First to Know, First to Act*

Assisting universal community service providers to identify and respond appropriately to family violence.

Research Report
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Acknowledgements

The authors and Wesley Mission Victoria would like to wholeheartedly thank the 30 managers and staff of universal community service providers and the eight former clients of services who were interviewed for this research. Without their support for the project and their honesty and frankness in answering the interview questions, our important findings regarding how universal community service providers currently identify and respond to family violence would not have been possible.

We would also like to thank the Lord Mayor’s Charitable Foundation for funding this project and our sincere gratitude goes to steering group participants:

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*First to Know, First to Act* is a name developed by Safe Futures Foundation. Its use in this report has been authorised to reflect the shared strategic vision of Safe Futures Foundation and Wesley Mission Victoria to create a holistic and integrated response to family violence.
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Glossary

The definition of **domestic violence** contained in the *National plan to reduce violence against women and their children* (the National Plan) is:

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**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.

(Council of Australian Governments (COAG), 2010, p. 2)

The National Plan also contains a definition of **family violence**:

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**Family violence** is a broader term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for domestic violence. As with domestic violence, the National Plan recognises that although only some aspects of family violence are criminal offences, any behaviour which causes the victim to live in fear is unacceptable. 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 2010, p. 2).

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**Opening-Doors Service Homelessness Entry Points or Opening Doors** provide an initial and immediate response for people homeless or at risk of homelessness. Homelessness Entry Points are providers of housing and homelessness information for people, i.e.: information about how to find private rental or sustain the current tenancy, information about alternative options, information about Public and social housing applications. Homelessness Entry Points are the referral points into funded homelessness services such as youth refuge, outreach support and transitional housing options. Entry points have some limited capacity to fund short-term crisis accommodation. They can also assist people to access the Housing Establishment Fund from the Victorian DHSS to assist with rent in advance or rent arrears for longer term options such as private rental options and rooming houses.

**Specialist homelessness services (SHS)** – Australian Governments fund a range of services to support people who are homeless or at risk of homelessness. These services are delivered by non-government organisations including agencies specialising in delivering services to specific target groups (such as people escaping domestic violence), as well as those that provide more generic services to people facing housing crises. These services support both those who have become homeless and those who are at imminent risk of homelessness.

**Universal community services** – mainstream service systems that are available to all community members.
Acronyms and abbreviations

**ABS**
Australian Bureau of Statistics

**CALD**
culturally and linguistically diverse

**CRAF**
The Common Risk Assessment Framework

**DAIP**
Domestic Abuse Intervention Programs

**DASH**
Domestic Abuse, Stalking and Harassment and Honour Based Violence assessment tool

**ECAV**
Education Centre Against Violence

**FRC and FRAL**
Family Relationship Centres and Family Relationship Advice Line Practice Framework for Screening and Assessment

**FVIO**
family violence intervention order

**HITS**
Hurt, Insult, Threaten, Scream (screening tool)

**IAP**
Initial Assessment and Planning

**ICPS**
Integrated Child Protection Scheme

**IVAWS**
International violence against women survey

**RAMP**
risk assessment and management panels

**RCFV**
Royal Commission into Family Violence

**WAST**
Woman Abuse Screening Tool
Executive summary

This research project explored the best ways for community service providers to identify and respond to women and children who are homeless or at risk of homelessness as a result of family violence, but who do not specifically identify themselves as such to service providers.

Many women present at homelessness crisis agencies citing relationship breakdown or financial difficulty, rather than family violence specifically, as a primary cause of their need for support. There is an urgent need to integrate family violence identification and support into crisis and universal service practice frameworks. ‘First to know’ service providers need to better understand the relationship between exposure to family violence and effects on women’s and children’s housing status and their physical, mental, social, emotional and financial wellbeing. Where services fail to initially identify those experiencing family violence, the assessments of client risk and planning for client safety can be inadequate. Clients may not receive the information they need on their legal rights and safe housing options, or be offered the early intervention, support and recovery options that are available.

This research project has been funded by the Lord Mayor’s Charitable Foundation and is a collaboration between Wesley Mission Victoria (Wesley) and Swinburne University of Technology. In 2014, Wesley provided homelessness and crisis support to over 980 women aged 26 to 65, and to over 300 accompanying children. Given the reported prevalence of family violence, it is likely that a large proportion of these were experiencing or had experienced family violence.

The overall project objectives are:

- to understand how community service providers with non-family violence specific services can most effectively identify women and children experiencing family violence, in order to inform appropriate service delivery and support
- to inform the community service sector on program design and practice for ‘first to know’ services, providing effective early intervention responses to women and children seeking support as a result of family violence.

The research on which this report is based aimed to answer two questions:

- How and to what extent are universal community service providers screening for family violence?
- Where screening tools are used, are they helpful to clients?

This report presents the findings from:

- a review of the relevant literature regarding family violence and screening for family violence
- individual, in-depth interviews with 30 professional staff and managers working at community service providers in the eastern suburbs of Melbourne
- individual, in-depth interviews with eight female former service clients who have had experiences of family violence.

We have revealed that screening for family violence is patchy, ad hoc and does not always meet clients’ needs. This is important because the Victorian Royal Commission into Family Violence (RCFV) has found that:

Universal service systems that are available to all community members are ideally placed to have a much greater role in identifying and effectively responding to family violence at the earliest possible stage ... Improvements need to be made in order for universal organisations to be able to take a greater role in identifying and responding to family violence.

(State of Victoria 2016)
Our recommendations, to Wesley and more generally, to enable this to happen are included below.

In the next stages of the project, Wesley will use the findings in this report to:

- develop a Wesley practice framework that includes a screening tool and practice toolkit
- develop policy and practice guidelines
- implement the practice framework across Wesley’s crisis services
- share the findings and new knowledge with other community service providers
- establish benchmarks for identifying and responding to incidences of family violence.

**Recommendations to Wesley**

Display a poster in waiting rooms and provide a leaflet for clients to help them self-identify family violence. These should include an explanation of what constitutes family violence. Staff should further enable clients to recognise whether they are living in a situation of family violence.

Develop a new practice framework regarding family violence, incorporating use of the amended CRAF to identify family violence.

Following the recommendations of the RCFV, Wesley should commit to practices in line with the amended CRAF and to using CRAF. Staff should be trained in how to identify family violence.

All Wesley homelessness staff should be trained to respond appropriately to clients experiencing family violence, and to undertake risk assessments and safety planning where necessary.

All female clients of Wesley should be screened for family violence experiences using direct questions where it is safe to do so.

Staff should refer clients to specialist family violence service providers when appropriate.

**General recommendations**

Service standards and funding agreements for universal services should incorporate family violence screening conditions. There needs to be a requirement for universal community service organisations to use CRAF for family violence screening purposes and for their staff to be routinely and adequately trained.

Staff should be aware of the benefits to their clients of family violence screening. Concerns about causing harm (or bringing about additional work) need to be addressed through training and adequate referral processes. Staff are currently not aware of the benefits of empowering clients to make informed decisions about their situations. Screening for family violence should allow clients to:

- recognise the situation they are currently in
- receive relevant information
- access support and counselling to help them and their children deal with their experiences
- achieve early recognition of patterns of abuse in future relationships
- understand that the abusive relationship is not their fault
- reduce incidence rates of family violence
- reduce intergenerational transmission of family violence abuse.
Introduction

Domestic and family violence (‘family violence’ in this report) is the leading cause of homelessness in Australia.

(Spinney & Blandy 2011; Spinney 2012b)

It is estimated that between one in three and one in 10 families experience family violence in Australia (Australian Institute of Criminology (AIC) 2011). Worldwide, one in three women experience some form of family violence in their lives (World Health Organization (WHO) 2013). We know that a woman is killed in Australia almost every week by a partner or an ex-partner (AIC 2010). A notable survey of over 6,500 Australian women found that more than one in three who had an intimate partner had experienced violence from that partner or ex-partner (Mouzos & Makkai 2004).

This research project explored the best ways for agencies to identify and respond to women and children who are homeless or at risk of homelessness as a result of family violence, but who do not specifically identify themselves as such to community service providers. Many women present at homelessness crisis agencies citing relationship breakdown or financial difficulty, rather than family violence specifically, as a primary cause of their need for support. These women face real danger when identification of their experiences of family violence and subsequent risk assessment and support provision are inadequate. There are many complex reasons why clients may not tell agencies of their family violence experiences. They may not themselves realise that what they are experiencing is family violence; they may have past experience of inadequate service response to family violence; and feelings of guilt or shame may prevent full disclosure of their circumstances.

There is an urgent need to integrate family violence identification and support into crisis and universal service practice frameworks. ‘First to know’ service providers need to better understand the relationship between exposure to family violence and effects on women’s and children’s housing status and their physical, mental, social, emotional and financial wellbeing. Where services fail to initially identify those experiencing family violence, the assessments of client risk and planning for client safety can be inadequate. Clients may not receive the information they need on their legal rights and safe housing options, or be offered the early intervention, support and recovery options that are available.

This research project has been funded by the Lord Mayor’s Charitable Foundation and is a collaboration between Wesley Mission Victoria (Wesley) and Swinburne University of Technology. In 2014, Wesley provided homelessness and crisis support to over 980 women aged 26 to 65, and to over 300 accompanying children. Given the reported prevalence of family violence, it is likely that a large proportion of these were experiencing or had experienced family violence.

The grant application to the Lord Mayor’s Charitable Foundation was initiated by Janene Evans, Manager, Crisis and Homelessness Services at Wesley. Janene had previously spent over 10 years working in family violence services. Upon taking on a position within the homelessness sector, she realised that recognition of and responses to family violence within the sector were inconsistent and frequently inadequate. Given that many women who experience family violence make their first support contact with a homelessness service, Janene is keen to improve both identification and response. Janene believes that all women who experience family violence have the right to an appropriate response from the first provider they come in contact with.
This drives her desire to ensure that all ‘universal’ services are equipped with information on how to identify and respond to family violence; in some cases this means knowing how to assess and manage the associated risks. This is particularly relevant to homelessness services because it is clear that many affected women presenting to these services do not themselves identify as experiencing family violence, and even where they do, many do not want referrals to family violence services. This means that homelessness services staff regularly work with family violence clients but usually do not have the appropriate training, resources or tools to best assist them.

This project will inform how Wesley identifies the specific needs of women and children who have experienced family violence. It will enable informed, early intervention that responds to the primary causes as well as to the consequence of homelessness. Wesley will share the findings with other relevant agencies to inform their delivery of ‘first to know’ services, such as health and community services, where women present seeking assistance.

The research on which this report is based aimed to answer two questions:

- How and to what extent are universal community service providers screening for family violence?
- Where screening tools are used, are they helpful to clients?

This report presents the findings from:

- a review of the relevant literature regarding family violence and screening for family violence
- individual, in-depth interviews with 30 professional staff and managers working at community service providers in the eastern suburbs of Melbourne
- individual, in-depth interviews with eight females clients who have had experiences of family violence.

Since this project commenced, the Royal Commission into Family Violence (RCFV) has recommended the development of a family violence identification tool as part of the next iteration of the Common Risk Assessment Framework (CRAF). Rather than developing a separate screening tool as originally envisaged, Wesley will develop a practice framework that incorporates the amended CRAF screening tool.

The overall project objectives are:

- to understand how community service providers with non-family violence specific services can most effectively identify women and children experiencing family violence, in order to inform appropriate service delivery and support
- to inform the community service sector on program design and practice for ‘first to know’ services, providing effective early intervention responses to women and children seeking support as a result of family violence.
Research design and method

The research project was led by Dr Angela Spinney and the data collection was conducted by Dr Farnaz Zirakbash, both from Swinburne University of Technology.

Dr Spinney is a highly experienced researcher specialising in the marginally housed, social and affordable housing, and the housing consequences of domestic and family violence. Angela is a leading Australian authority on the concepts, policy and practice implications of homelessness prevention for women and children who have experienced domestic and family violence, and has led several research projects on these topics. Angela appeared as an expert witness at the 2016 Royal Commission into Family Violence and was delighted that her recommendations to the Commission regarding the expansion of Safe at Home measures to prevent women and children becoming homeless were accepted. In April 2016 the Victorian Government committed $10 million to implementing these measures.

Dr Zirakbash is a research fellow, tutor and lecturer at Swinburne University. Farnaz has completed a PhD in sociology, which explores the lives of highly educated, professional Iranian women who migrated to Australia after the Islamic revolution of 1979. The study highlights the roles of gender and education in migration studies; issues not well addressed in previous research studies.

This research aims to inform ways in which homelessness and community service agencies (including Wesley) might identify the specific needs of women and children who have experienced family violence, but have not disclosed their family violence experiences to service staff. It assesses how to enable informed early intervention that responds to these needs. We used a qualitative four-stage approach for the research.

Reference group

In stage one, a research reference group made up of Janene Evans (Wesley), representatives of homelessness and universal community service providers, and the Swinburne researchers was formed to guide the research. The reference group met regularly throughout the research design, data collection, analysis and report writing stages.

Literature review

In stage two, the researchers analysed relevant literature regarding definitions, the extent of family violence and its consequences, and both Australian and international examples of family violence screening tool use. The literature review led to the development of relevant interview questions.

Data collection

Stage three consisted of face-to-face, in-depth individual interviews with 30 professional staff members and team managers or coordinators currently working for generalist homelessness and other universal community service providers in the eastern suburbs of Melbourne. It had not been our original intention to interview female clients of homeless and other community services, but as the research progressed it became clear that this would add to the value of the project. Face-to-face, in-depth interviews were conducted with eight female clients who had experiences of family violence and had used the services of universal community organisations. The interviews sought to explore which methods and screening tools that these agencies use are the most effective in identifying women and children at risk and informing appropriate support provision and service delivery. Members of the research reference group suggested relevant organisations as potential interviewee sources.
Potential organisations were sent details of the research and asked to participate. Team managers and coordinators provided consent for interviews, allowing staff members to volunteer to be interviewed. The researchers then contacted staff members individually, providing a project information sheet, sought written consent and set up interview times. Ongoing participation was completely voluntary and anonymous; interviewees were permitted to withdraw their participation at any time. The research inclusion criteria took into account staff members’ key roles and experiences in providing services for female clients who had, or might have had, experiences of family violence. Staff interviewees’ self-selection may mean that participants were more likely to be people who had established views on family violence screening, and/or who felt confident about the related issues.

Flyers, sent by email or presented in person by professional staff and managers/team coordinators of universal service providers, were used to recruit female interviewees who were former service clients (but not necessarily former clients of the participating service providers). Researchers then contacted the women who indicated their willingness to participate, using email, phone calls or text messages to set up interview times. Eight female former clients were successfully recruited and interviewed. Each provided her signed consent before the interview and received a $30 supermarket voucher for participating.

The interviews were conducted between June and September 2016. Interviews with staff took place at their organisations’ offices during staff working hours, with the agreement of team coordinators or managers. Client interviews took place at Wesley’s Ringwood office. All interviews were conducted in English, recorded (with interviewees’ permission) using a digital recorder and later transcribed. Interview lengths were around 45 minutes to one hour, according to participants’ preferences; no specific limit was imposed, so as to allow participants to provide as much information as they wished. The length and detail of participants’ responses were left up to them.

Both staff and client interviews were made up of open-ended questions. Interviewees were each given a few minutes before their interview to look at the questions they would be asked. Questions for staff focused on the services they provided, the prevalence of dealing with family violence clients, screening tools they used to identify family violence, and how they viewed the effectiveness of family violence screening tools. Questions for clients focused on whether they were asked about family violence when they sought services and whether they received appropriate support.

Project information and recruitment documents are included at Appendix A, consent forms at Appendix B and interview questions at Appendix C.
Research design and method

Participants
The research focused on non-family violence specialising homelessness service providers and organisations providing health and community services to clients. This was because of our aim to explore whether universal community service providers use family violence screening tools, and to what extend such organisations can identify and response to their clients’ risks of and experiences of family violence.

The 30 professional staff participants had a wide range of relevant work experiences and were from six homelessness and community health organisations across the eastern suburbs of Melbourne (see Table 1).

The organisations offer services including (but not limited to) food, housing and homelessness support, home-based care, financial support and youth services. The community health organisations provide services including (but not limited to) general practitioner and clinical services, family counselling, mental health support and substance abuse support services. In the health organisations, interviewees were workers who provided services related to mental health or substance abuse issues.

The eight client interviewees were not all clients specifically of the participating organisations. The women were recruited based on their experiences of family violence and use of community services.

Table 1. Summary of staff participants

<table>
<thead>
<tr>
<th>Type of organisation</th>
<th>Female interviewees</th>
<th>Male interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness service provider 1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Homelessness service provider 2</td>
<td>4</td>
<td>3</td>
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<td>Homelessness service provider 3</td>
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<td>Health service provider 1</td>
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</tr>
<tr>
<td>Health service provider 2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health service provider 3</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>
Data analysis

In stage four, the researchers thematically analysed the data collected from the literature review and the interviews with staff and clients of homelessness and community health organisations. Thematic analysis involves searching across datasets to find repeated patterns of meaning (Braun & Clarke 2006). In our approach, analysis was driven by what the research participants had told us and the information we gleaned from the literature review about relevant practices and events elsewhere.

Ethical issues

The research team and reference group carefully considered the ethical matters relevant to this research, including the need to minimise the risk of causing upset or distress for interviewees. Swinburne Human Research Ethics Committee approved the research project before participant recruitment commenced. The initial approval (SHR Project 2016/025) was granted on 22 March 2016 for one year. This was amended in August 2016 to allow for the interviews of female service clients and associated provision of supermarket vouchers. It was made clear to each participant that they could stop their interview at any time they felt distressed, and the choice to continue would be theirs. Participants were also assured that confidentiality and their anonymity would be maintained.
Literature review

This chapter reviews the relevant literature concerning definitions of domestic violence and family violence, incidence rates of family violence, impediments to disclosure, and the greater difficulties experienced by Indigenous Australian women and new immigrants and refugees, along with the correlation between experiencing family violence and becoming homeless for Australian women. We then look at the differences between family violence screening and risk assessment, the advantages of screening, issues for consideration and examples of screening questions.

Definitions of domestic and family violence

Domestic and family violence is different from other forms of violence such as war or criminal violence; the name itself presupposes a relationship between the people involved. Family violence is a harm that is purposely caused by significant others who are supposed to care for or depend on one another (Jouriles et al. 2001). This form of violence and its related problems are closely bonded to important relationships, and particularly family relationships (O’Leary 1993). Tolan, Gorman-Smith and Henry (2006) argue that regardless of age, violence between members of a family is more probable than violence between acquaintances or strangers. For this reason, family violence is a highly common form of violence that affects most societies.

This is the definition of domestic violence contained in the National plan to reduce violence against women and their children (the National Plan):

*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.*

(Council of Australian Governments (COAG) 2010, p. 2)

The National Plan also contains this definition of family violence:

*Family violence is a broader term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for domestic violence. As with domestic violence, the National Plan recognises that although only some aspects of family violence are criminal offences, any behaviour which causes the victim to live in fear is unacceptable. 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 2010, p. 2).
‘Family violence’ is the term often preferred by Indigenous Australians because it includes the broader issue of violence within extended families (Stanley, Tomison & Pocock 2003). Perpetrators and victims can include members of extended family such as aunts, uncles, cousins, and children of previous relationships. Family violence is the term used throughout this report.

**A widespread problem**

Family violence can happen to anyone, regardless of their age, culture, social status or economic background, but women are much more likely than men to become victims of family violence. Reported family violence statistics should be taken as underestimates of the true extent of the problem. Most family violence experiences are not reported to authorities (Tually et al. 2008). No single factor causes family violence. However, a range of factors can increase the risk that a person will experience it. These include age, financial difficulties, social disadvantages, isolation, low academic achievement and involvement in aggressive behaviour as a young person (Flood & Fergus 2008). Drinking alcohol and displaying aggressive and controlling attitudes are common behaviours for perpetrators of family violence (Mouzos & Makkai 2004).

Figure 1 (page 14) shows the Power and Control Wheel, developed by Domestic Abuse Intervention Programs (DAIP) for approaching and dealing with female clients who are victims of domestic violence. Commonly known as the Duluth Model, it is one of the most well-known family violence interventions based on a theory of power imbalance between men and women (DAIP 2011). The wheel lists power and control tactics that family violence perpetrators commonly use on their victims. Comparing the wheel to their own experience is one of the ways that women can recognise they are living in a situation of family violence.

**Family violence in Indigenous Australian communities**

Indigenous Australian women are more likely than non-Indigenous Australian women to experience family violence. Indigenous people make up three per cent of the total Australian population, but Indigenous Australian women are at least 35 times more likely than non-Indigenous women to experience family violence. (National Council to Reduce Violence against Women and their Children (NCRVWC) 2009). Nationally, between 2012 and 2013, 22 per cent of clients who sought help from specialist homelessness services were Indigenous people.

The causes of family violence in Indigenous communities are increasingly accepted as stemming in part from the history and impact of colonisation (Spinney & Blandy 2011, p. 20). Ongoing trauma from the displacement of Indigenous people from their traditional lands and kinship groups, the removal of children from their families and the ongoing negative relationship between Indigenous people and the criminal justice system all contribute to heightened levels of interpersonal violence. Of relevance to this screening research, Cripps (2010) has identified that Indigenous Australian women may use language that minimises the violence, such as describing it as a frequent innocuous event, in order to protect their family from the intrusion of agencies; to protect people from looking bad and from the impact that full disclosure could have on their small communities.
Literature review

Figure 1: Duluth Power and Control Wheel (DAIP 2011)
Family violence in immigrant and refugee communities

The National Action Plan for Australia to Reduce Violence against Women and their Children 2009–2021 (COAG 2010) acknowledges that immigrant and refugee women are more likely than other women in the general Australian population to be murdered as a result of family violence. Psychological, social, cultural and structural factors can all combine to increase risk levels (Rees and Pease, 2006).

The United Nations High Commissioner for Refugees estimates that 80 per cent of all refugee women have experienced rape and sexual abuse (Zannettino et al. 2013). Pre-arrival trauma contributes to the disproportionate impact of family violence on those from culturally and linguistically diverse (CALD) communities (Settlement Council of Australia 2013).

After refugee women arrive in Australia, certain factors increase the likelihood that they will experience – but not disclose – family violence. These include social isolation, a sense of not belonging, separation from family, racism and discrimination, low socioeconomic status, lack of knowledge about support services, language difficulties, a lack of appropriate housing and a lack of education support (Zannettino et al. 2013; Spinney 2014).

The incidence of family violence in Victoria

Most people who experience family violence do not approach agencies for assistance, so it is very difficult to know the true extent of family violence in Victoria. However, the number of family violence intervention order (FVIO) applications heard by the Magistrates’ and Children’s Courts of Victoria can be taken as one measure. Between 2009–2010 and 2013–2014, the number of FVIO applications finalised by the Magistrates’ Court increased by 34.5 per cent, from 26,124 to 35,147 applications (Crime Statistics Agency 2016).

About 10 per cent (n=23) of the 250 murder cases prosecuted in this period were related to family violence (Crime Statistics Agency 2016). The number of finalised FVIO applications in the Children’s Court of Victoria increased by 33 per cent between 2009–2010 and 2013–2014, from 1407 to 1872 applications.

Homelessness and family violence

Homelessness causes deep distress. It can lead to the onset of mental and physical health problems and exacerbate pre-existing conditions. Homelessness contributes to problems of financial insecurity and hardship (Spinney 2012) and much of the homelessness in Australia can be attributed to experiencing family violence.

Indigenous and non-Indigenous homeless Australians are alike in that the single largest reported cause of their homelessness is domestic and family violence, with women and children most likely to seek to access to homelessness services.

(Australian Institute of Health and Welfare (AIHW) 2011)

In 2012 the Australian Bureau of Statistics (ABS) has developed a statistical definition of homelessness. Under this definition, people are considered homeless when they do not have suitable accommodation, or if their current housing arrangement is inadequate, they have no tenure, the lease is not extendable or the conditions of their dwelling limit their control of and access to space for social relations. This definition is informed by an understanding of homelessness as the state of being without a ‘home’. It emphasises the key aspects of a home identified by Mallett (2004): a sense of security, privacy, safety and the ability to control living space. A homeless person is someone whose dwelling lacks one or more of the elements that represent ‘home’ (ABS 2012).
Fifty-nine per cent of people supported by specialist homelessness services are female. Women aged 18–34 are the group most likely to access specialist homelessness services, and each year one in 42 women aged 15–24 will access this type of service. In 2012, over 2,200 women in Australia were living in improvised dwellings and tents or sleeping out, and around 85,000 women were supported by specialist homelessness services (Homelessness Australia 2013).

The Specialist Homelessness Services Collection collates state-based data on the provision of services to people who are homeless or at risk of homelessness, including women escaping family violence and their children. These sources include the majority of the women’s specialist family violence services. Since July 2011 the number of support periods provided to all clients in Victoria has increased by 47 per cent, from 128,694 in 2011–2012 to 188,775 in 2013–2014, and the number of people seeking assistance from the police because of family violence experiences has increased from 50,586 to 74,292 (Crime Statistics Agency 2016).

Seventeen per cent of specialist homelessness services clients are children aged under 10 years, and the single most common reason (at 24 per cent) women and their children cite for seeking assistance is experiencing family violence. However, in 2012 accommodation could only be provided for 65 per cent of those who requested emergency help, because of a shortage of available resources (AIHW 2012). This is a very different picture to the Australian stereotype of a homelessness person as a single man, often with a substance abuse problem. In reality, specialist homelessness services now deal with a wide array of people who have become homeless for very different reasons and who have very different support needs. Services can range, for example, from providing crisis support for rough sleepers with mental health problems to providing homelessness prevention advice for professional women who are owner-occupiers and have experienced family violence.

These are very different sorts of work with very different policy responses, which require different skills and aptitudes. This is one of the reasons that screening for family violence by universal services is so important.

The invisibility of women’s homelessness in Australia has been previously linked to general marginalisation of women in society, but more recent arguments link the issue to women’s reluctance to self-identify as victims of family violence (Johnson, Gronda & Coutts 2008). When children are involved, women’s reluctance is particularly related to social values associated with ‘good’ mothering – women do not want to be labelled as ‘bad’ mothers or ‘victims’ of family violence, so they pretend that things are ‘normal’ (Tually et al. 2008).

The links between experiencing family violence and women’s housing instability and risk of homelessness are complex and multifaceted. There are many factors that may put a woman and her children at risk of housing instability and homelessness once they are apart from her abusive partner. These include economic factors such as underemployment and insufficient income, lack of affordable housing, histories of crime or credit problems, receiving threats and assaults from an ex-partner and even potential discrimination when seeking housing as known domestic violence survivors (Baker, Cook & Norris 2003).

Other studies similarly reveal that women’s vulnerability post-relationship separation is reinforced by their weaker economic position compared to men’s, regardless of whether domestic violence is involved. Economic gender inequalities, including unequal employment opportunities and low-paid employment, can contribute to women’s vulnerability to homelessness after a relationship breakdown (Macdonald & Langvogt 2012; Spinney & Blandy 2011). Finding secure housing can be further complicated by a lack of affordable housing stock and shortage of funding for public housing.
Even in cases where women have economic resources to afford secure housing, landlords might refuse to rent to them in order to avoid risk to other tenants or damage to property should the perpetrator continue to pose a threat (American National Law Center on Homelessness & Poverty 2007).

**Identifying domestic and family violence**

Most family violence is not currently disclosed to services in Australia. Women may not report their experience of it, or might report in a way that obscures its nature or extent, for example by reporting an injury, but not attributing it to violence (this is sometimes called ‘hidden reporting’) (ABS 2013a). This accords with our interview findings, which are discussed in the next chapter. None of the managers or staff interviewees knew what proportion of their clients had experienced family violence. The ABS has found that when people do report family violence, organisations may not record it properly or consistently (this is sometimes called ‘under-recording’) (ABS 2013a). All six of the agencies where we conducted interviews were not specifically funded to deliver family violence services, which may be why they did not record such experiences accurately. However, a one-day family violence snapshot survey conducted by homelessness providers in Melbourne’s east in October 2016 found that 53 per cent of homelessness crisis clients seen on that day said they had experienced family violence in the past two years and for 30 per cent of crisis clients, family violence was a major contributing factor to their current state of crisis. The homelessness support services found that 51 per cent of their clients had experienced family violence within the past two years and for 21 per cent of clients currently in support services, family violence was a major contributing factor to their current state of homelessness.

Many varied and complex factors lie beneath hidden reporting and under-recording, including shame, fear and stigma, practical or technical barriers (including the ways that service providers pose questions and the languages and settings in which the questions are asked). Additional barriers including linguistic, cultural or geographical isolation and disability or homelessness can also make people less visible in data collection. Clients themselves may not recognise that certain behaviours, including emotional and economic abuse, constitute family violence (this is the case in our client interview findings), and there is a lack of capacity among multiple systems and services to identify family violence (State of Victoria 2016).

The 2012 ABS Personal Safety Survey (ABS 2013b) reveals that of people who had experienced violence at the hands of a current partner (approximately 66 per cent of whom were women and 34 per cent were men), 26 per cent of the women and 54 per cent of the men said they had never told anyone about a current partner’s violence. Furthermore, 39 per cent of the women and 70 per cent of the men said they had never sought advice or support in connection with a current partner’s violence. The survey also found that, of those people who had experienced violence perpetrated by a previous partner, seven per cent of women and 21 per cent of men had not told anyone, and 24 per cent of women and 48 per cent of men said they had never sought advice or support in connection with previous partner violence (ABS 2013b).

Even when family violence is disclosed, information about clients can be incompletely or inaccurately recorded. Some datasets might not record particular demographic characteristics or might record them unreliably or inconsistently – see, for example, the statement of Commissioner for Aboriginal Children and Young People Andrew Jackomos (cited in State of Victoria 2016) regarding family violence experienced by Indigenous Australian women.
In addition, organisations and service providers collect data differently, making it difficult to draw robust conclusions about trends or patterns (State of Victoria 2016).

Importantly, organisation staff may not recognise family violence as an issue for a particular client because they have not explicitly asked that client whether they are experiencing family violence. For instance, although a client may both have substance abuse issues and be experiencing family violence, substance abuse service providers may not specifically ask about family violence. Without direct questions about it, the client may not disclose their family violence experience, so the provider has an incomplete picture of the issues that person faces and may miss crucial information on contributing factors (White et al. 2013). Our interview findings back this up: staff interviewees from substance abuse and mental health service providers had the least amount of family violence related training and exhibited the least capability to identify whether their clients are experiencing family violence.

**Screening tools**

The simplest way to identify if a client has experienced family violence is to ask them (White et al. 2013). Clients who are not invited to make a disclosure may be reluctant to do so, and indeed may feel that a disclosure would not be welcome (White et al. 2013). As discussed later, our client interviewees stressed the importance of being encouraged to talk about their family violence experiences.

The following section considers family violence screening tools used in Australia and internationally by universal service providers, and the extent to which the screening is effective. We start, however, by making an important point about the difference between risk assessment and screening.

**The difference between risk assessment and screening**

Family violence screening is a systematic approach that involves asking clients a series of questions in order to identify if there is sufficient risk of violence to benefit from further investigation and/or direct preventative action tools (Laing 2004; Peckham & Dezateux 1998). Screening tools are a lens through which practitioners gain a clearer picture of the victim’s experience and what action is required. They can help a practitioner to understand why a victim may stay with a perpetrator (Laing 2004; Peckham & Dezateux 1998). Screening provides a way of thinking and talking in depth about family violence risk with a person. Family violence screening can be seen as the first step to a risk assessment process, but the two processes are not interchangeable.

Family violence risk assessment is the process of identifying whether a person is at risk of family violence, and then determining the likelihood that they will be affected by violence or, if violence is already occurring, the likelihood that it will escalate (Australian Attorney-General’s Department 2010). Although risk assessment cannot eliminate the possibility of unpredicted events occurring, it does allow for an informed and tailored response that can reduce the risk that the person will be harmed. Various service providers, including specialist family violence services and police and justice services, perform family violence risk assessments when they come into contact with women, children and families. Some might detect the risk of family violence and make a referral to a specialist family violence service provider that can perform a full risk assessment. Tools used to identify and respond to risk differ according to the role and function of the practitioner assessing the risk and the service context (Australian Attorney-General’s Department 2010).
Put simply, screening is the process of seeking to discover whether someone is, or has been, living in a situation of family violence. Risk assessment is the process of determining what level and of types of family violence are occurring and what safety planning is required. Our analysis revealed that more research literature is available on family violence risk assessment than on screening.

The Education Centre Against Violence (ECAV) in New South Wales provides a four-day training course, ‘Practical skills in responding to people experiencing domestic violence’, for workers in health sectors, other government and non-government organisations. The course aims to support the continuance of the Domestic Violence Routine Screening Strategy in New South Wales. Specific courses are also offered for New South Wales health workers such as substance abuse, mental health and early childhood services workers. The portfolio is also responsible for conducting training about family violence in same-sex relationships and abuse of older people. ECAV (2004) argues that screening communicates to people experiencing family violence that:

- they are respected
- they are not alone
- the worker has encountered family violence before
- the worker is willing to listen
- the issue is being taken seriously.

Examples of screening use

In New South Wales since 2001, routine screening of women regarding their experiences of family violence has increasingly been introduced, particularly by antenatal, early childhood, substance abuse and mental health services. Following a pilot that found strong support from female patients, this strategy is now well established in New South Wales public health services (New South Wales Department of Health 2007). A pilot study in 2004 that targeted women attending New South Wales health centres explored women’s responses to family violence. It found that 97 per cent of women screened felt okay or relieved to be asked if they were experiencing family violence and 94 per cent thought the health service should screen women this way (New South Wales Department of Health 2004).

Pregnant women’s attitudes to their midwife asking about experiences of family violence were researched in 2001 in Sweden. The study interviewed 879 women who were screened for family violence throughout their pregnancy. The findings suggest that women may feel uncomfortable when asked about family violence. Women especially showed hesitance in responding to abuse assessments in pre- and post-pregnancy clinical settings (Stenson et al. 2001). However, the AVERT family violence facilitator’s manual (Australian Attorney-General’s Department 2010) argues that screening tools and assessments of risk are stages in an ongoing process of risk management. They are beneficial not solely to predict the possibility of future violence, but more importantly to inform what can be done to prevent further violence in the future, and ensure service processes (especially those mandated) do not contribute to harm. Screening is intended to identify victims and provide a trigger for responding; screening itself is not the response (Australian Attorney-General’s Department 2010).
Focusing mainly on developed countries, Garcia-Moreno (2002) emphasised the important role of health sectors in secondary and tertiary prevention of violence against women. Health professionals, according to Moreno, are most likely to require information from a client about family violence, particularly intimate partner abuse, if the client has any physical injury symptoms. Yet, many women may receive treatment without being asked about the cause of an injury. This has been explained by a lack of formal assessments and insufficient data on their effectiveness across health sectors (Garcia-Moreno 2002).

Evidence from United States studies illuminates difficulties across health care settings in training and family violence screening programs (Campbell et al. 2001; Thompson et al. 1998). Such studies argue that most intervention programs in health care sectors are limited to emergency departments. Even though routine use of family violence questionnaires and placement of posters in clinical areas led to increases in identifying family violence, sustaining such gains was difficult. Physicians cited barriers to asking women about abuse, including lack of time and support resources, fear of offending the woman, lack of training and frustration at the perceived lack of patient responsiveness to their advice (Larkin et al. 2000).

The family violence screening tools used most commonly in health care services in Australia and internationally are known as HITS (Hurt, Insult, Threaten, Scream), and WAST (Woman Abuse Screening Tool). Despite the importance of using such tools in health care organisations, they have rarely been evaluated, are used inconsistently across health care sectors, and some include only one direct question about family violence (Rabin et al. 2009).

**Screening questions**

The Family Relationship Advice Line is a national telephone service established to assist families in Australia affected by relationship or separation issues. The Advice Line provides information on relationship issues and advice on parenting arrangements after separation. Staff can also refer callers to local services for assistance. The Advice Line complements the information and services offered by Family Relationship Centres.

Family violence screening frameworks such as those used by FRC and FRAL (Family Relationship Centres and Family Relationship Advice Line Practice Framework for Screening and Assessment) recommend asking four broad family violence related questions, synthesised from a range of screening tools used internationally (Australian Institute of Family Studies (AIFS) 2010).

FRC and FRAL was an Australian project conducted by the Australian Integrated Child Protection Scheme (ICPS). It involved consultations with expert practitioners, research on and development of a practice framework and practice guide for screening and assessment, and testing of the framework and guide by workers in the family relationships field.

The four recommended questions are:

1. Do you have any reason to be concerned about your own safety or the safety of your children?
2. Do you have any other concerns about your children’s wellbeing at the moment?
3. Do you have any reason to be concerned about the safety of anyone else?
4. (Optional) How do you think your partner/ex-partner would answer these questions?

**Literature review**
These questions are helpful in identifying an absence of safety in various areas, including potential child abuse, violence or self-harm. However, they lack directness and are considered entry points to disclosure. Deeper follow-up questions are recommended (Gawande 2010, Rabin et al. 2009).

More direct and deeper family violence related questions are used in New South Wales health services, including (AIFS 2010):

- Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner?
- Are you frightened of your partner or ex-partner?

If the woman answers yes to either or both of these questions:

- Are you safe to go home when you leave here?
- Would you like some assistance with this?

The Family violence assessment and intervention guideline: child abuse and intimate partner violence from Ministry of Health New Zealand (Fanslow & Kelly 2016) points out the importance of engaging with women who make a disclosure about family violence. The guideline suggests a statement such as:

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I am sorry that this has happened to you. No one deserves to be hurt in that way. There are options – people and places – that can help to make you safer. We can help you sort these out, but first, we need a little more information about what has been going on for you. We ask all people who have been hurt by their partners to do this. It will help us to provide you with the best care we can.

(Fanslow & Kelly 2016, p. 58)

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The guideline suggests these health and risk assessment questions:

Is your partner here now?
Are you afraid to go/stay home?
Has the physical violence increased in frequency or severity over the past year?
Has your partner ever choked you (one or more times?)
Have you ever been knocked out by your partner?
(If applicable) Have you ever been beaten by your partner while pregnant?
Has your partner ever used a weapon against you, or threatened you with a weapon?
Do you believe your partner is capable of killing you?
Is your partner constantly jealous of you? If yes, has the jealousy resulted in violence?
Have you recently left your partner, or are you considering leaving?
Has your partner ever threatened to commit suicide?
Have you ever considered hurting yourself/suicide?
Is alcohol or substance misuse a problem for you or your partner?
Have the children seen or heard the violence?
Has anyone physically abused the children?

(Fanslow & Kelly 2016, pp. 58-59)

New South Wales Department of Health studies (2007) have found that health professionals may not use family violence screening tools if a client’s partner, other family members or friends are present. Screening needs to ensure that women’s safety is not compromised, so workers need to be trained in how to undertake screening safely in a way that does not put women who may be experiencing family violence at further risk (AIFS 2010).
Literature review

The Common Risk Assessment Framework

Although this literature review concerns family violence screening rather than risk assessment and safety planning, it is appropriate to discuss the Common Risk Assessment Framework (CRAF, Victorian Government Department of Human Services 2012). This is the tool most commonly used by Victorian agencies to assess whether a client is experiencing family violence, and the level of associated risk for them.

In 2007, the Victorian Government introduced the Family Violence Risk Assessment and Risk Management Framework (known as the Common Risk Assessment Framework, or CRAF) to enable risk assessments to be conducted whenever a person at risk of or experiencing family violence makes contact with a service. The CRAF was considered a vital mechanism for facilitating consistent practice throughout the family violence system, relevant to all departments’ policies and practice and their interoperability. The manual is available online at www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies-guidelines-and-legislation/family-violence-risk-assessment-risk-management-framework-manual.

The Victorian Government is currently reviewing the CRAF. The recent Victorian Royal Commission report (State of Victoria 2016) emphasised that to ensure improvement in current approach to family violence, we need to ensure that all Victorian organisations use the CRAF or a CRAF-aligned risk assessment tool when dealing with family violence matters. Since victims, children and perpetrators may come into contact with multiple services, all relevant agencies, including health services, should align their risk assessment practices with the CRAF. This is not currently happening.

The Royal Commission report (State of Victoria 2016) questions whether the CRAF introduced in 2007 met its aims regarding family violence screening, and whether improvements are now required. The report highlights that gaps in the current CRAF include (but are not limited to):

- insufficient recognition of various forms of family violence and therefore untailored responses to particular needs of the victim
- lack of targeted resources to meet specific needs of children
- key personnel in universal systems, such as health services and schools, being inadequately equipped to recognise that family violence may be occurring and often not knowing what to do when it is identified
- victims’ safety being undermined by inadequate methods for sharing information between agencies about perpetrator risk, a problem exacerbated by outdated information technology systems.

These points are mirrored in the findings from our interviews with service provider staff and clients. The Royal Commission found that people who have experienced family violence may disclose it to family or friends or approach a range of different service providers. They might tell a teacher, a general practitioner, a dentist, a counsellor or a maternal and child health nurse about the violence. They might call the police when violence is occurring or report it later. They might approach a registrar at a local court, a community legal service or a private legal practitioner. However, people who decide to tell someone about their experiences of violence often find the responses of police, courts, government agencies and service providers inconsistent, and they may not receive the advice and further support they need. The Commission held that all services that come into contact with family violence victims should be equipped to identify them, assess and manage their risk where appropriate, and ensure that victims are supported.
In order to achieve this, universal services will need to boost their family violence capability. Workers need to be equipped to recognise signs that family violence may be occurring and know what to do next to ensure safety (State of Victoria 2016).

The Royal Commission has recommended the development of a family violence identification tool as part of the next iteration of the CRAF. Given this recommendation, Wesley intends to develop a practice framework that incorporates the amended CRAF screening tool, rather than developing a separate screening tool (as envisaged when we began this research project).

The government’s recommendation is for the next generation (revised form) of the current CRAF to include evidence-based risk indicators specific to children. Risk assessment and management panels (RAMPs) should be rolled out as a matter of urgency, a central information repository should be established and legislative impediments to information-sharing should be removed. The revised Framework must include a sustained workforce development and training strategy, and should also provide for minimum standards and core competencies to guide identification, risk assessment and risk management practice in family violence specialist services, mainstream services and universal services. These recommendations accord with our interview findings.

The workplace training must include general practitioners and hospital, mental health, substance abuse, child protection and aged care and disability workers. In addition, sharing information about risk within and between organisations is crucial to keeping victims safe. It is necessary for assessing risks to a victim’s safety, preventing or reducing the risk of further harm, and keeping perpetrators ‘in view’ and accountable (State of Victoria 2016). We would add that workers need to know about screening as well as risk assessment, and understand the process differences, as using the CRAF includes both.

The Royal Commission found that broadening responsibility for addressing family violence will require each sector of the system to reinforce the work of other sectors, to collaborate with and trust others in order to understand the experience of family violence in all its forms. The system needs to look outwardly, and be open to new ideas and new solutions (State of Victoria 2016). The non-family violence services staff we interviewed said repeatedly that specialist family violence agencies did not trust them to screen for family violence, which was a disincentive to ask their clients whether they had experienced family violence.

**Conclusion**

In this section we have reviewed relevant literature on family violence screening and presented examples from Australia and other parts of the world. There is a relatively small amount of available literature regarding screening, as opposed to risk assessment, but what there is reveals our understanding of family violence is hindered by under-reporting and a lack of capacity in universal community service organisations to identify family violence. There are advantages to screening, and women are mostly not opposed to being asked questions about their experiences of family violence, but issues of privacy, confidentiality and trust must be taken into account.

In the next section we discuss in depth the results of our interviews with workers and clients of community organisations in the eastern suburbs of Melbourne, regarding their knowledge and experience of screening for family violence.
Manager, staff and client interviews

This chapter explores the findings from our interviews with managers and staff of universal community service providers, and with former clients. Family violence was not a current issue for any of the eight clients who participated in this research. They had experienced family violence in the past, or if they were still dealing with the matter (emotionally or legally) they were separated from the perpetrator and were safe.

Five themes emerged from our analysis of the interview data:

• recognising family violence
• confidence in identifying family violence
• screening constraints
• views on the use of family violence screening tools within non-specialist services
• creating opportunities for clients to be heard.

Recognising family violence

Staff from the six participating agencies were asked about the importance and incidence of family violence as an underlying factor when clients approach their services for assistance. While all staff acknowledged family violence as a probable cause for service use, the responses regarding family violence frequency varied across and even within agencies.

The inconsistent responses reveal that the participating services do not have accurate information regarding family violence; in fact, they do not collect client data concerning family violence. Staff interviewees, who had relevant work experience periods ranging from six months to 20 years, reported that family violence is not a primary motive for which clients approach their agencies. Instead, they cited homelessness and finding a place to live, financial difficulties and mental health or substance abuse problems as clients’ main reasons for seeking help.

Family violence was recognised as a secondary factor, and some interviewees said it is a common factor in many clients’ situations. The existence of family violence, either in the history of a client’s life or as a current experience, might become clear during the assessment process even where clients did not give it as a primary reason for needing support. A third of staff in management positions were unsure about the prevalence of family violence as a factor, or said it was ‘not very common’, but all 30 staff acknowledged that a percentage of their clients have dealt or were dealing with family violence.

Family violence is sometimes a factor, but I am not really sure about the statistics. I would guess maybe about 20 per cent of our clients have had or are currently experiencing family violence.

(Health service provider; male worker with seven months experience)

Compared with staff interviewees dealing with clients who have substance abuse or mental health problems, interviewees who worked for providers of homelessness support, services in relation to financial difficulties and general family counselling identified family violence as a concern more frequently. For instance, one worker in the second category said:

A reasonable number of women who present to me have had experiences of family violence. They may not always tell you but they intimate often that there is some kind of family violence going on […] it might be emotional abuse rather than physical, though. It is not the reason for which they come to me but they tend to reveal it if they trust [me].

(Health service provider; female worker with three years experience)
As this reveals, clients might not disclose experiences of family violence if they feel they cannot trust the worker. Also, staff might not be able to successfully conduct family violence screening if the client does not trust them. Other staff interviewees similarly commented on the issue of trust:

For more than half of the families we see here, family violence is a factor in their homelessness even though it might not be the main reason for which they have come to us ... once they trust the worker it will come up.

(Homelessness service provider; female worker with eight years experience)

Another worker said:

Family violence as a factor is fairly common here, though disclosure is not very common, specially in first contact [...] we have seen a significant increase in family violence referrals coming to our case management recently but data-wise I cannot give you an exact percentage. I would say about a quarter to half of our clients have a background of family violence.

(Homelessness service provider; male worker with 18 months experience)

These comments indicate that women’s family violence self-disclosure to a universal service without a formal screening system might not be a common occurrence, particularly at initial contact. If the woman does not approach the provider again or the staff do not identify the family violence risk at first contact, the significance of the violence and its impacts on the client remain unknown. Some staff interviewees who acted as the first point of contact for clients considered family violence a common underlying factor for approaching service providers:

[Family violence is absolutely a very common reason [for seeking support]! It is not an obvious indicator and it will come up when you start talking to them [...] they may have contacted before and have not disclosed it because they have not connected well with the worker. The main reason they call us is financial support and the caller often has not realised that there is an abusive relationship [...] you only recognise that when you start the conversation.

(Homelessness agency, male worker with 10 years experience)

This indicates that clients themselves may not recognise they are experiencing family violence, so workers need knowledge and skills to elicit information and bring the situation – and the support available – to the client’s attention. This theme also arose during some of our interviews with former clients, reinforcing the significance of workers’ training, skills and experience and the availability of screening tools for detecting family violence.
Manager, staff and client interviews

Two out of the eight female former clients of community services we interviewed said that despite seeking (mainly financial) help from various community organisations they had not recognised they were in abusive relationships for a long time. None of the workers they met across their journey asked questions about family violence, pointed out they were in a family violence situation or offered related support. One participant explained:

> We lived in a domestic violence situation for eight years and I never realised I was in an abusive relationship [...] I always thought domestic violence is when you are beaten up, you are bruised and broken, and I never understood it could be anything less. It was not until it was pointed out to me that my kids and myself were severely abused [...] for a good eight years I approached multiple agencies and church groups for financial supports such as school funding, etc. and I was never asked about family violence [...]. It wasn’t until my boys’ school teacher pointed out that to me, but before that I was just sent from one agency to another one. It was finally with the help of [homelessness support agency] and [family violence support agency] that we received the right help, because they worked together and they were both on the job and communicated well to one another to assist me [...] that was the moment I could make a decision and take a direction.

(Female client B)

Clients who have not realised that their experiences are family violence cannot disclose their abuse without deliberate screening. Although staff interviewees expressed confidence in their ability to detect, without specific screening questions, when a client is experiencing family violence, both of these client interviewees said they only became aware of their family violence situation when they saw a screening document and realised that they ‘ticked all the boxes’. Clearly, it is important for universal community service providers to ask direct screening questions regarding clients’ experiences. One of the women told us:

> When you have just a laid-back conversation, so much can get lost and missed [...] When you have the questions on a paper and they are clearly spelled out [as a list of behaviours that are not acceptable] and it is very much on the page, that to me was a real ‘eye opener’ [...] my ears were full of people’s opinions and my husband’s comments about me [...] but to see that on a page, it kind of solidified everything to me and I finally made my decision.

(Female client E)

Using a screening tool and a ‘tick box’ method seems a useful approach from this client’s perspective, despite what some staff interviewees thought. This suggests that the effectiveness of screening tools and the types of questions asked could be measured and improved by considering feedback from clients who have been assessed, rather than only consulting practitioners and service providers.
Confidence in identifying family violence

Staff interviewees at the service providers we researched all said they used their particular service’s ‘own’ initial assessment tool. These tools each focused mainly on the particular provider’s primary service by assessing specific matters such as risk of homelessness, substance abuse, mental health problems and so on.

All staff said they refer clients to a specialist family violence agency if family violence is detected. All of the participant service providers’ assessment tools appeared to be narrative-based, using conversations around certain themes and topics rather than asking clients a series of screening questions or using a checklist method. Overall, however, the interviews revealed the risks of screening using dialogue rather than a screening tool that asks specific questions about family violence.

Of the providers that took part in our research, homelessness service providers seemed to have more knowledge about family violence. The majority of staff from these services had access to CRAF or at least some kind of family violence awareness training. Interestingly, staff from providers that offered less or no family violence training did not appear less confident about identifying whether clients were experiencing family violence. In fact, regardless of the amount of training they had received, the length of their experience or their general level of family violence familiarity, all 30 staff interviewees felt they had a high level of proficiency in identifying family violence in their clients’ experiences. They all said they felt confident in their ability to establish trust and a comfortable environment for clients, and knew how to start a conversation that would reveal family violence.

Staff had volunteered to take part in this research knowing the area of interest. Many other staff members chose not to take part, and we note that staff who felt confident about screening for family violence may have been more likely to volunteer. This would explain their unanimity, but means their views are perhaps not representative of all workers. In fact, our interviews suggest that some staff may be overconfident about their ability to identify and manage family violence.

As the following comments indicate, despite their firm belief in their ability to recognise family violence, some staff had little or no familiarity with CRAF or had not received family violence training:

As a natural theme when I meet a client I will ask questions about family violence such as, ‘Is there anything at home that concerns you?’, but we don’t have any specific question in our assessment about family violence […]. I am very experienced in forming a good relationship with clients so I build trust and in most cases my clients disclose the existence of [family violence] themselves […]. I don’t know about CRAF, never heard of that, but if it is a good tool and helps to pick up instances of [family violence] I would be more than happy to use it in my assessment […]. In my six years study as a counsellor I had no specific education or training about [family violence] and had no specific [family violence] training for my current role. But if they offer me [family violence] training I would like to be trained.

(Health service provider; female worker with three years experience)
Manager, staff and client interviews

Another staff member from a different provider said:

*CRAF sounds familiar, but I am not sure what exactly that is. I have done ‘DV-alert’ training earlier this year but not been trained for CRAF [...] in our [substance abuse] assessment we have a question [about] if the client feels safe at home, and if the answer is no I will ask further questions. If we were a primary [family violence] agency I guess [family violence] questions [would be] more relevant. If I identify the risk of [family violence] I refer the client to [family violence] specialist agencies such as Safe Steps.*

(Health service provider; female worker with 18 months experience).

This assessment worker said she had not done any family violence training other than DV-alert domestic violence response training, which is funded by the Australian Government Department of Social Services as a key initiative of the National Plan (COAG 2010).

A homelessness service worker likewise said she had heard about CRAF but never used it, nor was she trained to use it. She mentioned she had been trained for another family violence risk assessment many years ago, but she could not recall its name, and said that she only uses the tool ‘in my head’:

*I will do a general, open-ended questions conversation. I don’t have any screening tool in front of me when I interview a client. I use a laid-back narrative assessment and then calculate quickly in my head about the situation and what the needs of the client are [whether she is safe at the moment or not]. [The] vast majority of workers across welfare organisations have had some family violence assessment trainings but they might be reluctant to go into another one because they know what is it like and they may think, ‘I already had one’. I would be interested to be trained for new ways of identifying family violence if there is any training that recommends new methods.*

(Homelessness service provider; female worker with seven months experience).

Some interviewees demonstrated little understanding of the difference between screening for family violence and conducting a risk assessment, saying when asked about family violence screening that they used a risk management tool with a list of questions:

*It is pretty easy to identify [family violence] using a risk management tool; I am very confident that I won’t miss it if there is a risk.*

(Health service provider; female worker with 12 months experience).
The homelessness service provider workers specified that the assessment tool they use is part of the Initial Assessment and Planning (IAP) tool, which has a family violence section. IAP is the main access point for clients experiencing or at risk of homelessness throughout Victoria. The homelessness service provider’s assessment tool is included at Appendix D. These staff said if they identified a risk of family violence, they might use CRAF to investigate further, but stressed that if they realised there was a ‘definite’ family violence risk they preferred to refer the client to a specialist family violence support provider, or to an experienced staff member in their provider’s team.

Even staff who were trained in CRAF said they rarely used the tool. Despite the compulsory CRAF training in one of the homelessness service provider teams, it was unclear whether family violence training gave the staff more ability to effectively identify and respond to clients’ family violence experiences. One staff interviewee who had done compulsory CRAF training said:

> It’s only now in this interview that I am thinking maybe I should take CRAF with me into the interview room [laughing] […] very busy sometimes here, hard to dig into family violence matters.

(Homelessness service provider; female worker with eight years work experience)

Regardless of their training, staff interviewees felt that some team members have a ‘natural’ ability to deal with family violence matters and to help clients open up in conversation. If they identified family violence and had a choice, they preferred to refer the client to a team member who was ‘naturally good’ at working with clients who have experienced family violence. Arguably, then, family violence training for homelessness service workers has been helpful for identifying family violence, but not necessarily for increasing staff members’ capability to take appropriate action or respond effectively.

Very few interviewees had heard of family violence screening tools, although some knew other service providers used the CRAF risk assessment tool. Only one interviewee could name another screening tool:

> I am aware of and read through the DASH [Domestic Abuse, Stalking and Harassment and Honour Based Violence] assessment tool which is kind of an American (sic) version of CRAF, but I have not had a chance to compare the two frameworks yet.

(Homelessness service provider; female worker with eight years experience)
Manager, staff and client interviews

Screening constraints

Some staff interviewees believed it was a great idea to have a common family violence screening tool used by all community service providers. However, they felt that some CRAF questions can be confrontational and may scare a client whose main presenting reason is not family violence. From the client’s point of view, they said, being asked specific questions about family violence when they have sought help for another reason (such as mental health issues, substance abuse or homelessness) can be overwhelming.

One worker said:

Based on experience, you may get this question from the client […] ‘Why are you asking me these questions? This is not why I’m here.’

(Health service provider; female worker with 18 months experience)

Staff interviewees trained in the CRAF were also unsure about its practicality for a universal service provider because of its complexity and time-consuming depth. They did not seem to have a clear understanding of the distinction between screening for family violence and undertaking risk assessment to allow safety planning.

These workers seemed unaware of the different CRAF levels, and some suggested that a simpler form of CRAF might be preferable for a universal service provider:

CRAF is too thorough and complex for a homelessness agency and needs to be used by a specialised agency and needs a specialised training and practice. A secondary CRAF, let’s call it ‘CRAF 2’, which can be used by any generalist service provider, would be more useful. Perhaps CRAF 2 could identify the level of risk and then [the worker could] make a referral to an appropriate service. […] For an agency [where family violence] is a secondary focus, CRAF is too complex. […] I don’t really think our workers would be confident to use CRAF, specially here [where] 85 per cent of our team are male; that can create a barrier for a female client to open up about [family violence] experiences.

(Homelessness service provider; female with 10 years experience)

Workers cited a lack of time, coordinated screening resources and follow-on support as a barrier to providing effective services:

First and foremost, the issue is lack of resources to respond to the needs of the client […] We are not a [family violence] service and sometimes it is hard because the case is so complex and there are so many issues, financial, legal, etc. […] There are cases where we have identified [family violence] but the level of risk is not that high to give the client priority for [family violence]. Then we prioritise housing, but then there is no housing available, then we have to find another agency and they are in the same boat as us […] The issue is also lack of consistency. We all do things and ask questions differently with all of our assessments. If there was something specific that we all use that would [be] helpful

(Homelessness service provider; female worker with eight years experience)

Team coordinators and managers repeatedly pointed out that lack of consistency among community services is a significant problem. Specifically, a lack of consistency in sharing information was reported as one of the biggest hurdles in providing effective services.
One interviewee said:

My point is it doesn't seem there is coordination among the services [...] it is very difficult for me, for example, to speak to a woman's or her partner's worker because of the privacy law [...] we have a problem in communication to resolve the problem as a whole [...] we are segregated as service providers because of privacy law around this family and therefore the violence in this incident is just perpetuated. And in the middle of this are the children [...] Something is missing in coordination of services and sharing information. I am actually quite shocked because in the other area [mental health] that I have worked in for a long time there is a great coordination among services. In cases that [family violence] has been involved, however, it seems something is missing.

(Health service provider; female worker with three years experience)

According to most interviewees there is a massive gap in information-sharing:

We are quite cautious of unpacking the full story again because it can be very traumatic for the client [...] we are often a secondary agency, which the client has referred to if [family violence] is a recent incident that has led the client to be homeless [...] An ever-increasing workload is a big problem. The agency may just pack someone off; put the client in a taxi and send her over to us in a 'cold referral' form, which means someone just arrives here and says, 'Another agency sent me here'[...] agencies think someone else will help the client when they are very busy. For a person who has just [taken off in] a taxi it is very difficult to repeat the whole story again. Specially when they arrive here very late, when it's closing time [5 pm], so we cannot even contact the first agency to seek consent and to gather information about the client.

(Homelessness service provider; female worker with 10 years experience)

Homelessness service interviewees in particular stressed that they regularly receive a large number of family violence referrals and face difficulties in getting women and children into refuges or crisis accommodation. Clients referred from family violence service providers are all assessed using CRAF, but often no information is given to the homelessness service provider at the time of referral.

Some staff also noted that for a distressed client, repeating their story and answering the same questions causes extra stress, and in some cases might stop the client asking for help or encourage them to return to the perpetrator of violence. Two staff interviewees said that screening for family violence as a secondary agency can be pointless, as family violence specialist services will reassess a client after referral, not trusting the assessment of a non-specialist service provider. A client who is referred by a family violence service to a homelessness service provider because they are not currently at risk can lose their specialist family violence support. In effect, homelessness services routinely support clients who have experienced family violence because there is no other agency involved.
Many interviewees talked about a lack of time as a key barrier to screening for family violence. For example, one worker said:

(In) a homelessness agency, the question is how much time I [as a worker] should spend trying to focus on housing problems and how much time I should spend on [family violence] problems? If the safety risk is high, we should refer the client, for example, to Safe Steps and I think this is what we can really do [...] I admit that if the client's main presenting reason is rough sleeping or not able to pay rent then she will be mainly assessed for homelessness issues, but the underlying reason might be [family violence]. ‘Why is she dealing with financial problems?’, but delving into the issue and finding out what the financial difficulty stems from requires time. So screening-wise I would argue that if we build in a [family violence] specific screening tool in a crisis service then we should screen everyone. And do we have time for that? We should also remember that for most clients it takes them a lot of time to open up.

(Homelessness service provider; female worker with two years experience)

This illustrates that even if they have sufficient family violence skills and training, workers might back away from screening clients for family violence due to time constraints, because once family violence has been disclosed there is an obligation to respond to the disclosure. The interviewee admits here that family violence might be the underlying reason for a client’s financial or housing problem, but emphasises that delving into the root of the problem requires time, so the worker might be unavailable to other clients who also need help.

Interviewees who were former service clients said that staff having the ‘right attitude’ was a crucial factor in providing effective screening. Showing empathy, validating women and demonstrating a non-judgemental attitude were considered important skills for engaging with clients. For example, one former client said:

If they employ staff [who have] had the experience before themselves, maybe I can open up easier to them [...] maybe I can trust easier [...] a male worker in a homelessness agency once told me that because I kept going back to the agency and to him I must like it [...] I then grabbed my boys and went back to the abuser [...]. I have been into so many women’s shelters and to be honest in most of my experience I felt the workers were so cold [...] feels like after working in this kind of job for a while they become numb and don’t care anymore [...] how can you understand or have empathy to someone if you have not been through that situation yourself? Most workers I have met never engaged with me.

(Female client B)

Former clients did not particularly mention workers’ gender as a factor in their inappropriate approaches, but repeatedly talked about trust as a barrier to opening up, regardless of the gender of the worker they dealt with:

It took me a long time to trust somebody. As a client we do a mental assessment in our head like the worker that does the same thing about the client. I ask in my head, ‘Is this agency able to help me?’ And if the answer is clearly ‘no’, then I leave.

(Female client C)
Views on universal community service providers using family violence screening tools

As already noted, staff interviewees showed a high level of confidence about their ability to detect family violence using their own service providers’ assessment tools. Several questioned the necessity for a specific family violence screening tool, and one asked:

*Is that just for formalising the [family violence] assessment and having it in a written format? [...] And what do we do with the more in-depth information? The problem isn’t identification of [family violence], but rather a lack of resources and dysfunctional relationships between the sectors. If I gain more detailed information, what more can I offer to my client?*

(Health service provider; female worker with 18 months experience)

Similarly, another interviewee from a different service provider said:

*There are not enough refuge options for women that require it. Because they are very limited, there are strict rules about who should get [accommodation ...]. There are often women who are at high enough risk to go to a refuge but [...] they will be placed into motel accommodation when other family members [need accommodation too], so you put everybody else at risk as well. There is a huge gap in the availability of housing options for women and children who are at risk [...] And the risk level for women and children can be so different from one to the next [...] One might be at risk and the other might be definitely at risk, but ‘might be at risk’ is as dangerous. There is definitely a lack of safe, secure accommodation for women in that risk bracket. So the issue is not identifying the risk, the question is where do we go to once the risk is identified? What options do we have once we identify there is an issue? There is not enough resources. It is so frightening!*

(Homelessness service provider; female worker with eight years experience)

These views reinforce our findings that staff may detect family violence and try to refer clients to appropriate service providers, but they are frustrated by the lack of resources available, or do not know how to effectively respond when the risk is identified. Staff were clearly concerned that even if they ask the right questions, they have limited or no resources to respond:

*Where do we go to when we identify the risk? When Safe Steps says we don’t believe the woman is on that high level of risk, what should we do? What do we do with the woman who is at risk? And Safe Steps is in the same boat as us, when they don’t have enough refuge, what should they do?*

(Homelessness service provider; female worker with eight years experience)
Workers were also unsure how their service could use detailed information from a screening tool in an effective way:

_The information has to be shared in an effective way so the family won’t need to repeat the story to another agency. If we use [a family violence] specific screening tool, my question is, ‘How is this information helpful to the family?’ This is what is often missed by professionals, because we only focus on screening. We don’t ask clients’ opinion about our questions. What questions have been helpful for you? Did any question frighten you? [...] It is also important to look at questions we ask men and the work we do for them. CRAF is a good tool to be used for victims of [family violence], but what about perpetrators, and what about men? There are men that simply do not understand what they are doing. It can be related to cultural or religious background or whatever. Most men may deny their violent actions [and] behaviour. What are the important questions to ask men? What are important questions to ask children? My challenge with CRAF as a family therapist is how do you assess a family with CRAF? CRAF is very adult, individual focused. Is CRAF useful for a 10-year-old child as a member of a family?_

(Health service provider; male worker with seven months experience)

It appears that more clarification is needed for service providers and workers about why and how CRAF should be used. An effective screening tool should not just help the practitioner to identify situations of family violence, but should also assist clients to identify significant issues in their own lives and circumstances. Helping clients to become aware of their circumstances and informing them that there are options and help available is a vital component of screening, as some interviewees pointed out:

_Education is the key [...] the more you expose it the [higher] the likelihood that you can fix the problem. There are a lot of men and women [who] deal with mental health issues and from a psychological background there is an attitude problem. There is no ‘one thing’ that can cause [family violence] and there is a lack of education around this._

(Health service provider; female worker with 12 months experience)

To improve the services, I suppose it is more about teaching people about safety plans. That there are apps you can install in your phone and you can search for help and get out of that situation and teach them what services are available for them and how they can access them [...] We have a lot of screening tools available for various issues, but with screening we also need to have a purpose. We need to know why we ask the question and what we can offer.

(Homelessness service provider, female worker with eight years experience)

### Creating opportunities for clients to be heard

Some female staff interviewees did comment that gender can play a role in providing effective service. This was specifically raised as a concern in one homelessness service provider where the majority of staff were male. As one female worker at a homelessness service provider said, clients’ reluctance to talk about family violence with a male worker can be for cultural reasons:

_Women with non-Western cultural backgrounds sometimes ask for a female staff [member]. We have had female clients [who] simply say ‘I don't want him’, and that's fine, if we have available female staff we refer them to a female [worker]._

(Homelessness service provider; female worker with two years work experience)
Interestingly, the eight male workers interviewed considered experience and ability to build trust more important factors than gender:

**Gentle approach and non-judgemental attitude are very important in helping women to open up and share; it is about experience and training, not the tool you use or being male or female.**

(Homelessness service provider; male worker with two years experience)

“Individual workers have different perspectives. Some workers have really bad attitudes towards the client and that is when the sector fails [...] Those clients might be [...] at a high level of [family violence] risk [...] There is a lot of prejudice that comes in the sectors, and not enough is done to reduce it.

(Homelessness service provider; male worker with 10 years experience)

This second male worker was highly praised by his team manager and colleagues, and considered the preferred staff member for referring family violence clients to, because of his experience and attitude. He had received family violence training, including in CRAF (which he said he does not use), and had 12 months of child protection work experience. In his view:

**Agencies need staff [who] are able to validate women [...]. Some women [who] approach here have very low self-esteem. You need to remind them how strong they are to be able to get to this point [...] it is not about the checklist screening tool to use, but the experience and passion of the worker [...] it is not just about training or the tool, but also about how the staff utilises that tool or training.**

(Homelessness service provider; male worker with 10 years experience)

Unfortunately, former client interviewees complained of a lack of support relating to their experiences of family violence:

**If you don’t check off the criteria they don’t really dig into the [family violence] problem. Their offers are so limited. They have their set agenda like referring you to a counsellor [...] they have to assess clients case by case, every individual’s case is different [...]. Structures are so rigid and therefore the system is dysfunctional [...] there are people that may not tick the boxes but they still need support.**

(Female client C)

I belong to a church and every time I spoke about my situation it was more or less put under the rug and they were more supportive of the perpetrator and even the police supported him [...] police [were] absolutely useless. [...] I was pushed down the stairs and even in hospital the doctor straight away recognised the situation, but only offered [for] me to speak with a social worker and then I was sent home with my husband [...] I was misdirected the whole time and I was more traumatised. It was [...] a friend from church who helped me to find a safe room through a homelessness agency.

(Female client B)
The women particularly emphasised the important role of police as the first point of contact, but stressed that they found police support ineffective:

*Between 2009 [and] 2015 in my two abusive relationships, every time I called the police they were unable to fully understand me and they were completely useless [...]. In the recent incident back in 2015 I could not clearly articulate my situation to the police officer because I was in such a state of confusion and I was so emotional [...] my short-term memory was affected so she [the officer] just got a snapshot of what was happening [...] they removed my husband for the night but the next morning he texted me that he [was] coming back [...] I panicked and called Safe Steps and they advised if I [was worried] for my safety I should change the lock [...] by 1 pm he came along with his friend and tried to come in and started abusing me verbally from outside when he noticed the lock [was] changed [...] they blocked the driveway so I could not leave the house [...] I called the police. The same officer came and first thing she said to me when she arrived was, 'Do you still require our service?' And then with a casual attitude she continued, 'Oh, what have we got this time? Who told you to change the lock? You shouldn’t have done it.'*

(Female client E)

All eight former client interviewees said that regardless of their immediate needs and reasons for presenting to service providers, they wanted to talk to someone and, most importantly, wanted someone to give them hope. They all felt, however, that staff had limited time to let them talk or cry. One woman said:

*On one occasion [the most recent incident that the client could remember], which was a Friday, I was beaten up and I approached a refuge [...] with my three boys and we were starving [...]. They didn’t encourage me to talk about my circumstance. We were met by a lady who gave me a $20 Coles voucher and she introduced me to other people in the house and said ‘I’ll see you on Monday’ [...] I was left alone all weekend. We were hungry, but maybe I needed someone to tell me it’s going to be fine and to hug me rather than that $20 voucher and leaving me alone [...] to be frank, I wanted to leave and go back home.*

(Female client A)

This highlights the importance of workers showing empathy to clients and ensuring that they are not left alone, particularly when an incident is recent or current. The women’s emphasis on their need to talk is in contrast to what most workers considered their first responsibility – to respond to the client’s immediate need and her reason for presenting to the service. It suggests that investigating and asking about family violence is important regardless of the reason for a client’s contact. If no one asks, the woman may not make further contact and may never receive the support she needs.

**Summary**

Five themes emerged from the analysis of our interview data. It is notable that staff and client interviewees had different views on almost all of them.

**Recognising family violence**

Staff interviewed for our research did not always have up-to-date training on what family violence encompasses and how abuse can manifest. It was therefore not possible for them to assist clients to come to the realisation that they may have been experiencing family violence.

Staff appeared overconfident that clients would tell them about family violence experiences. This is contrary to our findings from the literature review and from interviews with former service clients.
Clients need to be asked direct questions about their experiences of family violence in order to be assured that the conversation will be welcomed. Clients are not always aware that they have been living in a situation of family violence, so workers need to provide information about what constitutes family violence, allowing clients to make informed decisions about disclosure.

Confidence in identifying family violence

There is a lack of comprehension among workers concerning the value of screening tools over more general conversations with clients that cover many issues. Staff of universal community service providers are not knowledgeable about CRAF, so are not aware of its two-part structure or that it can be used for family violence identification (screening) as well risk assessment. This is a training issue – the workers we interviewed had patchy CRAF training experiences.

Screening constraints

Some staff of universal community service providers are concerned that they will not be able to deal effectively with clients’ disclosures of family violence. In particular, they do not have confidence that they can make successful referrals to specialist family violence support services. This illustrates, as the Victorian RCFV (2016) has noted, that referral and information-sharing systems need to be much improved.

In addition, women who experience family violence do not always want a referral to a specialist family violence support provider. Universal community service staff must be trained in what to do in these circumstances, including the risk assessments they should make, the safety planning processes they can conduct, the resources that are available within their organisation, and the mandatory reporting requirements they need to meet (for example, where children are involved).

Views on universal community service providers using family violence screening tools

Staff interviewees working in universal community service providers did not always understand the benefits of asking clients direct questions about family violence. Our literature review and interviews with former service clients confirmed that women may need to receive clear information about what constitutes family violence and then be asked clear, direct questions in order to feel able to disclose their experiences.

Screening for family violence allows clients to:

- recognise the situation they are currently in
- receive relevant information
- access support and counselling to help them and their children deal with their experiences
- achieve early recognition of patterns of abuse in future relationships
- understand that the abusive relationship is not their fault
- reduce incidence rates of family violence
- reduce inter-generational transmission of family violence abuse.

Creating opportunities for clients to be heard

Our interviews with former service clients highlighted the need for organisations and staff to purposefully create opportunities for clients to be heard. Safety, privacy, confidentiality, trust and empathy must be established before clients are likely to feel able to talk about their experiences of family violence.

Staff interviewed however made clear their anxiety about a lack of adequate time in which to do this, and to deal with the additional workload created by receiving a disclosure of family violence.
Conclusion and recommendations

This research’s aim is to improve life outcomes for women and children who experience homelessness and family violence.

Understanding how community service providers can better respond to affected clients who do not self-identify as victims of family violence will have a positive impact on women as parents and role models, promoting positive, healthier relationships in their futures and their children’s. Wesley has found that more women are presenting at service providers experiencing financial and housing crisis as a result of family violence, but not articulating that family violence is the cause of their situation. As a result of not being willing or able to make disclosures about family violence, these women often do not receive access to the full range of services that might otherwise be available to them.

We have revealed that screening is patchy, ad hoc and does not always meet clients’ needs. This is important because the Victorian RCFV has found that:

*Universal service systems that are available to all community members are ideally placed to have a much greater role in identifying and effectively responding to family violence at the earliest possible stage ... Improvements need to be made in order for universal organisations to be able to take a greater role in identifying and responding to family violence.*

(State of Victoria 2016)

Our recommendations, to Wesley and more generally, to enable this to happen are included opposite.

In the next stages of the project, Wesley will use the findings in this report to:

- develop a Wesley practice framework that includes a screening tool and practice toolkit
- develop policy and practice guidelines
- implement the practice framework across Wesley’s crisis services
- share the findings and new knowledge with other community service providers
- establish benchmarks for identifying and responding to incidences of family violence.

The research aimed to answer two questions:

1. How and to what extent are universal community service providers screening for family violence?
2. Where screening tools are used, are they helpful to clients?
**Recommendations to Wesley**

1. Display a poster in waiting rooms and provide a leaflet for clients to help them self-identify family violence. These should include an explanation of what constitutes family violence. Staff should further enable clients to recognise whether they are living in a situation of family violence.

2. Develop a new practice framework regarding family violence, incorporating use of the amended CRAF to identify family violence.

3. Following the recommendations of the RCFV, Wesley should commit to practices in line with the amended CRAF and to using CRAF. Staff should be trained in how to identify family violence.

4. All Wesley homelessness staff should be trained to respond appropriately to clients experiencing family violence, and to undertake risk assessments and safety planning where necessary.

5. All female clients of Wesley should be screened for family violence experiences using direct questions where it is safe to do so.

6. Staff should refer clients to specialist family violence service providers when appropriate.

**General recommendations**

1. Service standards and funding agreements for universal services should incorporate family violence screening conditions for staff. There needs to be a requirement for universal community service organisations to use CRAF for family violence screening and for their staff to be routinely and adequately trained.

2. Staff should be aware of the benefits to their clients of family violence screening. Concerns about causing harm (or bringing about additional work) need to be addressed through training and adequate referral processes. Staff are currently not aware of the benefits of empowering clients to make informed decisions about their situations.

Screening for family violence should allow clients to:

- recognise the situation they are currently in
- receive relevant information
- access support and counselling to help them and their children deal with their experiences
- achieve early recognition of patterns of abuse in future relationships
- understand that the abusive relationship is not their fault
- reduce incidence rates of family violence
- reduce intergenerational transmission of family violence abuse.
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Appendix A:

Recruitment documents

Email of Introduction

Dear _______________________

My name is Farnaz Zirakbash and I am a research fellow at Swinburne University. Recently Swinburne Institute for Social Research in partnership with Wesley Mission Victoria has undertaken a research project that aims to assist mainstream agencies in identifying women and children experiencing family violence. The research will conduct interviews with Victorian crisis and homelessness agencies in Eastern suburbs of Melbourne. On behalf of the research team I would like to take this opportunity to invite you to participate in this research project.

This action research project will explore the best ways for agencies to identify women and children who are homeless or at risk of homelessness as a result of family violence but do not specifically identify as having experienced domestic and/or family violence by agencies. This research will benefit women and children who are homeless or at risk of homelessness as a result of family violence. This research is a valuable opportunity for you as a service provider to share with us screening methods and tools that best assist early identification of women and children experiencing family violence. For more information about the project and the interview process please see attached, the project information statement.

Should you agree to participate, an interview will be organised with you at a convenient location and time. You will take part in an interview of around one hour. All the questions will be open-ended and you may wish to not answer some or wish to talk further on specific questions. The interview will be recorded and I will type up our conversation.

We appreciate your participation and looking forward for your reply.

Kindest Regards
Dr Farnaz Zirakbash
Faculty of Health, Arts and Design
Swinburne University of Technology

Wesley Mission Victoria
Swinburne University of Technology
Lord Mayor’s Charitable Foundation
Information Statement
(for organisations and professional staff)

Assisting mainstream agencies to identify female clients and their children who have experienced domestic family violence (DFV).

Hello

My name is Farnaz Zirakbash, the co-researcher of the above project. I would like to take this opportunity to provide you further details about the project and a brief description of the interview process should you agree to participate.

This action research project which is a joint project between Swinburne University and Wesley Missions Victoria, will explore the best ways for agencies to identify women and children who are homeless or at risk of homelessness as a result of family violence but do not specifically identify as such to agencies. Failure by services to initially identify those experiencing family violence results in inadequate assessment of risk and safety planning and can prevent services from providing information on legal rights and safe housing options or offering early intervention, support and recovery strategies. The project objectives therefore are:

1. To understand how agencies can most effectively identify women and children experiencing family violence in order to inform appropriate service delivery and support.

2. To inform the sector on program design and practice for ‘first to know’ services in providing effective early intervention responses to women and children seeking support as a result of family violence.

Should you agree to participate, an interview will be organised with you at a convenient location and time. You will take part in an interview of around one hour. All the questions will be open-ended and you may wish to not answer some or wish to talk further on specific questions. The interview will be recorded and I will type up our conversation. If you wish, I can contact you after the interview so you can read or listen to it and make any changes before it is included in the research. We will not include your name or anything that might show who you are in any published material or in any discussions about the research findings. Published material will include a report from Swinburne University and Wesley and perhaps an academic paper. The researcher (myself) and the project’s chief investigator (Dr Angela Spinney) will keep all data collected for this study for 5 years before being destroyed. Accordingly, your responses will only be accessible by Dr Angela Spinney and myself.
Your participation is thoroughly voluntary and you may withdraw at anytime. This means that even if you change your mind in the middle of the interview or after that, we can withdraw your participation. Before we start the interview, I will ask you to sign a form for giving me the permission to interview and record your voice.

This research is a valuable opportunity for you to share with us your experiences as a service provider in identifying and assisting women and children whom have experienced domestic and/or family violence. I do not feel that there is any risk to you in taking part in this research.

Should you require any further information, or have any concerns, please do not hesitate to contact either of below contacts:

Dr Farnaz Zirakbash: 0404727567
Dr Angela Spinney: 9214 5637

Or email at: fzirakbash@swin.edu.au

This project has been approved by or on behalf of Swinburne’s Human Research Ethics Committee (SUHREC) in line with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the conduct of this project, you can contact:

Research Ethics Officer, Swinburne Research (H68),
Swinburne University of Technology, PO Box 218, HAWTHORN VIC 3122.
Tel (03) 9214 5218 or (03) 9214 3845 or resethics@swin.edu.au
Appendix B:

Consent forms

Swinburne University of Technology
Professional staff and female clients consent form

Assisting mainstream agencies to identify female clients and their children who have experienced domestic family violence (DFV).

Investigator(s):
Chief investigator: Dr Angela Spinney
Researcher: Dr Farnaz Zirakbash

Agreement
I, (name of participant) ____________________________________________

* Have read and understood the information provided in the information statement. I have been provided a copy of the project information statement and this consent form and any questions I have asked have been answered to my satisfaction.

Please circle your response to the following:

• I agree to be interviewed by the researcher:   Yes  No
• I agree to allow the interview to be recorded by electronic device:  Yes  No
• I agree to make myself available for further information if required: Yes  No

I acknowledge that:

(a) My participation is voluntary and that I am free to withdraw from the project at any time without explanation; (I have been informed that in event of my decision to withdraw from the research, all data related to me will be completely destroyed and will not be incorporated in any stage of the research).

(b) The project is for the purpose of research and not for profit.

By signing this document I agree to participate in this project.

Name of Participant: ________________________________________________

Signature and Date: ________________________________________________
Swinburne University of Technology  
Crisis and homelessness organisations consent form

Assisting mainstream agencies to identify female clients and their children who have experienced domestic family violence (DFV).

Investigator(s):  
Agreement of (name of organisation)  
Researcher: Dr Farnaz Zirakbash

Agreement  
in (name of participant) _______________________________________

Have read and understood the information provided in the form of disclosure. I have been provided a copy of the project information statement and this consent form and any questions I have asked have been answered to my satisfaction.

Please circle your response to the following:

• I agree for staff to be interviewed by the researcher: Yes   No
• I agree to allow the interview of staff to be recorded by electronic device: Yes   No
• I agree for staff to make themselves available for further information if required: Yes   No

I acknowledge that:

(a) The participation of staff is voluntary and that they are free to withdraw from the project at any time without explanation; (they will be informed that in event of decision to withdraw from the research, all data related to them will be completely destroyed and will not be incorporated in any stage of the research).

(b) The project is for the purpose of research and not for profit.

By signing this document I agree for staff to participate in this project.

Name of Participant: ________________________________________________

Signature and Date: ________________________________________________
Appendix C:
Research and interview questions

**Research questions**
- How and to what extent are mainstream/generalist services screening for FV?
- If a screening tool was used, was it helpful to the client?

**Mainstream agencies: staff questions**
- What support services this agency centre provides/offer?
- Is having experienced family violence a common reason for which your clients use your services? (If not what are the common reasons).
- Is it common for clients to discuss experiences of FV?
- Do you use any specific assessment tool that is sensitive and respectful to the experiences of diverse families?
- Do you often refer your clients to other agencies that can respond to their type of needs and which agencies?
- Do you share information with other agencies routinely? If not, what are the barriers?

**Screening tools questions**
- What screening tools do you use to identify people at risk?
- How do use these tools, do you read them out for example? How confident are you using these tools?
- How useful do you think are screening tools?
- Do you use the Victorian government CRAF or a CRAF-aligned risk assessment tool when dealing with FV matters?
- Do you use any specific family violence screening/assessment tools at all?
- Do you use any screening/assessment tool to determine whether or not your female clients have ever experienced FV?
- If you use FV screening tool does that include any evidence-based risk indicator specific to children or young people?
- Are you aware of any FV screening/assessment tools used by other agencies?
- What approaches tends to work well with supporting your clients that have had experiences of FV?
• What screening/assessment tools used in this agency in your opinion are the most effective ones and why?
• Do you think it would be helpful to have screening tools for FV? Why yes/no.
• Do you think there is room to build in a FV screening tool to your current screening/assessment practice?
• Would you like to add anything else into this interview? Do you think we missed anything important?

Client questions
• How many times did you present here before you were asked about FV experiences?
• Were you asked about FV?
• What type of questions did they ask you?
• If they asked you questions about FV, did they ask any follow-up questions?
• Did you feel listened to and believed when they responded?
• Were you referred to a FV service for support? If not, would you have liked to have been?
• Did the service provide any information regarding family violence and your situation/options, including safety planning?
• Was there ever a time you thought someone could have asked you about FV and didn’t?
• Did this agency asked you to complete any particular questionnaire or verbally asked you a list of questions to assess your case?
• In your opinion what is missing in the agency’s approach in assisting their clients?
• Would you like to add anything else into this conversation? Did I miss any important question to ask?
Appendix D:

Homelessness service provider’s assessment tool

**Housing need**

**Housing situation/history:**
- Current situation, past housing history
- Private rental, OOH, THM, Rooming House
- Exploration of short term housing options, family, friends
- Blacklisting, reasons for this
- Access to RIA, bond, etc

**Support need**

**Financial:** Income, financial commitments, debts, fines, savings, budgeting, gambling

**Work/education:** work history, school/training history, literacy, numeracy, future plans.

**Supports:** Agencies/workers involved, friendship networks.

**Family/relationships:** current supports, boy/girl friend, DV/Family violence/other safety issues, gender issues, pets.

**Children:** full names and D.O.B, access/custody arrangements, parental details, school/childcare details, health/developmental issues, Family violence, Child protection/Child First, other services.

**Cultural issues:** Country of Birth, time in Australia, visa status, proficiency of English, cultural supports, religious considerations.

**Legal:** intervention orders, previous/pending court matters, bail/parole/office of corrections conditions, legal representation.

**Health:** illnesses, injury, diagnosis, medication, doctors, recent medical check, hospital admissions, pregnancy, health concerns, lifestyle issues.

**Disability:** Physical, intellectual, learning disability, acquired brain injury, living skills.

**Mental health:** diagnosis, present/past history, medication, admissions to hospital, doctors/services, CTO, suicidality, self harm, challenging behaviour, anger management, personality disorder.

**Drug and alcohol:** current/past use, use of counseling/detox/rehab, related health issues, details of specific use.

**Current safety issues:** DV/family violence, neighbors, unsafe areas, risk factors.