Intimate partner violence in Australian refugee communities
Scoping review of issues and service responses

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Summary

This paper looks at what is currently known about intimate partner violence in Australian refugee communities, and what service providers can do to ensure appropriate support is available to this client group. The first half of the paper provides a scoping review of current research. The second half of the paper looks at real-life case studies of service practice through consultations with organisations of importance to refugee communities in Queensland, Western Australia and Victoria.

Key messages

- Intimate partner violence (IPV) is the most commonly experienced form of family violence used against women in Australia and takes place across all cultures and faith groups.

- In addition to physical and sexual violence, women from refugee backgrounds are particularly vulnerable to financial abuse, reproductive coercion and immigration-related violence.

- Intersecting factors relevant to the experience of IPV in refugee communities include migration pathways and traumatic pre-arrival experiences, as well as settlement issues such as acculturation stress and social isolation.

- Integrated, trauma-informed care is regarded as promising practice in services targeting individuals from refugee backgrounds to address women’s experiences of IPV.

- To assist in overcoming barriers to engagement, service providers can implement strategies to enhance cultural safety. Promoting community involvement and leadership has been shown to be important in developing culturally competent programming and should underpin violence prevention strategies.
Introduction

Intimate partner violence (IPV) is violence within a married or partnered relationship. In Australia, IPV is the most commonly experienced form of family violence. It takes place across all cultures and faith groups (Devries et al., 2013; Our Watch, 2018; World Health Organization [WHO], 2012).

Due to low rates of service engagement and few rigorous studies into Australian refugee communities, there is little available knowledge to inform practitioners about effective strategies for engaging with, and appropriately responding to the needs of, women from refugee backgrounds. However, we know that IPV is an important issue to culturally and linguistically diverse (CALD) populations. There is a growing research interest in the experiences of women from refugee backgrounds, and an emerging evidence base to provide guidance to service providers about promising practices with these groups.

We also know that service providers face challenges in developing culturally safe programming for these groups and in involving communities in violence reduction strategies (Australian Institute of Health and Welfare [AIHW], 2018). Here we differentiate between cultural safety and cultural competency, which is defined as the development of knowledge, awareness and skills in staff that equip them with greater contextual understanding of victims/survivors’ experiences (Wilson, Fauci, & Goodman, 2015). Cultural safety adds to that definition by providing a broader understanding of empowerment, identity and the value of cultural beliefs (Phiri, Dietsch, & Bonner, 2010).

The need for greater provision of services to CALD women experiencing violence has been acknowledged by the Commonwealth Government in the National Plan to Reduce Violence Against Women and Their Children 2010–2022 (Department of Social Services [DSS], 2010). Its Third Action Plan (2016–19) (DSS, 2016) emphasised the need for increased cultural awareness in service systems and practitioners. Similarly, state and territory governments in recent years have reviewed and updated their policies on family violence and multiculturalism to ensure recognition of cultural diversity and strategies to promote inclusivity. Police and family law system services have also implemented strategies to better engage with diverse communities and foster positive relationships with community-specific organisations.

Child Family Community Australia (CFCA) has produced this paper to support practitioners working in the child, family and community welfare sector. This resource is based on two pieces of work. The first is a comprehensive scoping review of the available literature, which provides an overview of the underlying issues and relevant factors associated with IPV in Australian refugee communities. It identifies intersecting factors relevant to the experience of IPV (such as migration pathways and pre-arrival experiences of refugees), as well as settlement issues for refugee communities more generally (including acculturation stress and social isolation).

The scoping review revealed the need for further investigation into the practical aspects of engaging women from refugee backgrounds with experiences of IPV. For this reason, CFCA also conducted stakeholder consultations with organisations of importance to refugee communities in Queensland, Western Australia and Victoria to contribute to the emerging body of literature on promising practice. These consultations form a diverse set of case studies that represent the main issues raised in the literature. They offer a practical perspective on service strategies that have not been widely studied or evaluated in Australia.

How do we define Australian refugee communities?

A definition of community in a refugee context is applied here as, ‘those individuals who share a common country or area of birth and/or extended residence in that country; and/or identify as such and are accepted as such, due to familial or other kinship or social ties’ (Fisher, 2009, p. 4). The concept of community is important to discussions about how services can develop and improve on culturally safe interventions and programs to meet the needs of individuals from refugee backgrounds who are victims/survivors of IPV.

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1 The United Nations 1951 Convention Relating to the Status of Refugees defines refugees as: ‘[...] any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear is unwilling, to avail himself/herself of the protection of that country’ (United Nations High Commissioner for Refugees [UNHCR], 2018).

2 Men can also be victims/survivors of intimate partner violence; however, there is little research into experiences of this in Australian refugee communities. For more general information see: AIHW (2018) Family, Domestic and Sexual Violence in Australia, 2018; Oliffe et al. (2014) Gay men and Intimate Partner Violence: A Gender Analysis.
In Australia, the refugee visa category\(^3\) is one part of the offshore component of the Commonwealth Government’s Humanitarian Program. In 2017/18, 16,250 places were included in the Australian Humanitarian Program. This will increase to 18,750 places in 2018/19 (Department of Home Affairs [DHA], 2018a). In September 2015, the Australian Government provided an additional 12,000 places in response to the conflict in Syria and Iraq (DHA, 2018a). All 12,000 additional Humanitarian visas have been granted (DHA, 2018a). Individuals entering Australia through other visa categories under the Humanitarian Program can also be considered refugees or coming from refugee-like contexts and are included in general service definitions of refugees.

Great diversity exists among individuals from refugee backgrounds. This diversity extends to communities from the same countries, regions and faiths – as well as between families and individuals in those communities. It is no easy task to discuss Australian refugee communities without making choices about what to include and exclude. This paper focuses on individuals who have permanent residence in Australia through the Humanitarian Program. These individuals have greater eligibility for services and are more likely to seek support for experiences of IPV than those with more precarious immigration status – a fact that is reflected in the available Australian literature.

While the scope of this project is largely limited to discussions regarding individuals from refugee backgrounds who have permanent residency in Australia, the experiences of those on temporary visas (particularly those on spousal visas) are also noted in sections regarding immigration-related violence (page 6). (For more information about the official aims of the Humanitarian Program, see rda.gov.au/news/2018/20180503-humanitarian-program.aspx).

**Methodology**

The research design applied in this paper includes a scoping review and stakeholder consultations. The need for this approach was identified in the early stages of research that found a paucity of Australian literature available on the topic. The qualitative stakeholder consultations were devised as a way to supplement the literature with strategies for services on how to engage women from refugee backgrounds experiencing intimate partner violence. This aligns with the general goals of CFCA to support the service sector with perspectives relevant to current practice. The scoping review was undertaken in the first instance, in order to develop our understanding of the general forms of IPV, mitigating factors and experiences of service engagement. The semi-structured interview schedule (Appendix B, page 24) was developed based on three main strategies found in the literature about how to overcome barriers to service access and engagement: cultural safety, involving community in responses to family violence, and applying integrated trauma-informed care in programming and practice. Stakeholder consultations were undertaken with three services, across three states in Australia.

The literature search strategy used several electronic social science databases including: ProQuest, Elsevier, Ovid PsyArticles and others. The AIFS library system was used to identify relevant materials from Australia and abroad, including research reports, peer-reviewed articles, service frameworks and guidelines, and government documents. The literature search took place from December 2017 to May 2018 and drew on materials published between January 2008 and May 2018.

The initially identified keywords (see Appendix A, page 23) were refined over the course of the search, and a snowballing approach was applied to the main Australian literature on the subject. Initial keyword searches indicated that refugee communities are included in studies into general CALD populations, communities and services, and the literature presented here is generally relevant to CALD as well as refugee communities. Similarly, studies into family violence in these communities included data about IPV and were included in the scoping review.

This research predominantly draws on Australian literature, including 58 peer-reviewed studies and documents from government services and non-government organisations. A small number of studies and documents have been included from outside of Australia (\(n = 17\)), mainly from the USA, Europe and Canada. A total of 75 documents were reviewed in this study. Details of the inclusion criteria for documents viewed in the literature search are available in Appendix A.

A scoping review was deemed more appropriate for this research than a systematic literature review, which would require a clearly identified research question and explicit inclusion criteria for the types of studies selected. In this scoping review we found gaps in research, a lack of evaluative studies and only a small number of guides for practical service delivery. This will inform future research and stakeholder engagement undertaken by CFCA in this area.

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3 This category includes the following visas: The Refugee visa (subclass 200), the in-country Special Humanitarian visa (subclass 201), the Emergency Rescue visa (subclass 203), and the Women at Risk visa (subclass 204).
This research includes peer-reviewed studies that underwent abstract screening to determine relevance to the topic of this paper – a process that was subject to research limitations such as timelines and available resources. Aggregative synthesis with a focus on summarising the available data was applied to the selected materials (Dixon-Woods et al., 2006). In summarising the data, this paper applied categories that were already widely used in available studies rather than developing new concepts or categories. For example, categories comprising previously identified forms of IPV are included in this research based on recurring categories across the data pool. Certain sub-categories (e.g. acculturation and trauma) were present in many of the broad-level categories, while others (e.g. financial abuse as a form of IPV) were coded into distinct categories in the data analysis process. A method of aggregative synthesis that describes general themes and applies existing categories from the literature is appropriate to scoping reviews into emergent and/or ‘hard to reach’ communities (which present challenges to primary research), and where the research questions are not clearly defined.

Throughout June 2018, consultations were held with services identified through CFCA networks. Engaging the sector through stakeholder consultations worked to provide concrete examples of emergent practice mentioned in the literature. Seven services were initially contacted and three were selected for consultations based on their availability during the fieldwork period. These three services represent a small sample of services that offer support for women from refugee backgrounds experiencing IPV in Western Australia, Queensland and Victoria. Telephone consultations were undertaken with service representatives using a semi-structured interview schedule (Appendix B, page 24) that was based on themes identified in the scoping review.

Qualitative analysis of the stakeholder consultation data is presented here alongside descriptions of the services; however, this information is anonymised and we do not use the names of the services or representatives who participated in consultations. Consultation data were coded under categories identified in the scoping review, and analysed alongside key aspects of the literature about strategies to support service uptake and engagement in Australian refugee communities.

Ethics approval for this research was obtained through the Australian Institute of Family Studies’ human research ethics processes.

Scoping review

Intimate partner violence is a specific term used to describe forms of family violence that WHO has defined as, ‘behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship’ (2012, p. 1). An intimate partner can include a husband/wife, fiancé/fiancée, de facto partner or boyfriend/girlfriend who may or may not share a residence, or who may or may not have shared a residence in the past (Stavrou, Poynton, & Weatherburn, 2016; WHO, 2012).

The Australian Bureau of Statistics (ABS, 2016) reported that one in four Australian women (or 2.2 million) have experienced at least one incident of IPV since the age of 15. It is unknown what percentage of these victims/survivors are from refugee backgrounds. Based on the available data, it is not possible to ascertain whether women from refugee backgrounds face greater levels of IPV than other groups of women in Australia. However, it has been found that CALD women are particularly vulnerable to family violence due to factors such as social isolation, language and cultural barriers, and lack of knowledge about rights and available services (DSS, 2015; InTouch Multicultural Centre Against Family Violence [InTouch], 2010; Segrave, 2017; Vaughan et al., 2016).

Forms of intimate partner violence

Intimate partner violence is the predominant type of family violence experienced by women. It can take multiple forms, including coercion and control (e.g. through finances and/or technology), and can be perpetrated both directly and indirectly (Our Watch, 2018; Segrave, 2017; Vaughan et al., 2016; WHO, 2012). Studies into the experiences of women from refugee backgrounds have found that threats and coercion feature heavily in abusive relationships; however, it has been pointed out that many CALD women do not recognise forms of IPV outside of physical violence that causes injury – particularly financial abuse and reproductive coercion (Khawaja & Milner, 2012; Mengesha, Perz, Dune, & Ussher, 2017; Metusela et al., 2017; Ogunsiji, Wilkes, Jackson & Peters, 2010; Segrave, 2017; Ussher et al., 2012; Vaughan et al., 2016).
Physical and sexual violence

Pre-arrival experiences of physical and sexual violence can have harmful, lasting effects and negatively impact on settlement experiences (Taylor & Lamaro Haintz, 2018). Women from refugee backgrounds face multiple threats to their health and wellbeing in transit, including during their time spent in refugee camps and/or detention centres (Taylor & Lamaro Haintz, 2018; Tourneur et al., 2015).

Research from Australia’s National Research Organisation for Women’s Safety (ANROWS) found that women from immigrant and refugee backgrounds were subjected to pre-arrival family violence – particularly IPV – and experienced significant pressure from families and communities to normalise and tolerate violence (Vaughan et al., 2016). Another Australian study found that pre-arrival experiences of sexual assault exacerbated the social isolation felt by women during settlement, causing anxiety that any disclosure of IPV would lead to ostracism from their community (Zannettino et al., 2013). Moreover, past violent acts perpetrated by government institutions and/or military in a country of origin can affect women’s ability to form trusting relationships and engage with police and other authorities in Australia (InTouch, 2010; Vaughan et al., 2016).

Multi-perpetrator violence

While not exactly a form of IPV, CALD women are more likely to experience multi-perpetrator violence – violence perpetrated by multiple extended family and/or community members that often takes place concurrently to IPV (DSS, 2015; Salter, 2014). Close family ties can often act as a source of support for women experiencing IPV; however, in some cases cohabitation or living within close proximity to extended family can place CALD women at risk of further violence (DSS, 2015; Vaughan et al., 2016).

Kitchen table consultations carried out by the Department of Social Services (DSS) with CALD women throughout Australia between 2014 and 2015 showed that these women are more likely to live in extended family households and experience violent behaviours from family members (DSS, 2015). In addition to IPV, these women were subjected to violence perpetrated by their mother-in-law, husband’s siblings and adolescent sons (DSS, 2015).

Young people

There is little research into IPV in young people's intimate relationships and a significant gap in knowledge about IPV in young refugee and CALD people’s intimate relationships. Although the age of consent is between 16 and 17 years across the states and territories, young people are ineligible to access family violence support services until they reach 18 years – representing a gap in service delivery and placing young people at high risk. A University of South Australia study commissioned by Multicultural Youth South Australia (MYSA) investigated experiences of IPV in relationships formed by young people from refugee backgrounds. The study found that IPV can affect young people aged 12 years and over, and that many young people were hospitalised as a result of the violence (MYSA, 2017). Further, MYSA noted an increase in unplanned teenage pregnancies among young women from CALD and refugee backgrounds (MYSA, 2017).

Financial abuse

Financial abuse is characterised by the perpetrators’ use of finances to increase dependency, exert control and limit the physical activity of their partner. It is a form of IPV to which women from refugee backgrounds are particularly vulnerable (Ragusa, 2017; Segrave, 2017; Vaughan et al., 2016). That vulnerability can be partially attributed to the financial stress caused by common settlement issues experienced by recently arrived refugees, such as long periods of unemployment, language and cultural barriers, and discrimination (Cortis & Bullen, 2015).

Attitudes informed by rigid gender roles can lead to unequal practices around employment and create conditions that are conducive to financial abuse (Fisher, 2013; Muchoki, 2013). Evidence suggests some women from refugee backgrounds are discouraged from engaging in paid work by their partner. This increases their financial dependency and limits their capacity for independent activities and decision making (Cortis & Bullen, 2015).

Moreover, family conflict may arise due to a woman’s receipt of Centrelink payments, giving her increased opportunities for independence (Fisher, 2013). Research shows that some men from refugee backgrounds perceive Centrelink payments made directly to women as against the established patriarchal family structure where men are the breadwinners and control family finances (Fisher, 2013). It has been found that this creates tension in relationships due to a perceived loss of cultural identity (see the section on acculturation stress (on page 8) for more).
Reproductive coercion

Any behaviour that interferes with or obstructs women's autonomous decision making about reproductive issues can be described as reproductive coercion (Grace & Fleming, 2016). Forms of reproductive coercion can include pregnancy coercion, interference with birth control and controlling pregnancy outcomes (Grace & Fleming, 2016). Cultural values can influence women’s normalisation of reproductive coercion, as shown in qualitative research into women from recently arrived migrant and refugee communities living in Sydney and Vancouver (Metusela et al., 2017).

Participants in this research reported that they felt unable to refuse the sexual advances of their partners and/or seek help for sexual pain. Participants also felt unable to ask their partners to check their own sexual health, particularly in testing for sexually transmissible infections. Further, the research showed that these women were prevented from accessing general sexual and reproductive health care due to cultural taboos that forbid premarital sex (Metusela et al., 2017).

Other research from Australia finds that CALD women have low levels of uptake of sexual and reproductive health services, particularly with regard to preventative sexual health measures (Ussher et al., 2012). These findings demonstrate the complexities involved in identifying the presence of reproductive coercion, and the challenges in providing sexual and reproductive health care to women from CALD and refugee backgrounds.

Another study has investigated the perspective of Australian health care professionals in the provision of services to these groups (Mengesha et al., 2017). Findings reveal that these women experience reproductive coercion that often leads to unplanned and unwanted pregnancies. The study found that health care workers observed dominating behaviour by male partners; for example, in situations where male partners would act as interpreters between their female partners and health care workers, not allowing the use of an independent interpreter (Mengesha et al., 2017). This was described as a major challenge to providing confidential, women-centred care. It also limited the opportunities for health care workers to screen for family violence during appointments (Mengesha et al., 2017).

Immigration-related violence

Immigration status can contribute to and worsen IPV by creating an unequal power dynamic between spouses (Bhuyan, 2012; Ghafoor, 2011; Segrave, 2017; Thronson, 2012). Their visa category can increase women’s vulnerability and the risk of violence, particularly when immigration status can limit eligibility for employment and access to health and education services (Segrave, 2017). Research from Australia finds that women with precarious migration status are less willing to seek help for IPV and engage with services than those with permanent residency (InTouch, 2010; Segrave, 2017; Vaughan et al., 2016). There is a growing body of research into this group showing that perpetrators, ‘wield power and control over women, including through [the use of] threats of deportation, threats to family living overseas and threats that women would lose access to their children’ (Vaughan et al., 2016, p. 31). However, in this study we focus on women from refugee backgrounds that have obtained permanent residency in Australia.

Relevant factors contributing to intimate partner violence

There is no definitive driver of IPV in refugee communities; however, the literature points to intersecting factors that can assist in our understanding of the violence experienced by women from refugee backgrounds and in CALD communities more generally. Traumatic pre-arrival experiences and stress associated with settlement acculturation can contribute to the occurrence of family violence, as well as affect the help-seeking behaviour and service engagement of victims/survivors.

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4 Many of the health care workers interviewed recommend that men be included in some discussions about their partner’s sexual and reproductive health, as this ensures women’s safe and ongoing engagement with health services and can provide information useful to men (Mengesha et al., 2017).
Intimate partner violence in Australian refugee communities

Traumatic pre-arrival experiences

Traumatic pre-arrival experiences affect the ability of individuals from refugee backgrounds to cope in a new environment and can worsen family functioning issues during and post-settlement. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a traumatic event as exposure to war, threatened or actual death, serious injury or sexual violence (American Psychiatric Association [APA], 2013). An individual’s knowledge of a close friend or family member’s experience of a traumatic event also classifies as traumatic for that individual. The DSM-5 notes that mental ill-health can be caused by trauma, and trauma- and stressor-related disorders can result from exposure to the traumatic event(s); however, it does not recognise complex trauma and its effects on mental health. Complex trauma is described as:

trauma that is the result of stressors that are interpersonal – usually severe, sustained and perpetrated by one human being on another – and where clients may not meet all of the specific diagnostic criteria for post-traumatic stress disorder (PTSD). (Wall, Higgins, & Hunter, 2016, p. 1)

It is important for service providers to understand complex trauma and its effects on the mental health of individuals from refugee backgrounds. Thousands of refugees settle in Australia every year from Africa, the Middle East and South-East Asia. They have often experienced traumatic events in their country of origin and/or in transit to Australia (DHA, 2018a; Harris, 2018; Khawaja & Milner, 2012; Schlock, Bottche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016; Vaughan et al., 2016).

The Victorian Foundation for Survivors of Torture (Foundation House; 2012) notes that one in four individuals from refugee backgrounds has endured pre-arrival experiences of torture, while approximately three-quarters have experienced traumatic events, such as interpersonal violence. Prior to settlement, individuals from refugee backgrounds may have experienced torture, sexual assault, threats to themselves and their families, food shortages and/or been witnesses to the destruction of their communities and homes (Harris, 2018; Khawaja & Milner, 2012; Segrave, 2017). These experiences are often compounded by perilous migration pathways and periods of time spent in refugee camps and/or detention centres, which can cause further psychological stress (Harris, 2018; Segrave, 2017; Vaughan et al., 2016; Zannettino et al., 2013).

Trauma-informed care

In order to address complex trauma, services working with refugee communities use principles of trauma-informed care, which prioritise client safety and apply empowering, strength-based modes of practice (Bateman, Henderson, & Kezelman, 2013; Wall et al., 2016; Wilson et al., 2015). Research from the USA has defined trauma-informed care as grounded in the following principles (Wilson et al., 2015):

- establishing emotional safety
- restoring choice and control
- facilitating connection
- supporting coping
- responding to identity and context
- building strengths.

Trauma-informed care is underpinned by an understanding of the effects of trauma on an individual’s behaviour and the need for programs to effectively respond to the contexts and experiences of their client groups (Bateman et al., 2013). Australia’s Mental Health Coordinating Council (MCC) has noted:

When a human service program seeks to become trauma-informed, every part of its organisation, management and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services. By facilitating recovery through trauma-informed care, re-victimisation can be minimised and self and community wellness and connectedness can be promoted. (Bateman et al., 2013, p. 5)

Due to the effects of trauma, individuals from refugee backgrounds are likely to have highly complex physical and mental health needs. Research finds that pre-arrival trauma, in addition to migration-related stress and post-migratory factors, affects physical and mental health and can lead to depression and anxiety (Harris, 2018; generally, the agreed definition of settlement refers to the first five years of permanent residence in Australia after a visa has been granted. The term ‘post-settlement’ refers to the period of time following this initial five years.)
Kartal & Kiropoulos, 2016; Schlock et al., 2016; Vaughan et al., 2016). Further, experiences of family violence are themselves traumatic, with often severe and/or ongoing effects on physical and mental health (Wall et al., 2016).

Trauma can affect the help-seeking behaviour and service engagement of victims/survivors of IPV. Mental ill-health can be difficult for service providers to identify and manage in individuals from refugee backgrounds due to language barriers and cultural differences (APA, 2013; Foundation House, 2012; Harris, 2018). For this reason, service providers must take into account traumatic pre-arrival experiences and the stressors associated with the settlement experience in their service delivery models and programming (Foundation House, 2012).

**Acculturation stress**

Acculturation stress can arise during periods of settlement in a new country. A post-migratory experience, acculturation is a two-dimensional process of concurrent involvement in a new culture while maintaining aspects of one’s original cultural identity. This process may cause significant stress to individuals from refugee backgrounds (Kartal & Kiropoulos, 2016; Khawaja & Milner, 2012; Sam & Berry, 2010).

Research into Australian refugee communities shows that settlement acculturation worsens pre-arrival traumatic experiences, often affecting mental health and leading to social isolation (both of which are relevant factors to IPV) (Anderson, 2015; Australian Multicultural Education Services [AMES], 2017; Harris, 2018; InTouch, 2010; Ragusa, 2017; Segrave, 2017; Taylor & Lamaro Haintz, 2018; Vaughan et al., 2016).

**Acculturation stress and gender inequality**

There is some evidence to suggest that settlement acculturation causes stress on marital and family relationships when individuals within the family adapt to life in Australia at varying rates. Many individuals experience changes to gendered family dynamics as part of settlement acculturation and this can be perceived as a loss of cultural identity. For example, a study of individuals from a South Sudanese refugee community in Brisbane showed that marital conflict arose during periods of acculturation because men were more resistant than women to new cultural values, including with regard to changes to their gender role and status within their families and wider society (Khawaja & Milner, 2012). Conversely, the study showed that women embraced their new rights and social and financial freedoms, which led to difficulties in relationships due to shifting power dynamics (Khawaja & Milner, 2012).

These shifts can breed tension and create situations that are conducive to family violence (InTouch, 2010; Khawaja & Milner, 2012; Vaughan et al., 2016). Studies have found that some men from refugee backgrounds believe that Australian service providers prioritise the needs of women and children over the needs of men (Muchoki, 2013; Vaughan et al., 2016). Other studies into migrant and refugee communities in Australia reflect similar findings, and note that intra-relationship conflict, as well as conflict between parents and children, can arise during periods of settlement acculturation for this reason (Doney, Pittaway, & Turvey, 2010; Fisher, 2013; Muchoki, 2013; Ogunschii et al., 2010). Adjusting to this perceived lack of control, coupled with the absence of family and community support, can be a major challenge and source of stress for some men from refugee backgrounds (Fisher, 2013; Khawaja & Milner, 2012; Ogunschii et al., 2010; Vaughan et al., 2016; Zannettino et al., 2013; Zufferey, Chung, Franzway, Wendt, & Moulding, 2016).

Research into violence in CALD communities finds that a shift in widely held values on gender equality from the country of origin can affect an individual’s adjustment to Australia during settlement acculturation (AMES, 2017; Muchoki, 2013). For example, research into the attitudes of men from Horn of Africa refugee communities (including Sudan, Somalia, Ethiopia, and Eritrea) found that they experienced shifts in gender roles and dynamics that differed considerably from their countries of origin, and this affected their intimate lives and family relationships (Muchoki, 2013). Women and children are considered to be at high risk of family violence when the male partner/father begins to view them as disempowering agents or participants in the changing family roles (Fisher, 2013). However, other research emphasises that men’s views in this regard may be determined more by their individual beliefs and characteristics than the cultural values of their community, faith or country of origin (Vaughan et al., 2016).

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6 Though outside the scope of this research, acculturation stress is particularly salient in discussions about wider issues of family violence in refugee communities, such as conflict between parents and children. There is little research into this but for more general information about children and young people from Australian refugee communities see: Due, Riggs, & Augustinos (2015) The Education, Wellbeing and Identity of Children With Migrant or Refugee Backgrounds; Kaplan, Stolk, Valibhoy, Tucker, & Baker (2015) Cognitive Assessment of Refugee Children: Effects of Trauma and New Language Acquisition; and Zwi et al. (2017) Protective Factors for Social-Emotional Well-Being of Refugee Children in the First Three Years of Settlement in Australia.
Barriers to service engagement

Women from refugee backgrounds face barriers to accessing support services when seeking help for experiences of family violence. Australian research into CALD victims/survivors (including from refugee backgrounds) identifies several overlapping factors affecting decisions to seek help and support (DSS, 2015; Ghafoournia, 2011; Harris, 2018; McCulloch, Maher, Fitz-Gibbon, Segrave, & Roffee, 2016; Vaughan et al., 2016; Zannettino, 2012):

- immigration status
- limited knowledge of rights and/or available services
- language barriers
- fear and distrust of authorities
- lack of cultural safety
- family and community factors.

Here, we define cultural safety as important to the cultural competency of service providers. On its own, cultural competency does not sufficiently address power imbalances and the marginalisation of certain cultures (Kirmayer, 2012). However, the development of cultural safety in family violence services does provide a broader understanding of empowerment, identity and the value of cultural beliefs (Phiri et al., 2010).

The above factors can support understandings of the complexity of CALD women’s experiences of IPV and guide service providers in developing culturally competent programming. Studies find that CALD women often seek assistance following long periods of family violence, and their service engagement often follows a critical incident and/or grave concerns for their children’s safety (Australian Muslim Women’s Centre for Human Rights [AMWCHR], 2013; InTouch, 2010; Vaughan et al., 2016).

While it is useful to understand the general barriers to effective service provision, it is also important to note that CALD women are affected by IPV in different ways and undertake different help-seeking strategies (InTouch, 2010; Kim & Lee, 2011; Ragusa, 2017). One of the main underlying issues to affect women from refugee backgrounds’ engagement with services is exposure to traumatic pre-arrival experiences.

Immigration status

Individuals from refugee backgrounds experience many different migration pathways to Australia and permanent settlement can be achieved through different classes of visa. A significant number of individuals move between visa categories and many individuals on temporary visas (workers and students) are successful in their applications for permanent residence in Australia (Vaughan et al., 2016). There can be considerable differences in service uptake and engagement between humanitarian entrants and individuals who apply for permanent residence while living in Australia on temporary visas (Segrave, 2017).

The Commonwealth Government’s Humanitarian Program allows a number of individuals from refugee backgrounds to settle in Australia every year, with access to health and education services including English language programs (DHA, 2018a; Segrave, 2017; Taylor & Lamaro Haintz, 2018; Vaughan et al., 2016). In contrast to this, individuals who hold temporary visas are ineligible for certain services (such as health, education and employment services) that are available to humanitarian entrants (Segrave, 2017; Zannettino et al., 2013; Zufferey et al., 2016).

This can create conditions within relationships that are conducive to IPV and present as a barrier to victims/survivors’ help-seeking behaviour. Australian research into family violence support and service delivery in the context of temporary migration and the vulnerabilities women face while on spousal and sponsorship visas finds that visa class is a major factor influencing women’s experiences of violence (Shabbar, 2012; Segrave, 2017; Vaughan et al., 2016).

Family violence provisions

Family violence provisions allow individuals in the process of applying for permanent residence in Australia to complete their applications if their relationship breaks down due to family violence (DHA, 2018b). These provisions contain a definition of ‘relevant family violence’ that includes actual or threatened violence towards the applicant, a family member or their property, which leads the applicant to feel unsafe or fearful for their wellbeing (DHA, 2018b). The violence can include physical harm, psychological abuse, financial abuse and other forms of controlling and harmful behaviour (DHA, 2018b).
Family violence provisions require either judicially or non-judicially determined evidence to support the applicant’s experiences of violence. Judicially determined evidence can include court orders against a perpetrator under state or territory law, court injunctions under the *Family Law Act 1975* (Cth), or evidence of past convictions or findings of guilt of violence perpetrated against the applicant or a member of their family (DHA, 2018b). Non-judicially determined evidence can include the applicant’s submission of a statutory declaration including the perpetrator’s details and a summary of the violent behaviour; or a minimum of two other acceptable forms of evidence listed in the Commonwealth legislative instrument (DHA, 2018b). For example, a medical report, hospital report or discharge summary noting that either the mental health treatment or physical injury of the applicant is consistent with family violence, or a statutory declaration made by either a police officer or a witness to a police officer (Migration Regulations 1994, Schedule 1). 7

Both the judicial and the non-judicial evidentiary requirements request that the applicant provide evidence of a genuine relationship and evidence that family violence took place during that relationship (Vaughan et al., 2016). These requirements are challenging for women who face language and cultural barriers, difficulties in accessing information and services, and/or little understanding of their rights and legal processes in Australia (Segrave, 2017). Moreover, knowledge about these provisions may be unavailable to women from refugee backgrounds who are dependent on their partners for information about their rights and available services (Segrave, 2017).

**Limited knowledge of rights and/or services**

High rates of under-reporting of family violence among general populations of CALD women in Australia are influenced by a limited knowledge of rights, laws and available services (InTouch, 2010). Often the reluctance of CALD victims/survivors’ of IPV to report violence is due to a distrust of authorities and concerns about the severity of consequences (InTouch, 2010; Ogunsiji et al., 2010). An Australian study in to women from West African refugee communities noted the ways in which their decisions to report experiences of IPV were shaped by sociocultural factors (influenced by pre-arrival experiences, including social mores in their country of origin) that led victims/survivors to choose not to disclose their experiences or access support (Ogunsiji et al., 2010). This is true for other groups of women from refugee backgrounds, some of whom have suggested that settlement services must do more to provide information and resources about violence that may arise in marital and familial relationships during and post settlement (Khawaja & Milner, 2012).

**Language barriers**

Language barriers can prevent CALD women from accessing services and information and can affect decisions to disclose experiences of violence to police (InTouch, 2010; Vaughan et al., 2016). The Federation of Ethnic Communities Council of Australia (FECCA; 2016, p. 5) has noted:

> ![T]he inability to communicate is one of the harshest forms of isolation. Physical disconnection from the community caused by language barriers, financial constraints and inadequate access to transport can intensify a sense of isolation.

The lack of language-appropriate information and resources about IPV can contribute to victims/survivors’ limited knowledge of rights and/or services. This may help to explain why CALD women often only learn about their rights from police and crisis workers following their first report/disclosure of IPV (InTouch, 2010).

Studies show that perpetrators of IPV may use the family law system to intimidate their partners when they have more advanced English-language skills and greater familiarity with Australian legal processes (InTouch, 2010; Vaughan et al., 2016). Building language skills in men is often prioritised over women in families where the men are viewed as breadwinners, and women are at a disadvantage when their language skills are perceived as less important (Vaughan et al., 2016).

**Interpreters**

Service providers can face difficulties in employing interpreters, particularly those who are themselves from refugee backgrounds. These interpreters risk experiencing secondary (or vicarious) trauma through their work with victims/survivors of family violence, and often receive little support and limited training about family

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violence matters (Vaughan et al., 2016). A study from Victoria found that failings in police interventions with CALD women were often caused by a lack of interpreter services when officers responded to reports of family violence (InTouch, 2010). This highlights the potential challenges regarding the use of interpreters, such as the limited number of available interpreters at certain times/locations (particularly at court dates), the use of male interpreters (which can dissuade women from disclosing IPV), and fears regarding confidentiality (in cases where an interpreter may be known to the victim/survivor) (InTouch, 2010; Vaughan et al., 2016).

Lack of cultural safety

It is useful for service providers to understand help seeking as a social act, connected to community attitudes and a sociocultural context, in order to create culturally safe service environments. Faith and culture are two factors that can affect women's disclosure of IPV and act as barriers to service engagement (InTouch, 2010; McCulloch et al., 2016; Vaughan et al., 2016). Women from countries that have a strong culture of silence around IPV and lack a legal definition of family violence are less likely to report their experiences of IPV in Australia (Ghafournia, 2011; InTouch, 2010; Lewig, Arney, & Salveron, 2010; Zannettino et al., 2013). Moreover, many CALD victims/survivors of IPV may want to stay with their partner (but want the violent behaviour to stop) and may fear that disclosures of IPV will break up their family unit (Access Community Services [ACS], 2017).

Fear and distrust of authorities

Fear and distrust of authorities (brought about by pre-arrival experiences) can influence the help-seeking behaviours and service engagement of individuals from refugee backgrounds, especially in decisions about whether to seek assistance from police or follow through with legal proceedings (InTouch, 2010; Segrave, 2017; Vaughan et al., 2016; Zannettino et al., 2013). Creating cultural safety and involving communities in responses to family violence is important for these reasons (InTouch, 2010; Segrave, 2017; Vaughan et al., 2016). Victims/survivors’ unwillingness to contact police can be partially informed by previous experiences of violence perpetrated by authorities, systemic violence and experiences of racism in Australia and/or in transit to Australia or in their country of origin (AMWCHR, 2013; InTouch, 2010). This fear and distrust of authorities can often be exploited by those who use violence, leading victims/survivors to ‘conflate lawyers, police and government departments as representatives from the one authority that can demand their deportation if the relationship breaks down’ (InTouch, 2010, p. 18).

Family and community factors

Many CALD victims/survivors of IPV may prefer informal support and demonstrate a reliance on family, friends and community leaders rather than services (TimsheL, Montgomery, & Daigaard, 2017). Findings from an Australian study in to women from a West African refugee community show that informal networks of extended family members often act as mediators following incidents of family violence – and women were reluctant to access formal service systems to resolve IPV in the absence of those support networks (Ogunsiji et al., 2010). This reliance on informal support is a general characteristic of CALD families and can cause challenges for services attempting to engage these groups, particularly as absence of family and community support can lead to social isolation and worsen acculturation stress.

Social isolation

Social isolation and fear of ostracism from family and community can influence victims/survivors’ decisions to report IPV to police and/or to remain in a violent relationship (InTouch, 2010; McCall-Hosenfeld, Weisman, Perry, Hillemeier, & Chuang, 2014; Ragusa, 2017; Segrave, 2017; Vaughan et al., 2016). Many victims/survivors from refugee backgrounds do not report incidences of IPV for fear of community ostracism, which may cause them to lose their sense of belonging in Australia (Vaughan et al., 2016). Research has found that, ‘perpetrators used isolation as a deliberate strategy to control women and ensure they were unable to leave [a violent relationship]’ (Vaughan et al., 2016, p. 32). For many women from refugee backgrounds, community is a source of practical and emotional support especially when their own English-language skills are limited (InTouch, 2010; Vaughan et al., 2016).

Fear of social isolation can be worse for CALD women living outside of metropolitan areas with more restricted access to services (InTouch, 2010). Geographic location can influence the level and type of support available to victims/survivors of family violence, including CALD women and those from refugee backgrounds.
Research into the effect of rurality on victims/survivors’ decision making shows that help-seeking behaviour is limited by the lack of services and transportation options, social stigmatisation and concerns regarding anonymity in a small community (Ragusa, 2017). There is evidence that regional women’s refuges are used by CALD women, many of whom identify as refugees (Ragusa, 2017). This is particularly salient due to the Commonwealth Government’s plans for increased regional settlement of individuals from refugee backgrounds. More research is needed to explore possible strategies for service provision to these emerging Australian communities.

**Stakeholder consultations**

Child Family Community Australia conducted stakeholder consultations with three services of importance to Australian refugee communities to provide practical guidance on how the strategies identified in the scoping review might be implemented. These services wish to remain anonymous and identifying details have been removed from service descriptions and consultation data. Consultations were carried out over the telephone using a semi-structured interview schedule (Appendix B), and were undertaken with:

- a family violence program for CALD women (delivered through a settlement service for CALD communities)
- a support service for CALD communities
- a group pregnancy care program for women from refugee backgrounds.

See Box 1 for more of an overview of these services’ programs.

General findings from these consultations are presented below. The following section combines the findings of the literature and case studies, and highlights practical ways of overcoming barriers to service uptake and engagement.

**Box 1: Programs of consulted services**

We briefly describe here the programs provided to CALD and refugee women by each of the consulted services.

**Family violence program for CALD women**

This program operates through a joint partnership between a settlement service for CALD communities and a legal service for multicultural women in a metropolitan region. In order to safely engage women – many of whom do not want to leave their partner but want the violence to stop – staff have developed and adapted a number of strategies for women to access support in empowering and confidential ways. The program applies principles of trauma-informed care to offer both counselling and legal support for CALD victims/survivors, a client group that includes women from refugee backgrounds. The program collaborates with other locally based services, such as mainstream family violence services, in order to meet the needs of these women and their children.

**Support service for CALD women**

The family violence service supports CALD communities at several different metropolitan locations. The service addresses the needs of up to 300 CALD women per year, from 80 different countries. While this number includes women from refugee backgrounds, it is difficult to ascertain exactly how many. However, a number of women who access the service either hold temporary visas or arrived in Australia as asylum seekers and obtained permanent residency at a later stage. Clients are referred to the service by police, hospitals, child health services, counsellors and psychiatrists, and general practitioners.

**Group pregnancy care for women from refugee backgrounds**

The group pregnancy care program has been designed for women and families from refugee backgrounds and is held at various sites across a metropolitan region and its outer suburbs. Group pregnancy care is a general term to describe antenatal care with a focus on women who are pregnant. The program also provides support and health care to women after they have given birth (post-partum).
Generally, antenatal care is provided by maternity hospitals (and others, including obstetricians and midwives) and post-partum care is provided by maternal and child health services. Generally, antenatal care is provided by maternity hospitals (and others, including obstetricians and midwives) and post-partum care is provided by maternal and child health services. Public health research identified that health care providers can find it difficult to engage with women from refugee backgrounds in a post-partum context, and the program aims to support continued engagement with health care services. Group pregnancy care offers a coordinated multi-disciplinary team including clinicians and bicultural workers in order to provide women with an integrated, wraparound service that encourages service engagement with mother and child post-partum care.

Women who are pregnant generally have more contact with health care workers and this can be an opportune time to provide information and support to women who are experiencing IPV. Women who are pregnant generally have more contact with health care workers and this can be an opportune time to provide information and support to women who are experiencing IPV. While the main focus of this program is general care and support for women during their pregnancy and in a post-partum context, staff have participated in training to assist them to identify and respond to social stressors (including IPV) and provide a culturally safe environment for disclosures to occur, as well as to provide other forms of support (such as referrals).

General consultation findings

The forms of IPV generally experienced by clients engaged with the above services include physical and sexual violence, reproductive coercion and financial abuse. These services also noted controlling behaviours as a major form of IPV and, in particular, perpetrators restricting social activities and women's movements outside of the house (including visits with family and friends), preventing women from attending English-language classes, and hiding women's (and children's) passports and other immigration-related documentation.

Women from refugee backgrounds on a temporary visa (such as a spousal visa) have been found to experience other forms of immigration-related IPV. These forms of IPV include a range of behaviours, such as threats of 'cancelling' spousal visas and/or deportation back to the country of origin (without their children). Moreover, staff find that the majority of family functioning issues, including IPV, tend to surface post-settlement.

The stakeholder consultations generally identified the main drivers of IPV as the power imbalance between men and women, a lack of English-language and/or communication skills, and a lack of knowledge and understanding of legal rights and entitlements. The consulted services note that many couples previously lived with extended family members in their country of origin, which may have provided women with some protection from certain forms (or some extremes) of IPV due to other family members' intervention. Consultations show that a lack of extended family to mitigate IPV may worsen the violence used against these women.

However, staff also notice that many clients from non-English speaking countries are married to Australian men, and it is therefore important to acknowledge that while some IPV is perpetrated by CALD men (including those from refugee backgrounds) incidents of IPV may also be carried out against women from refugee backgrounds by their Australian partners. More research into the characteristics of individuals who use violence against women from refugee backgrounds is needed to better understand this finding.

Strategies for service providers

Here, we combine our findings from the scoping review and the stakeholder consultations to provide concrete Australian examples of emergent practice mentioned in the literature.

As detailed in the methodology, the semi-structured interview schedule used in the stakeholder consultations was developed based on three main strategies found in the literature about how to overcome barriers to service access and engagement: involving community in responses to family violence, cultural safety, and applying integrated trauma-informed care in programming and practice.
The stakeholder consultations provide examples of how the three strategies can be adapted to a specific service type and used in different areas of service provision. Many of the strategies identified in the scoping review applied to family violence service provision more broadly, particularly with regard to general models of safety and trauma-informed practice.

In addition, we also provide practitioner resources that can be used to develop and refine strategies that practitioners may already have in place at their service.

## Community involvement and leadership

The first strategy we look at for improving service access and engagement for women from a refugee background is community involvement and leadership. Table 1 outlines how this has been implemented by the consulted services. Box 2 at the end of this section provides some useful resources for practitioners on community involvement and leadership.

### Table 1: Strategies used to support community involvement and leadership

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Service</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community involvement and</td>
<td>Family violence program</td>
<td>• Training about family violence delivered by program staff to CALD community leaders</td>
</tr>
<tr>
<td>leadership</td>
<td></td>
<td>• Training about community and culture delivered by CALD leaders to program staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Program training for CALD women about family violence and program support for women's community empowerment activities</td>
</tr>
<tr>
<td>Group pregnancy care</td>
<td></td>
<td>• Community consultations to co-design program, which support cultural safety</td>
</tr>
<tr>
<td>care program</td>
<td></td>
<td>• Community advisory group established and consulted in program development and evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bicultural workers employed to provide appropriate information to refugee communities and act as cultural brokers for mainstream service providers</td>
</tr>
</tbody>
</table>

As noted in Table 1, staff at the family violence program deliver training to CALD community leaders on how to recognise and respond to family violence, in addition to receiving training from community leaders about how to safely engage CALD women in the family violence program. This works to develop staff knowledge and understanding about cultural values and community issues. Staff also support CALD women’s empowerment activities that incorporate education and training about how to recognise and respond to family violence. The family violence program builds skills through these activities so that women are able to self-refer or refer others in their community to the program if needed.

The group pregnancy care program is an example of a community-service partnership that shares decision making to create a culturally safe program that is filling an identified gap in services. During the program development phase, community consultations were held with families from refugee backgrounds to identify women and men’s needs and discover factors that could contribute to the cultural safety of the group (see Table 1). These consultations highlighted gaps in service provision and ensured the accessibility and cultural safety of the program and staff. As well as community involvement in the establishment of the program, community advisory groups have been consulted in developing and undertaking evaluation strategies. Staff note that this supports culturally competent evaluation and ensures that outcome measures are suitably adapted to specific community groups.

Community-led responses to violence are essential to addressing the harms and preventing the perpetration of family violence in refugee communities (Chen, 2017; Larasi, 2013; Segrave, 2017; Vaughan et al., 2016). Research has shown that there have been a range of community-led responses to violence against CALD women, including those from refugee backgrounds (Vaughan et al., 2016). This work is based on a strong understanding of diversity in contemporary Australian society, and a growing acknowledgement of the need for human services to provide an inclusive response to family violence in refugee communities.

### Bicultural workers

As noted in the scoping review, victims/survivors from refugee backgrounds face challenges in accessing support and information. This is often influenced by pre-arrival trauma and transit experiences that are not well understood by practitioners or integrated into programs or service-delivery models. Promising practice with these groups includes the employment of bicultural workers to assist in program development, implementation and evaluation, and this is demonstrated in the group pregnancy care program. In our consultation with the group pregnancy care program staff, we found that individuals from refugee backgrounds have increased health
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literacy due to the role of bicultural workers, who assist in their navigation and engagement with health services during pregnancy and post-partum.

Findings from the scoping review note that, ‘bicultural workers provide a bridge to reduce the social distance that often exists between health professionals and clients’ (Riggs, Yelland, Duell-Pienning, & Brown, 2016, p. 1). Bicultural workers can be an asset in addressing service gaps and meeting the needs of specific clients through community consultations and the implementation of co-design strategies. Our consultation with the program found that bicultural workers can assist in undertaking cross-cultural research (including community consultations) during program design and evaluation, which ensures that the needs and wants of the specific community are heard and considered.

Box 2: Practitioner resources on community involvement and leadership


Cultural safety

The second strategy is cultural safety and Table 2 outlines how this has been implemented by the consulted services. Box 3 at the end of this section provides some useful resources for practitioners on cultural safety.

Table 2: Strategies used to support cultural safety

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Service</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural safety</td>
<td>Family violence program</td>
<td>• Staff draw on culturally safe and empowering strategies in safety planning (underpinned by a strengths-based approach)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Program exercises discretionary strategies often used in family violence services, due to the associated risks of disclosures and need for privacy</td>
</tr>
<tr>
<td></td>
<td>Support service for CALD communities</td>
<td>• Addresses and supports the needs identified by CALD women in a culturally safe way as opposed to imposing a service agenda</td>
</tr>
<tr>
<td></td>
<td>Group pregnancy care program</td>
<td>• Training provided to health care workers on how to create culturally safe spaces and identify and respond to the needs of women</td>
</tr>
</tbody>
</table>

Research from Australia shows that some services face difficulties in translating theories on cultural safety into practice (Gill & Babacan, 2012; Werkmeister-Rozas & Klein, 2009). Here we define cultural safety as important to the cultural competency of service providers. On its own, cultural competency may not sufficiently address power imbalances and the marginalisation of certain cultures (Kirmayer, 2012). This is important for service providers working with CALD victims/survivors of IPV, particularly those from refugee backgrounds, who often report feelings of shame and fear in disclosing their experiences (Zufferey et al., 2016).

Many victims/survivors may want to stay with their partners, which can challenge some models of service provision and limit women’s eligibility for certain programs (ACS, 2017). Creating a culturally safe environment and providing clients with staff and programs that are culturally safe includes understanding the different needs and contexts of women from refugee backgrounds. This can extend to aspects of service provision such as safety planning and increasing staff knowledge of how IPV is understood in CALD communities. Victims/survivors of IPV may want to remain with their partners and should be supported to do so as safely as possible by family violence workers. This can be perceived as working against the established service delivery paradigm applied in many
support services for women experiencing IPV; however, it is important that women living with violence should be able to engage in autonomous decision making, be supported in their choices and access services confidentially if they choose. The latter point may be particularly important if the individual is from a small and close-knit community. Our consultation with the family violence program showed that cultural safety strategies may overlap with the provision of general security to mitigate community factors that women experiencing IPV may face.

Staff at the family violence program for CALD women apply culturally aware safety planning8 for victims/survivors who do not want to leave their partners. The program uses the Sharing Strength resource for guidance on how mainstream community and support services can work with CALD communities in culturally safe ways using a strengths-based framework. The toolkit offers an overview of factors that can contribute to violence in CALD communities, barriers to disclosure and information about the context in which family violence may arise in CALD communities. Practice recommendations include ways to work with CALD individuals who use violence, as well as risk assessment strategies and safety planning for victims/survivors.

The resource suggests collaborative safety planning with victims/survivors that includes information about how to contact the police and ask for an interpreter, as well as strategies to dispel fear of authorities, such as descriptions of police processes, should intervention be required. The resource recommends that practitioners apply patience, respect for women’s autonomy and regular contact with the victim/survivor to develop trusting relationships (ACS, 2017).

As noted in Table 2 (on page 15), the family violence program does not advertise in the community and displays no signage or printed materials (pamphlets or information about the program) in order to maintain a discreet profile. This aligns with the discretionary strategies generally used by family violence support services to ensure the privacy of clients seeking help for experiences of violence. In order to increase general client security and privacy, the family violence program now operates off site at a separate location to the wider settlement service, which reduces the clients’ chances of being recognised by another community or family member (as noted in Table 2).

Before moving off site, staff operated under the assumption that other programs within the settlement service may be providing support or assistance to the individual who uses violence at the same time that the victim/survivor is receiving a service from the family violence program. Staff have noticed the development of more trusting relationships between themselves and clients, and greater rapport with clients, since running the program from a separate location. Additionally, in coordination with local organisations, the settlement service delivers community outreach services at several different locations referred to as ‘community hubs’. Family violence workers receive high rates of disclosures of IPV on their regular outreach visits to the community hubs, which are discreet, safe environments that allow space for disclosures.

The support service for CALD women aims to provide a culturally safe environment. The service bridges the gap in engagement and addresses specific needs identified by CALD communities. Staff report that relationships between the service and specific CALD communities are two-fold: on the one hand, the service is viewed with suspicion by some groups because it exists outside of (or separate to) their community. On the other hand, however, that separateness can also mean it is safer for victims/survivors to access the service. Further, the staff member from that service commented that their diverse workforce enhances their professional understanding of CALD women and culturally safe practice. While this does not mean that the cultural group of the client is ‘matched’ to the worker, there are advantages to having a staff body familiar with the process of migration and the challenges of settlement acculturation. The service also demonstrates cultural safety in its use of female interpreters in their work with clients. The service screens interpreters prior to their engagement to ensure that the client does not know them from their community.

Staff at the group pregnancy care program, including clinicians and bicultural workers, receive tailored professional training about the social determinants that affect women’s health during pregnancy and following childbirth. Staff report that pregnancy is a good time to engage women from ‘hard-to-reach’ communities as families have sustained contact with the health systems and health care workers. This can create opportunities to approach women from refugee backgrounds about other issues, such as mental health and family violence. Staff note that more work must be done to provide information and resources about family violence to CALD communities in culturally safe ways, as the use of interpreters is insufficient on its own. Staff also find that, while women may disclose experiences of IPV to health care workers, many may not choose to access support services for various reasons, including fear of being ostracised from their communities, financial dependence and fear of deportation. In such cases, victims/survivors must be supported with culturally safe strategies about how to remain in their relationships and seek help if needed.

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8 The Sharing Strength resource defines safety planning as, ‘a specifically designed tool that assists workers to develop systematic processes to ensure the safety of clients and their understanding of the processes’ (ACS, 2017, p. 22).

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Integrated trauma-informed care

The third strategy we look at is integrated trauma-informed care. Table 3 outlines how this has been implemented by the consulted services. Box 4 at the end of this section provides some useful resources for practitioners on integrated trauma-informed care.

### Table 3: Strategies used to support integrated trauma-informed care

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Service</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated trauma-informed</td>
<td>Family violence program</td>
<td>• Staff draw on culturally safe and empowering strategies in safety planning (underpinned by a strengths-based approach)</td>
</tr>
<tr>
<td>care</td>
<td></td>
<td>• Coordinates with community organisations to provide outreach to women at a range of locations</td>
</tr>
<tr>
<td>Support service for CALD</td>
<td></td>
<td>• Addresses and supports the needs identified by CALD women in a culturally safe way as opposed to imposing a service agenda</td>
</tr>
<tr>
<td>communities</td>
<td></td>
<td>• Coordinates with local health care services to support women’s access and engagement</td>
</tr>
<tr>
<td>Group pregnancy care program</td>
<td></td>
<td>• Training provided to health care workers on how to create culturally safe spaces and identify and respond to the needs of women</td>
</tr>
</tbody>
</table>

Intimate partner violence affects many aspects of an individual’s life, such as housing, health and financial stability. Victims/survivors may need to engage with a range of services due to the far-reaching effects of violence (Zufferey et al., 2016). Integrated care requires that multiple services work together; for example, specialised services (responsible for the initial engagement of victims/survivors and case management) and primary health care services (addressing the health, mental health and social needs of victims/survivors) (Harris, 2018). Research from Australia recommends three strategies to build trust between services in order to develop integrated care systems for individuals from refugee backgrounds (Harris, 2018):

- the development of shared communication tools
- practice visits by specialist staff
- the use of existing support networks.
Partnerships between family violence services and other organisations can be helpful in supporting practice models of integrated care to meet the needs of refugee women through collaboration and information sharing (see following for examples of partnerships in consulted services).

Over the last decade, trauma-informed care has become a more established practice in Australian human services, and aims to challenge and adapt programs and the manner of service delivery to appropriately respond to individuals from diverse backgrounds (Wilson et al., 2015). Trauma-informed care promotes collaborative relationships between clients and staff as a way of centering on the needs of victims/survivors (Donisch, Bray, & Gerwirtz, 2016). For example, the consulted family violence service offers an employment and education program, which grew out of an identified need of clients experiencing high levels of disadvantage and social isolation as a result of leaving a violent relationship.

The employment and education program, co-managed with a local TAFE, offers an accredited leadership course to provide women with practical employment skills and information about workplace issues in Australia. As well, this course provides an opportunity for empowerment and social connection, which is particularly important if women have been ostracised from their community or forced to leave due to risk of violence against themselves and their children. It also affords women the opportunity to consider their long-term goals, as the course can provide pathways to further study and – as the course is recognised by Centrelink – women can obtain child care benefits to support their attendance. Staff note that the program aims to act as a ‘circuit breaker’; that is, to stop the cycle of violence by supporting women to gain employment and financial independence so that they are less likely to return to abusive relationships.

Australian research recommends targeted responses for CALD women, particularly those from refugee backgrounds, that take into account the complex issues facing victims/survivors through the application of an intersectional framework (Chen, 2017; McCulloch et al., 2016; Segrave, 2017; Vaughan et al., 2016; Victorian Royal Commission into Family Violence [VRCFV], 2016). An intersectional framework avoids ‘explanations or solutions that use single categories to describe people or issues and [acknowledges] that we are shaped by many factors’ interaction together’ – and recognises that family violence is culturally produced as well as individually experienced (Chen, 2017, p. 6). For example, programs for women from refugee backgrounds must consider the intersecting factors affecting their experiences of IPV, such as socio-economic factors, pre-arrival trauma and visa status (Chen, 2017; InTouch, 2010; Vaughan et al., 2016).

Many organisations that offer support to women who are experiencing IPV now provide some level of service to CALD victims/survivors, and this group includes individuals from refugee backgrounds (AMWCHR, 2011; InTouch, 2010; MCWH, 2015; Zannettino et al., 2013). As service providers become more aware of the particular needs of CALD communities in their catchment areas, they are more likely to design programs that consider the structural and cultural factors affecting their service engagement and apply principles of trauma-informed care to reduce the risk of triggering secondary trauma (Carmody, Salter, & Presterudstuen, 2014; Murdolo & Quiazon, 2015).

The group pregnancy care program supports women with multidisciplinary integrated care. It is intended to address gaps in service engagement and meet the needs identified through community consultations. The program offers a cross-sectoral, coordinated team of clinicians (including maternity hospital staff, maternal and child health service staff), settlement services and bicultural workers in order to provide women with an integrated wraparound service. The staff apply a holistic and intersectional framework in their engagement with women that is grounded in an understanding of the indirect impact of settlement issues such as poverty, housing and social isolation. Group processes and reflective practice are important elements of group pregnancy care and staff are supported to work in this new way with women from refugee backgrounds during pregnancy and in a post-partum context.
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Box 4: Practitioner resources on integrated trauma-informed care


Conclusion

While there is limited research regarding IPV in Australian refugee communities, many family violence services now engage with CALD women experiencing IPV. This includes a number of women from refugee backgrounds. The scoping review provided an overview of literature about the IPV experiences of women from refugee backgrounds, including the forms of IPV most commonly experienced, and relevant factors contributing to IPV, such as traumatic pre-arrival experience and acculturation stress. While there is no definitive driver of IPV in refugee communities, an understanding of the intersecting factors contributing to abuse is important to service providers. As well, the scoping review offers perspectives from the literature about what kinds of barriers women from refugee backgrounds face in reporting IPV and seeking help for those experiences.

The qualitative stakeholder consultations were devised as a way to supplement the literature with strategies for services on how to engage women from refugee backgrounds experiencing IPV. The three services consulted in this paper have developed response strategies to engage and support women from refugee backgrounds, and these provide examples of promising practice with these groups. The range of responses is underpinned by principles of trauma-informed care that recognise exposure to pre-arrival trauma as part of the refugee experience. The combined discussion of the scoping review and consultation findings supports an understanding of how to overcome barriers to service access and engagement and promote help-seeking behaviour in women experiencing IPV.

Author and Acknowledgements

Dr Alissar El-Murr is a Senior Research Officer at the Australian Institute of Family Studies. Alissar trained as a social scientist and has expertise in violence against women, public health policy and programming, and qualitative methods. Alissar has worked in academic settings, and in non-government organisations focused on culturally and linguistically diverse communities and the prevention of violence against women and their children. At the Institute, she is currently undertaking research that explores the support services available to victims/survivors of violence in Australian communities.

The author wishes to acknowledge the generosity of the individuals and services that participated in consultations for the case studies presented in this paper. The author would also like to thank Foundation House and Flinders University for their support of this project.
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# Appendix A: Inclusion criteria

Table A1 outlines the inclusion criteria used for the scoping study.

**Table A1: Inclusion criteria**

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Australia (primary interest)</td>
</tr>
<tr>
<td></td>
<td>Europe, USA, Canada (secondary interest)</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>English</td>
</tr>
<tr>
<td><strong>Publication date</strong></td>
<td>January 2008–May 2018</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Women from Australian refugee communities who have experienced intimate partner violence</td>
</tr>
<tr>
<td></td>
<td>Women from recently arrived migrant communities who have experienced intimate partner violence</td>
</tr>
<tr>
<td></td>
<td>Women from Australian culturally and linguistically diverse communities who have experienced intimate partner violence</td>
</tr>
<tr>
<td><strong>Type</strong></td>
<td>Primary research with women from the above populations including qualitative, quantitative and mixed methods research</td>
</tr>
<tr>
<td></td>
<td>Literature reviews and other secondary research analysis on issues related to the above topics</td>
</tr>
<tr>
<td></td>
<td>Grey literature including framework, strategy and evaluation documents from organisations in the Australian human services sector and government</td>
</tr>
</tbody>
</table>
| **Examples of initial keyword searches** | Family violence CALD women Australia  
Intimate partner violence refugees Australia  
Family violence services refugees Australia  
Health and wellbeing CALD women Australia |
Appendix B: Semi-structured interview themes and questions

Table B1 lists the interview themes and questions used for the qualitative stakeholder consultations.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example question</th>
</tr>
</thead>
</table>
| Description of service and need for service in refugee communities | What does the service offer to refugee women experiencing intimate partner violence?  
Follow-up/secondary question: How was the need for this service identified? |
| Specific forms of intimate partner violence | Does the service provided differ according to the specific type of intimate partner violence being experienced by a client?  
What forms of intimate partner violence do you come across in your engagement with women from refugee backgrounds? |
| Client groups in service catchment areas | What kind of client populations engage with this service?  
What kind of criteria qualify an individual to engage with this service? |
| Barriers to service engagement | What kind of barriers do women from refugee backgrounds face in engaging with your service/program?  
What kinds of strategies are employed to overcome these barriers? |
| Community involvement | Have any community engagement strategies been used in developing programs to support women from refugee backgrounds experiencing intimate partner violence?  
What kind of strategies does your service use to engage with refugee communities?  
Follow-up/secondary question: What are some examples of ways that your service has engaged community in either development or evaluation of a particular program? |
| Theoretical or practice frameworks that inform program and service delivery | What type of particular theoretical/practical frameworks underpin your service delivery and/or programming for refugee communities?  
How does this differ from that which would be employed in engaging with non-refugee culturally and linguistically diverse communities?  
Do you apply any integrated and/or trauma-informed practices at your service? Provide examples of how these are implemented at your service. |
| Cultural safety | What kind of strategies are employed to ensure culturally safe programming and service delivery?  
Follow-up/secondary question: What kind of support and/or training is provided to staff members who work with women from refugee backgrounds? |