Groups and communities at risk of domestic and family violence

A review and evaluation of domestic and family violence prevention and early intervention services focusing on at-risk groups and communities

Sarah Tayton, Rae Kaspiew, Sharnee Moore and Monica Campo

Australian Institute of Family Studies

Australian Government

Australian Institute of Family Studies

Contents

Acknowledgements

Executive summary

This report sets out the findings of research into domestic and family violence (DFV) prevention initiatives focused on groups and communities identified as being at greater risk of experiencing DFV and/or having difficulty accessing support services. These groups include Aboriginal and Torres Strait Islander women, women from Culturally and Linguistically Diverse Communities (CALD), people who identify as Gay, Lesbian, Bisexual, Transsexual, Intersex and Queer (GLBTIQ), young women and women in regional, rural and remote (non-urban) communities.

Background

This research was commissioned and funded by the NSW Department of Family and Community Services. It contributes to the development of the knowledge base on DFV prevention strategies and the needs of at-risk groups and communities, and supports the implementation of aspects of the *National Plan to Reduce Violence Against Women and Their Children* (*National Plan*) and the NSW Government's *It Stops Here: Standing Together to end Domestic and Family Violence* (*It Stops Here*) strategy.

As a field of knowledge and practice in Australia, DFV primary prevention is in its early phases. Australian developments in this area have been strongly influenced by international approaches, particularly the World Health Organization's *World Report on Violence and Health* (2002) and the subsequent *Preventing Intimate Partner and Sexual Violence Against Women Framework* (World Health Organization [WHO], 2010). DFV primary prevention is premised on a public health approach that focuses on preventing DFV before it occurs, through the delivery of universal and targeted strategies. The under-pinning theory of causation in this framework holds that DFV occurs as a result of the interplay between factors at four levels of influence: individual, relationship/family, community and wider society. The *National Plan* is based on this framework and the Victorian health promotion foundation, VicHealth, has pioneered the development of a primary prevention framework (Preventing Violence Before it Occurs) and program of action in that state.

The research focused on identifying the needs of the at-risk groups detailed above and the extent to which these needs are met within existing DVF prevention approaches. Two other studies were also taking place at the same time as this one: one focused on DFV initiatives for children in the 0–8 year age groups (also conducted by AIFS); and the other focused on primary prevention initiatives for men and boys (conducted by a team led by Professor Moira Carmody at the University of Western Sydney).

This report **does not** focus on prevention and early intervention initiatives aimed at men and boys. We acknowledge the need for holding perpetrators, and not the victims of DFV, accountable for DFV. It is clear that women are overwhelmingly the victims of DFV. Many of the programs identified and examined in this report are aimed exclusively at women. As the key focus of this report is on prevention and early intervention strategies for at-risk groups and communities, it is beyond the scope of this report to engage in a detailed discussion of perpetrator programs or primary prevention activities targeting men and boys. The study undertaken by the University of Western Sydney in parallel to this one, focused on primary prevention initiatives for men and boys, addresses these issues in detail.

In accordance with the study tender details, AIFS periodically liaised with the University of Western Sydney team leading this project to ensure that the studies complemented, rather than duplicated, each other.

The research

This study employed a mixed methods approach to the research topic. It had four main elements: a literature review, a series of consultations with relevant stakeholders, a Request for Information about existing programs and initiatives, and two evaluations of specific programs. The literature review consisted of two main tasks: 1) collating and analysing current evidence relating to the impact of DFV on at-risk groups, as well as evidence regarding the effectiveness of prevention and early intervention activities targeted at these groups. Examination of conceptual frameworks and best practice models was also undertaken as part of this aspect of the literature review. 2) A service scoping exercise that identified examples of prevention and early intervention activities focused on at-risk groups and communities in NSW and other Australian states and territories. The consultation with relevant stakeholders was undertaken in two stages. Initially, phone interviews and conversations were conducted with a range of service providers involved in the delivery of prevention and early intervention programs. This helped to inform and shape the early stages of research by identifying some of the key issues faced by those involved in the DFV service sector. This was followed by three more formal stakeholder consultations. These took the form of roundtables in Melbourne, Sydney and Brisbane.

Service providers who deliver a range of DFV programs completed the Request for Information online. We circulated details of the Request for Information via networks established through our stakeholder consultation processes, as well as relevant mailing lists and email notices. The Request for Information asked a broad range of questions, including requesting details about the types of programs delivered, numbers of clients, funding sources and key aspects of effective practice. The programs that were evaluated for this report are the Healthy Family Circle Program operated by the Mudgin-Gal Aboriginal Corporation and the Domestic Violence Community Education Project run by the St George Migrant Resource Centre. The evaluation process involved the collation and analysis of administrative data associated with each of the programs, interviews with the professionals involved in the delivery of the programs, and focus groups with program participants.

Main findings and policy implications

The gaps in DFV prevention and early intervention programs for at-risk groups and communities need to be addressed

Our service scoping and stakeholder consultations indicate that there are gaps in prevention and early programs for all at-risk groups and communities. These gaps are more marked in relation to some communities than others. There is a particular dearth of services for people who identify as GLBTIQ, regional, rural and remote women, and women with disabilities and mental ill-health. In some geographical areas, the lack of services that address the specific needs of people from these communities is stark. Other

at-risk groups, such as CALD and Aboriginal women, have more prevention and early intervention programs aimed at them. However, this does not mean that there are no gaps, and in some instances there are questions about the capacity of some services to cope with the diversity within these communities. Questions of community acceptability of, and access to, programs are relevant for all at-risk groups and communities. **When reviewing the allocation of funding for services focusing on at-risk groups and communities, it is important to consider how well the needs of those groups and communities are met by existing programs and services, and to allocate resources based on greatest need.**

Universal and targeted prevention and early intervention approaches are both needed

Our stakeholder consultations found that there was a need for large scale, population-wide prevention messages, but that such messages need to be relevant for communities that are identified as at high risk of DFV. Large-scale public health campaigns aimed at preventing DFV cannot run in isolation—they need to be delivered in conjunction with community-based initiatives, so that initiatives work across multiple levels in the community. A combination of these forms and levels of DFV prevention activity is understood to have the most promise in addressing DFV. **It is important to critically assess how prevention or early intervention initiatives engage with, and respond to, the needs of at-risk groups and communities.**

Mainstream DFV services and prevention programs, as well as interlinked services such as health and legal services and the police, need to be able to cater for the needs of at-risk groups and communities, and be accessible and culturally competent in meeting their needs. It is not acceptable for mainstream services to defer to, or rely on, specialist services to provide services to members of at-risk groups and communities. **There is a clear need to build the capacity of DFV and related services (such as health, policing and legal) to ensure practitioners working in those services have access to sufficient training to support sensitive and appropriate service delivery to at-risk groups and communities.**

DFV prevention and early intervention initiatives aimed at at-risk groups and communities need to be community driven

While at-risk groups and communities should be able to access all DFV services and have their needs met, there is also a need for prevention and early intervention initiatives to be community-driven. Each of the at-risk groups has specific sets of issues and needs, giving rise to different best practice approaches. Generic approaches are often inappropriate. Organisations that are enmeshed within communities, have established relationships of trust and can engage effectively with members of their community are often best placed to deliver DFV prevention and early intervention initiatives. **This finding highlights the need for the organisations located within the communities specifically considered in the report to be engaged in developing DFV prevention and early intervention initiatives to ensure that such initiatives meet the needs of the particular groups for whom they are intended.**

Programs that aim to empower women and educate them about their rights are critical to reducing DFV and need to be supported through policy and funding

The evidence regarding the effectiveness of DFV prevention programs that empower and educate women is still emerging, but it is promising (WHO, 2010). Prevention and early intervention initiatives aimed at women are not a comprehensive response to DFV. We acknowledge the need for prevention and early intervention activities aimed at women to be delivered in conjunction with initiatives aimed at perpetrators. DFV is a complex and multifaceted problem that needs to be addressed at multiple levels. It is clear that men's violence against women is critically linked to historically unequal power relationships between men and women (Wall, 2014). Given this, empowerment and education programs aimed at women that address this inequality are a necessary component of attempts to ensure that women and children live free from violence (WHO, 2010). **Empowerment and education programs aimed at women should be supported through policy and funding arrangements.**

Funding needs to be long-term and sustainable

The disadvantages that arise from short-term and ad hoc funding pools were a significant theme in the literature and consultations. This is an issue of general relevance in the DVF area but has particularly acute implications for the groups considered in this report. In light of the need for initiatives to be community driven, short-term and fragmented funding approaches mean that the knowledge, trust and expertise that are developed when a program is developed are dissipated when it is discontinued. This stands in the way of the development of sustained and coherent approaches that will support long-term change. **It is clear from this research that funding arrangements need to be longer term and better coordinated to enable the DFV sector to provide high quality services and build on expertise.**

Better evidence of the impact of DFV on at-risk groups is needed

In order to support effective DFV prevention and early intervention practice, better evidence about the impact of DFV on at-risk groups and communities is needed. There is considerable variation in the extent to which the evidence base on the impact of DFV is developed in relation to each of the at-risk groups and communities that are the focus of this report. This report considered the available evidence regarding the prevalence of DFV in each of the at-risk groups. Better evidence is required across the board but empirical understandings are particularly under-developed in relation to the extent and impact of DFV on CALD women, people who identify as GLBTIQ, women with disabilities and women from regional, rural and remote communities. Lack of knowledge about the specific circumstances of these groups is particularly striking. There is more evidence regarding the impact of DFV on Aboriginal and Torres Strait Islander women, and younger women than the other groups and communities, however there are gaps in this evidence as well. **There is a need to invest in building the evidence base through rigorous research and evaluation; including supporting research that is coordinated,**

is focused on collecting data that can be compared with other research, and is sensitive and responsive to the particular needs of at-risk groups and communities.

DFV prevention and early intervention work in Australia is an emergent field and there is a need to build an evidence base about effective practice

In order to support effective DFV prevention and early intervention practice, better evidence about the effectiveness of initiatives is needed. Only one approach, school-based healthy relationship programs, has been established to be effective (WHO, 2010). Aside from this one example, there are significant gaps in the evidence in relation to "what works" with the various at-risk groups and communities. Our stakeholder consultation process confirmed that there is a significant amount of practice knowledge within the DFV service sector. However, there is relatively little formal evidence about the effectiveness of prevention and early intervention activities that focus on at-risk groups and communities. There is consensus from the literature and consultations that a concerted effort to develop the evidence base about what is effective in DFV prevention and early intervention is required. **It is important that funding agreements acknowledge the value of program evaluations and that separate or additional funding is available to build organisational evaluative capacity and to undertake evaluation activities.**

When evaluation requirements are tied to funding sources, methodologies and materials need to be practicable and appropriate. For instance, some services may have limited capacity for delivering internal evaluations due to a lack of staff resources and training, and evaluation processes that may be resource intensive and not adaptable to the specifics of the service. Evaluation materials also need to cater for a diversity of literacy, numeracy and English language capacities in clients. **When designing program evaluations in relation to programs targeting at-risk groups and communities, it is important to ensure that evaluation materials are tailored to the particular program and service, and where appropriate, reflect the needs of clients who access programs.**

DFV prevention and early intervention work in Australia exists within a dynamic policy environment and the move towards a coherent policy framework in NSW is positive and should be supported

Over the last 20 years or so, there has been a move in many jurisdictions to an integrated policy and practice approach to complex social issues such as DFV. Throughout Australia, there are differing levels of integration of approaches to the issue of DFV and related service provision. Consistent with the findings of the NSW Auditor General in 2011, our study shows fragmentation in response to DVF in NSW. One of the most important implications for policy that emerges from the research set out in this report is the need for a policy framework to support understanding and practice in DFV primary prevention in NSW. The report suggests that the governance infrastructure established to support *It Stops Here* provides a means of supporting the formulation of such a framework. **The development of a clear and coherent policy framework is welcome and should better enable discrete service sectors to work towards common goals, and help to ensure the needs of at-risk groups and communities are met across the various sectors.**

Summary

The focus of this report is DFV prevention and early intervention activities aimed at several groups identified as being at greater risk of experiencing DFV and/or having difficulty accessing support services. These groups include Aboriginal and Torres Strait Islander women, women from Culturally and Linguistically Diverse Communities (CALD), people who identify as Gay, Lesbian, Bisexual, Transsexual, Intersex and Queer (GLBTIQ), young women and women in regional, rural and remote (non-urban) communities. This report has examined the scope of prevention and early intervention activities aimed at these groups in NSW as well as in other states. It has also extensively engaged with current approaches to the prevention of DFV, and assessed the available evidence about the effectiveness of prevention practices. Current policy contexts have also been examined. This report has found that there is extensive knowledge within the DFV service sector, and a strong commitment by those working in the sector to preventing DFV in the community. Services are working hard to deliver high-quality prevention and early intervention activities that meet the needs of their communities. There are several areas, however, where difficulties were identified. These include: a lack of rigorous evidence about effective prevention practices; structural issues such as a lack of a coherent policy framework in which to situate practice; and a lack of funding and ad hoc funding mechanisms. These issues will be discussed in detail in the following chapters.

1   Introduction and methodology

1.1   Introduction

This report sets out the findings of research examining the effectiveness of current domestic and family violence (DFV) prevention and early intervention initiatives that target groups and communities known to be at higher risk of experiencing domestic and family violence, or who face barriers in accessing existing services. These groups include: Aboriginal and Torres Strait Islander women; women with disabilities and mental ill-health; women from culturally and linguistically diverse communities; gay, lesbian, bisexual, transgender, intersex and queer people; younger women; and women in rural and remote communities. The research was commissioned by the NSW Department of Family and Community Services. We acknowledge the need for holding perpetrators, not women and children accountable for DFV, and the necessity of ongoing primary prevention of DFV addressing men. However, as the key focus of this report is on prevention and early intervention strategies for at-risk women, it is beyond the scope of this report to engage in a detailed discussion of perpetrator programs or primary prevention activities targeting men and boys. However, there is a further study, also commissioned by the NSW Department of Family and Community Services and undertaken by a team overseen by Professor Moira Carmody at the University of Western Sydney, that focuses on prevention targeting men and boys.

This research was carried out by the Australian Institute of Family Studies (AIFS) between July 2013 and June 2014. It sought to understand the characteristics of effective practice in undertaking DFV prevention and early intervention activities with at-risk groups and communities. The study methodology included a literature review and two main strategies for collecting data from a range of professionals who work in or with services in the DFV sector in Australia. These strategies were a series of roundtable consultations and a Request for Information that was completed online. The study also involved an evaluation of two primary prevention and/or early intervention programs targeted at one or more at-risk groups and communities in NSW. The programs were the Healthy Family Circle Program at Mudgin-Gal Aboriginal Corporation, and the Domestic Violence Community Education Project at St George Migrant Resource Centre. The evaluations were based on data collected from staff, managers and clients associated with the programs, as well as administrative data from the programs.

This study is one of three related projects commissioned by NSW Department of Family and Community Services following a competitive tender process conducted in May 2013. The other related projects are concerned with:

▪ domestic and family violence prevention, early intervention and response programs focusing on children aged 0–8 years who are affected by domestic and family violence (also conducted by AIFS);

▪ domestic and family violence prevention programs focusing on men and boys (conducted by a research team led by Professor Moira Carmody from the University of Western Sydney).

This research program will aid in building a stronger evidence base on prevention and early intervention and will support the implementation of the *National Plan to Reduce Violence Against Women and Their Children 2010–2022* (*National Plan*) (2009). The research is also intended to inform funding decisions by the NSW Department of Family and Community Services by setting out recommendations for enhanced or new approaches and exemplar models to support implementation in NSW and providing a framework for future program evaluations. Initially, the project plan also involved participation in a planned Prevention Partnerships Advisory Committee that was to be convened by the NSW Department of Family and Community Services. This committee did not proceed so this element of the project did not come into fruition.

1.2   Background

The *National Plan*, endorsed by the Council of Australian Governments (COAG), establishes a template for national action to reduce DFV over 12 years across state and territory governments and at Commonwealth level. The *National Plan* is an important element in demonstrating Australia's commitment to upholding the human rights of Australian women as a party to the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration to End Violence Against Women and the Beijing Declaration and Platform for Action.

The *National Plan* is being delivered through a series of four three-year plans, commencing with the First Action Plan, which was released in conjunction with the *National Plan*. A further three action plans, each covering a three-year period, will be developed sequentially to support the overall plan. At the time this report was being prepared, the second three-year action plan was being developed.

The First Action Plan includes four priorities that the various states and territories will work towards while also developing plans that reflect their specific priorities. The four overarching priorities are:

- Building primary prevention capacity;
- Enhancing service delivery;
- Strengthening justice responses;
- Building the evidence base.

Complementing and supporting the *National Plan* are the actions of various state and territory governments that seek to improve the way government and non-government organisations work together to prevent and respond to DFV. In NSW, this intention is reflected in the *It Stops Here: Standing together to end domestic and family violence* reforms which propose a number of priority areas for action, including:

- an integrated and coordinated state-wide system that has an increased focus on violence prevention;
- changes to victim service and support systems;
- implementing programs and services that hold perpetrators accountable and reduce re-offending.

The *National Plan* and the NSW *It Stops Here* reforms recognise that there are particular challenges in addressing the needs of certain groups who are at significantly higher risk of experiencing DFV than women in the general population, or who face barriers in accessing DFV services or programs. A complex set of issues underlies these groups' vulnerability to DFV, reporting of incidences, and willingness or ability to seek help when needed. However, evidence about the particular needs and experiences of some or all of these at-risk groups is sparse.

This study helps to address this evidence gap by focusing on identifying the specific DFV needs of the various at-risk groups and communities and identifying and analysing the elements of effective practice. Drawing on the evidence and analysis from each of the various aspects of the research, this report offers insights into enhanced approaches to preventing DFV in at-risk groups and communities.

1.3   Research methodology

As noted at the outset, the overarching aim of this study is to shed light on the issue of effective practice in undertaking DFV prevention and early intervention activities with groups and communities who are at higher risk of experiencing violence, or who face barriers in accessing domestic and family violence services. A series of research questions examining issues pertinent to understanding the practice and organisational approaches of DFV prevention and early intervention services guided data collection for this study. These were:

- What is the effectiveness of existing approaches, strategies and projects that target at-risk groups and communities in NSW? What are the gaps?

- What are the characteristics of good practice in targeting at-risk groups and communities?

- What strategies and programs should be developed or enhanced to build on existing good practice? What new approaches or programs may be needed?

- What funding mechanisms could be pursued in the context of the new DFV reform governance structure to ensure locally owned and driven work?

The study utilised a mixed methods approach to address these research questions. These were: a literature review, stakeholder consultations and interviews, and an online Request for Information from services delivering DFV prevention and early intervention programs or undertaking activities that were concerned with prevention or early intervention. This strategy supported the collection of data from a variety of perspectives and allowed the research questions to be addressed using multiple sources of data.

The development of the methodology was informed by: the literature on effective prevention and early intervention to reduce violence against women; reviews of existing evaluations about prevention initiatives; current debates about how to engage at-risk groups and communities in violence prevention and encourage utilisation of services; and a health promotion perspective on behaviour change (i.e., in order to achieve positive changes in behaviour, the drivers of behaviour—fear, attitudes, capacity and so on—need to be targeted in addition to knowledge or awareness). Key decisions on implementing

aspects of the methodology were made in consultation with the NSW Department of Family and Community Services.

The AIFS Human Research Ethics Committee provided an ethical review for this study. No incidents occurred that required reporting to the committee. Although the research questions did not seek to understand individual experiences of domestic and family violence, the nature of the research, and the potential vulnerability of the populations who access or participate in the services and programs on which the research was focused, generated some ethical issues that required consideration by the research team, including the need to:

- ensure that data collected from potentially vulnerable populations, including from Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations, was collected sensitively and without causing trauma;

- ensure that data collected from participants in the two prevention programs being evaluated as part of this study, where the participants may have been unaware of the underlying domestic and family violence prevention focus, was collected in a way that ensured participants understood the nature of the research without causing undue harm by highlighting the underlying aims of the program or being perceived to label the participants as potential victims;

- maintain confidentiality for professional and client respondents and report data in a way that means no individual who provided information on a confidential basis could be identified.

The research team employed several strategies to address these considerations.

First, the research team comprised researchers with a history of conducting research on a variety of sensitive topics, including domestic and family violence, the needs of peoples from Aboriginal and Torres Strait Islander and CALD communities, and with participants of diverse backgrounds. The research team was acutely aware of the need for a sensitive approach in respect of each of the at-risk groups and communities. This was particularly relevant in relation to the evaluation of two programs in NSW, which focused on prevention programs targeting Aboriginal and Torres Strait Islander women in inner-metropolitan Sydney and culturally and linguistically diverse communities in outer-metropolitan Sydney, respectively. Additionally, the research methodology relied on close collaboration with the service providers to ensure the approach was sensitive to the various language, cultural and other considerations.

Second, when designing the participant materials and interview schedules to be utilised in the evaluation of two prevention programs in NSW, the research team were alert to the possibility that some program participants, for example participants in a mother's group or other skills building program, may have been unaware of an underlying domestic and family violence prevention focus. The research team took care to ensure the materials utilised in relation to those consultations were sensitive to this particular dynamic.

In order to maintain confidentiality, care has been taken to report research data in a way that does not identify individual informants. In some instances, findings have been presented in a way that reflects high-level conclusions without detailed discussion of the data. Particular care has been taken to ensure that the identity of participants in the programs and professionals (who did not give permission to be identified) cannot be

gleaned from this report. In accordance with ethics requirements, all interview and consultation transcripts were de-identified, and the original transcripts and recordings destroyed.

The following sections set out the particular approaches taken for each aspect of the methodology, which were undertaken in stages over a 12-month period.

1.3.1   Literature review and identification of program examples

This aspect of the project involved two tasks: 1) an analysis of current evidence, conceptual frameworks and good practice trends related to primary and early intervention initiatives targeting at-risk groups and communities; and 2) a service scoping exercise to identify examples of prevention and early intervention initiatives focusing on at-risk groups and communities in NSW, and other Australian states and territories.

Literature review

The literature review was based on a rapid evidence assessment methodology to provide an overview of existing research focusing on the characteristics of good practice in relation to domestic and family violence prevention and early intervention activities targeting at-risk groups and communities. This approach was selected for this study in response to the timeframe set out in the project brief, and also allowed the research team to manage the breadth of the research process necessitated by the variety of at-risk groups and communities.

The research team searched a range of databases through EBSCOhost, which hosts academic, scientific and grey literature.[1] Additionally, the research team searched several Australian databases (e.g., Australian Family and Society Abstracts, APAIS (Australian Public Affairs Information Service), and CINCH (Australian Criminology database)); AIFS Promising Practice Profile databases; relevant websites of peak bodies; and other clearinghouses such as the Australian Homelessness Clearinghouse, Council to Homeless Persons, and the Australian Domestic and Family Violence Clearinghouse. The following international databases were also included in the review: PsychInfo and SocIndex. In addition, the research team utilised web-based search engines (e.g., Google) to capture other online resources that were included in the review.

The literature review strategy specified keywords, publication dates, and research methodologies to ensure the most relevant, reliable and up-to-date information was collected.

The search covered a range of topics: (a) conceptual frameworks and debates on DFV prevention and early intervention approaches with at-risk groups and communities, as described in the research (both peer-reviewed and grey literature), and policy frameworks and approaches (including the recent Service-Mapping and Gap Analysis Study and preparatory work completed for the Request for Information reforms); (b) criteria and guidelines for good DFV practice; and (c) published evaluations of existing DFV

---

[1]   Grey literature refers to published and unpublished reports, documents and evaluations that are not peer-reviewed.

prevention and early intervention programs or projects focusing on at-risk groups and communities.

As the literature review progressed, members of the research team continually assessed the relevance of identified literature for inclusion using a common set of criteria. These criteria were that the report or publication concerned any of the following:

- conceptual frameworks and debates on DFV prevention and early intervention;
- particular DFV programs or services targeting at least one of the specified at-risk groups or communities;
- DFV practice with at-risk groups and communities; or
- DFV practice criteria or guidelines more generally.

The literature search was supplemented by a manual search of bibliographies and references for highly cited references. This allowed the team to identify prominent researchers in the field and perform a further search of references by such authors to identify key ideas, concepts of relevance, or historical knowledge that may have been overlooked.

Identifying examples of prevention and early intervention initiatives focusing on at-risk groups and communities

In addition to reviewing the existing research focusing on the characteristics of good practice in relation to domestic and family violence prevention and early intervention activities targeting at-risk groups and communities, the research team assembled a database of examples of prevention and early intervention initiatives focusing on those at-risk groups and communities. Given the breadth of the research brief, the available resources and the variety of at-risk groups and communities, this database is not a comprehensive catalogue of all available services.

The research team utilised a number of methods to identify examples of relevant prevention and early intervention initiatives and the approach was largely based on a "snowball" strategy, including:

- identifying relevant services and programs from the reports and publications sourced as part of the literature review process;
- stakeholders and key informants providing information about various services and programs;
- web-based searches.

Members of the research team assessed the relevance of services and programs for inclusion in the database using a common set of criteria. These criteria were that the information available about the service or program indicated the following:

- the program or service had a focus on DFV issues;
- the program or service focused on one or more of the identified at-risk groups and communities;
- the program or service undertook activities that could be classified as prevention or early intervention (broadly defined);
- the program or service was currently or recently operational.

Once an identified service or program was assessed as broadly relevant, the research team entered details about the program in the database of examples. The database is included for reference in Appendix 1.

1.3.2 Stakeholder consultations

A process of consultation was conducted with key stakeholders in several Australian states and territories. The consultations focused on identifying current characteristics of DFV practice and the key issues in undertaking prevention and early intervention activities in respect of each particular at-risk group. Although the consultations were initially intended to be conducted specifically in relation to the issues concerning services focusing on at-risk groups and communities (with separate consultations taking place for the other AIFS research project focusing on services targeting young children), the research team found that the boundaries between service and program activities were blurred to the extent that separate consultations were not always appropriate or feasible. As a consequence, much of the stakeholder consultation activity for this project was undertaken jointly with stakeholders who were also concerned with DFV prevention, early intervention and response programs focusing on children aged 0–8 years who are affected by DFV. For this reason, the data reported from stakeholder consultations is reflected in the findings of both AIFS reports.

The research team undertook stakeholder consultations in two stages. First, drawing on the information obtained through the literature review and existing relationships within the DFV sector, relevant key stakeholders and organisations that either represented the interests of the particular at-risk groups or had expertise in delivering DFV programs to meet their needs were identified. Preliminary consultations were conducted with 27 identified key stakeholders, with the aim of 1) raising awareness about the research and securing their support, and 2) understanding the key issues in DFV prevention and early intervention from their particular practice perspective.

These preliminary consultations were conducted by telephone and predominantly took place in September and October 2013. Consultations were usually conducted with one researcher and one participant, however in some instances two or more participants were involved. These consultations ranged in length from 5–10 minutes to up to 60 minutes, depending on the participant. These preliminary consultations were not recorded or transcribed, but the researcher took notes on the key issues.

Following the preliminary consultations, in November 2013, the research team conducted a series of more formal stakeholder consultations in the form of five half-day roundtables held in Sydney, Melbourne and Brisbane. Decisions about the locations for the roundtables were made in the context of project resourcing and were based on an assessment of where identified services and stakeholders were predominantly located.

The three stakeholder roundtable sessions involved 40 participants, representing 31 organisations. The research team also undertook three additional individual interviews with service providers who had been unable to attend one of the roundtable sessions. Drawing on the insights gleaned from the preliminary consultations, the purpose of the roundtables was to understand the practice experiences and perspectives of service providers and

program managers and to document key insights that would assist in formulating recommendations for enhanced or new approaches and exemplar models in NSW.

The roundtable sessions were conducted in person using conference rooms located at the Australian Institute of Family Studies (Melbourne), the NSW Department of Family and Community Services (Sydney) and the Women's Legal Service (Brisbane). Participants for each roundtable were recruited using a "snowball" strategy that initially employed a variety of AIFS communication networks (e.g., AIFS website and the various AIFS email alerts) and making direct contact with identified services and programs. These initial contacts were then recruited to circulate information about the research, including invitations to attend the roundtable sessions, via email through their own practice networks. A list of services that participated in the roundtables is included in Appendix 2.

With the consent of the participants, the sessions were audio recorded and transcribed. In order to protect the identity of individual participants, the transcriptions were rendered anonymous and the original recordings destroyed.

In the original project brief, a third element of the consultation strategy was to have been conducted by participating in the Prevention Partnerships Advisory Committee, managed by the NSW Department of Family and Community Services. The planned Committee did not go ahead and consequently the research team was not able to fulfil this aspect of the original consultation plan.

Data from the stakeholder consultations were synthesised to support the formulation of a response to the research questions. Together with the other data, the conclusions set out in the final chapter inform the implementation of enhanced or new approaches and exemplar models in NSW.

1.3.3   Request for information

Drawing on the insights obtained from the various stakeholder consultations and the literature review, the research team developed and circulated a Request for Information to service providers and program operators. Using an online data collection instrument, the information requested included:

- the type of initiative or program;
- the nature of the host organisation through which the program or initiative is delivered;
- risk assessment or screening protocols;
- the theoretical underpinnings of the program;
- the range of services provided as part of the program;
- the structure and content of the program;
- client characteristics (including attendance and completion rates);
- whether any internal or external evaluation has been undertaken;
- whether any administrative program data exists that could contribute to an evaluation; and
- any other information identified as being relevant.

A copy of the Request for Information is included for reference at Appendix 3.

The Request for Information also gave service providers and program operators the opportunity to identify what they viewed as the characteristics and principles of good practice. The information request was initially promoted through AIFS' e-communication channels (e.g., Australian Centre for the Study of Sexual Assault (ACSSA)-alert; Child Family Community Australia (CFCA)-alert) and our stakeholder networks. Participants were also recruited using a "snowball" strategy that relied on these initial contacts circulating information about the request to their own practice networks.

Sixty-nine service providers and program managers completed the Request for Information in full, and a further 35 service providers and program managers submitted usable, partially completed responses. As was the case with the stakeholder consultations, service providers and program managers responding to the Request for Information often indicated that the service or program had a focus on both young children and also at-risk groups and communities. For this reason, data from the Request for Information is reflected in the findings of both AIFS reports.

1.3.4 Evaluation of two prevention or early intervention initiatives in NSW

Drawing on the combined insights obtained through the other components of this study, two initiatives in primary prevention and early intervention aimed at at-risk groups and communities in NSW were evaluated. Decisions about the programs to be evaluated and the evaluation methodology were informed by insights from the literature review, the consultations and the request for information. The decision was also made in consultation with the Department of Family and Community Services on the basis of the available budget.

The evaluation methodology draws on the insights obtained through the other components of this study and is informed by insights from the literature review, the stakeholder consultations and the request for information. This section sets out the general approach to the evaluation. The specific approach to the evaluation in respect of each service is set out in the chapters pertaining to each evaluation (i.e., Chapters 8 and 9). The evaluation was conducted between March and May 2014.

Selection of programs to evaluate

The two specific services/programs to be evaluated were identified through a "filtering" process described below. In addition, the NSW Department of Family and Community Services had expressed a preference that one of the programs to be evaluated was to have a focus on delivering services to Aboriginal and Torres Straight Islander Women. The other would be drawn from the pool of programs focusing on one of the other at-risk groups.

The following steps were followed in selecting the programs for evaluation:

- From the pool of programs identified through the literature review, stakeholder consultations and Request for Information, the research team identified programs targeting the selected groups.

- The research team then assessed programs within that selection using a variety of criteria, including: program reach, existing evidence about effectiveness and impacts, program scalability and transferability to other communities.

- Finally, the research team worked closely with service managers/program managers from programs identified as suitable for evaluation to ensure organisational support for the evaluations and a collaborative approach.

After applying these criteria, nine programs in NSW were assessed as potentially suitable for evaluation: four programs targeting Aboriginal women, two programs targeting young women, two programs targeting culturally and linguistically diverse women and one program focusing on women with disabilities. Following further consultations with the NSW Department of Family and Community Services, five programs were ultimately "short-listed" for the evaluation.

The research team initially approached four of the five short-listed services to establish their suitability and gauge their interest in participating in the evaluation. At this stage, one program was assessed as not suitable, as the particular prevention program of interest was no longer operational, and a second service declined the invitation to participate as their own program evaluation was already planned. The other two programs—the Health Family Circle Program conducted by Mudgin-Gal Aboriginal Corporation and the Women's Group and the Domestic Violence Community Education Project conducted by the St George Migrant Resource Centre—were assessed as suitable and the program managers agreed to participate in the evaluation. As a result, the research team did not make contact with the fifth short-listed program about the evaluation.

Overview of the evaluation approach

The evaluation had a broad focus on both the implementation (process evaluation) and impact of the program (impact evaluation) and was therefore concerned with assessing the program rationale and program logic, as well as the implementation and impacts of the identified programs. In the context of the time and resource constraints applicable to this project, the evaluation method made use of existing administrative data and collected qualitative and quantitative data from program staff and program participants.

A central strategy in the evaluation was to combine qualitative and quantitative information from these different sources and informants. This allows findings from each of these sources to be drawn together in order to produce robust and reliable evaluation findings.

The research team developed a series of research questions examining issues pertinent to understanding the practice and organisational approaches of the two services. Broadly, these questions concerned:

- The extent to which the program is based on well-accepted theory or developed from a continuing body of work in the field;

- The objectives of the program;

- How the program identifies the needs of the focus client group and the extent to which the needs of the focus client group are met;

- How the program works and how it is implemented;

- The program's impact and the changes generated (including any unintended consequences/outcomes);
- The extent to which the model/approach is sustainable and can be more broadly implemented.

The specific research questions were as follows:

- *Evidence base:* whether or not the program is based on a well-regarded theoretical model or is developed from a continuing body of work in the field.
- *Meeting client needs:* whether or not clients receive the support they need when they need it. That is:
  - How the program aims to meet the needs of the client group.
  - Effectiveness of the program intake and referral process, including:
    - means of accessing the service;
    - whether clients experience difficulties accessing the service and, if so, the nature of those difficulties;
    - the relationships/linkages between this program and other programs;
    - perceived timeliness and appropriateness of referrals.
  - How the program identifies:
    - presenting needs;
    - potential needs requiring early intervention; and
    - other service needs.
  - How the program responds to:
    - presenting needs;
    - potential needs requiring early intervention; and
    - other service needs.
  - Whether clients report feeling satisfied with their interaction with the program:
    - overall impressions of the program;
    - what clients like about the program;
    - what clients dislike about the program;
    - how the program could be improved to better meet their needs.
  - What clients gain from accessing the program.
  - Impediments to meeting the needs of the client group.
- *Implementation and operation of the program:* operational process and impact aspects of the evaluation:
  - program design, implementation and operation:
    - whether the program objectives are clearly documented;
    - the nature of the activities undertaken;
    - the program reach and target client group;
    - program participation, attendance and drop-out/non-return rates;

- the adequacy of resourcing, provision of training, skills development and support to staff to effectively deliver the program and whether program resources are being used effectively;
- availability of performance measures and other assessment instruments to provide information regarding the effectiveness of the program and implementation;
- availability of performance measures and other assessment instruments to provide information regarding the efficiency of the program and program implementation;
- availability of processes for dealing with customer complaints or feedback; and
- if the program is offered at multiple sites, whether there are differences in design or implementation between sites and the reasons for this.

▪ *Program impacts:* the program objectives and the extent to which the program has achieved its objectives and/or generated change:

  – The degree to which the program has achieved its stated objectives and whether those objectives changed over time.

  – The elements of the program that are most critical to achieving the objectives and whether there are any missing elements, or less effective components.

  – Whether there are any unintended consequences from program activities (positive or negative).

  – Whether there have been any other impacts on clients or the broader community.

▪ *Sustainability:* extent to which the model/approach is sustainable and can be more broadly implemented:

  – Whether the processes (including training, resources, and systems) are cost effective.

  – The extent to which the community context affected the implementation and outcomes.

  – What is needed in the "climate" for the activities to be or to remain successful?

Given the nature of prevention and early intervention and health promotion (i.e., outcomes are long-term, not easily quantifiable and aim for change at the population level), traditional cost-effectiveness analysis was not possible. However, the research team identified a range of interim or "proxy" measures to inform suggestions about the intervention's capacity for increasing factors associated with preventing violence from occurring and achieving systemic or community-level change.

Data collection

Data collection for the evaluations relied on a composite approach that included sourcing existing administrative data from the two services about the respective programs, and conducting qualitative interviews and focus groups with program users and with professionals involved in delivering the programs. Decisions about the data collection methods utilised in respect of each of the two programs were made in consultation with the service provider and in the context of the nature and scope of the program and the client base. Administrative data was collected in April 2014. Interviews and focus groups were conducted during April and May 2014. The specific details about the approach taken in respect to each service is set out in the chapters pertaining to each evaluation (i.e., Chapters 8 and 9).

1.4   Structure of this report

This introductory chapter has discussed the rationale for and methodology of the Domestic and Family Violence Prevention Review and Evaluation focusing on at-risk groups and communities. The next chapter sets out the background, definitions of DFV and policy contexts. Chapter 3 provides an overview of the impact of DFV on each of the at-risk groups and communities that are the focus of this report. Chapter 4 moves on to consider characteristics of effective prevention and early intervention approaches. Chapter 5 begins the detailed discussion of our findings from our stakeholder consultations. This Chapter provides an overview of the key themes that emerged from our consultation process in regards to prevention and early intervention activities. Chapter 6 provides a more focused discussion regarding the evidence base of prevention and early intervention activities that focus on at-risk groups and communities, and offers some examples of current prevention and early intervention activities. Chapter 7 outlines the evaluation framework for exemplar projects. Chapters 8 and 9 detail the findings of the evaluations of two prevention and early intervention programs in NSW. The final chapter brings together the main findings of the research and addresses the key research questions.

2 Background, definitions and policy contexts

This chapter addresses some important policy issues of relevance to the discussion in this report. It discusses definitions of DFV, influential contemporary policy frameworks and the concepts of primary prevention, early intervention and response in relation to DFV. Frameworks that are relevant nationally and in NSW are a particular focus of the discussion. This chapter establishes the backdrop to the specific discussion that follows in subsequent chapters.

2.1 Definitions

There is no single definition of DFV and varying terminology is used in policy, practice and research, including family violence, intimate partner violence, and domestic violence. The term domestic and family violence (DFV) is applied in this report because it is consistent with the terminology applied in NSW. In relation to the wider phenomenon of DFV, legislative, policy and practice definitions vary but there is a significant amount of overlap between the definitions adopted in various areas. In recent years there has been a move towards broader definitions of DFV that acknowledge a range of abusive behaviours wider than physical harm. Many contemporary definitions refer not only to physical abuse but also to a range of other behaviours including emotional abuse, sexual abuse, financial deprivation and social and cultural isolation. These definitions often refer to behaviours that are coercive and controlling, recognise that DFV is gendered in nature, and that children are often exposed directly or indirectly to family violence (WHO, 2010).

The Commonwealth Government's *National Plan to Reduce Violence Against Women and Children* (the "*National Plan*") (2009) acknowledges that laws and polices in each state have their own definitions, and distinguishes between the terms "Domestic Violence" and "Family Violence".

> Domestic Violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal, and non-criminal. Domestic violence includes physical, sexual, emotional and psychological abuse … Family Violence is a broader term that refers to violence between family members, as well as violence between intimate partners … the term "family violence" is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur. (COAG, 2009, p. 2)

"Domestic *and* family violence" is the term adopted in the most recent NSW policy framework *It Stops Here* (2014) which defines it as:

> any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually

manifested as a part of a pattern of controlling or coercive behaviour. (NSW Government, 2014, p. 5)

This definition was developed in consultation with government and community organisations to reflect the diversity of women's experiences and acknowledge that "women in intimate partner relationships are the group in overwhelming need but that protection is essential for all victims" (NSW Government, 2014, p. 6). Further explanation refers to an inclusive definition of "intimate relationship", encompassing past and present circumstances and not limited to situations where there has been a sexual relationship (NSW Government, 2014, p. 7). "Family relationship" is explained as, "people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, siblings and extended family relationships". It includes the full range of kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships, and constructs of family within GLBTIQ communities. People living in the same house, people living in the same residential care facility and people reliant on care "may also be considered to be in a domestic relationship if their relationship exhibits dynamics which may foster coercive and abusive behaviours" (NSW Government, 2014, p. 7).

Like some statutory definitions, the *It Stops Here* definition provides a non-exhaustive list of examples of the kinds of behaviour that may constitute DFV. They include:

- physical violence including assault or abuse;
- sexual assault and other sexually abusive or coercive behaviour;
- emotional or psychological abuse including verbal abuse and threats of violence;
- economic abuse, for example denying a person reasonable financial autonomy or financial support;
- stalking, for example harassment, intimidation or coercion of the other person's family in order to cause fear or ongoing harassment, including through the use of electronic communication or social media;
- kidnapping or deprivation of liberty, as well as unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture;
- damage to property, irrespective of whether the victim owns the property;
- causing injury or death to an animal, irrespective of whether the victim owns the animal.

The gendered nature of DFV is acknowledged and emphasised by both the *National Plan*, and the NSW framework. For example, the *National Plan* states that while a small number of men experience DFV and/or sexual violence, "the majority of people who experience this kind of violence are women—in a home, at the hands of men they know". (COAG, 2009, p. 1). *It Stops Here* states that "DFV is predominately, but not exclusively, perpetrated by men against women and children" (NSW Government, 2014, p. 6).

2.2 A public health approach to DFV

In this section we provide a descriptive overview of policies and frameworks that are influential in current approaches to DFV prevention, early intervention and response. As explained earlier, the *National Plan* establishes the national agenda and the NSW

Government's *It Stops Here* framework sets out the reform approach for that state. Each of these frameworks emphasises the importance of reducing the prevalence of DFV through primary prevention initiatives, in addition to recognising an ongoing need for early intervention and improved tertiary responses to DFV.

Since the 1990s, a public health model conceptualisation of DFV has been influential in the development of Australian policies (Murray & Powell, 2011; Walden, Barrett Meyering & Wall, 2014) and in frameworks such as those developed by the World Health Organization (WHO) (2002, 2010) and VicHealth (2007). We discuss the theoretical background and debates in greater detail in chapter 3. Here we briefly explain the public health approach taken by the main policy frameworks in Australia. A public health approach acknowledges that DFV "is preventable and should therefore be the focus of sustained government and community effort" (Walden, 2014). A socio-ecological understanding of DFV as having "multiple causes" is a key feature of the public health model (Walden et al., 2014; WHO, 2002; 2010). The socio-ecological conceptualisation of DFV, and more broadly gender-based violence and sexual assault, views it as the outcome of "multiple risk factors and causes, interacting at four levels of a nested hierarchy" (WHO, 2010, p.7). These four levels are: individual; relationship/family; community; and wider society. This perspective recognises that each of these factors may have varying levels of influence, in particular social, economic, biological, cultural and political contexts in the occurrence of family violence, but that gender inequality is the underlying cause (WHO, 2010).
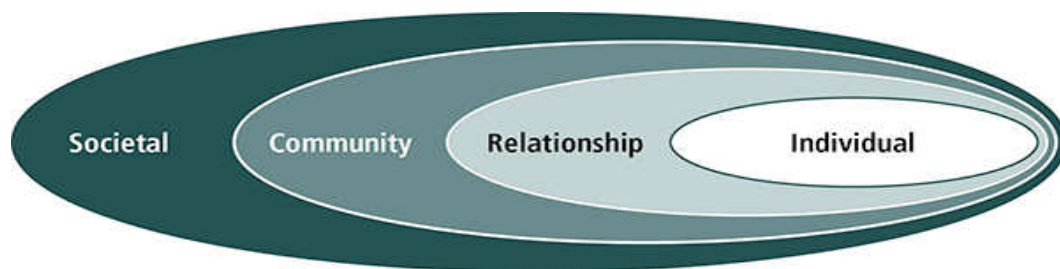
Source: Quadara & Wall, 2012, p. 4

Figure 1:   Ecological model of the factors influencing sexual violence perpetration

2.2.1   VicHealth: Preventing violence before it occurs

In 2004, the Victorian Government commissioned VicHealth to conduct a study into the economic cost of DFV in Victoria. The report outlined the economic "burden of disease" caused by DFV, finding that DFV was the leading cause of preventable death, disability, and illness for Victorian women aged between 15–24 years (VicHealth, 2004, p. 10). Walden et al. (2014, p. 7) noted that this analysis reflected a "growing acknowledgement" internationally that gendered violence is a heavy health-related burden that is prevalent but also preventable. This led to the development of the 2007 *Preventing Violence Before It Occurs: A Famework and Background Paper to Guide the Primary Prevention of Violence Against Women in Victoria.* This framework adopted a public health approach to DFV and argued that the prevalence of DFV is too high to only intervene *after* violence has occurred. It is based on the socio-ecological understanding of DFV proposed by WHO in 2002, and recognises that the underlying causes of DFV are a result of gendered relations of power. On the basis of this research evidence, the VicHealth report recommended that action to prevent violence against women is best guided by three interrelated themes:

1. Promoting equal and respectful relationships between men and women;

2. Promoting non-violent social norms and reducing the effects of prior exposure to violence (especially on children);

3. Improving access to resources and systems of support.

2.2.2 The World Health Organization: Preventing intimate and sexual violence against women

The WHO's *Preventing Intimate Partner and Sexual Violence Against Women* framework (2010) drew on gender, human rights and criminal justice perspectives on DFV prevention. It aimed to provide information for planners and policy-makers to develop evidence-based prevention programs. There is a strong emphasis throughout the framework on the need to draw upon evidence of what is known about the causes of DFV when developing policies and implementing practices, as well as the need to generate evidence through rigorous evaluations (WHO, 2010). This report followed on from the earlier *World Report on Violence and Health* (WHO, 2002), which located DFV and sexual assault in a continuum of interpersonal violence against women and framed it as a worldwide public health issue. The 2010 report was designed to review international evidence regarding the causes of violence against women and models of good practice in the area of prevention. A key point regarding evidence is that (at the time of publication), only one approach has been established as effective—school-based programs to prevent violence in dating relationships. However, the report also encourages the consideration of other contexts in which DFV prevention programs are run, as those most at risk of being a victim or perpetrator are often not engaged in formal education and so will not access programs run in schools, universities and other educational facilities.

2.2.3 The National Plan

The National Council to Reduce Violence Against Women and Their Children was formed in May 2008, following a commitment by the Australian Labor Party during the 2007 election campaign. *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and Their Children, 2009–2021* was released, along with a Background Paper, in March 2009. This was followed by the *National Plan to Reduce Violence Against Women and their Children 2010–2022* in February 2011. This plan was endorsed by COAG and included a three-year action plan. The National Implementation Plan for the First Action Plan 2010–2013 was released in 2012. The Second Action Plan 2013–2016 (Department of Social Services, 2014) was released on 27 June 2014, just as this report was being finalised. A further two action plans, each covering a three-year period, will be released to support the overall plan. Australia's National Research Organisation for Women's Safety (ANROWS) was also established as an initiative under the *National Plan.* ANROWS administers a research program under the National Research Agenda to Reduce Violence Against Women and Their Children. Additionally, a prevention-focused organisation based in Victoria has been established. The Foundation to Prevent Violence Against Women and their Children has government funding from the Commonwealth, Victoria and the Northern Territory and will focus on DFV prevention.

The *National Plan* is based on a public health, socio-ecological model for understanding violence, directly drawing on the *World Report on Violence and Health* (WHO, 2002) and *Preventing Violence Before it Occurs* (VicHealth, 2007).

Key issues identified in *Time for Action* include:

- the fragmented nature of state, territory and national systems;

- the significant barriers to collaboration and partnership, which impede the capacity to implement cross-departmental and inter-agency reforms and to monitor such reforms;

- the gaps between policy intent and implementation. For example, policies and laws at times interact to the detriment of women and children's safety. There is inadequate portability of DFV orders across state borders and contradictory impacts of dealing with the family law, child protection and justice systems. There is variation in definitions regarding consent in sexual assault matters.

- the failure to invest in primary prevention. Anti-DFV communication campaigns are not sustained and do not have a coherent message. Evidence indicates that positive campaigns focused on messages promoting cultural and behavioural change, rather than focused on victims, and encouraging people to access services, are most effective, yet this is not reflected in the funding of primary prevention campaigns.

- the inadequate funding of services. This has impacts on the workforce—it is difficult to attract and retain skilled staff to work in a complex and underpaid area.

- responses that are not tailored and accessible. Current services do not meet the diverse needs of women and children. Services (such as housing, employment, children's health, education, etc.) are not integrated to address the multiple impacts of violence.

- the lack of evidence about what stops men's violence against women. Instead, focus is on the criminal justice system and sentencing.

- the inadequate monitoring and reporting. Data and evaluation evidence is consistently lacking. It is necessary to set a baseline for monitoring change over time, which is agreed to by all levels of government.

The *National Plan* focuses on six high-level outcomes:

- Communities are safe and free from violence.
- Relationships are respectful.
- Indigenous communities are strengthened.
- Services meet the needs of the women and their children experiencing violence.
- Justice responses are effective.
- Perpetrators stop their violence and are held to account.

The first action plan (2010–2013) included four priorities that the various states and territories were to work towards while also developing their own plans that reflect their specific priorities. These are the four overarching priorities:

- Building primary prevention capacity;
- Enhancing service delivery;
- Strengthening justice responses; and
- Building the evidence base.

The second action plan (2013–2016) intends to build upon these aims with five new priorities:

- Driving whole of community action to prevent violence;
- Understanding diverse experiences of violence;
- Supporting innovative services and integrated systems;
- Improving perpetrator interventions; and
- Continuing to build the evidence base.

2.2.4   NSW: It Stops Here

The NSW framework *It Stops Here: Standing Together to End Domestic and Family Violence in NSW* focuses on the reforms that have been developed in response to systemic problems identified in the DFV service sector in NSW. It draws on the NSW Auditor-General's report *Responding to Domestic and Family Violence* (2011) and wide consultations with the DFV sector which "made it clear" that the way NSW was responding to DFV needed reform. Problems identified included:

- victims facing obstacles in gaining support and protection, specifically:
  - barriers to speaking up and identifying themselves as victims of DFV;
  - difficulty negotiating pathways within and between services to get the help they need.

The reforms focused on in the report include:

- changes that enable better identification and support of people who face a threat to their safety;
- increased cohesion and integration between workers from government and non-government agencies to better respond to people needing support;
- better information sharing, enabling people to move between agencies without having to retell their story.

There is also a strong emphasis on using evidence to inform targeted primary prevention work in the NSW community. The framework aims to deliver five broad outcomes:

- DFV is prevented.
- DFV is identified early.
- Victims are safe and supported to recover.
- Perpetrators stop using violence.
- A supported, professional and effective sector is developed.

The framework recognises that underlying causes of DFV are complex but that "to a large extent they reflect deeply held views in society about gender, masculinity, power and relationships" (2014, p. 14). Thus, it recommends that prevention should focus on challenging "disrespectful, discriminatory attitudes and beliefs that allow violence to occur" (2014, p. 14).

2.3   Prevention, early intervention and response: blurred boundaries

What is primary prevention?

Primary prevention of DFV is a key focus of international, national and state policy frameworks (Victorian Government, 2012; NSW Government, 2014; WHO, 2010; VicHealth, 2007). Primary prevention approaches address the underlying causes of DFV and aim to prevent violence before it occurs by "changing behaviours to prevent an undesirable social consequence" (Quadara & Wall, 2012, p. 3). Primary prevention is not (only) about increasing knowledge and awareness, but must also aim to influence attitudes to bring about behavioural change. DFV and sexual assault primary prevention strategies target the risk factors or conditions that may give rise to gender-based violence, such as: gender inequality; gender socialisation; and social norms (Quadara & Wall, 2012; Walden, 2014).

Broadly, it is understood that:

▪ primary prevention approaches address the underlying causes of DFV and aim to prevent violence before it occurs. Primary prevention strategies may be delivered universally to whole populations, or directed at people at a higher risk of experiencing DFV (Walden, 2014);

▪ secondary prevention, or early intervention, focuses on those at risk of perpetration or victimisation (the VicHealth Framework uses the term "early intervention strategies". (2007, p. 8));

▪ tertiary prevention addresses the longer-term needs that follow on from the experience of violence, including, for example, rehabilitation and strategies to reduce trauma. (WHO, 2010, p. 7). The VicHealth Framework uses the term "intervention strategies" (2007, p. 8).

There are several aspects of this schema that raise complexities that are relevant to the presentation of findings in this report. These complexities are also acknowledged in the literature on prevention approaches in DFV (and sexual assault) (Quadara & Wall, 2012; VicHealth, 2007; Whitaker, Murphy, Eckhardt, Hodges & Cowart, 2013). Fundamentally, they relate to the way that theoretical distinctions at each level of prevention may not be reflected in practice, with some programs operating at two or more levels. These distinctions are pertinent to several dimensions of prevention (Quadara & Wall, 2012). The first dimension relates to the timing of the intervention, reflected in the terms "primary", "secondary" and "tertiary", implying that the strategies address prevention at different time points—in practice, some programs operate across these time points.

The second dimension is the population group targeted by the strategy (Quadara & Wall, 2012). This dimension has a number of significant aspects, and one fundamental aspect is whether the strategy is aimed at preventing perpetration or victimisation. Again, some prevention strategies, particularly those that operate at the population level and are intended to support attitudinal change, address the prevention of perpetration and victimisation. Other strategies may be targeted at preventing either perpetration or victimisation. But in some contexts, such as measures to prevent the transmission of inter-generational violence, the distinction between the status of victim and perpetrator is ambiguous, since measures targeted at helping victims (for instance, children exposed to

DFV) are also intended to prevent them from becoming perpetrators or being re-victimised (Jaffe, Wolfe, & Campbell, 2012).

The third overarching dimension concerns the way the prevention strategy operates in the wider socio-ecological context (Quadara & Wall, 2012). In this regard, the basis of the strategy and how it is formulated to address DFV in its particular context, require consideration. Relevant issues in this area necessitate attention being paid to the characteristics of the target population, the factors that contribute to that population becoming perpetrators or victims and how the strategy addresses each of these issues, as well as the extent to which it is intended to operate as a primary, secondary or tertiary strategy (see, for example, Whitaker et al., 2013). These theoretical insights have informed the way that the data collection and analysis strategies in this research have been applied.

2.4 Integrated approaches

2.4.1 Integrated systems: Current thinking and practice

The integration of responses to DFV from government and non-government agencies is increasingly understood as critical in addressing such a complex problem. The development of integrated responses has occurred because of concerns about the effectiveness of service provision for service users and the perceived need to address differences in philosophical and organisational responses to the issue (Ross, Frere, Healey & Humphreys, 2011). At the base of integrated approaches is the understanding that a complex, seemingly intractable issue such as DFV requires a coordinated response (Healey & Humphreys, 2013). There is an assumption that sector coordination improves outcomes for victims, reduces secondary victimisation and can assist in addressing gaps in the service sector (Healey & Humphreys, 2013).

There are various understandings of what an integrated system means, as well as questions about how coordinated or integrated a system needs to be to be most effective (Healey & Humphreys, 2013; Marcus 2011). However, most commentators agree that systems tend to sit somewhere on a continuum from collaboration at the local, service delivery level; to coordination between agencies in at least some of their processes; to integration, which usually involves a strategic, jurisdiction-wide approach with multiple tiers of management.

Marcus (2011) identified some of the key features of integrated models as including:

- identified lead agency (i.e. a government department);
- shared vision, values and principles;
- common goal/action plan;
- common protocols and responses;
- cross-agency training;
- clear internal actions for each agency;
- enhanced evidence gathering/protective strategies;
- information sharing and agreements and protocols;
- common risk assessment protocols and tools; and
- multi-agency case management review.

Healey and Humphreys (2013) stress the importance of governance structures. They argued that a clear governance system must be implemented in some form in order for integration to survive in the long term (Healey & Humphreys, 2013). This does not need to be a strictly hierarchical arrangement but must involve coordination and monitoring (Healey & Humphreys, 2013).

Most integrated systems involve "horizontal" integration (aligning the actions and goals of various service areas) and "vertical" integration (coordinating the actions and priorities of services, agencies and government departments up and down the lines of accountability) (Ross et al., 2011).

Coordinated and integrated responses to DFV are evident in all jurisdictions in Australia, although where they sit on the spectrum of integration is variable (Healey & Humphreys, 2013). Healey and Humphreys (2013) provide a good overview of the arrangements in each Australian jurisdiction.

2.5   Summary

This chapter has considered the policy context for this report, including the development of the VicHealth Framework, the *National Plan* and the NSW-based *It Stops Here* strategy. The definition of DFV applied in this report is consistent with the broad and inclusive definition set out in *It Stops Here*, recognising the diversity of women's experiences and acknowledging the gendered nature of DFV. Additionally, this chapter has outlined the key international and national frameworks for the primary prevention of DFV, which espouse a public health socio-ecological approach. The socio-ecological approach is premised on an understanding that DFV has multiple causes at varying levels of influence, but that gender inequality is key to understanding the pervasiveness of DFV. As such, policy frameworks both nationally and internationally emphasise that prevention activities should aim at challenging gender stereotypes and attitudes towards gender roles and power.

The chapter has also considered the complexity of the concept of primary prevention in a practice setting, with practice approaches often positioning themselves as operating at this level, in addition to the secondary and tertiary levels. The need for prevention strategies aimed at Aboriginal and Torres Strait Islander women, women in culturally and linguistically diverse (CALD) communities, people who identify as GLBTIQ, young women, and women in non-urban communities is based on recognition of the necessity to address the specific needs of these groups.

3 The impact of DFV on at-risk groups and communities

There is a high level of diversity between, and within, the at-risk groups and communities that are the focus of this report. Consequently, there is significant variation in the contexts in which DFV occurs, as well as its impact. This chapter begins by examining the issue of housing, which impacts on all at-risk groups and communities. The following sections provide an overview on the evidence on prevalence and impact in relation to each group. The strength of evidence regarding the prevalence and impact of DFV in each of the at-risk groups and communities is variable.

3.1 DFV and housing

Housing is a critical issue for all people who have experienced DFV. It impacts particularly on women and children; DFV is a major contributor to women and children's homelessness (Barrett Meyering & Edwards, 2012; Oberin & Mitra-Kahn, 2013). Housing issues tend to be dealt with during the tertiary response to DFV. Until recently, women (and their children) escaping violence have tended to leave their homes. Increasingly, however, polices and practices that aim to enable women to remain in their homes after experiencing DFV have been developed in many Australian jurisdictions (Barrett Meyering & Edwards, 2012). These initiatives can be categorised as secondary prevention because a central aim of such initiatives is to reduce future violence (Oberin & Mitra-Kahn, 2013). The development of these policies and practices has been in response to the acknowledgment that a lack of housing options may mean that women stay in, or return to, violence. Finding new accommodation may also have many other negative consequences for women and children leaving violence, such as:

- removal from established support networks;
- impinging on the capacity for women to continue to work or to seek work;
- disruption of children's education if there is a need to change schools;
- financial hardship arising from, for example, a loss of possessions, moving costs and/or storage costs; and
- poorer quality replacement housing due to housing availability and affordability issues, which has several flow-on effects, such as:
  - poorer physical conditions of housing and surrounding neighbourhood; and
  - poorer safety of housing (Barrett Meyering & Edwards, 2012).

Safe at Home programs have been implemented in a number of states and territories in Australia (Barrett Meyering & Edwards, 2012; Spinney, Blandy, & Hulse, 2013). The UK's Sanctuary Schemes project, introduced in 2002, has been an influential model in the development of similar programs in Australia (Barrett Meyering & Edwards, 2012). Most programs consist of a range of elements that include stabilising a woman's housing through advocacy, increased safety of the house, and the legal exclusion of perpetrators (Barrett Meyering & Edwards, 2012). Existing research indicates that current programs are effective in meeting women's needs and achieving program objectives (Mackay, 2011; Spinney, 2012). Spinney et al. (2013) found that successful Stay at Home programs are well

integrated in the broad range of DFV response and support services, such as the police and judicial system, legal support and counselling.

Questions have been raised about how appropriate such programs are for the at-risk groups and communities that are the focus of this report. For some at-risk groups, the program may be particularly useful. For instance, programs such as NSW's Staying Home Leaving Violence prioritise women with disabilities. This reflects the fact that for women with disabilities leaving their home may be especially challenging, particularly where there are adaptations to their home and equipment that accommodate for their disability. Short-term accommodation (such as in refuges) may not be able to provide appropriate support for women with disabilities, meaning that they cannot be accommodated or that accommodation is not as safe or comfortable as it should be. Finding longer-term accommodation that meets the needs of women with disabilities and/or adapting housing and replacing equipment is both disruptive and expensive. While not all women with disabilities may currently receive the support they need to stay in their own homes under such programs, the prioritisation of their needs is positive. This issue is further discussed in section 6.3.

However, the needs of other at-risk groups may not be so well met by such programs. For instance, CALD women and Aboriginal and Torres Strait Islander women are particularly likely to lack information about their legal rights to stay in their home and so may not actively seek access to such programs (Spinney et al., 2013). For Aboriginal and Torres Strait Islander women, in particular, it has been suggested that the focus needs to be on providing culturally appropriate support that enables women to stay in their community (Barrett Meyering & Edwards, 2012). In some Aboriginal and Torres Strait Islander communities, there are differing understandings of what constitutes "home" (Memmott, Nash, Balfour, & Greenop, 2013). There may be a high level of mobility between houses in a community as well as highly fluctuating number of visitors from other locations (Memmott et al., 2013). Exclusion of perpetrators may not be practicable or culturally appropriate in these contexts. Women may not want to stay in the house they normally live in due to highly stressful, overcrowded environments (Memmott et al., 2013).[2]

Another issue for women in at-risk groups is housing affordability. While the emphasis in Stay at Home programs is on women staying in their home, and many programs incorporate some level of financial support, in the long term, women may have difficulty meeting rental or mortgage payments after leaving their relationship (Barrett Meyering, 2012). This is an issue that impacts on all women, but especially those from some at-risk groups. For instance, women with disabilities, Aboriginal and Torres Strait Islander women and CALD women, in particular, are often more financially marginalised than other women. These issues highlight that any Safe at Home program needs to take into account the specificity of the issues in any community in which it is being implemented.

---

[2]   It should be noted, however, that crowding and overcrowding are not fixed concepts, and that a high number of people in a household does not automatically correlate to perceptions of a stressful housing situation by those living in such households (Memmott et al., 2013).

3.2   Prevalence and key issues

3.2.1   Aboriginal and Torres Strait Islander women

Prevalence

A large body of evidence, accumulated over many years, demonstrates that violence, and in particular DFV, occurs at significantly higher rates in some Aboriginal and Torres Strait Islander communities than in non-Aboriginal and Torres Strait Islander communities (Day, Francisco & Jones, 2013). It is important to keep in mind, however, that there is a great degree of diversity within Aboriginal and Torres Strait Islander communities. DFV does not affect all Aboriginal and Torres Strait Islander communities equally.

Aboriginal and Torres Strait Islander people are overrepresented in homicide statistics. In figures from 2008–09 and 2009–10, they were approximately four times more likely to be the victims of homicide than their non-Aboriginal and Torres Strait Islander counterparts (Chan & Payne, 2013). More than half (55%) were killed in a domestic dispute, of which the most common subcategory was intimate partner violence (Chan & Payne, 2013). Family violence disproportionally impacts on women in Aboriginal and Torres Strait Islander communities in comparison with their male counterparts. Based on 2006–07 figures, female Aboriginal and Torres Strait Islander victims of homicide were killed by an intimate partner or family member in 73% of cases, in contrast to 41% of their male counterparts (Dearden & Jones, 2008).

The proportion of Aboriginal and Torres Strait Islander people who had been victims of physical or threatened violence in the previous 12 months did not change significantly between 2002 and 2008, and remained around twice the proportion of non-Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare [AIHW], 2011).

In 2008–09, Aboriginal and Torres Strait Islander women were 31 times more likely to be hospitalised for injuries caused by assault than other women (AIHW, 2011; Day et al., 2013). In remote areas, Aboriginal and Torres Strait Islander people were hospitalised as a consequence of family violence 35.6 times more than non-Aboriginal and Torres Strait Islander people (AIHW, 2011; Day et al., 2013).

Key issues

As the prevalence statistics detailed above indicate, Aboriginal and Torres Strait Islander women are at significantly higher risk of being subjected to family violence than their male counterparts and it is critical to take account of the intersection of race and gender when considering the issue of DFV. DFV in Aboriginal and Torres Strait Islander communities has a multitude of contributing factors (Cripps & Davis, 2012). Overcrowding of housing and high levels of alcohol consumption are repeatedly identified in the literature as key compounding factors in family violence in Aboriginal and Torres Strait Islander communities (AIHW, 2011; Blagg, 2000; Steering Committee for the Review of Government Service Provision [SCRGSP], 2011).

It is generally agreed that DFV in Aboriginal and Torres Strait Islander communities occurs within a context in which the impact of colonisation and its practices, such as

forced removal of family members, displacement of people from traditional lands, the breaking down of social bonds and identities, loss of language, and sexual and physical violence, are still in effect and being worked through (Day, Martin, & Howells, 2008).

It is, in part, due to this focus on the ongoing legacy of colonialism and its role in DFV that many Aboriginal and Torres Strait Islander people and communities have expressed a preference for the term "family violence" rather than "domestic violence". Not only is the term understood to better account for the complexity and diversity of relationships between people who perpetrate and are effected by violence (Blagg, 2000), it also reflects a different approach to the issue and understanding of its causes. Blagg points out that while there is significant overlap with the domestic violence framework, the family violence approach differs in critical ways. It has less of an emphasis on criminalisation as the primary response to DFV and less reliance on feminist analyses and explanations of violence. It places greater emphasis on the role of colonialism, trauma, family dysfunction and alcohol as primary causes, and understands male violence less as an expression of male power and more as compensation for lack of status and esteem (Blagg, 2000). However, as discussed in chapter 2, socio-ecological understandings of DFV emphasise the interplay of factors such as race and gender, and rather than minimise any particular factor, considers their intersection.

3.2.2   CALD women

Prevalence

There is significant diversity within the CALD community. It includes refugees and asylum seekers, newly arrived migrants on temporary or permanent visas, people from well-established communities and international students. This diversity certainly contributes to the fact that there is limited data on the prevalence of DFV in CALD communities (Australian Bureau of Statistics [ABS], 2013; Ghafournia, 2011; Mouzos & Makkai, 2004; Poljski & Murdolo, 2011; Trijbetz, 2013). As Mouzos and Makkai point out, "quantifying the level of violence experienced by women from minority populations compared to women from the general population is fraught with difficulty" (Mouzos & Makkai, 2004).

The evidence that is available is ambiguous: some studies find that CALD women in Australia are at higher risk of DFV than their non-CALD counterparts; others argue that the risks are similar (Ghafournia, 2011; ABS 2013). Statistics from population-based studies do not tend to correlate to those from service utilisation—CALD women are often underrepresented in the former and overrepresented in the latter (Poljski & Murdolo, 2011). There are various factors that are thought to influence this including reluctance to report violence, difficulty recruiting CALD women to research projects, research methodologies that do not enable participation from CALD women (e.g., English-only surveys), and women's variable perceptions of violence (Poljski & Murdolo, 2011). These issues are common in the international data on CALD communities—for instance, the US has similar gaps in data and ambiguous findings (Jaycox, Aronoff, & Shelley, 2007).

Key issues

Although the prevalence of DFV in CALD communities is unclear, the literature suggests that some cultural practices may increase the risk of CALD women experiencing DFV (Ghafournia, 2011). In addition, refugee women's common exposure to various forms of violence before arrival in Australia may compound their risk of being subject to DFV (Zannettino et al., 2013).

The literature indicates that cultural issues and immigration intensify the complexities associated with DFV. These compounding factors include:

- isolation from established family and social support networks;
- language barriers;
- a lack of knowledge about legal rights and legal and financial support services available (for instance, family allowance payments and similar from Centrelink);
- fear of deportation or the cancellation of visas;
- the high dependence of some CALD women on their partner (for financial support, language assistance, social and cultural connections and so on);
- lack of employment and occupational skills;
- "traditional" ideas about the role of women in relationships and family;
- cultural stigma, fear of humiliation and rejection from their communities;
- fear and/or distrust of the police, legal systems, government institutions and support services due to negative past experiences (often in their country of origin);
- the limited availability of culturally appropriate services, including culturally sensitive translators (Ghafournia, 2011; Poljski & Murdolo, 2011; Trijbetz, 2013).

3.2.3   Women with disabilities and mental ill health

Prevalence

A review of the literature suggests it is difficult to estimate the extent of experiences of DFV among women with disabilities. The literature generally indicates that women with disabilities are at least as likely as women without disabilities to experience DFV and some literature estimates the prevalence of DFV to be as high as one in two women with disabilities (see, for example, Hager, 2011; Healey, Howe, Humphreys, Jennings, 2003; Jennings & Julian, 2008; Lund, 2011; McClain, 2011; Plummer & Findley, 2012).

Likewise, the incidence of DFV among women with mental ill-health is difficult to estimate. Fernbacher (2006) suggested that, while the relationship between DFV and mental ill-health is not clear, there is strong evidence that mental health issues are common for women who have experienced physical and sexual violence. Laing and Toivonen (2010) cited a study by Golding (1999) that made similar assertions and Hager (2011) reported data from a 2004 VicHealth study suggesting that mental health effects make up to 73% of the total burden of disease associated with DFV.

Key issues

Women with disabilities are at risk of experiencing DFV from a variety of perpetrators. In addition to being exposed to a risk of violence perpetrated by their intimate partners or other family members, the literature also indicates that women with disabilities or mental ill-health are at risk of experiencing DFV from carers or personal assistants, friends and healthcare professionals (Cummings, 2003; Lund, 2011; Thiara, Hague, Bashall, Ellis, & Mullender, 2012). Fernbacher (2006) noted similar risks for women with mental ill-health, and cites a report from the Victorian Department of Human Services (1997) that described women feeling particularly vulnerable when they are admitted to health and other facilities on an involuntary basis.

Women with disabilities are often more vulnerable to DFV because of restricted mobility or emotional, physical or financial dependency on the perpetrator, which can make it difficult to act protectively and creates significant barriers to leaving a violent situation (Healey et al., 2008; Lund, 2011; Plummer & Findley, 2012). For some women, a fear of being institutionalised or being placed in some other care facility (such as a nursing home) if they report DFV also compounds the sense of isolation (see Hague, Thiara, & Mullender, 2011).

Physical access to services is a key theme arising from the literature. Healey et al. (2008) provided an overview of several studies illustrating how not being able to overcome practical limitations—either physical or communication barriers—means women with disabilities are unable to flee violent situations. This is particularly pertinent where the carer is the perpetrator. Difficulties also arise for women who are able to flee but have specialised requirements that local services, such as support services or refuges, are unable to accommodate.

Jennings (2003) cites research illustrating that some women with disabilities, who may have spent long periods of time in oppressive or restrictive situations, may have difficulties defining what is abusive and what is not. Similarly, often women with disabilities rely on a "gatekeeper" to provide information (see also Cummings, 2003: Jennings, 2003; Plummer & Findley, 2012:).

Fernbacher (2006) noted similar difficulties for women with mental ill-health, particularly for women with an established mental illness, in accessing support services and exercising legal rights. Fernbacher also notes that women with mental ill-health report being disbelieved by police, service providers and health professionals if they do seek help for DFV.

3.2.4   Gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) communities

Prevalence

The evidence seems to indicate that people who identify as GLBTIQ experience DFV at similar rates as those who identify as heterosexual (Pitts, Smith, Mitchell, & Patel, 2006). However, there are a number of methodological concerns about the Australian data on the prevalence of DFV in GLBTIQ communities, and the reliability of the data is variable.

There is little population-wide data available. For instance, the commonly quoted sources for information on the prevalence of DFV, such as the ABS' Personal Safety Survey (PSS), do not collate data on DFV in GLBTIQ communities and the Australian component of the International Violence Against Women Survey focused on violence perpetrated by men. The consequence of this is that most data on DFV in GLBTIQ communities comes from research that is based on convenience samples and this raises questions of how representative such figures are. Murray and Mobley (2009) provide a good overview of these methodological issues and frameworks for addressing them in future research.

The *Private Lives* report (Pitts et al., 2006), examined the health of people who identify as GLBTIQ across Australia, and asked questions regarding DFV in its survey.[3] From a sample of 5,476 people who completed an online survey in 2005 (Pitts et al., 2006), 33% of respondents reported having been in a relationship where the partner was abusive, 41% and 28% of women and men respectively (Pitts et al., 2006).

In 2008, the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University published the report *Coming Forward*, focusing on GLBTI people in Victoria and their experiences of heterosexist violence and same-sex partner abuse. Its findings were based on an online survey of 390 respondents (Leonard, Mitchell, Patel, & Fox, 2008). Almost a third reported having been in a relationship in which abuse had occurred, with the figures higher for women than men (35% versus 29%) (Leonard et al., 2008).

Another key issue affecting GLBTIQ communities is DFV directed at young people, often by family members, in response to their sexuality or gender diversity. The *Writing Themselves In* series of reports focus on young people's experiences of sexuality-related violence. They asked questions about the respondents' safety in various contexts, including the family home. Nearly one-third (29%) of respondents to the first survey "believed they had been unfairly discriminated against" *because of their sexuality* (Hillier et al., 1998). Of these, family members were the abusers in 10% of cases (Hillier et al., 1998). Six per cent of the total number of young people reported feeling unsafe at home (Hillier et al., 1998). In response to the second survey, 38% of those surveyed reported unfair treatment on the basis of their sexuality (Hillier, Turner, & Mitchell, 2005). The family home was the site of abuse in 18% of these cases (Hillier et al., 2005). Most respondents felt safe at home (82%) and home was the safest place reported, in contrast to at school or on the street, for example (Hillier et al., 2005). Of the 18% of respondents who did not report feeling safe at home, this was a mix of people who felt "unsafe" and "OK" (Hillier et al., 2005). The exact breakdown of these figures is not clear in the report. The third survey in the series asked participants about verbal and physical abuse separately, rather than the overall question about unfair treatment in the previous surveys. Sixty-one per cent of respondents reported experiencing verbal abuse, and 18% reported physical abuse, because of homophobia (Hillier et al., 2010). Twenty-four per cent of people who were abused (verbally or physically) were abused at home, often by parents (Hillier et al., 2010).

---

[3]   The follow up study, Private Lives 2, published in 2012, did not include these questions. Leonard, et al. (2012). Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual (GLBT) Australians. Australian Research Centre in Sex, Health & Society, Melbourne.

Key issues

A key theme that emerges within the literature is the issue of the invisibility of DFV in GLBTIQ relationships. For instance, Ball and Hayes (2009) critiqued the omission of consideration of GLBTIQ relationships in the governmental, policy and criminological responses to DFV. They argued that such responses overwhelmingly assume a heterosexual framework in which women feature as victims and men as perpetrators (Ball & Hayes, 2009). While the GLBTIQ community has made some impact regarding the acknowledgement of the issue within government agencies, they argue that this has not translated into a substantive response to the issue (Ball & Hayes, 2009).

They, and other authors, also documented the lack of acknowledgment of DFV within the GLBTIQ community. The reasons for this are multiple and complex, but include an inability to recognise abuse outside of dominant understandings of gendered power dynamics (Irwin, 2006; Ristock, 2011). The influence of feminist discourses on DFV are often cited here as influencing the lack of acknowledgement of DFV outside of heterosexual relationships (Ball, 2011; Ball & Hayes, 2009; Peterman & Dixon, 2003; Ristock, 2011). Many authors have also identified idealised understandings of GLBTIQ relationships as an inhibitor to acknowledging DFV, particularly among lesbian women, whose relationships have often been understood to exist outside of traditional power dynamics (Merlis & Linville, 2006; Paroissien & Stewart, 2000; Peterman & Dixon, 2003).

While some patterns of DFV in GLBTIQ relationships are similar to those in heterosexual relationships, others are more specific. The latter includes the use of "outing" or disclosing HIV status, or threats to do so, as part of DFV (Ball & Hayes, 2009). Some lesbian abusers will present as victims (to shelters, support groups, and so on), in order to further perpetuate DFV against their partner by accessing them in these spaces, or by making it impossible for them to seek support at these services (Peterman & Dixon, 2003).

3.2.5 Younger women

Prevalence

The Australian evidence indicates that young women are at increased risk of DFV in comparison to their older counterparts. The 2012 ABS Personal Safety Survey (PSS) found that they were certainly more at risk of violence in general than older women (ABS, 2013b). The latest PSS found that 13% of women aged 18–24 years experienced at least one incident of physical and/or sexual violence in the 12 months prior to the survey (ABS, 2013b). This compared with 8% of women aged 35–44 years, and 2% of women aged 55 years and over (ABS, 2006; ABS, 2013b).[4]

The 2004 Australian component of the International Violence Against Women Survey also indicated that young women are at higher risk of violence than older women. Nearly one-quarter of women aged 18–24 years had experienced violence, compared to 8% of women aged 35–44 years, and 3% of women aged 55–69 years (Mouzos & Makkai, 2004).

---

[4]   More detail is available from the 2012 PSS data regarding how many young women experience violence from partners or ex-partners. This data has yet to be analysed but will be provided in the final report.

There are few studies that focus on the issue of dating violence in Australia. The largest study was undertaken by the National Crime Prevention (NCP) branch of the Attorney-General's department in 2001 (NCP, 2001). The study surveyed 5000 young people aged 12–20 years. The findings indicated that 26% of girls/young women who had been in a dating relationship had been pushed, grabbed or shoved by their boyfriend, 25% experienced an attempt to be physically controlled by their boyfriend, 19% had been physically threatened by their boyfriend, and 14% had had their boyfriend try to force them to have sex (NCP, 2001).

Key issues

Key issues include young people's perceptions of what constitutes DFV and how DFV is understood. A central finding from the analysis of the qualitative data from the NCP study was that although young people can identify DFV in certain contexts (for instance, where there is a clear demarcation between victim and perpetrator), and consider such examples of DFV negatively, when it comes to their own experiences or issues that may be considered more "grey", they are much less likely to identify a particular behaviour as problematic. In these instances, they are more likely to think abusive behaviour is justifiable or understandable.

These findings correlate with those of Chung (2007) who undertook a qualitative study in South Australia that involved semi-structured interviews with 25 young women aged 14–18 years. Chung found that DFV is common in young people's relationships (Chung, 2007). Chung argued that adolescence is a key time for young people to form ideas about relationships and their sense of identity in them (Chung, 2007). Young women often minimised their partner's violence and considered it to be an individualised problem, often for which they were responsible, rather than an expression of gender inequality (Chung, 2007). Specifically, Chung (2007) argued that in an era when the discourse of equality is dominant, the idea that women "choose" to stay in violent relationships, and hence are responsible for DFV, is common.

Consequently many young women found it difficult to speak up, seek help or leave a partner (Chung, 2007). Chung's conclusions compound previous findings that young women are reluctant to seek help from formal services, more commonly seeking assistance from informal networks such as peers (Chung, 2007). Chung recommended that these various findings be taken in to account when framing responses to DFV (Chung, 2007).

Murphy and Smith (2010) carried out quantitative research in which 146 girls (14–18 years old) attending schools in a semi-rural area completed a purpose-built questionnaire. They explored adolescent girls' experiences of, and responses to, seven domains of partner behaviour that are considered to be early warning signs of relationship abuse.[5] Substantial proportions of girls (a) reported exposure to each of the domains, (b) lacked awareness, particularly of the risks associated with jealous/possessive partner behaviours, and (c) regardless of their level of risk awareness, lacked knowledge of behavioural responses that

---

[5] The seven domains were: gender denigration; personal put-downs; public debasement; verbal aggression; jealousy/possessiveness; social restriction; and exit-control tactics.

might discourage continued warning-sign behaviours by their partners in all domains except for social restriction tactics.

3.2.6 *Women living in regional, rural and remote (non-urban) communities*

Prevalence

It is unclear whether women living in non-urban (RRR) communities are more at risk of DFV than their urban counterparts. There is some research that indicates that women are more likely to be the victims of DFV in rural than urban locations (Grech & Burgess, 2011) and that DFV is less likely to be disclosed to formal services than in urban contexts (Hogg & Carrington, 2006; Mitchell, 2011; Ragusa, 2013). However, the strength of the evidence on these issues is unclear (Mitchell, 2011).

Mining town: fly in, fly out workers and their families

The rapid expansion of the mining sector and long commute practices such as fly in fly out (FIFO) and drive in drive out (DIDO) have raised concerns that such communities may have higher rates of DFV than other parts of Australia. However, Nancarrow, Lockie and Sharma (2009) did not find an increased risk of DFV in a study undertaken in 2007 about a Queensland mining community that considered both FIFO and non-FIFO mining workers and their families. A recent survey of the literature regarding the effect of FIFO work practices on children and family relationships found that there is limited evidence on its impact (Meredith, Rush, & Robinson, 2014). However, the evidence that is available does not indicate an increase in DFV in this population and that while there are challenges and potentially negative impacts of FIFO work, FIFO families "are likely to be healthy, functioning families" (Meredith et al., 2014).

Key issues

There are many commonalities in women's experiences of DFV, and the barriers to leaving violent situations, between women in non-urban communities and women from other geographic locations. These include fear of their partner's threats if they leave; economic concerns for themselves and their children; limited means to leave; and societal and/or familial pressure to stay in the relationship (Wendt, 2009b).

However, there are issues that are specific to the experience of DFV for women living in non-urban communities (Crinall, Laming, Healey, & Smith, 2013; Wendt, 2009b). Themes that emerge from the literature include:

▪ heightened concerns relating to privacy and confidentiality due to living in a small community with a limited number of service providers;

▪ lack of services, or a lack of appropriate services;

▪ delayed response times (e.g., by police) due to a lack of services and distance;

▪ distance to services and transport access issues;

▪ rural community norms/conservative or traditional norms, esp. relating to family and gender roles;

- isolation as a compounding aspect of the impact of DFV, and one that may be explicitly exploited by perpetrators, particularly in remote locations or on farms;
- easier access to firearms than in urban communities;
- higher rates of alcohol consumption than in urban areas;
- amplification of risk due to the impact of natural disasters (e.g., fire, flood, drought, etc.), economic downturn and higher unemployment.

There is significant diversity within RRR communities. The social, cultural and economic characteristics of non-urban communities vary significantly within, and between, such communities (Immigrant Women's Domestic Violence Service [IWDVS], 2006; VicHealth 2007). As a consequence, the issues outlined above impact unevenly on women from RRR communities, and some women may face additional barriers to seeking help following, or when they are at risk of, DFV. For instance, the nature and context of DFV differs markedly between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women living in non-urban communities (Wendt & Hornosty, 2010). Culturally appropriate DFV services for Aboriginal and Torres Strait Islander women may be even more limited in RRR communities than in urban settings due to fewer service providers and issues of confidentiality may be heightened in close-knit communities (Lumby & Farrelly 2009). CALD women in non-urban communities may also face further barriers to accessing services due to lack of cultural awareness and sensitivity amongst service providers, language barriers, cultural isolation, xenophobic attitudes and fears about residency/visas (see especially IWDVS, 2006). These factors are important to keep in mind when considering in detail the issues facing women living in non-urban communities and their experiences of DFV. Responses to the issue must be relevant to communities and specific local contexts, and sensitive to the diversity within them.

3.3   Summary and policy implications

Better evidence is needed regarding the prevalence and impact of DFV in at-risk groups. Investment in a more comprehensive evidence base is needed in order to:

1. **inform effective prevention and early intervention practice through a good understanding of the problem and its issues; and**

2. **measure success of any prevention and early intervention initiatives over time.**

This chapter has examined the evidence about what is known about DFV in each of the communities and groups that are the focus of this report, in addition to identifying key issues in relation to each group that has implications for the design and implementation of strategies. The discussion highlights considerable variation in the extent to which the evidence base on DFV is developed in relation to each group. Better evidence is required across the board but empirical understandings are particularly underdeveloped in relation to CALD women, GLBTIQ communities and women with disabilities. Lack of knowledge about specific circumstances of the sub-groups in each of these areas is particularly striking.

4 Causes and prevention

Theories and evidence in relation to the causes of DFV are explored in this section. Approaches and strategies to prevent DFV are premised within various theories and assume various models of causation. There is widespread acknowledgement in policy frameworks that primary prevention of DFV should address the underlying causes contributing to violence, yet evidence regarding both the aetiology of DFV, and the effectiveness of various prevention strategies is limited and very few prevention programs have been adequately evaluated (Flood, 2013; WHO, 2010; Whitaker et al., 2013).

The most widely accepted contemporary approach, the socio-ecological theory, was introduced in chapter 2, and is examined in more depth here. Other influential theories are explored briefly as they provide some foundation for some of the approaches considered in this report.

4.1 Feminist conceptualisations

Feminist responses to DFV developed from the women's health and women's refuge movements of the 1970s and 1980s. In Australia, feminist organisations and campaigners have been influential in ensuring violence against women and children became a policy issue (Murray & Powell, 2011). In their overview of DFV policy in Australia, Murray and Powell argued that early government prevention efforts were largely based in a crime prevention or law and order approach, which placed emphasis on victims and "less commonly focused on attempts to change the behaviour of offenders themselves" (Murray & Powell, 2011, p. 144). However, the feminist perspective on violence resulted in a "conceptual shift" (Murray & Powell, 2011) in terms of policy that saw DFV move from being an individual problem, to a structural/societal problem. Though there is no one feminist theory of DFV perpetration, it is broadly understood as an effect of patriarchal social structures and gender roles placing men in positions of power over women (Bell & Naugle, 2008; Murray & Powell, 2011; Woodin & O'Leary, 2009). Feminist explanations locate cause of DFV in unequal power relationships; men's violence is both an outcome of and a response to gendered inequality. As such, it is argued that greater gender equality would reduce men's violence against women (Whaley, Messner, & Vesney, 2013). A gendered perspective on DFV recognises that:

> domestic violence is one form of violence amongst others, including sexual assault and sexual harassment, that are experienced primarily by women, and that are … almost exclusively perpetrated by men. (Murray & Powell, 2011, p. 38)

The feminist perspective has, however, been critiqued for its failure to account for the ways in which ethnicity, sexuality and race intersect with gender to produce different experiences (Bell & Naugle, 2008; Murray & Powell, 2011). It has also been argued that it fails to adequately account for DFV in same-sex and gender-diverse couples (Ball & Hayes, 2009). Most recently, the socio-ecological model encompasses a feminist approach but also emphasises individual, community and societal factors relevant to the prevalence of DFV.

4.2   The socio-ecological model

As briefly described in the previous chapter, a public health socio-ecological approach to primary prevention has been adopted in international and Australian policy (COAG, 2009; NSW Government, 2014; Victorian Government, 2012; VicHealth, 2007; WHO, 2010). The World Health Organization has produced several key reports promoting a socio-ecological, public health model of primary prevention of DFV (Dahlberg & Krug, 2002; WHO 2002; WHO 2010), which are widely cited and influential in local policy frameworks. First theorised by Dutton (1985) and further developed by Heise (1998), the socio-ecological theory of DFV acknowledges that there is no single factor to explain DFV. Rather, violence is determined by a complex interplay of multiple and interrelated factors at four levels of influence: individual, family, community and society (Casey & Lindhorst, 2009; Dahlberg & Krug, 2002; Dutton, 1985; Heise, 1998; Quadara and Wall, 2012; WHO 2010).

A gendered understanding of DFV is central to this model. Gender inequality, traditional gender roles and patriarchal social structures are understood as being at the core of violence against women, and these issues interact with other risk factors such as exposure to violence in childhood, substance abuse and socio-economic status. A socio-ecological model encourages primary prevention of DFV in various contexts and on multiple levels of influence (Carmody et al., 2009; Flood & Pease, 2008; Heise, 1998; NSW Government, 2012; VicHealth, 2007; WHO 2010). It prioritises a shifting of societal attitudes and norms regarding gender in order to create a "climate of non-tolerance" of DFV (WHO, 2010, p. 35; Murray & Powell, 2011).

The literature indicates the need for primary prevention strategies to be focused on attitudinal change, be informed by local community context, and be offered across the lifespan, including during childhood, in order to be effective (Casey & Lindhorst, 2009; Chan et al., 2009; Michau, 2007). Thus, it is argued that primary prevention should occur in schools, local communities, peer groups, sporting and leisure organisations and workplaces (Ellis et al., 2006; Flood & Fergus, 2008; Hughes & Fielding, 2006; Human Rights and Equal Opportunity Commission [HREOC], 2006; VicHealth 2007; Walden et al., 2014 (forthcoming)). Broader societal-based preventions targeting the national population, such as large-scale media/social media campaigns, have also been identified as necessary in addressing and altering attitudes and societal norms (Campbell & Manganello, 2006; Murray & Powell, 2011; VicHealth, 2007; WHO, 2010). The WHO acknowledges that "dismantling the hierarchical constructions of masculinity and femininity" and eliminating inequality are long term, challenging goals and recognises that these broader macro-strategies should be complemented by "measures with more immediate effects" and informed by an evidence base (2010, p. 36).

4.2.1   Evidence base for a socio-ecological model

There is general recognition that the evidence basis for many primary prevention strategies remains emergent (Chalk, 2000; Cornelius & Resseguie, 2007; Flood, 2013; Murray & Graybeal, 2007; Whitaker et al., 2013; WHO, 2010;). Chalk (2000), for example, argued that prevention and early intervention programs lack a rigorous evidence base, largely because

they are difficult to evaluate due to heterogeneity and complexity of target populations and are often based on "perceptions of individual need" rather than epidemiological data.

Murray and Graybeal's (2007) systematic review of North American primary prevention program evaluations found a gap between research and practice. They argued that prevention is difficult to measure since outcomes are based on subtle attitudinal changes towards gender roles, violence and power in relationships. Moreover, very few program evaluations or studies are randomised, that is, they lack a comparable control group (Chalk, 2000; Murray & Graybeal, 2007; WHO, 2010). Whitaker et al. (2013) also asserted that the paucity of longitudinal studies on primary prevention initiatives means that long-term outcomes of programs or strategies are uncertain. However, Flood noted that while many have argued that the "gold standard" of evaluation is the randomised controlled trial, this type of study is inappropriate for many primary prevention projects, which are largely conducted by not-for-profit community organisations who "typically do not have the capacity to conduct evaluations based on an experimental design" and/or that have features which are not compatible with experimental study design/randomised controlled trials (2013, p. 13). Kwok (2013) reasoned that we should instead, focus on shorter-term gains/outcomes of prevention work, since shifting the root causes of DFV is a long-term endeavour requiring sustained effort over time which is unlikely to be seen in our lifetime (2013).

Since evidence of what works in primary prevention is scarce, the rationale for a public health, socio-ecological approach to DFV prevention is largely "theory driven" (Kwok, 2013, p. 9) and based on what is known about factors associated with perpetration, particularly the correlation of violence against women with community attitudinal factors (Casey & Lindhorst, 2009; Flood & Pease, 2008; Heise, 1998; Kwok, 2013; Murray & Powell, 2011; VicHealth, 2007; WHO, 2010). Cross-sectional international studies and systematic reviews of the literature indicate that perpetration of violence against women is associated with attitudes supportive of traditional gender roles, gender inequality, beliefs about male entitlement and acceptance of violence as a form of conflict resolution (Flood & Pease, 2008; Fulu, Jewkes, Roselli, & Garcia-Moreno, 2013; Hagemann-White, Kavemann, Kindler, Meysen, & Puchert, 2010; Jewkes, 2002; VicHealth, 2007; WHO, 2010). However, studies that have sought perpetrator childhood history and other social determinants, have found alcohol abuse, childhood trauma and/or childhood abuse, and depression have also been associated with perpetration (Fulu et al., 2013; Hagemann-White et al., 2010).

4.3   Factors associated with perpetration

A recent systematic review of evidence in the "factors at play in perpetration" of violence and sexual violence against women and children concluded that overall the available evidence in this area is "unsatisfactory" (Hagemann-White et al., 2010). Hagemann-White et al. reviewed 130 studies in scientific journals and a further 90 peer reviewed, research-based publications using a rating system that prioritised meta-analyses, cross-cultural comparisons, and longitudinal studies. The authors were able to extract some conclusions about various factors associated with the perpetration of violence against women. They identified four levels of influence in perpetration: ontogenetic, which includes individual life history factors such as family exposure to violence; micro, which includes peer,

community, workplace or school influence; meso–societal, which refers to larger institutions such as government and church as well as norms, sanctions, etc.; and macro, which refers to the "overall cultural, historical and economic structures of society"(Hagemann-White et al., 2010, p.6).

On the macro level, Hagemann-White et al. (2010) found that devaluation and subordination of women, normative beliefs about gender roles and unequal distribution of power contributed to acceptance of violence against women. Strong adherence to "normative heterosexual masculinity" (2010, p. 12) was also associated in some studies with perpetration. Cross-cultural studies, for example, suggest that societies that idealise masculinity have higher levels of violence. On the meso-societal level of influence, Hageman-White et al. found that a failure of agencies/governments to implement sanctions on violence against women was associated with higher levels of violence. Other meso-societal factors linked (causally) to violence included: poverty and disadvantage, gender discrimination in workplaces, "honour" codes and "hate groups". Hagemann-White et al. found a "strong bias" in the research literature towards ontogenetic (causations) of perpetration. Several factors were associated by Hagemann-White et al. as being linked in studies to perpetration; these include history of poor parenting, maltreatment or abuse, early trauma, emotional disturbances/personality/cognitive disorders, and drug and alcohol abuse.

Fulu et al. (2012) conducted a multi-country, cross-sectional study on men and violence in Asia and the Pacific. A total of 10,178 men aged between 18–49 years were interviewed via household surveys in seven countries, which included questions regarding DFV and sexual assault perpetration, gender attitudes, and potential multivariates associated with perpetration of DFV such as poverty, low education, exposure to childhood trauma and alcohol abuse. Results suggested a correlation between perpetration of physical partner violence and:

- low education;
- experiences of trauma and abuse in childhood (particularly witnessing DFV);
- alcohol abuse;
- engagement in contractual sexual practices (specifically associated with perpetration of sexual abuse/rape);
- controlling behaviour by men toward their intimate partners; and
- "gender-inequitable attitudes" (2012, p. 204).

Traditional attitudes toward gender roles have also been associated with higher tolerance for violence against women (Berkel, Vandiver, & Bahner, 2004; Goode, Heppner, Hillebrand-Gunn, & Wang, 1995; Simbandumwe et al., 2008). For example, a qualitative study with immigrant men in Canada (Simbandumwe et al., 2008) found that some men felt the threat to their role as male breadwinner and identity as head of the family, to be a justification for violence.

Attitudinal surveys of young people in Scotland, the United States and Australia suggest that violence-supportive attitudes are present among some peer groups (Burman & Cartmel, 2005; Casey & Lindhorst, 2009; Indermaur, 2001; Rosewater, 2003; Young, 2004) and a VicHealth survey (2009) found that a significant minority of Victorian men believed

violence against women could be excused in certain circumstances. Several reviews of the literature (Casey, Beadnell & Lindhorst, 2009; Flood & Pease, 2008; Heise, 1998; WHO, 2010) suggest that incidences of family violence are found to occur more frequently in communities where there are low sanctions for violence, or in communities where there is a view that violence against women is sometimes justified, for instance in cases of infidelity.

4.3.1 Childhood exposure to DFV and future perpetration

There is some debate within the literature regarding the association between childhood exposure to DFV and future perpetration (Ali & Naylor, 2013; Bevan & Higgins, 2002; Ellis et al., 2006; Shorey, Cornelius & Bell, 2008; Temple, Shorey, Tortolero, Wolfe, & Stuart, 2013; Tomison, 2000). Social learning theory posits that DFV is intergenerational, learned in childhood through behavioural modelling and observations of parents and peer relationships (Bell & Naugle, 2008; Ellis et al., 2006; Shorey et al., 2008; Woodin & O'Leary, 2009). In this model, it is hypothesised that "coercive and aversive interpersonal behaviours are learned through violent interaction in one's family of origin" (Shorey, et al., 2008) and it is understood that children learn that violence is an acceptable method of dealing with conflict (Jaffe et al., 2012). According to Jaffe et al. (2012), gender role modelling is an important aspect of this theory, as it is thought that children model behaviour on the parent they identify with: thus boys may become violent and girls may learn to become victims (Jaffe et al., 2012). In the social learning model, it is thought that prevention and early intervention should thus focus on developing skills and knowledge that will enable children to learn different ways of dealing with conflict, and in "unlearning" problem or undesirable behaviours (Ellis et al., 2006).

A further, and related, theory is the intergenerational transmission of violence theory, which sees perpetration in males as resulting from the trauma of witnessing or being victim to violence as a child (Kim, 2011). However, there is also some debate surrounding this theory. The argument put forth in the literature is that not all children who experience DFV go on to become perpetrators or victims and, likewise, not all perpetrators have a history of childhood violence or abuse: the social and family context in which DFV occurs is important for understanding these outcomes (Bevan & Higgins, 2002; Casey et al., 2009; Stith et al., 2000).

Fergusson, Boden, & Horwood's (2006) longitudinal analysis of a cohort of 10,000 young adults in New Zealand found that the association between adult perpetration of violence and child exposure to DFV was "weak". Fergusson et al. suggest that instead, the correlation can be explained by the "confounding psychosocial" context in which the DFV took place (2006, p. 103). The study found that DFV was more common among participants whose childhoods were "characterised by a number of adversities" such as parental mental ill-health, unemployment, poverty, family dysfunction, sexual abuse and "impaired parental bonding" (Fergusson et al., 2006, p. 103). In a smaller sample involving 36 male perpetrators, Bevan and Higgins (2002) found a unique correlation between childhood exposure to DFV and psychological abuse of spouses. However, closer analysis of inter-correlations of variables suggested that "rather than physical abuse or witnessing family violence, … other forms of child maltreatment … are important risk factors for perpetration of domestic violence in adulthood" (2002, p. 239). Bevan and Higgins found

that childhood neglect, in particular, had a strong association with future physical perpetration of DFV.

Social learning theory or the intergenerational transmission of violence theory, as a *comprehensive* explanation for causation is thus viewed with some caution. Conversely, Whitaker et al. (2013) acknowledge that while the correlation is weak, exposure to DFV in childhood nonetheless needs to be addressed as it appears often enough as a factor associated with perpetration. Whitaker et al. believe that exposure to DFV should be viewed alongside an array of risk factors in childhood that should be addressed via specific prevention strategies.

4.4   Summary and policy implications

- **The literature indicates that primary prevention should address the underlying cause of DFV: gender inequality, idealised masculinity and violence-supportive attitudes.**

- **Primary prevention should focus on affecting attitudinal change in multiple and localised contexts including communities, workplaces, schools and sporting organisations, as well as in populations on a whole through large-scale public campaigns.**

- **There are complexities in linking childhood exposure to DFV with future perpetration: childhood exposure should be viewed as a risk factor alongside other risk factors.**

This chapter has outlined the most prominent theories of causation and prevention of DFV. Feminist theories have been widely influential in understanding DFV as directly linked to gendered relations of power. In the socio-ecological model, gender remains central, though there is acknowledgement that DFV is the result of a complex interplay of factors, at varying levels of influence. The socio-ecological approach to primary prevention thus aims to address the underlying cause of DFV by focusing on attitudinal change in various contexts and across the lifespan. There is general agreement in the literature that since there is a paucity of evidence for "what works", the socio-ecological model of primary prevention is largely theory-driven. That is, prevention strategies are based on what is known about perpetration. The literature around factors associated with perpetration strongly point to DFV as being linked with traditional/normative beliefs about gender, poor community sanctions for gendered violence, idealised masculinity, attitudes supportive of violence, low education, substance abuse, and a childhood history of trauma or DFV. However, the association between childhood exposure to DFV and future perpetration or victimisation was much debated in the literature with other forms of maltreatment in childhood being seen to play a crucial role for whether childhood exposure leads to future perpetration. The rationale for the need for a universal socio-ecological approach to prevention work lies in targeting/addressing multiple levels of risk.

5 Prevention and early intervention activities: overview and key themes

5.1 Summary of participating services

The review process of current approaches, strategies and projects involved a range of stakeholder consultations with DFV service providers, including an online Request for Information,[6] roundtables and interviews. Desktop searches were also undertaken as part of the service review process. This review does not provide an exhaustive account of DFV services in Australia or in any particular state. A focus on NSW and Victoria was adopted because of the need to consider programs in NSW in particular and the extent of developmental approaches in Victoria. This discussion provides an overview of the DFV prevention programs (widely defined) and outlines the key themes that emerged from our stakeholder consultation process. The themes discussed in this chapter are general issues that were raised in discussion across the at-risk groups. A more specific discussion of the issues faced in delivering prevention and early intervention activities to each of the at-risk groups is provided in the following chapter.

A total of 193 DFV services were identified (see Table 1). They consist of a mix of services; some focus primarily on at-risk groups and others are more general services. They range across the response, early intervention and prevention spectrums. The review shows that there is some prevention and early intervention activity in the DFV sector that targets at-risk groups and communities in some states. However, it is also evident that there are gaps in relation to service provision and prevention and early intervention programs for at least some at-risk groups and communities. These gaps will be discussed in more detail in the next chapter.

Most of the services that engaged in our stakeholder consultation process indicated that they undertake work that could be understood as prevention and early intervention. Prevention and early intervention activities are undertaken in a range of contexts. They are not necessarily undertaken separately from other types of responses, such as crisis services. There are relatively few "pure" prevention and early intervention activities. As discussed in previous chapters, practice-based distinctions between tertiary, secondary and primary prevention activities are not strictly maintained in the DFV sector. We also had responses from groups that undertake sector capacity-building, such as training for services and employees. While not directly working in the prevention and early intervention field, such capacity building strengthens the ability of services and communities to effectively deliver prevention and early intervention programs. A range of organisations deliver the programs identified in our review process. These include legal services, health services, government

---

[6]   Our Request for Information elicited responses from 104 services, which comprised of 69 full responses and a further 35 partially completed usable responses, however these included responses for both the at-risk groups and children's responses. Furthermore, the nature of responses and the nature of the services themselves meant it was difficult data to quantify. For example, most services indicated that they targeted/catered for more than one at-risk group in addition to targeting children and men, and most services conducted primary prevention activities in conjunction with crisis response, counselling and other DFV work. It was therefore not possible to delineate meaningfully, between service types or groups targeted. Refer to Appendix 3 for further details about the Request for Information, including the survey administered.

departments or agencies (federal, state and local), community organisations, welfare organisations, non-government organisations and peak bodies.

	Aboriginal and Torres Strait Islander women	CALD women	Women with disabilities	Women with mental ill-health	GLBTIQ persons	Young women	RRR women	Older women	General	TOTAL
NSW	21	11	4	0	4	6	0	0	16	62
VIC	7	10	10	2	1	19	3	2	19	73
QLD	2	2	1	0	1	2	0	0	6	14
WA	15	1	0	0	1	0	0	0	0	17
SA	3	0	0	0	0	1	0	0	0	4
NT	9	0	0	0	0	0	0	0	0	9
TAS	0	0	0	0	0	0	1	0	1	2
ACT	0	0	0	0	0	0	0	0	1	1
National	1	0	3	0	0	6	1	0	0	11
TOTAL	58	24	18	2	7	34	5	2	43	193

Table 1: Summary of participating DFV services

5.2 Key themes from the stakeholder consultation process

This section provides an overview of some of the key themes that emerged in the stakeholder consultation process. They include issues that are relevant to the delivery of prevention and early intervention activities and the DFV sector generally, and were relevant to all, or at least some, of the at-risk groups that are the focus of this report.

5.2.1 Universal and targeted approaches

Generally, stakeholders indicated that they considered a mix of universal and targeted prevention and early intervention activities to be the best response to the issue of DFV in at-risk groups and communities. For instance, most stakeholders communicated support for a population-wide DFV public health campaign, similar to the previous federal government campaign on violence against women, or other public health campaigns for issues such as smoking or road safety. Stakeholders expressed the view that any such public health campaign would need to address the broad issues of DFV, as well as those more specific to the groups most at-risk of DFV. Reflecting the need to address DFV at multiple levels, stakeholders suggested that such a population-wide strategy would only work in conjunction with community-driven change. Some stakeholders also argued that any such public health campaigns should be based on a positive approach rather than a negative or avoidance approach—promoting equality, healthy family relationships and non-violence.

The question of whether services for specific at-risk groups should be provided in mainstream services or by specialist services raised some complex questions. Some stakeholders identified an issue with identifying people as "at risk" because such a label may not be welcome by members of those groups:

> And I know particularly from a perspective of women with disabilities, any linkage of risk with vulnerability is not welcome. What we know from our data is that certain population groups, probably identified as at greater risk, potentially, but it's nothing to do with them as individuals per se, it's all those other levels that are operating. (Roundtable participant, Victoria).

There was also concern that mainstream services should still be expected to provide inclusive services for all women, and should not defer to specialist services to deal with the complexities faced by many women:

> I feel really torn. Because it can be really important to have specialised services because that can demonstrate a value and a recognition of individual experiences, or individual community's experiences of something, and that's really wonderful. But then it sort of takes away responsibility or recognition that everyone, or other services, should be able to work with everyone as well. You can't just wash your hands of that: "oh, I don't, I don't work with women who have got a disability so I don't need to worry about that", which I think can be so problematic and limit access. But then if you've got somebody who might fit into a few categories and there are three or four services, you know, how do you navigate that? So I think there needs to be a bit of both." (Roundtable participant, Victoria)

The need for mainstream DFV services to be capable of responding appropriately to clients from at-risk groups is particularly important given that some members of at-risk groups may prefer to access services outside of their immediate community. This may be due to concerns about privacy, shame, or problematic kinship relationships or conflict with those who are running services (Lumby & Farrelly, 2009). In other contexts, for instance in rural areas, there may be no suitable specialist services available, and members of at-risk communities will need to access mainstream services (Lumby & Farrelly, 2009). Stakeholders identified providing sector capacity-building to ensure that services are culturally competent as critical:

> I think there's often a perception within services that we might think we know how to deal with women with disabilities or, you know, a gay man or transgender women for example. And we say, "Yep, we can do that," but we know that when it comes to the approaches and really understanding the needs of clients that there's a huge gap there. And that's not necessarily the fault of services but it could be around funding and capacity building within organisations so that they give workers the time to develop their skills around those sorts of things. (Roundtable participant, NSW)

5.2.2 Community ownership, trust and responsiveness to the specific needs of at-risk groups

A recurrent theme in our stakeholder consultations focuses on the need for DFV prevention and early intervention activities to be community driven and accepted by the communities in which they are delivered. This needs to occur through community consultation and by enabling services within communities who have established relationships to deliver prevention and early intervention programs. The capacity to

undertake responsive, localised program development was identified by stakeholders as one of the most important characteristics of effective practice:

> There needs to be flexibility in programming to fit for localised areas. Local knowledge and input is essential, not imposing programming but working with communities, schools and services is key. (RFI response, nationally-based organisation)

The establishment of trust between services and members of the community was also identified as central to the successful delivery of prevention and early intervention programs. Some stakeholders described how they often take a "soft entry" approach with prevention and early intervention activities. Such services and programs may not be clearly identifiable as DFV prevention and early intervention activities. For instance, they might focus on sporting activities, teaching skills such as sewing, or mothers' groups, but provide information on DFV once a connection is made with clients and trust is established.

The "soft entry" approach to prevention and early intervention activities reflects the need to be responsive to the specific needs of at-risk groups. Not all at-risk groups, or at least not all community members, will be equally responsive to prevention and early intervention campaigns and activities. Initiatives need to be tailored to the level of awareness of DFV in particular communities, as well as to the degree of receptiveness to hearing messages regarding DFV.

Another instance of the need to tailor responses to the particular needs of at-risk groups was raised in relation to how prevention and early intervention activities address the issue of gender inequity. While there was general consensus among stakeholders that prevention and early intervention activities need to address the gendered nature of DFV, there were caveats raised about how this should be done. Our stakeholder consultations suggest that other risk factors intersect with, and may supersede, gender inequality for some at-risk groups. In these instances, a model that assumes a broad socio-ecological approach may be appropriate.

5.2.3   Funding arrangements

A strong theme emerging from the literature review and stakeholder consultations relates to funding arrangements. As mentioned, current funding arrangements are ad hoc and most involve applying and re-applying for sources of funding from a range of bodies: federal, state and local governments, philanthropic organisations, and non-government organisations. In particular, short-term and rigid funding arrangements are seen to have several adverse consequences. These include program "churn", which affects community and sector trust in, and awareness of, programs and services. Stakeholders indicated that in order for funding arrangements to support effective practice, funding needs to be long-term and flexible:

> My program was funded for 18 months and others [are funded] for three years. And then the program is suddenly not needed anymore or it's completed but in fact you're only just starting a program and you've barely piloted it and you probably haven't had time for evaluation. So the funding model isn't ongoing and sustainable and it doesn't allow proper program development and evaluation. (NSW, Roundtable participant)

Another key theme that emerged in our stakeholder consultations was that current funding arrangements can create tensions between services competing against each other for a limited pool of funding and then being expected to collaborate. At times, this may compromise the capacity for multi-agency service collaboration within the sector:

> You feel like you're competing, and now that I'm not in a service, I don't have to compete with anyone. So I can be a little bit magnanimous now, because I'm sure I was (indistinct) as anyone else was: "Oh, what about money to do this for my program because I believe my program's the best program." And I think the reality is we all have so much to offer, so how do we harness that as opposed to all compete for that one thing and we'll knock each other over on the way to get to that one little piece. (Victoria, Roundtable participant)

Applying for grants, funding and maintaining relationships with philanthropic organisations and individual donors was identified as time consuming and detracts from the service provision:

> A lot of managers, a lot of service providers, they're too busy fighting for funding or trying to manage that side of things to be actually on the ground doing what's to be done. (Service provider consultation, NSW)

Some stakeholders reported that a lack of funding results in services having to prioritise women who are less safe at the expense of helping all women who use services. A related issue was that lack of funding, or failure to increase funding, compromised services' "capacity to match physical resources and human resources to the demand for service which is constantly increasing" (Community-based organisation (small), Victoria). Some services also highlighted that a lack of increases in funding means that they are unable to deliver prevention and early intervention activities alongside tertiary responses:

> The service is limited as we have not had staffing increases in many years. [We] have requests to provide numerous prevention and early intervention programs but are not staffed to do so. (RFI response, Victoria)

5.2.4 Policy frameworks and integrated approaches to service delivery

Throughout the consultation process, stakeholders emphasised that a coherent, agreed upon policy framework contributes to the capacity of services and programs to work towards shared goals. Stakeholders argued for policy frameworks to be flexible enough to enable local initiatives that are driven by the communities in which they are located. Policies, and accompanying funding processes, need to consider how to strengthen existing capacity within the sector:

> Because it just gets a bit frustrating when you can see there's a number of really great programs happening across different areas that have been driven from the ground up, but then whenever there's a new policy push from a government there's a whole new, brand-new, shiny sort of program that's got that infrastructure in place and it's not within local communities and it can be quite frustrating. (Service provider consultation, NSW)

Prevention and early intervention activities need to be delivered in the context of a collaborative and integrated DFV sector. An integrated model needs high-level support and coordination to enable services aimed at specific at-risk groups to operate independently, but in collaboration with, mainstream services. As well as concerns about the coherence within the DFV sector, stakeholders also raised concerns about the disconnection between larger, or adjoining, policy spheres. In particular, the intersections of DFV policy and practice with federal and state government policy and funding in the areas of homelessness, DFV and child protection are in need of improved integration and communication.

Some stakeholders raised concerns about policy and plans not being backed with sufficient funding:

> … in the National Plan, all of those things, there's a lot of goodwill and a lot of interest in government and then in the community sector in moving forward and changing—doing things differently, but at the same time at this stage in Queensland that's not matched by any increase in funding and it seems unlikely to be although there may be some around child protection, who knows, it will really depend on what's decided with that. (Roundtable participant, QLD)

5.2.5   Building an evidence base

There is extensive practical knowledge about what works within the DFV sector. Stakeholders expressed frustration with the fact that current funding arrangements often fail to provide for evaluation activities. This has the effect of limiting the formal evidence about the effectiveness of existing approaches, strategies and projects, and compromises the sector's capacity to contribute to the building of an evidence base:

> There are a lot of good parts of programs but all programs can improve and if you don't have money to put aside in funding agreements to do proper—not internal—evaluation, proper evaluation with time and expertise, which costs money ... (Roundtable participant, NSW)

There was also concern expressed by stakeholders about existing evidence being imposed from the top down and dictating program design and delivery:

> "Do it our way because we've done these studies, and this is what works. So come on." As opposed to "oh, you've got this stuff already going on, how do we bring some of the stuff that we know needs to start happening, and integrate it". (Roundtable participant, Victoria)

Stakeholders also argued for evaluations to be designed to measure medium and long-term outcomes, as the impact of prevention and early intervention activities can be difficult to measure and may not be apparent for some time.

5.3   Summary

- **A coherent primary prevention framework is necessary in order for services and governments to work towards shared goals and outcomes.**
- **Targeted and universal approaches are both necessary to address the prevention of DFV.**

- **Community-driven and community-owned strategies are needed in specific at-risk communities, particularly CALD and Aboriginal and Torres Strait Islander communities.**
- **Funding needs to be long-term and incorporate an evaluation component.**

This chapter has provided an overview of the key issues raised by stakeholders who engaged in our consultation process. The issues detailed here were raised across the at-risk groups that are the focus of this report. Concerns focused on the need for prevention and early intervention activities to utilise both universal and targeted approaches and to be community-driven and consultative. Stakeholders also identified structural issues as key concerns. These included the interwoven concerns of how relevant policy formats frame the practice of DFV prevention and early intervention services, how funding decisions are made, and how prevention and early intervention activities can be assessed to determine their effectiveness. The next chapter moves on to discuss the existing evidence regarding prevention and early intervention activities in relation to each of the at-risk groups. It also provides an overview of prevention and early intervention programs identified in the review process, and details key concerns raised by stakeholders in the consultation process in relation to prevention and early intervention activity targeted towards each of the at-risk groups.

6 Prevention and early intervention activities aimed at at-risk groups

6.1 Effective practice evidence, an overview of services and key issues identified in the stakeholder consultation process

This chapter provides a discussion of the effective-practice evidence in relation to each of the at-risk groups that are the focus of this report. An overview of the prevention and early intervention activities targeting each at-risk group that were identified in our scoping exercise and via the Request for Information, and key issues identified in the stakeholder consultation process are also outlined. Examples of best practice of prevention and early intervention activities in each at-risk group are briefly described. Our review process identified prevention and early intervention activities aimed at all of the at-risk communities. However, some groups had more programs tailored to addressing the needs of their communities than others. Those groups with a greater number of prevention and early intervention activities than others are not without issues. There are gaps, barriers to effective implementation and concerns regarding access to services for all at-risk groups. These issues are discussed below. Examples of good practice programs are provided throughout this chapter. They are based on insights gained from the literature and stakeholder accounts about what is thought to constitute effective primary prevention and early intervention with the specific at-risk groups.

6.2 Aboriginal and Torres Strait Islander women

Effective-practice evidence

Reviews of the existing literature and evidence tend to agree that although there is a significant amount of knowledge within the service provider network (Day et al., 2013), there is a lack of formal evaluation evidence on programs aimed at reducing DFV in Aboriginal and Torres Strait Islander communities (Cripps & Davis, 2012; Day et al., 2013; Memmott et al., 2006). While there are more evaluations of Aboriginal and Torres Strait Islander focused programs than programs aimed at other at-risk groups, the quality of these evaluations is uneven (Day et al., 2013). The diversity of programs delivered in Aboriginal and Torres Strait Islander communities, combined with limited evidence regarding effective practice, also makes articulating a clear overview of what constitutes effective practice challenging (Day et al. 2013).

From the evidence that does exist, one of the key aspects of successful prevention activities is a high degree of community consultation and ownership (Cripps & Davis, 2012; Day et al., 2013). Such an approach needs to be applied comprehensively from the outset—from the identification of the issue needing to be addressed, to design of the program, how it will be implemented and by whom (Day et al., 2013). On this last note, the issue of Aboriginal and Torres Strait Islander staff being employed to run programs specifically aimed at Aboriginal and Torres Strait Islander communities is noted as crucial in much of

the literature on prevention activities (Cripps & Davis, 2012). There is also a need for Aboriginal staff in mainstream services in order to increase accessibility for Aboriginal and Torres Strait Islander people (Cripps & Davis, 2012).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

Prevention and early intervention activities and DFV response services aimed at Aboriginal and Torres Strait Islander women are more common than those aimed at the other at-risk groups discussed in this report. Despite the fact that there are more DFV services targeted at Aboriginal and Torres Strait Islander women, there remain many gaps in services and access to existing services is not always assured. Reflecting the diversity within, and between, Aboriginal and Torres Strait Islander communities, there is a broad range of programs aimed at such communities. These are varied in nature and are spread across justice system agencies, community groups (including Aboriginal organisations) and NGO-based services. Examples include night patrols, legal support, art therapy groups and mothers' groups. Prevention and early intervention programs tend to address the broad cultural and familial context in which women are located.

Stakeholders suggested that **prevention and early intervention activities need to address a lack of community awareness of DFV**. The normalisation of violence, and a lack of knowledge about rights and laws, was identified as an issue for Aboriginal and Torres Strait Islander populations:

> There's inadequate knowledge about an individual's rights and responsibilities. That women need education to know what the signs are, to know what they can respond to, what they're entitled to respond to. They need an increase in the awareness of rights and availability of services. (Stakeholder Consultation, QLD)

> So learning and how normalised it's become within communities and learning how little Aboriginal people actually know about their rights, how little information—there is lots of information that is available but how little actually gets to the community where people are able to quantify it, process it and then put it into a practice that enables them to feel some level of engagement or power or respect or appreciation for their situation. (Stakeholder Consultation, NSW)

Stakeholders cited the need for **prevention and early intervention activities to be community-driven** as a key concern. In part, this concern was raised in relation to another key issue identified by stakeholders—a lack of culturally appropriate mainstream services. This applied not just to DFV prevention and early intervention and response services, but also to many other intersecting services, such as health, mental health, police and law enforcement:

> There's a great lack of culturally appropriate service provision, that's across the continuum, culturally appropriate education through to culturally appropriate counselling services, culturally appropriate workers in providing support for clients through court processes and afterwards—there needs to be ongoing

service provision rather than temporary services that are probably going to disappear. (Stakeholder Consultation, QLD)

In particular, stakeholders suggested that **the criminal justice and police sector responses to Aboriginal and Torres Strait Islander communities are ill-equipped to deal with the complex interplay of risk factors of DFV and issues including the inter-generational mistrust of authority figures**:

I think the police [understanding of] the impacts of domestic violence on the whole family unit—my observation has been a lot of young police don't have an appreciation, especially the young Anglo-Australian police who come from, let's say, well, just a working-class family, it doesn't have to be middle class, a working-class family—that go into the force can be quite isolated from or removed from the impacts especially for Aboriginal people about generational and transgenerational trauma. They don't deliver the full service that they could possibly to the victims, or to the perpetrators, and what's going on within the family dynamic … (Stakeholder Consultation, NSW)

The police responses can be, "Oh it's just the blacks going at it again, leave them be," and it's got to the point where in some communities the response has been that the women are ringing the fire brigade to report violence being acted out because the police response is one of negligence, so some of them have been calling in the fire brigade to get a response. (Stakeholder Consultation, NSW)

Stakeholders suggested that **education and cultural awareness training of the police force and all services involved in responding to DFV is needed** in order to build a cooperative, working relationship between Aboriginal and Torres Strait Islander communities and services.

Some stakeholders communicated that there is some **concern regarding the use of a gender framework in addressing DFV in Aboriginal and Torres Strait Islander communities**. Generational disadvantage, historical destruction of communities and culture, poverty, drug and alcohol abuse are often considered more important for understanding DFV in Aboriginal and Torres Strait Islander communities than gendered power relations.

Good practice examples

"Sisters' Day Out" program, Family Violence Prevention Legal Services (FVPLS)

- Community consultation
- Community ownership
- Soft entry approach
- Targeted
- Prevention and early intervention

Background: The FVPLS program funds a network of over 30 legal services. Services offered by each FVPLS vary, however they primarily include culturally appropriate legal advice, court support, casework and counselling to victims of DFV. Initiatives that are focused more on prevention and early intervention activities are also administered by FVPLS. For example, the Victorian FVPLS runs the well-regarded and popular "Sisters' Day Out" and "Dilly Bag" programs.

Project aims: To reinforce Koori women's sense of identity and importance; provide support and information to women at risk of FV.

Project activities: Wellbeing sessions for Aboriginal women: pampering and fun; wellbeing workshops; discussions about FV; and information on legal, health, support and referral networks.

Community ownership of FVLPS, and consultation, diversity, and the "soft entry" approach (i.e., programs that are not specifically labelled as family violence programs) were identified as contributing factors to their effective implementation from a key driver of these programs:

> But I think probably for us, because we're an Aboriginal community-controlled organisation, and so that means that our board of directors are all Aboriginal, they're all from different parts of Victoria, and our CEO's an Aboriginal woman, and then we have Aboriginal and non-Aboriginal staff, but we kind of—we have those community networks through the CEO and through the board. And the two main project workers who run "Sisters Day Out" and "Dilly Bag", they've been doing it for quite a long time. And so they've really got good connections in other communities as well. So we don't actually have to advertise "Sisters' Day Out" at all … There's that, and there's also a lot about kind of knowing the community's structure and the community history, because, quite often you might end up with half a community that won't access—you might end up in a situation where half of the community don't access particular services run by particular Aboriginal families. (Victoria, Roundtable participant)

6.3   CALD women

6.3.1   Effective practice evidence

Poljksi and Murdolo (2011) provide the most comprehensive overview of primary prevention practices focusing on CALD communities in Australia. They argue that there is a lack of evidence about service provision for DFV in CALD communities, in particular mapping existing services and programs, and high quality evaluations of these. In their overview of primary prevention programs, they point out that this is due to a range of factors, such as short-term funding arrangements of programs that do not have an evaluation component built in to the proposal, and lack of evaluation capacity within the support sector (Poljski & Murdolo, 2011). Hence, evaluation design and implementation is uneven and based on trial and error (Poljski & Murdolo, 2011). They recommend that service mapping be carried out to avoid duplication of services, that evaluation be built in to program proposals rather than being considered an addendum, and that the evidence gathered from this process be utilised to implement strategic decisions about service provision (Poljski & Murdolo, 2011). They also recommend that this information be

collated and distributed by a central clearinghouse to ensure effective dissemination of evidence (Poljski & Murdolo, 2011).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

Somewhat similarly to services focused on Aboriginal and Torres Strait Islander women, services aimed at CALD women tend to focus on the broad cultural and familial context in which women are located. The network of migrant resource centres delivers programs across a broad spectrum of areas, including settlement programs, skills-based programs and social support programs. Many have programs that directly or indirectly address the issue of DFV. Other programs are run through a variety of non-government and welfare organisations, charities, local councils, and legal and health centres.

Stakeholders noted that **prevention and early intervention activities need to begin by raising awareness of the issue of DFV**, at least in some community groups. There are differing understandings of domestic violence in some cultures. There is a need for education of survivors and victims on their rights and assessing help. There is also a need to educate men and communities as a whole:

> Because some cultures don't see it as domestic violence. So we need to work carefully with the groups when we're starting to talk about it because we try to push the domestic violence concept in every way so we should be very careful to—that's why we need to do different programs … And we educate them in different topics like mental health, healthy relationships, what is a respectful relationship and things like that. And we do tours with them to take them to hospital and different places to show them how Australian system works, things like that. (Roundtable participant, NSW)

In addition, young people from CALD communities might have different ideas about what is sexually acceptable:

> And coming to Australia is a different socialisation process and then when some of these refugee young people feel that you know, in Australia what does that mean when you say no? We need to let them know. You go to a party, yeah the women—the girls may be talking to you but when they say no, it means no. You know, but in some cultures they would feel that maybe this woman is encouraging because it's the normalisation process of the gender relationship. Because in some cultures woman don't talk to you openly, so they know no, but they do not understand what you mean by no, it means no. (Roundtable participant, NSW)

Even once the issue of DFV is raised, stakeholders pointed out that there may be issues with **misinterpreting information about DFV due to cultural barriers**, which intersect with differing understandings of DFV:

> The issues around having a vocabulary to even have these conversations. And then the cultural issues where they might be culturally interpreting what's being said. So you might be talking about what domestic violence is and they might be saying, "Actually in our community you don't need to worry about this

> because it's not domestic violence." So you can get cultural interpretation and it's very difficult. (Roundtable participant, NSW)

A key finding from our stakeholder consultations and one that correlates with the literature is that **programs for CALD communities need community engagement and consultation**. Building and gaining the trust and involvement of community leaders, religious leaders is essential:

> Community engagement, and listening to what those communities have to say. I think our role in this process is really to guide them, to give them information, particularly about legal rights, about the law—give them the framework to work within. But we really have to listen to what they have to say because they're in the best position to know how their communities work and what would work for their communities. And really empower them to take action because if we go out there and talk to the community we are strangers, we don't have trust, we don't know how to do things. So for long-term success of any of the prevention projects it is a lot about empowering communities so to work on their own. (Stakeholder Consultation, Victoria)

All forms of response to DFV (prevention, intervention and response) need to be tailored to specific cultural groups:

> All the responses had to be tailored—there are a lot of factors that need to be taken into account when designing any program or any type of response. Pre-migration experiences, settlement, length of stay in Australia, cultural values, religious values, all of those things differ greatly from community to community and they have to be taken into account. (Stakeholder consultation, Victoria)

There was general acknowledgment that the approach to DFV in CALD communities may need to be undertaken in subtle ways, using soft entry. Issues are often best raised in the context of other formats such as general settlement transition programs, language and occupational skills development, and programs aimed at increasing social connectedness.

Other findings from the stakeholder consultation process:

- It was suggested that some CALD women might be concerned about attending a refuge or service affiliated with a different religion from their own.
- Mainstream services need to gain an understanding of cultural issues.
- Relationships need to be built with police in order to address gaps in the knowledge of cultural issues.
- The complexity of dealing with the impact of trauma for both victims and offenders, particularly in relation to refugees: *"Perpetrators have also been victims."* (Roundtable participant, NSW)

Good practice examples

Whittlesea CALD Communities Family Violence Project, Whittlesea Community Connections

- Integrated model
- Prevention and early intervention
- Targeted and universal

Project aims: To develop, implement and evaluate an integrated approach to addressing FV in the CALD community of the City of Whittlesea. The model aims to support CALD communities, newly arrived migrants, refugees and asylum seekers to break the cycle of violence and empower communities to confront and respond to the challenge of preventing violence against women.

Project activities: Empowering women by increasing social participation and access to supports through a multi-year women's support group grant scheme; building the capacity of religious and community leaders to respond to family violence; piloting a whole-of-school respectful relationship program; strengthening early intervention in the settlement processes by addressing settlement stressors that can hinder safe and respectful relationships.

Week Without Violence & Clothesline Project, Whittlesea Family Violence Network & Plenty Valley Community Health

- Prevention
- Universal

Project aims: To raise awareness of the extent of family violence and the services available to the women and men in the City of Whittlesea.

Project activities: Clothesline Project t-shirt painting workshops, with corresponding educational components and displays of t-shirts and family violence resources in various locations around the municipality.

6.4   Women with disability and mental ill-health

6.4.1   *Effective practice evidence*

As with other at-risk groups, there is limited rigorous evidence about the effectiveness of prevention and early intervention activities aimed at women with disabilities and mental ill-health. However, there are key themes that emerge from the literature:

- Community awareness-raising activities should be undertaken to address lack of knowledge and negative stereotypes about women with disabilities (Thiara et al., 2012; Wickham & Plompen, 2006). Existing networks and services could be used to promote awareness (Jennings, 2003).

- Training about the particular needs of people with disabilities and mental ill-health should be introduced in all services and sectors (Chang et al., 2003; Fernbacher 2006; Thiara et al., 2012).

- Women with disabilities should be involved in all levels of policy and practice (Thiara et al., 2012).

- Prevention activities should be inclusive of, and also tailored to, women with disabilities and ensure that messages reflect the legitimacy of these women's experiences and are not patronising (Thiara et al., 2012).

- Women with disabilities need more information about DFV (Jennings, 2003: Thiara et al., 2012).

- Prevention work should focus first on helping women to identify what physical and psychological safety means generally, then what it means for them, then on strategies, skills and tools they can apply to support safety (Hager, 2011).
- Development and introduction of a standard screening and assessment tool that can be used by a range of services, including non–DFV specific services (Plummer & Findley, 2012; Wickham & Plompen, 2006).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

There is a striking lack of DFV services aimed specifically at women with disabilities and mental ill-health. There have been a number of pilot programs run over the last decade or so, but many of these have not continued to be funded. The Staying Home, Leaving Violence program, operating in NSW, while not specifically aimed at women with disabilities, does prioritise women with disabilities. This is because it is acknowledged that women with disabilities may have extra barriers to leaving their homes, that they are particularly vulnerable, and that supports already in place to make their home accessible can be difficult to replicate in a refuge setting and are expensive to replace in the longer term. Other programs are run by peak bodies, such as Women with Disabilities Australia and Victoria, health centres, and community and welfare organisations.

In relation to women with disabilities, stakeholders identified **a lack of emergency accommodation** for women with disabilities due to physical access issues as well as services not feeling capable of dealing with women with "high needs": *"women who generally fall into this category—their needs are too high, so they kind of tend to be just put aside"* (Roundtable participant, NSW).

Some stakeholders also argued that **service providers in the disability sector require further education and training so that they are able to identify violence as gender-based**. There is a lack of understanding of the intersection of gender, violence and disability. In addition, stakeholders pointed out the need for recognition that women with disabilities are at greater risk of sexual assault. There is a lack of legislative recognition of the types of violence women with disabilities experience, for instance in institutions and boarding houses.

Stakeholders involved in our consultation process stressed the point that **women with mental ill-health are a distinct risk group from women with disabilities, with different issues and needs**. One of the primary concerns raised by stakeholders was access to services. Women with mental ill-health are often excluded from accommodation and other DFV services because services don't have the staffing resources to deal with their complex needs:

> And most of the refuges in Victoria, though some of it is shifting a bit now, were set up on a communal model so for women with mental health issues they're often excluded from refuge on the grounds that they will change the dynamics in the refuge or it wouldn't be a good fit or they need intensive support and from one refuge worker and that's not possible. (Stakeholder Consultation, Victoria)

> The women are not explicitly told that … it will be something like—well the referrer would be told, "Well no probably wouldn't quite fit the dynamics or we don't have the level of staffing resources" … "We don't know how to support her, what if she has a psychotic episode or has depression?" (Stakeholder Consultation, Victoria)

Stakeholders argued that **there is a need for greater understanding in DFV services of mental health issues** and a practice framework for working with women with mental illness. Stakeholders pointed out that there is a lack of integration across different services, for example mental health, GPs, hospitals and DFV services, and this means that women with complex mental health needs are not provided with continuity of care.

6.5 Gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) communities

6.5.1 Effective practice evidence

There are very few prevention and early intervention strategies aimed at people who identify as GLBTIQ (Duffy, 2011). Many authors argue that the invisibility of DFV within GLBTIQ relationships and communities and the heteronormativity of responses to DFV contribute to its perpetuation and a lack of reduction in rates. For instance, Ball and Hayes (2009) critiqued the implicit assumption that DFV almost exclusively occurs in heterosexual relationships, which is evident in many prevention and early intervention campaigns, such as the campaign "To Violence Against Women, Australia Says No" run by the then federal government. They argue that the differences in DFV between heterosexual and non-heterosexual relationships need to be addressed in such prevention and early intervention strategies.

Donovan and Hester (2008), using findings based on a UK study, argued that school sex and respectful relationship education should include discussion of same-sex relationships because young people who identify as GLBTIQ have few role models for healthy relationships and because DFV in GLBTIQ relationships is so rarely acknowledged. This is especially the case given that young people who identify as GLBTIQ can be particularly at-risk of DFV from family members due to their sexuality and/or gender identity, and this contributes directly to youth homelessness and a range of other issues (Donovan & Hester, 2008).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

On the response level, the federal police and all states and territories (except for the Northern Territory) have liaison officers who work with members of the GLBTIQ community. NSW has the highest concentration of DFV programs aimed at the GLBTIQ community. These consist of a mix of response, legal advice, sector capacity-building, and prevention and early intervention activities. The most established of these is the LGBTI Domestic and Family Violence Project run by the AIDS Council of NSW (ACON). This project has a number of aspects, including a website called *Another Closet*, which provides information about DFV and where to get help, and campaigns about DFV in GLBTIQ relationships. ACON also coordinates the NSW Same Sex Domestic Violence Interagency,

which raises awareness of the issues facing people who identify as GLBTIQ experiencing DFV and builds relationships between mainstream DFV services and those focused on addressing the needs of people who identify as GLBTIQ. There is a scattering of programs across other states. To date, none of these programs have been evaluated.

Many healthy relationship and sexuality education programs delivered in schools address issues of diversity and contain content that addresses issues affecting same sex attracted and gender diverse young people (Mitchell et al., 2011; Ollis, Harrison, & Richardson, 2012; SHine South Australia, 2005). However, the majority of information in these programs is focused on heterosexual relationships and sexuality: the "Writing Themselves In 3" survey found just under one-fifth of same sex and gender diverse people were able to access information regarding gay and lesbian relationships from their school (Hillier et al., 2010). The internet was their primary source of information regarding relationships, followed by GLBTIQ communities (Hillier et al., 2010). In some contexts, there may be barriers to the delivery of material that is inclusive: Ollis et al. (2012) found that teaching about sexuality was one of the topics that parents of students were most unsure about, and was also one of the topics that teachers felt less confident in delivering. Other school-based programs are aimed at directly addressing heterosexism and homophobia. Evaluations of these programs indicated that students completing these programs had more positive attitudes towards gay men and lesbian women than they did before participating in the program (Bridge, 2007; Higgins, King, & Witthaus, 2001;)

In 2009, ACON released a report into the gaps in services in NSW for people who identify as GLBTIQ experiencing DFV (ACON, 2011). It focused on mainstream response services and its primary findings showed a lack of awareness of, and sensitivity to, the specific issues and needs of GLBTIQ clients, and looked at how to address this. In 2009, the Victorian Department of Health released a guide to inclusive practice for GLBTIQ clients accessing health and human services (2009).

Our stakeholder consultations suggested that DFV prevention activities for people who identify as GLBTIQ should start with **breaking the silence and demystifying and recognising that violence happens** in GLBTIQ relationships and in the families of same sex attracted and gender diverse young people:

> The first step is about demystifying a lot of what happens, or just breaking the silence, and I know that that's used a lot, but to really be able to start preventing something, it needs to be known that it happens … Because if we're not talking about it, how are people ever going to be able to get support or be able to recognise that that's their experience, if it's so hush hush and we can't talk about this because we don't know how to work with these people. (Roundtable participant, Victoria)

As well as targeted responses that raise awareness within the GLBTIQ community, **broad-based prevention campaigns need to address the specificities of GLBTIQ people** (Ball & Hayes, 2009).

Addressing the specificity of people who identify as GLBTIQ facing DFV raises **concerns about the gendered framework that is often used to discuss DFV**. It can be limiting and excludes people who don't identify within the gender binary and/or are not in heterosexual relationships:

> The feminist ideas and the history of family violence and support around family violence in that having that focus on a gendered view can be a really powerful way of getting family violence on the agenda and having a way of responding to that, but there are still so many limitations to that. And that's not just in relation to men experiencing violence from women, but for people who don't identify within a gender binary, or who are not in heterosexual relationships. So I think broadly the way we talk about family violence isolates a lot of people from being able to talk about their experiences. Or having services to access (Roundtable participant, Victoria)

Other issues that emerged from our stakeholder consultations in relation to mainstream response services:

- A lack of understanding of the specific issues facing people who identify as GLBTIQ from service providers, ranging from a lack of awareness and insensitivity through to explicit trans/homophobia.

- Some people who identify as GLBTIQ may be reluctant to report DFV to the police due to concerns about the potential for trans/homophobic or insensitive responses

    – As a result, the use of informal support networks, such as that provided by friends, is common.

- A lack of crisis accommodation (or a lack of appropriate accommodation) for gay and bisexual men and transgender people.

- Concern about trans/homophobia from other clients, especially in emergency accommodation.

6.6   Younger women

6.6.1   Effective practice evidence

Prevention programs for younger women tend to focus on school-based programs, although it should be noted that most of these programs are delivered to both young men and women, and are not targeted specifically at the latter. The literature examining the value and efficacy of school-based programs for adolescents and young people is now extensive and there are several evaluations and studies of such programs (Antle, Sullivan, Dryden, Karam, & Barbee, 2011; Bradford & Nancarrow, 2005; Fergus, 2006; Flood et al., 2009; Foshee et al., 2004; Fox, Corr, Gadd, & Sim, 2014; Jaycox et al., 2006; Ollis, 2011; Thiara & Ellis, 2005; Tharp, 2012; Tutty et al., 2005). School-based programs are generally based in the socio-ecological approach and aim to change attitudes and behaviours around gender roles, raise awareness about gendered violence, and work to promote healthy or "respectful" relationships by fostering gender equality, and non-violent social norms, thereby affecting future behaviours. They are sometimes framed within an anti-bullying model, focusing on building non-violent conflict and resolution skills. Evaluations of Australian-based primary prevention programs for secondary school students suggest that there are positive outcomes in relation to attitudinal change and that the programs are associated with an increase in knowledge with regard to DFV and gender equality (Fergus, 2006; Flood & Kendrick, 2012; Flood et al., 2009; Inner Melbourne Community Legal, 2013; SHine SA, 2005).

When considering prevention programs for young women, it is important to keep in mind that some young women are not engaged in formal education. These young women may be socially marginalised and potentially at greater risk of being victims of DFV, and prevention initiatives need to consider how to engage with this cohort of young women (Rawsthorne & Hoffman, 2007; Rawsthorne & Hoffman, 2010). As discussed in chapter 3, the literature indicates that young people often prefer to seek advice and assistance from informal networks such as friends, rather than formal health services through teachers, police or social workers. Consequently, strategies aimed at young women should include bystander approaches that address how young people can respond to peer disclosures (Sety, 2012).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

Many prevention and early intervention activities aimed at younger women focus on school-based programs promoting healthy and respectful relationships. Our consultation process highlighted the fact that such **programs in schools need the support of the whole school**. It is important to establish strong support from the school principal and the broader school community. Some participants in the stakeholder consultation indicated that there was some community resistance to the gender framework being used in schools:

> I've been researching how teachers and students have responded to that material and, interestingly enough, the issue around male violence in one particular school, there are a number of men who were very uncomfortable with the use of the words, you know, "gender-based violence", or, "crimes against women", and were really happy to be using words like, "respectful relationships". (Roundtable participant, Victoria)

> Some are good, some have, it's an antifeminist thing too, if you have in schools women usually who are looking to bring gender into the conversation, they will be slapped down by and large and I've been through that myself, you know, you have to be very brave and have a lot of support to start having critical discussions about construction of gender, bullying, homophobia, violence and connecting bullying to domestic violence or family violence and sexual assault down the line. (Roundtable participant, QLD)

Stakeholders also commented on the **difficulty of "selling" prevention to schools because the impacts are not going to be seen until the future**:

> And to sell prevention, to sell something that isn't going to affect that child for 20, 30, 40, 50 years, you're not going to see the impact until later, is really difficult when these schools are facing so many crises with some many other aspects. (Roundtable participant, Victoria)

6.7 Women living in regional, rural and remote (non-urban) communities

6.7.1 Effective practice evidence

As with other at-risk groups, there is limited evidence about the effectiveness of prevention and early intervention in non-urban communities. Key themes that emerge from the literature:

- The need for responses to be tailored to the specific contexts in which DFV occurs in non-urban communities (Wendt 2009a; Wendt 2009b).

- There is a high degree of diversity within non-urban communities, and prevention activities need to take this into account in their design and implementation (Wendt & Horonsty, 2010).

- Physical access of participants to programs and services needs to be addressed (Wendt 2009a).

- The safety of individuals delivering programs needs to be addressed, both in relation to living in a small community and potentially visiting isolated locations such as farms to support clients (Cox, Cash, Hanna, D'Arcy-Tehan, & Adams, 2001).

Overview of prevention and early intervention activities identified in this report and key issues identified in the stakeholder consultation process

Access to services in non-urban locations is severely compromised by their scarcity and the distance that women often have to travel to access them. While there are services in non-urban locations, and many cater well to the needs of women in their catchment area, approaches that address the issue of isolation and lack of services by creating networks between services and programs are essential. This has often occurred informally in the past. However, such arrangements are increasingly being formalised and recognised as a way of maximising women's access to DFV services across the response, prevention and early intervention spectrums in regions where there are limited services.

For example, in June 2011, DHS Victoria Loddon-Campaspe Region local government cluster was formed as part of the Victorian Family Violence Reform (VFVR) strategy that was launched in 2005 (Ross et al., 2011). It involved a whole of government approach including Victoria Police, the Department of Human Services and the Department of Justice, Planning and Community Development (Ross et al., 2011). This was one of three local government clusters funded through the Local Government Preventing Violence Against Women in Our Community Program. The three clusters were allocated $1,260,000 over four years.

The Loddon-Campaspe Region comprises the Mount Alexander Shire Council, Greater Bendigo City Council and Macedon Ranges Shire Council. The aim of the initiative is to drive attitudinal and behavioural change across a range of settings and services in communities. There is a strong focus on inter-agency coordination in order to maximise the effectiveness of the response to DFV given that there may be limited services across a large geographical area. Prevention initiatives are to be delivered by service providers via government, sports clubs, schools, workplaces and the media.

Services in the area include:

- Centre for Non-Violence (Bendigo);
- Women's Health Loddon Mallee (Bendigo);
- Emergency Accommodation and Support Enterprise (EASE) (Bendigo);
- Loddon Campaspe Community Legal Centre (Bendigo);
- CASA (Bendigo, with outreach to Maryborough, Kyabram, Kyneton and Echuca);
- Victoria Legal Aid (Bendigo).

Good practice example

Preventing Violence against Women & Children (PVAW&C) Strategy, Women's Health Goulburn North-East

Program aim: Hume region women and their children live free from violence in safe communities. A major aim of the PVAW&C Strategy is to build the capacity of stakeholders to understand and implement effective primary prevention of violence against women through:

- increased knowledge of the determinants of DFV; and
- increased knowledge of primary prevention and evidence-based practice in DFV.

The strategy aims to increase equity within key community settings and reduce the reinforcement of gender stereotypes embedded across the community.

Program activities: A whole of community approach, which fundamentally addresses the determinants of violence against women in key settings across the community. Organisations will implement policies and practices that promote equity and respectful relationships between men and women.

6.8   Summary and policy implications

- **There are significant gaps in evidence in relation to "what works" with the various at-risk groups.**
- **Each of the at-risk groups has its own set of issues and needs, giving rise to different best practice approaches.**
- **There are, however, some commonalities across all groups and there was consensus that prevention strategies need to be culturally appropriate, physically, culturally, and geographically accessible, community-driven and inclusive of whole communities.**
- **There is a need to address the lack of understanding of at-risk groups among mainstream services, including DFV services, as well as health services and the police force.**

This chapter has provided an outline of effective-practice evidence in relation to each of the at-risk groups that are the focus of this report. It has highlighted the fact that there is variation in the level of evidence but that there are significant gaps in relation to prevention and early intervention activities aimed at all the at-risk communities considered in this report. This chapter has also provided an overview of the programs and services identified in our scoping and stakeholder consultation processes. The key themes that emerged in relation to effective practice through these aspects of the research project were also detailed.

7 Evaluation framework for exemplar projects

7.1 Overview and context

This chapter sets out the elements for an evaluation framework for exemplar projects, consistent with the fourth aspect of the project requirements. This element of the project raises some complex issues. Although the features of potential exemplar programs are identified in chapters 5 and 6, the scope and budget of any such programs are at this stage undefined. For this reason, the framework set out in this chapter outlines the principles that should be applied in any such evaluation and identifies more specific potential approaches that may be applied in any particular instance. Further, any evaluation that takes place within the parameters outlined here needs to take account of evaluation activities occurring under the Domestic and Family Violence Reform Evaluation Strategy in *It Stops Here*.

As discussed in chapter 2, the field of violence prevention is in its developmental phase. Limited empirical evidence exists on the kinds of approaches that are effective, and significant challenges arise in assessing such approaches. There are several challenges that are relevant in this context, some of which are conceptual and methodological and others that are practical. From a conceptual standpoint, it is acknowledged that the measurement of the impact of prevention initiatives is inherently difficult because what is being measured is the absence rather than the presence of certain phenomena (DFV), and there is no certainty that the phenomena would have occurred in the absence of the prevention measures.

Further, the intended impact of such programs is often wide and relatively non-specific. Some programs are intended to have shorter-term effects, but the impact of other programs is intended to be long-term and attitudinal. Any effects of the program might well not be evident for a significant amount of time. Even if they do become evident, it may be difficult to determine the extent to which effects consistent with the intention of the program are attributable to the impact of the program or other developments, including individual circumstances and broader social influences. The corollary of this is that the absence of effects inconsistent with the intention of the program may also be attributable to issues other than the failure of the program to achieve its objectives. These issues are particularly relevant in the current environment in Australia, where a number of prevention initiatives are being implemented at federal, state and local level, including those such as The Line and others identified throughout this report and listed at Appendix 1.

From a practical perspective, the other challenges for the evaluation of family violence prevention programs arise from the funding and organisational context in which these programs are embedded. As spelt out in section 5.2.3, often such projects are funded out of specific-purpose grants emanating from a variety of sources, including federal, state and local government grant programs and grants tied to specific purpose organisations, including philanthropic organisations. Often these grants have a short lifespan.

The value of and need for evaluation of violence prevention programs is well-recognised (WHO, 2010; VicHealth, 2007; Flood, 2013) because of the emergent nature of the policy, practice and the body of knowledge in this field. Such evaluations not only support sound

funding decisions but they add to the body of evidence on violence prevention by developing practice-based knowledge. This is one of the arguments for building evaluation funding into program funding packages.

The level of grant funding and the life of the program may provide limited scope to do evaluation and any such evaluation may occur on a very modest basis (Flood, 2013). So called "gold-standard" evaluation approaches involving external evaluation experts and methods based on experimental design (based on two groups—one that receives the intervention and one that doesn't) are often out of reach, not just for financial reasons but also because a control group may not be readily identifiable for some programs (Flood, 2013). For this reason, the value of smaller scale evaluations has been emphasised in the family violence prevention literature, along with recognition of the importance of supporting program providers to develop the capacity and expertise to evaluate their own programs. Such approaches are recognised to have a number of advantages including supporting the development of empirically informed reflexive and self-critical or self-aware practice.

A significant direction in the literature on evaluation of family violence prevention programs, notably in recent reports produced by VicHealth (Flood, 2013; Kwok, 2013), is the endorsement of "empowerment evaluation" where the agencies and staff implementing programs are supported to perform their own program evaluations. The main justifications for this are twofold: first, that prevention initiatives are often implemented by community-based organisations with limited resources, including very limited resources for evaluation. Thus prevention is seen as a community-driven responsibility and the context and purpose of evaluation activities are based on self-reflective practice and ongoing improvement in program development (Flood, 2013). Second, empowerment evaluation is seen as a capacity-building exercise in which program staff become skilled not only in delivering their programs but in assessing and evaluating program effectiveness, thus supporting "self-determination" in the family violence prevention field.

This direction has emerged in a policy and funding context where an agency—VicHealth—has implemented a focused primary prevention program supported by a comprehensive framework (VicHealth, 2007) for the past seven years. VicHealth has thus developed a philosophy and infrastructure to support a direction of this nature and worked intensively with the agencies delivering programs to equip their staff to conduct these kinds of evaluations. This approach to evaluation is thus embedded in a particular policy and organisational context designed to support this direction. As will be discussed in more detail below, internal evaluations have their limitations, and questions regarding their validity have been raised (Dyson, 2014). In light of such concerns, internal evaluations may often benefit from structural support from a larger organisation or policy and practice framework.

In the absence of these conditions in the NSW context, and in light of the developing nature of practice and knowledge in the prevention field, there are several strong rationales for supporting external, rather than internal, evaluations of new programs or programs that are being funded but have not yet been evaluated, depending on the size of the funding package. External evaluation is independent and this will ensure the evaluation is informed by the exercise of objective judgment. This is important for three reasons. First, the judgment exercised by the evaluators will not be influenced by any interest in whether or

not the program continues. Second, the evaluators have a professional distance from the program and are thus able to consider professional practices, attitudes and dispositions from a neutral standpoint. Nonetheless, working with professionals in the program to develop an informed understanding of professional practices, attitudes and dispositions is important. Third, distance from the program and the professional and client relationships within the program means that data from professionals and clients will be gathered by a neutral third party, and will not be affected by any existing relationships and dynamics within the program and its client group. It is important that such dynamics are examined from an external rather than internal perspective. Having said that, it is acknowledged that the programs in the areas being considered may raise issues of particular sensitivity arising from the circumstances of the client group and it is important that the evaluators work with the program professionals to ensure that these sensitivities are dealt with appropriately.

For new programs, planning for the evaluation should begin with planning for the implementation of the program. External evaluation should be implemented in a collaborative manner with the evaluation team working closely with the program implementation team.

The nature of evaluation strategies adopted will depend on the aim of the evaluation. Formative evaluation refers to the process of examining a program or initiative in its pilot or developmental phases with the intention of using the evaluation information to refine the final form of the program or initiative. Summative evaluation refers to examining the impact of a program of initiative. Further, evaluations may focus on processes or outcomes. Process evaluations examine the impact and effectiveness of the processes applied in a program. Outcome evaluations focus more specifically on the result achieved by the program. Decisions in relation to the nature of the evaluation approach applied are informed by which of these foci is the core purpose of the evaluation. Some evaluation designs may include all of these elements.

7.2   Principles and implications

- Careful consideration should be given to the question of whether evaluation is carried out internally or externally. It may be that external evaluation is the preferred approach in light of the current policy and funding context in NSW, at least in the short to medium term.

- Planning for the evaluation should commence with planning for program implementation. The evaluation should be planned and implemented in a collaborative approach with the program staff. A collaborative approach will not only ensure the program aims and context are appropriately reflected in the evaluation approach but can support capacity building for reflective practice in the future.

- The scope and nature of the evaluation should be proportionate to the funding package for the program. Larger funding packages require a more rigorous evaluation approach.

- Internal evaluation may be an appropriate approach for programs that are being funded to expand and have previously been externally evaluated.

- Internal evaluation on a regular basis should be supported when a program is out of its establishment phase.

7.3   Evaluation methodology

The following sections set out the steps and approaches to developing appropriate evaluation methodology for the kinds of exemplar programs discussed in chapter 6. This discussion draws on the literature on evaluation generally, as well as evaluation literature in relation to family violence programs specifically. To illustrate the steps in the process, examples have been drawn from the evaluation of the St George Migrant Resource Centre key program, discussed in chapter 9. Other documents and reports that have informed this approach include:

- *Evaluation and Innovation in Family Support Services* (Child Family Community Australia [CFCA], 2013a);
- *Planning for Evaluation I: Basic principles* (CFCA, 2013b);
- *Planning for Evaluation II: Getting into detail* (CFCA, 2013c).

Additionally, the experience of the researchers at AIFS more broadly in conducting evaluations and developing evaluation frameworks across a range of areas, informs this discussion.

In broad terms, evaluations have four main elements. These are an initial conceptual element that involves identifying the objectives of the programs and developing an understanding of how the program aims to achieve these objectives. The second involves developing a series of evaluation questions to identify whether the program meets its objectives. The third entails identifying what information can be collected to answer the questions. The fourth entails implementing the data collection strategies. The fifth involves analysing the data and using them to answer the evaluation questions. These steps are discussed in more detail in the next sections.

7.3.1   Step 1: Identifying the aims of the program and the elements of the program designed to achieve them

Program objectives and theory of change

Evaluation strategies need to be based on an understanding of the objectives of the program and how the activities undertaken as part of the program are intended to support the achievement of these objectives. One way of achieving this is through the development of a program logic (also know as result logic), which is a diagram showing the "underlying assumptions of a planned program. A results logic illustrates why and how a program is presumed to work. Results logic diagrams are read from the bottom with the 'inputs' or what is being done and follow the pathway and steps that will need to occur" for the program to achieve its aims, (Adamson et al., 2010, p. 10).

In the DFV prevention context, the process of developing a program logic, and articulating the objectives of the program and how its activities support the achievement of these objectives, should be informed by the application of the socio-ecological theory of violence. The program should identify which of the four levels of influence (individual, close relationship, family and society) the program is intended to address. One or more of these may be the focus of the program. The program logic should also identify how the

activities undertaken in the program are intended to support the achievement of the objectives by developing a "theory of change" that identifies how the activities being undertaken in the program produce the outcomes to support the objectives. The theoretical position underlying the assumptions made about how the program will achieve its objectives should also be considered and made explicit in this context. In addition, features of the personal, organisational and social context of the program that may prevent the program achieving its intended aims should be identified.

Program context

In the process of developing the program logic and identifying objectives, the context for the development and implementation of the DFV prevention program requires detailed consideration to identify how different factors involved in the four levels of influence impinge on the fulfilment of the aims of the project. This requires consideration of the organisational context in which the program is being implemented, the features and needs of the individuals and groups for whom the program is designed, and the needs the program activities are designed to address. It also requires consideration of the features of the environment in which the program is being implemented that may compromise the achievement of the program's objectives.

Principles and implications

- Program logic development should clearly identify the extent to which the program is intended to influence individual, community, institutional or cultural approaches to family violence.
- The program logic should identify how this impact is intended to occur.
- The program logic should clearly identify the important features of the organisational and social context in which it is being implemented that may support or impede achievement of the program objectives.

7.3.2 Step 2: Formulating evaluation questions and evaluation design

On the basis of the insights developed from identifying the program objectives, and considering the program context, a series of questions need to be developed to guide the strategies for collecting information for the evaluation. These questions should be framed in a way that reflects the objectives in a measurable way. If it is important to understand particular aspects of the context in which the program is being implemented because they may affect the achievement of the objectives, then the questions should also examine these issues.

The evaluation design should include strategies for measuring outcomes, to the extent possible in the context and within the resources available. The broad level challenges in this context were discussed in the introduction to this section. Bearing these complexities in mind, there are two main strategies for measuring outcomes. The first is through the inclusion of a "control" or comparison group in the evaluation design. This is also known as experimental design and is considered the "gold standard" in evaluation design. The control group is a group that has similar features to the group that receives the program

intervention but does not receive the intervention. Data is collected from both groups so that the differences between the groups can be measured. It can be difficult to identify control groups, particularly in small populations with distinct features. This is likely to be an issue for several of the groups considered in this report, particularly Aboriginal and Torres Strait Islander women, CALD women, women with disabilities, GLBTIQ communities, and, in some circumstances, rural, regional and remote women.

An alternative to experimental design is a strategy based on collecting data from the group that receives the program intervention before and after they have participated in the program (pre and post-test design). Comparison of data from these timeframes provides one means of assessing the impact of the program.

A further potential strategy involves comparing data from program participants with existing population level data sources. The applicability of this method depends on the availability of appropriate population level data and comparability between these data and the evaluation data. In some circumstances, this may be a valid method, particularly where larger groups are involved in the program being evaluated. Larger samples are more likely to support valid statistical comparisons with population level data. One area of relevance to the current report where this may be appropriate would be in relation to larger-scale educative initiatives for young women, if sources of comparison data could be identified. Again, because of the particular nature of most groups considered in this report, it is unlikely this would be an appropriate strategy for most.

An important consideration is the time-frame over which data collection is conducted. Many evaluations are conducted in parallel with the implementation of the program within a limited time-frame, for reasons of cost and convenience. This means the short-term impact of the program is examined in the evaluation but not whether these impacts are sustained over time or whether other impacts become evident in a longer time-frame. Given the long-term attitudinal focus of prevention initiatives, a longitudinal evaluation design could be considered in appropriate circumstances.

Understanding complexity

It is vital to consider the context in which data is collected and to acknowledge the complex social factors that influence perpetration of violence against women and children. The variety of factors, working at multiple levels of influence, may make evaluating the impact of prevention interventions difficult, particularly where those impacts are based on targeting different social factors. Ideally, the evaluation design phase would incorporate a consideration of the complexity of measuring social change and allow for the generation of contextualised information to support a broader understanding of the effectiveness of the intervention. The two evaluation examples provided in this chapter provide some illustration of how these considerations can be incorporated into the evaluation design (Wall, 2013).

Principles and implications

- Specific and measurable evaluation questions need to be developed to guide the evaluation.

- For programs with a larger target group (such as those aimed at young women), experimental design, pre and post-test design and population level comparison may all be feasible approaches. Program implementation may be designed to allow for an experimental design to be applied by identifying demographically comparable contexts (high schools or universities, for example) and applying the program in one context but not the other to support an experimental design. From an ethical perspective, this approach is justifiable in relation to pure prevention approaches but may be questionable in relation to programs that operate at the secondary or tertiary level.

- For programs with a restricted and specialised target group, pre and post-test design approaches may be the most feasible. These approaches will depend on planning for the evaluation starting early and the pre-test data collections being applied at the outset.

- For some groups with small populations and diverse needs, including some CALD groups, Aboriginal and Torres Strait Islander women, women with disabilities and GLBTIQ communities, the small numbers involved may mean that even the pre and post-test design approach is not feasible. In these instances, the evaluation may need to rely on insights purely derived from qualitative data. This was the approach applied in the evaluations conducted for this report.

- For larger programs requiring a more significant financial investment, a longitudinal design may be justified to assess whether program outcomes are sustained over time. Such a design, however, would need to take into account the extent to which changes in outcomes may be attributable to factors other than the program.

- When designing an evaluation, it is important to consider and acknowledge the complex social factors that influence how the effectiveness of prevention interventions can be measured.

Evaluation example 1: Evaluation of the Northern Region Prevention of Violence Against Women Strategy

The *Evaluation of the Northern Region Prevention of Violence Against Women Strategy* (2013), conducted by Women's Health in the North (WHIN) in partnership with Monash University's Gender, Leadership and Social Sustainability Research Unit, is an example of a multi-stranded process and outcome evaluation with elements of a pre and post-test design and longitudinal data collection. The evaluation is intended to have two phases. Phase 1 was completed in 2012/2013 and Phase 2 will be conducted in 2016/2017.

The Building a Respectful Community: Preventing Violence Against Women. A Strategy for the Northern Metropolitan Region of Melbourne 2011–2016 (the Strategy) provides the framework, context and evidence base to guide primary prevention in the region. The evaluation is conducted as part of the monitoring and evaluation commitments within this Strategy.

The evaluation utilises a variety of data collection methods to understand the different factors that influence changes in knowledge, attitudes and behaviour in relation to the prevention of violence against women. Phase 1 is intended to collect baseline data using quantitative surveys of regional partners (local governments, primary care partnerships and community health services); focus groups with professionals drawn from the sector; and targeted interviews with professionals involved in the sector. Data collection for Phase 2 will also include mapping prevention programs, practice and policy; education and training forums; more detailed evaluations of specific elements of the Strategy (such as written resources, partnerships and planned events); and reflective sessions.

The evaluation questions identified at the outset of the project examine 1) the ways in which the activities within the Strategy have achieved their respective aims, and 2) how, and in what ways, a regional approach is successful in relation to a preventing violence against women strategy where regional partners are involved in the activities.

This evaluation demonstrates many of the elements discussed in this chapter. In particular, it is an example of a large-scale evaluation activity that was built into the program (in this case the development of the prevention strategy and implementation of activities under the "umbrella" of that strategy) from the outset. This evaluation also provides an illustration of using a variety of data collection methods to support an analysis that contextualises the data and acknowledges that program impacts may be influenced by a variety of social factors.

7.3.3 Step 3: Identifying the information needed to answer the evaluation questions and collecting the information

This step involves identifying how to collect the information (data) that will enable the evaluation questions to be answered. There is a range of types and sources of data, and the availability of these will depend on the nature of the program and the context in which it is being implemented. A rigorous evaluation design will involve more than one, and in some cases several, types of data being collected and analysed. The main types of data are now described.

Administrative data from the program/organisation covering issues such as: the number of clients that completed the program or to whom services were provided and information about referrals in or out of the program. Programs are often required to maintain these kinds of records for the purpose of reporting to funding bodies.

Quantitative data from surveys. These data support statistical assessment across a range of areas. These may include experiences (e.g., questions about whether the program worked for you), attitudes (e.g., are particular kinds of attitudes more or less common after the program). Surveys involve information being collected in a format where the questions are carefully worded and participants are required to choose an answer from a pre-determined series of possible responses. Surveys may be administered by pen and paper, over the telephone or online. The decision about whether to use this approach, and in which format, should be based on the number of potential participants that may be

surveyed and their levels of literacy and access to computers and telephones. The decisions that need to be made in this area can be quite complex, but they may also be limited by the strategies available for practical or resource reasons. These kinds of data should be collected from staff and clients. Consideration should be given to including other stakeholders in data collection, such as referring agencies, as this can contribute valuable insight into how a program is operating.

For three of the groups considered in this report—Aboriginal and Torres Strait Islander women, CALD women and women with disabilities, particular care would need to be taken in identifying appropriate data collection strategies since language and literacy issues are likely to be pertinent for each of these groups. If a quantitative strategy is necessary, then it is likely that these groups would need the option of having the survey administered verbally.

Qualitative data is information gathered from in-depth interviews or focus groups with professionals associated with the program and clients. Unlike quantitative data, information collected in this way does not lend itself to statistical analysis and comparison. However, it allows rich information to emerge that can be very informative, particularly in understanding the perspectives and experiences of individuals and developing an understanding of how a program works. An interview format based on open-ended questions allows issues to be explored flexibly and deeply. Focus groups support a dynamic and interactive discussion that can be particularly useful for exploring practitioner perspectives. Caution should be used in applying focus groups for client data collection due to the possibility that sensitive material may be disclosed and confidentiality is not in the interviewer's control in a group setting.

Principles and implications

- Administrative data sources should be sought for any evaluation. For new programs, program design and reporting requirements can be established to provide useful administrative data for evaluation and reporting purposes. Such data may include inward referral sources, outward referral patterns, client commencement and completion data, commencement and completion time-frames, and client demographic data.

- For most programs, optimum evaluation designs include quantitative and qualitative data sources, unless the target groups for programs are too small and too diverse to support quantitative approaches. Data sources should include staff and clients and may include other stakeholders. In some instances, where the reach of a program is intended to be widespread and attitudinal, such as school-based approaches, an evaluation based on quantitative data from the target audience may be a justifiable primary strategy supplemented by qualitative insights from program staff and clients.

- Data collection methods need to be carefully considered to accommodate differences in language and literacy levels. For some groups, such as young women, online surveys may be appropriate. For others, such as CALD women, women with disabilities and Aboriginal and Torres Strait Islander women, these methods will be inappropriate.

- Issues related to sensitivity and confidentiality should also inform choice of data collection methods. Focus groups may not be appropriate in some instances. Interviewers and interview approaches need to be carefully considered to support appropriate responses to sensitive issues. In some instances, the gender of the

interviewer may need to be considered. Interviewers should be trained to be sensitive to the needs of the particular client group. This may include cultural sensitivity.

Ethical issues

Data collection can raise complex ethical issues, particularly where the program being evaluated deals with groups that have particular vulnerabilities, such as those evident among several groups of concern in this report. Data collections should proceed in accordance with the principles outlined in the National Statement on Ethical Conduct in Human Research (2007), Updated March 2014, (NHMRC). In particular, the provisions in relation to informed consent, participant confidentiality and researcher obligations in regard to certain kinds of disclosures should be observed.

7.3.4 Step 4: Drawing conclusions from the information collected

The evaluation conclusions will be based on the findings that emerge from analysis of the data. Quantitative data is analysed to produce evidence based on statistics. As explained in *Evaluation and Innovation in Family Support Services*, quantitative data may be analysed to produce descriptive or inferential statistics. Descriptive statistics "summarise, organise and simplify the data so that its basic features become clear and it is more easily managed and presented" (CFCA, 2013a). Such data support understanding of issues such as how many clients have used a program or service, what demographic characteristics they have and the time-frames in which services are delivered.

Some types of quantitative data may also be analysed to produce inferential statistics that examine more complex issues and associations than descriptive statistics. This type of analysis may be applied to survey data derived from a pre and post-test design, from experimental design or to measure differences among sub-groups of programs users. Differences in the patterns in the data are then used to support conclusions that are drawn by inference on the basis of these patterns: for example, a shift in attitudes to gender equality may or may not be evident from pre and post-test design and this shift may be attributed to the impact of the program, in the absence of indications of other causes.

The analysis techniques applied to qualitative data are different from those applied to quantitative data. There are a variety of approaches but the approach most relevant to program evaluation is based on analysing interview and focus group data to understand the experiences of professionals and/or clients in the program. Such analysis might be focused on identifying themes that emerge from the data and the extent to which themes are similar or different for the individuals whose experiences are being examined. This kind of analysis supports a deeper understanding of personal views and experiences and the kinds of dynamics that influence them. They may be used also to support interpretation of quantitative data or to examine the validity of inferential conclusions.

Evaluation example 2: Aboriginal Women Against Violence Evaluation Report

The *Aboriginal Women Against Violence Evaluation Report* (2010), conducted by Dr Margot Rawsthorne from the University of Sydney for Joan Harrison Support Services for Women, relates to the Aboriginal Women Against Violence (AWAV) initiative funded under the National Crime Prevention Program.

The AWAV program undertakes a range of violence prevention activities with Aboriginal and Torres Strait Islander women in the Liverpool and Campbelltown area, including training women to become mentors and advocates against violence and other community education activities.

The evaluation adopts an ecological framework to consider the broader socio-cultural factors influencing effective violence prevention initiatives. In order to capture data in respect of the multiple project objectives, multiple methods of data collection were used; including pre-program questionnaires with program participants, focus groups with program participants and program workers, analysis of artwork created by program participants, interviews with program managers and analysis of available administrative data. The evaluation report notes that a flexible methodology was important and provides an example of needing to amend the methodology during data collection to be more responsive to the needs of program participants (pre and post-program questionnaires were originally planned for program participants, but participant literacy levels necessitated a change to focus groups instead).

The evaluation questions clearly highlight the focus on understanding multi-level impacts and include questions about 1) the ways in which the project has impacted on the different elements of the guiding ecological framework, 2) which "level" of the ecological framework has the program been most successful in impacting, 3) how the project has strengthened bonding and social capital, and 4) in what ways the project has built social cohesion to ameliorate the negative impacts of social disadvantage.

Contrasting with example 1 above, this evaluation also provides an example of how evaluation can be undertaken at an individual program level, in partnership with an external evaluator.

8 Evaluation of the Mudgin-Gal Aboriginal Women's Corporation Healthy Family Circle program

8.1 Background

The Mudgin-Gal Aboriginal Women's Corporation is an independent incorporated organisation based in inner city Sydney. Mudgin-Gal is a service run by and for Aboriginal women; the name means "women's place".

Mudgin-Gal operates a variety of services for Aboriginal women including a drop-in centre, in-home family support, and provision of referrals for accommodation, legal, medical and court support, and post-release services. Mudgin-Gal has also developed and delivers a number of programs to address family violence. Notably, the Black Out Violence campaign won the Violence Against Women Prevention Award in 2004 and has since been rolled out—with help from Mudgin-Gal trainers and ambassadors—to communities in regional NSW. The program has been cited by the Human Rights and Equal Opportunity Commission (now the Human Rights Commission) as a best-practice model for addressing violence in urban Aboriginal communities.[7]

The focus of this evaluation is the suite of mentoring and education programs run through the Healthy Family Circle program, developed by Mudgin-Gal in partnership with Relationships Australia. The program is an 8-week capacity-building seminar series delivered as weekly sessions. The broad objective of the Healthy Family Circle program is to empower women and young girls with the self-esteem, confidence and life skills they need to become role models for their own children and families and, by extension, for their community. By increasing Aboriginal women and young girls' leadership capacity and personal power within their family and community, and fostering peer networks for the women who participate in the suite of programs, Healthy Family Circle also has an underlying focus on domestic and family violence prevention and early intervention. As we have understood from the discussion in chapters 3 and 4, effective violence prevention relies on such multi-level interventions; building women's self-esteem and sense of identity, improving individual and community capacity, and addressing social factors such as skills and attitudes are critical elements of working to prevent violence. For Aboriginal women, cultural factors—such as strengthened cultural connections and cultural relevance/sensitivity—are also important.

8.2 Evaluation methodology

The data collection for the evaluation comprised a combination of methods intended to examine the views and experiences of program users and professionals involved in

---

[7] Refer to Mudgin Gal Aboriginal Corporation publication, *Seeding Hope*, http://www.redfernfoundation.org.au/mudgingal.pdf, (accessed 5 August 2014) for a more detailed overview.

delivering the program. Decisions about the data collection methods to be utilised were made in consultation with Mudgin-Gal, in the context of the nature and scope of the Healthy Family Circle program and the client base. The AIFS Ethics Committee reviewed the evaluation methodology.

8.2.1   Data collection

Data to inform the evaluation was collected in three ways. First, Mudgin-Gal, and where appropriate Relationships Australia, were asked to provide non-identifiable administrative information about the Healthy Family Circle program. The content and format of the information ultimately depended on what administrative information Mudgin-Gal routinely maintained. The administrative information that was available was very limited. Where the available information was relevant to the evaluation, it is reflected in this chapter.

Second, individual semi-structured interviews were conducted (face-to-face) with service managers and program workers. The interviews focused on their professional perspectives of the Healthy Family Circle program. Two professionals from Relationships Australia who have been central to the development of the partnership between the organisations were also interviewed. In order to maintain confidentiality, where we have used quotes from these interviews we have not distinguished between different positions within Mudgin-Gal and have used the identifier 'Mudgin-Gal representative' for all Mudgin-Gal consultations. We have identified quotes arising from the consultations with Relationships Australia as 'Relationships Australia representative'.

Oral consent was obtained from each professional participant. Interview times depended on the individual participant but ranged from 30 to 60 minutes. The interviews were electronically recorded and transcribed.

Third, program participants were invited to share their experiences of the program via a face-to-face semi-structured group interview, held at the Mudgin-Gal offices. As the program is delivered on a group basis, and many of the service activities operate in a group setting more generally, in discussion with the program coordinator at Mudgin-Gal, the research team determined that a group interview was the most appropriate method of interacting with participants in the Healthy Family Circle program.

Participants of two different groups were asked to share their perspectives on the program: one group of participants who completed the program in September/October 2013 and one group of participants who finished the program in May 2014. Initially, we had planned to run two separate group interviews for participants of each of the series. However, the program worker advised us that the participants would be more comfortable taking part in one group interview with both previous and current participants. As a result, we ran one group interview and a further individual interview. The interview focused on the participants' experience of the program, rather than individual experiences of domestic and family violence. Participants were asked to give oral consent. The group interview took approximately 1 hour and was electronically recorded and transcribed.

8.2.2   Recruitment

Participants were recruited in two ways. Professional participants are managers and workers from Mudgin-Gal and were recruited directly by the research team.

Clients of the program were recruited with the assistance of the program worker at Mudgin-Gal. Mudgin-Gal advised us that most Healthy Family Circle program participants remain connected with the service after completing the training (and often go on to engage with the service in other ways, such as through art shows, networking groups or by attending other seminars on topics such as financial literacy).

Cultural sensitivity

The research team are acutely aware of the need for a culturally sensitive approach in respect of each of the services evaluated as part of this report. Two of the four members of the research team have culturally diverse backgrounds, however no members of the research team identify as Aboriginal. Each of the members of the research team are experienced researchers with a history of conducting research on a variety of sensitive topics, including domestic and family violence in the context of both Aboriginal and CALD communities, and with participants of diverse backgrounds. Additionally, the evaluation methodology relied on close collaboration with the two service providers to ensure the approach was sensitive to the various language and cultural considerations.

English language proficiency

All professionals involved in the consultations spoke English to a standard that enabled them to give informed consent to participate in the project and to take part in interviews and focus groups.

Service users who wished to participate were required to have sufficient levels of spoken English to understand the nature of the evaluation and give informed consent, but evaluation materials were tailored in consultation with the particular services to ensure that the comprehension level reflected the needs of participants who speak English as a second or subsequent language.

Participant incentives

Participants were offered a supermarket voucher as a token of appreciation for their involvement. The value of this voucher was $25, and was determined in consultation with the services (and what was appropriate within that cultural context). During fieldwork with professionals and clients, lunches were provided to participants.

For the two services evaluated as part of this report, following submission of the final research report, the research team will prepare a separate report or summary of the individual service evaluation that each service can keep for their use (for example, in relation to future funding applications) or as an organisational record.

8.2.3   Limitations

The scope of this evaluation reflects some constraints. The first of these is timing. Because of the nature of the wider research program to which this evaluation contributes, the programs for evaluation were identified well into the research period and the programs themselves had been going for some time. This means evaluations provide insight into the operation of the programs at a point in time (February to May 2014). For this reason, an evaluation design based, for example, on pre and post-test methodology was not possible. Further, the evaluation approach reflects the issues outlined in chapter 2, with several features of the program meaning that quantitative analysis was not suitable and a primarily qualitative approach was the most appropriate option. These features are the scale of the program, the limited administrative data maintained about the program, the mode of delivery, the flexible and responsive nature of the service provided and the participant group. These features also mean that it is not possible to conduct any meaningful analysis of the cost-effectiveness of the initiative.

8.3   Implementation of the program

This section outlines the organisation context in which the Healthy Family Circle program is delivered, beginning with an overview of the governance and funding arrangements for Mudgin-Gal followed by a discussion of the partnership between Relationships Australia and Mudgin-Gal in respect to the Healthy Family Circle program.

8.3.1   Governance, funding and oversight arrangements

Mudgin-Gal is a community-based organisation that supports an inner-urban community of Aboriginal women. Mudgin-Gal developed out of the South Sydney Women's Centre. The latter was incorporated as Mudgin-Gal Aboriginal Corporation in 1992, thereby transferring control to the community who primarily accessed the services at the South Sydney Women's Centre. It has a management committee consisting of seven Aboriginal women.

Mudgin-Gal receives recurrent funding from the NSW Department of Family and Community Services, which covers wages and basic running costs. Programs for women and children and additional expenditure depend on grants and vary in amounts.

As one Mudgin-Gal representative explained, the community that Mudgin-Gal supports demonstrates significant diversity and includes longer-term residents of the area as well as newcomers:

> [The] … community is the Aboriginal community here is the inner city … Ultimo, Redfern, Waterloo. But having said that, we have others—Redfern is very much a railhead here so Aboriginal people come here, and we've had people coming to the door to Mudgin-Gal just because we have the shower and drop in facilities.

The organisation has been set up to support and empower Aboriginal women in this community:

> The philosophy behind Mudgin-Gal is that Aboriginal women can fend for themselves basically, that we can really identify and work with our communities to make things better, that is basically the philosophy of Mudgin-Gal … (Mudgin-Gal representative)

> We can work with women who are not part of a family, often single women or women that have children that are living with them, often gay women … [there is diversity] of the women in the group … (Mudgin-Gal representative)

Mudgin-Gal identifies what this community needs through being embedded in it:

> We don't really identify through statistics … we do it down through the level of experience of women that are on the board, friends and family, conversations that take place in the community every day … when you live in a community in a village … then you are interacting all the time … (Mudgin-Gal representative)

Recognition of the need for the Healthy Family Circle program came from this understanding of the needs of the community:

> We got some money from the casino fund … and so the whole thing was about a workshop and taking them away in camp type environments, women and children and there was a number of issues, domestic violence being one of them and a number of others, health … (Mudgin-Gal representative)

8.3.2 Mudgin-Gal and Healthy Family Circle partnership with Relationships Australia

The Healthy Family Circle program is delivered by Mudgin-Gal in partnership with Relationships Australia. The partnership between Mudgin-Gal and Relationships Australia developed over a number of years. A worker from Relationships Australia made the initial contact between the two organisations when she was doorknocking in the area looking for services to partner with as part of a research project. Mudgin-Gal was in the process of developing Healthy Family Circle, and assistance with developing a program, administration and funding was needed. While Mudgin-Gal has always delivered the programs, Relationships Australia has fulfilled various "behind the scenes" roles. These have included providing professional supervision to program workers, drafting tenders and reports and carrying out evaluations as part of funding agreements.

The development of the partnership was a gradual process that took place over a number of years:

> Healthy Family Circle just didn't come like that, it was us trusting them and what they wanted to do because, you know, Bronwyn and I were already of the mind that people weren't just going to pick up RA coming in here and doing a big counselling on them. That just wasn't going to happen and we knew that and they said "well we can come and we can provide a group for them to come to", and we said oh no, because there had to be a lot more around the women owning it and it really being theirs. So was just things backwards and forwards, until we eventually—and I must say the RA women were very, very good, very

> open and you know, it would be one of the best, better partnerships we've ever had. And I think there was a lot of digging deep that you couldn't just come into an Aboriginal community and say that this is what we're going to do and youse are going to jump on board because that was never going to happen. So that, I think for us with Healthy Family Circle, allowed us to be more creative and innovative about how we approach and bring women into a conversation that maybe at times very challenging but also very beneficial. (Mudgin-Gal representative)

The caution that marked the early stages of the relationship is also highlighted by one Mudgin-Gal representative:

> I was always very conscious that they could take our ideas and a big organisation could swallow us up, we need to keep really very strong and [hold onto] our identity.

Overall, the partnership with Relationships Australia is considered highly valuable by Mudgin-Gal:

> The value of partnerships is extremely important 'cos, you know, at the end of the day we live in a very diverse country and we don't have all the answers, you know, there are answers within our communities but certainly when we have access to organisations like Relationships Australia and there's a good two-way equal partnership, it's only beneficial to both parties. (Mudgin-Gal representative)

One Mudgin-Gal representative explained how tailoring the language used was a very important part of the initial process of developing the Healthy Family Circle program. In the worker's words, this process was about the need to "Aboriginalise" the program developed by Relationships Australia and ensure that the program reflected the life experiences of Aboriginal women. The research team understands the concept "Aboriginalise" to be a description of an active process of reworking a program designed for use in mainstream services—in terms of language, content and mode of delivery—to be relevant for the Aboriginal women to whom Mudgin-Gal provides services and the context in which those services are provided.

The partnership has had many different phases, in part due to changes in staff at both Relationships Australia and Mudgin-Gal. The relationship is currently in the process of changing. By agreement between Mudgin-Gal and Relationships Australia, Relationships Australia is planning to step back from the program administration aspect of its role in the partnership. Within the next 6–12 months, the Healthy Family Circle program will be administered by Mudgin-Gal alone.

8.4   Program model, objectives and delivery

The Healthy Family Circle program focuses on empowering women and young girls with the self-esteem, confidence and life skills they need to become role models for their own children and families and, by extension, for their community. Through building women's capacity, networks and leadership skills, the program aims to help reduce the incidence of

violence against women, their children and their families. The program is flexible and the content is adapted to meet the needs of the women using the program.

Also integral to the program model, is the "soft-entry" approach to DFV education and prevention, which delivers prevention in indirect ways. The "soft entry" approach to prevention reflects the need to be responsive to the specific needs of at-risk groups and is consistent with research indicating it can be a helpful service delivery strategy (Robinson, Scott, Meredith, Nair, & Higgins, 2012).

Program participants are urban Aboriginal women, mostly drawn from the inner south-western suburbs around Redfern in Sydney. As the program is a primary prevention program, rather than a response or intervention to an individual experience of domestic and family violence, program participants have not necessarily experienced violence or abuse, although as Aboriginal women they are at higher risk. The women that participated in the evaluation data collections were mostly mothers of young children, many of whom were sole parents. At this point, a primary role of the program is to support these women in their parenting roles.

The limited administrative data that was available to the research team indicates that the number of participants in the program and related activities varies considerably, but is estimated to be around 10–20 women per activity.

The following sections discuss the findings on particular aspects of the evaluation. A point reinforced strongly through several aspects of the evaluation data is the significance of Healthy Family Circle being delivered by an Aboriginal community organisation.

8.4.1   Examples of program activities

The Healthy Family Circle program is an 8-week capacity-building seminar series delivered as weekly sessions. In addition to this core program activity, other related program activities are hosted periodically and participants from the Healthy Family Circle program may be involved. The following examples are consistent with the objectives around building social connections and improving self-esteem, which are important factors in reducing vulnerability to DFV:

- Mudgin-Gal hosted a pampering day for a number of women. It is understood from the consultations following on from this activity, some of the women expressed interest in exploring options for vocational training in the beauty industry.

- In 2012, as part of activities on 26 January, participants in the Healthy Family Circle program had a market stall to sell handmade jewellery and raise money for future program activities.

- Mudgin-Gal periodically hosts art workshops and displays the art at exhibitions hosted on site.

8.5 Meeting client needs

8.5.1 Program accessibility

Most clients found out about the program through informal networks. Mudgin-Gal is a well-known organisation within the Aboriginal community in Sydney's inner west and word-of-mouth networks were cited as the most common way that clients heard about the program. The place of Mudgin-Gal in the community is succinctly reflected in one participants' response to a question about how participants found out about the program:

> I'm a Redfern community woman up here so I pretty much grew up at Mudgin-Gal. (Program participant)

For Mudgin-Gal and its clients, the issue of accessibility is a complex one. The quote below reflects the experience of one Mudgin-Gal representative who describes how once women know about the program, it is not a matter of simply signing them up and starting. Preparatory work that establishes trust, ownership of the process and familiarity with the format is needed:

> Most of the groups we have usually run from eight to ten weeks and there's always that engagement period with the groups. So people are coming in, then you don't just sort of [say] OK, 3 June everybody turns up and you start the group. There is this thing about coming and feeling comfortable, and people are like, what are we going to do?, let's have a look at —you know people want to know what's going to be coming their way. And I think that's very important to extend that because if you're gong to come in and you're going to start talking about grief that someone has had buried down or you're talking about living in a violent relationship, and they go oh this is me, I don't really want to be around here, you know. So we—I think we've learnt that, we've learnt that you can't just pluck a date out … [you need to] ease into it and I think that's being more respectful. And people start to own, "Well I'm part of this and this is what I can do". So we've been able to engage women in doing that. (Mudgin-Gal representative)

The lack of a strict, prescriptive structure was clearly seen as positive by some of the current program participants:

> I'm a young, (indistinct) young single mum so I didn't want something too full on but I did need to have a place to go outside of the house-type thing. That's why I originally would come here as well because (indistinct) what to go and talk to other women, you know, not necessarily about in-depth things, but also just drop in and have kind of like a social spot, so to speak. (Program participant)

> That was the first thing was that was quite a relaxing place and it wasn't a formal structured learning facility where it is. (Program participant)

8.5.2 The significance of Healthy Family Circle being delivered by an Aboriginal organisation

Our consultations indicated that participants placed a high value on the fact that the program was delivered by an Aboriginal organisation. This was important for a number of reasons. First, as an Aboriginal community organisation, Mudgin-Gal is trusted by the community. The reluctance of many Aboriginal peoples to engage with non-Aboriginal services is well documented in the literature (e.g., Family Law Council, 2012, p. 38) and has a number of foundations. These include concerns that such engagement may lead to involvement with child protection systems and a lack of trust in mainstream services to provide culturally safe and respectful services. This concern was powerfully evident in the data collected for this evaluation, as discussed further below. Second, Mudgin-Gal's position in the community is integral to its capacity to provide responsive and appropriate programs for members of that community and to foster connections among members of that community.

This latter point is illustrated in the confidence that participants expressed that Mudgin-Gal programs offered a high level of understanding of the issues affecting them and the context of their lives.

> I remember when I was doing programs with other [non-Indigenous] places, you just didn't connect with anyone … there's no friendship after … (Program participant)

> Like if I didn't go into this I probably wouldn't be involved in any other ones. Like [indistinct] nothing else has engaged me … if Mudgin-Gal wasn't here I don't know where I'd be … (Program participant)

The following excerpt from a discussion in the participant focus group session shows responses from Healthy Family Circle participants to a question about the significance of the program being run by an Aboriginal community organisation. The women's comments highlight the lack of trust expressed in relation to services operated in a non-Aboriginal context. The discussion also demonstrates the significance of the point made earlier regarding concern about evoking the interest of child protection departments in the context of past practices and contemporary high rates of child protection involvement with Aboriginal children. The first response to the question indicates that the "only reason" one participant was prepared to be involved in the Healthy Family Circle program was because it was delivered by an Aboriginal community group. The discussion then turned to the reasons for this:

> Participant: There's no way I'd go to the [indistinct]. Even like with Barnardos and stuff I go to the Aboriginal Early Childhood or if you're going to organisations [indistinct] go to the Aboriginal section and I'm not—I'm quite educated. I've got an educated family but still there's just barrier there.

> Participant: [Indistinct] see people look down at me, you know.

> Participant: And there's still things that we would consider like normal behaviour, they may not …

> Participant: Because we're different.

Participant: Yeah, [indistinct].

Participant: When it comes to the children it's quite scary because it could be seen as neglect or, you know …

Participant: [There is a new] stolen generation.

Participant: Yeah, there's a new stolen generation. They've got a march on it today. You know what I mean, like it's a whole range of things, racism, judgment, yeah. But it is, you know, worry about the DoCS and stuff. These are every day things that we worry about, you know what I mean, when we go into white organisations.

Participant: You can tell by the way that they talk to you like that misjudgement and I suppose it is that new stolen generation, [indistinct] and knowing now that more kids are being taken than in the Stolen Generation we see it just in our generation.

8.5.3   The importance of flexibility and responsiveness

Participants and the professionals involved in delivering Healthy Family Circle highlighted the fact that the program is delivered in a manner that responds to the needs and interests of the participants, both immediate and longer term.

One Mudgin-Gal representative reflected on the need to respond to events in the community that may be distressing for participants. For instance, when drug raids occur, the small nature of the community means that the effect is often widespread and this has to be taken into account when delivering the program:

> So you know that people [when they] come down for the circle or come down to Mudgin-Gal, that's going to be foremost on their mind. So that day you might say we'll go and do a bus trip somewhere and have a picnic rather than have to sit and try and get people to sit down and think about what's wrong with them, you know, and have these conversations somewhere else.

In the current program, identifying participants' needs and working collaboratively in addressing them has been a central part of the program. The current Healthy Family Circle facilitator makes an agreement with each participant that both parties will take small steps each week to address the issue identified. She describes the goal-setting process in this way:

> [We identify] their barriers, each week they have to do one thing from those barriers, I don't care if its a phone call to Housing Commission to get a form, you do one thing, I do one thing. So I bring in an organisation that they need to access that they haven't been able to. And that's how we ended up with Wesley Mission coming in and we've had housing issues.

The present groups involved in Healthy Family Circle are mothers with young children and current programming focuses on the needs that arise in this context. This has not always been the case, however, and in one past group, the issues addressed arose from the history of the women in the group as members of the Stolen Generation:

> A few years back we had a group of older women who had turned up here and I think there was about six to eight of them and all the women unfortunately

had had the experience of being in and out of orphanages or being removed from their families. So the young woman who was running the group said, OK let's work towards us maybe going to, you know, some said they didn't have their records, some said they did, some would like to. And they did it, an overnight trip down to Canberra to look at their Aboriginal records and that was pretty awesome. (Mudgin-Gal representative)

8.6   Program impacts and changes generated

Primary prevention of DFV is long-term goal and direct impacts, particularly in relation to attitudinal change about gender, power and gender relations, are often difficult to ascertain (Flood, 2013). Consistent with the reasoning of Kwok (2013), discussed in detail in chapter 3 (that it can instead be more useful to focus on shorter-term gains/outcomes of prevention work rather than assessing longer-term impacts) the qualitative insights presented in this chapter reflect the experiences of the individuals and their perception of how their involvement with the program has had an impact on their personal circumstances.

8.6.1   Insights from clients

Perspectives from clients about the impact of the Healthy Family Circle program were primarily gleaned from participants currently undertaking the program. In the present group, activities are focused on encouraging women to set goals to support them to address issues of current concern, in addition to activities of a lighter nature such as pampering days. As the quotations set out below demonstrate, even ostensibly light activities such as beauty therapy sessions support women in their role as mothers. The following discussion illustrates the role the group and the activities has played in supporting the most recent group of women, whose circumstances are clearly not easy. The comments reinforce the importance of the social and community support the women and their children derive from the group and the connection it fosters with the wider community and their Aboriginal culture.

Connection to community and culture

One of the important impacts of the program was a strengthened connection to community and culture. It is generally acknowledged within the literature that DFV in Aboriginal and Torres Strait Islander communities occurs within a context in which the impact of colonisation and its practices, such as forced removal of family members, displacement of people from traditional lands, the breaking down of social bonds and identities, loss of language, and sexual and physical violence, are still in effect and being worked through (Day, Martin et al. 2008). Program participants viewed aspects of the Health Family Circle program that sought to strengthen social bonds and community and cultural connections positively. These included the role that contact with other Aboriginal women plays in militating against isolation and providing mutual support:

It's empowering here to hear other young black mothers, you know, telling a similar story and enjoying each other's company. (Program participant)

One focus group participant commented on how the program worked to address isolation and issues of trust:

> [The program helped with] identifying that you're not the only one, being able to relate to other women in terms of cultural issues as well and building that trust again in other people after being through domestic violence relationships and family violence, you know, growing up in that and knowing that.

Of significance for some women was the opportunity to have their cultural identity supported and reinforced through contact with Aboriginal peers and other members of the community. Support for cultural knowledge—including outings to places of cultural significance—was also valued:

> … your culture is one of the main essences of everybody … I'm not me without my culture … (Program participant)

> So I grew up in the city and just for me, like when I was growing up I got taken out of the country and that but not very much for me and my children now, how do you find that cultural … space for them, you know what I mean, because it's all about identity. If you don't have your own identity then you'd be lost … searching for something and that's about, and that's our mission as Aboriginal parents because that's one of the major things … dealing with kids because we know how empowering it is for them. (Program participant)

> Like as a parent because my sister-in-law… she knows the language from where we're born, she said to my daughter … that she's making me feel like I don't [indistinct]. They're little things, so just wanting to be aware of our … cultural heritage. (Program participant)

> Just more really for the cultural aspect, you know, learning more about how—where an Aboriginal woman's role is and what it is and you know self-worth with other women and actually saying we are the backbones of our communities, we raise our kids to be better stronger people, so in doing so we need to raise our boys to be better men, we need to raise our women to be stronger women. So that these things stop, breaking the cycle and it all starts with us. And as a young mum as well, you know like it was good to have those conversations with other women who were saying it as well but we didn't know how, so it was empowering each other and bouncing off each other's ideas of how we can do that. And coming to the realisation that it starts at home and it starts with you. And I think that in the programs of Healthy Family Circle, 'cos they've all changed over the years and now there's a new program with Relationships Australia, but each and every one of those have always been culturalised back to our culture and it's always been about being a positive person to yourself, being honest to you and loving you for who you are because first and foremost you're a black woman. And with that comes you know all these cultural kinship responsibilities that it will not—many other people couldn't understand nor do and it's a given you know, like it's an honour really. (Program participant)

Skills, knowledge and confidence in dealing with other services

The focus groups offered a number of important insights about the role the program plays in helping participants to develop skills, knowledge and confidence in engaging with other services. For the current group of participants, the program has had a role in supporting them to overcome obstacles, including strategies for dealing with government services (such as housing services) as well as other issues (such as their individual domestic arrangements). Many participants reported feeling that they have an increased capacity to make decisions for themselves and their families, seek help, and navigate support services. In particular, participants reported feeling more confident about addressing housing and legal issues, and to successfully deal with agencies such as Centrelink. For many of the participants who may have limited formal education and have experienced a lack of cultural sensitivity and/or institutional racism when dealing with services, this was a significant outcome.

This excerpt from the focus group discussion illustrates the significance of this focus on empowering participants to deal with government and other services:

Participant: Yeah, it just helps. It gives you that push to do that extra when you've got other empowering women. Yeah.

Participant: Because you get pushed down a lot. A lot of organisations, you know, whether it be Centrelink, the doctors, housing, do you know what I mean?

Participant: But these are not people that are like welcoming.

Participant: The whole experience has just never been, especially if you're a young Aboriginal parent, it's horrible.

Participant: It's stressful but when we sit here in a group of woman and knowing that it's happening to all of us, we can sit here and have a laugh about it, you know, whereas if we're not doing that we're stressed about it.

Participant: And everybody's stressing about it but here because we're all basically going through the same stuff you can [indistinct] actually talking and get a life out of it you know and that pushes us to actually go out and then finally put them paperwork and [indistinct] whatever and stuff.

Interviewer: Yeah. That was going to be my next question, having this group, does that mean that you feel you're better able to kind of go out to those places and deal with them with more strength in you?

Participant: Yeah, yeah. More confident and just not taking them to such—because it's like, you know, it builds up if you don't have like someone here that goes oh, I understand, you know mean.

Participant: And you're constantly walking into walls and you can't really [indistinct] this for you and you're living in circumstances that aren't great.

Participant: And it's also we've learnt—it's sort of learning anger management because you're learning how to speak to people and saying, well, because of my situation, you know, you've got to deal with your problems and sort of learning how to speak to people when you're going to the organisations as well.

Program participants also commented on how the group provides more than mutual support for dealing with such issues. There were also reflections on peer-to-peer sharing of specific knowledge about how to navigate a particular issue and/or organisation:

> Participant: But also because we're all different ages and got two like [indistinct] see that one might need helping out [indistinct] with housing and then after being someone that dealt with it a year ago [indistinct] you can do this, this and this and you can [indistinct].

> Participant: It's all scary so that helps too.

Strengthened self-esteem

A number of elements of the program contribute to strengthening women's self-esteem, in addition to the peer and community support aspects already mentioned. This is significant in helping women to be more resilient and less vulnerable to DFV. For one woman, activities designed to support self-awareness were important in this respect.

> For me, I think to recognise yourself … to know the identity of yourself, to allow yourself to be more aware of yourself … its just beautiful to understand and recognise the thing that you think you don't have there and a lot of the time you'll say I'm feeling empty today but you're sitting up writing … and you know you're writing a positive story …

For others, pampering activities provided a way of experiencing care amidst the demands of motherhood:

> So it's just all them little things that mothers don't usually get around to doing, yeah. You're having little outings or having the little beauty session or stuff like that, because you just don't find time. It's not important enough to find time for. But when you're here, yeah.

Capacity building

There is wide agreement within the literature that DFV in Aboriginal and Torres Strait Islander communities has a multitude of contributing factors (Cripps & Davis, 2012), which can be compounded by factors such as overcrowding of housing and high levels of alcohol consumption (Blagg, 2000; SCRGSP, 2011; AIHW, 2011). Additionally, it is generally agreed that DFV in Aboriginal and Torres Strait Islander communities occurs within a context in which the role of colonialism and the associated trauma and family dysfunction must be acknowledged. Some researchers also stress that DFV must be understood less as an expression of male power and more as compensation for lack of status and esteem (Blagg, 2000).

In that context, building individual and community capacity is an important element of violence prevention and the consultations suggest the Healthy Family Circle program has had an impact in this regard for some participants. This experience is reflected in the following comments:

> I'm trying to get back into doing a course for [indistinct] so it's sort of a bridge. (Program participant)

> So I'm no longer preaching, I'm teaching, active and living a healthier life as well, and I do you know say that it's because of the Healthy Family Circle and knowing that Mudgin-Gal has always been here to run those programs. (Program participant)

For some program participants, building personal capacity may start with what seem to be small, but tangible first steps. The following quote reflects the experience of one mother:

> … we haven't put the kids into pre-school and like this was the first step like when I first put my babies downstairs with, you know, to be left downstairs. Like I was anxious about it but I did it and I'm thinking, well, it's only just there … So that was the first step, yeah. They're just there, I can check on them, you know. She messages up here if there's any problems or whatever so it helps also getting into pre-school and stuff because it's the first step of that separation from them which we don't really have. (Program participant)

Other program participants valued the opportunity afforded by the program for more personal reflection, as is illustrated by the experience of the program participant quoted below:

> [The program] relates to us … because we done a lot of work on the subconscious part of the brain … that was a highlight for me … (Program participant)

8.7   Program gaps and barriers

Participants in the evaluation research identified a number of other activities that would be of value if they were able to be included in the program. These included more opportunities for outings to sites of cultural significance, parenting courses, and budgeting/financial management courses.

> And one of the things that the women have identified is budgeting and I think everybody needs budgeting so in partnership with Wesley Mission we're going to be starting a financial literacy course next Tuesday and that's a three-week course and it's all about understanding your money, impulsive buying, all that kind of stuff and then budgeting at the end. So what I say—talk about the budgeting thing I say that that's something that the women identified, so it's helping them identify their barriers and then I research how to address those realistically.

> … people want to come and engage, they want to do art classes, they want to come and do Healthy Family Circle … so many people want to do parenting classes …there's a lot of young mums out there that want to engage in this … even you know mums that don't have their children, they want to come and do self-developing programs to get their kids back you know from the Department of Community Services …

The benefits of activities of the kinds described by the participants above are supported in the literature, particularly activities that help to strengthen the bond between mothers and their children. For example, Humphreys (2011; 2014) argues that there needs to be more interventions that focus on both caregivers and children in the Australian context. Further,

one of the key findings of the reviews by Rizo, Macy, Ermentrout, & Johns (2011) and Humphreys and Houghton (2008), and reflected in the wider literature, was that some of the strongest evidence available on responding to children exposed to violence focused on interventions that address both caregivers (mostly mothers) and children, in order to repair the potentially damaged parental relationship following experiences of DFV (Bunston, 2008; Bunston & Heynatz, 2006; Graham-Bermann & Hughes, 2003; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Humphreys, 2011; Humphreys, Thiara, & Skamballis, 2011; Lieberman, Ippen, & Van Horn, 2006; Sullivan, Bybee, & Allen, 2002) .

8.7.1   Barriers to effective practice

The administrative and governance capacity of Mudgin-Gal is stretched at times due to a lack of training and resources. There have also recently been significant staff and leadership changes at Mudgin-Gal. Dixie Link-Gordon, who acted as CEO for a number of years, resigned at the end of 2013. There was a delay in appointing a new CEO and in this period Mudgin-Gal closed for a period of time. As a consequence, there was disruption to the delivery of the Healthy Family Circle program and the service more generally:

> … we're not always, although we like to, we would like to be in a position to act in any emergency, if anything happens, we're not always in that position. (Mudgin-Gal representative)

There have been gaps in having a facilitator of the Healthy Family Circle program, in part because of the difficulty recruiting people to the position:

> There aren't that many Aboriginal women trained to run groups and so that's part of the work that I've wanted to do, to actually build the skills of the person that's been employed. (Relationships Australia representative)

These issues have had an impact on how the program is facilitated:

> I don't think that there's enough time, in terms of preparation for the program itself. I mean like there was no handover for me and the previous worker so you know I picked it up and ran that same week so I think in doing that I was lucky enough that I could do that. (Mudgin-Gal representative)

> I think that the program needs to be extended to maybe ten weeks' worth of running the weekly programs with more outcomes, I think that, you know, which I'm working towards is getting some training for working, you know what I mean, 'cos some of these women have never worked, wouldn't know the first thing about a tax file form and all of that kind of stuff that's just a given, you know, timesheets and every workplace is different and just—just those things that the everyday worker sees as a norm, you know these are young mums who pretty much from school have become mothers and just that's all they've pretty much known,. So there's no formal training in that and self-esteem building around that as well. (Mudgin-Gal representative)

The impacts of the program are long-term for participants, and the benefits of delivering programs are also cumulative for Mudgin-Gal:

> And things like the Healthy Family Circle, it kind of goes in a cycle and you know, grows in knowledge and mentoring it's a slower process … So I think the impact of that is probably seen today of those seven, eight, ten years ago … perhaps in the way women … [are] making better decisions in their families and for their families. (Mudgin-Gal representative)

8.8   Conclusion

At a broad level, the findings from the evaluation of Mudgin-Gal's Healthy Family Circle program indicate the program is consistent with the features of effective practice identified in the literature on DFV primary prevention and program implementation for Aboriginal peoples. In particular, the Healthy Family Circle program demonstrates key elements of effective practice such as being community driven, community owned, and responsive to the needs of its user group—at this stage, Aboriginal women with young children. The program is also consistent with the community-strengthening focus of the Indigenous-specific outcome of the National Plan to Reduce Violence Against Women and their Children. Features such as the use of "soft entry" points for engaging with women and offering broader opportunities to build skills and capacity also seem to be key elements of effective practice in this context.

As was described in chapter 4, the socio-ecological theory of DFV acknowledges that there is no single factor to explain DFV. Rather, violence is determined by a complex interplay of multiple and interrelated factors at four levels of influence; individual, family, community and society (Casey & Lindhorst, 2009; Dahlberg & Krug, 2002; Dutton, 1985; Heise, 1998; Quadara & Wall, 2012; WHO, 2010). Further, it is widely recognised in the literature that effective DFV prevention has universal and targeted elements. For example, WHO acknowledges that "dismantling the hierarchical constructions of masculinity and femininity" and eliminating inequality, are long-term, challenging goals (2010, p. 36) and recognises that these broader macro strategies should be complemented by "measures with more immediate effects". This is perhaps especially pertinent for women who are at higher risk of experiencing DFV.

For many Aboriginal women these shorter-term protective factors include strengthening cultural bonds and connections to community, enhancing knowledge about DFV and services, improving self-esteem and personal capacity and strengthening community capacity. The insights from the interviews with participants in the program reinforce the community need for programs like Healthy Family Circle. The program plays an important role in reducing isolation, supporting community and cultural connections and increasing the capacity of participants to engage effectively with other services and agencies. The continuing impact of an entrenched lack of trust of mainstream and government services among Aboriginal people—based on the past history of removal of children and contemporary over-representation of Aboriginal children in child protection systems—cannot be over-emphasised. The participants interviewed for this evaluation clearly expressed a need for support of their parenting to be provided in a safe and culturally appropriate way. The benefits of strengthening parenting capacity and reducing isolation through connection to community and culture has direct benefits for the children of the participants, who also have their own social and cultural engagement supported through the childcare that is provided when their mothers attend the group. The evaluation data

also suggest that Healthy Family Circle supports capacity building, with engagement in the program operating in some circumstances as an initial step in supporting engagement in further study and work.

As such, although it is important to acknowledge that the Healthy Family Circle program is not explicitly or solely focused on preventing DFV and there are no data to show whether or not it directly reduces the incidence of DFV in those who participate, the approach is supported by the literature and is consistent with evidence-based practice.

8.8.1 Implications arising from the policy and organisational setting

As the preceding discussion indicates, it is critically important to the efficacy of the Healthy Family Circle program that it is delivered by an Aboriginal organisation. In this context, it is also important to acknowledge some of the wider policy issues that are pertinent in NSW in this context. The recent NSW Aboriginal Affairs policy document, *OCHRE: Opportunity, choice, healing, responsibility and empowerment* (NSW Government, 2013), acknowledges a lack of clarity in the relationship between Aboriginal communities and government agencies, the inadequate levels of community investment to sustain staffing, funding and leadership development and a need for strengthened government mechanisms in support of self-management (NSW Government, 2013). Aboriginal organisations are recognised to have a critical role in building bridges between Aboriginal communities and government agencies, but it is also evident that significant demands are placed on them in the context of limited resources and the necessity to prioritise other community needs. Notwithstanding the positive indications about the impacts of the Healthy Family Circle program, the implications of these issues are evident in the evaluation of the Healthy Family Circle program operated by Mudgin-Gal. The evaluation evidence strongly reinforces the need for such a program but it also highlights some constraints in the capacity of Mudgin-Gal, as a community organisation with limited funding and limited administrative resources, to deliver the service and to meet the many and varied needs of its client group. It is evident from the data presented in this chapter that the needs of the women in the Healthy Family Circle group go beyond the services delivered in the group. It is also clear that in some, if not many instances, these needs are complex and require a level of support that goes beyond what is available within the current boundaries of Healthy Family Circle. The evaluation data suggest that, consistent with the direction established in OCHRE, that Mudgin-Gal itself requires strengthening to support its capacity to meet the needs of its client group if its move to self-management of Healthy Family Circle is to be sustainable.

In this regard, some further important points are made in an analysis of Indigenous and government organisational capacity published by the Closing the Gap Clearinghouse (Tsey, McCalman, Bainbridge, & Brown, 2012). This analysis identifies the following factors as impediments to effective practice in this context: programs that do not reflect community priorities, fragmented or rapidly changing government processes, an overload of reform and change initiatives, ad hoc funding, poorly co-ordinated and monitored programs and multiple accountability requirements. These points resonate with the discussion in chapter 6 of this report identifying the elements of effective practice of DFV prevention generally and with Aboriginal communities in particular.

When considering the policy implications of this report generally, the insights from this evaluation should inform further thinking about how programs like Mudgin-Gal's Healthy Family Circle can be supported in the context of the implementation of the Indigenous-specific priorities in the National Plan and the goal of strengthening partnerships between Aboriginal community organisations and government in OCHRE. That is, further consideration might be given to ensuring adequate levels of community investment to sustain staffing, funding and leadership development, and strengthening mechanisms in support of self-management.

9   Evaluation of the St George Migrant Resource Centre Domestic Violence Community Education Project

9.1   Background

The Domestic Violence Community Education Project, delivered by St George Migrant Resource Centre (SGMRC), is an umbrella program encompassing a range of activities that support domestic and family violence prevention among the service's culturally and linguistically diverse (CALD) client base. In particular, the program targets the South Asian (Nepalese and Bengali) and Chinese communities in the St George local government area of outer Sydney through community education and support programs.

The program is a bilingual-bicultural domestic violence awareness raising and community education project with multiple sub-programs that aim to increase women's awareness, social networks and personal empowerment, and prevent and minimise the impact of DFV in the selected communities. Various community reference groups (e.g., the Nepalese/Bengali Reference Group) are created as part of the overall program to build community capacity to address violence. Particular sub-program activities include mothers groups, sewing groups, grandparents groups, and sporting and cultural activities—each with an underlying focus on domestic and family violence prevention. The focus of this evaluation is the South Asian Mothers Group and Family Harmony Initiative.

As the program is a primary prevention program, rather than a response or intervention to an individual experience of domestic and family violence, program participants have not necessarily experienced violence or abuse, although as CALD women (who may also be newly arrived migrants), they are at higher risk.

9.2   Evaluation methodology

The data collection strategies for the evaluation encompassed getting the views and experiences of program users, the professionals involved in delivering the sub-programs, and community representatives consulted in the development of the programs. Decisions about the data collection method to be applied were made in consultation with SGMRC, in the context of the nature and scope of the identified program and the client base. The AIFS Ethics Committee reviewed the evaluation methodology.

9.3   Data collection

Data to inform the evaluation were collected in three ways. First, SGMRC was asked to provide non-identifiable administrative information about the Domestic Violence Community Education Project. These included:

- general information about the program, such as the program objectives, the number of staff working on the program, the number of clients, the program duration, how the

program is delivered, the contents of the training package and how clients are referred into and out of the program;

- information about program funding and any in-kind arrangements;
- evaluative materials, such as project reports, client satisfaction surveys, pre and post-training surveys; and
- program promotional materials, such as flyers and posters.

Second, semi-structured interviews were conducted with service managers and program workers within the SGMRC offices in Rockdale. The interviews focused on their professional perspectives of the program, the program objectives, program strengths and areas for improvement.

Oral consent was obtained from each professional participant. In total, we conducted one group interview of four program workers, and three individual program interviews with service managers. In order to maintain confidentiality, where we have used quotes from these interviews we have not distinguished between different positions within the organisation and have used the identifier "program worker" for all SGMRC consultations. Interviews took approximately 45–60 minutes and were electronically recorded and transcribed.

Third, program participants were invited to share their experiences of the program in a group interview. In consultation with the service manager, it was agreed that participants of the South Asian Mothers Group and members of the Nepalese Reference Group would be approached. The interview focused on the participants' experiences of the program. Participants were not asked to share any individual experiences of domestic and family violence. Six women took part in a face-to-face group interview in the SGMRC offices, Rockdale. Three members of the Nepalese Reference Group participated in a face-to-face group interview, which also took place in the SGMRC offices. Oral consent was obtained and the interview was electronically recorded and transcribed.

9.3.1 Recruitment

Professional participants are managers and workers from SGMRC and were recruited directly by the research team. Clients of the South Asian Mothers Group program were recruited directly by the program workers at SGMRC via phone calls and in person. Program managers also contacted members of the Nepalese Reference Group directly and invited them to participate in the research.

Cultural sensitivity

The research team were acutely aware of the need for a culturally sensitive approach in respect of each of these services. Two of the four members of the research team have culturally diverse backgrounds. The members of the research team are experienced researchers with a history of conducting research on a variety of sensitive topics, including domestic and family violence in the context of both Indigenous and CALD communities, and with participants of diverse backgrounds. Additionally, the evaluation methodology relied on close collaboration with SGMRC to ensure the approach was sensitive to the various language and cultural considerations.

English language proficiency

All professionals and clients involved in the interviews were able to speak English to a standard that would not preclude them from participating in the project and giving informed consent.

Participant incentives

Participants were each given a supermarket voucher to the value of $25 as a reimbursement of their time and travel coasts and as a token of appreciation for their involvement. During fieldwork, participants were given lunch.

For SGMRC, following submission of the final research report, the research team will prepare a separate report or summary of the individual service evaluation that each service can keep for their use (for example, in relation to future funding applications) or as an organisational record.

9.3.2   Limitations

The scope of this evaluation reflects some constraints. The first of these is timing. Because of the nature of the wider research program to which this evaluation contributes, the programs for evaluation were identified well into the research period and the programs themselves had been going for some time. This means evaluations provide insight into the operation of the programs at a point in time (February to April 2014). For this reason, an evaluation design based, for example, on pre and post-test methodology was not possible. Further, the evaluation approach reflects the issues outlined in chapter 2, with several features of the program meaning that quantitative analysis was not suitable and a primarily qualitative approach was the most appropriate option. These features are the scale of the program, the administrative information available, the mode of delivery, the flexible and responsive nature of the service provided and the participant group. These features also mean that it is not possible to conduct any meaningful analysis of the cost effectiveness of the initiative.

9.4   Governance, funding and oversight arrangements

The SGMRC commenced operations in 1981 and was one of a number of migrant resource centres established following the release of the Galbally report on migrant services and programs (Galbally, 1978), which recommended establishing migrant resource centres to meet the needs of migrant communities. The stated objectives of the SGMRC are to:

1.   link culturally and linguistically diverse (CALD) communities to build community capacity and make connections with the whole community;

2.   deliver holistic and accessible services for diverse community groups and individuals at different stages of their lives; and

3.   advocate for social inclusion and rights for all.

The Domestic Violence Community Education Project is one of several integrated programs operated by the SGMRC in support of these objectives. Other programs focus on settlement support, aged care, disability support and referral, and a variety of

community programs, for example, the permaculture-based gardening project. Additionally, the SGMRC hosts other services provided by co-located agencies or outreach services including legal advice, immigration advice, tax help, Australian Hearing, and the domestic violence court advocacy service.

By constitution, a board consisting of 12 directors governs the SGMRC; this group is made up of the office bearers and up to six ordinary members, each of whom is to be elected at the annual general meeting.

Several culturally specific reference groups also have input into the focus and activities of the Domestic Violence Community Education Project; including a Nepalese Reference Group and a Bengali Reference Group. Members of each reference group are drawn from their respective communities and the groups are intended to support a culturally appropriate and community-driven approach to addressing their settlement issues, including domestic and family violence.

The SGMRC receives recurrent funding from the Department of Social Services (through the Settlements Grants Program), which covers many of the basic running and infrastructure costs, including the wages of a number of SGMRC staff. Additionally, SGMRC receives funding through the NSW Department of Family and Community Services (through the Domestic Violence Proactive Support Service (DVPASS) program). SGMRC also depends on other small grants, assistance and volunteer labour for some programs or services. The Domestic Violence Community Education Project was initially funded by an $85,000 grant over 18 months and additional funding is drawn from the DVPASS program, however a number of the broader program activities are delivered as part of the education and awareness activities undertaken through the Settlements Grants Program and are enabled by the general SGMRC administration and infrastructure.

As one program worker pointed out:

> I think that our finance and in-house support plus our existing network make this program [the Domestic Violence Community Education program] actually still alive till now, continue. (Program worker)

9.5   Program model, objectives and delivery

The Domestic Violence Community Education Project was developed in 2011 after a review of casework and referrals, including police reports, showing high rates of DFV and suicides, which those professionals perceived to be linked to DFV, in the St George local government area among South Asian newly arrived migrants. Newly arrived Chinese migrants were also identified as experiencing high rates of DFV in the area. Program workers reflected that the rate of financial abuse and social isolation among women in these new migrant populations was also high but that the women they were seeing in the centre generally did not understand their rights, nor have clear knowledge about what constituted DFV:

> Maybe, big majority are women so when I say women actually I will probably say DV victim, that they probably don't understand that what they do—what they experience actually is DV. (Program worker)

The program is broadly defined as a prevention and harm-minimisation program aiming to prevent DFV in South Asian and Chinese communities through community education, empowerment, and awareness-raising via the delivery/facilitation of various groups and activities. One of the main objectives of the program is to change attitudes towards the "right to live free of violence" (St George Migrant Resource Centre [SGMRC], 2013). While the South Asian Mothers Group specifically targets women, the Family Harmony Initiative encompasses the whole family with groups such as the Nepalese grandparents group, men's yoga group, community soccer tournaments and children's dance class. Specific activities and outings are also organised for Chinese women. The main foci for this evaluation are the South Asian Mothers Group and the Family Harmony Initiative.

Community consultation and community capacity-building are integral to the model. Cultural reference groups, such as the Nepalese Reference Group and the Bengali Reference Group were formed through recruitment of community leaders, who were supported to increase their awareness of DFV as a critical settlement issue. These groups provide the "gateway" (Program worker) to local communities and allow the prevention activities to be tailored to suit the needs of the specific community. For instance, the Family Harmony Initiative was developed because community leaders indicated that conflict and sometimes violence was occurring inter-generationally (between parents and children, adult children and their parents or parents-in-law) not only between spouses.

Also integral to the program model, is the "soft-entry" approach to DFV education and prevention, which delivers prevention in indirect ways via various group activities. The "soft entry" approach to prevention reflects the need to be responsive to the specific needs of at-risk groups and is consistent with research indicating it can be a helpful service delivery strategy (Robinson et al, 2012). Not all cultural groups, or at least not all community members, will be equally responsive to prevention campaigns and activities. Initiatives need to be tailored to the level of awareness of DFV in particular communities, as well as to the degree of receptiveness to hearing messages regarding DFV. Program workers suggested that the soft-entry approach was utilised for a number of reasons at SGMRC. First, it avoids stigmatising a specific community: as one program worker stated: *"Nobody wants to say we have DV and our community is like that."*

Second, there was recognition that few women would attend programs marketed/promoted as DFV programs, partly because in some cultural groups there is no recognition or understanding of what DFV is, and partly due to concerns about community gossip and stigma. Thus, the program uses group activities as an entry point for future discussions about DFV. DFV information sessions follow on from a range of social activities and groups for women, men and children:

> And on that session when they finish … then lunchtime, we talk—I just deliver some information sheets about family relationships and domestic violence and I talk to them of the different kinds of domestic violence and many of them, it's the first time to hear about financial is also domestic violence so yeah, its very strange to them yeah. (Program worker)

Program workers emphasised the importance of subtlety in raising DFV in some groups and that talking about family "relationships" or contextualising DFV in the broader context

of settlement/migration adjustment problems, rather than directly addressing DFV, was sometimes necessary:

> … we don't put to any of them violence, we just put the family relationship and after—most of them because they are mothers, they will talk about the parenting and education, these things, and for the family relationship usually it's intergeneration and for the first few sessions they won't tell you anything about some issues happening at their home. Even in the survey they won't tick that but the program goes on and they will talk to you, yeah, about these things. (Program worker)

> Another good example, I think this is a good example of soft entry for the Nepalese community is, you know, every Saturday morning we are meeting for the children's dance and value's education … and most of the mothers they bring their children and then children often dance here and they sit at the back and they just talk to each other and then through that forum, that meeting, we slowly teach them … their rights or, you know, we talk about the domestic violence, not directly but, yeah, using that forum. (Program worker)

As highlighted in the comments above, and reiterated by other program workers, the approach to prevention is slow paced and takes time. After each activity, participants are asked to fill in a survey ascertaining their needs including questions about family relationships. This allows program workers to plan suitable activities and information sessions. Program workers note that it takes a few different sessions before women start acknowledging they would like information about family relationships and DFV.

Activities through which the program is delivered include sewing classes, swimming lessons, picnics, craft workshops, cultural celebration days, cooking classes, yoga, parenting education and children's activities, as well as more formal forums and information seminars. Some activities are delivered by way of the South Asian Mothers Group, some target Chinese women (e.g., the swimming lessons involved elderly Chinese women) and some through the Family Harmony program (yoga, children's dance classes, soccer tournaments). Outreach via external programs, such as the Rockdale Library's Baby "Rhyme Time" (a parent/child interactive activity) is also undertaken.

Although the SGMRC provided some administrative information as part of this evaluation, because of the nature of the service model and the informal structure of many activities, statistics about the number of participants in various aspects of the program were not available. The data that is available indicates that the number of participants in each activity varies considerably; for example, attendees at information sessions may range from 12 to 36 people, community consultations and forums may attract between 15 and 130 attendees, and community activities (such as family picnic days, cupcake decorating classes or craft workshops) may have between 18 and 80 participants depending on the particular activity. Consultations with SGMRC during the evaluation suggested that, on average, around 20 women from the local community participate in the South Asian Mothers Group each year.

9.5.1   Examples of program activities

- A Muslim psychologist delivered a culturally and religiously appropriate information session on family relationships, mental health and DFV for Bengali men and women.

- At the request of the Bengali community, a family picnic day was held at a local park to address social isolation. 80 people attended. The Police delivered an informal information session on DFV and safety after the picnic.

- A cupcake decorating class was held for Bengali and Pakistani women at the Rockdale City Library. This provided an "entry point" for future discussions about family relationships and DFV. Following the class, participants were asked to fill in a survey including questions about DFV; this was to ascertain their needs and receptiveness to future information about DFV.

- A DVF session was held at the Rockdale City Library for the South Asian Mothers Group with a guest speaker from the Southern Sydney Domestic Violence Court Advocacy Service. A translated factsheet and other materials, including a Bengali language bookmark, were distributed about DFV. A total of 12 mothers and their toddlers attended.

9.6 Meeting client needs

Formal and informal consultation and engagement with the wider community and clients ensure that the program meets the needs of clients. As described above, cultural reference groups act as conduit to local communities and ensure that programs delivered are appropriate and meet the needs of the community. SGMRC also has strong relationships with external reference groups and stakeholders such as the Asian Women at Work group, Pakistani Australian Women's Association, Rockdale City Council, NSW Police, St George Hospital, NSW Multicultural Health (South Eastern Sydney Local Health District), and the Red Cross, who are also regularly consulted. Additionally, SGMRC is an active member of the local St George DV Committee, comprising DV service providers, and the newly formed St George and Sutherland Post-Settlement Forum, comprising service providers and community leaders. These committees help to facilitate the exchange of information between service providers in the community and create important networks.

Clients are regularly consulted informally through group forums and/or surveyed following activities to ascertain their interests and needs:

> Interviewer: So how do you come up with those ideas, how do you work out that swimming is the one or felting is the one, how does that happen?

> Program worker: Because when I say that we're doing the consultation at first even in some forum or in some other consultation program so we ask them what they're interested in. So we're doing what they want and we think this is a very good approach for them to access our service and also for us to educate them. So we just provide the activities they want, really want to [be involved in].

Access to program activities

Participants in our client group interview indicated that they had mostly heard about the South Asian Mothers Group through word-of-mouth via family and friends, or through their involvement in other programs or activities at SGMRC:

> Interviewer: And how did you find out about the South Asian Mothers Group? How did you come to join?

> Mothers Group member: I, one day I just walked in here to make some photocopies of my papers […] And then I just came to know that there are mothers groups … And also another time I went to a program which is Bangladesh Mothers Families Day, on International Mother's Day.

> Suddenly in the park I met a lady and she's an Indian lady, she told me about the mothers group which was the first time it started in, I think, 2011 … So they told me to go—she told me there's a Rhyme Time thing for kids and all, which I never knew before and I was looking after my kids. I have been there and I found like as in the help, a community, people, laughter, everything. (Mothers Group member)

Clients may also be referred to the program through the centre's other services, such as settlement casework, the DVPASS service or through the court advocacy outreach service hosted at SGMRC. Program workers commented that some women will not talk to support workers about DFV issues they may be experiencing, but will feel more comfortable speaking to other women/mothers of similar cultural and language background:

> I will see when I feel that that client is isolated from, feels that they don't have anyone, anyone in Australia, no family, no friends, and many of my clients because they come from domestic violence background, I can identify that it will be beneficial for them to mix with those groups. So that is when I refer them but also when I feel that they are not very comfortable talking to me and as soon as I mention there is someone who speaks their language, and I ask if they prefer to be referred and it's OK for the worker to call them and talk to them, as soon as I get the consent from the person, I will refer them. (Program worker)

SGMRC's existing infrastructure and networks allows them to meet client needs in ways that smaller organisations may not; for example, they are able to provide a community bus to pick up clients and drive them to activities, meeting rooms for social gatherings and provision of information sessions and a venue that caters for disability and pram access. Program workers also highlighted the value that is derived from the reputational goodwill in the community towards the SGMRC, stemming from a history of serving the community for 30 years.

9.7   Program impacts and changes generated

Primary prevention of DFV is a long-term goal and direct impacts, particularly in relation to attitudinal change towards gender roles, violence and power in relationships, are often difficult to ascertain (Flood, 2013). Consistent with the reasoning of Kwok (2013), discussed in detail in chapter 3 (that it can instead be more useful to focus on shorter-term gains/outcomes of prevention work rather than assessing longer-term impacts), the qualitative insights presented in this chapter reflect the experiences of the individuals and

their perceptions of how their involvement with the program has had an impact on their personal circumstances.

9.7.1 Insights from clients

Perspectives from clients about the impact of the Domestic Violence Community Education Project were primarily gleaned from participants in the South Asian Mothers Group. These women reported participating in a range of activities and receiving a range of information as part of the mothers group and the broader Domestic Violence Community Education Project including:

> … outing for family, employment, training, they are giving us lots of sessions, family relations, they're working on family relationship, in the session they are giving us lessons like domestic violence, decision making jointly or separately and childcare benefit—I mean childcare education, childcare systems. Then like parenting and sometimes they are funded, like cooking demonstrations, sewing things, craft ... (Mothers group member)

> You got various information about like some medical emergency, first aid, then something with health and nutrition, mother's health, childcare and some of them do go to Rhyme Time in library, yeah, this sort of information, yeah. (Mothers group member)

> … like when they took us in the park for a picnic we had lots of fun, we got free henna, you know painting, face paintings and we also got some advice, we met the police who was a woman, we are so happy, I was so happy, just to admire a woman like me, she's a police …(Mothers group member)

Strengthened connections to community and culture

One of the most important impacts of the program from the perspective of the women we interviewed was a strengthened connection to community and culture. As was discussed in chapter 3, the literature indicates that isolation and a lack of community connection—which may be particularly pertinent issues for CALD and immigrant communities—are factors that compound vulnerability to DFV. In particular, there is some evidence that prevention activities that help to create social and support networks (especially networks that are independent from a husband or partner), strengthen women's connections to their community and aid in overcoming stigma and fear of being rejected by that community (Ghafournia, 2011; Poljski and Murdolo, 2011; Trijbetz, 2013).

A number of women who participated in this evaluation recalled feeling isolated and reported that these feelings were alleviated by their involvement with the mothers group. This sentiment is reflected in the comment below.

> [The most helpful thing about the program] is obviously I think the improvement of family relationship because this is what we lack a lot here, also the isolation. When we are isolated now we have our own group we can ring for mother's day, what are you going to do, take my kids, your kids, let's go for a family outing. (Mothers group member)

Many women also highlighted the program's role in providing a forum for support and knowledge sharing. This was particularly important for those women who lacked a connection to their own mothers and extended family:

> The main thing I found here, the support, like is the support, because we have no relatives here that time, no mum, no auntie, no senior person … so after my children are born so I don't know much, what should I do, if he's crying at night time, he is screaming, what should I do? When you came here to mothers group, oh he's the same as like you must … we can share, what should I do when he starts weaning, so what are the first foods. So oh my God when his tummy is upset, what should I do, so they give some tips, oh my mum said like this, my mum said do this. (Mothers group member)

> When you are alone you get lots of problems, you don't have anybody to discuss, so here I've got a place to come and talk to somebody and discuss to get some good advice. (Mothers group member)

Another mother reiterated the value of the group as a place for the women to share knowledge, but also noted that it provided an opportunity for her child to learn new things:

> I really enjoy it, I think my baby can learn new things and we can learn also, we can discuss our problems, and we can—we can know the solutions, what we have to do for baby, for our family, for everything. (Mothers group member)

As well as fostering a sense of community in their new home, some women also recognised the importance of maintaining links to their culture and passing this knowledge and sense of connection on to their children. Some participants noted the role of the program in helping to maintain these links and giving value to the different cultural groups and their heritage:

> So educating your kids, children with I mean not only the school education but also other education is important so if you do not mingle with your own community you're not giving them the proper thing. Australia—we do respect Australian culture and everything obviously, with due respect we follow that also, but we need to have the root as well so they should know their own people …. (Mothers group member)

> Mothers group member: I joined in at the park … it was Mothers Language Day … We had stalls, it was a barbeque, free, yeah, it's a lot for us and you go there, enjoy and you feel welcome. We are in Australia but you see this is my day, this happens in my country and it's happening here.

> Interviewer: Yeah so that cultural recognition.

> Mothers group member: […] this is the organisation who has done that for us, we all know how respected we are here in Australia.

> Interviewer: Yes, so your values and your culture is respected.

> Mothers group member: Yeah.

Strengthened self-esteem

A number of women reported that being involved in the mothers group and other aspects of the program helped them to feel stronger and that they had a greater sense of their own value and capacity. The research literature suggests that poor self-esteem, high levels of dependence on a partner and a lack of development and training opportunities are factors that may increase the risk of experiencing DFV (Ghafournia, 2011; Poljski and Murdolo, 2011; Trijbetz, 2013). The following quote provides some insight into the role of the mothers group in helping to build the women's self-esteem.

> Now we are strong, why I was suppressing myself, no, I haven't done anything wrong and there are good peoples, when I came to this group I got a very good friend who is sitting here right now. And lots of support like lots of knowledge, we are educated from our country but here nobody knows us, nobody recognises us and we feel like very helpless, powerless. We do nothing, we have nothing, we are a foreign body here and it makes us very vulnerable. (Mothers group member)

In particular, some women noted that their involvement with the program created opportunities to recall existing skills or gain new experiences including the opportunity to gain work experience through volunteering at the centre:

> But this it mostly give me new opportunity and work as a volunteer here before do other thing. They gave me job experience; they gave me "can do" attitude. (Mothers group member)

> I got engaged here in a free sewing class and it gave me a lot of happiness, I got back my hobby, what I completely forgotten. Yeah, so emotionally I got strengthened here and also some knowledge and also like when I started working here as a volunteer I started to think oh yes, I still can do things. (Mothers group member)

One participant noted the results of an internal participant survey conducted before and after an information session to highlight her view that the session had empowered many women to feel like they could share family decision-making with their husbands.

> Many of us is getting help like the thing they give us education, and back home our cultural thing is usually we believe we will depend on the man, I mean the spouse like the male partner, so we don't make the decision together and everything. Like, so now after when they gave us the session, so before the program 41 per cent of women said like yes, we think we don't make any decision at home, but after the session they helped us for family relationship and other things, 90 per cent women say now they are doing the joint decision-making. (Mothers group member)

Improved knowledge about DFV and personal safety

A number of the women reported taking part in activities that had a focus on increasing knowledge about domestic violence and improving personal safety. These women indicated that they found the information helpful and felt more empowered as a result.

Most of the women, they don't know domestic violence, they don't know their rights and when they come and join the session they know… . (Mothers group member)

We had a session we joined the White Ribbon Day […] we met ladies from Women Speakout, Migration Women's Speakout. We knew our rights, we knew you know, there are so many information which was very—as a woman we are always neglected, we are always discriminated, you know, it's our culture. We are always put down by our husband or husband's family or even the culture, the society. So we got so many information there, which was very helpful. It makes us strong. (Mothers group member)

I mean these things really very, very important and another important thing, I have discovered myself here. I used to know that being educated and everything I knew everything, no, I wasn't even, because I never knew what is the domestic violence included like pushing, small like you know just a slap or something and even raising voice, making like violent things at home, breaking things and all. We used to think like these are like normal, he's angry, he's doing it, but we never knew that these are domestic violence as well, like mental violence, could be physical, it could be emotionally, lots of things, like we are really educated—they are really educating ourselves. (Mothers Group member)

Broader impacts on family relationships

Some women perceived the value of the program in terms of the impact on their family relationships. One woman suggested there was a direct link between strengthened community connections and improved family harmony.

It helps in the family, when the wives are stressed and doing with the kids thing and all and the settlement and everything and the husband is also in and he doesn't know how to properly support the wife, what happens in between then the clashes starts. So if they see their wife settled, happy with the friends, going out and a little bit shopping, they are also settled, they can also sit in peace, say OK she is doing fine. So this is how this also helped our relationship. (Mothers group member)

Other women noted that often husbands were directly involved in information sessions and suggested this could help to reiterate the key messages.

We had a session here within domestic violence so lots of women bring their husbands [...] One [participant] she told me too much about many thing about domestic violence and [other issues …] what should we do, what should I do so it was lots of question and answer that time, it was a good time […] plus her husband was present … (Mothers group member)

They had a session on mental stress and management. And I ask my husband, no don't give me, I want you to go as well because darling if I have the stress and I will know how to manage but you don't know, that's not going to help you. If you come and listen that helps both of us … (Mothers group member)

9.7.2 Community attitudinal change

While the main aim of the program is harm minimisation and prevention of DFV by increasing women's awareness, social networks and personal empowerment, the model of community consultation gave rise to a strong element of community ownership of the programs.

Program workers reflected on the way in which some parts of the program had, in a sense, evolved and taken on a life of their own. The Nepalese Reference Group, in particular, had grown to take leadership in the direction of the Family Harmony Initiative and program workers noted significant attitudinal change among male community members. According to program workers, the Nepalese Reference Group, made up only of men, had come to see DFV as an important issue to be tackled in their community and this had led to the group wanting to help other communities, though their conception of DFV differed from the program workers/program theory:

> So when you are down the road already to talk about DV, not as the group but informally, it's very informally. I was not surprised at all. Last Nepali event he actually went up on the stage as part of a speech saying that we would like to help other community not only being help and we work on many issues including DV, and I was like "did he actually talk about DV"?. But the fact that he actually publicly acknowledged that DV—that we, because on many things helping you know, Nepali people get jobs and stuff like that. But back to that yoga, that's how they said that let's work about—let's work on anger management and stress, it's very good because it helps us to calm down as man. So we say OK we'll go there first and we didn't really touch on it first and now we just let it—let that happen first and when you're ready we'll bring them back to the table. Then something else progress … So now I think we are ready to go in the next meeting and talk about family relationship because he mention it in front of everybody, like 200 people about the fact that we work on … issues. So in a way it's indirectly the issue even though we know stress and anger management is not direct, it is the anger thing but it's OK, we can work on the anger you know … So I call that the way we approach it in a different way. So I would say to sum it up, is the journey different but the destination is the same because we look at the whole family wellbeing. So if that's the way Nepali want to go, fine, but the Bengali because we have South Asian Mothers Group. (Program worker)

As the program worker, above, describes, the male Nepalese Reference Group tended to view DFV as a result of anger and thus approached DFV prevention by addressing men's stress through yoga and through family activities designed to bring families closer together:

> I found here there are too many things toward the violence in the family but one main thing is the at home stress message, because people too busy in work and they don't have enough time to spend their time with the family and they found that the stress when they're apart from any stress they found that, violence and aggressive and around myself I try to teach the people don't' be too busy in work, find some time to spend the time with the family and enjoyment, take enough rest and they calm down. So it's important thing to …

make a time to get the family and most the time they spend with the family in that case. (Nepalese Reference Group member)

Members of the Mothers Group also highlighted family stress as a cause of conflict:

Then the wives are stressed and doing with the kids thing and all and the settlement and everything and the husband is also in and he doesn't know how to properly support the wife, what happens in between then the clashes start. (Mothers group member)

There is considerable discussion in the literature about the associations between traditional ideas about the role of women in the family, the financial dependency of women on their partners and cultural norms that support beliefs about male entitlement and a greater risk of DFV (Flood & Pease, 2008; Fulu et al., 2013; Ghafournia, 2011; Hagemann-White et al., 2010; Jewkes, 2002; Poljski & Murdolo, 2011; Trijbetz, 2013; VicHealth, 2007; WHO, 2010). These are pertinent factors for CALD and immigrant communities; as one program worker explained, women in new migrant communities were often better able to secure employment, often in the community sector, while the men, though skilled, could only secure employment in menial labour or driving taxis and this was often a source of conflict within some cultural groups. The comment below, concerning income disparity, from a member of the Nepalese Reference Group provides an illustration of how these issues are perceived:

And we found out that, you know like when looking at them, we found out that you know like it was probably lack of the balance of the income, you know, when you go to the … income between us and wife right, and then the income, we found that one of the major [issues] was the income … (Nepalese Reference Group Member)

Although many of the program participants initially had a limited understanding about DFV, there were some indications that both Nepalese men and South Asian Women had over time developed broader understandings of DFV, and these changes may be attributed to their involvement in the community education program.[8] For example, members of the Mothers Group and the Nepalese Reference Group demonstrated how they had over time developed a more nuanced conceptualisation of DFV, linking it to gender inequality and male dominance:

Male dominated, like male dominated terrorism right, because according to our culture like husbands do some wild things to the wife is normal you know. We need to have someone who can educate them in Australia law is different you know, like not like that, and back in our country you know, like I've seen the incident that one husband broke her ankle here and then she was just staying at home and just three days later they calm down and he was carrying her and taking her to the hospital you know. So here we need to educate the people from our community that OK once you link it to a domestic violence case that,

---

8   Though it should be noted that as there were no pre-participation attitudinal surveys conducted at the beginning of the program, it is not possible to ascertain whether these views were a result of participation in the Domestic Violence Community Education Program

that … will be there forever, you know, so that is serious matter. (Nepalese Reference Group member)

The Nepalese Reference Group indicated that their role was not only to communicate the needs of their community, but also to disseminate the message that DFV was not acceptable, and was against the law in Australia. In this regard, the group indicated that there had been positive change in the community as a result of the DFV education:

> So basically that's been taking time but it has given the very positive message to our community people. So like here, people come and go, come and go, and not many people are like they will have gone long, long time right, but it's still there consistency right, and then this is spreading around the other circle as well. So we think that it has made that impact. (Nepalese Reference Group member)

9.7.3   Building community capacity

While the various activities within the Domestic Violence Community Education Project appear to be beneficial when viewed through the prism of harm minimisation and domestic violence prevention within the SGMRC focus-community, the consultations also suggest the program has a role in helping to build individual and community capacity more broadly. The SGMRC engages with different communities in different ways, as the needs and capacity of each community changes over time, and program workers were also mindful of the need to be responsive to the particular "developmental stage" of each community. This evolutionary process, and the approach of the SGMRC, is described in some detail in the following quote:

> The Pakistani, Indians are all settled for us. So the Pakistani has grown partly because of the religious aspect, they work well with Bengali woman to support their spiritual and social and cultural, only these three elements. Not so much the whole DV even though we train them, we're very careful about DV, we always say refer it back to us and your risk management as well. So they are so proactive that they even created their own DV community and so this is how we really start to know them to provide cultural support to link it back. They meet here every Tuesday, so some Bengali woman start to come and there's not a Bengali group as they are structured here. And we have two kinds referred and they are good friends with the Pakistani and they prefer it that way because nobody knows them from their own community. So we train them in […] risk assessment, refuge, visa, court advocacy […] So it's good for them because then they understand how it works and this group of woman have been with us for over 10 years. And [...] we helped them to form into their association. So we have been supporting them, auspicing them we have [indistinct] fair-trading to come into our governance, and DV come a bit much later and then they help us with White Ribbon last year. So that relationship that takes time to build. But mainly the commitment from them, they understand this is important and just a few woman but they're so empowered. Like actually I think that is training yeah. And then as part of our Settlement Grants Program we create a program they are a bit more sustainable, like we

have the forum, after the forum we built community groups, so the community group is where they come and represent their community. And with this conference we want them to go and then present you know, like the next conference we have the Nepali group because they are ready. So it all depends on the readiness of the community. Or DV, there's the Pakistani women and they are women—Pakistani Women's Association so it is quite appropriate. So that's the capacity building we do …(Program worker)

The following quote is indicative of the views of several program workers who reflected on how the capacity of individual program participants also develops over time.

They join our reference group, then we put them on [additional training] so we actually get a job in the sector, many of them have gone to study certificate in [indistinct] programs, they already have the groundwork of how they run the programs. (Program worker)

This perception of the program workers was reflected in the experiences reported by a number of members of the mothers group, as the following comment demonstrates.

Two years before I participated here as like […] Mothers Group yeah. I'm working here now doing so many things and I'm doing work as a volunteer. (Mothers group member)

Program workers also detailed instances when individual participants have been able to use the knowledge and experiences they have gained through their participation in the program to help other individuals or community groups.

He [one of the Reference Group Members] actually went up on the stage as part of a speech saying that we would like to help other communities not only help and we work on many issues including DV… (Program worker)

The women that have formed the group, the women formed the group where we have a lot of discussion so she feel that you know she feels that she have got a lot of support if she needs because she feels empowered and that's why she speaks up. And her speaking up actually empowers another woman who's there, yeah. (Program worker)

9.8   Program gaps

9.8.1   Need for ongoing case management

The main gap in the program identified by all program workers we interviewed, was the need for ongoing medium-term case management in order to be able to respond to women's longer-term needs. While short-term casework and referral was being provided (usually limited to one hour per client only and provided through the SGMRC Settlement Grant funding only), longer-term case management was not possible within the limitations of the program funding:

Like I recently had a client, she's been in a relationship … it's lot of domestic violence happening and she's confused and she would like to have a better relationship with her husband. So because we are a referral service that we—I

> couldn't manage her case, I have the knowledge, I can do it but I couldn't do it. And she actually found out that from the South Asian Mothers Group that we do have case workers here and she came to our service and I couldn't provide that case management to make her life better, I feel very sorry about that but you try to do you know, maximum support but we are lacking on that case management. (Program worker)

> And also we are restrained by our funding, like if we provide case work it should be no more than one hour and when someone comes and discloses domestic violence, one hour is not enough. (Program worker)

> And also say the clients they come to us, and we say that we use the soft entry to build a rapport with them, usually it takes maybe a few weeks then they can talk about their issues, but later when they came to us we don't have the case work here, we only do the—we don't have the case management here, we don't—only the case work. So they trust you and then they saw that you speak the same language it's important to communicate with you, OK because they don't have the idea about what's the difference of a case worker and the case management. They always thought oh you are the community worker, you can help me, so they came to us and then later we can only say we'll have to refer you to somewhere else because we don't do case management here. (Program worker)

Program managers raised problems in a model that puts so much effort into building trust and strong relationships with communities and clients in order to be able to talk about DFV, yet when they receive disclosures of DFV, it is necessary to refer women out to mainstream services which may not be culturally appropriate. As one program manager reflected, the ideal model would be a prevention and case-management model because delivering primary prevention and community education to communities at higher risk of DFV inevitably leads to disclosures. A significant problem noted was that women referred to external services were not actually going on to utilise services and may stay in violent relationships:

> I personally I feel that I create a rapport with a client, they start disclosing things like yes my husband done this to me and then I will say OK I have to refer you to another service. What happens to me because I also work in the domestic violence helpline, it happens sometimes that I got clients and they recognise my accent and they ask me—it happened in the past—they ask me, are you [program worker's name] I say, yes I am … I say what happen to you because I thought that I done a referral to a refuge and you say no, no, no, I'm going to go with friends, I'm going to stay with friends. But this was back two months ago and what happened that now you're calling DV line? And she say like yes, you know, my family was advising me to go back to my husband and I wanted to try, and I said well that's fine but why didn't you go to the places that I refer you because I referred you to the domestic violence helpline, I also referred you to a support service like domestic violence support service. She went like no, I only like talking to you. So of course they get—we create that relationship, initial relationship and it's a big gap we close there and we say there is a service you can go there, probably they will never go. Some

> percentage will do and some a percentage will, yeah, will never attempt to talk to someone else. (Program worker)

> So we're looking for that short to medium-term case management and I think that would be a need because we found a lot of them who get referred out, come back. If they come back in three months … when we come you know, [they say] we don't want to see [name of service] you know. But we don't have resources to continue that—if the program actually covered the whole spectrum until they really reach out for another service that would be good. (Program worker)

Program workers commented that there were significant problems with women accessing mainstream services in terms of cultural and language barriers:

> And then when the clients, we refer them to some other service, they will ask me do they have a Chinese speaking worker, I said maybe they have and if they don't have they will use the interpreter service to you and I found a lot of the clients they don't want to contact, even we refer them, for example, to Centrelink or to the police, they don't want to—they don't want to be referred to this mainstream service. For example, they say that Centrelink, I don't want to go to Centrelink because I'll need to spend a lot of time waiting on the phone and they cannot help me a lot. And the police they have some— sometimes they got some bad experience with the police so they don't want to go back again. So usually we refer them to there and after a few, after some time they come back to us, said could you, if you want to refer me to somewhere else, another service. (Program worker)

9.8.2   Staffing difficulties

Program managers indicated that funding limitations also prevented them from being able to both employ more highly skilled staff, especially those with experience working in the DFV sector, and retain current staff. Short-term funding cycles meant that program support workers were mostly employed for only a few hours a week and for limited time-frames and this meant the program was not always able to meet client needs. There was a large crossover in the work that staff at SGMRC were engaged in: staff employed under the Settlements Grant Program, for instance, were also involved in providing short-term case work for DVF clients. Retaining staff was also noted as difficult due to the limited number of hours available and low wages:

> So whatever we can we train and some of them leave for different reasons, you know, some will get a better job, because it's only 10 hours and what we can give is three days. Some people want five days. And salary also, for that workload even though it's part-time … (Program worker)

Program workers described the difficult logistics and dynamics in delivering prevention activities and providing advocacy and support to complex communities in the context of broader settlement issues, requiring staff to be multi-skilled and often go above and beyond their work requirements:

> One way I've got is staffing challenges and I think managing 10-hour-week workers is difficult […]And you have the Nepali, Bengali, Chinese and you're talking about cross-cultural management […] And also the fact that they were hired for prevention education mostly so it's not just refer to the SGP [Settlements Grant Program] colleagues but eventually they get involved somehow. (Program worker)

Employees needed to be culturally aware and bilingual but this also meant that issues of confidentiality, rumours and gossip within their own community could impact on their own safety and privacy as well; one program worker reflected that working at SGMRC wasn't "just a job" and workers needed be aware they were accepting a complex "package":

> We can all take a course in DV but we actually … it has multiple implications, your children, yourself, your husband, you know. So I think that's the most challenging, to let them know if you take this job this comes as a package, [you] can't say "I can't do this and can't do that".

It was suggested that a possibility for improvement to the program might be employing one more highly-skilled/trained full-time DFV worker rather than several part-time workers:

> Program worker: So and then the pays that you're working because we have quite a lot actually and a lot [indistinct], you come in two days a week and it doesn't [indistinct], you need to get used to the system because you know, learn the organisation process and system […] So if you're really asking me how am I going to sort of restructure the program if I have a choice I would say if you really want the program to work faster you need a full-time worker. I know this isn't in reality can be but if you really look at the way we work, it's not just information sessions. You know how we got DV information sessions, you don't need to be full-time, no, it's not information sessions. Information sessions lead to case work, then we are Outreach, so the same face you see that has been - -
>
> Interviewer: So you want somebody doing all of that.
>
> Program worker: Yeah […] The same face you see that is coordinating the information session, I don't invite you to come in but it's me that you trust, me right, you say [indistinct]. Then I will tell you I'm at the library next week and talk to me private confidential so they will come. Then we do big community event, we do cultural event, we do intercultural event and then we do skills event. So it's building that to include what is important, so this woman may have issues about self-confidence, then slowly they will reveal about their family issues, what is acceptable and not acceptable. Financial management, English, so the whole thing.

9.8.3   Longer term funding cycles

SGMRC is in a unique position as existing staff and infrastructure funded through the Settlement Grant Program could be drawn on for the Domestic Violence Community Education Project. However, reflecting the findings in chapter 5, several program workers

described the difficulties in achieving continuity when management have to constantly apply for funding to maintain the program:

> Program worker: I think it's a long-term project [rather] than a small-term project.
>
> Interviewer: So a long-term funding cycle.
>
> Program worker: Long-term funding cycle yeah[…] And it should be—not asking us to apply again and again
>
> The early intervention program models should be continuous rather than breaking into like small programs, maybe a bit you know like more funding for us to continue that program because we are lucky to have that [Settlement Program] integrated and have worked towards that to integrate this program. (Program worker)

The challenges that can arise from short-term funding cycles for intervention programs generally are well documented in the literature and discussed in this report in chapter 5. These challenges are compounded by the scarcity of evidence about what works in primary prevention and the consequential "theory driven" basis of many interventions (Kwok, 2013, p. 9), which are based on what is known about factors associated with perpetration, particularly the correlation of violence against women with community attitudinal factors (Heise, 1998; VicHealth, 2007; Flood & Pease, 2008; Casey & Lindhorst, 2009; WHO, 2010; Murray & Powell, 2011; Kwok, 2013).

9.9   Conclusion

The SGMRC Domestic Violence Community Education Project is an example of a dynamic, culturally appropriate, community-driven primary prevention model targeting newly arrived South Asian and Chinese families in southern Sydney. The approach demonstrates a number of key elements of effective violence prevention practice: it is community driven, supported by extensive community consultation, culturally specific and the model delivers various group activities as a "soft entry" point to facilitating primary prevention and raising awareness of DFV. Programs such as the South Asian Mothers Group and the Family Harmony Initiative aim to change attitudes, raise awareness, empower and educate. Through group activities such as outings, sewing classes, yoga, cooking and cultural celebrations, as well as formal information sessions, program workers develop the trust of clients and communities in order to develop receptiveness to DFV education and prevention messages. This approach is well supported in the literature (e.g., Casey & Lindhorst, 2009; Flood & Pease, 2008; Fulu et al., 2013; Hagemann-White et al., 2010; Heise, 1998; Kwok, 2013; Murray & Powell, 2011; VicHealth, 2007; WHO, 2010). Cross-sectional international studies and systematic reviews of the literature indicate that perpetration of violence against women is associated with attitudes supportive of traditional gender roles, gender inequality, beliefs about male entitlement and acceptance of violence as a form of conflict resolution.

As described above, the soft-entry, community education model takes some time to establish: community consultation, relationship-building, and establishing the reference groups took nearly two years, for example. In addition, relationships with clients and

community trust take time to establish. These are important foundational aspects within the socio-ecological model on which the key prevention frameworks are based (VicHealth, 2007; WHO, 2010) as well as the NSW Government policy document, *It Stops Here*.

The Domestic Violence Community Education Project undertakes activities that help to mitigate the risk factors associated with DFV. As was described in chapter 4, the socio-ecological theory of DFV acknowledges that there is no single factor to explain DFV. Rather, violence is determined by a complex interplay of multiple and interrelated factors at four levels of influence: individual, family, community and society (Casey & Lindhorst, 2009; Dahlberg & Krug, 2002; Dutton, 1985; Heise, 1998; Quadara & Wall, 2012; WHO, 2010). Further, it is widely recognised in the literature that effective DFV prevention has universal and targeted elements. For example, WHO acknowledges that "dismantling the hierarchical constructions of masculinity and femininity" and eliminating inequality, are long-term, challenging goals (2010, p. 36) and recognises that these broader macro strategies should be complemented by "measures with more immediate effects".

This evaluation found that there are several positive program outcomes, consistent with the protective factors advocated by WHO and others. These outcomes were described by SGMRC staff, participants of the South Asian Mothers Group, and members of the Nepalese Reference Group and relate to strengthened connections to community; reduced social, cultural and financial dependency of one person within relationships; enhanced knowledge about DFV and services; improved self-esteem and personal capacity; and strengthened community capacity.

The perspectives of the South Asian Mothers Group suggest that the group has strengthened social networks, increased community cohesion and increased participant confidence, skills and self-esteem. Our interview with the South Asian Mothers Group also indicated that participation in the group, and the broader activities of the program and information sessions, resulted in an increased knowledge and awareness of DFV. There was some evidence to suggest attitudinal change had occurred in the Nepalese community, as demonstrated in the way the Nepalese community had taken ownership of the issue, publically acknowledged the problem and was working towards solutions with the SGMRC.

As such, although it is important to acknowledge that while the Domestic Violence Community Education Project is not explicitly or solely focused on preventing DFV, and there are no data to show whether or not it directly reduces the incidence of DFV in those who participate, the approach is supported by the literature and is consistent with evidence-based practice.

A significant limitation of the program was the inability to provide ongoing case management. This meant that when women disclosed DFV, and sought assistance from program workers, they had to be referred out to external mainstream services that were not culturally or linguistically appropriate. The program would also benefit from long-term funding arrangements, which would enhance service delivery and further support building community   trust.

10   Summary and implications

This chapter aims to support further policy and program development by setting out the main insights from this research based on a synthesis of the evidence. Three overarching points inform this discussion. The first concerns the emergent state of knowledge and practice in this area, particularly in relation to the groups considered in this report. In some areas, empirical evidence is very limited but the consultation process revealed a significant amount of practice knowledge. The second concerns the extent to which practice approaches to primary prevention overlap with secondary and tertiary responses. Rigid distinctions are not necessarily sustained in practice and there is acknowledgement of a continuing need for complementary action at all three levels. Third, there is strong recognition of a need for a framework to guide further policy and program development in this area.

10.1 A coherent philosophy and integrated responses

This research has demonstrated that a range of approaches and understandings of primary prevention subsist among key stakeholders and that theoretical distinctions are not maintained in practice. In part this reflects the complexity of primary prevention in DFV and it also evidences a need for a clear framework to guide understanding and practice.

A further issue that emerged strongly from the research, and has been highlighted in other analyses of DFV responses in NSW (e.g., Auditor General's Report, 2011) and nationally (Australian Law Reform Commission & NSW Law Reform Commission, 2010) is the extent to which services of different types with varying client bases operate independently and in isolation from each other. The research suggests a significant need for better interconnections at several levels:

- between different types of services, including mainstream and specialised services;
- between family violence services and other systems including the child protection system, the state-based justice system, family support systems such as those that deliver maternal and child health services, and the education system.

The need for a more streamlined approach to service delivery is recognised in *It Stops Here*. In addition to a primary prevention policy framework, the insights from this research indicate a need for a mechanism to bring service providers, policy-makers and researchers with expertise in DFV prevention together to strengthen links and share knowledge. In Victoria, organisations such as VicHealth and Domestic Violence Victoria have played such a role along with regional networks of service providers. Such leadership is now being driven at a national level by the Foundation to Prevent Violence Against Women and their Children. The groups involved in the governance structures set out in *It Stops Here* have the potential to make similar contributions in NSW and could fulfil the identified need. Services and individuals with expertise in relation to the groups considered in this report should be included in these groups.

The wider question of the extent to which the actions of NSW government departments in the DFV context align is also relevant, but was beyond the scope of this research. However, the cross government committees that are part of the *It Stops Here* governance

structure have the potential to support the development of a consistent approach to and understanding of DFV primary prevention in NSW.

10.1.1 Policy implications

- The need for a framework to support a primary prevention approach has strong support in the literature and among stakeholders. The role of such a framework has several elements including articulating the nature and aims of primary prevention as a policy strategy in order to support the shared understanding across agencies and among professionals and the community.

- The governance structure developed to implement the *It Stops Here* framework is welcome and should better enable discrete service sectors to work towards common goals and help to ensure the needs of at-risk groups and communities are met across the various sectors.

- Policy-makers should consider whether more clearly articulating and assigning responsibility for oversight of DFV prevention and early intervention activities in NSW could enhance the *It Stops Here* framework.

10.2 Gaps in evidence and services

The discussion in this report reinforces the need for specialised services in addition to mainstream services that have the capacity to meet the needs of people from the groups covered in this research. For many specialised programs and groups considered in this report, including programs for Aboriginal and Torres Strait Islander and CALD women, DFV prevention is a core part of their practice but this is not necessarily explicitly acknowledged. As a consequence it can be difficult to identify and scope the extent of prevention and early intervention activities being undertaken in the sector. The two programs evaluated as part of this research—the Healthy Family Circle program (chapter 8) and the Domestic Violence Community Education project (chapter 9)—are examples of this "soft entry" approach to DFV prevention.

This report highlights a particular lack of DFV primary prevention services developed for non-urban women and women with disabilities, especially mental ill-health. Evidence on the needs and circumstances of women in these groups is also lacking. A further area where service coverage is sparse is in relation to people who identify as GLBTIQ and women with disabilities. There are a limited number of specialised services for these groups. The evidence suggests a need for the development of further services as well as strategies to ensure that mainstream services are adequately equipped to meet their needs.

The number of services available for Aboriginal and Torres Strait Islander women and, to a significantly more limited extent, women in CALD groups is greater, however there is only a small amount of evidence on how these services operate. Moreover, each of these groups includes a variety of sub-groups with significant variations in circumstances and needs.

10.2.1 Policy implications

- There is a need to invest in building the evidence base through rigorous research and evaluation; including supporting research that is coordinated, is focused on collecting

data that can be compared with other research, and is sensitive and responsive to the particular needs of at-risk groups and communities.

▪ There is need for further empirical evidence on the needs of non-urban women and women with mental ill-health to understand the needs of these groups in relation to DFV response and prevention services.

▪ The evidence base on the experiences of people who identify as GLBTIQ and women with disabilities, CALD, and Aboriginal and Torres Strait Islander women accessing DFV prevention and response programs requires further development through evaluation to better understand the effective elements of these approaches.

▪ There is a need for further investigation of appropriate formats and modes of delivery for DFV prevention programs for people who identify as GLBTIQ. Possible avenues for exploration should include programs to be delivered in the context of existing support groups for young people beginning to identify or identifying as members of these groups.

▪ When designing program evaluations in relation to programs targeting at-risk groups and communities, it is important to ensure that evaluation materials are tailored to the particular program and service, and where appropriate, reflect the needs of clients who access programs.

▪ Organisations need to be supported to help contribute to the evidence base by developing more systematic approaches to collecting and maintaining administrative data and other evidence that supports service or program evaluations. This would most usefully be a collaborative process between funding bodies and organisations, where each party is a partner in the development of evaluative capacity.

10.3   Supporting effective programs

10.3.1 Community involvement

Some very clear principles for developing and delivering programs to the groups considered in this report have emerged from the research. Key among them is the need for services and initiatives to be community-driven. This is an important principle in primary prevention in general and is particularly important in relation to the groups considered in this report for a number of reasons. Each of these groups considered has particular needs and these needs vary within and among groups. The particular nature of these needs mean that a sharp focus of the characteristics of each of these groups needs to inform the way programs are developed and delivered. This was a key strength of the Healthy Family Circle program (chapter 8) and the Domestic Violence Community Education project (chapter 9). For both programs it is evident that community engagement, consultation and "buy-in" are critical to achieving the respective program objectives.

For some groups, establishing trust in the community can have additional challenges. For example, in relation to Aboriginal women, a lack of trust in engaging with government organisations among many women has implications for the kinds of agencies that should be selected to deliver primary prevention programs; how this issue affects practice is illustrated in the discussion at section 8.5.2 about the significance —for both clients and program workers—of the Healthy Family Circle program being delivered by an Aboriginal

organisation. Another illustration is that for people who identify as GLBTIQ, the underlying premise of primary prevention theory and gendered power dynamics needs to be reframed, with attention paid to sexual prejudice, discrimination and vulnerability in a broader sense.

Policy implications

- The findings on the characteristics of effective services set out in this report reinforce the need for primary prevention services to be tailored to the particular needs of the communities for whom they are intended.

- Existing services within communities should be engaged to develop and deliver primary prevention programs, independently or in partnership with other organisations. Where existing services are not available or appropriate, policy-makers might consider drawing on other networks and relationships within communities to help build trust and understand community needs.

- The specific needs and characteristics of each group mean that there is no one model or template that can be generally applied.

10.3.2 Building organisational capability

This research underlines the importance of community-driven, which often also means community-based, services and programs, especially in respect to delivering DFV prevention and early intervention services for at-risk groups and communities. However, this research has also highlighted that while there is strong practice knowledge within many organisations, there are also significant demands placed on organisations in the context of limited resources and the necessity to prioritise other community needs. The evaluation of the Healthy Family Circle program operated by Mudgin-Gal illustrates these challenges in a practice context. While there is clear evidence in support of such a program, and for such a program to be delivered by an organisation that is well-established in the community and that understands the particular needs of that community, it is also clear that community organisations with limited funding and limited administrative resources are constrained in their capacity to deliver the service and to meet the many and varied needs of their clients.

The evidence suggests there is a need for a stronger focus on building the organisational capability of programs and services targeting at-risk groups and communities, particularly where governance frameworks look to place more emphasis on local or self-management.

Additionally, mainstream DFV services and prevention programs, as well as interlinked services such as health and legal services and the police, need to be able to cater for the needs of at-risk groups and communities, and be accessible and culturally competent in meeting their needs. It is not acceptable for mainstream services to defer to, or rely on, specialist services to provide services to members of at-risk groups and communities.

Policy implications

- It is important to give value to the practice knowledge and specialist experience of services and programs working with at-risk groups and communities, while also supporting organisations to strengthen their administrative capacity and their capacity to meet the often many and varied needs of clients.

- There is a clear need to build the capacity of DFV and related services (such as health, policing and legal services) to ensure practitioners working in those services have access to sufficient training to support sensitive and appropriate service delivery to at-risk groups and communities.

10.3.3 Funding structures and cycles

Fragmented and limited funding sources and structures have been identified in this research and other literature as factors that contribute to the ad hoc nature of prevention initiatives. This has several adverse implications. First, short-term funding cycles and small funding pools mean that programs are limited in scope and have little capacity for evaluation. Second, the need for programs to be community-driven and delivered in a context where community needs are well-understood and delivered in a way that means the service has the trust of the community result in longer lead times for the establishment of programs and the loss of community support if effective programs are unable to be maintained. Third, the disestablishment of services leads to the dissipation of professional capacity and expertise. Fourth, competition among services for limited grants and short-term grant funding undermines capacity for interagency collaboration.

We acknowledge that in an emergent area such as primary prevention in relation to at-risk groups, there is a balance involved in committing public funds to developing programs between responsible allocation of limited resources and creating the appropriate conditions for sound program development. This balance can be addressed through careful consideration of funding timeframes, reporting requirements and program evaluation requirements. Further discussion of evaluation is set out in chapter 7. It is notable that in the federal sphere, funding agreements for a range of family support programs delivered by the community sector, including in the Family Support Program (Department of Social Services and Attorney General's Department), have recently been moved to five-year cycles (in the absence of performance concerns) in response to concerns of the nature just outlined: (http://kevinandrews.dss.gov.au/media-releases/89).

Policy implications

- It is clear from this research that funding arrangements need to be longer term and better coordinated to enable the DFV sector to provide high quality services and build on expertise.

- There is a clear need for funding agreements that support effective program implementation and are structured to take into account the full scope of program development and implementation activities, including the intensive establishment phase of DFV activities for at-risk groups and communities and the need to develop trust within the client community.

- Program evaluations are critical for building the evidence base. It is important that funding agreements acknowledge the value of program evaluations and that separate or additional funding is available to build organisational evaluative capacity and to undertake evaluation activities.

10.4 Summary

This report has examined DFV prevention and early intervention activities targeted at at-risk groups and communities in Australia, with a particular focus on NSW. It has outlined the sometimes very limited evidence on the impact of DFV on these groups and communities as well as the scope of prevention and early intervention activities that address the issue from within the DFV service sector. The report has considered current evidence and approaches to prevention and early intervention of DFV and has situated this analysis in the current government policy context. The research has found a significant amount of activity in the prevention and early intervention sphere, however there remain gaps in services for all at-risk groups, although the extent and nature of these gaps vary between communities. Evidence regarding the effectiveness of prevention and early intervention strategies is limited. Building this evidence base, alongside developing strong policy frameworks and funding mechanisms to support the development and delivery of programs, is critical for progressing the goal of reducing and preventing DFV in NSW.

References

Adamson, E., Bromfield, L., Edwards, B., Gray, M., Hilferty, F., Katz, I. et al. (2010). *Keep Them Safe: Evaluation framework. Final report: Report for the NSW Department of Premier and Cabinet.* Melbourne: Australian Institute of Family Studies & Social Policy Research Centre, University of New South Wales.

AIDS Council of NSW. (2011). *Responding to domestic violence in gay, lesbian, bisexual and transgender relationships: A toolkit for service providers.* NSW: ACON.

Ali, P. A., & Naylor, P. B. (2013). Intimate partner violence: A narrative review of the feminist, social and ecological explanations for its causation. *Aggression and Violent Behavior*, *18*(6), 611–619.

Antle, B., Sullivan, D. J., Dryden, A., Karam, E. A., Barbec, A. P. (2011). Healthy Relationships education for dating violence prevention among high-risk youth. *Children and Youth Services Review*, *33*, 173–179.

Australian Institute of Health and Welfare. (2011). *The health and welfare of Australia's Aboriginal and Torres Strait Islander people: An overview 2011.* Canberra: AIHW.

Australian Bureau of Statistics. (2006). *Personal Safety Survey, Australia, 2005.* Canberra: ABS.

Australian Bureau of Statistics. (2013a). *Defining the data challenge for family, domestic and sexual violence, Australia: A conceptual data framework.* Canberra: ABS.

Australian Bureau of Statistics. (2013b). *Personal Safety Survey, Australia, 2012.* Canberra: ABS.

Australian Law Reform Commission & NSW Law Reform Commission. (2010). *Family violence: A national legal response.* Sydney: ALRC & NSWLRC.

Ball, M. (2011). Gay men, intimate partner violence, and help-seeking: The incomprehensivibility of being a victim. In B. Scherer & M. Ball. (Eds.) *Queering Paradigms II: Interrogating Agendas* (pp. 313–330). New York: Peter Lang.

Ball, M. & Hayes S. (2009). Same-sex initimate partner violence: Exploring the parameters. In B. Scherer (Ed.) *Queering Paradigms* (pp. 161–177). New York: Peter Lang.

Barrett Meyering, I. (2012). *Staying/Leaving: Barriers to ending violent relationships*, (Fast Facts No. 7). Sydney: Australian Domestic & Family Violence Clearinghouse.

Barrett Meyering, I., & Edwards, R. (2012). *Safe at Home Programs*, (Fast Facts No. 8). Sydney: Australian Domestic & Family Violence Clearinghouse.

Bell, K. M. & Naugle, A. E. (2008). Intimate partner violence theoretical considerations: Moving towards a contextual framework. *Clinical Psychology Review*, *28*(7), 1096–1107.

Berkel, L. Vandiver, B., & Bahner, A. (2004). Gender role attitudes, religion, and spirituality as predictors of domestic violence in white college students. *Journal of College Student Development*, *45*(2), 1719–1734.

Bevan, E. & Higgins, D. (2002). Is domestic violence learned? The contribution of five forms of child maltreatment to men's violence and adjustment. *Journal of Family Violence*, *17*(3), 223–245.

Blagg, H. (2000). *Crisis intervention in Aboriginal family violence: Summary report.* Canberra: Crime Research Centre, University of Western Australia.

Bradford, M. & Nancarrow, H. (2005). *Koora the Kangaroo: Violence prevention at Woorabinda State School. Evaluation report.* Mackay: Queensland Centre for Domestic and Family Violence Research, Central University Queensland.

Bridge, D. (2007). Breaking a spell of silence: The Tasmanian evaluation of the 2006 Pride & Prejudice program. *Youth Studies Australia*, *26*(1), 32–40.

Bunston, W. (2008). Baby lead the way: Mental health group work for infants, children and mothers affected by family violence. *Journal of Family Studies*, *14*, 334–341.

Bunston, W. & Heynatz, A. (2006). *Addressing family violence programs: Groupwork interventions for infants, children and their parents*. Parkville, Vic.: The Royal Children's Hospital.

Burman, M. & Cartmel, F. (2005). Young people's attitudes towards gendered violence. Edinburgh: NHS

Campbell, J. C. & Manganello, J. (2006). Changing public attitudes as a prevention strategy to reduce intimate partner violence. *Journal of Aggression, Maltreatment & Trauma*, *13*(3/4), 13–39.

Carmody, M., Evans, S., Krogh, C., Flood, M., Heenan, M., & Overton, G. (2009). *Framing best practice: National standards for the primary prevention of sexual assault through education*. Sydney: National Sexual Assault Prevention Education Project University of Western Sydney and VicHealth

Casey, E., Beadnell, B., & Lindhorst, T. (2009). Predictors of sexually coercive behavior in a nationally representative sample of adolescent males. *Journal of Interpersonal Violence*, *24*(7), 1129–1147.

Casey, E. & Lindhorst, T. (2009). Toward a multi-level, ecological approach to the primary prevention of sexual assault: Prevention in peer and community contexts. *Trauma, Violence, & Abuse*, *10*, 91–114.

Child Family Community Australia. (2013a). *Evaluation and innovation in family support services*, (CFCA Fact Sheet). Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/cfca/pubs/factsheets/a145794/index.html>.

Child Family Community Australia. (2013b). *Planning for evaluation I: Basic principles* (CFCA Fact Sheet). Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/cfca/pubs/factsheets/a145859/index.html>.

Child Family Community Australia. (2013c). *Planning for evaluation II: Getting into detail* (CFCA Fact Sheet). Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/cfca/pubs/factsheets/a145914/index.html>.

Chalk, R. (2000). Assessing family violence interventions: Linking programs to research-based strategies. *Journal of Aggression, Maltreatment & Trauma*, *4*(1), 29–53.

Chan, A. & Payne, J. (2013). *Homicide in Australia: 2008–09 to 2009–10. National Homicide Monitoring Program annual report*. Canberra: Australian Institute of Criminology.

Chan, Y., G. Lam, & Cheng, H. (2009). Community capacity building as a strategy of family violence prevention in a problem-stricken community: A theoretical formulation. *Journal of Family Violence*, *24*, 559–568.

Chang, J., Martin, C., Moracco, K., Dulli, S., Scandlin, D., Loucks-Sorrel, et al. (2003). Helping women with disabilities and domestic violence: Strategies, limitations and challenges of domestic violence programs and services. *Journal of Women's Health*, *12*(7), 699–708.

Chung, D. (2007). Making meaning of relationships: young women's experiences and understandings of dating violence. *Violence Against Women*, *13*(12), 1274–1295.

Council of Australian Governments. (2009). *National plan to reduce violence against women and their children*. Canberra: COAG.

Cornelius, T. L. & Resseguie, N. (2007). Primary and secondary prevention programs for dating violence: A review of the literature. *Aggression and Violent Behavior*, *12*, 364–375.

Cox, H., Cash, P., Hanna, B., D'Arcy-Tehan, F., & Adams, C. (2001). Risky business: stories from the field of rural community nurses' work in domestic violence. *Australian Journal of Rural Health*, *9*(6), 280–285.

Crinall, K., Laming, C., Healey, L., & Smith, J. (2013). *Preventing and Responding to Violence Against Women in Rural Victoria: Searching for evidence using a critical interpretive synthesis approach. SAFER: Victorian Family Violence Reform Research Program*. Melbourne: Centre for Excellence in Child and Family Welfare, Inc.

Cripps, K. & Davis, M. (2012). *Communities working to reduce Indigenous family violence.* Canberra: Indigenous Justice Clearinghouse, Australian Institute of Criminology.

Cummings, C. (2003). *Triple disadvantage: Out of sight, out of mind. Violence Against Women with Disabilities Project.* Melbourne: Domestic Violence and Incest Resource Centre.

Dahlberg, L. & Krug, E. (2002). Violence: A global public health problem. In E. Krug (Ed.), *World report on violence and health*, (pp. 3–21). Geneva: World Health Organization.

Day, A., Francisco, A., & Jones, R. (2013). *Programs to improve interpersonal safety in Indigenous communities: Evidence and issues*, (Issues Paper No. 4). Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

Day, A., Martin, N., & Howells, K. (Eds). (2008). *Anger and indigenous men: understanding and responding to violent behaviour.* Leichhardt, NSW: Federation Press.

Dearden, J. & Jones, W. (2008). *Homicide in Australia: 2006–07 National Homicide Monitoring Program annual report.* Canberra: Australian Institute of Criminology.

Department of Social Services. (2014). *Second Action Plan 2013–2016: Moving ahead. Of the National plan to reduce violence against women and their children 2010–2022.* Canberra: DSS.

Donovan, C. & Hester, M. (2008). Because she was my first girlfriend, I didn't know any different: Making the case for mainstreaming same-sex sex/relationship education. *Sex Education*, *8*(3), 277–287.

Duffy, K. (2011). There's no pride in domestic violence: The same sex domestic violence interagency, Sydney, Australia. In J. L. Ristock (Ed.), *Intimate Partner Violence in LGBTQ Lives*, (258–273). New York, & Oxford, UK: Routledge.

Dutton, D. G. (1985). An ecologically nested theory of male violence toward intimates. *International Journal of Women's Studies*, *8*, 404–413.

Dyson, S. (2014). *Doing program evaluation.* Melbourne: Partners in Prevention Workshop. Retrieved from <partnersinprevention.org.au/wp-content/uploads/2014/03/Sue-Dyson-Presentation.pdf>

Ellis, J., Stanley, N., & Bell, J. (2006). Prevention programmes for children and young people. In C. Humphreys & N. Stanley (Eds.), *Domestic violence and child protection: Directions for good practice*, (69–82). London: Jessica Kingsley Publishers.

Family Law Council. (2012). *Improving the family law system for Aboriginal and Torres Straight Islander clients: A report to the Attorney-General prepared by the Family Law Council.* Canberra: Attorney-General's Department.

Fernbacher, S. (2006). *Building Partnerships between mental health, family violence and sexual assault services.* Victoria: Department of Human Services.

Fergus, L. (2006). *An evaluation of the Respect, Protect, Connect program.* Melbourne: South Eastern Centre Against Sexual Assault.

Fergusson, D. M., Boden, J. M., & Horwood, L. J. (2006). Examining the intergenerational transmission of violence in a New Zealand birth cohort. *Child Abuse & Neglect*, *30*(2), 89–108.

Flood, M. (2013). *Trends in evaluation: Preventing violence against women, paper 1.* Melbourne: VicHealth.

Flood, M. & Fergus, L. (2008). An assault on our future: The impact of violence on young people and their relationships, (White Ribbon policy research series No. 1). North Sydney: White Ribbon Foundation.

Flood, M., Fergus, L., & Heenan, M. (2009). *Respectful Relationships Education: Violence prevention and respectful relationships education in Victorian secondary schools.* Melbourne: Department of Education and Early Childhood Development.

Flood, M., & Kendrick, V. (2012). *Love Bites: an evaluation of LoveBites and Respectful Relationship Programs in a Sydney school.* Wollongong: University of Wollongong.

Flood, M., & Pease, B. (2008). *The factors influencing community attitudes in relation to violence against women: A critical review of the literature.* Melbourne: VicHealth.

Foshee, V. A., Bauman, K. E.,Ennett, S. T., Linder, G. F., Benefield, T., & Suchindran, C. (2004). Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health*, *94*(4), 619–624.

Fox, C. L., Corr, M.-L., Gadd, D., & Sim, J. (2014). Evaluating the effectiveness of domestic abuse prevention education: Are certain children more or less receptive to the messages conveyed? *Legal and Criminological Psychology* (January 2014).

Fulu, E., Jewkes, R., Roselli, T., & Garcia-Moreno, C. (2013). Prevalence of and factors associated with male perpetration of intimate partner violence: Findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health*, *1*(4), e187–e207.

Galbally, F. (1978). *Migrant services and programs : report of the Review of Post-Arrival Programs and Services for Migrants, May 1978.* Canberra: Australian Government.

Ghafournia, N. (2011). Battered at home, played down in policy: Migrant women and domestic violence in Australia. *Aggression and Violent Behavior*, *16*(3), 207–213.

Golding, J.M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta analysis. *Journal of Family Violence*, *14*(2), 99–132.

Good, G. E., Heppner, M. J.. Hillenbrand-Gunn, T.L., & Wang, L. (1995). Sexual and psychological violence: An exploratory study of predictors in college men. *Journal of Men's Studies*, 4(1), 59–71.

Graham-Bermann, S. A. & Hughes, H. M. (2003). Intervention for children exposed to interparental violence (IPV): Assessment of needs and research priorities. *Clinical Child & Family Psychology Review*, *6*(3), 189–204.

Graham-Bermann, S. A., Lynch, S., Banyard, V. DeVoe, E. R., & Halabu, H. (2007). Community-based intervention for children exposed to intimate partner violence: An efficacy trial. *Journal of Consulting and Clinical Psychology*, *72*(2), 199–209.

Grech, K. & Burgess, M. (2011). *Trends and patterns in domestic violence assaults: 2001 to 2010*, (Issue Paper No. 61). NSW: Bureau of Crime Statistics.

Hagemann-White, C., Kavemann, B., Kindler, H., Meysen, T. & Puchert, R. (2010). *Review of research on factors at play in perpetration of violence against women, violence against children and sexual orientation violence: A multi-level interactive model. Report to the Directorate-General Justice in the European Commission.* Brussels: European Commission.

Hager, D. (2010). *Finding safety: Provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services.* New Zealand: HomeWorks Trust.

Hague, G., Thiara, R., & Mullender, A. (2011). Disabled women and domestic violence: Making the links, a national UK study. *Psychiatry, Psychology and Law*, *18*(1), 117–136

Healey, L., Howe, K., Humphreys, C., Jennings, C., & Julian, F. (2008). *Building the evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria.* Victoria: Women's Health Victoria and Victorian Women with Disabilities Network.

Healey, L., & Humphreys, C. (2013). *Governance and interagency responses: Improving practice for regional governance. A continuum matrix*, (Topic Paper 21). Sydney: Australian Domestic & Family Violence Clearinghouse.

Heise, L. L. (1998). Violence against women: an intergrated, ecological framework. *Violence Against Women*, *4*, 262–290.

Higgins, D., King, R., & Witthaus, D. (2001). Pride and Prejudice: Facilitating change in the attitudes of students towards gay men and lesbians. *Health Promotion Journal of Australia*, *12*(3), 238–241.

Hillier, L., Dempsey, D., Harrison, L., Beale, L., Matthews, L., & Rosenthal, D. (1998). *Writing themselves in: A national report on the sexuality, health and well being of same-sex attracted young people*. Melbourne: National Centre in HIV Research.

Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., Mitchell, A. (2010). *Writing themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*. Melbourne: National Centre in HIV Research.

Hillier, L., Turner, A., & Mitchell, A. (2005). *Writing themselves in again: 6 years on. The 2nd national report on the sexual health and well-being of same sex attracted young people in Australia*. Melbourne: National Centre in HIV Research.

Hogg, R. & Carrington, K. (2006). *Policing the rural crisis*. Annandale: The Federation Press.

Hughes, N., & Fielding, A. (2006). *Targeting preventative services for children: Experiences from the Children's Fund. The national evaluation of the Children's Fund*. Nottingham: University of Birmingham.

Human Rights and Equal Opportunity Commission. (2006). *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities: Key issues. An overview of the research findings by the Human Rights and Equal Opportunity Commission 2001–2006*. Sydney: HREOC.

Humphreys, C. (2011). Rebuilding together: Strengthening the mother–child bond in the aftermath of violence. *DVRC Quarterly*, *3*, 6–10.

Humphreys, C. (2014). Children and Family Violence: Finding the Right Responses. *Insight: The Journal of the Victorian Council of Social Services*, *9* (February), 40–42.

Humphreys, C. & Houghton, C. (2008). Provision for children and young people experiencing domestic abuse. In C. Humphreys, C. Houghton, & J. Ellis (Eds.) *Literature review: Better outcomes for children and young people affected by domestic abuse. Directions for good practice*. Edinburgh, Scottish Government.

Humphreys, C., Thiara, R. K., & Skamballis, A. (2011). Readiness to change: Mother–child relationship and domestic violence intervention. *British Journal of Social Work*, *41*, 166–184.

Immigrant Women's Domestic Violence Service. (2006). *The right to be safe from domestic violence: Immigrant and refugee women in rural Victoria*. Melbourne: IWDVS.

Indermaur, D. (2001). *Young Australians and domestic violence*, (Trends and Issues in Crime and Justice No. 195). Canberra: Australian Institute of Criminology

Inner Melbourne Community Legal Centre. (2013). *Youth advocates against family violence: Responding to & preventing family violence in the secondary school setting. Project evaluation & final report*. Melbourne: Inner Melbourne Community Legal Centre and Doutta Galla Community Health. Retrieved from: <www.partnersinprevention.org.au/wp-content/uploads/2014/01/YAAFV-Project-Evaluation-Final-Report.pdf>.

Irwin, J. (2006). Lesbians and domestic violence: Stories of seeking support. *Women in Welfare Education*, *8*(1), 28–36.

Jaffe, P. G., Wolfe, D. A., & Campbell, M. (2012). *Growing up with domestic violence: Assessment, intervention, and prevention strategies for children and adolescents*. Cambridge: Hogrefe Publishing.

Jaycox, L., McCaffrey, D. F., Eiseman, B., Aronoff, J., Shelley, G.A., Collins, R. L., & Marshall, G. N. (2006). Impact of school-based dating violence prevention program among Latino teens: Randomised controlled effectiveness trial. *Journal of Adolescent Health*, *39*, 694–704.

Jaycox, L. H., Aronoff, J., & Shelley, G.A. (2007). The Break the Cycle Evaluation Project. In D. J. Whitaker & L. Reese. *Preventing intimate partner violence and sexual violence in racial/ethnic minority communities: CDC's demonstration projects*, (pp. 101–115). Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control, Coordinating Center for Environmental Health and Injury Prevention, Centers for Disease Control and Prevention.

Jennings, C. (2003, April). *Violence and women with a disability: Break down the barriers*. Paper presented at the "Beyond the Divide" 3rd National homelessness conference.,for the Australian Federation of Homelessness Organisations, Brisbane, Qld.

Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet*, *359*(9315), 1423–1429.

Kim, K. (2011). The role of culture in theories of the intergenerational transmission of violence. *Child & Family Social Work*, *14*, 395–405.

Kwok, W. L. (2013). *Trends in evaluation: Preventing violence against women, paper 2*. Melbourne: VicHealth.

Laing, L and Toivonen, C. (2010). *Bridging the gap: Evaluation of the Domestic Violence and Mental Health Pilot Project:.Joan Harrison Support Service for Women*. Sydney: Faculty of Education and Social Work, University of Sydney.

Leonard, W., Mitchell, A., Patel, S. & Fox, C. (2008). *Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria*. Bundoora, Victoria: Australian Research Centre in Sex, Health and Society.

Leonard, W., & Pitts, M. (2012). *Private lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual (GLBT) Australians*. Melbourne: Australian Research Centre in Sex, Health & Society.

Lieberman, A., Ippen, C. G., & Van Horn, P. (2006). Child–parent pyschotherapy: 6 month follow-up of a randomised controlled trial. *Journal of the American Academy of Child and Adolescent Psychology*, *45*(8), 913–918.

Lumby, B. & Farrelly, T. (2009). *Family violence, help-seeking and the close-knit Aboriginal community: lessons for mainstream service provision*, (Issues paper 19). Sydney, NSW: Australian Domestic and Family Violence Clearinghouse.

Lund, E. (2011). Community based services and interventions for adults with disabilities who have experienced interpersonal violence: A review of the literature. *Trauma, Violence & Abuse*, *12*(4), 171–182.

Mackay, R. (2011). *Bsafe Pilot Project 2007–2010*. Wangaratta, VIC: Women's Health Goulburn North East.

Marcus, G. (2010, May). *Integrated responses to domestic and family violence: What, how, when and why*. Paper presented at the Australian Institute of Criminology Conference, "Meeting the Needs of Victims of Crime". Sydney, Australia.

McClain, L. (2011). *Women, disability and violence: Strategies to increase physical and programmatic access to victim's services for women with disabilities*, (Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities, 2011 series). Melbourne: Centre for Women Policy Studies, International Women's Development Agency, Inc.

Memmott, P., Chambers, C., Go-Sam, C., & Thomson, L. (2006). *Good practice in Indigenous family violence prevention: Designing and evaluating successful programs*, (Issues Paper No. 11). Sydney, NSW: Australian Domestic and Family Violence Clearinghouse.

Memmott, P., Nash, D., Balfour, B., & Greenop, K. (2013). *The Women's Refuge and the Crowded House: Aboriginal homelessness hidden in Tennant Creek*. Brisbane: Institute for Social Science Research, The University of Queensland.

Meredith, V., Rush, P., & Robinson, E. (2014). *Fly-in fly-out workforce practices in Australia: The effects on children and family relationships*, (Child Family Community Australia Paper No. 19). Melbourne: Australian Institute of Family Studies.

Merlis, S. R. & Linville, D. (2006). Exploring a community's response to lesbian domestic violence through the voices of providers: A qualitative study. *Journal of Feminist Family Therapy*, *18*(1/2), 97–136.

Michau, L. (2007). Approaching old problems in new ways: Community mobilisation as a primary prevention strategy to combat violence against women. *Gender and Development*, *15*(1), 95–109.

Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing. (2009). *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Melbourne: Department of Health Victoria.

Mitchell, A., Smith, A., Carman, M., Schlichthorst, M., Walsh, J. & Pitts, M. (2011). *Sexuality education in Australia in 2011*. Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

Mitchell, L. (2011). *Domestic violence in Australia: An overview of the issues. Backgrounds Notes*. Canberra: Parliamentary Library of Australia.

Mouzos, J., & Makkai, T. (2004). *Women's experience of male violence: Findings from the Australian component of the International Violence Against Women Survey (IVAWS)*, (Research and Public Policy Series). Canberra: Australian Institute of Criminology.

Mudgin-Gal Aboriginal Corporaton, *Seeding Hope*, retrieved from: http://www.redfernfoundation.org.au/mudgingal.pdf.

Murphy, K. A. & Smith, D. I. (2010). Adolescent girls' responses to warning signs of abuse in romantic relationships: Implications for youth-targeted relationship violence prevention. *J Interpersonal Violence*, *25*(4), 626–647.

Murray, C. E. & Graybeal, J. (2007). Methodological review of intimate partner violence prevention research. *Journal of Interpersonal Violence*, *22*, 1250–1269.

Murray, C. E. & Mobley, A. K. (2009). Empirical research about same-sex initimate partner violence: A methodological review. *Journal of Homosexuality*, *56*(3), 361–386.

Murray, S. & Powell, A. (2011). *Domestic violence: Australian public policy*. North Melbourne: Australian Scholarly Publishing

Nancarrow, H., Lockie, S. & Sharma, S. (2009). Intimate partner abuse of women in a Central Queensland mining region. *Trends and Issues in Crime and Criminal Justice*, No. 378. Canberra, ACT: Australian Institute of Criminology.

National Council to Reduce Violence against Women and their Children. (2009). *Time for action: The National Council's plan for Australia to reduce violence against women and their children, 2009–2021*. Canberra: FaHCSIA

National Crime Prevention. (2001). *Young people and domestic violence: National research on young people's attitudes to and experiences of domestic violence*. Canberra: National Crime Prevention, Attorney General's Department.

NSW Auditor General. (2011). *New South Wales Auditor General's report: Performance audit. Responding to domestic and family violence*. Sydney, NSW: Audit Office in conjunction with Department of Family and Community Services; Department of Attorney General and Justice; Ministry of Health; NSW Police Force.

NSW Government. (2013). *OCHRE: Opportunity, Choice, Healing, Responsibility, Empowerment. NSW Government Plan for Aboriginal affairs: Education, employment and accountability*. Sydney: Office of Communities (Aboriginal Affairs).

NSW Government. (2014). *It stops here: Standing together to end domestic and family violence in NSW*. The NSW Government's Domestic and Family Violence Framework for Reform. Sydney: Department of Family and Community Services.

Oberin, J. & Mitra-Kahn, T. (2013). Stopping violence before it occurs: Responding to the pathways into gendered homelessness. *Parity*, *26*(7), 15–17.

Ollis, D. (2011, May). *A "Respectful Relationships" approach: Could it be the answer to preventing gender based violence?* Presented at the AWA White Ribbon Day Every Day Conference, Brisbane, Australia.

Ollis, D., Harrison, L. (2012). *Building capacity in sexuality education: The Northern Bay College experience*. Melbourne: School of Education, Deakin University.

Paroissien, K. & Stewart , P. (2000). Surviving lesbian abuse: Empowerment groups for education and support. *Women Against Violence: An Australian Feminist Journal*, *90*, 33–40.

Peterman, L. M. & Dixon, C. G. (2003). Domestic violence between same-sex partners: Implications for counseling. *Journal of Counseling & Development*, *81*(1), 40.

Pitts, M., Smith, A., Mitchell, A. Patel, S. (2006). *Private lives: A report on the health and wellbeing of GLBTI Australians*. Melbourne: Australian Research Centre in Sex, Health & Society.

Plummer, S., & Findley, P. (2012). Women with disabilities' experience with physical and sexual abuse: A review of the literature and implications for the field. *Trauma, Violence & Abuse*, *13*(1), 15–29.

Poljski, C. & Murdolo, A. (2011). *On her way: Primary prevention of violence against immigrant and refugee women in Australia*. Collingwood, Vic.: Multicultural Centre for Women's Health.

Quadara, A. & Wall, L. (2012). *What is effective primary prevention in sexual assault?* (ACSSA Wrap No. 11). Melbourne: Australian Institute of Family Studies.

Ragusa, A. (2013). Rural Australian women's legal help seeking for intimate partner violence: Women intimate partner violence victim survivors' perceptions of criminal justice support services. *Journal of Interpersonal Violence*, *28*(4), 685–717.

Rawsthorne, M. & Hoffman, S. (2007). *Liverpool Women's Health Centre Young Women's Healthy Relationships Project: Evaluation Report (No. 1)*. Liverpool: Liverpool Women's Health Centre.

Rawsthorne, M. & Hoffman, S. (2010). Supporting safe and healthy relationship choices: a peer education approach. *Women Against Violence: An Australian Feminist Journal*, *22*, 28–40.

Ristock, J. L. (2011). Introduction: Intimate partner violence in LGBTIQ lives. In J. L. Ristock (Eds.). *Intimate partner violence in LGBTQ lives*, (pp. 1–9). New York & Oxford, UK: Routledge.

Rizo, C. F., Macy, R.F., Ermentrout, D. M. & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior*, *16*(2): 144–166.

Robinson, E., Scott, D., Meredith, V., Nair, L., & Higgins, D. (2012). *Good and innovative practice in service delivery to vulnerable and disadvantaged families and children*, (CFCA Paper No. 9). Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/cfca/pubs/papers/a142861/cfca09.pdf>

Rosewater, A. (2003). *Promoting prevention, targeting teens: An emerging agenda to reduce domestic violence*. San Francisco: Family Violence Prevention Fund.

Ross, S., Frere, M., Healey, L., & Humphreys, C. (2011). A whole of government strategy for family violence reform. *Australian Journal of Public Administration*, *70*(2), 131–142.

Sety, M. (2012). *What do we know about dating violence among Australian adolescents?* (Thematic Review 4). Sydney: Australian Domestic & Family Violence Clearinghouse, UNSW.

SHine South Australia. (2005). *Health, Respect, Life: The final report on the sexual health and relationship education (share) project 2003–2005*. SA: SHine South Australia.

Shorey, R. C., Cornelius, T.L., & Bell, K.M. (2008). A critical review of theoretical frameworks for dating violence: Comparing the dating and marital fields. *Aggression and Violent Behavior*, *13*(3), 185–194.

Simbandumwe, L., Bailey, K., Denetto, S., Migliard, P., Bacon, B., & Nighswander, M. (2008). Family violence prevention programs in immigrant communities: Perspectives of immigrant men. *Journal of Community Psychology*, *36*(7), 899–914.

Spinney, A. (2012). *Home and Safe? Policy and practice innovations to prevent women and children who have experienced domestic violence from becoming homeless*. Melbourne: Australian Housing and Urban Research Institute, Swinburne Research Centre.

Spinney, A., Blandy, S., & Hulse, K. (2013). *Preventing Homelessness for Women and Children who have Experienced Domestic and Family Violence*, (Research and Policy Bulletin Issue 164). Melbourne: Australian Housing and Urban Research Institute.

St George Migrant Resource Centre (SGMRC). (2013). *Annual report*. Rockdale, NSW: SGMRC.

Steering Committee for the Review of Government Service Provision (SCRGSP). (2011) *Overcoming Indigenous disadvantage: Key indicators 2011*. Canberra: Productivity Commission.

Stith, S. M., Rosen, K.H., Middleton, K. A., Busch, A. L., Lundeberg, K., & Carlton, R. P. (2000). The intergenerational transmission of spouse abuse: A meta-analysis. *Journal of Marriage and Family*, *62*(3), 640–654.

Sullivan, C. M., Bybee, D. I., & Allen, N. E. (2002). Findings from a community-based program for battered women and their children. *Journal of Interpersonal Violence*, *17*(9): 915–936.

Temple, J. R., Shorey, R. C., Tortolero, S. R., Wolfe, D. A., Stuart, G. L. (2013). Importance of gender and attitudes about violence in the relationship between exposure to interparental violence and the perpetration of teen dating violence. *Child Abuse & Neglect*, *37*(5), 343–352.

Tharp, A. T. (2012). Dating Matters (TM): The next generation of teen dating violence prevention. *Prevention Science*, *13*(4), 398–401.

Thiara, R. K. & Ellis, J. (2005). *WDVF London-wide schools' domestic violence prevention project: An evaluation. Final Report*. London: Westminister Domestic Violence Forum.

Thiara, R., Hague. G., Bashall, R., Ellis, B., and Mullender, A. (2012). *Disabled women and domestic violence: Responding to the needs of survivors*. London: Jessica Kingsley Publishers

Tomison, A. (2000). Exploring family violence: Links between child maltreatment and domestic violence. *Issues in Child Abuse Prevention*, 13.

Trijbetz, T. (2013). *Domestic and family violence and people from immigrant and refugee backgrounds*, (Fast Facts 11). Sydney: Australian Domestic Violence & Family Violence Clearinghouse, UNSW.

Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). *Improving Indigenous community governance through strengthening Indigenous and government organisational capacity*, (Closing the Gap Clearinghouse Resource Sheet No. 10). Canberra: Closing the Gap Clearinghouse.

Tutty, L., Bradshaw, C., Thurston, W.E., Barlow, A., Marshall, P., Dunstall, L. et al. (2005). *School-based violence prevention programs: A resource manual*. Alberta: RESOLVE

VicHealth. (2004). The health costs of violence: Measuring the burden of disease caused by intimate partner violence. Melbourne: VicHealth..

VicHealth. (2007). *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*. Carlton: VicHealth.

Victorian Government. (2012). *Victoria's action plan to address violence against women & children 2012–2015*. Melbourne: Department of Human Services, Office of Women's Policy

Walden, I. (2014). *Primary prevention of violence against women*, (ADFVC Fast Facts). Retrieved from <http://www.adfvc.unsw.edu.au/documents/ADFVCFastFacts12_000.pdf>.

Walden, I., Barrett Meyering, I., & Wall, L. (2014 (forthcoming)). *Reflecting on primary prevention of violence against women: The public health approach so far*, (ACCSA Issues Paper No. 19). Melbourne: Australian Institute of Family Studies.

Wall, L. (2013). *Issues in evaluation of complex social change programs for sexual assault prevention*, (ACSSA Issues Paper No .14). Melbourne: Australian Institute of Family Studies.

Wall, L. (2014). *Gender equality and violence against women: What's the connection?* (ACSSA Research Summary). Melbourne: Australian Institute of Family Studies.

Wendt, S. (2009a). Constructions of local culture and impacts on domestic violence in an Australian rural community. *Journal of Rural Studies*, *25*(2), 175–184.

Wendt, S. (2009b). *Domestic violence in rural Australia*. Annadale, NSW: Federation Press.

Wendt, S. & Hornosty, J. (2010). Understanding contexts of family violence in rural, farming communities: Implications for rural women's health. *Rural Society*, *20*(1), 51–63.

Whaley, R. B., Messner, S.F., & Veysey, B. M. (2013). The relationship between gender equality and rates of inter- and intra-sexual lethal violence: An exploration of functional form. *Justice Quarterly*, *30*(4), 732.

Whitaker, D., Murphy, C. M., Eckhardt, C. I., Hodges, A. E., & Cowart, M. (2013). Effectiveness of primary prevention efforts for intimate partner violence. *Partner Abuse*, *4*(2), 175–195.

World Health Organization. (2002). *World report on violence and health: Summary*. Geneva WHO

World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva: WHO.

Wickham, L. & Plompen, T. (2006). *Out of sight and out of mind: Connecting family violence and disability services in Cardinia and Casey. Final report*. Cranbourne: Cardinia Casey Community Health Service.

Wilcox, K. (2010). Connecting systems, protecting victims: Towards vertical coordination of Australia's response to domestic and family violence. *University of New South Wales Law Journal*, 33(3), 1013–1037.

Woodin, E. M. & O'Leary, K. D. (2009). Theoretical approaches to the etiology of partner violence. In D. Whitaker and J. Lutzker (Eds.). *Preventing partner violence: Research and evidence-based strategies*, (pp. 41–67). Washington, DC: American Pyschological Association.

Young, U. K. (2004). *National framework for sexual assault prevention*. Canberra: Office for the Status of Women, Commonwealth of Australia.

Zannettino, L., Pittaway, E., Eckert, R., Bartolomei, L., Ostapiej-Piatkowski, B., Allimant, A., & Parris, J. (2013). *Improving responses to refugees with backgrounds of multiple trauma: Pointers for practitioners in domestic and family violence, sexual assault and settlement services*. Practice Monograph 1. Sydney: Australian Domestic & Family Violence Clearinghouse, UNSW.

Appendix 1: At-risk groups and communities service map

Table 1: Services for Aboriginal and Torres Strait Islander women, NSW

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Aboriginal Counselling Services <www.aboriginalcounsellingservices.com.au/index.html>	ACS		ATSI				Response
NSW	Broken Hill Aboriginal Family Violence Prevention Legal Service	Broken Hill Aboriginal Family Violence Prevention Legal Service (BHAFVPLS)		ATSI, young women	This is a self-esteem program for young Aboriginal women (12–16 year olds) to raise awareness and provide culturally appropriate advice on violence issues.			Prevention
NSW	Carrie's place Women's and Children's Service	Carrie's place Women's and Children's Service		General, but focus on ATSI women's needs	This organisation provides a continuum of support services to women with or without their dependent children from domestic violence and family violence backgrounds. It also provides an Aboriginal outreach position to deliver culturally appropriate early intervention, outreach and court support for Aboriginal women experiencing domestic and family violence.		Crisis accommodation, DV education workshops for women. social & support groups, such as craft, creative Writing, gardening, cooking, free legal clinics on family law and Victims of Violent Crime Community Education, Vocational Education & Training Project, individual intervention work with women in crisis, participation in community awareness raising events, participation in essential networking forums, assist women to remain safe, free GP medical appointments	Early intervention, crisis and post-crisis services

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Connections: Aboriginal women's art therapy group	St Vincent's hospital. Program partners include Centrelink, Health Promotion (Living Strong), City Of Sydney Council, Work Ventures and the National Centre for Indigenous Excellence.		ATSI	This weekly program uses art therapy and group work to support Aboriginal women who experience mental illness. Established in 2001 by an Aboriginal mental health worker, it now takes place with the additional support of an art therapist as a program of Sydney's St Vincent's hospital.		The program offers women a culturally safe setting in which to express mutual support for mental health issues and to explore issues of Aboriginal identity. The meetings also offer participants the opportunity to develop art skills through involvement in personal and collective art projects. These include individual paintings, group murals, and commissioned projects for clients such as hospitals and health agencies. Transport and healthy lunches are provided to participants as part of the program.	Prevention and early intervention
NSW	Dubbo Neighbourhood Centre—Aboriginal Family Health Centre	Dubbo Neighbourhood Centre		ATSI				Early intervention & response
NSW	Aboriginal Programs, Education Centre Against Violence (administered by Sydney West Area Health Service) <www.ecav.health.n sw.gov.au/>	ECAV		General, with an MoU Aboriginal Community Matters Advisory Committee	Statewide specialised training, consultancy, clinical supervision, policy advice and resource development for NSW Aboriginal Health workers and their Aboriginal colleagues, community members and non-Aboriginal frontline workers. ECAV Aboriginal staff and contractors are responsible for delivering a total of 17 separate courses, including a range of community development programs such as Strong Aboriginal Women (SAW), Strong Aboriginal Men (SAM) and Weaving The Net (WTN) courses for non-Aboriginal front line service providers and managers and programs targeted directly to Aboriginal workers and community members		Training	Training for service providers
NSW	Family Violence Prevention Legal Service			ATSI	The FVPLS program provides culturally sensitive assistance to Aboriginal people who are victim-survivors of family violence and sexual assault. The FVPLS provides legal assistance, court support, casework and counselling.			Response

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Healthy Family Circle program: supporting women caring for children	Mudgin-Gal Aboriginal Women's Corporation (developed in partnership with Relationships Australia)		ATSI	Supports ATSI women facing family violence, social isolation and disadvantage. The program was developed in partnership with Relationships Australia (NSW) (RANSW), and offers mentoring and support to women caring for children and their families in order to help them identify healthy and safe choices for their wellbeing. Operating through a range of workshops, activities and informal exchanges—such as lunchtime conversations or "yarning"—the program aims to empower women through skill and knowledge-sharing and the development of tools to identify and reach life goals.			Response
NSW	Hey sis, we've got your back: Aboriginal women's sexual assault network	Collaboration between Mudgin-Gal Aboriginal Corporation and NSW Rape Crisis Centre		ATSI	Aims to create a network of Aboriginal women from all around New South Wales who are working to prevent sexual violence. The network seeks to bring together Aboriginal women who are working against sexual assault in their communities, or who would like to stand strong and support others in their communities who have experienced or been impacted by sexual assault.			Prevention
NSW	Intereach Children & Family Services— Aboriginal Family Support <www.intereach.com.au/>							Response
NSW	Mirang Din Aboriginal Women's Resource Centre Inc.	Mirang Din Aboriginal Women's Resource Centre		ATSI	Mirang Din Aboriginal Women's Resource Centre provides a culturally adequate support for ATSI women victims of family violence.		The organisation offers women the use of computers, a sewing machine and a massage centre.	Response
NSW	NSW Police (Domestic & Family Violence Team)			General, but particularly ATSI				

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Preventing domestic violence and alcohol abuse program	Gunawirra		ATSI	Aims to minimise domestic violence and alcohol use within Aboriginal families.		Gunawirra works with up to 60 families in Marrickville and Miller with professional staff who work directly with families to avoid the impact of violence, abuse and neglect. The program does this by: creating a neutral setting that is nurturing and protective; providing high quality and timely care to people who have experienced violence; offering education services about the dangers of alcohol and drug use; giving group support to pregnant women and mothers of children aged 0–5 years old; coordinating support services to aid the recovery of people experiencing violence; information sharing between service providers and police and governments.	Prevention, early intervention & response
NSW	South West Sydney Family Project	Gunawirra		ATSI young pregnant women and young mothers	Prevent DFV for target group and their children		Communal groups at the Family Centre at Casula, parent meetings, home visits, workshops on parenting, etc., weekly therapy group, family camps in the Southern Highlands	Prevention & early intervention
NSW	Inner Suburbs Family Project	Gunawirra		ATSI young pregnant women	Prevent DFV for target group and their children		Home visits, 24-hour support, community leadership program, weekly psychotherapy.	Prevention & early intervention

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Rekindling the spirit	Rekindling the Spirit		ATSI	Rekindling the spirit is a community-based project run by Aboriginal people, for Aboriginal people. The aim of the project is the empowerment of Aboriginal people through a process of spiritual, emotional, sexual, and physical healing.		Rekindling the spirit has a family-based approach, and conducts counselling services combining traditional and contemporary methods. This program assists family violence perpetrators to take responsibility for their offending and provides an opportunity for behaviour change. It includes one-on-one counselling and support, group work, and referral to specialist mainstream services. Rekindling the spirit also provides a range of support services for Aboriginal families who are victims of violence. Community and government agencies work together on this project for the wellbeing of Aboriginal people.	Early intervention & response
NSW	Waminda South Coast Women's Health and Welfare Aboriginal Corporation			ATSI	Waminda aims at empowering Aboriginal and Torres Strait Islander women of the Shoalhaven to make decisions about their health and wellbeing. The organisation provides domestic violence and sexual assault supports.			Response
NSW	Wirringa Baiya Aboriginal Women's Legal Centre			ATSI	Wirringa Baiya provides Aboriginal and Torres Strait Islander women, children and youth, a gender specific service and culturally appropriate service. Aboriginal and Torres Strait Islander women who are victims of violence have access to appropriate legal representation, advice and referral.			Response
NSW	Yoorana Gunya Family Violence Healing Centre Aboriginal Corporation			ATSI	Provides spiritually and culturally appropriate healing facilities, awareness and education programs to enhance a zero tolerance to family violence within the community.		Free legal advice and casework; community legal education; early intervention and prevention programs; counselling; information, support and referral; court support; law reform and advocacy; outreach legal clinics; and intensive support for sexual assault victims.	

State	Name of service/project/ program	Host organisation	Nature of host organis- ation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Weaving the Net	Education Centre Against Violence	Community NFP	ATSI families	*Weaving the net* is a series of consultative, educational and community development modules that aim to increase capacity in Aboriginal communities to respond to child abuse. The program is offered to Aboriginal communities wanting to promote community and family-based solutions to child abuse and family violence. A key outcome is to develop a pool of accredited workers and community members who could facilitate education and community development programs.	Community Capacity building	2-day consultation process followed by training on child sexual assault, physical and emotional abuse and neglect of children and child protection in the context of family violence. The community education module is followed by a community-building module to further develop a child protection community plan.	

Table 2: Services for Aboriginal and Torres Strait Islander women, states other than NSW and territories

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
National	Family violence prevention legal service program			ATSI	Free legal and counselling service for victims of family violence and/or sexual assault who are ATSI, or whose partner or children are ATSI. There are over 30 FVPLS units throughout Australia		Provides culturally sensitive assistance to Indigenous victim-survivors of family violence and sexual assault through the provision of legal assistance, court support, casework and counselling. FVPLS delivers the following services: legal advice and casework assistance; court support; counselling to victims of sexual assault; assistance and support to victims of sexual assault; child protection and support; information, support and referral services; community engagement; referrals; law reform and advocacy; early intervention and prevention, and community legal education.	All
VIC	Sisters Day Out (on hold pending funding)	Aboriginal Family Violence Prevention & Legal Service	Legal service	ATSI women	Reinforce Koori women's sense of identity & importance; provide support & information to women at risk of FV		Wellbeing sessions for Aboriginal women: pampering & fun; wellbeing workshops; discussions about FV; and information on legal, health, support and referral networks	Prevention & early intervention
VIC	Standing Firm Against Family Violence	Aboriginal Family Violence Prevention & Legal Service	Legal service	ATSI	Raise awareness of impact of FV & how to prevent it		Social marketing materials promoting key messages; list on website of "101 ways Koori women and men can make changes to reduce vulnerability to FV"	Prevention
VIC	Capacity building for mainstream services	Elizabeth Hoffman House	Community organisation	ATSI women	Improve capacity of mainstream services to undertake culturally appropriate case management, and build capacity to keep women housed while in debt		Two three-hour workshops developed and delivered, one focusing on culturally appropriate case management and one focusing on keeping housing while in debt	Early intervention
VIC	White Ribbon event	Northern Aboriginal Family Violence Regional Action Group	Community organisation	ATSI & broader community	To model non-violence and make a public stand to show male leadership in preventing violence against women		Since 2009 the Northern Aboriginal Family Violence Regional Action Group has coordinated the Aboriginal segment to the annual "Not 1More" event at Federation Square on White Ribbon Day	Prevention

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Women's Cultural Strengthening Project	Victorian Aboriginal Community Services Association (VACSAL)	Community organisation	ATSI women				
VIC	Aboriginal family violence program	Rumbalara Aboriginal Cooperative	Community organisation	ATSI			The program focuses on delivering support services to Aboriginal women and children experiencing family violence and to Aboriginal men who use violence against family members.	
VIC	Indigenous Family Violence	Goulburn Valley Community Health Service	Health Service	ATSI			This service helps women and children who are affected by family violence. It provides a range of free and confidential services in a safe environment. Depending upon the client's individual circumstances, this service may help with alternative accommodation, counselling, advocacy, court support and access to other relevant services.	Response
WA	Aboriginal mediation services	Department of the Attorney General	Government department	ATSI	While the service is not a crisis intervention tool, it is highly successful when parties express a desire to voluntarily participate in the mediation process in a good faith attempt to resolve a dispute. It aims to resolve conflicts before they escalate into violence. Any intervention by the service will be negotiated with all parties involved in the conflict.			
WA	Anawim emergency housing intake service	Ruah Community Services	Community organisation	ATSI women	The service is for sole Aboriginal women who are homeless or at risk of homelessness due to family violence or other life crisis, and is short term			

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
WA	Ruah Safe at Home Program	Ruah Community Services	Community organisation	ATSI women	Aim of the program is to support women and children who have experienced domestic violence to stay in their housing when it is safe to do so. The program is based on an individual assessment of risk and safety to allow women to make an informed choice about staying in their home after violence.		Providing written and/or telephone information to women—including support, safety checks, and safety planning and implementation.	
WA	Building Solid Families Program	Yorgum	NGO/ community organisation	ATSI	Provides social and emotional well being services including culturally secure information, support and advice services to Aboriginal communities particularly those affected by trauma, grief and loss; affected by mental health problems; and at risk of self-harm, in particular youth.		Client assessments and care plans; provision of and referral to general counselling and support services. Establish counselling and referral protocols and support services networks. Develop and support clear pathways for referral and receipt with Department of Health mental health services	Early intervention & response
WA	Family Violence Aboriginal Advocacy and Counselling Program (funded by FaHCSIA)	Yorgum	NGO/ community organisation	ATSI	The project aims to reduce the number of ATSI children, youth, adults and families affected by family violence, sexual abuse and associated issues. It promotes and sustains a non-violent, safe environment in which ATSI people can live, nurturing and reflecting ATSI values of caring and sharing, to support and meet the emotional, physical, spiritual and social needs of family members.		Counselling and advocacy	Early intervention & response

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
WA	Djooraminda's Indigenous family program	Centacare	Charity	ATSI	Aims to provide information and assistance to individuals to keep children and family members safe		Home visits every week, or more often if required; assistance in dealing with referral issues; assistance to identify and manage changes; counselling for participants and their family members; referral or help accessing and dealing with other agencies, if required; assistance in resolving conflict, differences or disputes with other agencies.	Early intervention & response
WA	Indigenous parents support (IPS)	Collaboration between Dr Andrew Guilfoyle from the School of Psychology and Social Science at Edith Cowan University and Save the Children Australia	University & charity	ATSI	The IPS project aims to enhance parenting skills, build more connected and resilient communities, reduce disadvantages due to isolation and increase social engagement among families		It is delivered through three levels of involvement: Information, promotion and prevention; Assistance and Family Engagement –Practical or therapeutic; and Early Intervention support and referrals to local specialised services.	All
WA	Kalgoorlie accommodation support service	Anglicare WA (Kargoorlie office)	Charity	Mainstream but with ATSI content	Aims to provide access to Department of Housing accommodation for women, with or without children, who are homeless or escaping family domestic violence for a period of 12 months.		A housing support worker visits regularly and has phone contact with residents to develop a collaborative support plan with them. Working together identifies any issues that have contributed to the individual's homelessness and proposes solutions, including referrals to useful organisations, financials strategies, and appropriate education and training opportunities. Referrals to counselling, etc.	
WA	Kununurra women's fishing group	Anglicare	Charity	ATSI women	Established to provide community support to local women. The group aims to address some of the social issues facing these women, including: housing and welfare; family and domestic violence; alcohol and drug use; cultural breakdown; disruptive neighbours; caring for children; marginalisation.		The group runs fortnightly, and provides a culturally secure environment from which the women can share food that they have caught, have a cuppa, a yarn, or just sit quietly in the company of supportive women on their country.	

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
WA	StrongFamilies	Department of Child Protection and Family Support	Government Department	Mainstream with Indigenous content	The program recognises that sometimes families can experience complex problems that cannot be addressed by a single agency—or even many agencies if they work in isolation.		Plan and coordinate services for consenting families who have complex needs and are receiving services from two or more agencies. They bring family members and agency workers together to work in a coordinated way, share relevant information, identify goals, and develop plans to help meet the family's needs.	
WA	Karnany Aboriginal centre	Swan Emergency Accommodation	Community organisation	ATSI			Crisis accommodation; housing and advocacy; information; emergency relief; drop in centre; information / referrals; agent for NILS (low cost loans for white goods).	
WA	Walk Tall Program	Palmerston Association	Community organisation	Mainstream but with ATSI content	Aims to support individuals in overcoming issues (including substance use, violence, and hopelessness) through education and support.		Substance use services; health support through its community nurse; guidance and referral to primary health and other support services; family support through its Yarning and parenting program.	
WA	Wooree Miya woman's refuge	Aboriginal Alcohol and Drug Service (AADS)			Provides crisis accommodation for up to three months.		Provides: assessment, support planning, crisis accommodation, transitional accommodation, non-residential support; counselling, information, referral, advocacy, practical assistance (e.g. transport), support for children; assistance to access services (e.g. legal, accommodation, health, income support, drug and alcohol treatment services, and services for children); access to other AADS programs, including flower therapy, kinesiology, art therapy and parenting programs.	

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NT	Alice Springs integrated response to family violence project	Department of Children and Families (DCF) and the Department of Justice (DoJ), Northern Territory (NT)	Government departments	Mainstream but with ATSI focus	Links government and local non-government agencies together, including the Alice Springs Women's Shelter, National Association of Prevention of Child Abuse and Neglect (NAPCAN), Tangentyere Council, Central Australia Aboriginal Congress, local legal services and the NPY Women's Council.			
NT	Night Patrols	Central Desert Shire			Core functions are to provide basic services such as: safe transportation; diversion from contact with the criminal justice system; intervention to prevent disorder in communities.			All
NT	East Arnhem community night patrol and sobering-up services	East Arnhem Shire Council	Local council	ATSI	The services are delivered in response to the need for culturally appropriate assistance to Indigenous people at risk of either causing harm or being harmed, including: intoxicated people; people under the influence of substances; young people; victims of violence; homeless people.		The services assist communities to take responsibility in preventing anti-social, harmful, destructive and illegal behaviour by offering patrolling and safe transport. The activities undertaken by the night patrol teams include: relocating people to a "safe" environment such as a relative's home, recognised safe house, women's refuge, sobering-up shelter, or medical facility; diffusing violent situations where it is safe to do so; diverting intoxicated people away from contact with the criminal justice system; providing advice, information or referral to appropriate services.	Early intervention & response
NT	Gunbalanya family safety program	Gunbalanya Service Delivery Centre			Draws on the knowledge and experience of local people and culture in developing and implementing initiatives and services to address issues such as substance use and family violence.		Sports programs, strong women's group, family safety program, cultural programs, men's programs, music shed.	

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NT	Healthy families	Council for Aboriginal Alcohol Program Services (CAAPS)	Community organisation	ATSI	Providing families with a safe and supportive environment to address substance use issues		12-week residential program. The program is made up of a range of different education sessions and activities that cover substance use including: healthy lifestyles; livelihood; cultural sessions; art therapy; family relationships. Case work and health checks.	Early intervention & response
NT	Outreach Support and Transitional Housing for Itinerant Women	Catherine Booth House	Community organisation	ATSI women	This program addresses the needs of single homeless Aboriginal women requiring assistance when escaping or recovering from violence and other difficult life situations.		Services include Outreach Support, Case Management, and Transitional Housing.	Response
NT	Piliyintinji-ki stronger families	Anyinginyi Health Aboriginal Corporation	Health Service	ATSI	Assisting to reduce the level of family violence and child abuse in the community by capacity-building communities, families and individuals in addressing these issues. This is done by providing counselling, education on issues, self-help measures, monitoring and case management by counsellors and Community Support Workers		Services include: access to a wide range of services to assist with substance use and work collaboratively with other service providers; culturally appropriate services for men, women and children of the region which include promotion and prevention initiatives fundamental to improve physical, social and emotional health status; Bringing Them Home (Stolen Generation) services; support for families experiencing emotional and social wellbeing problems associated with trauma and grief, forced separation of children from their families or family violence and suicide.	All
NT	Safe Families Program	Tangentyere Council	Community organisation	ATSI	Provides family support and outreach services, a safe environment for children, and a safe environment for families who are exiting a family violence situation.		Family support and outreach; children's safe house; family safe house.	Early intervention & response

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NT	Yuendumu mediation and justice committee	Central Desert Regional Council		ATSI	The committee consists of respected Yuendumu Elders who meet to discuss the sentencing of Yuendumu offenders awaiting charges in their own Warlpiri language. The Elders have the capacity to make recommendations to the NT Magistrate's Court regarding sentencing, and put forward any concerns they may have. The Elders also discuss strategies to promote community safety and address family violence.			Prevention & response
SA	Change-I am	Centacare Country South Australia (SA) in partnership with Davenport Tji Tji Wiru Youth Centre	Charity/ Community organisation	ATSI young women	The program aims to prevent violence against Aboriginal women in the Davenport community by providing local female children and youth with a journey of self-discovery, community participation and community education			Prevention & early intervention
SA	Family and community healing program	Central Northern Adelaide Health Service	Health Service	ATSI	The focus of the program is on early intervention and capacity building for Aboriginal families, family and community healing, aiming to equip people with the skills for effective communication and conflict resolution.	Evidence-based design, holistic approach, clinical focus, committed staff, inter-sectoral linkages, peer support, mentoring, and Aboriginal cultural focus.	It comprises a complex and dynamic set of group activities for Aboriginal women, men and youth. Capacity building in mainstream agencies and services is also addressed so that issues of family violence could be tackled within the broader community context.	Early intervention

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
SA	Family support service	Umoona Tjutagku Health Service	Health Service	ATSI			Provides counselling, support and referral for people that are, or have been, subjected to domestic violence. The family support service also provides clients with social, mental, physical and financial help.	Response
QLD	Domestic Violence—it's not our game	Normanton Building Safer Communities Action Team (BSCAT), Carpentaria Shire Council	Local council	ATSI	Aims to create positive role models in the Normanton community, reduce the prevalence of domestic and family violence, and create a safer community to live in		Sponsorship of the local Stingers Rugby League Team. The slogan was adopted by the team who also agreed to become role models in the community. The penalty for violence is exclusion from games and ultimately the team. Commercial advertisements are run on Imparja Television during the football season featuring the players and the message.	Prevention
QLD	Numula Family violence project	Kurbingui Youth Development Association (KYDA)	Community organisation	ATSI	Aims to build the capacity of families in dealing with issues of family violence		Provides safety strategies, healing, education and challenges behaviours that allow violence and abuse to occur in the community. Builds personal skills and capacities that will support individuals to make healthy and positive choices.	Early intervention & response
?	Chisholm Care	Baptist Community Services	NGO or charity	General, but specific services for ATSI			Crisis and medium term accommodation for women and children escaping DV and housing specifically for Aboriginal women. Counselling, case work, group work, support, child support and activities. Conducts groups for pre-school up to high school age children on DV and healthy relationships.	Response & early intervention
WA	Aboriginal Family Law Service	n/a	Legal service	ATSI	The AFLS provides legal representation and community education to Aboriginal people in Western Australia in the areas of family and sexual violence.		Case work and community education	Response & early intervention

State	Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
WA	Western Australia Family Violence Prevention Legal Service Aboriginal Corporation		Legal service	ATSI				

Table 3: Services for culturally and linguistically diverse women

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Domestic Violence Project	Immigration Women's Speakout Association NSW	NGO	CALD women			Project Officers primarily do case work/response and community development work. Policy Officer works lobbies, represents NESB women at state level, etc.	All
NSW		Immigrant Women's Health Service	Health Service	CALD women			No specifically tailored ongoing program, but provide general advice and run workshops, info sessions, etc. on DFV as well as events such as 16 Days of Activism	All
NSW		Immigration Advice and Rights Centre Inc.	Legal Service	CALD			No specific program but provide migration advice to women experiencing DFV, especially those on temporary visas.	Response
NSW	DV Community Education Project	St George Migrant Resource Centre	Community organisation	South Asian (Nepalese and Bengali) and Chinese CALD women	Aims to help women experiencing DV and their communities through changing attitudes towards the right to live a life free of violence; increasing knowledge on supportive community and legal systems; and better appreciation for respectful family relationships.		Consultations were held to understand cultural attitudes towards DV, gender power relations and cultural interpretation of family relationships and gender roles. Through this process, it has identified key stakeholders and gatekeepers in the community with whom we have jointly devised strategies to raise awareness and educate community members on non-tolerance of DV.	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	CALD Early Intervention Family Support Services	SydWest Multicultural Services	Community organisation	CALD parents expecting a baby and families with children up to eight years of age.	The main aim is to assist parents to raise a happy and healthy family by helping them address their issues in a supportive environment		The project is led by a Team Leader and comprises of a Senior Project Officer and a number of Project Officers who work with the families. Project Officers offer information on health, education, parenting and local services. They also provide group work and outreach from a number of locations in the community. Home visits are done on a needs basis, for example, after the birth of a baby, difficult pregnancy, etc. The Project Officers assist service providers to work more effectively with the target communities by sharing information on cultural issues. The project currently runs a number of women's support groups and playgroups for families.	Early intervention
NSW	Family Safety Project	SydWest Multicultural Services	Community organisation	Newly arrived African and South Asian communities, with a focus on Sudanese, Ethiopian, Sierra Leonean, and Liberian communities and Afghan, Iranian, Indian, Pakistani and Tamil communities	Provides support to communities and families and focuses on prevention and intervention activities to address issues surrounding domestic violence		Referral and case management services; Consultations with local and community leaders, young people, men, women and their families; Information sessions and information dissemination; Training for victims, those at risk of becoming victims and their peer groups including men and women from existing community structures such as leaders, elders and other community members; Support for groups to meet with other survivors and to share experiences; Research to identity key issues, strategies, and how to find solutions to solve these issues, and; Facilities for discussions groups, and networking to other service providers.	Prevention & early intervention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Family Harmony Project/ Family Support Project	SydWest Multicultural Services	Community organisation	CALD families	To ensure children have the best start in life by focusing on targeted early intervention approaches that bring about positive family functioning, safety and child development outcomes for children and their families, particularly those who are most vulnerable, disadvantaged or in disadvantaged circumstances.		Provides assistance for refugee and CALD families to participate in community and family life through support, skills development and mentoring programs; Provides peer mentoring for parents including parenting skills training and address risk taking behaviours for their children; Facilitates workshops and seminars on intergenerational conflict and risk-taking behaviours for participants and volunteers/mentors; Provides ongoing support and implement training strategies for volunteers/mentors; Delivers information sessions to improve service referral and support pathways for families	Early intervention & prevention
NSW	Multicultural Family Support	Metro Migrant Resource Centre	Community organisation	CALD families and communities, in particular Arabic-speaking, African, Pacific and Aboriginal communities			This program has run groups on how to work with communities around issues of violence and domestic violence. Its core activities include: appropriate service referral relating to accommodation, legal, educational, health and immigration matters; Support with safe family environments, positive parenting strategies; Building relationships with young people and their environment; Assistance communicating to other services; Information about referrals to other services and networks.	All
NSW	Families in Cultural Transition (FICT) Program	NSW Service for the Treatment and rehabilitation of Torture and Trauma Survivors	Community organisation	CALD families	Designed to help newly arrived refugees learn about Australia and settle successfully in their new country.		Nine-week series of workshops. As well as finding out about Australian culture and systems, participants can talk about how their torture and trauma experiences may affect them and their families. They also learn about organisations that can help. Includes sessions on how traumatic experiences impact on family.	All
QLD	ZigZag Young Women's Resource Centre	ZigZag Young Women's Resource Centre	Not for Profit/NGO	Young women <25 (45% of cliental are CALD)	To support and assist young women at risk of homelessness and/or who have experienced violence or sexual abuse	Feminist advocacy model	Supported accommodation, counselling, information and support /referral	

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
QLD		Immigrant Women's Support Service	NGO/ Community organisation	CALD women			IWSS offers free confidential, practical and emotional support to immigrant and refugee women from non-English speaking backgrounds and their children who have experienced domestic and/or sexual violence	Response
VIC		Immigrant Women's Domestic Violence Service (IWDVS)		CALD women			Offers referral and advice service, advocacy and co-case management. Also undertake training and community education/outreach	All
VIC		InTouch, the Multicultural Centre against Family Violence	NGO/ Community organisation	CALD	Our organisation strives to create a world where all women and children will be safe and free from violence.	Holistic, culturally sensitive	Provides services, programs and responses to issues of family violence in CALD communities. By acknowledging the rights and diverse experiences of clients, develops and implements a number of culturally sensitive and holistic models for the provision of services to both victims and perpetrators of family violence. In tackling the issues of family violence acts on multiple levels— individual, relationship and community.	All
VIC	CALD Communities Leading the Way to Respectful Relationships— a community engagement initiative to prevent family violence in Victoria.	InTouch, the Multicultural Centre against Family Violence	NGO/ Community organisation	CALD communities— Indian, Sudanese, Vietnamese and Croatian	Attitudinal change in relation to gender equity issues and respectful relationships.		Task force committees for each community develop action plans in consultation with community to raise awareness about DFV and respectful relationships.	Prevention
VIC	Healthy Relationships in a New Culture	Spectrum Migrant Resource Centre	NGO/ Community organisation	CALD communities- Sudanese, Somali, Iraqi (Arabic and Kurdish speaking), and Indian	Attitudinal change in relation to gender equity issues and respectful relationships		Delivery of healthy relationships course/workshops with follow on activities such as drama productions aimed at target communities	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Family Relationship Support Services	Spectrum Migrant Resource Centre	NGO/ Community organisation	CALD			Men & Family Relationships—targeting Iraqi, Sudanese, Kurdish and Somali communities; Parenting in a New Culture; Family Mediation within Arabic Communities; Parenting and Adolescent Consultant (Intergenerational Conflict Skills Development); Family Relationship Centres —partners in the Broadmeadows and Greensborough offices.	
VIC	Preventing domestic violence against women	Australian Vietnamese Women's Association	NGO/ Community organisation	CALD - Vietnamese women	Raising awareness among Vietnamese women on human rights, equality, domestic violence and how to get help		Two workshops will be run to raise awareness of family violence, how to identify, where to refer and get support. Articles will also be written for Vietnamese Newspaper and interviews conducted on Vietnamese radio.	Prevention & early intervention
VIC	Living in Harmony	North Yarra Community Health	Community Health Centre	Six largest cultural communities living on the Collingwood Public Housing Estate (Vietnamese, Somali, South Sudanese, Ethiopian, Chinese, Eritrean)	Reduce the prevalence of family violence amongst diverse communities of the Collingwood Housing Estate.		Recruit 16 community representatives. Develop and implement a 12-month leadership training program including a 5-week primary prevention course with DVRCV, four units of a Cert IV in Community Services and a seminar series from primary prevention projects and relevant local services.	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Whittlesea CALD Communities Family Violence Project	Whittlesea Community Connections	Community-based organisation	CALD	The project aims to develop, implement and evaluate an integrated approach to addressing FV in the CALD community of the City of Whittlesea. The model aims to support CALD communities, newly arrived migrants, refugees and asylum seekers to break the cycle of violence and empower communities to confront and respond to the challenge of preventing violence against women.	Integrated model	Empowering women by increasing social participation and access to supports through a multi-year women's support group grant scheme; building the capacity of religious and community leaders to respond to family violence; piloting a whole-of-school respectful relationship program; strengthening early intervention in the settlement processes by addressing settlement stressors that can hinder safe and respectful relationships.	Prevention & early intervention
WA	Multicultural Women's Advocacy Service (MWAS)	Women's Health & Family Services	NGO/ Community organisation	CALD women	Promotes the safety of women, with or without children, from Culturally and Linguistically Diverse (CALD) backgrounds. The service is available to women who are recent arrivals or long-term residents. Women may be in crisis situations, in refuges, still remaining in their relationships or re-establishing themselves in the community after leaving refuges.		Discussing available options; Applying for a restraining order; Obtaining support and advices from Legal Aid; referrals to other agencies (including counselling services); Outreach services	Response

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Penrith Women's Health Centre		Health Centre	CALD women & lesbian women	Increase women's knowledge and skills regarding their own health/wellbeing/safety and equip women for ongoing healthy lifestyle choices. Increase women's awareness and use of services and resources within the community that supports their own health/wellbeing/safety and/or the health/wellbeing/safety of those close to them. Ensure that violence issues for women and children are addressed as core business.		Counselling, Education, support groups i.e. Healthy Relationships, Confidence and Assertiveness, Specialist DV Groups, Community Awareness Talks and Safety Plans, Audits and equipment i.e. CCTV, Sensor lights, etc.	Early intervention & prevention
VIC	Week Without Violence Clothesline Project	Whittlesea Family Violence Network/Plenty Valley Community Health	NGO, community organisation, health service	CALD women, ATSI, women with disabilities, young women	To raise awareness of the extent of family violence and the services that are available for women and men in City of Whittlesea		Clothesline Project t-shirt painting workshops, with corresponding educational components and displays of t-shirts and family violence resources in various locations around municipality.	Prevention
VIC	Counselling and Casework	North Richmond Community Health Ltd	Health Service	Existing and emerging CALD communities	To provide counselling and assistance to women experiencing family violence		Group work, which looks at identifying healthy and unhealthy relationships. Promotion to general community of White Ribbon, Week without Violence, etc. Also run two groups a year with interpreters. Produced a book of poetry that is distributed and tells women's stories.	Prevention & early intervention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Samaritan Accom-modation	The Salvation Army	NGO, charity	CALD	To support people who experience human trafficking, slavery and slavery-like conditions in Australia. This includes women subjected to servitude in marriage (slave-like marriage), servile marriage, women fleeing forced marriage, women and young women at risk of forced marriage. Most of these situations present as domestic violence and include physical, psychological, emotional and financial abuse.		Residential & Non-residential case management, Prevention case management, International support/migration advice and assistance	Response

Table 4: Services for women with disabilities and mental ill-health

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Intensive case management program	Women's Health West (WHW)	Women's heath service	General service population is women living, working or studying in the western region. Program target population is women with disability in the region.	Increase access to family violence services in the region for women with disabilities.	Improve access by working with disability services providing direct and indirect services and though intensive case management.	Redevelopment of WHW intake and assessment process for women with disabilities; training for disability and family violence workers; case discussion group for disability and family violence workers; secondary consultations for disability workers who had family violence related concerns for the clients; intensive case management of 10 women who had experienced significant family violence from an intimate partner.	Prevention/early intervention/ response
VIC	Out of Sight and Out of Mind: Connecting Family Violence and Disability Services in Cardinia and Casey	Cardinia Casey Community Health Service	Community health service	General service population is people living, working or studying in the Cardinia Casey region. Program target population is women with disability in the region.	Improve service provision and integration for women with physical and intellectual disabilities experiencing family violence in the Shire of Cardinia and the City of Casey.	Improved access through better service integration.	Primary prevention/early intervention activities were meetings and other awareness raising activities (such as workshops, media and promotions activities with disability and family violence services to raise awareness of service provision issues and barriers)	Prevention/early intervention

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
National	Resource Manual on Violence Against Women with Disabilities	Women with Disabilities Australia	Peak body	Wide target population: targeted information for disabled women, information for students, policy makers, service providers, academics and researchers.	Overall aim of project is to prevent violence against women with disabilities by developing and promoting accessible information resources and to educate women with disabilities about domestic violence. Specific project aims to research, develop and produce a resource manual that reflects the identified information needs of women with disabilities.	Improved access to information.	Development of a resource manual for DFV services to assist in responding to the needs of women in rural and remote areas.	Prevention/early intervention
VIC	Triple Disadvantage: Out of Sight, Out of Mind Violence Against Women with Disabilities Project	Domestic Violence and Incest Resource Centre	Community organisation	Target population: disability and domestic violence workers within services located in identified region.	Improve access to inclusive support by creating partnerships between disability services and services for women experiencing domestic violence.	Improved access through better service integration.	Project funded the cost of a project worker who undertook a variety of activities to build partnerships between disability and domestic violence services in the region. Activities included consultations, training for disability and domestic violence workers and a community forum.	Prevention/early intervention
VIC	Building Partnerships Between Mental Health, Family Violence and Sexual Assault Services	Mental Health Branch, Department of Human Services	Government	Target population: mental health, sexual assault and domestic violence workers	Improve outcomes for women with a mental illness who have experienced domestic violence and/or sexual assault by facilitating improved relationships and collaboration between services, improved service pathways and referrals between services and improved outcomes for female consumers of mental health services.	Improved access through better service integration.	The project funded the cost of a project worker who undertook a variety of activities, including: Two statewide forums of family violence, sexual assault and disability workers, consultation process of workers from each of the three focus sectors, literature review.	Prevention/early intervention

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Looking After Me Project	Penrith Women's Health Centre	Community health service	Women with intellectual disability in the Penrith Local Government area	Promote safe and healthy relationships by improving the self-esteem of women with an intellectual disability, their knowledge of healthy relationships and capacity to respond to domestic violence; by providing support for women with intellectual disability experiencing domestic violence; to raise awareness in mainstream and disability services that women with intellectual disability experience domestic violence in high numbers; to raise the profile of women and girls with intellectual disability in the wider community.	Prevention of violence through awareness about and promotion of what represents a safe and healthy relationship.	The project funded the cost of a project worker who understood a variety of activities, including: an 8-week program for women with intellectual disability covering building self-esteem, understanding feelings, relationships in life, healthy relationships, domestic violence and what to do if there is violence, building relationships with other groups in the community (CALD and ATSI in particular), developing partnerships and training with community workers in the region, developing a schools program for teachers.	Prevention/early intervention
NSW	Joan Harrison Support Services for Women—domestic violence and mental health worker pilot project	Joan Harrison Support Services for Women	Crisis accommodation service	Women with mental health issues who experience domestic violence	Provide support, information and referrals for women with mental health issues who experience domestic violence. Improve collaboration between services.	Women with mental health needs who experience domestic violence often "fall between the cracks". Service sought to connect with women who were accessing inpatient mental health or other services and provide support and assistance when they left the service.	The project funded the cost of a mental health worker who would make contact with women in inpatient mental health services or community mental health services and, if they decided to leave their abusive relationship, work with them directly when they left those services. The mental health worker also built relationships with mental health services.	Early intervention and response

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Disability and Family Violence Crisis Response	Safe Futures Foundation	Crisis support	Women and children with disabilities who experience domestic violence	Provide disabled women and children with immediate funding for disability related goods and services when they are experiencing family violence.	Provide immediate funds to enable women and children experiencing domestic violence to leave violence and meet their particular needs.	The project provides up to $9000 per person over three months to meet the cost of disability related goods and services.	Response, with prevention elements
VIC	Bsafe Pilot Project	Women's Health Goulburn North East, in partnership with Victoria Police	Community health service	Women escaping family violence and sexual assault who have a current protection order that excludes the perpetrator from the premises and is at risk of the order being breached.	The program aims to improve women's safety and support them to stay safe in their own homes. The program also aims to strengthen relationships between services in the community.	Prevention by increasing safety and autonomy and supporting women to stay in their own homes.	The program provides eligible recipients with an emergency safety kit, which consists of a personal alarm that operates through a home or mobile telephone line and risk management framework for people escaping violence who wish to remain in their home. If the alarm is activated and an alert is sent to a 24-hour response centre and 000 for a police response. The alert call is monitored and recorded and can be used as evidence in court proceedings if required.	Prevention/early intervention

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Staying Home Leaving Violence	Service is provided through eighteen Staying Home Leaving Violence services throughout the state. Sixteen are provided by non-government agencies funded by Community Services while two are auspice by Housing and NSW Police.	Government program	The Staying Home Leaving Violence program is targeted at women aged over 18 years (and their children), who have separated from a violent partner or family member and choose to remain in their own home, or in another home of their choice. The program gives priority to groups and communities where domestic violence is more prevalent or where people may find it harder to access support.	The program aims to improve women's safety and support them to stay safe in their own homes. The program also aims to strengthen relationships between services in the community.	Prevention by increasing safety and autonomy and supporting women to stay in their own homes.	Caseworkers assist clients with their choice to separate from a violent partner and safely stay in their own home by: conducting comprehensive risk assessments and safety audits; upgrading security in the home (through the use of brokerage funding); developing personalised safety plans; working with the police and local courts to remove the offender; providing court support and advocacy in applying for Apprehended Violence Orders and at family court proceedings; providing case work to address financial and tenancy issues, and counselling support and providing referrals to legal advice and other support services.	Prevention/early intervention
VIC	Making Rights a Reality	South Eastern Centre Against Sexual Assault (SECASA), in partnership with Springvale Monash Community Legal Centre and the Federation of Community Legal Services	Community service	Women with cognitive impairment who experience sexual violence	The program seeks to build on existing infrastructure and skills of agencies who work with the target group, provide ongoing support and advocacy to encourage reporting, provide support to access compensation, provide assistance with communication when required.	Improved access through better service integration	The program provides assistance to a victim when they make a report and throughout any court proceedings. A worker will act as an Independent Third Person when a report is being made, there is brokerage money for someone to sit with the victim for the duration of court proceedings and lawyers are available to provide support throughout the process.	Response, with prevention elements.

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
National	Strengthening Human Rights in Disability Services—Tools and Resources	National Disability Services	Peak body for disability service providers	Disability service workers and service providers	To increase the focus on human rights in disability services	Prevention through an increased awareness of human rights	The following human rights tools and resources are available to support organisations: Online human rights training program for disability support workers; Human rights competency tool; Human rights forums; Online video advice for boards of disability service providers; Zero tolerance to abuse project; and other human rights resources.	Prevention
National	Zero Tolerance: Preventing and responding to abuse & neglect of people in funded disability services	National Disability Services (NDS)	Peak body for disability service providers	All non-government disability service organisations who have contact with people with disability. Particular focus will be placed on environments that expose people with disability to potentially increased levels of risk of abuse	Zero Tolerance will develop a practical framework with resources for disability services providers, based on prevention, early intervention and remediation in cases of abuse and neglect of people with disability.	Prevention through an increased awareness of the experience of abuse of people with disability.	NDS is seeking input to the Zero Tolerance project via a series of consultation forums, to be held in each State and Territory in October and November. The forums will provide disability service providers and other relevant professionals with an opportunity to raise and discuss service and systemic issues related to abuse and neglect of people with disability in funded services. Other opportunities for participation will also be explored. The project is also informed by a reference group, formed from an expression of interest process in August 2013. The group brings together professionals from across Australia with contemporary expertise about abuse and neglect of people with disability, as well as professionals interested in improving service cultures and responses to abuse.	Prevention

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
NSW	Domestic Violence and Intellectual Disability training program	People with Disability Australia	Peak body	The program is targeted at women with intellectual disability and designed for two groups of participants. One group is women with intellectual disability, and the other is service providers and professionals whose work relates to the target group, including: Legal centres, DVLO from local police stations, advocacy services, domestic violence service providers, women's refuges, Australian Disability Employment Offices	This is a primary prevention program taking a broad approach, and seeks to address both service providers and women with intellectual disability to ensure coherence in supporting women in their personal lives.	Prevention of violence through the development of relationship skills.	Three-day training program run in three key regions around NSW.	Prevention
VIC	Living Safer Sexual Lives: Respectful Relationships	Australian Research Centre in Sex, Health and Society (Latrobe University)	Research organisation	The project targeted women with intellectual disability.	This project used action research to investigate the effectiveness of respectful relationships education for people with an intellectual disability and to understand the impact of peer education in respectful relationships programs for people with an intellectual disability.	Building the evidence based about prevention of violence through the development of relationship skills.	A peer led violence and abuse prevention program addressing violence against women with an intellectual disability. The program operated in three sites in Victoria and two in Tasmania to develop a peer education program and to facilitate local disability and violence and abuse prevention organisations to implement these programs locally.	Prevention

State	Name of service/project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
VIC	Integrated Family Services	South West Integrated Family Services	Community organisation	The project targeted women with intellectual disabilities.			Support those with an intellectual disability to gain skills, resources and access to services in the community to support them in their parenting role. Guest speakers from local organisations providing information to the families	Early intervention
VIC	Gender and Disability Professional Development Package	Women with Disabilities Victoria	NGO or charity	Women with disabilities	The objective of the program is to develop and deliver a training package aimed at improving the quality of gender sensitive practice amongst disability workers. The ultimate objective is that all services are competent to provide appropriate and gender sensitive services for both women and men with disabilities.		Workforce development in creating safe disability service environments	Sector development
QLD	WWILD-Sexual Violence Prevention Association		NGO or charity	Women with disabilities & men with intellectual disabilities who have been victims of crime	To provide counselling and case management support to people who have experienced criminal victimisation or exploitation including domestic and family violence		Community education for people with disabilities around topics od Domestic and family violence	Response

Table 5: Services for people who identify as GLBTIQ

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Federal and all States and Territories (except Northern Territory)	Gay and Lesbian Liaison Officers	Australian Federal Police and police services in all States and Territories (except Northern Territory)	Government	GLBTIQ people	Although it varies from state to state, in general the role of the liaison officer is to contribute to the creation of mutual trust between police, lesbians, gay men, bisexuals, transgender and intersex persons so they have increasing confidence in police through the provision of fair and equitable policing service. Liaison officers usually have an educative and monitoring function—particularly in relation to reported homophobic and transphobic crime and violence in same-sex relationships.	Prevention and improved access to services by raising awareness	The liaison officer undertakes a variety of activities concerned with education and advice in each State and Territory. Liaison officers also usually work with community groups, government and non-government agencies to assist in the development of appropriate programs for GLBTI people. Work within the gay community occurs through a number of avenues, these include attendance at community events, presentations to social and support groups and through regular contact with GLBTI community media.	Prevention/early intervention/response
NSW	LGBTI Domestic and Family Violence Project and Another Closet LGBTI domestic violence website	Aids Council of NSW (ACON)	Non-government organisation/health promotion	GLBTIQ people	The project aims to improve the outcomes for victims and to address the underlying causes of violence. The project also aims to educate the LGBTI community about domestic and family violence and work with mainstream services to improve their knowledge of and response to LGBTI DFV.	Prevention and improved access to services by raising awareness	The program supports GLBTI people in the communities who have experienced DFV through a variety of interventions, including counselling services. The project works with and trains a variety of services including the NSW Police Force, other government agencies, and mainstream and GLBTI community organisations. The project also undertakes campaigns and programs promoting community safety, engaging communities and responding to community needs.	Prevention/early intervention
NSW	Safe Relationships Project	Inner City Legal Centre	Community legal service	GLBTIQ people	The aim of the Safe Relationships Project (SRP) is to provide GLBTI people who are experiencing domestic violence with support,		The Safe Relationships Project can assist clients in accessing legal representation and to apply for Apprehended Domestic Violence Orders (ADVO) or Apprehended	Early intervention and response, with elements of prevention.

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
					advocacy, referral and information.		Personal Violence Orders (APVO). The Project Officer can also provide information about other services (e.g. housing, income security, counselling, ongoing support), which assist victims of domestic violence, and advice on how to deal with these problems.	
QLD	LGBTI Legal Service	LGBTI Legal Service Inc.	Community legal service	GLBTIQ people	The Service seeks to assist the Queensland LGBTI community to gain access to justice through the provision of legal and social welfare services. The Service also provides community legal education and resources in order to increase awareness of legal rights and responsibilities for the LGBTI community in Queensland.		The Service offers evening advice sessions for clients who have legal problems which arise from their identification as LGBTI and/or because they feel more comfortable in dealing with a solicitor with specific skills, interest and understanding of LGBTI legal issues and/or the barriers experienced by LGBTI peoples in accessing the legal system.	Early intervention and response, with elements of prevention.
VIC	How2 Program	Gay and Lesbian Health Victoria	Health and wellbeing policy and resource unit	Health and human services in Victoria	The program promotes the development of LGBTI inclusive health and human services.	Improved access and service delivery through more inclusive practice	The program consists of four workshops run over six months and assists participants implement LGBTI inclusive practices, protocols and procedures within their organisation.	Community readiness
WA	Same Sex Domestic Abuse Group (SSDAG)	SSDAG operates in partnerships with Communicare	Community organisation	Same sex attracted men and women	SSDAG works to inform and educate the community and support service providers and raise awareness of domestic violence and related issues.		Primary resource is a website with information about DFV and referral information to GLBTI-friendly support services in WA.	Prevention
NSW	Transgender Anti-Violence Project	The Gender Centre Inc.	Non-government organisation	Transgender and gender-diverse people	The project has several objectives in relation to transgender and gender-diverse people, including: increased reporting, support and referrals; awareness raising, support increased capacity of police and support services; provide an		The project funds support workers who can provide the following types of assistance to those experiencing anti-transgender violence includes counselling, assistance and support when reporting the violence, follow-up support, advocacy, assistance in	Prevention and response

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
					improved relationship between the transgender and gender-diverse communities, the NSW Police Force and the criminal justice system; and to increase awareness in the general community about violence against the transgender and gender-diverse communities.		organising legal support, support if appearing in court, appropriate medical support and referrals to any other service necessary.	
NSW	Speak out Against Relationship Abuse (SOAR)	Wimlah Women & Childrens Refuge and Outreach Service	Non-government organisation	Same sex attracted men and women	The SOAR initiative seeks to raise awareness in the community about same sex domestic violence.		Project activities include convening an interagency of community organisations and stakeholders, organising special events and participating in gay and lesbian festivals such as Gay Pride Picnic and Mardi Gras. Wimlah also has a same-sex domestic violence worker.	Prevention

Table 6: Services for young women

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/ program activities	Prevention/ early intervention/ response
VIC	Choices and Young women's Refuge	Anglicare	Charity	Disadvantaged young mothers <25	Aims to empower young pregnant women or young women with children by linking them with services and networks, providing social support. Young women's refuge for women under 25.	Prevention through empowering disadvantaged young women	Social support ,e.g. linking clients with services and agencies such as Centrelink, MCHNs, welfare services ; home visits, counselling, play groups and intensive parenting courses.	Prevention , early intervention
VIC	Respect, Protect, Connect Program for young women	SECASA House	Sexual assault service	Years 7–10 girls	The program runs parallel to a boys program and takes a rights-based approach aiming to provide young women with a framework for identifying violence and become pro-active in gaining support for themselves and others.	Whole of school, socio-ecological, peer education bystander approach	Using peer educators (aged 18–25) the program is run over 12 weeks for Years 7–10 (separate girls and boys programs) or can be a one-off session.	Prevention
VIC	Real Life	Women's Health Goulburn and North East	Women's Health Service	Years 8–10 girls and boys, young people aged 18–25	Primary prevention of DFV through school and community-based healthy relationship education and exploration of gender norms and gender equality	socio-ecological, community education	Respectful relationship education facilitated by trained educators and/or teachers over 4 weeks. The four sessions involve interactive workshops, class discussion and information provision regarding types of violence, support, ideas about gender and power	Prevention
VIC	SEA Change	Mallee Domestic Violence Service	DFV Service	14–17 year old girls	To empower and foster confidence and assertiveness in young women	Empowerment model	Weekly group sessions over an 8-week period. The program encourages participants to acknowledge their strengths, develop and refine assertiveness skills, improve their confidence and self-esteem. It also provides information on goal setting, turning problems into challenges, how to say no and dealing with conflict.	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/ program activities	Prevention/ early intervention/ response
VIC	Healthy Relationship Education	Gipplsand Women's Health Service (GWHS)	Women's Health Service	Secondary school students	To deliver DFV prevention and healthy relationships education to Gippsland Secondary School students and foster respectful school communities free of violence and increase knowledge about DFV and sexual assault	Whole of school, socio-ecological	Unlike other HRE programs, Gippsland HRE includes a school readiness tool and tailors a program specific to individual schools. Schools contribute to the program according to their own needs. GWHS provides student programs, staff development, resources and materials, with the aim of producing a self -sustaining school culture of respect, non-violence and discrimination.	Prevention
VIC	Y's Girls	Geelong YWCA	Not for Profit/ NGO	11–14 year old girls	Build confidence, assertiveness and self-esteem, positive peer relationships	Empowerment model	8-week program delivered in schools, can be delivered by teachers or trained facilitators from YWCA	Prevention
VIC	Fly Girl	YWCA	Not for Profit/ NGO	Secondary school girls	FlyGirl is a primary prevention program for girls and young women combining education based activities and circus training focusing on developing positive self-esteem, confidence and resilience.	Empowerment model	Can be delivered in schools or community settings, the program uses interactive circus activities and education re healthy body image, respectful relationships and DFV, sexual assault awareness.	Prevention
VIC	Youth Advocates against Family Violence	Inner Melbourne Com-munity Legal and Doutta Galla Com-munity Health	Legal Service, Com-munity Health service	Secondary school students (mostly CALD backgrounds in Melbourne's inner North-West)	The program sought to address the issue of DFV in the inner North-West CALD communities through engaging young people as 'potential gatekeepers of information about DFV for their families, peers, and communities. Based on knowledge the children are often used as interpreters. Project sought to equip young people skills and knowledge to share info with family	Community capacity building?	Project delivered with support of local schools, by a lawyer and youth worker. Focused on gender context of DFV, nature and extent of DFV, overview of Vic law and response to DFV, respectful relationships and positive communication skills, safe responding and help seeking to DFV.	Prevention
VIC	Asista Mentor-ing Program	YWCA	Not for Profit/ NGO	Young women aged 12–18 with involvement with DHS or Child Protection	To provide support, new opportunities, development and mentoring to at risk young women	Mentoring	Mentors are matched with young women and offer support and guidance through weekly recreational activities	Early intervention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/ program activities	Prevention/ early intervention/ response
National	HeadSpace	HeadSpace	Not for Profit/ NGO-mental health	Young people	Mainly provides info and support relating to mental health issues, family , sex and relationships, bullying , drugs and alcohol, however also delivers Healthy Relationship programs in community spaces across Australia			
National	The Line	Australian Government		Young people	Interactive website aims at providing information, support on healthy relationships, identifying unhealthy or abusive behaviour and 'where to draw the line'.		Covers a range of relationship types - family, peers, school, intimate relationships Also examines bullying and online bullying. Offers stories, interactive activities/quizzes, forums, factsheets, support phone line and web support.	Prevention
National	Love: The good, the bad and the ugly	Domestic Violence Resource Centre Victoria (DVRCV)	Not for Profit/ NGO	young people <25	To help young people make decisions about relationships and to identify healthy and unhealthy relationships and behaviours, abuse	Prevention, early intervention through awareness	The website includes stories, factsheets, articles, advice, links to support services	Prevention, early intervention
National	LoveBites	NAPCAN	Not for Profit/ NGO	Secondary school students	Primary prevention of DFV and sexual assault through the delivery of Respectful Relationship education to school students	Whole of school, socio-ecological	An integrated partnership approach to prevention and generates local ownership of the program. Local service providers facilitate the Love Bites program. Professionals such as sexual assault workers, domestic violence workers, youth workers and police can facilitate the program. The Love Bites manual and two day training provides everything you need to start up LOVE BITES in your local schools. It consists of two interactive education workshops on Domestic and Family Violence and Sexual Assault followed by creative workshops that consolidate the information from the morning.	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/ program activities	Prevention/ early intervention/ response
National	Reach Out	Inspire Foundation	Not for Profit/ NGO	young people <25	To provide information ,online support, forums for young people on a range of mental health issues, bullying, family violence, dating violence, alcohol and drug info, sex and relationships advice and info		Online website provides fact sheets, videos, articles, guides, apps , peer support, forums on range of issues.	Prevention, early intervention
SA	Sexual Health and Relation-ships Edu-cation (SHARE) now called Focus Schools	Shine SA	Sexual Health agency/ partner-ship with SA govt	Years 8, 9, 10 school students	To improve the sexual health safety and well being of young South Australians	Whole of school approach, Sex and relationship education	Sex education that includes education on healthy relationships and violence. Strong focus on gender equality. The program includes a staff personal development component	Prevention
NSW	BUMP	Raise Youth Mentoring Foundation	Not for Profit/ NGO	Pregnant Young women aged 13_23	Build confidence, self-esteem and assertiveness. Provide parenting info and meet new friends	Mentoring, empowerment model	At completion of program, women receive a TAFE certificate enabling them to become mentors	
NSW	Y-Ise Up Safe Relation-ships	YWCA NSW	Not for Profit/ NGO	High School students	Y-ise Up Safe Relationships is about promoting healthy relationships and providing high school students with effective communication strategies, which assist them to achieve safe and positive support networks.	Whole of school, socio-ecological	Y-ise Up workshops specifically address the issues that young people face throughout their formative years and equips them with understanding that will enable them to make informed decisions about present and future relationships. Workshops are tailored according to age group and school needs.	Prevention
NSW	Young Parent's Program	Red Cross	Not for Profit/ NGO	Young parents <25 (mostly mothers)	Aims to develop the skills, confidence, of young parents and empower them to manage daily challenges, overcome difficulties/challenges/trauma/violence, etc.		Residential service, outreach and after-service program, case management. Offers playgroups, parenting workshops, referrals to other agencies.	Early intervention
NSW	Young Women's Mentor-ing Program	The Women's Cottage	Com-munity Health Service	12_16 year old girls	The program trains 17–25 year old young women to mentor young girls aged 12–16 years on healthy relationship issues. Mentoring occurs through workshops, an annual camp, newsletters and producing DVDs on issues relevant to young women.		Workshops focus on raising girls' self esteem and giving girls an opportunity to work and have fun together. The emphasis on healthy relationships with self is based on the understanding that the way we treat and think about ourselves impacts on how we relate to others and what we will accept and not accept from others in relationships	Prevention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/ program activities	Prevention/ early intervention/ response
NSW	Girls can do Anything	Nepean Community and Neighbour-hood Services	Com-munity Service NGO	Secondary School girls	The program aims to build self-image, self-esteem, relationships and communication skills.	Empowerment model	Schools-based program that can be tailored to modules that meet school/student needs –such as healthy peer relationships, bullying or body image. Optional modules available are self defence training, anti bullying skills, drug and alcohol awareness, body image, healthy lifestyle choices, stress management and motivation.	Prevention
NSW	Kinks and Bends	Northern Sydney Central Coast Health, Violence, Abuse & Neglect Services	Health Service	14–17 year olds	To provide information on sexual violence, dating violence and healthy relationships in school or other youth-based settings		A resource for educating on dating violence and healthy relationships. Not delivered by the service, program designed for teachers and youth workers to deliver	Prevention
QLD	Young Mothers for Young Women	Micah Projects Inc.	Not for Profit/ NGO	Young mothers <25	Support young mothers		In addition to housing support, education support and advice, parenting groups, linking to social services and other agencies, Micah also facilitates peer education sessions for young mothers on healthy relationships, communication and parenting	Prevention, early intervention
QLD	ZigZag Young Women's Resource Centre	ZigZag Young Women's Resource Centre	Not for Profit/ NGO	Young women <25	TO support and assist young women at risk of homelessness and/or who have experienced violence or sexual abuse	Feminist advocacy model	Supported accommodation, counselling, information and support /referral	
WA, NSW, VIC	Deadly Sister Girlz	Wirrapanda Foundation	Not for Profit/ NGO, Aboriginal Org.	Young Aboriginal girls & women aged 8–17 years	The purpose of the Deadly Sista Girlz Program is to use our female role models to empower and enable young Aboriginal and Torres Strait Islander girls to make informed decisions about their personal health and wellbeing to lead a positive and healthy lifestyle.	Mentoring, empowerment model	Participants learn self-esteem, confidence, financial literacy, healthy relationships, sexual health, nutrition. Classes are run by young Aboriginal mentors.	

Table 7: Services for women from regional, rural and remote communities

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
VIC	Act@work: Preventing violence against women and children	Women's Health Grampians, City of Ballarat, WRISC and CAFS		RRR workplaces and employees	To address the attitudes and behaviours that support violence		Will work with 4 workplaces over 3 years to promote gender equality and nonviolence. Focuses on the role that bystanders can play in changing attitudes about and behaviours towards women.	Prevention
National	Stopping Violence Against Women Before It Happens: A practical toolkit for communities	National Rural Women's Coalition	Peak body	RRR women and services delivering programs to women in RRR areas.	To provide a practical toolkit that meets the needs of rural and regional communities and provides advice, practical resources and ideas for community-led action in relation to domestic violence prevention.		The toolkit, available online, includes activities, discussion questions and case studies that can be used by small groups to further explore issues concerning domestic violence.	Prevention
VIC	Family Violence Prevention Networks	Loddon Mallee Specialist Services Network, a formal collaboration between EASE, Mallee Domestic Violence Services, Loddon Campaspe Centre Against Sexual Assault and Mallee Sexual Assault Unit	Collaboration of community services	Service providers within the region and members of the local community	The Network aims to reduce the incidence of domestic violence by raising community awareness, monitoring prevalence trends, raising knowledge and skills of service providers, informing the community about available support services, identifying gaps in services and monitoring the effectiveness of legislation and enforcement mechanisms.		The Network undertakes a range of activities within the region including training for professionals, training for community organisations and coordination of various community activities.	Prevention
TAS	Partnerships Against Domestic Violence: Training Model for Rural Health Professionals	Department of Rural Health, University of Tasmania	Research body	Rural health professionals	The aim of the project was to develop a best practice model for delivering information and education to rural health professionals about domestic violence.		The project includes a number of education activities, for example, workshops for School of Nursing students, and desk resources for GPs and other health professionals.	Prevention/ early intervention

State	Name of service/ project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
VIC	Preventing Violence against Women & Children (PVAW&C) Strategy	Women's Health Goulburn North East	NGO, health service		Vision = "Hume region women and their children live free from violence in safe communities". A major aim of the PVAW&C Strategy, is to build the capacity of stakeholders to understand and implement effective primary prevention of violence against women (VAW) through increased knowledge of the determinants of Violence against Women and increased knowledge of primary prevention and evidenced-based practice in PVAW		A whole-of-community approach, which fundamentally addresses the determinants of VAW in key settings across the community. We aim to increase equity within these key settings and reduce the reinforcement gender stereotypes embedded across the community. Organisations will implement policies and practices that promote equity and respectful relationships between men and women.	

Appendix 2: Roundtable participants

A.   Sydney Roundtable Consultation Attendees

National

Human Rights and Equal Opportunity Commission, Children's Commissioner

Human Rights and Equal Opportunity Commission

Women with Disabilities Australia

ACT

YWCA Canberra

NSW

Insideout Disability

National Centre of Excellence to Reduce Violence Against Women and Their Children (now known as Australia's National Research Organisation for Women's Safety (ANROWS))

NSW Health Child and Family

Redfern Legal Service

Staying Home Leaving Violence

St George Migrant Resource Centre

WDVCAS, Blue Mountains

Women's Health New South Wales

YWCA NSW

B.   Melbourne Roundtable Consultation Attendees

VIC.

Aboriginal Family Violence Prevention and Legal Service

Researcher, La Trobe University

Bright Futures, Merri Outreach Support Service

Researcher, La Trobe University

Researcher, Youth Research Centre, The University of Melbourne

Commission for Children and Young People Victoria

Violence Free Families

Researcher, Deakin University

Researcher, The University of Melbourne

Researcher, The University of Melbourne

Safe from the Start Program, Salvation Army

Women's Health West

Partners in Prevention

C.   Brisbane Roundtable Consultation Attendees

National

Association of Women Educators

NAPCAN

Women's Legal Service

QLD

ACT for kids

Department of Communities, QLD

Ipswich Women's Centre Against Domestic Violence

Talera BCS

D. Phone consultations/interviews

NSW

Domestic Violence NSW (DV NSW)

Education Centre Against Violence, Sydney West Area Health Service

ACON

Far West Community Legal Service

VIC.

Berry Street

InTouch Multicultural Centre Against Violence

QLD

Phoenix House

Appendix 3: Request for information

Australian Government
Australian Institute of Family Studies

Domestic and Family Violence Prevention Review and evaluation: Request for information

ABOUT THIS RESEARCH

The Australian Institute of Family Studies is conducting two related research projects, commissioned by Women NSW, on domestic and family violence services. The projects focus on two types of services:

- prevention and early intervention services focusing on at-risk groups and communities; and
- prevention, early intervention and response services focusing on young children affected by domestic and family violence.

A third project – focusing on prevention programs targeted at men and boys - is being conducted by the University of Western Sydney.

This research has been commissioned and funded by Women NSW.

Project 1

The first AIFS project examines prevention and early intervention services that target groups and communities known to be at higher risk of experiencing domestic and family violence, or who face barriers in accessing existing services. These groups include: Aboriginal and Torres Strait Islander women; women with disabilities; women in culturally and linguistically diverse communities; people who are same-sex attracted, intersex, sex or gender diverse; younger women; older women; and women in remote communities.

Project 2

The second AIFS project examines prevention, early intervention and response services that target children aged between 0–8. In addition to examining prevention approaches for this age group, the research aims to identify what services children who are affected by domestic and family violence need, what is being done to support them, what models of service delivery are most effective, and what are the gaps in services.

Working closely with key stakeholders, these projects will examine:

- the role domestic and family violence services play in addressing the needs of at-risk groups and/or children, and the effectiveness of services in addressing those needs;
- the characteristics of good practices and exemplar models in targeting at-risk groups and communities and/or children;
- strategies to build on existing good practice.

This research will contribute to the implementation of the National Plan to Reduce Violence Against Women and their Children by expanding the evidence base on prevention initiatives. It will also inform funding decisions by Women NSW by setting out recommendations for enhanced or new approaches and exemplar projects/models to support implementation in NSW.

ABOUT THIS REQUEST FOR INFORMATION

To assist AIFS in developing a comprehensive understanding of current domestic and family violence practice across a range of services, we are seeking information from service providers and program managers.

For the purpose of this information request, we are taking a broad approach to how we define the various types of domestic and family violence interventions. That is, we are interested in hearing about services and programs that focus only on primary prevention activities, and also from services and programs that undertake work that could be characterised as primary prevention within the context of delivering other services. For further discussion of DFV primary prevention we refer you to Women NSW's discussion paper 'Preventing Domestic and Family Violence'.

If your service offers more than one relevant program, please complete one survey for each program.

YOUR PRIVACY

The participation of individuals in this research is confidential and we will not ask for the name/s of individual practitioners in this information request. However, the information provided in response to this information request **will be** attributed to particular programs or services in reports or publications that arise from this research.

INSTRUCTIONS

This information request will take an average of 30 minutes to complete.

For some questions, you need to select the option or options that correspond to your answer. In most instances, you are asked to type in an answer.

If at any stage you want to take a break from the survey and finish it later, press the Resume later button.

You will be asked to enter and save a name, password and email address for the survey.

After saving these details, you can simply close the window containing the survey.

Do not press the 'Exit and clear survey' button unless you want to delete your answers permanently.

To come back to where you left off after saving your answers:

- use the link that will be emailed to you, or
- press the load unfinished survey button on the first page of the survey and enter the name and password you provided.

QUESTIONS

1. **Please provide the name of the service or program that is the subject of this response.**

Please write your response here:

2. **If applicable, what is the name of the host organisation through which the service or program is delivered?**

Please write your response here:

3. **What is the nature of the host organisation?**

Please choose all that apply:

☐ Non-government organisation or charity
☐ Health service
☐ Community-based organisation
☐ Legal service
☐ Commonwealth government department/organisation
☐ State/Territory government department/organisation
☐ Local government organization
☐ Other: _____

4. **In which state or territory is the service or program located?**

Please choose all that apply:

☐ Australian Capital Territory
☐ New South Wales
☐ Northern Territory
☐ Queensland
☐ South Australia
☐ Tasmania
☐ Victoria
☐ Western Australia

☐National

5. What location does your service or program operate in?

Please choose all that apply:

☐Metropolitan

☐Regional

☐Rural

☐Remote

6. What is the target group for this service or program?

Please choose all that apply:

☐Aboriginal or Torres Strait Islander women

☐Women from culturally and linguistically diverse (CALD) communities

　　　Please specify focus community, if any: _____

☐Women with disabilities

☐GLBTIQ persons

　　　Please specify focus community, if any:_____

☐Women with mental ill-health

☐Young women

☐Older women

☐Women from rural or remote communities

☐Infants and children aged 0–8 years

☐Children and young people aged 8+ years

☐General

☐Other: _____

7. Does your client base generally reflect this target group?

Please choose only one of the following:

　　☐Yes

　　☐No

8. If no, please indicate the demographic characteristics that would apply to the majority of your clients.

Please choose all that apply:

☐Male

☐Female

☐Women from culturally and linguistically diverse (CALD) communities

　　　Please specify focus community, if any: _____

☐Aboriginal or Torres Strait Islander women

☐GLBTIQ persons

　　　Please specify focus community, if any:_____

☐Women with mental ill-health

☐Young women

☐Older women

☐Women with a disability

☐Women from regional, rural and remote communities

☐Infants and children aged 0–8 years

☐Children and young people aged 8+ years

☐General

☐Other: _____

9. Did the program or service keep records about the number of clients who were referred to/accessed the service or program for the 2012–13 period?

Please choose only one of the following:

　　☐Yes, please specify:_____

　　☐No

10. What is the funding arrangement for the service or program?

Please write your response here:

11. How long has the service or program been running?

Please write your response here:

12. What are the primary aims of the service or program?

Please write your response here:

13. Does the program or service undertake any work that could be characterised as primary prevention?

Please choose only one of the following:
☐ Yes
☐ No

14. If yes, please describe the primary prevention work the service undertakes. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

15. **Does the program or service undertake any work that could be characterised as early intervention?** Please choose only one of the following:
☐ Yes
☐ No

16. If yes, please describe the early intervention work the service undertakes. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

17. How are clients usually referred to the service or program?

Please write your response here:

18. Have clients usually already been screened for DFV indicators prior to being referred to/accessing the service or program?

Please choose only one of the following:
☐ Yes
☐ No

19. If clients have already been screened for DFV prior to being referred to the service or program, please describe how this information is shared between services.

Please write your response here:

20. If clients have not already been screened for DFV prior to being referred to/accessing the service or program, does the service or program have a protocol/process for screening for DFV?

Please choose only one of the following:
☐ Yes
☐ No

21. If the service or program does screen for DFV, please describe how the service or program undertakes this screening.

Please write your response here:

22. Does the service or program have a protocol for conducting risk assessments?

Please choose only one of the following:
☐ Yes
☐ No

23. If yes, please describe the process for conducting a risk assessment.

Please write your response here:

24. Please describe what happens when an assessment indicates a presence of risk.

Please write your response here:

25. Have there been any internal or external evaluations conducted of the service or program?

Please choose only one of the following:
☐ Yes
☐ No

26. If yes, please provide details of the evaluation. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

27. Which of the following best describe the model or framework underpinning the service or program.

Please choose all that apply:
☐ Therapeutic
☐ Cognitive behavioral therapy
☐ Feminist
☐ Community engagement
☐ Community education
☐ Early childhood education
☐ Primary school education
☐ Secondary school education
☐ Crisis support and intervention
☐ Advocacy
☐ Human rights framework
☐ Whole of community approach
☐ Parenting skills and education
☐ Child development
☐ Mother/child attachment
☐ Community awareness-raising
☐ Holistic/multi-component response
☐ Public health model

☐ Community capacity building
☐ Child focused/centred
☐ Protective behaviours
☐ Relationship skills
☐ Other: _____

28. What are the three most important characteristics of effective practice in your program type?

Please write your response here:

29. What are the three main challenges or barriers to effective practice in your program type?

Please write your response here:

Concluding comments

30. Are there services your client base needs but your program is currently unable to provide?

Please choose only one of the following:
☐ Yes
☐ No

31. If yes, please provide details:

Please write your response here:

32. Is there anything further you wish to add regarding the service or program?

Please write your response here:

Thank you for taking the time to complete this request for information