the perp etc) and then we will keep them informed of when we can pick them up. An example of this would be a request for court support for a counselling client, court is in 2022, a phone meeting would be set up and a timeline for in person support if not immediate, this will always include safety planning in case risk changes during this time. (Service ID 6)*

Some services provided limited services to clients on a waitlist and called this active holding. Examples provided by the service staff offered unique insight into the complexity of managing demand:

*Our service was 'full' and unable to allocate clients to a case manager, however we keep accepting case management cases and 'actively holding them'. Therefore, we are managing many more case management clients then it appears. Technically we are never 'full'. (Service ID 25)*

*Demand for support remains high. We have had significant issues around recruiting to our vacant positions and currently hold an extensive active hold list for clients awaiting allocation to case management. (Service ID 8)*

*We will sometimes get local referrals from our own counsellors, local maternal child health nurses etc for outreach case management, which we can support as about 10% of our workload. If we are unable to pick up a referral, we will support the client with a safety plan and a warm referral to the Orange Door or to Safe Steps intake and assessment. (Service ID 6)*

*When clients are on wait list/active hold list, intake workers will ask the referring workers to support the clients continuously at least until the clients are allocated for case management service. For self-referrals, clients will be provided with information on services that they require and/or be referred to the appropriate services whilst waiting for case allocation. We also provide crisis brokerage to support clients, if needed, in the interim. (Service ID 26)*

Services without a waitlist either provide a service to all clients or rely on The Orange Door to hold the clients until a space opens up.

*We do not maintain a wait list and endeavour to work with all clients who contact within 24-48 hrs. (Service ID 18)*

*No wait list in our service. TOD completes the intakes for allocation and will hold until we have capacity. (Service ID 16)*

*We don't have a current wait list because the work is backlogged at The Orange Door which opened [recently]. Once TOD is fully staff, we expect we will need a wait list and will prioritise risk rating to triage clients to allocation. (Service ID 5)*

*Self-referrals receive immediate response, the Orange Door referrals do have a delayed response. (Service ID 22)*

*At the moment, our team is managing because the workflow/allocations are slow from The Orange Door. If these increased, we would very quickly hit capacity and have to hold a wait list. (Service ID 5)*

## Number of clients exceeding targets

### Demand and case management target allocations

Services providing data included a diverse range of organisations of different sizes and serving populations in all regions of Victoria. Using data from Time series 2 only, 14 services entered information about case management target allocation for the service. The average target allocation across all 14 services was 19 case management clients with a range from 4 to 52.

During the data collection period, services provided case management to an average of 7 clients above their target allocation, with a range of 2 to 14 (Figure 30).[9] Four of the 14 services did report cases above their target allocation.

The range for target allocations is reflective of the broad size of services included. What the analysis shows is that most services were working with caseloads notably higher than their target allocation during the data collection period.

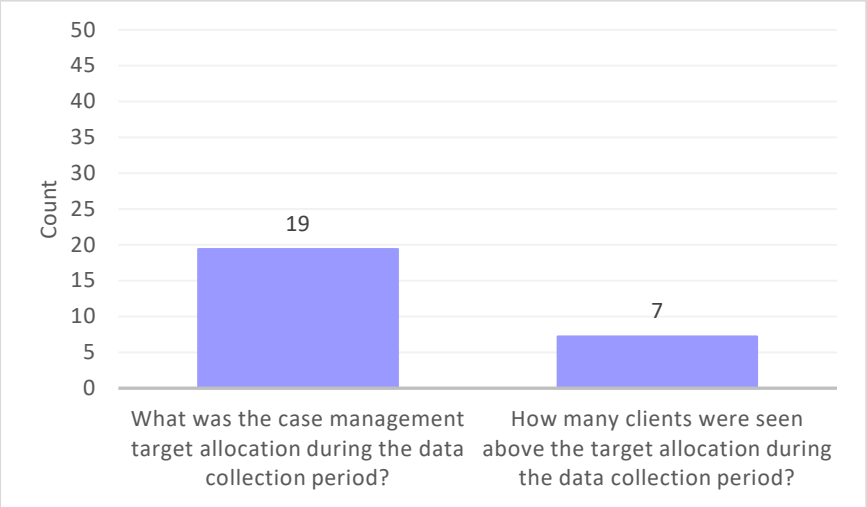
*Overall case management programs have observed that there is a need for an increase in total case management capacity. Anecdotal evidence indicates that intake services are operating over capacity, this creates: a backlog of clients needing allocation to case management; clients not having immediate needs met and compounding risk and trauma; some women being advised that they don't meet the 'threshold' for immediate service or on-going case management, thus not validating their experiences of family violence. (Service ID 28)*

*Most of our client group are complex clients and going through different crisis, safety, financial, mental health, immigration, child protection homelessness, systemic barrier when accessing mainstream services, they required immediate assistance to address some of these issues. Not having the capacity to respond on some occasions has a negative impact on client circumstances also adds extra stress on our case management team. (Service ID 20)*

*Clients that would come into our service would otherwise go into other refuges or remain in motel accommodation being provided by Safe Steps. Vacancies are offered with Safe Steps and filled when Safe Steps provide an appropriate referral- delays can happen when referrals are not sent through or are mismatched for the vacancy advertised. Biggest factor is that case management is limited by properties and unable to take in new clients until current clients moved on. Clients can stay past the 8-week funded support period which reduces overall capacity. (Service ID 19)*

[9] The questions to estimate the number of case management clients seen above target allocation changed between Time 1 and Time 2 data collection. Therefore, only data from Time 2 has been used to generate the average.

**Figure 30: Average number of target allocations for the service during the data capture (Time 2 data capture, N=14 services)**

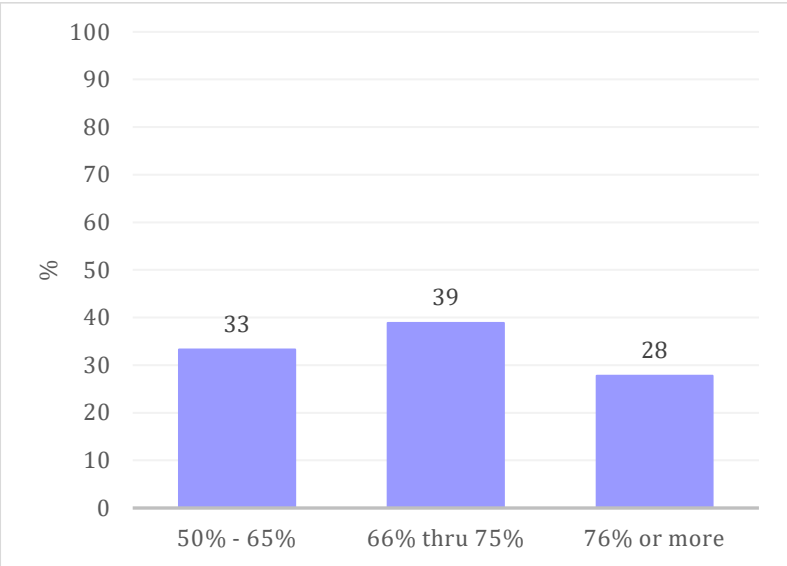



*Note: Case management target allocation Min=4, Max =52 Std Dev =15; Clients above target allocation Min=2, Max =14, Std Dev =5.*

## Staffing and vacancies

Two-thirds of the services (20 services) were operating with case management staff vacancies during the data collection periods. Of these, one third had only 50-65% of case management positions filled (Figure 31). Overall, only a quarter of services were operating with 76% or higher staffing levels met.

**Figure 31: proportion of case management staff working during data collection period (N=31 services)**




More than half of the services had case management positions vacant for between three weeks and fifty-two weeks – with half of the positions being vacant for three months or more. Competition for staff as well as the impact of COVID-19 were commonly identified as a reason for delays in staff recruitment and retention.

*Our team members continue to work hard to ensure that client need is met despite being understaffed. While we are currently only one worker down there were periods in the past 12 months when we have been 4- 5 team members down and the existing staff continued to support as many clients as possible as they have always been aware of the wait list at our local orange door. What this means is that client needs are met and then they are closed as quickly as possible and potentially referred out to other services for other needs eg. homelessness, parenting support, therapeutic counselling. (Service ID 2)*

*Retention and recruitment are our biggest challenge. (Service ID 5)*

*Covid 19 lockdowns and home schooling has impacted on staffing. (Service ID 8)*

*We have only just recruited to a full team, and this has taken a few months to fill. (Service ID 14)*

*The case managers we have are increasingly away due to sickness, their children being unwell, mental health issues, stress, fatigue and burnout. They seem to take it in turns for who needs a break or has some personal crisis unfolding that affects work, some of this is covid related though some isn't. The other case managers then pick up the slack until one of them fatigues and the cycle continues. They are so dedicated and willing to pitch in and help each other, we have frequent days with only 1 case manager . . . which is not sustainable. The level of client need and complexity of cases has massively increased at the same time meaning the staff who are present at work have longer, busier days and often work with multiple extra clients who are not on their usual case load. This causes an increased workload for our afterhours team as well as the client services coordinators who frequently step in to provide case management response due to lack of staff. The impact of this understaffing on clients is immense. A response by a different person each day who is not your usual case manager can be very frustrating, confusing and ultimately holds up progress on case plans, and erodes rapport. The lack of consistency in responses and case planning has a huge effect on client's ability to trust and work collaboratively towards their goals. (Service ID 29)*

**Staff experience**

Staffing vacancies was measured quantitatively but not staff experience. The issue was of sufficient importance to research participants that they provided qualitative data in response to the survey as well as the workshops. Staff experience had particular impact on caseload allocation, risk management and the role of supervisors. High staff turn-over translates to an inexperienced workforce and leads to longer case management, inappropriate risk management, impact on staff well-being and slows the opportunity for caseload vacancies.

*Staff turnover, staff on leave, new staff, time taken to do MARAM comprehensive risk assessment, extra time spent when using interpreter. (service ID 26)*

*It takes a lot of workforce development for staff to feel comfortable holding the risk - Team Leader, Safe and Equal member organisation*

*When we have lots of inexperienced staff its puts lots of pressure on our RAMP coordinator because they end up doing more consults because new staff are concerned and they don't understand the risk as much so they end up doing a lot more consults...and also with the*

*PSI...it's not just on the team leaders it puts pressure everywhere . . . when we have an experienced staff member at the orange door . . . everything feels high risk so then we have to manage the amount of high risk that is coming through and kind of back and go "no no no that's not high risk" so you know it takes a lot of development on both sides to bring those staff to a point where they are comfortable holding the risk and they understand the risk levels a bit more but it does I think it puts pressure on the whole organisation and I think we have to be very mindful of that. - Team Leader, Safe and Equal member organisation*

*We have struggled to recruit Indigenous women to our Specialist Aboriginal Program to provide the specialist cultural support required to meet the needs of this Community. This has had significant impact on the Program capacity to service the community and meet demand. (Service ID 28)*

*Lack of suitable applicants [for vacancies] impacted on recruitment success and workforce capacity. Lockdowns and restrictions impacted on on-boarding and orientation. (Service ID 12)*

*What we are trying to manage is caseloads, but also how many at risk, how many elevated…and I think it's becoming harder and harder the more that the demand increases the more that the expectation is that the clients wait so then your case load you know becomes really challenging and you're managing a lot of high-risk cases and you know there's lots of coordination, lots of safety planning...how much of that work can one person do well? You know we've got a part-time workforce as well… and when the workers aren't here, it's the other workers that have to pick up the other cases. Because you know, women aren't just calling in crisis or needing support on Wednesday-Friday... so that's the work that also needs to be measured… because we find that's the biggest pressure. Because they are the cases you don't know intimately. So, you're relying on someone's case notes and good case plan to put the piece together. - Team Leader, Safe and Equal member organisation*

**Unallocated cases: Discussion**

This data collection identified several strong indicators to estimate demand through unallocated cases. First, the number of clients coming through The Orange Door is a clear indication of significant demand. Adding to this, the number of clients being actively held by services before being allocated to case management provides a good picture of the excess demand cases.

Additionally, estimates of service provision above targets and staffing shortages provided measures of services struggling to meet demand. The qualitative data provided a rich understanding of the impact excess demand, pressures on staff well-being, and the impact of staff vacancies and turn-over.

- The data collected for this trial indicator identified:
- There is significant excess of demand beyond target allocations
- Services are facing notable staff shortages which impedes their ability to efficiently deliver services.
- Due to the high demand for service and high staff turn-over risk may not be efficiently managed which may over burden all areas of the system.

**Recommendation to improve the indicators:**

- Tighten the measures for estimating the length of time clients are waiting for being allocated to a service and for case management
- Include a measure of staff vacancies and turn-over

# Conclusion

## Analysis/integration of findings

This project trialled demand indicators across five thematic areas (case complexity, identifying and managing risk, meeting children's needs, crisis accommodation, monitoring unallocated cases) which specialist family violence team leaders and stakeholders agreed were indicative of demand in the service sector.

With some refinement, key demand indicators have been shown to be feasible in the areas of identifying and managing risk, crisis accommodation and unallocated cases. However, **all of the data required is not readily available and would need to be collected with a dedicated survey tool or current data collection tools would need to be modified.**

Proposed indicators measuring case complexity would benefit from refinement of what constitutes a complex case. Currently proposed characteristics appear to be too broad. **Upon determination of different measures of complexity, current data sets would need to be reviewed to assess the availability of data to measure those elements.**

In order to monitor these key indicators, **modifications would need to be made to current data collection tools. If not feasible, then a stand-alone data collection tool would need to be agreed upon to collect this data regularly from the sector.**

## Next steps

### Analysing indicators and data collection points

- Review and revise some indicators to refine some and remove others
- Conduct some additional qualitative analysis to increase understanding of case management decision-making when meeting client needs

### Scoping and developing a sustainable data collection methodology

- Undertake a follow-up review of data collection tools with Family Safety Victoria to explore the data gaps
- Advocate for changes to service provider data sets to include some of the key indicator data

# Appendix 1: Descriptive summary of client characteristics

Information was recorded on twenty client characteristics for each case management activity (Figure 40Figure 40 in Appendix 2). The most common characteristic included clients having protection orders in place, having younger children in their care, and being of a diverse background (culturally, linguistically, or inter-faith).

Some characteristics can be more challenging for case management when there are fewer resources available or higher demand, and multiple characteristics may result in additional complexity.

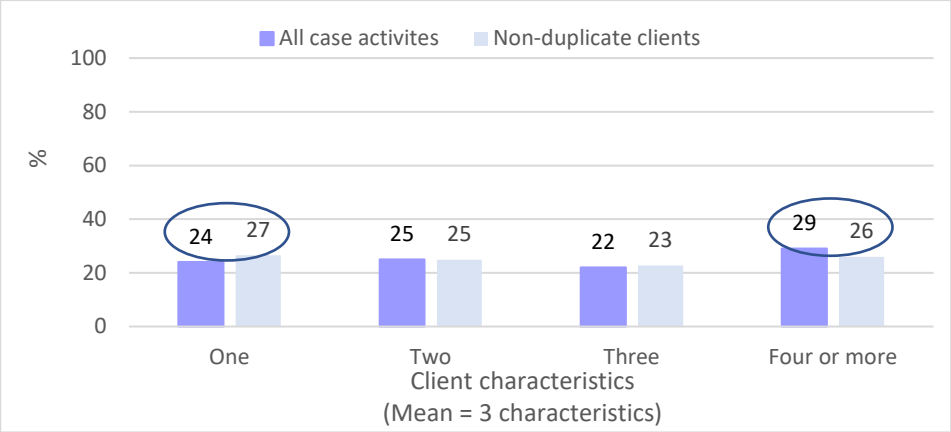
Client characteristics were compared between all case activities and non-duplicated cases and show very little difference between the two groupings (Figure 40Figure 40 in Appendix 2). The one slight difference was a higher representation of culturally, linguistically, and inter-faith diversity, as well as language other than English among the full group of client activities. This likely indicates that those cases required more case management activities and were therefore more likely to be recorded multiple times within the data collection period.

When examining multiple characteristics, similar proportions of clients (around one quarter) recorded one, two, three, or four plus characteristics. The distribution was similar for all case management activities (Figure 32). When comparing the deduplicated clients with all activities, de-duplicated clients had a slightly higher representation recording only one characteristic (27% compared with 24%) and slightly fewer recording four or more characteristics (26% compared with 29%). The average number of characteristics (3) was the same for both groups.

The useful information gathered from Figure 32 is that when looking at all case activities there is a five-percentage point difference between clients reporting only one characteristic and the proportion reporting four or more (blue circles in Figure 32). This could suggest one of two things, either those with more characteristics were likely to have required more activities during the data capture period, or more characteristics became apparent the more often a client was involved in case management.

Since the differences between the de-duplicated clients and the full activities were small and for reasons mentioned earlier (that clients might not reveal all characteristics or circumstances at the first client consultation), the discussion about characteristics will include characteristics for all activities going forward.

**Figure 32: Number of characteristics for all case management activities (N=4,412) and non-duplicated clients (N=1,633)**




Client characteristics along with case management activity may be used as an indirect and indicative measure of case complexity (see Indicator 1, Case Complexity).

This project was limited to the amount of information that could be collected on activities in a short survey and therefore will not reflect case complexity for all clients. However, this proxy measure is one way to review future data needs.

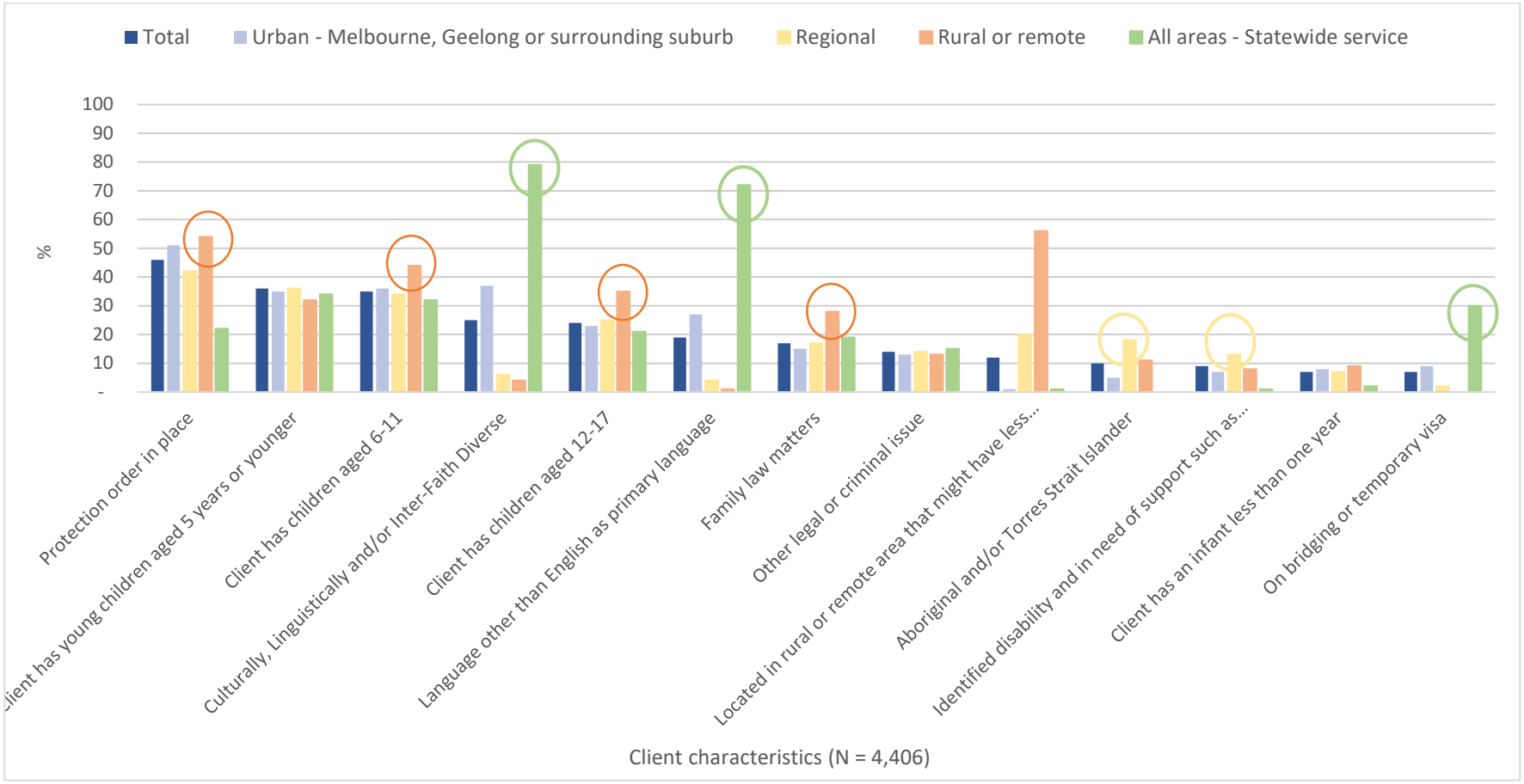
Figure 33 presents the thirteen most identified client characteristics for all activities by region serviced by the case management agency. Case managers can record multiple characteristics and the average number of characteristics identified was 3 (2.77), and this was the same for each geographic region serviced.

Some interesting patterns appear:

- Services providing state-wide response provided the smallest number of case management activities and were over-represented in providing service to culturally, linguistically, or inter-faith diverse clients, those who spoke a language other than English, and clients on bridging or temporary visas (green circles in Figure 33).
- Case management activity in rural and remote areas disproportionately recorded more children aged between 6-11 and 12-17, family law matters and protection orders in place (orange circles in Figure 33).
- Regional services were slightly over-represented in providing services to Aboriginal and Torres Strait Islander clients and clients with disabilities (yellow circles in Figure 33).

Comparative data recorded by Safe Steps during the same data collection period (October and November 2021) showed service provision for similar proportions of culturally and linguistically diverse clients (21%) and those not born in Australia (19%). Safe Steps clients included a similar, but a larger representation of Aboriginal or Torres Strait islander clients (10-13%), see Table 38 in Appendix 3. This comparative data assists to affirm common characteristics across the help-seeking population among the selected services electing to participate in this project.

**Figure 33: Client characteristics by region serviced by agency/ organisation (N=4,406)**



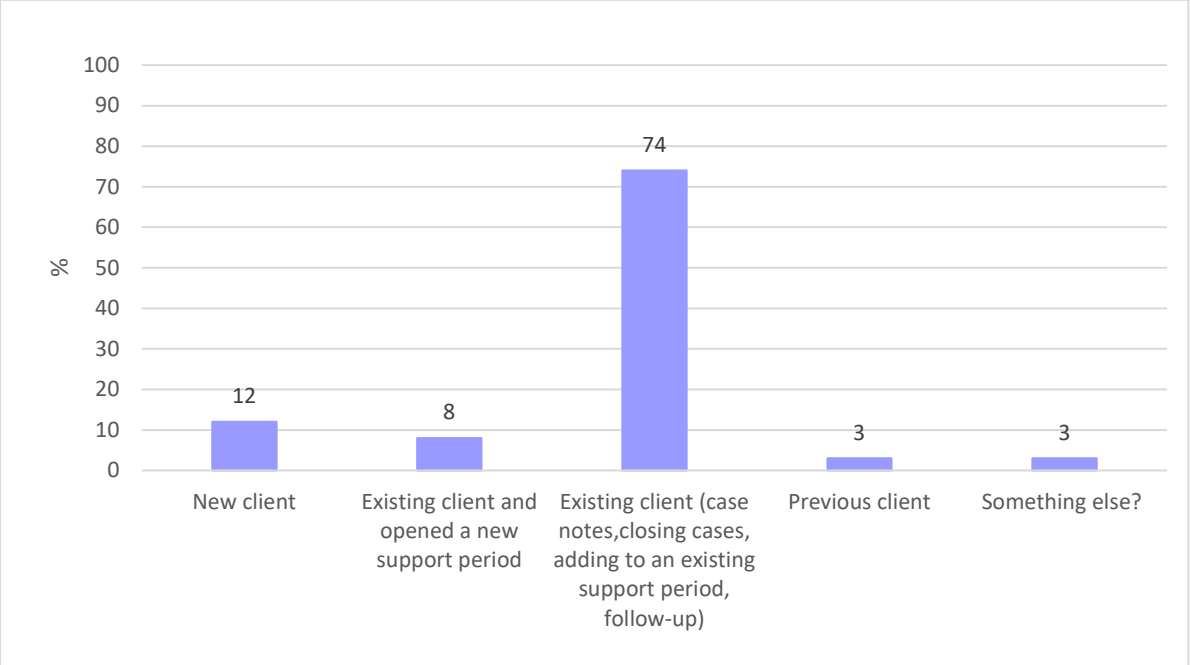
As previously discussed in the Service Demand section), four-fifths of the client activity recorded (85%) was for existing or current clients. However, as also mentioned, it was likely that a notable portion of these clients were in fact new case management clients. As revealed in the team leader focus groups, case managers were likely to consider the new case management clients as *existing* clients since they had been through intake and may have already received other services from the agency. This is an area for data collection that can be improved in future projects.

*There are issues with identifying the conceptualisation of "new clients". Clients may be new to case management but not new to intake. (Team leader focus group discussion)*

*We need more efficient ways to collect data on workers managing active hold lists as they are constantly working with new clients. One worker for example, was holding a caseload of 90-112 people and entering this data is not viable. (Team leader focus group discussion)*

A small proportion of activities were case management follow up with previous clients for general advice (3%) and slightly more new support periods (8%).

**Figure 34: Was the current activity undertaken for a new or existing client (non-duplicate clients N=1,817)**




Example responses from the three per cent responding *something else* included:

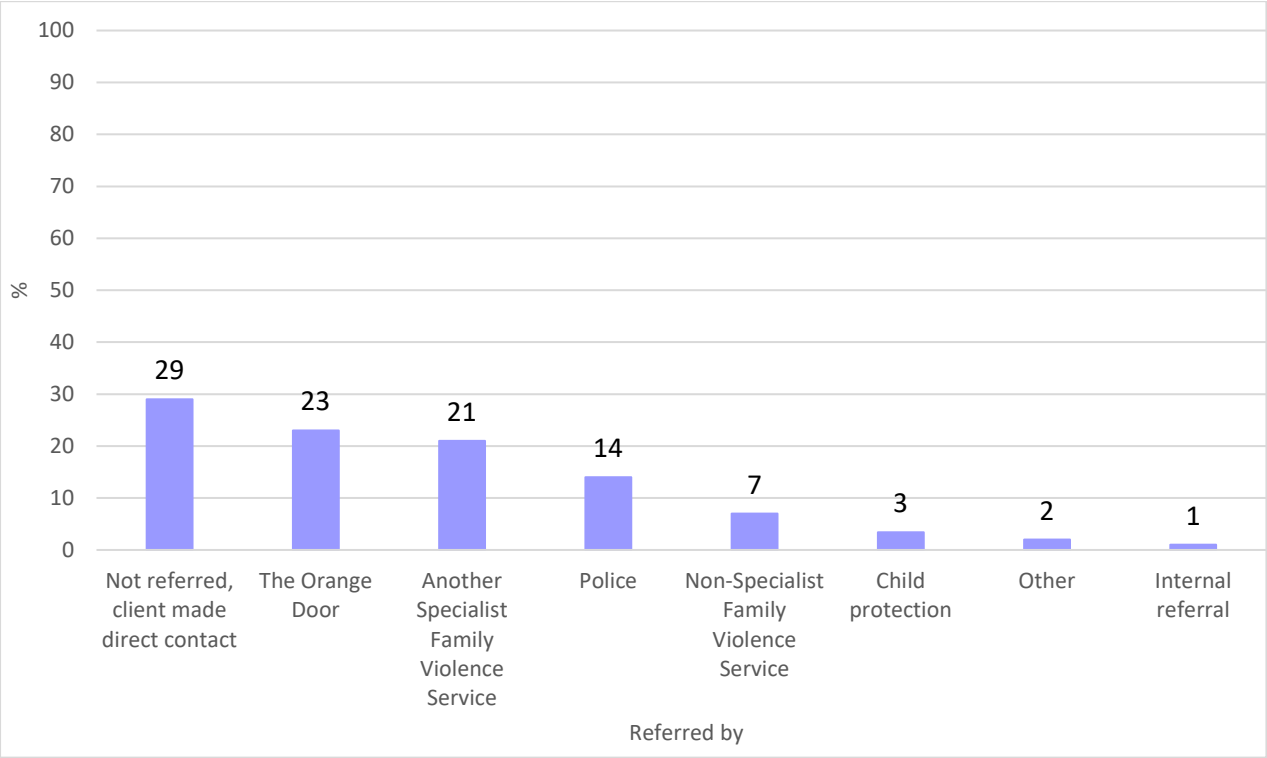
- Secondary consultations
- Meeting attendance
- Waiting for client to confirm she will accept service
- General enquiries from family or friends for advice without providing support

## Client referral

Information on how cases were referred to specialist family violence services was examined for the clients who could be identified as new referrals (Figure 35). Case managers were asked who referred the client and direct contact from the client was most commonly reported (29%) followed by The Orange Door (23%). A third (21%) were referrals from another specialist family violence service (including family safety checks with men's behaviour change programs). Together these three make up 75% of all referrals.

Police were the fourth most common referrer (14%). Referrals under the 'Other' category often included family members.

**Figure 35: Who client was referred by (new referrals for activity today n=1,091)**

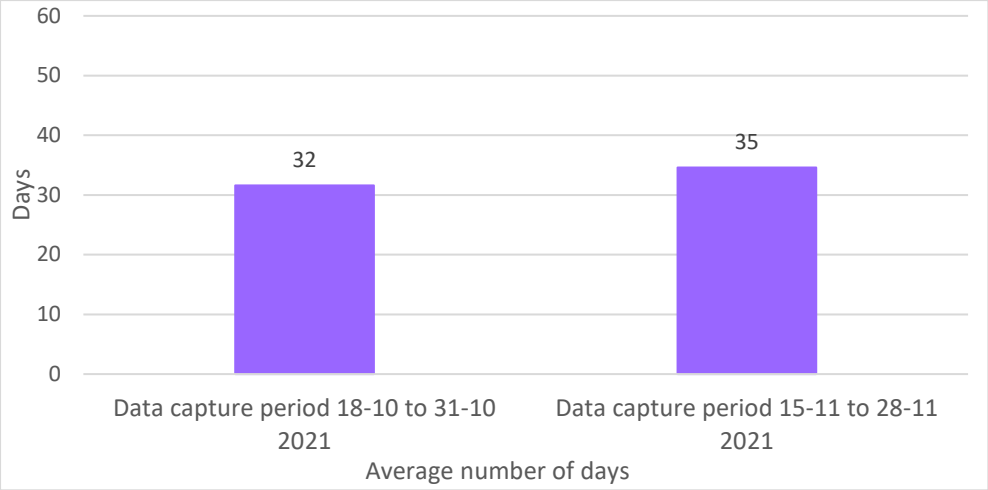



## The Orange Door referrals

As more Orange Door hubs open across the state, this referral pathway is likely to increase and put additional pressure on the SFVS.

Examination of The Orange Door case outcomes (reason for case closures) shows that approximately 50% of the cases coming through The Orange Door have their needs met either by The Orange Door (25%) or by engaging with the service system (27%, see Table 37). Most of the remaining cases disengaged or became uncontactable.

**Figure 36: The Orange Door: average number of days between screening and case closure (ie successful referral, service no longer required or lost contact) (N=7,768 cases)**




1. Cases closed within the reporting periods were matched with referrals data.

2. Invalid cases and clients identified as perpetrators excluded.

*I know in some regions, places like the Orange Door hold a lot of unallocated cases because [SFVS] case management lists would close. Therefore, they were holding a lot of those case management unallocated clients for significant periods of time. (Team leader focus group discussion)*

*We don't run a waitlist or active hold list, because we don't have capacity to pick up cases from TOD but that's becoming hard… I think we will probably move to…develop up an active hold list…because there's obviously KPIs we need to meet. (Team leader focus group discussion)*

## Case management activities

The most common case management activities were writing case notes (80%), and non-specific on-going case management tasks (69%). A complete list of activities is included in (Table 6, Appendix 2)

There was very little difference in the proportion of case management activities when duplicate and non-duplicate clients were compared. Differences that did appear were only by a few per centage points and what would be expected. Activities that were more likely to be part of an initial consultation such as risk assessment, safety planning and crisis support were slightly higher among non-duplicate cases whereas referral follow-up, secondary consultations and applications for support packages were slightly more common among duplicate clients. None of the differences were significant.

Analysis of the most common activities (excluding case notes and generic case management) showed that emotional support was clearly the most common activity (42%, see Figure 37). Emotional support includes a range of activities from general counselling support and talking with the client to get them through the day and survive. While a very important role, the depth and extent of emotional support required would be better suited to a dedicated counsellor. While the provision of emotional support and brief intervention-type

counselling is an integral part of case management, it is not a substitute for the deeper therapeutic support that can be provided through a dedicated counsellor. The intermingling of these modes of intervention can be distressing and at times counter-productive within the case management relationship, where specialist family violence practitioners may need to be the face of the system's limitations while also providing emotional support to a trauma impact individual.

**Emotional support**

*When it's really difficult and there's long waitlists to get into counselling, that's when we have to sit with a lot of that emotional support…which is really empathy, holding the FV lens, psycho-educational support so it's really working with women to understand what's going on and to reiterate it's not their fault...but that takes time and when we are under pressure, that's hard and when the whole system is under pressure, lack of housing options and counselling we find it really hard ...when there is a lack of funding for recovery ... we end up trying to do everything ... and we have to stop asking our workforce to do everything. (Team leader focus group discussion)*

*Validating a women's experience is sometimes a big part in the work that we do, especially if there's recent separation or there's perpetrators doing a lot of gaslighting and they are unsure of their experience. I guess also that psychoeducation and just validating their experiences and that they are experiencing family violence that's a big part of the work we do. (Team leader focus group discussion)*

*In case management and intake roles just getting people through that day through a phone call, or next hour, or to their next appointment...it's survival mode...the burden on the staff's own emotional state is the fact you enter survival mode with that woman anytime you speak to her, you walk alongside her intense crisis a lot of the time. (Team leader focus group discussion)*

*Supporting mental health services and police to assist client in making statement to police while client is in a psychiatric facility. (Survey case ID 2850)*

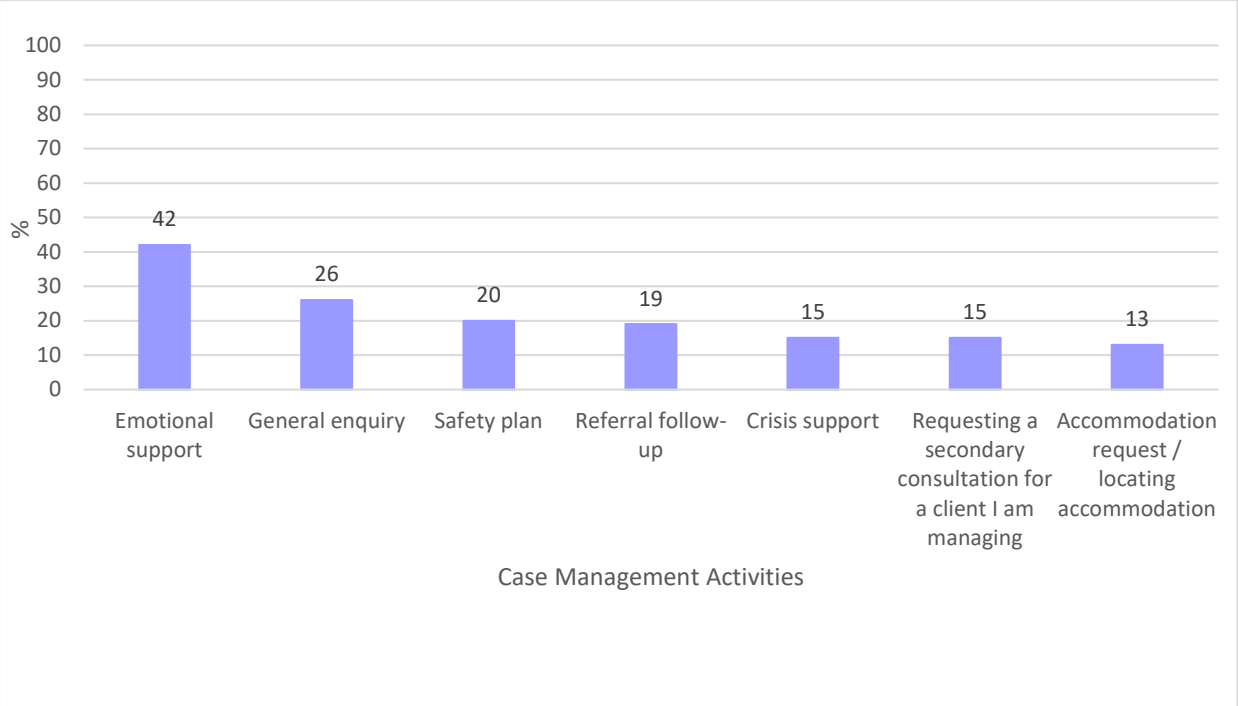
Other common activities included general enquiries (26%), safety plans (20%) and referral follow-ups (19%). An additional 16% of included 'Other' activities which included quite unusual requests for support thereby illustrating that for many survivors, the case manager becomes their primary support person, their lifeline:

- Snake catching (Survey case ID 2245)
- Support for client whose teenage son is becoming unmanageable at school due to ongoing fv perpetrated by the father in a 50/50 custody arrangement. (Survey case ID 5007)
- Supported this client to attend an appointment with her mother. Ensured she was physically okay after vomiting in a taxi. Consulted with her mother whether she required emergency assistance or not. Entertained the child client whilst her mother was at an important medical appointment. Supported the child client to access halal meat from a local butcher to be culturally sensitive around food. (Survey case ID 4466)
- Supporting client to advocate for additional phone calls to perpetrator who is in jail. Client wants them to be able to speak to their children. (Survey case ID 249)

- Schooling support, printing out work sheets and emailing school and talking to grandmother (Survey case ID  5346)

The average number of activities was 3.4 with a mode of 3 (Std Dev = 2.1).  There was very little difference between the duplicate and non-duplicate clients (average of 3.5 and 3.6 respectively, Table 7 in Annex 1)

**Figure 37:  Most common case management activities undertaken (all clients, excluding case notes and general case management activities N=3,713)**



# Appendix 2: Estimating demand indicators supporting tables and figures

## Time spent in meetings

More than one thousand (1,033) of the case activities entered in the data capture was time spent in meetings. There were five main types of meetings reported on and team meetings were the most common (58%) followed by supervision (18%) and professional development (15%) meetings (Figure 38). Most meetings took between 30 minutes to 2 hours with external client allocation meetings tending to be shorter and professional development being the longest (Figure 39).

**Figure 38: Type of meeting recorded (N=1,033)**

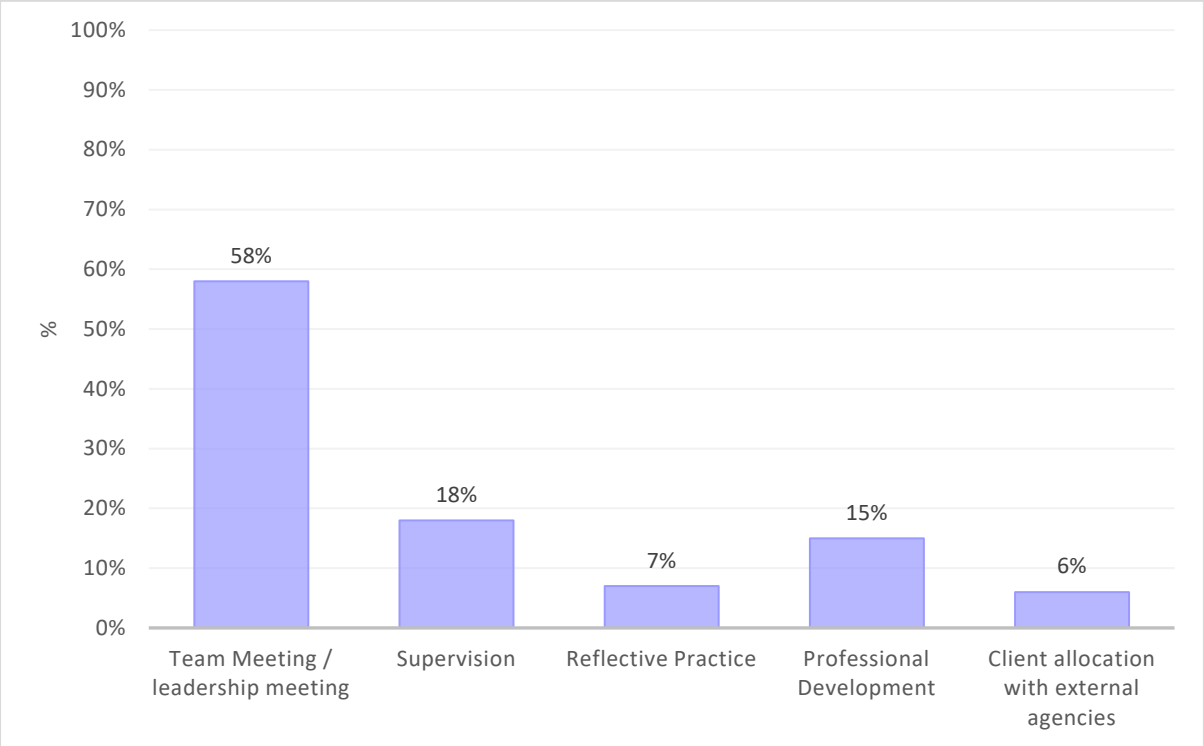
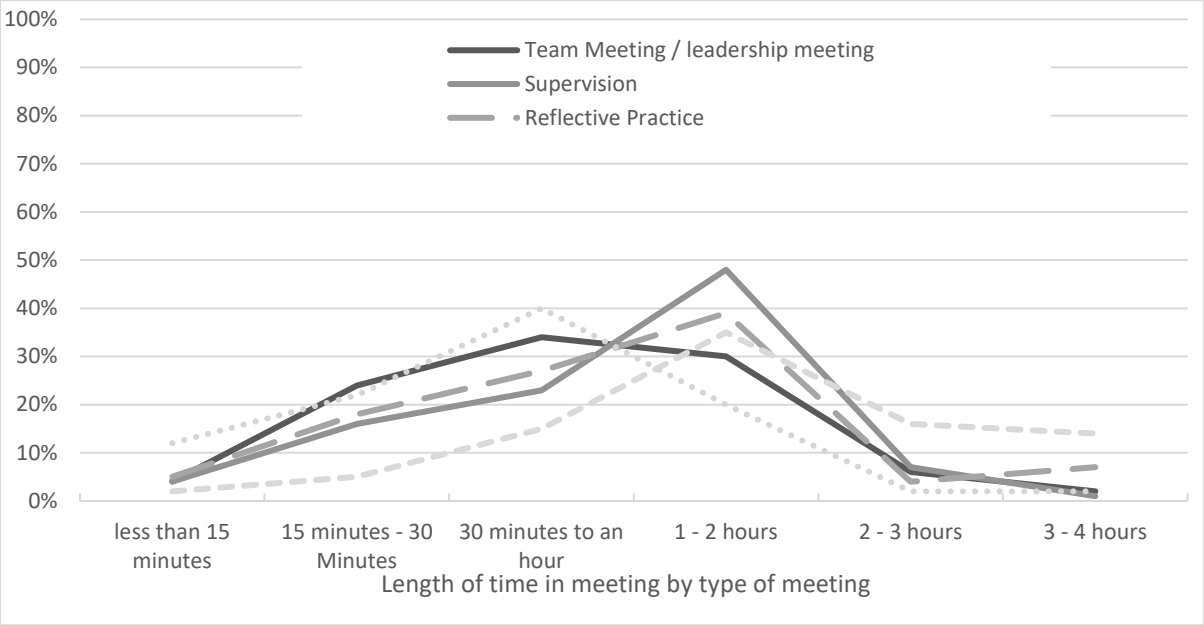


**Figure 39: Length of time in meetings by meeting type (N=962 where information was provided)**




## Client Characteristics

**Table 3: Client gender by duplicate status (N=4,723)**

| What is the gender of this client? | Duplicate client | | Non-duplicate client | | Total | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| Female | 2,932 | 99% | 1,714 | 98% | 4,646 | 98% |
| Male | 27 | 1% | 37 | 2% | 64 | 1% |
| Non-binary or gender diverse | 8 | 0% | 5 | 0% | 13 | 0% |
| Total | 2,967 | 100% | 1,756 | 100% | 4,723 | 100% |

**Table 4: Client age by duplicate status (N=2,901)**

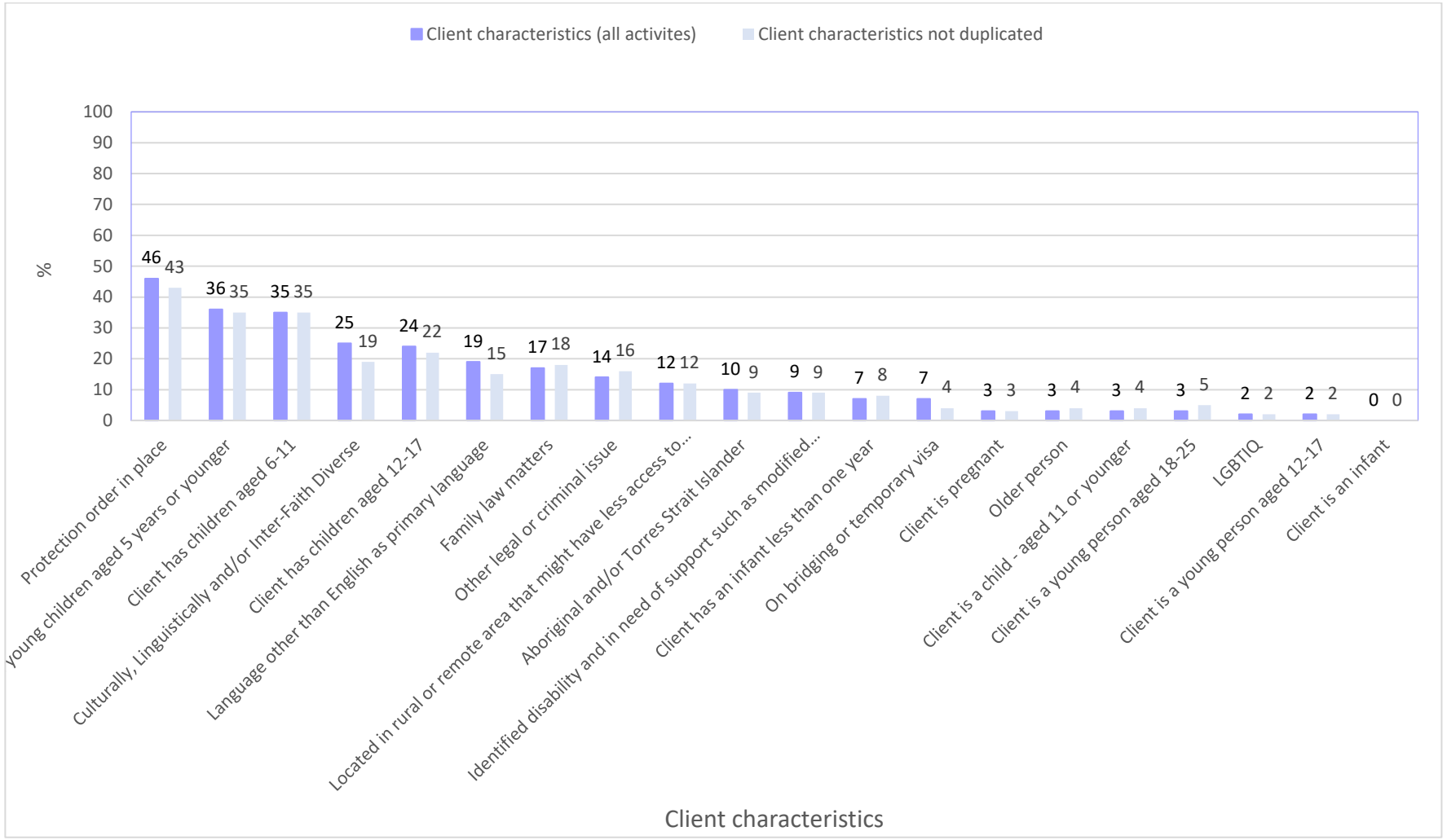
| Age: adult or child | Duplicate client | | Non-duplicate client | | Total | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| 1-17 years | 53 | 3% | 66 | 6% | 119 | 4% |
| 18 years and older | 1,743 | 97% | 1,039 | 94% | 2,782 | 96% |
| Total | 1,796 | 100% | 1,105 | 100% | 2,901 | 100% |

SAFE+EQUAL

**Table 5: Client characteristics by area serviced**

| | Urban - Melbourne, Geelong or surrounding suburb | | Regional | | Rural or remote | | All areas - Statewide service | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Aboriginal and/or Torres Strait Islander | 123 | 5% | 331 | 18% | 43 | 11% | - | 0% | 462 | 10% |
| Client is pregnant | 64 | 3% | 54 | 3% | 12 | 3% | 4 | 2% | 127 | 3% |
| Client has an infant less than one year | 179 | 8% | 131 | 7% | 36 | 9% | 4 | 2% | 317 | 7% |
| Client has young children aged 5 years or younger | 814 | 35% | 661 | 36% | 126 | 32% | 61 | 34% | 1,566 | 36% |
| Client has children aged 6-11 | 832 | 36% | 635 | 34% | 177 | 44% | 57 | 32% | 1,561 | 35% |
| Client has children aged 12-17 | 525 | 23% | 469 | 25% | 141 | 35% | 38 | 21% | 1,059 | 24% |
| Culturally, Linguistically and/or Inter-Faith Diverse | 850 | 37% | 109 | 6% | 16 | 4% | 143 | 79% | 1,105 | 25% |
| Family law matters | 355 | 15% | 317 | 17% | 112 | 28% | 34 | 19% | 744 | 17% |
| Identified disability and in need of support such as modified housing, mobility aids, carer support. | 150 | 7% | 239 | 13% | 31 | 8% | 1 | 1% | 397 | 9% |
| Language other than English as primary language | 613 | 27% | 77 | 4% | 4 | 1% | 130 | 72% | 821 | 19% |
| LGBTIQ | 58 | 3% | 32 | 2% | 15 | 4% | - | 0% | 103 | 2% |
| Located in rural or remote area that might have less access to services | 25 | 1% | 368 | 20% | 224 | 56% | 2 | 1% | 510 | 12% |
| Older person | 68 | 3% | 70 | 4% | 5 | 1% | 4 | 2% | 143 | 3% |
| On bridging or temporary visa | 199 | 9% | 41 | 2% | - | 0% | 54 | 30% | 294 | 7% |
| Other legal or criminal issue | 294 | 13% | 266 | 14% | 51 | 13% | 27 | 15% | 604 | 14% |
| Protection order in place | 1,165 | 51% | 773 | 42% | 214 | 54% | 40 | 22% | 2,022 | 46% |
| Client is an infant | 10 | 0% | 4 | 0% | 1 | 0% | - | 0% | 15 | 0% |
| Client is a child - aged 11 or younger | 80 | 3% | 21 | 1% | 6 | 2% | 15 | 8% | 119 | 3% |
| Client is a young person aged 12-17 | 40 | 2% | 21 | 1% | 4 | 1% | 7 | 4% | 71 | 2% |
| Client is a young person aged 18-25 | 83 | 4% | 73 | 4% | 12 | 3% | 1 | 1% | 154 | 3% |
| Total | 2,305 | 100% | 1,858 | 100% | 398 | 100% | 180 | 100% | 4,406 | 100% |

**Figure 40: Client characteristics for all activities (N=4,406) compared with non-duplicated clients (N=1,631)**



SAFE+EQUAL

## Case Management Activities

**Table 6: Case management activities undertaken today by client status (duplicate or non-duplicate, N=4,687)**

| Activities undertaken today | Duplicate client status | | | | | |
|---|---|---|---|---|---|---|
| | Duplicate client | | Non-duplicate client | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % |
| Case notes | 2375 | 81% | 1357 | 78% | 3732 | 80% |
| Case management - ongoing | 2216 | 75% | 1027 | 59% | 3243 | 69% |
| Emotional support | 891 | 30% | 660 | 38% | 1551 | 33% |
| General enquiry | 600 | 20% | 367 | 21% | 967 | 21% |
| Safety plan | 438 | 15% | 309 | 18% | 747 | 16% |
| Referral follow-up | 463 | 16% | 250 | 14% | 713 | 15% |
| Crisis support | 312 | 11% | 243 | 14% | 555 | 12% |
| Requesting a secondary consultation for a client I am managing | 368 | 13% | 188 | 11% | 556 | 12% |
| Accommodation request / locating accommodation | 258 | 9% | 225 | 13% | 483 | 10% |
| Application for support package / housing /other program or funding | 292 | 10% | 120 | 7% | 412 | 9% |
| Risk assessment of any type including screening tool | 230 | 8% | 185 | 11% | 415 | 9% |
| Outreach support | 189 | 6% | 165 | 9% | 354 | 8% |
| Administration related to client such as closing a case file or closing a support period | 118 | 4% | 53 | 3% | 171 | 4% |
| Case management initial consultation | 74 | 3% | 129 | 7% | 203 | 4% |
| Check-in of client eg overnight / refuge or other accommodation | 115 | 4% | 51 | 3% | 166 | 4% |
| Counselling | 145 | 5% | 61 | 3% | 206 | 4% |
| Intake | 71 | 2% | 132 | 8% | 203 | 4% |
| Opening a case file | 59 | 2% | 142 | 8% | 201 | 4% |
| Safety plan follow-up tasks | 158 | 5% | 44 | 3% | 202 | 4% |
| Initial consultation | 47 | 2% | 81 | 5% | 128 | 3% |
| Therapeutic support | 86 | 3% | 38 | 2% | 124 | 3% |
| Case management - interim | 57 | 2% | 59 | 3% | 116 | 2% |
| Child assessment | 63 | 2% | 38 | 2% | 101 | 2% |
| Court support | 69 | 2% | 36 | 2% | 105 | 2% |
| Information sharing for a client I am NOT managing - eg managed by another service | 53 | 2% | 20 | 1% | 73 | 2% |
| Support letter - preparation for client | 84 | 3% | 33 | 2% | 117 | 2% |
| Providing a secondary consultation for a client I am NOT managing | 21 | 1% | 22 | 1% | 43 | 1% |
| Client allocation meeting | 9 | 0% | 7 | 0% | 16 | 0% |
| Total | 2944 | 100% | 1743 | 100% | 4687 | 100% |

**Table 7: Number of case management activities undertaken today by client status (duplicate or non-duplicate, N=4,687)**

| | Duplicate client status | | | | | |
|---|---|---|---|---|---|---|
| Number of activities | Duplicate client | | Non-duplicate client | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % |
| 1 | 397 | 13% | 269 | 15% | 666 | 14% |
| 2 | 755 | 26% | 385 | 22% | 1140 | 24% |
| 3 to 4 | 1194 | 41% | 657 | 38% | 1851 | 39% |
| 5 or more | 598 | 20% | 432 | 25% | 1030 | 22% |
| Total | 2944 | 100% | 1743 | 100% | 4687 | 100% |

Mean number of activities: duplicate client = 3.5, non-duplicate client = 3.6

**Table 8: Time taken for case management activities undertaken by client status (duplicate or non-duplicate, N=4,656)**

| Duplicate client status | Time taken for CM activities | | | |
|---|---|---|---|---|
| | Mean | N | Std. Deviation | Median |
| Duplicate client | 0:58 | 2963 | 0:53 | 0:45 |
| Non-duplicate client | 0:58 | 1775 | 0:53 | 0:45 |
| Total | 0:58 | 4738 | 0:53 | 0:45 |

**Table 9: Child related client characteristics by number of characteristics (all activities, N=4,412)**

| Number of characteristics | Client is pregnant | | Client has an infant less than one year | | Client has young children aged 5 years or younger | | Client has children aged 6-11 | | Client has children aged 12-17 | | Client is an infant | | Client is a child - aged 11 or younger | | Client is a young person aged 12-17 | | Client is a young person aged 18-25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| **One** | 23 | 18% | 27 | 9% | 157 | 10% | 113 | 7% | 111 | 10% | 1 | 7% | 67 | 56% | 29 | 41% | 35 | 23% |
| **Two** | 12 | 9% | 80 | 25% | 311 | 20% | 259 | 17% | 191 | 18% | 5 | 33% | 16 | 13% | 26 | 37% | 42 | 27% |
| **Three** | 27 | 21% | 81 | 26% | 364 | 23% | 406 | 26% | 275 | 26% | 3 | 20% | 16 | 13% | 9 | 13% | 36 | 23% |
| **Four or more** | 65 | 51% | 129 | 41% | 735 | 47% | 786 | 50% | 484 | 46% | 6 | 40% | 20 | 17% | 7 | 10% | 41 | 27% |
| **Total** | 127 | 100% | 317 | 100% | 1567 | 100% | 1564 | 100% | 1061 | 100% | 15 | 100% | 119 | 100% | 71 | 100% | 154 | 100% |

**Table 10: Diversity related client characteristics by number of characteristics (all activities, N=4,412)**

| Number of characteristics | Culturally, Linguistically and/or Inter-Faith Diverse | | Language other than English as primary language | | On bridging or temporary visa | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| **One** | 59 | 5% | 6 | 1% | 9 | 3% |
| **Two** | 107 | 10% | 38 | 5% | 12 | 4% |
| **Three** | 253 | 23% | 182 | 22% | 73 | 25% |
| **Four or more** | 686 | 62% | 596 | 73% | 200 | 68% |
| **Total** | 1105 | 100% | 822 | 100% | 294 | 100% |

**Table 11: Legal related client characteristics by number of characteristics (all activities, N=4,412)**

| Number of characteristics | Family law matters | | Other legal or criminal issue | | Protection order in place | |
|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % |
| **One** | 17 | 2% | 32 | 5% | 117 | 6% |
| **Two** | 85 | 11% | 124 | 21% | 418 | 21% |
| **Three** | 172 | 23% | 138 | 23% | 524 | 26% |
| **Four or more** | 473 | 63% | 310 | 51% | 965 | 48% |
| **Total** | 747 | 100% | 604 | 100% | 2024 | 100% |

SAFE+EQUAL

**Table 12: Number of case management activities by client characteristics (all clients, all activities, N=4,319)**

| | Number of activities | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | One | | Two | | Three to four | | Five or more | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Protection order in place | 193 | 32% | 473 | 46% | 864 | 50% | 476 | 50% | 2006 | 46% |
| Client has young children aged 5 years or younger | 183 | 30% | 349 | 34% | 640 | 37% | 366 | 38% | 1538 | 36% |
| Client has children aged 6-11 | 204 | 34% | 399 | 38% | 595 | 34% | 337 | 35% | 1535 | 36% |
| Client has children aged 12-17 | 119 | 20% | 274 | 26% | 419 | 24% | 231 | 24% | 1043 | 24% |
| Culturally, Linguistically and/or Inter-Faith Diverse | 138 | 23% | 261 | 25% | 474 | 27% | 220 | 23% | 1093 | 25% |
| Family law matters | 86 | 14% | 153 | 15% | 306 | 18% | 192 | 20% | 737 | 17% |
| Other legal or criminal issue | 59 | 10% | 113 | 11% | 242 | 14% | 182 | 19% | 596 | 14% |
| Language other than English as primary language | 105 | 17% | 194 | 19% | 363 | 21% | 150 | 16% | 812 | 19% |
| Located in rural or remote area that might have less access to services | 76 | 13% | 145 | 14% | 192 | 11% | 90 | 9% | 503 | 12% |
| Identified disability and in need of support such as modified housing, mobility aids, carer support. | 67 | 11% | 71 | 7% | 155 | 9% | 89 | 9% | 382 | 9% |
| Aboriginal and/or Torres Strait Islander | 82 | 14% | 117 | 11% | 156 | 9% | 79 | 8% | 434 | 10% |
| Client has an infant less than one year | 62 | 10% | 59 | 6% | 122 | 7% | 66 | 7% | 309 | 7% |
| On bridging or temporary visa | 45 | 7% | 63 | 6% | 128 | 7% | 57 | 6% | 293 | 7% |
| Client is a young person aged 18-25 | 18 | 3% | 29 | 3% | 61 | 4% | 40 | 4% | 148 | 3% |
| Client is pregnant | 14 | 2% | 35 | 3% | 37 | 2% | 38 | 4% | 124 | 3% |
| LGBTIQ | 11 | 2% | 18 | 2% | 41 | 2% | 31 | 3% | 101 | 2% |
| Older person | 23 | 4% | 33 | 3% | 61 | 4% | 23 | 2% | 140 | 3% |
| Client is a child - aged 11 or younger | 16 | 3% | 35 | 3% | 51 | 3% | 15 | 2% | 117 | 3% |
| Client is a young person aged 12-17 | 7 | 1% | 14 | 1% | 29 | 2% | 18 | 2% | 68 | 2% |
| Client is an infant | 3 | 0% | 4 | 0% | 6 | 0% | 2 | 0% | 15 | 0% |
| Total | 602 | 100% | 1039 | 100% | 1727 | 100% | 951 | 100% | 4319 | 100% |

SAFE+EQUAL

**Table 13: Number of secondary consultations by client characteristics (all clients, all activities, n=1,540)**

| Client characteristics | Number of secondary consultations today | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | One | | Two | | Three | | Four or more | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Protection order in place | 518 | 51% | 170 | 47% | 41 | 42% | 31 | 44% | 760 | 49% |
| Client has young children aged 5 years or younger | 392 | 39% | 131 | 36% | 42 | 43% | 40 | 56% | 605 | 39% |
| Client has children aged 6-11 | 383 | 38% | 120 | 33% | 31 | 32% | 34 | 48% | 568 | 37% |
| Culturally, Linguistically and/or Inter-Faith Diverse | 267 | 26% | 72 | 20% | 14 | 14% | 5 | 7% | 358 | 23% |
| Client has children aged 12-17 | 252 | 25% | 92 | 26% | 21 | 22% | 30 | 42% | 395 | 26% |
| Language other than English as primary language | 196 | 19% | 55 | 15% | 10 | 10% | 5 | 7% | 266 | 17% |
| Family law matters | 192 | 19% | 65 | 18% | 7 | 7% | 5 | 7% | 269 | 17% |
| Other legal or criminal issue | 160 | 16% | 73 | 20% | 13 | 13% | 10 | 14% | 256 | 17% |
| Located in rural or remote area that might have less access to services | 105 | 10% | 41 | 11% | 6 | 6% | 4 | 6% | 156 | 10% |
| Aboriginal and/or Torres Strait Islander | 96 | 9% | 33 | 9% | 1 | 1% | 7 | 10% | 137 | 9% |
| Identified disability and in need of support such as modified housing, mobility aids, carer support. | 82 | 8% | 42 | 12% | 13 | 13% | 10 | 14% | 147 | 10% |
| Client has an infant less than one year | 65 | 6% | 24 | 7% | 5 | 5% | 5 | 7% | 99 | 6% |
| On bridging or temporary visa | 63 | 6% | 14 | 4% | 5 | 5% | 1 | 1% | 83 | 5% |
| Client is a young person aged 18-25 | 38 | 4% | 11 | 3% | 3 | 3% | 0 | 0% | 52 | 3% |
| Older person | 31 | 3% | 5 | 1% | 3 | 3% | 1 | 1% | 40 | 3% |
| Client is pregnant | 26 | 3% | 16 | 4% | 4 | 4% | 8 | 11% | 54 | 4% |
| Client is a child - aged 11 or younger | 28 | 3% | 15 | 4% | 4 | 4% | 1 | 1% | 48 | 3% |
| LGBTIQ | 36 | 4% | 7 | 2% | 1 | 1% | 0 | 0% | 44 | 3% |
| Client is a young person aged 12-17 | 18 | 2% | 8 | 2% | 3 | 3% | 2 | 3% | 31 | 2% |
| Client is an infant | 2 | 0% | 1 | 0% | 0 | 0% | 0 | 0% | 3 | 0% |
| Total | 1012 | 100% | 360 | 100% | 97 | 100% | 71 | 100% | 1540 | 100% |

Note: greyed cells highlight the most common characteristics in the columns.

**Table 14 Case management activity to locate accommodation by risk profile**

| What do you believe is the risk level for this client today? | Accommodation request / locating accommodation | |
|---|---|---|
| | Count | Column N % |
| Requires immediate protection | 53 | 12% |
| Serious risk | 101 | 22% |
| Elevated risk | 125 | 27% |
| At risk | 143 | 31% |
| Not at risk | 38 | 8% |
| Total | 460 | 100% |

**Table 15 Case management activity to locate accommodation by client characteristics**

| Client characteristics | Accommodation request / locating accommodation | |
|---|---|---|
| | Count | Column N % |
| Protection order in place | 192 | 44% |
| Client has young children aged 5 years or younger | 178 | 40% |
| Client has children aged 6-11 | 166 | 38% |
| Client has children aged 12-17 | 97 | 22% |
| Culturally, Linguistically and/or Inter-Faith Diverse | 85 | 19% |
| Language other than English as primary language | 67 | 15% |
| Other legal or criminal issue | 56 | 13% |
| Family law matters | 54 | 12% |
| Client has an infant less than one year | 37 | 8% |
| Located in rural or remote area that might have less access to services | 37 | 8% |
| Aboriginal and/or Torres Strait Islander | 32 | 7% |
| Identified disability and in need of support such as modified housing, mobility aids, carer support. | 31 | 7% |
| Client is pregnant | 23 | 5% |
| Older person | 16 | 4% |
| LGBTIQ | 8 | 2% |
| On bridging or temporary visa | 10 | 2% |
| Client is a young person aged 12-17 | 7 | 2% |
| Client is a young person aged 18-25 | 11 | 2% |
| Client is a child - aged 11 or younger | 6 | 1% |
| Client is an infant | 1 | 0% |
| Total | 441 | 100% |

**Table 16 Has this client had problems accessing suitable accommodation? (accommodation related activities, n=644 responses)**

| | Frequency | Valid Percent |
|---|---|---|
| Yes | 294 | 12 |
| Not sure | 67 | 3 |
| No | 283 | 12 |
| No information | 1765 | 73 |
| Total | 2409 | 100 |

**Table 17: Is this client living in crisis or temporary accommodation? (n=347 living in crisis or temporary accommodation)**

| | Frequency | Valid Percent |
|---|---|---|
| Refuge | 91 | 4 |
| Other short-term or crisis accommodation | 40 | 2 |
| Interim housing | 57 | 2 |
| Other - please explain | 118 | 5 |
| Hotel / motel | 41 | 2 |
| No, client is living in permanent accommodation | 294 | 12 |
| No information | 1768 | 73 |
| Total | 2409 | 100 |

Note: Other short-term accommodation included hospital or other health facility, transitional housing, rooming house, with family or friends, unsuitable temporary housing such as a garage or car, couch surfing, or permanent housing which she can no longer afford.

**Table 18: Has this client had problems accessing suitable accommodation by client living in crisis or temporary accommodation? (n=293)**

| | Has this client had problems accessing suitable accommodation? | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| crisis or temporary accommodation | Yes | | No | | Not sure | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Refuge | 72 | 33% | 13 | 5% | 6 | 13% | 91 | 17% |
| Other short-term crisis accommodation | 29 | 13% | 11 | 4% | 0 | 0% | 40 | 8% |
| Interim housing | 39 | 18% | 13 | 5% | 5 | 11% | 57 | 11% |
| Hotel / motel | 27 | 12% | 6 | 2% | 7 | 15% | 40 | 8% |
| No, client is living in permanent accommodation | 53 | 24% | 211 | 83% | 29 | 62% | 293 | 56% |
| Total | 220 | 100% | 254 | 100% | 47 | 100% | 521 | 100% |

**Table 19: What have been the issues with accessing suitable accommodation? (activities where client having problems accessing children n=341)**

| | Frequency | Valid Percent |
|---|---|---|
| Unable to find something affordable | 156 | 46 |
| Other - please explain | 109 | 32 |
| Nothing available | 65 | 19 |
| Nothing available with enough space for client with children | 10 | 3 |
| Children separated as boys over a specific age were not allowed | 1 | 0 |
| Total | 341 | |

**Table 20: Crisis or temporary accommodation by risk profile**

| What do you believe is the risk level for this client today? | Is this client living in crisis or temporary accommodation? - Selected Choice | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Refuge | | Other short-term crisis accommodation | | Interim housing | | Other - please explain | | No, client is living in permanent accommodation | | Hotel / motel | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Requires immediate protection | 18 | 21% | 3 | 9% | 1 | 2% | 4 | 4% | 13 | 5% | 2 | 5% | 41 | 7% |
| Serious risk | 13 | 15% | 8 | 23% | 10 | 20% | 14 | 14% | 38 | 14% | 12 | 31% | 95 | 16% |
| Elevated risk | 19 | 23% | 4 | 11% | 21 | 42% | 33 | 33% | 112 | 41% | 10 | 26% | 199 | 34% |
| At risk | 32 | 38% | 19 | 54% | 17 | 34% | 30 | 30% | 92 | 34% | 11 | 28% | 201 | 35% |
| Not at risk | 2 | 2% | 1 | 3% | 1 | 2% | 20 | 20% | 17 | 6% | 4 | 10% | 45 | 8% |
| Total | 84 | 100% | 35 | 100% | 50 | 100% | 101 | 100% | 272 | 100% | 39 | 100% | 581 | 100% |

**Table 21: Risk level by problems accessing suitable accommodation.**

| | Has this client had problems accessing suitable accommodation? | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| What do you believe is the risk level for this client today? | Yes | | No | | Not sure | | Total | |
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| Requires immediate protection | 24 | 9% | 12 | 4% | 5 | 10% | 41 | 7% |
| Serious risk | 45 | 17% | 43 | 16% | 8 | 16% | 96 | 16% |
| Elevated risk | 85 | 32% | 100 | 37% | 13 | 26% | 198 | 34% |
| At risk | 93 | 35% | 88 | 33% | 21 | 42% | 202 | 35% |
| Not at risk | 18 | 7% | 24 | 9% | 3 | 6% | 45 | 8% |
| Total | 265 | 100% | 267 | 100% | 50 | 100% | 582 | 100% |

**Table 22: Active holding by region**

| Was this client being actively held, or on a wait list with your own service before the case was allocated to you for case management? | Urban - Melbourne, Geelong or surrounding suburb | | Regional | | Rural or remote | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Count | Column N % | Count | Column N % | Count | Column N % | Count | Column N % |
| No - was seen immediately | 353 | 35% | 274 | 37% | 89 | 33% | 614 | 34% |
| We don't have a waiting list and we don't do any active holding | 189 | 19% | 324 | 43% | 73 | 27% | 563 | 31% |
| Yes, we have active holding, and the client was given service while being held. | 419 | 42% | 113 | 15% | 101 | 37% | 535 | 30% |
| Yes, we have active holding or a wait list - the client does not receive a service while being held. | 22 | 2% | 21 | 3% | 7 | 3% | 43 | 2% |
| Client is currently on waitlist or active holding with our service | 20 | 2% | 13 | 2% | 2 | 1% | 33 | 2% |
| Total | 1003 | 100% | 745 | 100% | 272 | 100% | 1788 | 100% |

# Appendix 3: Comparative data analysis Family Services Victoria, The Orange Door and Safe Steps

**Family Safety Victoria - Homelessness Data Collection Tool (otherwise known as SHIP)**

Notes regarding data collected using the Homelessness Data Collection Tool

- Data extracted for the family violence sector only (includes family violence case management, family violence intake, family violence men's services, family violence refuge, family violence telephone and referral, family violence women).
- Total of services provided will be more than total clients as clients can receive multiple services.
- Clients are counted if their record has complete identifying information (alphacode, date of birth, sex).
- To be a client, the person must directly receive a service and not just be a beneficiary of a service. Children who present with a parent or guardian and receive a service are considered to be clients. This includes a service that they share with their parent or guardian, such as meals or accommodation. Children are clients if the agency completes a needs assessment as an individual.
- Children who present with a parent or guardian but do not directly receive a service are not considered to be clients. This includes situations where the parent or guardian receives assistance to prevent tenancy failure or eviction.
- Data for the most recent month of November reflects only the agencies who submitted Data in time for the submission deadline. October Data will also include Data from agencies who submitted late files.

### Family violence support periods

**Table 23: Family violence support periods recorded in the Homelessness Data Collection Tool by age group - (formerly known as SHIP) October and November 2021**

| Age group | Number of unique support periods | Proportion of unique support periods |
|---|---|---|
| Under 10 years | 3,945 | 19% |
| 10-17 years | 1,899 | 9% |
| 18+ years | 15,135 | 72% |
| **Total** | **20,979** | **100%** |

**Table 24: Family violence support periods recorded in the Homelessness Data Collection Tool for children and young people only - (formerly known as SHIP) October and November 2021**

| Age group | Number of unique support periods | Proportion of unique support periods |
|---|---|---|
| Under 10 years | 3,945 | 68% |
| 10-17 years | 1,899 | 32% |
| **Total** | **5,844** | **100%** |

**Table 25: Family violence support periods recorded in the Homelessness Data Collection Tool by age group - (formerly known as SHIP) October 2021**

| Age group | Number of unique support periods | Proportion of unique support periods |
|---|---|---|
| Under 10 years | 2,042 | 19% |
| 10-14 years | 690 | 6% |
| 15-17 years | 310 | 3% |
| 18-19 years | 142 | 1% |
| 20-24 years | 664 | 6% |
| 25-29 years | 1,132 | 11% |
| 30-34 years | 1,481 | 14% |
| 35-39 years | 1,385 | 13% |
| 40-44 years | 1,077 | 10% |
| 45-49 years | 704 | 7% |
| 50-54 years | 467 | 4% |
| 55-59 years | 271 | 3% |
| 60-64 years | 142 | 1% |
| 65-69 years | 77 | 1% |
| 70+ years | 76 | 1% |
| **Total** | **10,660** | **100%** |

**Table 26: Family violence support periods recorded in the Homelessness Data Collection Tool by age group - (formerly known as SHIP) November 2021**

| Age group | Number of unique support periods | Proportion of unique support periods |
|---|---|---|
| Under 10 years | 1,903 | 18% |
| 10-14 years | 635 | 6% |
| 15-17 years | 264 | 3% |
| 18-19 years | 145 | 1% |
| 20-24 years | 650 | 6% |
| 25-29 years | 1,115 | 11% |
| 30-34 years | 1,479 | 14% |
| 35-39 years | 1,442 | 14% |
| 40-44 years | 1,056 | 10% |
| 45-49 years | 677 | 7% |
| 50-54 years | 460 | 4% |
| 55-59 years | 232 | 2% |
| 60-64 years | 120 | 1% |
| 65-69 years | 70 | 1% |
| 70+ years | 71 | 1% |
| **Total** | **10,319** | **100%** |

## Services provided to children aged <10 years old

**Table 27: Services provided to children aged <10 years old recorded in the Homelessness Data Collection - (formerly known as SHIP) October 2021**

| Services provided - activity group | Number of clients aged <10 years old | Proportion of unique support periods |
|---|---|---|
| Family/domestic violence | 1,469 | 31% |
| General services - Basic assistance | 1,000 | 21% |
| Accommodation provision | 535 | 11% |
| General services - Advocacy | 398 | 9% |
| General services - Finance/income | 311 | 7% |
| General services - Interpersonal | 195 | 4% |
| Family | 134 | 3% |
| General services - Child services | 117 | 3% |
| Other specialist services | 105 | 2% |
| General services - Legal assistance | 91 | 2% |
| Immigration/cultural services | 77 | 2% |
| General services - Personal assistance | 74 | 2% |
| General services - Education, employment, training | 64 | 1% |
| Assistance to sustain housing tenure | 40 | 1% |
| Mental health | 26 | 1% |
| Legal/financial services | 20 | 0% |
| Disability | 11 | 0% |
| General services - Assertive outreach | 7 | 0% |
| General services - incest/sexual assault | 2 | 0% |
| Drug/alcohol | 0 | 0% |
| | **4,676** | **100%** |

**Table 28: Services provided to children aged <10 years old recorded in the Homelessness Data Collection Tool - (formerly known as SHIP) November 2021**

| Services provided - activity group | Number of clients aged <10 years old | Proportion of unique support periods |
|---|---|---|
| Family/domestic violence | 1,418 | 32% |
| General services - Basic assistance | 924 | 21% |
| Accommodation provision | 520 | 12% |
| General services - Advocacy | 415 | 9% |
| General services - Finance/income | 269 | 6% |
| General services - Interpersonal | 189 | 4% |
| Family | 135 | 3% |
| Other specialist services | 116 | 3% |
| General services - Child services | 98 | 2% |
| General services - Personal assistance | 81 | 2% |
| General services - Legal assistance | 77 | 2% |
| Immigration/cultural services | 61 | 1% |
| General services - Education, employment, training | 60 | 1% |
| Assistance to sustain housing tenure | 35 | 1% |
| Mental health | 22 | 0% |
| Disability | 21 | 0% |
| Legal/financial services | 14 | 0% |
| General services - Assertive outreach | 9 | 0% |
| General services - incest/sexual assault | 1 | 0% |
| Drug/alcohol | 0 | 0% |
| | **4,465** | **100%** |

## MARAM risk assessments (Homelessness Data Collection Tool, otherwise known as SHIP)

Notes regarding MARAM data collected in the Homelessness Data Collection (otherwise known as SHIP)

- The figures represent the total number of risk assessments undertaken by the Homelessness data Collection Tool (formerly known as SHIP) - VIC users which includes users from both homelessness and specialist family violence services. However, the majority of these risk assessments would have been undertaken by specialist family violence services.

**Table 29: Number of MARAM risk assessments undertaken in the Homelessness data Collection Tool (formerly known as SHIP) – October & November 2021**

| | October 2021 | | November 2021 | |
|---|---|---|---|---|
| | **N** | % | **N** | % |
| **Number of risk assessments for children** | 606 | 24% | 620 | 26% |
| **Number of risk assessments for adults** | 1889 | 76% | 1781 | 74% |
| **Total** | 2495 | 100% | 2401 | 100% |

## Family violence clients with accommodation needs

**Table 30: Number of family violence clients with accommodation needs recorded in the Homelessness Data Collection Tool by type and provision status - (formerly known as SHIP) October 2021**

| Service assistance type | Need identified | Need identified as % of clients | Provided only | Provided and referred | Provided as % of need identified | Referred only | Not provided or referred |
|---|---|---|---|---|---|---|---|
| Long term housing | 367 | 21% | 9 | 0 | 2% | 75 | 283 |
| Medium term/transitional housing | 721 | 40% | 569 | 17 | 81% | 49 | 86 |
| Short term or emergency accommodation | 1040 | 58% | 810 | 96 | 87% | 32 | 102 |
| **Total** | **1786** | **100%** | **1354** | **142** | **84%** | **57** | **233** |

[a] total equals >100 due to multiple responses

**Table 31: Number of family violence clients with accommodation needs recorded in the Homelessness Data Collection Tool by type and provision status – (formerly known as SHIP) November 2021**

| Service assistance type | Need identified | Need identified as % of clients | Provided only | Provided and referred | Provided as % of need identified | Referred only | Not provided or referred |
|---|---|---|---|---|---|---|---|
| Long term housing | 367 | 21% | 7 | 0 | 2% | 88 | 272 |
| Medium term/transitional housing | 747 | 42% | 567 | 14 | 78% | 48 | 118 |
| Short term or emergency accommodation | 1031 | 58% | 796 | 92 | 86% | 25 | 118 |
| **Total** | **1765** | **100%** [a] | **1308** | **157** | **83%** | **62** | **238** |

[a] total equals >100 due to multiple responses

## Family Safety Victoria – The Orange Door (TOD)

Summary of The Orange Door areas that were operational during the reporting periods include:

- **18 October 2021 to 31 October 2021:**
  - As at 18 October 2021, The Orange Door was operational in 10 areas
  - As at 31 October 2021, The Orange Door was operational in 11 areas
  - Wimmera South West (South West) opened on 26 October 2021
- **15 November 2021 to 28 November 2021:**
  - As at 15 November 2021, The Orange Door was operational in 12 areas
  - As at 28 October 2021, The Orange Door was operational in 13 areas
  - Outer Gippsland opened on 16 November 2021

**Table 32: Persons referred to The Orange Door and screened who ended up with a case**

| Reporting period | Persons screened | Moved to case | Not moved to case | % Moved to case | % Not moved to case |
|---|---|---|---|---|---|
| 18-10 to 31-10 | 7109 | 5031 | 2078 | 70.8% | 29.2% |
| 15-11 to 28-11 | 9818 | 7104 | 2714 | 72.4% | 27.6% |

Notes: Data provided by Family Safety Victoria; 1. The data in the table above are persons screened during the reporting period. A person may be involved in multiple referrals and thus counted more than once. 2. After screening, a client may have a new case opened, receive service from a previously opened case, be referred immediately to a service, be designated as currently open with an existing service or be deemed ineligible. 3. Only "resolved" screenings included. 4. Clients identified as perpetrators at the screening stage excluded.

**Table 33: Average length of time from referral to case closure (days) - The Orange Door**

| Reporting period | Number of cases closed | Average length of time from referral to case closure (days) |
|---|---|---|
| 18-10 to 31-10 | 3551 | 31.6 |
| 15-11 to 28-11 | 4217 | 34.6 |

Notes: Data provided by Family Safety Victoria; 1. Cases closed within the reporting periods were matched with referrals data. 2. Clients identified as perpetrators excluded. 3. Cases created in error excluded.

**Table 34: Number of child clients by age group (TOD) – 18 to 31 October 2021**

| Age group | Number of child victim survivors | Proportion |
|---|---|---|
| 0-4 years | 166 | 29% |
| 5-9 years | 156 | 27% |
| 10-14 years | 171 | 30% |
| 15-19 years | 82 | 14% |
| **Total** | **575** | **100%** |

**Table 35: Number of child clients by age group (TOD) – 15 to 21 November 2021**

| Age group | Number of child victim survivors | Proportion |
|---|---|---|
| 0-4 years | 186 | 25% |
| 5-9 years | 239 | 32% |
| 10-14 years | 228 | 31% |
| 15-19 years | 88 | 12% |
| **Total** | **741** | **100%** |

**Table 36: Number of child victim survivors by combined age group (TOD) – 18 to 31 October and 15 to 21 November 2021**

| Age group | Number of child victim survivors | Proportion |
|---|---|---|
| Under 10 years | 747 | 57% |
| 10-17 years | 569 | 43% |
| **Total** | **1,316** | **100%** |

**Table 37: Services provided by TOD by survivor adult or child (TOD) – 18 to 31 October and 15 to 21 November 2021**

| TOD service provided | Victim Survivor (Adult) | | Victim Survivor (Child) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Engaged with service system | 583 | 25 | 333 | 31 | 916 | 27 |
| Needs met by The Orange Door | 563 | 24 | 292 | 27 | 855 | 25 |
| Client declined / disengaged with service | 546 | 23 | 239 | 22 | 785 | 23 |
| Unable to contact | 423 | 18 | 131 | 12 | 554 | 16 |
| Service no longer required | 73 | 3 | 37 | 3 | 110 | 3 |
| Case created in error | 78 | 3 | 13 | 1 | 91 | 3 |
| Transferred to another area | 49 | 2 | 20 | 2 | 69 | 2 |
| Contact deemed unsafe/inappropriate | 15 | 1 | 11 | 1 | 26 | 1 |
| Client deceased | 1 | 0 | 0 | 0 | 1 | 0 |
| **Total** | **2,331** | **100** | **1,076** | **100** | **3,407** | **100** |

Note: the field used to capture child data is child victim survivor, this does not include children that are the subject of a child wellbeing referral where family violence is a factor.

## Safe Steps

**Table 38: Accommodation clients (Safe Steps): demographic information for adults and children**

| Demographic data | Oct-21 | Nov-21 |
|---|---|---|
| CALD | 21% | 21% |
| Aboriginal and Torres Strait Islander | 10% | 13% |
| Not born in Australia | 18% | 19% |
| Under 5 years of age | 21% | 20% |
| Under 14 years of age | 41% | 42% |
| Between 26 and 45 years of age | 41% | 40% |

# Appendix 4: Team Leader Workshop summary report

**Date:** Wednesday 1 December 2021, 9.15am - 10.45am

**Platform:** Zoom

**Facilitators:**
- Dr. Kristin Diemer – University of Melbourne
- Emma Morgan – Safe and Equal
- Ella Longhurst – Safe and Equal

**Attendees (22 in total):**
- 22 team leaders in total
- 15 specialist family violence services in total

**Purpose:**
From October to November 2021 Safe and Equal led the Measuring Family Violence Service Demand Project. As we drew to the end of the two data capture periods, we commenced data collation and analysis. The purpose of the Team Leader Insights workshop was to present back some of the initial insights gleaned from the data, and draw on the expertise of Team Leaders from participating services to further understand what the data is telling us and to support future planning for this work.

Focus topics included:
- Unallocated clients & small number of new clients
- Intake management processes and risk triaging
- Access to appropriate accommodation (crisis and short-term) & intersection with homelessness sector
- Understanding what emotional support in case management service provision entails
- Staff well-being & capacity issues

Initial feedback on data capture process:

**Positives:**
- User-friendly tool and entering the data was clear.
- The support documentation and tally sheet were helpful to assist staff in embedding the tool into their workflow.
- The purpose of the project around advocacy made it an easy sell to the team as there was an acknowledgement of how crucial and important this work was.
- There was initial excitement felt across teams to start quantifying and highlighting their work. Helpful for team leaders as it gave a better understanding of the variability of case management.

**Challenges:**
- Common theme in discussion was the onerous nature of the data capture periods on top stressful workloads as practitioners are already facing high caseloads.

- Issues in coordinating and bringing data together. A Safe and Equal member organisation highlighted that they have five teams and coordinating outreach and refuge data to bring together for the capture was challenging.
- Staff were burnt out for the second data capture.
- Issues with having new staff on board and training them up alongside this work was challenging.
- Repetition of questions when you are having multiple contacts with the same client and having to plug the same information in again and again.
  Issues with identifying the conceptualization "new clients" – they may be new to case management but not new to intake.

**Improvements for future data capture planning:**

- Providing a drop down for services and separate teams within them, to further disaggregate the data so services do not have to coordinate this.
- Greater communication to incentivize staff and highlighting how this data will be operationalized in an advocacy space, ensuring we keep up a mentality of hopefulness.
- Increasing sophistication in the tool so it can pick up repeat clients so the process of data collection is more streamlined.
- Sending out the questions prior and staff are aware of what is going to be asked and capture.
- Including the different types of activities under refuge such as therapeutic support.
- Spread out the data capture periods to prevent burn out and fatigue.
- More efficient ways to collect data on workers managing active hold lists as they are constantly working with new clients. One worker for example, was holding a caseload of 90-112 people and entering this data is not viable.
- Trying to capture the CM caseloads is so important – maybe providing a direct question "as a case manager, who referred this client?"
- If you had a data project team who could travel around and support data collection; consider collecting data at different points in time rather than doing it all at once.
- Measure the hours of work completed by a case manager within the data capture time period.

**Theme One: Unallocated ClientsThe appointment of specific workers managing active hold lists**

Some participating organisations highlighted that to meet intensifying demand they have created a specialized worker to address unallocated cases because it was intensifying demand and victim-survivors needs were not being met. For example, one Safe and Equal member organisation have a large allocations spreadsheet with one case worker who looks after that and the team leaders do the allocating.

*"We keep in contact with clients on the active hold lists but it is resource intensive."*
– Team Leader, Safe and Equal member organisation

*"We have waiting lists up to 6-8 weeks, the cases sit, and it is really challenging to meet these needs from a capacity perspective."*
– Team Leader, Safe and Equal member organisation

*"We made a decision maybe about six months ago, to actually have an specialist family violence advocate run our allocation and waitlists because women and kids waiting were not getting a service and it was causing high levels of demand on our administration teams and then also our assessment and response team because women had questions or they had immediate issues and that's where all the work went to, at which then it clogged up the service because new women could not get into the service. So, we had to make a decision around what we would do. So, we have a big allocation spread sheet and we have one person who looks after that and then the team leaders do all the allocation off that and then I keep oversight over that to make sure that women who are waiting for a service. It's generally the women who are at lower risk of family violence or elevated risk tend to wait longer and we've got breakdowns of that. We really,* ***I suppose our criteria of women we try and push through are women who are experiencing high risk of family violence.*** *The wait times list* ***as we have more complexity and risk coming through it means women with perceived lower levels of risk wait longer for a service****….* ***then there are women who don't perceive themselves as high risk, but they are high need the support they get can take a while****. So that's where our allocation worker comes in and* ***she spends a lot of time managing that work before it gets to case managers and making sure we are in contact with those women either via phone calls or text messages, so they know someone is actually there and there's some sort of care over what's going on…it takes a lot of time"***

– Team Leader, Safe and Equal member organisation

*"We have a process whereby dependent on the women's level of risk, we contact her at certain intervals throughout that period whilst she is on the waitlist. We respond to any immediate needs, so we do find that sometimes we can respond to those immediate needs whilst she is waiting to be allocated and sometimes, we can close those women off from the case management waitlist rather than sending them through. It's just about being responsive to their needs while they are waiting and addressing any immediate needs.... Our waitlist can vary from 30 clients to 90 clients just depending on the demand. You know there's some days where I go into 25 different client files...whether to do phone calls or text messages.... You know sometimes the work that we do can be very brief and sometimes I might spend a whole day with one client other times I can be going into 20 - 25 client files."*

– Team Leader, Safe and Equal member organisation

**The intersection of unallocated clients with managing intake and risk triaging:**

The criteria in which victim-survivors get pushed through to allocation is determined through their risk level. However, there are complex clients at lower risk, whose support takes longer. While on the active hold list, services are responding to immediate needs.

*"As our waitlist blows out because we are wanting to respond to all those women who are on the waitlist, I then have to make sure that all my interactions with those women you know I guess are brief and we are just responding to that immediate risk because we need to try and get through all those women because we can have a lot of calls coming through and we want to make sure that we are responding to all that risk that's being held on the waitlist, it does add a lot of pressure and perhaps you may not be addressing everything that those clients are asking for at that time because we really need to be triaging and only responding to that immediate risk. Whereas you know when the waitlist is shorter, and we've got more*

*staff you know we can spend more time with women on the waitlist to have those conversations and provide more of the emotional support. It's often what they are seeking...but when they are on the waitlist we just don't have time to provide the emotional support...when you're on the waitlist it's really all about "is there immediate risk?" it's really about that brief intervention around providing support in safety and risk until they get allocated a case manager...the longer the waitlist blows out the shorter amount of time I have to work with each client and it becomes more challenging."*

– Team Leader, Safe and Equal member organisation

**The impact of unallocated clients on staff wellbeing and burnout:**

Staff are working with clients managing high risk for shorter periods of time, to be able to see allocate case management to new clients coming through. This high turnover of high-risk clients impacts staff wellbeing and clients are not getting the support they need when they need it.

*"We have really short support period of 6-8 weeks. We try and mitigate risk as fast as we can and then refer out. If we had longer support periods, our caseloads would blow out."*

– Team Leader, Safe and Equal member organisation

*"We have two avenues of waitlists (self-referred or L17) and they are supported in the interim until CM can pick them up – but sometimes we have high-risk clients coming through and senior staff will pick them up and try and juggle these cases on top of managing their other responsibilities."*

– Team Leader, Safe and Equal member organisation

*"Having longer support periods would be great but capacity wise we can't."*

– Team Leader, Safe and Equal member organisation

*"Lots of the allocation stuff, like we have short support periods. Our support periods are about 6-8 weeks in order to manage demand. So, we work really quickly, and we work to mitigate risk as much as we can and put safety stuff in place and then refer out. So, a lot of that you know taking on high risk and caseloads blowing out. You know it's all about how services manage that and how long caseloads are but like our waitlists and caseloads would blow out significantly if we had longer support periods.* ***We would like to run longer support periods and we do when we have to but as soon as we start wrangling longer support periods that impacts how long other women are waiting for and we try and get those high risk women through really quickly****, we have a turnaround of seven days...but I suppose when you talk about impact on staff...****I feel like sometimes we just...our services just run on the good will of staff and I think it's time to stop that. Like I know for me as a manager, I really try to be very mindful of that and I don't want to run on the good will of our staff because it goes against all our philosophies around feminist practice and I think as a sector we need to look at that as I think for a really long time the sector has run on the good will of staff because they'll keep putting their hand up and keep putting their hand up. You know women can move around a lot more than they used to, so they don't stay in the sector, and they don't stay at services for a long time...we find we get them for maybe three years. You know this is really hard work and it's intense work and I think all these things run together."*

– Team Leader, Safe and Equal member organisation

*"The longer the waitlist – the shorter amount of time I have to work with a client, victim-survivors get frustrated because we have such short amount of time."*

– Team Leader, Safe and Equal member organisation

**The impact of The Orange Door on case allocation:**

*"The Orange Door hold a lot of unallocated cases for long periods of time and perhaps some of those cases are going there and therefore aren't seen in the data."*

– Team Leader, Safe and Equal member organisation

*"We don't have a waitlist, case management referrals some through TOD and we can try and refer them to an ongoing case manager, in case we can't find someone who does interim case management, the crisis response team responds to TOD clients who are in crisis accommodation."*

– Team Leader, Safe and Equal member organisation

*"It is a very rare situation when we pause referrals, and they are getting service from The Orange Door."*

– Team Leader, Safe and Equal member organisation

*"We don't run a waitlist or active hold list, because we don't have capacity to pick up cases from TOD but that's becoming hard, and I think we will probably move to not being able to do that and have to develop up an active hold list…because there's obviously KPIs we need to meet."*

– Team Leader, Safe and Equal member organisation

## Theme Two: Staff well-being and capacity issues

*"When there's limited staff, other workers pick up cases and you have to reply on people's case notes and safety plans to pick up the pieces."*

– Team Leader, Safe and Equal member organisation

**Recruitment**

*"Due to the new recruitment of TOD, we had some reduced capacity, so across the two data capture periods we had significant recruiting as well, so it's been interesting looking at how that's impacted, and we had a very unusual brief pause of referrals during that time."*

– Team Leader, Safe and Equal member organisation

*"It's [the waitlist] also impacted when we are bringing on new staff and their new graduates as we rarely get experienced staff so then their caseloads really need to represent their newness into the sector so that also has an impact because you can't just expect them to work at the same level as everybody else and also the risk and complexity puts pressure on other staff and then also puts pressure on our waitlist worker because she has a lot more than she has to respond to and not to mention,* ***it puts pressure on women because they get really annoyed with having to wait which is fair enough***."

– Team Leader, Safe and Equal member organisation

*"The ongoing pressure on staff is underestimated and at some points not taken seriously. I think it is important to understand we are on intake and hold case management cases which increases the pressure on case managers when there already have to prioritize due to lack of staffing for intake to alleviate burden on case managers."*

– Team Leader, Safe and Equal member organisation

**The capabilities of new staff in managing risk and the pressures on senior staff**

- Challenges with training up a new workforce, largely comprised of recent graduates. Large caseloads comprised of high-risk clients erodes staff wellbeing and does not support victim survivors.

*"You can't just have new grads holding huge caseloads with complexity and high risk – there needs to be a consideration of staff wellbeing but also the victim-survivors needs."*

– Team Leader, Safe and Equal member organisation

- This then means senior staff pick up the higher risk and high case load, and this erodes the support and supervision capacity within the team overall. When recruitment challenges, staff caseloads increase, and senior roles pick up case management despite not being a part of their usual role.

*"Team leaders are picking up caseloads and then you aren't doing your role."*

– Team Leader, Safe and Equal member organisation

*"Being a senior, we've had some graduate new workers so it's training them up at the same time, their green and they haven't worked in the sector and that increases the workload on myself, you know I am doing a lot of my secondary consults that were around them needing support with the clients and telling them what they need to do and where to go...and you know another thing, like travel for one client was three hours in a day, you know regional areas we are traveling....long distances and your day is gone...you know just juggling those client loads."*

– Team Leader, Safe and Equal member organisation

*"How many cases can someone manage? You know we have had cases where people have ended up with two RAMP cases and then a couple of others who are really close to RAMP, that's a lot of pressure for one worker. You want to move things around and you look around and you're like "oh actually there's no room", so then the team leaders are also picking up*

*cases and then you find you're not doing your role as well, when you're also trying to respond to the cases."*

– Team Leader, Safe and Equal member organisation

- Training staff alongside managing high risk clients puts pressure on the organisation as a whole. Increase of secondary consults with senior staff to manage new workforce.

*"It takes a lot of workforce development for staff to feel comfortable holding the risk."*

– Team Leader, Safe and Equal member organisation

*"It's the pressure it puts the organisation as a whole. Like for me, I know that when we have lots of inexperienced staff in you know its puts lots of pressure on our RAMP coordinator because they end up doing more consults because new staff are concerned and they don't understand the risk as much so they end up doing a lot more consults...and also with the PSI...it's not just on the team leaders it puts pressure everywhere and same when we have an experienced staff member at the orange door because for them and very rightly everything feels high risk so then we have to manage the amount of high risk that is coming through and kind of woo that back and go "no no no that's not high risk" so you know it takes a lot of development on both sides to bring those staff to a point where they are comfortable holding the risk and they understand the risk levels a bit more but it does I think it puts pressure on the whole organisation and I think we have to be very mindful of that."*

– Team Leader, Safe and Equal member organisation

*"Also what we are trying to manage is caseloads but also how many at risk, how many elevated…and I think it's becoming harder and harder the more that the demand increases the more that the expectation is that the clients wait so then your case load you know becomes really challenging and you're managing a lot of high risk cases and you know there's lots of coordination, lots of safety planning...how much of that work can one person do well? You know we've got a part-time workforce as well… and when the workers aren't here, it's the other workers that have to pick up the other cases. Because you know, women aren't just calling in crisis or needing support on Wednesday-Friday... so that's the work that also needs to be measured… because we find that's the biggest pressure. Because they are the cases you don't know intimately. So, you're relying on someone's case notes and good case plan to put the piece together."*

– Team Leader, Safe and Equal member organisation

## Theme Three: Accommodation and intersection with homeless sector

### Overall lack of housing options is driving systemic stressors

- Overwhelming consensus that there are limited properties available. Unstable housing is a critical piece that underpins these stressors.

*"It's so difficult [for] the workers to be able to support them in that space when they have no stability and no safe space to sleep or they don't know where they are going to be next week...the housing piece and the homelessness piece is so massive, it actually underpins so much...we are lucky in the refuge sector that the accommodation comes with the rest of the support that we do. It's not definite but it's there, at least we have some inroads with our*

*emotional support because they've got that stability of where they are living at least for the time being...the emotional support a lot of the time."*

– Team Leader, Safe and Equal member organisation

- Homelessness is ongoing, with nothing affordable and safe. Other services have expectations for the SFV to provide accommodation, and funding for this is limited. However, housing services are at capacity.

*"We are putting women in motels due to lack of housing in regional areas. Had one in motel for two and half weeks. This is challenging for the client especially if she has children."*

– Team Leader, Safe and Equal member organisation

*"We have some funding around housing, and we see that we could close someone off in a really short sharp way around managing risk but homelessness is a really key factor and so you know they hold the housing funding than our. Agencies holding homelessness tend to not pick up these cases because we are already holding them...and for the staff that is really hard. You know we've got women who will say "I'll just have to go back to him, is that what you want" and so then that pressure is then transferred onto the staff, and I think especially this year, we all know the impact that covid-19 has had on housing and the rental market."*

– Team Leader, Safe and Equal member organisation

**Impacts of unstable housing on staff wellbeing**

- Huge pressures around resourcing and housing that then is transferred onto staff wellbeing. For example, limited housing creates pressure on staff with fears that victim-survivors will return to homes with perpetrators
- Tension of providing emotional support when there are limited housing options.

*"There is so much behind the scenes work around applying a family violence lens and really listening to the client it takes time. The whole system is under pressure and when there are no housing options it adds extra pressure onto other recovery aspects."*

– Team Leader, Safe and Equal member organisation

*"Staff wellbeing around housing is impacting hugely. I've got staff who say you know "I'm not sleeping at night, I feel responsible'.* ***You know we've got limits with our funding, the pressures around homelessness and lack of resourcing - there's no answers****, there's lots of validation that resourcing needs to increase but there's still not answers, you know people make complaints. So yeah,* ***I think staff wellbeing, wanting to do the best each day and being really present for your clients...you start to see some transference, some enmeshment, you know, disconnect you know all those things you'd see in that sort of supervision space. You know it not just about the risk but the staff wellbeing and how are they managing some of the complex cases*** *because it's easy to put cameras in and all those sorts of things but it's hard to get someone a rental property and there's no rental properties and they can't afford the rental properties."*

– Team Leader, Safe and Equal member organisation

## Theme Four: Emotional support

### More funding for emotional and therapeutic support is required

- There are long waitlists on family violence counselling.
- It is difficult and over time somewhat corrosive for practitioners providing that emotional support while also being the face of the limitation of the system, and to some extent being made to feel accountable for those limited options available to victim survivors and the risk and vulnerability this creates for them.

*"When it's really difficult and there's long waitlists to get into counselling, that's when we have to sit with a lot of that emotional support…which is really empathy, holding the family violence lens, psycho-educational support so it's really working with women to understand what's going on and to reiterate it's not their fault...but that takes time and when we are under pressure, that's hard and when the whole system is under pressure, lack of housing options and counselling we find it really hard.. **When there is a lack of funding for recovery... we end up trying to do everything... and we have to stop asking our workforce to do everything**."*

– Team Leader, Safe and Equal member organisation

### Increasing client complexity and systemic limitations erode case management staff wellbeing

- All referred cases involve complexity, due to overlap of mental health impacts, AOD use, homelessness and financial impacts etc. Increasing complexity impacts on case management. Huge increase during lockdown.

*"**The more the demand increases the more there is an expectation that at risk women wait, and so the caseloads become really challenging because you're managing a lot of high-risk cases**."*

– Team Leader, Safe and Equal member organisation

***"We are seeing a change in client groups and complexity coming through which includes because if existing trauma clients become overwhelmed and this impacts staff.** All case's which are referred are complex, mental health, ID etc. increasing complexity and impacts on case management. Again homelessness is ongoing with nothing affordable and safe. And other services expectations for the service accommodate which funding for this is limited and housing services are at capacity."*

– Team Leader, Safe and Equal member organisation

*"**We have also seen an increase in women re-partnering during the support period and unfortunately further experiencing of family violence with new perpetrator**, leading to us holding for longer."*

– Team Leader, Safe and Equal member organisation

- Case management staff are holding the tension of providing emotional support for trauma impacted clients in crisis, while also being the face of the system's limitations.

*"Family Law can also be a large part of work and a lot of emotional support needed for this due to the client having to rehash everything and Family Law not recognising family violence fully. The Family Law focus is on both parents having a relationship with the child without considering risk."*

– Team Leader, Safe and Equal member organisation

*"You know I used to be in case management and intake roles just getting people through that day through a phone call or the next hour or to their next appointment...**It's survival mode... The burden on the staff's own emotional state is the fact you enter into survival mode with that woman anytime you speak to her, you walk alongside her intense crisis a lot of the time**...It's massively burdensome on staff that then have no answers. Yeah, **you're really straddling that being on both sides of the system where you might be the only person that the client feels cares and that they can talk to, but you also have to be part of the system that waves a big stick that says 'I've got to close you' or like 'I can't offer you anything that really will help' - so it's very difficult."***

– Team Leader, Safe and Equal member organisation

- Staff manage this by naming and acknowledging the limitations, maintaining boundaries, providing appropriate referrals so clients feel supported, yet know that we are not a counselling service and referral pathways are provided. Case managers work to ensure clients do not become co-dependent on workers or service by adopting a strengths-based, empowering model.

*"Validating a women's experience is sometimes a big part in the work that we do, especially if there's recent separation or there's perpetrators doing a lot of gaslighting, and they are unsure of their experience. I guess also that psycho-education and just validating their experiences and that they are experiencing family violence that's a big part of the work we do."*

– Team Leader, Safe and Equal member organisation

*"Also building the women's capacity to be able to participate and engage about her short-term goals. **Part of the family violence experience is about building the women to find their own experience and their own voice and have agency in the decisions she wants to make in terms of keeping herself safe and the children safe**."*

– Team Leader, Safe and Equal member organisation

## Theme Five: Managing children's needs

### Working with children is very dynamic and complex, and significant increase in resourcing is required

- The needs are not currently being met, due to huge demand and the need for more specialized workers and training up an inexperienced workforce.

*"In terms of emotional support, we tend to just not have as much time as we want to provide emotional support. I think one of the key things that you see that you know is a real impact is the risk on the children and you know women's ability to attend to their children when they are really struggling emotionally, and they feel they aren't getting their needs met. It will impact on the children and that's sort of an unavoidable impact, and then we do tend to get calls from child protection wanting to know what their engagement is like with us and I get it's really from a feminist organisation that's really challenging because* ***we really want to partner with the non-offending parent and really support women to you know respond to the children and they want to respond to the children and be the best parent possible but under circumstances that are really challenging, we find that yeah it's just an impact around children..."***

– Team Leader, Safe and Equal member organisation

(on managing children's needs*) "I would say probably not that well. If I'm entirely honest…****you know when you have new workers coming through that are fresh out of their social work degree that have a very basic understanding of family violence and actually no experience in what that means practically and there trying to learn how to work with women and then also trying to understand that work around children you know is really difficult...working with children is really dynamic and it's really difficult because children have many different needs both emotionally and developmentally and getting workers to understand that.*** *One of the workers here a while ago was working with a woman who had nine children. If you counted all of those children as individual clients, she's got a full case load with just that one family.* ***So being able to do the work with children needs a much bigger focus on it, especially from government, because we just need more resourcing for it."***

– Team Leader, Safe and Equal member organisation

- Covid-19 has created more additional barriers. For example, local children's counselling services with family violence focus have been closed for months, putting pressure on case managers who are supporting adult victim survivor parents.

**Meeting children's needs in different housing situations varies and can be challenging**

- Children in refuge services are well in sight, almost to the point that their support needs eclipse their parent's supports.
- However, this is different in outreach services, where the parent victim survivor is the conduit to access to the child. Managing caseloads mean that children's files aren't being maintained to avoid duplication of work.

*"I think that's a significant point of difference for us when* ***we looked at the different case management roles so in refuge, children dominated we sometimes have had occasions where like "ooh where's mum in the picture" because the children's behavior was so obvious and we could work around them and their case plan goals around education, inclusion in activities, understanding behavioral needs, could get them into support in terms of external providers sometimes quicker than mum.*** *So, we had some really good outcomes, however,* ***some of the other case management with other outreach teams, it was really hard, they had worked through covid where they***

***were rarely seeing children, it's hard to ask about the needs of the children over the phone without the parent feeling it was an inquisition for a child protection questionnaire*** *- so we have talked a lot about that. With the rumor circulating at the moment that we are going to get more funding to respond to children particularly in refuge...however, we seem to have to continually redevelop the role to align with the recruitment opportunities we have rather than the needs of the individuals we need to service...so for me I find that a particular challenge.* ***Having worked in refuge for over twenty years where the children's worker role was used for so much and now, we are looking at possibly taking it away from the intensely therapeutic approach makes me sick.*** *But it does make you look at what the need is specifically, so* ***I think for us children particularly in refuge in sight but also in outreach it's been a struggle particularly in making sure that we aren't just duplicating mum's file for a child for the purpose of having a file, there's some judgement around that statement but it's really just about how we survive in delivering that service****."*

– Team Leader, Safe and Equal member organisation

- The case management work with adult and child victim survivors is relational work, in addition to the therapeutic/emotional support and case management support for the individuals.

*"It's also about the relational stuff you know because you can work with mum you can work with the kids but unless you do that relational work…what's the point?* ***Because everyone goes their separate ways and then they leave the service and then if you haven't done that relational with mum and the kids and you know working with mum around that who supports the kids ongoing and that's why I think the work with children is so complicated and complex and really needs to be looked at.*** *Because it's one thing to do direct service with children but* ***you cannot miss that relational work****. For me, that's the key in the long term is sustaining wellbeing for children."*

– Team Leader, Safe and Equal member organisation

*"Doing that work [relational support between parent and child] is near on impossible in the motel situation or a transitional housing situation or you know people living in their car on a waitlist, it's not going to happen."*

– Team Leader, Safe and Equal member organisation

**Funding and contract models are inflexible**

- Services are constantly adjusting the roles to funding models and not the needs of the sector

*"We've struggling with recruitment for Specialist Children and Young Person's Workers (both recruiting and retention) so when this role is vacant work falls to case managers, who then have to adjust from focusing more on Mum to the whole family - which is extra work and not all feel as comfortable working with children."*

– Team Leader, Safe and Equal member organisation

## Theme Six: Leave Balances and Sick leave

**Lots of new staff with no leave, and lots of staff have exhausted their sick leave.**

- EBA needs reviewing and better entitlements for case managers.
- Sick leave seems to be much more frequent, could be due to covid-19 and staff needing to be off work for any symptoms whereas previously may have 'soldiered through', or reflection on general burn out.

*"We have people who have no sick leave left, you know life happens outside of this work, but I know HR they are always curious about the impact of this work, and you know the impact on people's health, the holistic approach. But yeah, I don't know, we are working during a covid pandemic as well so I guess it's about we are working under extraordinary times so yeah we've got people who may have just started as well so they haven't got a huge amount of leave… but we are really general we've got an EBA, we've got gift days, we've developed pandemic leave. We feel really well supported but we've still got people who have exhausted their leave provisions."*

– Team Leader, Safe and Equal member organisation

*"All our CMs have very little to no sick leave and annual leave - leave without pay is common. Others have cancelled leave due to no other staff being available."*

– Team Leader, Safe and Equal member organisation

# References

Cargo, M., & Mercer, S. L. (2008). The value and challenges of participatory research: Strengthening its practice. *Annual Review of Public Health*, *29*(1), 325–350. https://doi.org/10.1146/annurev.publhealth.29.091307.083824

Cornwall, A., & Jewkes, R. (1995). What is participatory research? *Social Science & Medicine*, *41*(12), 1667–1676. https://doi.org/10.1016/0277-9536(95)00127-s

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory*. Strategies for Qualitative Research. Chicago: Aldine.

Jacobsen, KH. *Introduction to health research methods*. Burlington, MA: Jones & Bartlett Publishers, 2016.

Jagosh, J., Macaulay, A. C., Pluye, P., Salsberg, J., Bush, P. L., Henderson, J., Sirett, E., Wong, G., Cargo, M., Herbert, C. P., Seifer, S. D., Green, L. W., & Greenhalgh, T. (2012). Uncovering the benefits of participatory research: Implications of a realist review for health research and practice. *Milbank Quarterly*, *90*(2), 311–346. https://doi.org/10.1111/j.1468-0009.2012.00665.x

Redko, C., Rapp, R. C., & Carlson, R. G. (2006). Waiting time as a barrier to treatment entry: Perceptions of substance users. Journal of Drug Issues, 36(4), 831-852.

Ritter, A., Chalmers, J. & Sunderland, M. (2013) Estimating need and demand for treatment – a background briefing. Working Paper No 1 – Review of AOD prevention and treatment services. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW. Accessed: http://unsworks.unsw.edu.au/fapi/datastream/unsworks:43178/bin4002a4a5-f6f6-472d-b8d2-7219c56ca9c8?view=true&xy=01

Rokeach, M. *Beliefs, attitudes and values: A theory of organization and change*. San Francisco/London: Jossey-Bass, 1976, pp. 312