# Towards a more effective and sustainable community services system

The Service Sector Reform project aims to improve how government and the community services sector work together to improve the lives of vulnerable and disadvantaged Victorians.

As part of the project Professor Peter Shergold has published a discussion paper, *Towards a more effective and sustainable community services system,* to support consultation with community service organisations.

The discussion paper outlines the key issues facing the community services system in Victoria, identifies potential pathways for reform and poses questions for feedback.

Please use this form to provide a response to the questions outlined in the discussion paper.

Please note that it is not necessary for you to comment on every topic or answer every question unless you wish to do so. Instead, please use it as a starting point to provide feedback on the things that matter most to you or your organisation. You can also identify issues which you believe have not been adequately addressed in the discussion paper.

**Please email your completed submission form to feedback@vcoss.org.au or mail to:**

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**Are you are providing a submission on behalf of an organisation?**

☒ Yes ☐ No

**If yes, please provide the name of your organisation.**

Women's Health West Inc.

# Your feedback

The background to the Pathways listed below is outlined in *Towards a more effective and sustainable services system: A discussion paper*. These questions may be considered within the context of that information.

**About Women's Health West**

Since 1988, WHW has actively contributed to the health, safety and well being of women in the western region of Melbourne through a combination of direct service delivery, research, health promotion, community development, capacity building, group work and advocacy. The composition of our staff reflects the multicultural nature of the western region demographic profile. WHW delivers through two broad service arms – health promotion and prevention, and response.

Our health promotion, research and development arm offers a range of programs and projects targeted to prevention and early intervention strategies to improve outcomes for women's health, safety and wellbeing. A major achievement of the WHW Organisational Health Promotion Plan (2009-2012) is the development of *Preventing Violence Together: Western Region Action Plan to Prevent Violence Against Women*, a coordinated, action-based collaboration between local government, community and women's health services, designed to build sustainable environments through local initiatives for the primary prevention of violence against women.

Since 1994 WHW has delivered a wide range of effective high quality family violence services for women and children. The services range from crisis outreach and court support, to housing establishment and crisis accommodation options, counselling and group work programs. WHW has been an active and strong supporter of family violence reform at a regional and state level, integrating and coordinating family violence services within our region, and ensuring the integration of those services with a range of related sectors, including the housing sector.

These two main arms of the service place WHW in a unique position to offer a continuum of responses across prevention, early intervention and crisis response. WHW's strategic plan sets out our approach to partnership, and to our client-centred approach to service delivery and outcomes that support women to take control over their decisions and their lives.

In summary, WHW's core business is the development and implementation of strategies to prevent, intervene and respond to the homelessness, ill-health, dislocation and trauma facing women and children who experience family violence. We are leaders in the development of regional strategies to further our work, seeing partnership within and outside the sectors in which we work as crucial for bringing about effective and sustainable outcomes for women and children.

As a feminist organisation we focus on redressing the gender and structural inequities that limit the lives of women and girls. WHW's work is underpinned by a social model of health that recognises the important influence of, and aims to improve the social, economic and political factors that determine the health, safety and wellbeing of women and their children in our region. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequity and improve health outcomes will be more effective and equitable.

Our experience in integrated health promotion and integrated family violence reforms provides knowledge and expertise for participating in this discussion about community sector reform.

WHW services the western suburbs of Melbourne incorporating:

- Brimbank Hobsons Bay Maribyrnong
- Melton Moonee Valley Melbourne and Wyndham

Partners and stakeholders include individual women and children in the community as well as organisations, agencies and peak bodies, magistrate and family courts, local government, hospitals, community health services, Medicare Locals, general practitioners, state government departments, police and legal services, child and family services, housing services, mental health and drug and

alcohol agencies, primary, secondary and tertiary education sectors. Our broad range of partners places us well to respond to the consultation document by bringing our close and comprehensive knowledge to the discussion.

## Improving outcomes

## Pathway 1: Put people at the centre of service delivery

Women's Health West strongly support the objectives of the project for service reforms that will deliver 'a simpler, more integrated system that produces better outcomes' for vulnerable people and the achievement of real and lasting change through 'stronger collaboration, partnership and governance between government and CSOs' (Shergold 2013).

We are equally cognisant of the fact that **the community services sector is chronically underfunded** making a focus on individual need difficult in the face of increasing demand for service delivery; particularly where crisis services are sought for women and children experiencing family violence.

From WHW's standpoint - and in keeping with the core business of specialist women's health services - prevention and population-based principles and practices inform our health promotion work. Evidence suggests that a focus on individuals can mask political problems, leading individuals to internalise their problems rather than recognise the structural factors that cause those problems. This ensures that 'inequality comes to be popularly perceived as the result of individual inadequacy or an unfortunate aberration' (Kellough, 1996) allowing responsibility for socio-economic and political problems to be shifted from the culture collectively to individuals. For the vast majority, economic and social pressures severely constrain choice, because alternatives are not possible. Given that individuals do not determine the social framework in which they act, we need to focus less on the individuals and more on how to transform the social conditions that create problems that, in turn, result in demands for service delivery.

We also recognise the interaction between individuals and their circumstances, and so the ongoing need for a direct-service response. A well thought out, socially and ethically sound approach to supporting people is required and it is here that we should put people at the centre of service reforms that recognises their particular circumstances, the right intervention/support required at the right time, delivered by the right service. This will give individuals the best chance to recover and thrive, and provides the best chance of interrupting cycles of disadvantage and social exclusion. Additional funds are required to support this admirable approach.

**1.1 What barriers get in the way of putting people at the centre of service delivery?**

**High Demand for Services**

The high levels of demand for homelessness and family violence services has forced funding to be concentrated at the crisis end of support, and forced services to divert further funds from case management to deal with ever-increasing levels of demand for a crisis response. It is impossible to provide a tailored response to each individual under circumstances where the latest Victoria police reports show a 40 per cent increase in family violence incidents in 2011-2012, with a parallel increase in referrals to specialist family violence and child protection services. Additional funding for family violence services for case management and children's counselling prior to the latest police figures was welcomed, allowing WHW to replace and increase our case management transitional support. However, demand for crisis and one-off support make this short-lived, with December, January and February referrals breaking new records.

**Crisis Driven Service Delivery Model**

Current government policy and service delivery tends to focus on those individuals with the most acute need, generating a crisis-driven service delivery model whereby people 'flip in and out' of eligibility for support programs. This leads to difficulties accessing services, as people in, emerging from or at risk of crisis are more likely to have transient lifestyles and residencies. These circumstances also impact on their ability to consider or respond to longer term interventions and support, let alone involvement in shaping the nature of service delivery.

**Reform Ripple Effect – Unplanned Impact of Reform**

WHW operates a refuge providing accommodation to women escaping family violence. Demand has resulted in increasingly restrictive eligibility criteria, with 'crisis' now defined in funding terms as four -eight weeks of support. WHW has found this length of support insufficient for some families and we have previously accessed transitional housing to provide longer term support. The model of allocating transitional housing was changed in 2012, however, and our access to this type of housing reduced, in turn reducing our capacity to provide longer term support. A key aim of the transitional housing allocation reforms was to open up and share this limited resource with other agencies. Unfortunately, the reverse has occurred for family violence services.

**Cost Neutral Funding Environment**

Individuals and families will continue to seek the services of crisis response programs as long as access to affordable housing is limited, employment for marginalised individuals difficult to attain and problems like violence against women rife. The state government must be prepared to commit additional resources to enable individuals and families to overcome multiple and persistent disadvantage if we are to achieve the goal of putting people at the centre of service delivery. Moving already constrained resources from one part of the system (e.g. crisis funding) to build the system's capacity to provide longer term support will only jeopardise our ability to respond to people and families in crisis.

**1.2 What needs to change to put people at the centre of the system instead of focusing on programs?**

Rather than an either/or approach, to ensure that people are at the centre of the system, there must be a balance between 'client-centred' services and funding for specific programs. Client-centred 'wrap around' services can be effective for those people accessing the service system who require high and sustained levels of support and who are already connected with the mental health and disability sectors. However, there are many who require only short-term engagement with services. Family violence crisis outreach response and the family violence police referral system are examples of program-based funding that work well to provide one-off or short term assistance to women and their children to access support and referrals to other services. These services are well-integrated, with established referral pathways between services to assist clients to navigate otherwise complex systems (such as legal, judicial, health care, housing, education, employment and counselling systems). In recognising that individuals and families have varying needs, protecting diversity in the types of services available remains an important component of a responsive and effective system.

**In order to focus on putting people at the centre of the system, it is essential that we commit to long term outcomes, and this means investment beyond election cycles**. To this end, long term visioning and appropriate funding must commit simultaneously to an injection of funds into prevention work to enable, over time, reduced need for crisis intervention, while recognising that there will always remain a need for some crisis intervention supports and programs.

Collaboration is also required to ensure that people are at the centre of the system. Working together across services and programs ensures that individuals and families are able to receive streamlined and holistic assistance and support.

In short, well integrated specialist programs such as the family violence service system result in better outcomes for individuals. This includes a reduction in lengths and levels of homelessness, missed schooling, exclusion from employment and entrenched intergenerational disadvantage

- **Recommendation:** Invest in long term funding for primary prevention and early intervention to decrease the need for crisis intervention
- **Recommendation:** Invest in a balance of specialist program-based and 'wrap-around' services depending on the needs of clients and the nature of the problems they face

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**Case Study 1**: An example of the benefits of a dual focus on people and programs comes directly from one of our clients, who was housed in our women's refuge:

It was a blessing to be in the hands of such a loving, caring, courageous, compassionate, respectful, understanding organisation. From my point of view, they are in an important role of empowering both women and children who have been living in family violence. It is an individual woman's responsibility to call out for help once they have experienced some form of violence because it is not acceptable to live in violence.

I went through a tough experience. I had no one to talk to about the violence I was living under, and most of the time I just wished I could reverse time and have no husband. I even thought people could just see through me and know that I was having serious trouble. I was afraid of everything. The moment I realised that my self-esteem was under my feet was the worst pain ever and it used to kill me inside when I look at my children.

One day when my ex-husband was at work, I got on the computer and googled to find somewhere to get help. The organisation called In-Touch came up and I called them instantly. I did not know where to start or even how to describe my problems, but they really had that sensitivity and they referred me to Women's Health West.

I have no words to explain Women's Health West now because I am settled, overjoyed and focused. I am a healthy mum and grandmother. Their assistance makes me feel like they are family. I was so scared at first when they said that I was going to live in refuge but when I got there, it felt so safe compared to living with an abusive partner. I got financial assistance, help getting a peaceful and secure place; they even partly assisted with the rent.

It was such an experience to live in one place with other women and children affected by violence. Life was made a bit easier in terms of security given the set up of the place. The rules and regulations of staying in the refuge are about human tolerance and somehow it does not make one feel like a prisoner of thoughts.

I underwent [legal] proceedings that were scary because it was my first time, but these had to be dealt with for me and my children's safety. In all this Women's Health West was my guardian. They helped me with every detail, were with me in court and through the whole process of all intervention orders.

The most inspiring aspect was the way victims of violence, or women in my experience,

are being handled. A lawyer was available with no charge. It is indeed a mind relieving situation to be under such a compassionate set up. It was my first experience in court but I had all the emotional support all the way.

With all my heart I appreciate and cherish their good work, and I trust their level of confidentiality. It's like they really know how to treat a human being. Good on them; it's a great challenging task to deal with different heart broken and affected women and children.

**1.3 What organisational approaches and workforce capabilities are needed to achieve this – in CSOs, in public service agencies or in government policy?**

Following the commencement of the family violence reforms in 2005/2006, a dedicated role of integration coordinator was developed to facilitate integration and support planning, implementation and evaluation in each region. WHW believes this has been an invaluable tool in successfully implementing the reforms, maintaining its cohesion and continuously evaluating its efficacy. This provides a model that could be used to inform relevant aspects of this reform.

It is also essential to support collaboration rather than competition between agencies. Competitive tendering, for example, creates an environment in which collaboration between services is hindered by the business requirements associated with competing for the same pool of funding.

Localised approaches to service delivery are also a necessity as the needs of communities can vary greatly and a 'one size fits all' approach to policy and funding has the potential to further disadvantage already disadvantaged communities.

Workforce capabilities, particularly in the community sector, are hindered by staff turnover, a lack of professional development funds and uncompetitive wages. To attract and retain skilled staff these issues must be addressed. WHW identifies this as a particular problem, as the sector is overwhelmingly constituted by women. Financial and workplace stress is linked with the feminisation of poverty, compounding throughout the life course. Failure to address these pressing workforce issues thus represents a failure to adequately identify and respond to gender equity while threatening sustainable, responsive, efficient and effective service reforms.

Government and the sector must shoulder responsibility for addressing these issues, by recognising and building on the enormous and valuable expertise that the workforce brings to services and the public. The Western Integrated Family Violence Partnership (WIFVP) recently submitted a proposal to fund a project to develop a collaborative professional development approach across all agencies in the partnership. Unfortunately funds were unavailable, despite wide support for this approach from DHS. Such initiatives represent cost-effective portals to not only attract and retain this invaluable public resource, but also improve service delivery.

- **Recommendation**: Recognise women's contribution to delivery of community services by investing in workforce development, flexible workforce policies and remuneration
- **Recommendation**: Reward existing service partnerships by providing funding to continue good existing and prior work, rather than through the imposition of new competitive funding processes

### 1.4 What models of partnership and coordination would help create a more people-centred system?

The Western Integrated Family Violence Partnership (WIFVP) is an example of a model that creates a more people-centred system. It is made up of five partner agencies that have agreed to provide jointly a range of service components (see section 9 for more details). Shared values and approaches to service delivery result from the different approaches of partner agencies – specialist to generalist, Indigenous to mainstream, women-centred to child-centred services. This is one of the group's strengths.

**Governance group**: The role of the governance group is to provide a strategic forum:

- for the monitoring and further development of the partnership
- to enhance delivery of family violence services for women and children in the western region
- to influence and advocate for enhanced services, public policy and legislation that responds to women and children who experience family violence
- to consider innovative ideas to further service integration across sectors

**Program operations group**: This group provides operational accountability for the development and delivery of shared service responses.

The WIFVP structure has three levels of participation/involvement: Consortium members, complementary and other service agencies:

**Consortium members** are those delivering or managing one or more of the service components. Consortium members are members of the WIFVP governance group either directly or through sector representatives such as the community health services lead agency model.

**Complementary partners** are agencies with critical relationships to the core WIFVP service components, including statewide family violence services such as the Women's Domestic Violence Crisis Service, In-Touch, refuges, etc. Complementary partners are generally working with the same client/family groups as those targeted for the WIFVP services. They may be generalist or specialist service providers that are already linked with the family violence system, or are likely prospective partners for the WIFVP at subsequent levels of integration. The relationships may take the form of:

- referrals
- co-case management
- case conferencing
- collaboration to add value to each others services
- joint practice development and system capacity building
- delivering brokered services on behalf of the WIFVP
- other specific value adding roles

Complementary partners are key participants in the WIFV Committee and play a central role in contributing to family violence service integration in the west.

The **broader service system** includes those agencies that may be working with the same target group, but in a more generalised way. These agencies are the key to providing women and children

with relevant mainstream services, especially after exiting from the family violence service system.

The experience of WHW serves to impress the crucial role that specialist women's health organisations play in representing the interests of the diversity of women and children in the western metropolitan region of Melbourne. Core feminist principles frame our work as we embrace the diversity of our client groups, and strive for inclusion, equity and social justice across the spectrum of our clients and communities. This necessarily requires a merging of specialist and generalist expertise and experience from a range of sources.

- **Recommendation**: Recognise and support the particular ways in which specialist women's health services organise their work through the provision of appropriate resourcing, and governance structures and processes

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

### 2.1 Where would capability-building initiatives have the greatest impact on improving outcomes for people and families?

Capabilities, as defined by the federal government's social inclusion agenda, are the skills and abilities individuals need to take up opportunities (Commonwealth of Australia, 2009). These include life skills such as the 'ability to communicate, negotiate, organise, manage time, raise children and understand and navigate services, as well as the skills and abilities developed through formal education and training' (Commonwealth of Australia, 2009: 3).

The community services system has an array of programs and services that are designed to support individuals develop their capabilities. For example, WHW works to build the capabilities of women and their children who have experienced family violence to overcome the trauma and impact of violence and abuse and to live safely in their community, while our financial literacy program supports newly-arrived women gain practical skills to navigate Australian financial systems. These are two examples of programs we deliver that build and enhance women's skills, confidence and capabilities.

The potential benefits of capability-building initiatives alone are limited when such initiatives are not accompanied by structural change that works concurrently to redress the social determinants of health. This is because social conditions that lead to inequity and disadvantage – be that poverty, gender, racial discrimination, poor access to education, transport, affordable housing and employment – constrain people's capacity to develop and use their individual capabilities (Robyns, 2005). Without structural change, the greatest impact capability-building initiatives can have is to increase individual resilience to disadvantage, rather than working in tandem with individuals to redress those inequities that result in poor health and wellbeing outcomes.

The Australian Social Inclusion Board (2009) provides an effective framework through which to consider capability-building initiatives. The framework demonstrates the interaction between resources, opportunities and capabilities. Here *resources* refer to the skills and assets – or the various types of capital, including human, social and economic – that people possess. *Capabilities* refer to an individual's ability (agency) to use resources and opportunities to achieve particular self identified and defined outcomes. *Opportunities* refer to the environment, or structures that enable

individuals to use their capabilities and resources to achieve their particular outcomes. This framework acknowledges that for a capability approach to be effective, the services system must work to ensure that communities have access to appropriate resources and opportunities.

- **Recommendation:** Capability-building approaches must be supported by work such as sustainable housing, income support, and legislative change that is designed to create broader structural change aimed at redressing the social determinants of health
- **Recommendation:** Capability-building initiatives must be guided by practice frameworks such as client focused, strength based, anti-oppressive and culturally safe that recognise and work to enhance people's access to resources, opportunities and capabilities

### 2.2 What could the system do better?

In order to achieve sustainable and effective outcomes for all Victorians, the community services system and in particular government must work to influence structural factors that cause disadvantage, and allocate appropriate resources to meet this aim.

A greater focus on primary prevention, population health and health promotion are integral to the vision of a healthy and fair Victoria. A population health approach focuses on improving health and wellbeing through priority health approaches that tackle the disparities in health status between social groups in order to achieve health equity. Population health focuses on a broad range of factors that influence health and wellbeing at a population level. Indeed, one of the most important and complex roles of our community services sector is partnering with others to influence the social determinants of health.

Population health interventions are essential in the health field, as working to redress the social determinants of health will prevent ill health and disease in a way that is both sustainable and cost-effective. Such an approach is complex yet pivotal, as integrated strategies that work to redress the social, economic and political determinants that drive ill health and disease represent the most effective method of achieving improved health outcomes, particularly among disadvantaged communities. WHW recommends a stronger focus throughout the reform process on the social structures and conditions that impact upon the health, safety and wellbeing of Victorians.

WHW also advocates for a strong focus on integrated health promotion within the community services system. Integrated health promotion involves agencies in a catchment working collaboratively on priority health topics, using a mix of health promotion actions and capacity building strategies to achieve health and wellbeing outcomes. Integrated health promotion engages collaborative partnerships, a balance of individual and population-based health promotion interventions supported by capacity building strategies, and the clear identification of key partners across a broad range of sectors in order to bring about change.

- **Recommendation:** Ensure that the community service reform has a stronger focus on primary prevention, population health and integrated health promotion interventions

**2.3 How should one balance the need to support people's immediate needs with the imperative to build their capabilities?**

A strong sustainable community service sector working in partnership with government is essential to ensure that vulnerable Victorians receive the support and services that not only respond to their immediate needs but also build their capabilities to live safe and fulfilled lives. To achieve this community services need to be responsive, flexible and sustainable. WHW receives funding to provide a continuum of support to women and children from crisis to recovery as a result of the introduction of the integrated family violence service system. WHW's case management services previously focused on providing a crisis response with little capacity to provide longer term support. The suite of services has enabled us to respond more flexibly to the multiple, diverse and complex needs of the client group. As a result, women report improved longer term outcomes for them and their children; and the majority of clients report that the amount of contact with their worker and the support period available is sufficient (Women's Health West Client Feedback Report 2012).

**Quotes From Client Feedback Survey** (see also case study 1)

1. My children and I are living in safe housing. I am living without violence and fear. I am mentally stronger than I have been for a very long time. We are happy.
2. With all the support I managed to get my life back to a point I felt comfortable and strong enough to return home to Sydney

- **Recommendation:** The community service reforms support a holistic view of client needs and capabilities and that agencies are able to better respond to this diversity through flexible client or program funding that reflects the very different journey to recovery between individual clients.

**2.4 What would need to change in the system to make it easier to manage the trade-offs?**

Please see responses above.

## Pathway 3: Develop place-based approaches

**3.1 Where are place-based approaches already being applied successfully in the system, and what factors make them successful?**

The identification of geographical disadvantage and the use of place-based approaches to address geographical disadvantages are key components of the federal government's social inclusion policy agenda. These concerns are now commonly embedded in practice frameworks for many sectors in Victoria. Evidence shows that disadvantage can be concentrated in particular places and that focused efforts concentrated within specific locations, neighbourhoods and communities can work to ensure that health and social inequities are redressed. Most importantly place-based approaches can support flexible and integrated local area planning, economic and community development, as well as service provision in locations where people and communities experience concentrated disadvantage.

There is an array of literature and practice knowledge that outlines key factors that contribute to effective place-based approaches. In a model where various sectors collaborate to deliver a place-based approach, factors that lead to success commonly include: a common vision; a clearly defined geographic area for action, shared objectives and defined strategies that are integrated and mutually reinforcing, defined roles and responsibilities, and a clear governance structure (Randolph, 2004; Byron, 2010).

**Case study 2: Example of an effective place-based approach to direct service delivery**

WHW use place-based approaches as part of our family violence service delivery. Place-based support is provided in the local government areas of Melton and Werribee, which are two of Melbourne's four designated 'growth corridors'. Population growth is forecast to increase by 42.1 per cent by 2022 in these areas (Department of Health, 2011). Staff travel to and from our central office to the place-based location, allowing WHW to provide peer support and supervision, debriefing, collegial support, etc to staff, while also enhancing accessibility for clients.

WHW's place-based workers provide family violence support to women and children who might otherwise be unable to access services and support because of social and geographic isolation and disadvantage. These workers operate as case-coordinators who assist clients to navigate the integrated family violence service system, and provide referrals to local agencies such as Victoria police, family and housing services, and counselling services that support crisis response and longer-term interventions. There are additional costs associated with this model, including rent and travel costs.

Workers regularly attend regional family violence networks to build upon existing partnerships and share knowledge of new programs. The success of this approach lies in building collaborative partnerships and networks with key local agencies to deliver integrated family violence services to women and children in Melbourne's outer west. Central to this integrated approach is the use of a client-centred, strengths-based model that empowers women to make informed decisions about their options and their futures.

- **Recommendation:** The reform process must recognise and build on the good practice placed-based approaches that already exist within the system
- **Recommendation:** Capital investment in service hubs is required to house place-based approaches, as well as recognising the additional costs associated with this approach

### 3.2 What changes are needed to align people-based and place-based approaches in the system?

There is a long history of debate between the relative merits and value of place-based versus more mainstream people-based policy and practice (Byron, 2010). Many social policy researchers have argued that positioning the two approaches as a dichotomy is unhelpful. Rather, placed-based approaches are complimentary to – as opposed to a replacement for – people-based approaches, where the breadth and complexity of specific locational disadvantage requires the concentrated efforts of a suite of services and support (Randolph, 2004; Byron, 2010). Ian Bryon insists that the success of place-based approaches is 'largely contingent on the extent to which targeted place-based policies and mainstream people-based services and support are integrated and mutually reinforcing' (2010: 21).

There are various models that can support the alignment of people-based and place-based approaches in the Victorian community services system. A specialist service, such as WHW's family violence service, is a prime example of how organisations can effectively use both people and place-based approaches. WHW has a unique regional mandate to improve the health, safety and wellbeing of women and girls in Melbourne's west. Located in Footscray, women from the seven local government areas of Brimbank, Hobsons Bay, Maribyrnong, Melbourne, Melton, Moonee Valley and Wyndham access our service. Recognising that women affected by family violence experience a range of access barriers, we provide a co-located place-based service in two growth corridors where infrastructure and services are scarce (see case study 2 above).

An alternative place-based model involves having numerous services and sectors working in partnership in a specific location. This model includes bringing together organisations offering a diverse range of partners with a shared mandate to work with specific disadvantaged population groups. The model has a greater capacity to improve population health and wellbeing, and increase opportunities for community participation through collaborative action, redress the social determinants of health, establish environments that promote health and wellbeing, and thereby reduce health inequities.

**Case study 3: Example of an alternative place-based approach**

Over the past three years, WHW has led the development of *Action for Equity*, which is Victoria's first regional sexual and reproductive health promotion plan. This plan for Melbourne's west is underpinned by collaborative partnerships and uses both place-based and people-based approaches. It is a primary prevention plan designed to prevent sexual and reproductive ill-health before it occurs by working to redress the specific social determinants of sexual and reproductive health. *Action for Equity* was developed by WHW in conjunction with a regional partnership comprised of community health services, local government and a number of ethno-specific organisations. This work is best led by a specialist women's health service as we have given priority to, and specialised in, sexual and reproductive health promotion over more than a decade and will continue to do so into the future.

As previously mentioned, effective place-based approaches must work to enhance social infrastructure and community facilities in order to alleviate disadvantage. This is important in providing opportunities for community inclusion, participation and social connection. For example, access to affordable, safe and reliable transport (both public and private modes of transportation)

greatly increases women's capacity to participate in their community; to engage in work and educational opportunities, access health services and programs, and join in social and sporting activities. Indeed, research suggests that men and women experience transport differently; women are less likely to have access to a car and are more likely to walk and use public transport. Infrastructure that is poorly maintained (such as poor lighting, low levels of natural surveillance, cracked footpaths and graffiti) can greatly influence how women perceive and experience safety in their local area (GELG, 2012). It is imperative that place-based approaches commit to designing and maintaining community infrastructure that is inclusive, safe, and responsive to the different needs of women. This includes taking into account the differing needs of women – particularly those with dependent children, women with a disability and older women.

- **Recommendation:** Placed-based approaches need to be viewed as complimentary to people-based services and support.
- **Recommendation:** The reform agenda must prioritise both place-based service response models and place-based prevention work to ensure a healthy and fair Victoria.

**3.3 What roles should different stakeholders (for example, CSOs, public service agencies, local government, community advocates) have in delivering effective place-based approaches?**

In considering the unique and differing roles and responsibilities of various sectors in delivering place-based approaches it is essential that efforts are complimentary and mutually re-enforcing.

Clearly each of our three tiers of government play a key role in policy development and implementation, land-use planning and design, the provision of community infrastructure and the funding and delivery of services. Governments have a unique ability to establish built environments that promote health, safety and wellbeing.

In Victoria the women's and health promotion sectors including primary care partnerships are well established as leaders and innovators in primary prevention and population health initiatives that embed the social model of health across catchments, and within specific locations. WHW has led and participated in a number of collaborative initiatives in the western metropolitan region that have resulted in innovative strategies for planning, delivering and evaluating services across the spectrum of primary prevention to tertiary intervention. Indeed, community and women's health services provide a broad range of programs and specialist health services, most commonly delivered in community-based settings. Community health and primary healthcare services seek to intervene early to slow and prevent ill-health and provide a strong a platform for the delivery of a range of primary health services and health promotion actions to disadvantaged population groups.

There is clear evidence available to support the fact that women and children experience better outcomes where there are specialist women's services available.

- **Recommendation:** Place-based frameworks must acknowledge the unique roles, responsibilities and specialist expertise of different organisations and sectors.
- **Recommendation:** Specialist services should continue to be funded

**3.4 What are the main risks of using flexible, place-based approaches in the system and how can they be mitigated?**

A key challenge associated with place-based approaches is that they do not automatically equate to better coordination or integration across different spheres of policy or practice. The presence of separate silos of government funding, policy-making and service delivery can function as systemic

barriers to providing effective place-based approaches. A case study of a place-based initiative undertaken in western Sydney found that 36 separate programs across 13 different government departments were operating with different methods and within different location boundaries (Randolph, 2004). Hence, the need for a consistent overarching framework to guide implementation and integration is essential to the success of place-based interventions.

Julia Griggs et al (2008) in their assessment of person and place-based policies found that most policies designed to redress disadvantage either target individuals directly, or focus on areas with the objective of directly benefiting residents. Very few policies focused on identifying logical synergies between people *and* place or indeed structural factors leading to disadvantage and health inequity (Griggs et al, 2008). While research shows that over and above the personal characteristics of the people living in a location, it is the factors such as limited social, educational, employment, health and recreational resources that contribute most significantly to disadvantage. These limiting factors and the disadvantage that they tend to import are coupled with stigma and discrimination commonly associated with living in a particular location, along with the lower levels of social capital and social connections associated with living in disadvantaged neighbourhoods (Australian Social Inclusion Board, 2010).

There are therefore inherent tensions associated with place-based approaches. Communities may become isolated and stigmatised, thus ultimately requiring policies to respond to that isolation. Additionally concentrating resources in 'growth corridors' may occur at the expense of resourcing other areas of disadvantage, running the risk of engendering isolation and exclusion. Growth corridors, while attracting resources, may fall prey to private developers not attending to their financial commitments and obligations to resource new communities adequately. Therefore, unless place-based policy and practice works to improve social and economic conditions that determine the health and wellbeing of a community, place-based approaches are unlikely to be effective or sustainable, and perversely may compound and amplify challenges to equitable and good outcomes.

- **Recommendation:** Place-based approaches require a consistent overarching framework to guide implementation and ensure collaboration and integration across different sectors and spheres of policy and practice
- **Recommendation:** Place-based practice must focus on synergies between people and place and work to redress structural factors that lead to disadvantage and health inequity

## Pathway 4: Recognise and reward good outcomes

### 4.1 How realistic is it to re-focus the community services system around outcomes?

The desire to reorientate the community services system to focus on outcomes (as opposed to inputs and outputs) is undoubtedly a long-term process of reform. While such an approach is achievable and has the potential to ensure that people receive more holistic service provision, it requires significant political will, adequate funding and support from the community services system.

A focus on outcomes and the extent to which an intervention has achieved its intended results first requires a consideration of how outcomes are defined and by whom. A key aim of the reform agenda is to 'put people at the centre' of the system by supporting them as active participants who make service system decisions on their own behalf. This marks an important shift in approach from those previously and strongly suggests that clients and communities must determine what the system outcomes need to be. For this approach to be successful, the reform process must be underpinned by a client and community participation strategy that promotes inclusive, purposeful and responsive service interactions and that ultimately recognises that clients are the experts in determining whether or not a program or service has improved their lives.

Another key consideration in refocusing the community services system around outcomes lies in

recognising the challenges inherent in measuring outcomes. This is particularly salient in prevention work that is designed to redress the social conditions impacting on population health and wellbeing.

**Case study 4: Example of the difficulty in measuring outcomes of primary prevention work**

Health promotion primary prevention work is designed to improve the social and cultural conditions that determine health, safety and wellbeing. Measuring the outcomes associated with long-term prevention work is therefore challenging. WHW's work to prevent violence against women is a case in point.

In the context of monitoring efforts to eliminate violence against women, outcome indicators are those that measure a reduction in the prevalence and incidents of violence against women. However, the rate of violence against women measured by police reports is notoriously unreliable given underreporting. Additionally any increase in reported rates should be perceived in a positive light, as it indicates that women are accessing support and making active choices not to accept violence. Hence, the measurement of 'proxy indicators' is recognised as good practice in the evaluation of primary prevention efforts. A proxy indicator is a measure that approximates or represents a phenomenon in the absence of a direct measure.

There is growing international literature and consensus that primary prevention action can prevent violence against women before it occurs, when prevention efforts are targeted at the social determinants of violence against women (e.g. by promoting equal and respectful relationships between women and men). Given the limitations around measuring outcomes, this work focuses on evaluating proxy indicators that demonstrate an increase in protective factors (e.g. an increase in gender equity indicators that have come about as a result of the intervention.

It is also important to consider the differences between measuring system outcomes in theory and practice. In theory, clients in partnership with the community sector would lead the development of a series of outcomes, develop valid and reliable measurement tools for these outcomes (including unintended outcomes), use these tools to measure change for clients over time, and demonstrate a cause and effect or correlation connection between the service provision and the outcomes.

In practice, however, the community services system is dealing with increased demand, rising expenditure and escalating cost pressures with limited, if any, additional funding or resources. The sector's ability to meet increased client demand is consistently challenged. As a result, there is a conflicting demand between resource use for direct service provision and resource use for data collection and the measurement of outcomes.

The system also encounters a range of practice dilemmas that complicate the service sector's ability to measure outcomes. For example, many organisations within the system provide short-term case management services that impede the ability to track and measure long-term outcomes. Further, these organisations and the programs and services they provide are only one part of the service system. Without integrated data sets, services only have the ability to measure individual program and service outcomes, as opposed to systems outcomes.

There are also conflicting demands between good service delivery practice and good measurement and data collection processes. Most notable are the tensions between client confidentiality and data collection methods. It is these practical implications associated with refocusing the community services system around outcomes that must be resolved, ultimately indicating the need for additional resources for research, monitoring and evaluating, if such an approach is to be viable.

This is notwithstanding evidence demonstrating better outcomes for women and children when specialist women's services are accessible. For example, violence against women (VAW) has increasingly come to be seen as a violation of human rights and an important concern for social policy, with many countries, including Australia, adopting comprehensive policies to combat the problem. Using an original dataset of social movements and VAW policies in 70 countries over four

decades, evidence shows that feminist mobilisation in civil society – rather than intra-legislative political phenomena or economic factors – accounts for variation in policy development. In addition, autonomous movements produce an enduring impact on policy through the institutionalisation of feminist ideas in international norms (Htun & Weldon, 2012). The key is investment in research that enables the identification and analysis of those outcomes.

- **Recommendation:** Community service system outcomes need to be determined by the clients and communities who access these services and supports
- **Recommendation:** Alternative outcomes measures must be designed to effectively measure prevention and health promotion interventions
- **Recommendation:** Additional resources are required for research, monitoring and evaluation in order to effectively measure service system outcomes
- **Recommendation:** A research agenda that develops the necessary suite of theoretical, methodological and research resources and processes to demonstrate what works and why e.g longitudinal studies with hubs or portals to nest pilots and other locally based studies is required in order to demonstrate the human and economic value of prevention and early intervention work

**4.2 Where in the system is an outcomes focus most, or least, appropriate and feasible?**

This question must be premised on the acknowledgment that the community services system works with a diverse range of clients and communities with highly complex needs. Experiences of poverty, long-term unemployment, homelessness, drug and alcohol (ab)use, family violence, mental health difficulties, systemic discrimination, among other complex experiences, is the norm for many clients who access the service system.

WHW therefore strongly suggests that an outcomes focus is most appropriate in the context of a systems approach, rather than an approach that examines individual program or organisational outcomes. Such an approach is necessary when measuring outcomes, as holistic service and program provision is dependent upon numerous organisations partnering to achieve a coordinated and integrated response.

A case in point is WHW's family violence service, which forms part of the Victorian integrated family violence service system. Positive outcomes for women and children who use our services are dependent upon specialist family violence services, legal and statutory services and mainstream services working in an effective and coordinated manner. While the desired outcome for women and their children who access our services is enhanced safety and a life free from violence, this is only achievable when the system operates effectively, and when men who perpetrate violence are held to account for their behaviour. A reform agenda designed to enhance collaboration and integration by measuring systems outcomes is the most appropriate and feasible option.

In relation to direct work with individuals, outcomes-based funding does little to address entrenched disadvantage because it provides perverse incentives to avoid working with people with complex needs, as there is little likelihood of demonstrating positive or immediate outcomes. An outcomes-based funding model may in fact encourage work with populations in which change is easier to demonstrate.

- **Recommendation:** A focus on measuring outcomes at a systems level is preferable to measuring individual program and organisational outcomes

**4.3 To what extent is it possible to provide better measures of the outcomes of government expenditure on services (for example, assessing the social returns on public investment)?**

This strikes us as a question to ask social economists! There is an enormous amount of evidence that could be sourced with time and resources.

**4.4 If there was better data on outcomes, what would be the most effective ways to recognise and reward positive outcomes?**

Policies addressing rewards based on outcome require careful consideration. By its very nature service delivery that aims to address social exclusion and evaluate outcomes is challenging: the very task of identifying valid and sensitive outcome indicators alone is challenging. This is compounded by the reality that such agendas require long term resource commitment, both in terms of cash funding, but also and importantly in terms of the sustained presence of key personnel working at the human services level – a major challenge in itself. The risk of rewards-based funding is that the policy could engender a segregated system whereby organisations focus their efforts where positive outcomes are more likely and easier to demonstrate than if they had invested in the more complex and challenging work associated with responding to socially excluded individuals, groups and communities.

- **Recommendation**: If outcomes were to be recognised and rewarded, the reward model must be carefully calibrated against sophisticated assessments based on social profiling that positively discriminates for appropriately funded programs that identify and respond to the particular characteristics and articulations in a service context of social exclusion

**4.5 How would an outcomes-focus foster (or potentially hinder) innovation and/or sharing of best practice?**

A service system that works in partnership with clients and communities to develop agreed upon outcomes can be a catalyst for innovation. An outcomes focus allows services and the sectors greater autonomy and the ability to use their expertise to develop flexible and responsive processes and practice.

On the other hand, agencies are less likely to share ideas and information where they are – or perceive they are – in competition for funds.

- **Recommendation**: Reward existing service partnerships with funding on the basis of continuing good work, rather than through the imposition of new competitive funding processes

## Improving how the system is funded

## Pathway 5: Consolidate government funding programs

The reform proposal in pathway five of this discussion paper is difficult to respond to as it is not clear with whom the proposed consolidated funds would sit; what programs would be merged, and how an individual would access services across different merged activities. There appears to be an assumption that poor 'outcomes'; the absence of 'holistic' service provision; incapacity to redress 'multiple disadvantage'; and increased administration creating system 'burdens', have been directly caused by an increase in the number of specialist services. The focus might be better placed on the

causes of disadvantage that lead to individuals requiring specialist services, or the causes of our incapacity to develop efficient service delivery processes once the sector reaches a certain size.

Additionally specialism, we argue, must be seen as an integral part of any service system that seeks to be sensitive and responsive to diversity. The merits of specialist women's health services, and the significance of their being founded on the principles of equity, justice and inclusion as actively embracing diversity, have already been outlined in this response. Funding programs that do not identify the diversity within service provision requirements but instead lean towards uniformity and standardisation across the sector are not likely to be optimally responsive to clients or their providers and proxies, and thus do not optimally serve efficiency and effectiveness.

The discussion paper does not mention the challenge in monitoring the activities of funded services, despite the fact that much of the burden of reporting results from this.

There are a range of funding models that are relevant for different sections of a diverse community services sector meeting diverse needs. For instance, block funding is most appropriate for women's health services, while disability services would benefit from a client-based funding model focused on a holistic and person-centred approach to funding.

A comprehensive description of issues requiring reform in the disability field is well articulated in the recent inquiry into disability care and support (Productivity Commission 2011). Similar issues occur in all areas of the community service sector. The report 'Disability expectations: Investing in a better life, a stronger Australia' (PricewaterhouseCoopers, 2011) echoes the same themes identified by the Productivity Commission. Of particular note in the PWC report for our purposes is its redress of challenges facing specialist support agencies in the current system:

> 'despite providers' best intentions to put the individual at the centre, the principal customer is government…Workforce challenges are one of the sector's main obstacles…Support organisations currently have difficulty coping within a system that is failing and this drastically limits their capacity to innovate' ( PricewaterhouseCoopers, 2011, 38).

If funding streams were consolidated the system could expect to continue failing if the principle customer continued to be government. This is because compliance administration would remain the same. Presently, service audits, funding application processes and compliance activities all centre around risk management goals and policy-defined outcomes, rather than on service user satisfaction and improvements in holistic wellbeing.

Consolidated funding is not likely to dramatically reduce obstacles to holistic service delivery alone, nor is it likely to automatically increase collaboration between services. Ethical work cultures, effective communication, contained bureaucracy, and processes that foster service user control over what assistance they receive are the keys to holistic service provision. Similarly, effective collaboration between services is better achieved through staff retention, a mutual understanding of the individuals' expressed needs and barriers, service agreement on who has authority and responsibilities in relation to joint activities; and time to action agreed tasks. These ambitions are best supported where there is a shared culture based on reflective practice and learning, and shared broad and long term goals that are enabled to develop over time without the distraction of reacting to insecure or competitive funding.

The system will also continue to fail if demand exceeds resources, and where there isn't an injection of capital funds that seek to achieve long term outcomes that outlive any one political term, regardless of the funding model and client group. Without this investment the service sector will continue to be crisis driven and frustrate the long term goals of preventing injury, ill health, exclusion and disease at the individual and population levels.

**5.1 What are the major benefits for CSOs or service users of consolidating program funding?**

The potential benefits of consolidating funds is a limited short term reduction in compliance reporting administration and slightly more cost effective reporting processes (including the use of technology to do so)—depending on how it is done.

Consolidating also has the potential for better monitoring of individual access to funds. However the benefit of improved monitoring is entirely dependent on how that information is collected and how it is used. If not collected or used appropriately it would create more risks than benefits (explained in 5.2).

**5.2 What are the major challenges or risks associated with consolidating program funding?**

The major risks include:

- The removal or diluting of specialist services and the outcomes they currently achieve.
- The merging or grouping of 'programs' in a way that limits choices for individuals if they don't have needs that are similarly grouped.
- The mainstreaming of services implies fewer and larger services, reducing choice for the service user and leaving them with fewer alternatives if they are not happy with a service. In addition, there is a tipping point for services when they become so large that the administrative processes created to support them develop a life of their own. When this happens the pathway for service users to obtain assistance becomes extremely laboured and leads to poorer outcomes.
- If consolidating funding results in better monitoring of the total amount of funding any one individual receives this could result in services effectively reducing the funding received by some individuals in order to increase the funding accessed by others. This would result in a 'robbing Peter to pay Paul' scenario. Spreading disadvantage more evenly across services users is not the same as reducing disadvantage over all, and the latter should be the sector's priority.
- The merging of funding also has the potential to hide underfunded areas as specific need is no longer tracked and identified. For example, disability facility-based respite funding data does not capture the fact that some individuals are residing permanently in respite facilities because they have become homeless.
- A loss of specialist knowledge both in the community services sector and within government, as services become homogenised and individuals a 'jack of all trades'. This approach could lead to knowledge and policy vacuums.
- Large services with a greater capacity to present and submit for funds end up with a monopoly on services regardless of their expertise or capacity to deliver client-centred services.
- Small, localised and/or client-driven services that are responsive to/champion local needs and reflect and value client experience in the development of services lose their funding or become 'swallowed up' in larger services.
- Government loses the value of local knowledge, on-the-ground services, client experience and volunteers.

- **Recommendation:** Ensure that specialist services are not diminished
- **Recommendation:** Put plans in place that protect service users from getting caught between program groupings if their needs are not grouped the same way
- **Recommendation:** Set a limit on the size that any one service can become as a consequence of merging

**5.3 Are there types of services that consolidated program funding would work best or poorly for?**

The consortia-based funding model that now applies to the provision of family violence services has worked well and increased the capacity of the sector to provide a broader range of integrated specialist services able to work closely and collaboratively with mainstream service providers.

Whichever funding model may be adopted in the future, it is essential that specialist family violence services for women and children, and independent women's health services are properly maintained and funded.

**5.4 What is needed to minimise the impact and maximise the benefit of consolidating program funding?**

Minimising the impact of consolidated program funding requires that any new reporting or application processes are less onerous than the ones currently in place. Usually the biggest issue for staff in both government and non government services in relation to new reporting processes is that they lose a lot of valuable time trying to interpret what information is being asked for.

Equally important to finding the optimal funding models is the modelling of a system that enables clients to access the right service at the right time. Pathways to services can become inefficient and cumbersome, especially when a client has overlapping needs. The 'single conversation' is a model of streamlining services for clients with complex needs but who usually have a primary need for stable housing. This involves clients telling their story once, rather than undergoing multiple telling. Typically the single conversation adopts an integrated case management model. Central to this model is the rationalisation of reporting and application processes.

## Pathway 6: Adopt different funding models

A guiding principle with respect to funding programs is that different services require different funding models because their practices, client groups and deliverables are entirely different. As a case in point, WHW provides services across the prevention, early intervention and response spectrums. Appropriate funding models must recognise and support the challenges in these very different work practices. Long term funding and funding frameworks that support rather than jeopardise partnership are not only most appropriate, but are also imperative to success.

**Funding for women's health services**

The proposed funding model must reflect the long-term goals of prevention and should not adopt a one-size-fits-all approach. Competition for funding would hinder the delivery of services, rather than facilitate effective and efficient use of funds.

WHW proposes a mix of funding types across the community services system to accurately reflect the work being carried out by different services. Because many women's health services are focused on prevention, long-term change, and population-wide measures, the four funding models proposed in the discussion paper are not suitable to purpose and desired outcome.

Women's health services and others working in prevention argue that, funding must be long-term in order to reflect the nature of prevention work. Funding cycles of 15-20 years reflect the type of investment that demonstrates the potential of preventative efforts to deliver positive outcomes.

Block funding would represent the most appropriate funding model for preventative services, by acting as a long-term investment for government to achieve long-term outcomes. Block funding would provide a fixed sum of money to women's health services to use to pursue broad goals. It would allow women's health services, through their agenda to share common goals, to use different approaches to achieve those goals. It would allow for flexibility and creativity. Block funding is currently used effectively in Victoria in many small regional hospitals.

***Client-directed funding***

**6.1 How far should client-directed funding be extended beyond disability services into other areas of community services (for example, aged care, community mental health, access to training)?**

It is worth considering whether individuals would 'purchase' advocacy, health promotion or population-wide preventative health initiatives. Although delivery is not always individually based, the value of these services is undeniable.

Prevention is the most efficient way of addressing the growing burden of disease and its associated costs. Treating the range of preventable conditions that impact on women costs the economy billions of dollars. Investing in the prevention of adverse health outcomes for women ultimately delivers a healthier, more productive economy. Research has found that preventative approaches that address environmental and social conditions 'were generally more cost-effective than clinical interventions or non-clinical, person-directed interventions' (Chokshi & Farley, 2012).

Many community services, especially those that are likely to be involved with the individual and/or family long term, are best suited to a client-centred approach that ensures that interventions are collaborative and individualised, and seek to empower the individual to direct the intervention and assess what resources are needed. Groups with the greatest need for continuity of support that could break the cycle of disadvantage include young people leaving state care, families at risk of involvement with the child protection system, prison leavers and people with severe mental illness.

While some programs run by women's health services are client-directed, the majority of the work of women's health services is not direct service delivery. Instead, the focus is on population-wide improvements to women's health. Both types of programs are important to the community services system.

The discussion paper notes that client-directed funding relies on clients having sufficient information and support to navigate available services and make well-informed decisions. Women and children experiencing family violence are in crisis and so in desperate need of help when they are first referred to/contact our service. Our goal is to ensure their safety and then support them to make informed choices in dealing with a range of legal, health, housing and child-related issues.

Client funding would need to be sufficient to meet often complex support requirements for extended time periods. Simultaneously, service providers require sufficient funding to ensure an

appropriate crisis response during transition to any direct client funding arrangement.

A potential risk arising from client based funding in a constrained fiscal environment at both state and federal level is that client funding provision may not meet the full suite of client needs and that clients may then return for further support by crisis agencies with reduced funding and capacities for additional response. There is a well-recognised pattern for many women experiencing family violence of returning to and leaving their perpetrator partners several times during the course of the violence. This is often linked to lack of safety, housing options or poverty.

The client-directed funding model requires additional elements like policy advocacy, research and evaluation, consumer engagement and workforce development. It is a concern with the current National Disability Insurance Scheme (NDIS) that workforce development on specialist issues such as violence against women with disabilities and/or mental illness will be extremely difficult to put in place because services will be seeking to be competitive and deliver at the cheapest price.

Any introduction of client-directed funding in conjunction with structural consolidation across the service sector would need to be implemented carefully and phased in to avoid degrading existing support services that are already under heavy demand pressures.

Client-directed funding is unlikely to be a sustainable model for smaller organisations that are not part of larger service delivery consortia.

- **Recommendation:** Funding models must be tailored to support the particular purposes of the range of providers
- **Recommendation:** Specialist women's health services must be provided with long term and ring-fenced funding to acknowledge the long term goals of their work

**6.2 What information and support is required for people as they move to client-directed funding?**

Other relevant services will have greater expertise in answering this question.

**6.3 What is the best way to manage the trade-off between giving an individual flexibility to make his/her own decisions and ensuring they use funds for their intended purpose?**

Other relevant services will have greater expertise in answering this question.

***Outcomes-based funding***

**6.4 In what areas is outcomes-based funding most appropriately provided?**

Outcomes-based funding is appropriate in contexts where outcomes can be easily measured, are directly relevant to improving outcomes for individuals, families and communities, and where there are sufficient funds available to support research and the building of tools that measure the outcomes we desire. Forms of evaluation and evidence generation that isolate single determinants such as the health risk associated with cigarette smoking or obesity, are more readily 'proven' or not, but this is at the cost of distilling out the broader social and cultural context in which people live their lives, and through which social determinants of health are amplified.

This relates to a broader question around how and what services are valued and their contribution evaluated. The temptation is to model all programs and interventions on those that most readily demonstrate a predetermined outcome. This 'gold standard' is championed by academics, policy makers and practitioners alike, but it does not recognise the complexity and inextricability of the significance of multiple determinants and importantly the power structures that inform this complexity. Despite some shifts in social medicine and related disciplines in a promising direction we still largely lack a vocabulary that adequately recognises this complex interplay, and our research and broader program funding agendas remain as largely paying lip service to reforming to this end.

- **Recommendation**: Outcome based funding remains inappropriate for community development-informed projects
- **Recommendation**: The research, policy and practice sectors work to redress the current program funding model such that different project models are appropriately resourced to demonstrate different types of outcomes

**6.5 Are there areas in which outcomes-based funding is unrealistic?**

For women's health services and others working in health promotion, outcomes are long-term in nature – women's health services and health promotion organisations routinely evaluate the *impact* of their work, rather than long-term outcomes of their work. A funding model based on short-term outcomes will not encourage long-term change and is ill-suited to funding preventative efforts. Programs to prevent smoking or skin cancer are good examples of long-term health promotion campaigns that have resulted in lasting change. Had these interventions been constrained by funding restrictions to working within a short-term, outcomes-based model, these demonstrated long term results would not have been achieved.

In relation to direct work with individuals, outcomes-based funding does little to address entrenched disadvantage because it perversely provides incentives to avoid working with people with complex needs, as there is little likelihood of easily demonstrating positive or immediate outcomes. An outcomes-based funding model may in fact encourage work with populations in which change is easier to demonstrate. Such an observation is clearly and directly in contradiction to the aims and ambitions of *Closing the Gap* policy directives.

- **Recommendations**: see above

***Consortia-based funding***

**6.6 What is needed to make consortia work effectively and to ensure accountability? Does government have a role in the creation of consortia?**

The consortia-based funding model that now applies to the provision of family violence services has worked well and increased the capacity of the sector to provide a broader range of integrated specialist services able to work closely and collaboratively with mainstream service providers.

While consortia-based funding can be effective, it is not appropriate for women's health services as the bulk of the work of those services is not client-based service delivery.

See our response and case study in section 1.4 for an example of an effective consortia-based funding model within a direct service delivery system. This model was developed as a direct result of government support and funding for an integrated service system.

- **Recommendation**: Whichever funding model may be adopted in the future, it is essential that specialist family violence services for women and children, and independent women's health services are properly maintained and funded

***Area-based funding***

**6.7 How can one manage the risk that an area-based funding approach generates, specifically that communities may have different approaches and different outcomes?**

There are nine regional women's health services and two statewide women's health services in Victoria. Area-based funding, in which local governments are responsible for deciding how to meet the needs of their residents, may mean that small, specialist organisations such as women's health services are not, or are under, supported.

The immediate challenge of area-based funding is the disparity in funding and service provision between different areas of Victoria. In many parts of the sector, access to services in regional Victoria is not comparable with access to service provision in the metropolitan area. In other parts of the sector, including services for Aboriginal people, services are restricted to rural and regional areas, and there is limited availability in urban areas. If area-based funding were to be applied according to a methodologically consistent, needs-based analysis, substantial new investment in service delivery would be required across the state.

Similarly, area-based funding must be based on service delivery within strong, collaborative community partnerships with stable funding sources. Investment in the development of community partnerships with strong governance frameworks and in leadership to undertake the necessary research, analysis and planning to guide investment, is key. Similarly, short term grant-based funding, with its high compliance and reporting obligations, works against successful area-based approaches. WHW has extensive experience of the time commitment required to establish partnerships that lead to a workable area-based approach, such as *Action for Equity* (see case study 3) and *Preventing Violence Together* (see case study 8). If appropriately resourced, these approaches can have significant outcomes for vulnerable populations.

Drawing on existing evidence, successful implementation of area-based funding on a scaled-up basis will also require harmonisation of federal, state and local government policies, programs and accountability requirements. Political and budgetary cycles do not readily align with longer term planning and funding commitments.

There is nothing inherently contradictory between a number of the funding models presented in the Shergold discussion paper. Family violence services operate as sectoral consortia, are regional and local in their focus enjoying strong community support and directing their funding to deliver contracted services for clients with the objective of improving their life outcomes.

Area-based, rather than centrally-administered, services established as cost-saving measures are common in the United States of America – one clear example being the education system. The resulting disadvantage that is entrenched in schools in poor areas; and the lack of progressive policies or programs in conservative areas (for example a refusal to incorporate sexual and reproductive health programs in schools based on other than 'abstinence' models) has further entrenched poverty and disadvantage – and similarly, wealth and privilege – with little opportunity to bring about changes that will benefit the most vulnerable.

- **Recommendation**: Whichever funding model may be adopted in the future, it is essential that specialist family violence services for women and children, and independent women's health services are properly maintained and funded to work in partnership with others

**6.8 What is needed to deliver best practice (including building capabilities) between communities?**

Where approaches develop particular and localised solutions to local problems within the context of a central policy framework based on equity and social justice, area-based approaches are likely to be more successful. If left with a policy vacuum, short-term and/or inadequate funds, without local champions, or without support for ensuring an equal voice for disadvantaged and marginalised communities, such approaches can further entrench problems. See above for further details of requirements for best practice.

- **Recommendation**: That local government authorities and community and women's health services be recognised as leaders in the development and implementation of a responsive population-health, research and policy making cycle

## Pathway 7: Explore the range of social finance opportunities

**7.1 Where is 'social finance' currently being used successfully in Victoria and what characteristics influence success?**

It is unclear where social finance is being used successfully in Victoria, although in theory groups such as Foresters and community banks advertise access to such funds. Amounts large enough to purchase capital assets, such as buildings, are limited where organisations do not already have capital or assets to offset any loans.

It is likely that social finance investors will be limited by their desire for 'innovation' – on one occasion when applying for funds WHW was told 'we didn't ask for something that works, we asked for something that was innovative'. Larger organisations and popular causes (often already well funded) are more likely to be successful in applying for funds, given their greater capacity to positively influence the market the social finance company seek to attract.

Characteristics like ethical investments influence the way in which opportunities might fit with the mission and values of organisations.

**7.2 What opportunities and challenges might arise from the range of social finance initiatives that are emerging?**

WHW is currently exploring the possibility of securing finances to refurbish an identified premise that might be available for long-term, peppercorn lease. If successful, this will provide long term sustainability, security and prosperity for the organisation and our clients. Our concerns are especially heightened because of recent cuts to our funding, and the threat of further cuts. This case study demonstrates the challenges and barriers that we are encountering.

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**Case study 5: The challenges in attracting social finance**

WHW have explored access to social finance initiatives to support the refurbishment of a building from where we can deliver services. Increasing rental costs are pricing us out of the market in areas that are accessible to our clients. We have in turn approached two community banks for a loan to support this venture. While the banks have confirmed our ability to service a loan of the amount required, they are less than willing to provide a loan unless it is secured by a registered first mortgage. This might include taking on a leasehold. However, any leasehold must be marketable, such that it would have value and be readily saleable to an open market, requiring a quite specific, long-term and unrestricted lease. However, it is very difficult to get council approval for a leasehold that is not restricted to one lessee, and for a specific purpose. In turn, banks are concerned if leases are not freely saleable/transferable e.g. from a women's health service to a real estate agent - or even to a brothel. Understandably council is loath to provide such a leasehold, and deals remain hinged on whether or not we can secure a marketable lease. Every restriction council places on a lease will impact on a bank's ability to 'on-sell' the lease to recover the loan in the event that we defaulted on repayments. Watering down the lease through restrictions to its marketability diminishes security. The other options are for the bank to have a fixed and floating charge over the agency in the event of non-performance over the contract, potentially resulting in the bank winding up the organisation. Neither our board nor funding bodies would, nor indeed should, support such an option. Our remaining option is to place a matching term deposit with a bank. However, this creates difficulties for agencies without additional funds. Having government guarantee a loan against funding would greatly facilitate us.

- **Recommendation**: Government support the growth and sustainability of small essential services by adopting a business model such that they become guarantors in certain circumstances

**7.3 What should be the role of the government in facilitating further uptake of social financing?**

See above

## Improving how the system operates

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

We have not had time to adequately respond to this complex series of questions and so will leave them to other agencies for response.

**8.1 What needs to change to make current roles and responsibilities more seamless and effective?**

**8.2 What additional roles could CSOs play in policy design, and what benefits would this bring?**

**8.3 How should government's role in service provision differ by program, service need or geography?**

**8.4 Are there any parts of service provision which government should not transfer to CSOs?**

**8.5 As roles change and/or new stakeholders enter, what challenges will this create?**

## Pathway 9: Make the system more collaborative

**The successful implementation of integrated cross government and community sector integrated family violence reforms serves to demonstrate how the system can be made more collaborative.**

The aims of the family violence reforms in Victoria are to improve the safety of women and children, particularly those at greatest risk of experiencing family violence, ensure that men who use violence are held accountable for their actions, and prevent violence from occurring.

The reform process, introduced in 2006, is a long term strategy that commenced in 2002 with the Statewide Steering Committee to Reduce Family Violence. The group was tasked with providing advice on the development of a multi-agency integrated response to family violence. The implementation of the reforms relied on securing ongoing partnership between community and government, and collaboration with the range of agencies involved at a service response, legislative and resourcing level. A 2005 report to government formed the basis of the reforms that were implemented from 2006.

The reforms went beyond the auspices of the community sector to include a legislative response (Family Violence Protection Act), a judicial response (introduction of family violence specialist services at three Magistrates Courts), and police response (*Police Code of Practice for Police Response and Investigation of Family Violence; Living Free From Violence – Upholding The Right: Victorian Police Strategy to Reduce Family Violence Against Women and Children 2009-2014*) shifting the focus from victim-initiated responses toward police-initiated responses, referrals to appropriate agencies and provision of intervention orders.

The integrated family violence reforms were supported by comprehensive state and regional reporting structures (see figure 1 below). These structures ensure that the service response is coordinated, transparent and accountable, and that the  agencies required to work together, including community health, local government, child and family services, police, courts, family violence services, homelessness - are sitting around the one table,

In the western metropolitan region a consortium of local agencies (Women's Health West, Western Region Health Centre on behalf of community health services, MacKillop Family Services, MCauley Community Services for Women and Elizabeth Hoffman House) was established. This integrated multi-agency approach provides a range of support services, counselling and group work programs to ensure that women and children receive an appropriate, gendered response, regardless of the pathway through which they seek assistance.

The partnership builds on a long history of effective service provision to provide a strengthened, integrated service model and is a key member of the Western Region Integrated Family Violence Committee. This committee has been given the task to drive, inform, guide, communicate, coordinate, monitor and report on the reform.

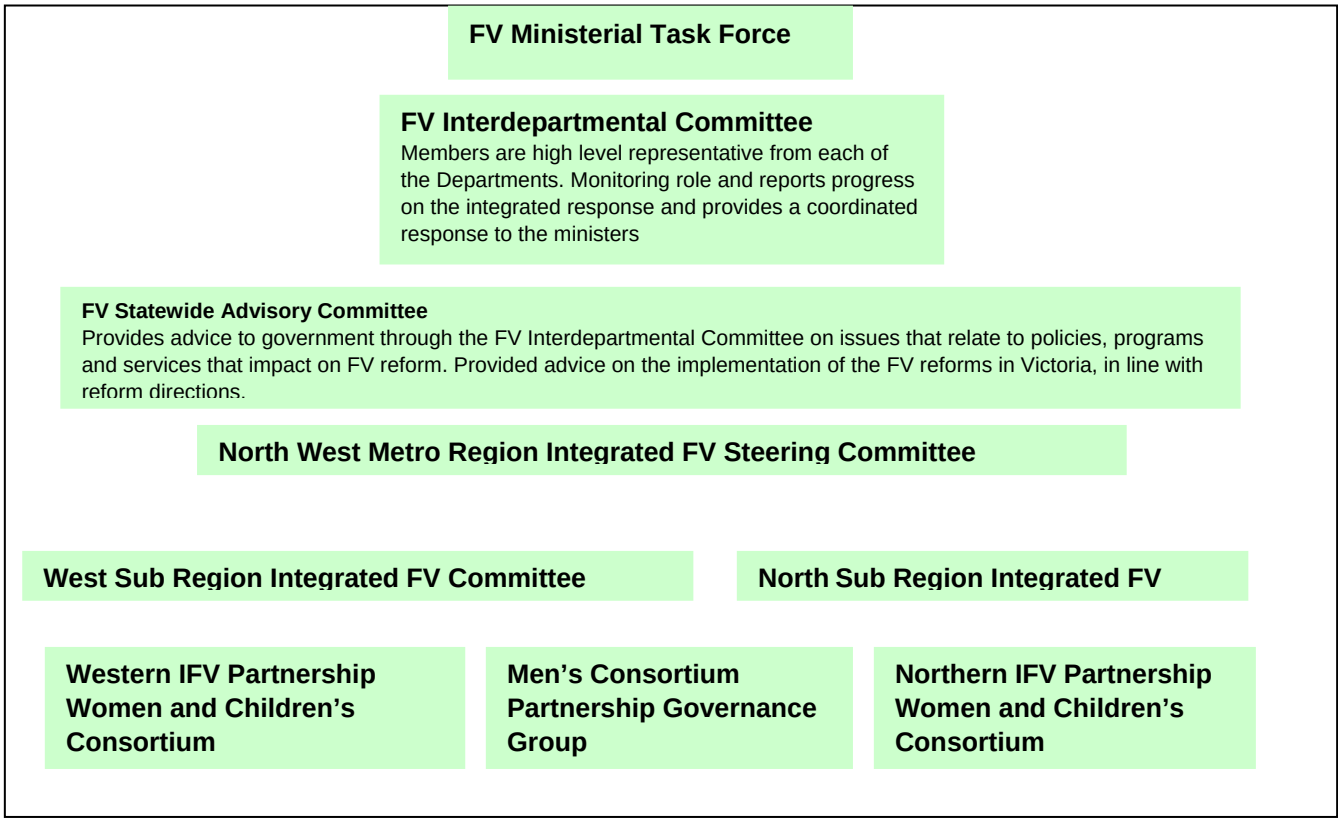
**Western Integrated Family Violence Partnership (WIFVP)**

WIFVP Is a consortium of community agencies providing family violence services to women and children in the Western Metropolitan Sub Region of Melbourne.

WIFVP is an example of mainstream and family violence specific services working together for a shared goal.

Figure 1: Integrated Family Violence

Governance Structure 2010




**9.1 Where does increased collaboration have the greatest opportunity to improve outcomes for people and their families?**

Preventing health problems before they occur is clearly the most effective way to improve outcomes for individuals, families and communities. This is best achieved through a social determinants approach that recognises the impact of economic, social, cultural and political conditions on the wellbeing of communities. A social determinants approach is the most effective way to redress entrenched disadvantage (Wilkinson & Marmot 2003). This approach requires work across various sectors and systems and is therefore reliant on effective collaboration and dynamic partnerships.

Effective service system collaboration supports positive health and wellbeing outcomes for communities by bringing together the diverse and complimentary skills, expertise and resources of numerous sectors and organisations. Collaboration between government and community service organisations has a greater opportunity to improve outcomes for communities when it occurs not only in the delivery of services and programs, but in the design of the policy and systems that shape service and program delivery. Sector collaboration in the design as well as the delivery of services and programs supports an approach that is congruent, responsive and ensures greater accountability within the system. A collaborative partnership approach is also recognised as having greater capacity to impact outcomes across a range of different sectors, particularly on health and wellbeing outcomes for disadvantaged communities (VicHealth, 2011).

The Women's Health Association of Victoria is a key example of an ongoing collaboration that has been demonstrated to be responsive, flexible, supportive and effective, greatly enhancing outcomes for Victorian women's health, safety and wellbeing. It works well because**:**

- Women's health services are independent
- Women's health services share the same vision of improved health for women in Victoria through action on the social determinants of health
- There are agreed goals and commitment to those goals over the long-term
- The services collaborate in, rather than compete for, funding; and
- There are common funding, planning and reporting structures

- **Recommendation:** The community services system reforms are guided by a social determinants approach that supports inter-sectoral collaboration

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**Case Study 6: Example of a collaborative response – Western Integrated Family Violence High Risk Client Strategy**

In 2005-06 statistics from the Australian Institute of Criminology showed that 80 per cent of intimate partner homicides involved a man killing a woman. In 53 per cent of cases, there was a known history of family violence.

In response, Victoria Police convened a High Risk Client Forum in 2008 in the western suburbs of Melbourne, bringing together specialist family violence services for women and children, and for men who use violence against women. This involved WHW, Djerriwarrh Health Service, Relationships Australia (Sunshine) and Life Works (Werribee) in discussions around how we could better respond to clients at risk of fatality or severe injury from violence. The forum led to the joint development of the Western Region High Risk Client Strategy, now operating across the seven western local government areas.

The strategy focuses on identifying victims most at risk of experiencing violence in the future, with tools such as the Police Family Violence Incident Report (L17) providing a structured method for officers to gather detailed and relevant information from victims about their specific needs, which is then shared with other agencies. It is well known that incidents of family violence escalate in severity over time, so by directing more resources upfront to those identified at high risk, we aim to prevent future incidents, including homicide.

Victoria Police now formally refer victims of family violence via e-back to WHW's Crisis Response Service and the perpetrator via e-back to a local Men's Behavioural Change Program. WHW then undertake a comprehensive risk assessment leading to an interim strategy negotiated with the local duty sergeant, and ultimately to a High Risk Client Strategy (HRCS) meeting. Clients are supported to attend the meeting as they are central to the response.

### 9.2 What are the barriers to having greater and better collaboration in the Victorian community services system?

A collaborative approach to improving outcomes requires the development and maintenance of a shared vision and objectives, clear roles and responsibilities, and governance structures that are effective and sustainable. A major barrier to greater collaboration is the overwhelming demand for direct services. Most community service organisations do not have the time, staffing and resources required to undertake sustained collaboration and partnership work. Greater collaboration therefore requires a community services sector with the resources and capacity to build and sustain long-term partnerships. Given the pressures of high demand on community service organisations, this shift will only occur if funding models that explicitly support this work are introduced.

- **Recommendation:** Revise the existing funding models and service-delivery target requirements to include collaborative partnership work as a recognised and funded part of the community services system

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**Case study 7: Barriers to collaboration**

The children's counselling program at WHW focuses on children who have witnessed or experienced family violence. Concerns for a child's safety are often raised and assessments made by family violence workers, leading to a child protection notification. The Child Protection service works with its own understanding of risk, and they make their own assessments, based on different training and thresholds that are in turn dependent on particular circumstances of funding and demand. This can sometimes lead to different interpretations of risk resulting in service barriers. Problems are compounded by the high turn over of staff in the Victorian community services system, impacting on the building of professional relationships, information sharing and understanding of each others services.

### 9.3 What can government do to improve collaboration between public sector agencies and CSOs, and where would it make the most difference?

The Department of Human Services' (2004) *Collaboration and consultation protocol for the Department of Human Services and the health, housing and community sector* suggests that effective collaboration occurs when there is shared decision making, adequate time and the application of available resources.

As such, collaboration between government and community service organisations needs to evolve alongside collaboration in the delivery and implementation of services, to a model that includes collaborative design, planning, governance and monitoring of the service system. This cultural shift requires moving from the current practice of consultation, to active and genuine participation in decision-making, valuing the expertise of community service organisations as partners with expertise in achieving better outcomes for people and families. Realistic timelines for participation in decision-making are required, reflecting the policy and practice commitments required to sustain long-term change. Good practice suggests that for inter-departmental, inter-agency and inter-sectoral partnerships to be successful and effective, participatory decision-making systems that are accountable, responsive and inclusive are necessary (VicHealth, 2011).

Services communicate well when there is co-location. For example at Women's Health West programs such as health promotion, family violence and children's counselling share a site. This provides ease of

opportunity for cross fertilisation of expertise and for specialities to work together to support women and children access their diverse and dynamic needs. Family violence workers are then more aware of the child's needs and the trauma impact of family violence, and mothers are easily referred for support and case management via on site communication.

Joint training models that include workers from different sectors, such as family violence services, mental health services, drug and alcohol services, and the police promotes an awareness of the similarity and differences between services. This can foster mutual respect, highlight areas of potential collaboration, and more sophisticated and incisive appraisals of work practices, cultures and ethics. The Common Risk Assessment Framework (CRAF) training recently promoted this model whereby workers from family violence, children's counselling and the police co-participated in training.

Similarly secondment of workers from different programs represents an opportunity for exchange of perspectives, experiences and expertise. WHW considers that having a housing worker from a community housing organisation on secondment with the family violence service would offer enormous mutual reward at the level of professional performance and ultimately in client experience. An example of this already occurs in family services programs where a community based child protection worker is on site for consultation and direct support with families where there are concerns and the professional opinion of family services workers is taken seriously.

- **Recommendation:** Review existing public service structures so that community service organisations are active participants in the design of the community services system
- **Recommendation**: Secondment opportunities be embedded as examples and enablers of good practice throughout the sector

**9.4 To what extent can public service agencies and CSO providers become partners (or 'co-producers') in the design and delivery of government programs and services?**

It is our experience that public service agencies and community service organisations can be genuine partners and co-producers in the design and delivery of programs and services. We highlight an example of WHW's regional partnership *Preventing Violence Together* (PVT). This example exemplifies the potential of such partnerships.

**Case study 8: Regional collaboration to prevent violence against women**

*Preventing Violence Together* is the Victorian first regional prevention of violence against women action plan. It facilitates a coordinated, action-based approach across women's and community health, local government and primary care partnerships, building organisational capacity and partnerships to achieve a community free from gender-based violence.

The success of PVT is largely due to strong partnerships that were cultivated over many years. Importantly, this partnership recognises that in order to achieve better outcomes for communities (through the prevention of violence against women), a collaborative approach is required that draws on the diverse expertise, resources and capacities of all partnering agencies including community service organisations and the public service sector.

This project demonstrates the extent to which genuine collaboration between different sectors can occur. A recent evaluation of the project using the VicHealth Partnerships Analysis Tool identified that the PVT partnership has 'realised genuine collaborative status' (VicHealth 2011). WHW recommends that this model be adapted to redress other social problems and in turn

improve outcomes for vulnerable people and their families.

While the PVT project demonstrates the extent to which local government and community service organisations can establish effective and strong partnerships, for such a collaboration to occur at a state government level it would require significant cultural change. Change is premised on an understanding that community service organisations would need to be reconceptualised as collaborative partners with valued expertise extending beyond service and program delivery. This would, in turn, require a shift in the way in which community service organisations are engaged by state government to enable the community sector to have an active role in the decision-making spheres of influence, rather than merely in a consultative, or advisory capacity.

- **Recommendation:** The VicHealth Partnerships Model (2011) is applied across the community services system, to ascertain the extent to which genuine collaboration is already occurring and to identify where there are areas for change.
- **Recommendation:** Consider the applicability of the PVT partnership model to redress other social health problems.

## Pathway 10: Make the system more effective and efficient

**10.1 What is the scale of the benefit you would expect from reducing ineffectiveness and inefficiencies in the current system?**

Women's Health West challenges the premise that the entire community services sector is ineffective and inefficient and therefore in need of reform. The sector is not one amorphous mass, but a range of sometimes connected and sometimes siloed service systems, suffering chronic underfunding, indiscriminate blame for problems well outside its control, and constrained by a commonly held, though ideologically-based, assumption of inefficiency (with the private sector, equally wrongly, assumed to be always the more efficient and effective option).

While particular areas might suffer from such problems – and an approach that looks at different components of the service system in more detail will ultimately be more effective in bringing about change – there are also multiple examples of effective and efficient work. In fact, in many instances the sector works very effectively on the 'smell of an oily rag' – and often on the back of volunteers and/or low paid women workers.

WHW has won consecutive bronze awards for transparency in annual reporting from the Australasian Reporting Awards. The judges, in awarding our prize, commented on their surprise at our budget, assuming it was ten times the size to achieve the outcomes detailed.

**10.2 What parts of the system should be left alone, either because they are working well or because recent changes are still being bedded down?**

See our responses above in terms of the existing effective and efficient work of the women's health services independently and through the Women's Health Association of Victoria; as well as services funded via the integrated family violence reform process.

**10.3 What is the opportunity for improving operations through partnerships between multiple service providers, and what is stopping this from happening more frequently today?**

See our answers above in relation to the integrated family violence service system, Preventing Violence Together and other examples of broad collaboration; as well as concerns about service demand and chronic underfunding of services.

**10.4 To what extent is a 'rationalisation' of Victoria's not-for-profit sector necessary? If so, in what form?**

If the purpose of the service sector reform process is to provide for a genuinely better response to those people requiring services, then additional funds are required as outlined above. If, on the other hand, the purpose is to create smaller government, fewer contracts to manage and to rationalise cutting funds to service, then our time would be better used in meeting identified client need.

WHW does not accept the premise that the entire system is fragmented, complex and difficult to navigate. There are examples of excellent integrated, client-focused and/or community-focused practice that must be recognised and built upon.

## Pathway 11: Use digital technology to empower people and CSOs

**11.1 To what extent is 'e-government' a reality in the community services system?**

'e-government' is an emerging reality for the community services system. For example, WHW has adopted e-government systems where relevant as a part of our communication strategy, including:

The state government Funded Agency Channel sends e-bulletins and WHW managers access the My Agency secure area of the site for information on service agreements, business contracts and funded activities.

WHW's health promotion team accesses government websites and communicate via email and Twitter, although e-government does not feature greatly in their work. The core communication with partners, community women and service providers happens via in person via meetings, by telephone and through letters and newsletters. Integrated health promotion reporting mechanisms remain traditional paper documents emailed directly to the department.

In 2011, WHW's family violence service adopted the Specialist Homelessness Information Platform (SHIP) client management system; a web-based, password protected database that records client information in a central storage space backed up by government.

WHW's business unit is preparing to engage with the Australian Charities and Not-for-profits Commission reporting requirements. WHW welcomes the idea of streamlining the acquittal process and urges government to continue to develop memorandums of understanding with the commission so that this added layer of reporting becomes the only layer and not an additional one. The current annual report, however, is a traditional printed document that is also available on our website.

Notwithstanding the efforts of the World Wide Web Consortium to ensure that the web is for everyone, the evolution of the internet and digital technology has focussed on a digital ideal of literate, able bodied, English-speaking participants with access and digital literacy using high speed broadband.

- **Recommendation**: WHW recommend that the path of e-government be planned, user-centric and mindful of improving the lives of all of the community rather than the ideal audience and the workers implementing it.

**11.2 How and where could digital technology be used to further empower people and families who use community services?**

Studies show that social isolation and digital exclusion are not only linked but can compound each other, so the introduction of greater levels of digital technology must take these concerns into account and prepare the ground before launching into new and exciting technological advances. WHW works with some of the most vulnerable communities in Victoria, including four LGAs in the top ten most disadvantaged LGAs in metropolitan Melbourne and two growth corridors. The west is also home to new and emerging communities from the Integrated Humanitarian Settlement Scheme, many of whom are vulnerable to social isolation and digital exclusion because of language barriers and lack of public transport in the outer suburbs. WHW runs programs with women with a disability and we are aware these women experience social isolation and digital exclusion. 'In fact, women with disabilities too often face the compounding effects of poverty, lack of education and employment, fear of exploitation and gender stereotypes. These multiple layers of disadvantage create barriers to accessing ICT that are extreme' (Women with Disabilities Victoria 2012).

A Price Waterhouse Coopers' study in 2009 found that while it would be cost effective for the UK government to switch to an entirely digital environment, yielding savings of up to £900 million per annum , a purely fiscal approach would exclude those without access or the skills to use the internet. The digitally excluded incorporates 1.8 million Australian households who have no internet connection (Infoxchange 2011). This section of the population is more likely to rely on government and CSO services, so any moves toward e-government and a 'digital default' need to take into account digitally-excluded and socially isolated communities.

Research shows that gender inequality impacts on 'women's access to technology, opportunities for empowerment and the damaging impact of sexist and violence-supportive technologies on women and girls, boys and men' (United Nations, 2005). Much work needs to be done to create an online environment that is non-threatening to women.

- **Recommendation:** Existing community hubs such as libraries and community centres could be resourced to provide free internet access for low income, disability, CALD, indigenous, older communities, homeless people and those transitioning from supervised care settings (e.g out of home care, prisons) at no cost, with many accessible terminals and workers to provide education and assistance.
- **Recommendation:** Universal accessibility needs to be built into ICT policy and purchasing decisions
- **Recommendation:** Work to reduce the online gender divide that exacerbates existing inequalities between women and men (United Nations 2005)

From a CSO point of view, digital technology could be used to improve services through:

- Automatic SMS/email systems to remind clients of appointments
- Supplying outreach workers with tablets instead of computers to reduce costs and increase mobility

Extension of a system like SHIP could connect services with each other by client file e.g. Magistrate receives one digital parcel containing information on one client from child protection, women's services, men's services, housing services and police.

**11.3 What is holding the system back from embracing digital technology in a much bolder manner?**

**Community Services Sector Barriers**

- Access to ICT knowledge and skills
- Funds and resources to purchase and maintain equipment and software
- Awareness of benefits and opportunities as well as pitfalls

**Community Barriers**

Putting aside the lack of funds for equipment, staff, knowledge or skills, the community sector is understandably wary of embracing digital technology in a bolder manner by virtue of the work we do. As mentioned, we work with the most vulnerable in our community and this population is generally situated on the wrong side of the digital divide. Gender, language, age, income, digital literacy, internet access and broadband speed, disability and work status are all potential barriers to digital inclusion that must be taken into account when migrating government services online to continue to service those who are not computer-literate.

Internet use by people with a disability in the UK is about half that of non-disabled (Low Incomes Tax Reform Group 2012) and research shows that women with disabilities are particularly vulnerable to being digitally excluded because of safety concerns that are more likely to be held by women than men, stereotyped perceptions about ICT and gender, cost and a lack of access or support (Women with Disabilities Victoria 2012).

The following UK research (Low Incomes Tax Reform Group 2012) is broadly applicable here in Australia:

Digital literacy

- A sufficient level of digital literacy required to be able to locate, evaluate and make effective use of the online systems
- Three out of four of those broadly socially excluded lack a meaningful engagement with the internet

Internet access

- The government considers ICT to be the 'third skill for life' after literacy and numeracy, yet 33% of UK households don't own a PC
- 77% of those not online are not working

Income

- In 2011 people in households in the highest income category were more than twice as likely to use the internet as the lowest income category (99% vs 43%)
- Of those living in households earning less that $11.5k per annum, 47% did not use the internet compared to only 4% of those with an annual income of over $30k

- **Recommendation:** Fund CSOs to develop ICT knowledge, skills, equipment and software
- **Recommendation:** Support CSOs to engage in ICT professional development
- **Recommendation:** Develop service delivery to cater for the significant minority who are

digitally excluded

- **Recommendation:** Provide alternatives for those who are unable to use online methods or find it excessively difficult
- **Recommendation:** Develop ways for those out of work to access the internet

**11.4 How can government, public service agencies and CSOs together build the capabilities they need to facilitate increased use of digital technology for beneficial social impact?**

**Plan**

Develop a comprehensive digital inclusion strategy that encompasses at-risk groups including women, people with disabilities, CALD and refugee people, older people, those in or exiting prison, and the homeless.

**Tailor tasks to those best suited**

The benefit of the relatively flat structures and lean natures of CSOs is an agility and responsiveness not seen in larger organisations. When combined with (free) open source technologies, CSOs are in a better position to tailor services to smaller sections of the population, e.g. small language communities, groups experiencing specific overlapping barriers (e.g. women, low literacy, low income, aged or disability).

**Support**

All elements of the system (government, public service agencies and CSOs) need to understand that it is not going to be possible to bring *everyone* along on the digital journey and that those who cannot access ICT should not be penalised as a result. For example, internet use among the 65+ age group in the UK hovers around the 30 per cent mark compared with 85 per cent of 22-55 year olds; this means either a paper or oral equivalent is required, or research into what *will* work with that cohort (PricewaterhouseCoopers 2009).

- **Recommendation:** Divide tasks according to the strength and capacity of government and organisations
- **Recommendation:** Government can better afford to do research into tricky infrastructure questions such as how to create non English-centric digital hardware for community hubs, how to make ICT accessible and affordable for women with disabilities, how to use ICT as a tool to tackle social isolation and exclusion (Women with Disabilities Victoria 2012)
- **Recommendation:** Government is in the privileged position of receiving reports about all CSO projects and should use that position to be the conduit for best practice; monitor and identify effective projects and inform other CSOs who would benefit from that knowledge
- **Recommendation:** Promote universal design of information and communication equipment by incorporating accessibility criteria in all government procurement policies and publicly funded service provider contracts. Ensure all levels of government and contracted public service providers deliver best practice in the accessibility of electronic, print, web and audio-visual communications (Women with Disabilities Victoria 2012)
- **Recommendation:** CSOs can benefit from existing free or inexpensive resources through training in use of open source software and Web 2.0 technologies to meet the particular needs of smaller community groups

**11.5 What are the trade-offs, challenges and risks associated with a greater focus on digital technology?**

There are many complex challenges associated with increasing digital technology uptake so rather than try to cover them all, we have focused on the complexity of a single aspect: language.

Most services are provided for a generic, predominantly literate and non-disabled audience, so may not meet the needs of less literate users (Low Income Tax Reform Group 2012). There is limited availability of internet content in many community languages. Available content is difficult to access because translated pages often use English navigation to click into a site (Vicnet 2009).

To compound this problem further, many minority language groups have limited or no support within computer operating systems or applications. A greater focus on digital technology will create a major challenge for all CALD communities. At WHW, for example, Burma is the most common country of birth for female settlers in the western region by humanitarian migration stream (Women's Health West 2013). Most Karen women arrive with little or no experience of modern information technologies and have regularly experienced interrupted schooling.

# General response

Please provide any further feedback here.

WHW endorses the submissions made by the Women's Health Association of Victoria and Domestic Violence Victoria. All information in these submissions is echoed by WHW and should be considered as part of our own submission.

Improving how the community services system works is a worthwhile endeavour however this will not happen overnight. We need a shared vision and a detailed plan on how to achieve this in different sectors, acknowledging differences across programs. The reform plan needs to be sustainable, flexible and be able to respond to external and internal forces including political and economic.

- Community services system reform should not be based on the assumption that the current challenges being faced by the system can be resolved by realigning the system to become more client centred
- Community service agencies work tirelessly to ensure that services and programs are client-focused
- In acknowledging the diversity of our clients and the complexity of their needs, abilities and circumstances, including their personal and social environments, we also acknowledge that one approach or response will not fit all. We also know that a more flexible model is needed to support individuals and families who experience the most disadvantage in our community

The Victorian Government must work to address key structural barriers that create and reinforce cycles of disadvantage for many Victorians.

- The current shortage of public housing is a fundamental structural obstacle and should be addressed as part of any community sector reform that addresses disadvantage. The level of income support payments need to be urgently increased since insufficient income itself is a significant structural obstacle to breaking the cycle of disadvantage. This is particularly true for single parents, the majority of whom are women. The state government in partnership with community services sector should continue to put pressure on the Australian government to address this major structural barrier.

This ultimate focus of this discussion paper – seeking reform that falls within current funding allocation – is limiting. Given the history of chronic underfunding of the community services sector, it is highly unlikely that reform will be achieved without the leverage of additional investment to make the system and capacity changes that are necessary to support reform. Increased efficiency and productivity may offset some of the costs over the longer term, but there is ample experience throughout the public sector of the benefits of increased productivity being consumed by increasing demand.

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