Victorian Centres Against Sexual Assault Forum Response

TOWARDS A MORE EFFECTIVE AND SUSTAINABLE COMMUNITY SERVICES SYSTEM

We found this document ambiguous. In places in acknowledges the difficulties facing agencies with clients with increasingly complex needs. It then assumes generic services can deal with these needs as well as pre-empting the debate about client directed funding models in other places.

Sexual assault is always a crime. It is essential that any worker who has contact with victim/survivors has an understanding of not only the counselling and therapy to recover from trauma but the judicial system and the associated fields. This makes it different from many other areas that are part of the community services system.

Reforms across the sexual assault sector and pressure on society and Government to address sexual assault properly has brought about by the sector. In a non specialist world who would drive such reforms.

Pathway 1: Put people at the centre of service delivery

1.1 People who access sexual assault services, including Centres Against Sexual Assault (CASA), access these services because their primary issue is sexual assault either childhood or more recent. CASAs operate with Counsellor/Advocates whose job is to put people at the centre of the services provided and make sure that the service attends to all the needs that clients presents. Often people have a broad range of issues which can include homelessness, drug and alcohol, mental health, legal and other vulnerabilities. Approximately 10 percent of CASA clients have multiple issues that, until the person arrived in the CASA service system, have been dealt with in a fragmented manner. Dealing with these multiple issues is labour intensive and expensive. Sacred Heart Mission currently has a program funded to deal with these clients that has approximately $4 million over 3 years for 40 clients. CASAs work with all these issues as part of their advocacy role. Advocacy for these people is difficult in the current service system when agencies have narrow criteria for working hours, geographical catchment and service provision.

1.2 These service systems need to be more flexible and engage in collaborative practice and responses. This entails funding services realistically. Providing services with people at the centre is not a cheap option.

1.3 There needs to be involvement of the whole of Government. The State wide Committees to Reduce Sexual Assault and Family Violence established by Christine Nixon operated for five years and enabled close relationships to be established across service sectors. These Committees have ceased to meet even in their revised format. Collaboration needs to be multi-tiered with Inter Departmental Committees, State wide Committees and regional networks. These need to have a secretariat attached. The Integrated Family Violence Reform Partnerships struggled until the Regional Integration Coordination positions were created. We need collaboration between sectors and organisations as detailed before. We also need targeted, trained workers. For the sexual assault field the Government funds, and the sector co-ordinates and runs, workforce development for all workers in the field.

1.4 As above

Pathway 2: Focus more on supporting people to build their capabilities

2.1 The sexual assault service system focuses on capacity building and strengthening resilience of clients as well as support and stabilisation in a crisis. Not only do we provide crisis care,

counselling and treatment we provide advocacy, community education, training and health promotion programs. We assist people with long histories of childhood sexual assault, family violence and adult sexual assault, abused children and young people and their families, carers and significant others make major gains in living meaningful lives.
2.2 Other service systems should adopt the CASAs underlying philosophy of assistant victim/survivors, adult and child, to recover from trauma and develop resilience. If this means working with a child or young person's school, a financial counsellor or a mental health provider this will be arranged. Prevention is different to the above issue. Prevention of sexual assault is a global matter. It is not a service provision issue. CASA prevention programs address societal attitudes towards women, some men and children and young people. This is separate to crisis response, group programs and medium and long term therapy all of which CASAs provide.

Pathway 3: Develop place-based approaches
3.1 Regional services provide the best approach for sexual assault. This approach allows regional variations to inform service provision, prevention programs and collaborative practice locally. In addition, CASAs co-locate in a number of areas in Multi Disciplinary Centres (MDC) with Victoria Police and Department of Human Service Child Protection. This provides a one-stop-shop for sexual assault victim/survivors both child and adult. The plan is to roll out MDCs across the state.
3.4 The risk is the balancing of having a structure with sufficient boundaries to be manageable but has the capacity for the flexibility that is need to work with vulnerable and traumatised people. It is not a cheap exercise working in a flexible manner with vulnerable people. It requires a capacity to function beyond the usual 9.00 – 5.00 service hours.

Pathway 4: Recognise and reward good outcomes
Measuring outcomes is an extremely difficult exercise with vulnerable, damaged clients. Outcomes can be the focus with children, young people and adults who have been sexually assaulted. However, you need to make the outcomes measurable in a concrete manner. For example Can you keep the abused child or young person in school? Will they be able to finish school? Can they read and write? (Being able to read and write is a strong indicator of being able to cope with a history of child abuse when you are older. This is a very practical outcome and requires considerable resources when you have a child or young person who is disaffected and not attending school, coming home at night or having any respect for adults due to their abuse.) The following are the measurable outcomes in our view.

- Schooling
- Housing
- Job opportunities
- Health
- Dental

4.3 As above

4.5 It makes no difference what focus you have. Services are either innovative or not. It goes to their basic philosophy. Either you try and provide a responsive service or you fall back on your guidelines and protocols and refuse to be flexible. This is not a call for anarchy just an objection to inflexibity when it hinders good service provision.

Pathway 5: Consolidate government funded programs

In the past decade there has been a great improvement with consolidated funding as opposed to a multiplicity of funding streams all of which require accountability. Accountability is essential but it should not be your main and most time consuming function. As previously mentioned in 1.1 CASAs and their Counsellor/Advocates work with the issues that a person brings which can be mental health, drug and alcohol, homelessness, legal and a myriad of others.

The assertion that a by-product of specialisation has been a focus on programs and not people and on particular needs rather than the inter relationship of multiple disadvantage is inaccurate. CASAs deal with clients in a holistic manner addressing the multiplicity of their requirements such as mental health, drug and alcohol, homelessness, legal and family relationship matters.

5.1 The benefit for the funding body is that they have less agencies to manage. There is no substantial evidence that larger organisations cost less to run. Their CEOs often command high salaries and they end up top heavy with layers of management all on substantial salaries.

5.2 The risks are:-

- Regional services could end up run from a major hub
- Loss of flexibility of service provision
- Have reduced local collaborative practice
- Clients would have less choice
- Would lose the benefit of specialisation. If you need cardiac surgery you do not go to a GP. Expertise, training, evaluation and research improve specialist serv ices. These items cannot be provided for sexual assault workers in a generic service.
- The current Royal Commission and the Victorian Parliamentary Inquiry show that the past limited access to specialist sexual assault services had a detrimental effect on thousands of people.
- The current practice of listing family violence as including sexual assault is still silencing victims and limiting their access to the services required. It is concerning that in the new DHS structure sexual assault services are not listed. This does not imbue confidence in victim/survivors finding benefits in a consolidated funding model.

5.3 Consolidated program funding works poorly for sexual assault. This is a specialist area which requires dedicated trained and qualified staff and funding that allows political advocacy. It is easy, as we can see with the current Royal Commission and Parliamentary Inquiry, to silence victims. CASAs see their role as breaking that silence which is different to seeing your role as only providing counselling or therapy.

5.4 For sexual assault services to minimise the impact of consolidated program funding it is essential that the services are not consolidated into other services. Sexual assault services need to stand alone in order to give victim/survivors a voice. It is quite clear from the current situation with churches and other non government organisations that you cannot trust large organisations to care for the vulnerable when it is against the organisation's interest without rigorous accountability. Rigorous accountability appears to be difficult to have present consistently.

Pathway 6: Adopt different funding models

Any funding model needs to acknowledge the need for a whole of Government approach to dealing with vulnerable people. Collaboration needs to be multi tiered with Inter Departmental Committees, State wide Committees and regional networks.

6.1 In principle client directed funding is a good idea. In practice it is extremely difficult to operate in some of these service systems. Before Governments extend client directed funding they need to

simplify service provision. For example aged care has three tiers of service. Their local boundaries vary. Their qualifying criteria are different. Vulnerable people struggle with bureaucracies. Those who know how to work them get excellent service. This is not equitable. Families who find out their children have been sexually assault by the local paedophile have enormous difficulty just coping with this fact. In some cases just feeding their children and getting them to school is as much as they can manage let alone being asked to make choices about systems of care. Not to mention the mandated nature of much of their contact with the service system.

6.2 This question pre-empts the discussion. Client-directed funding is not appropriate in some areas such as sexual assault. These services are specialist because you require a highly qualified specialist approach. You require staff with tertiary qualifications and on-going training.

6.3 You cannot do this. You either allow people to spend as they will or you do not. You cannot have it both ways and create an unmanageable hybrid system.

6.4 See Pathway 4.

6.5 Yes sexual assault.

6.6 Consortia need funding to have a secretariat as do the Integrated Family Violence Response Partnerships now.

6.7 Communities vary from region to region. Individuals have varying requirements. This is how state wide services function in different regions. You need flexibility to deliver an adequate service. What is appropriate in Mildura may well not be appropriate in Melbourne CBD

6.8 To share best practice between communities needs to start at a whole of Government approach. See 1.3.

Pathway 7: Explore the range of social finance opportunities

7.1 Sexual assault is a crime. It is not appropriate to seek most corporate funding. There is always the problem of a conflict of interest, a perception of pressure being able to be brought to stop disclosures being pursued and the concern about bad press. Powerful people exert their power to stop some matters becoming public. There would need to be extremely stringent conditions to prevent this occurring. It may well be appropriate to seek social financing for child care centres or aged care but not in the area of sexual assault.

Working with victim/survivors of sexual assault requires expertise in dealing with a range of systems such as criminal, Family Court. Children's Court, police, schools, community agencies and many others. This requires significant levels of expertise and non-aligned funding. Workers need to know about a wide range of legislation. Generalist counsellors will not be able to know all this as well as understanding the impact of sexual assault.

7.2 As mentioned not appropriate for an area that deal with crimes.

7.3 It would be useful if the Government assisted people to work out what social financing might be acceptable in which area.

Pathway 8: Change 'who does what' in the system

The sexual assault field is not inefficient. There are 16 CASAs and a number of other agencies who provide some sexual assault services. CASAs are a discrete group with Standards of Practice, a Peak Body and regular meetings with Government Departments, community agencies, Police, Courts and

other organisations. It is easier and more efficient or everyone to deal with a peak body than 16 agencies. This is an effective model for communication and collaboration.

8.1 If you want a change in the system you need new structures with administrative support. The structures needs to allow for inter agency collaboration. You also need adequately qualified staff. For example, many aged care facilities have Certificate III staff with limited training. This does not make for an effective service system even if it is cheap.

8.2 See 1.3

8.3 See previous comments.

8.4 This is not the issue. What should or should not be transferred to CSOs is not the main issue. The issue is around accountability, staffing structures and peak bodies, Standards of Practice and funding.

8.5 Managing change is always difficult. It will require resources to manage the change effectively. It cannot be imposed on CSAs.

Pathway 9: Make the system more collaborative

9.1 Where there are shared clients.

9.2 Space, time, resources and a structure to allow collaboration.

9.3 See 1.3

9.4 Consultation and collaboration on the design and delivery of Government programs and services is a good idea.

Pathway 10: Make the system more effective and efficient

10.1 Do not know

10.2 Sexual assault, child protection, sexually abusive treatment services.

10.3 See 9.2

10.4 It depends on what part of the not-for-profit sector you discuss. It is not a homogenous entity.

Pathway 11: Use digital technology to empower people and CSOs

11.1 E Government is a limited reality at present. The use of e-mail has made a dramatic difference to how business is conducted but most other parts of the social media network have limited use generally.

11.2 Digital technology could be used to provide services to people in remote areas, supervision and consultation for staff, those with access issues for various reasons and people who are illiterate or semi literate. However, people need to be able to afford the hardware.

11.3 There are a number of factors which limit people from embracing digital technology in a much bolder manner

- Worker knowledge
- Expertise
- Time and resources to adjust organisationally
- Privacy issues need addressing

- Legislation needs to catch up with technological advances

11.4 Need an integrated, collaborative process to look at this issue

11.5

- Lack of privacy
- Improved access
- Need to develop protocols
- Hacking
- How do you deal with system failures
- Unintended consequences
- Pace of technological change
- Change fatigue
- Worker skill levels

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