inLanguage, inCulture, inTouch:

Integrated model of support for CaLD women experiencing family violence

FINAL EVALUATION REPORT
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INTOUCH MULTICULTURAL CENTRE AGAINST FAMILY VIOLENCE was established in 1984. It is the leading statewide accredited service, providing services, programs and responses to issues of family violence in culturally and linguistically diverse communities.

By acknowledging the rights and diverse experiences of its clients, InTouch develops and implements a number of culturally sensitives and holistic models for the provision of services to both victims and perpetrators of family violence.

The InTouch vision is for culturally and linguistically diverse families to live a life free from violence.

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Acknowledgements

This report aims to contribute to the growing evidence base of health justice initiatives in the Australian context, and in particular those that seek to address the needs of women from diverse cultural and linguistic backgrounds who are experiencing family violence. It acknowledges the foundation laid by other legal/health initiatives in the state of Victoria, Australia, in particular *Acting on the Warning Signs: An advocacy-health alliance to address family violence through a multi-disciplinary approach*, a legal advocacy-health alliance between Inner Melbourne Community Legal and The Royal Women's Hospital.[1]

Most importantly, the report acknowledges the accounts and input from women experiencing family violence and the workers supporting them. These cases will contribute to a raised collective awareness of the experiences of family violence in diverse contexts and the critical success factors for effective interventions to address complex need, hopefully serving to break the cycle of abuse for others.

[1] K Hegarty, C Humphreys, K Forsdike, K Diemer, S Ross (2014) *Acting on the Warning Signs Evaluation: Final Report*. University of Melbourne: Melbourne

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Definitions

This evaluation has adopted the following definitions for these key terms.

Family violence:

> *Behaviour by a person towards a family member that is 'physically or sexually abusive, emotionally or psychologically abusive, economically abusive, threatening, coercive or controls or dominates the family member', causing fear for safety or wellbeing.*
>
> *s.5, Family Violence Protection Act 2008* (Vic)

Family violence encompasses financial abuse and social abuse such as forced isolation from family and support groups.

This definition also includes childrens' exposure to the effects of family violence whether heard, witnessed or experienced.

Culturally and linguistically diverse (CALD):

People born overseas in countries other than those classified as 'English speaking' (that is, Canada, Republic of Ireland, New Zealand, South Africa, United Kingdom and the United States of America). 'Culturally and linguistically diverse' is a contemporary descriptor and is synonymous with the term 'ethnic communities'.

Executive Summary

Violence against women is a complex and pervasive social problem, with around one in five women in Australia experiencing physical or sexual violence by a partner. True measurement of the extent of the problem is difficult as a great deal of violence goes unreported or is hidden. Family violence can include intimate partner violence, but also extends to violence, threats, intimidation or force to control or manipulate another family member. Family violence is found across all cultures, ages and socio-economic strata however culturally and linguistically diverse (CaLD) groups of women are more likely to encounter barriers to support, in particular legal support services. This contributes to a cycle of further marginalisation, poorer health, isolation and potential exposure to greater harm. In the state of Victoria, intimate partner violence is the leading contributor for ill-health, death and disease for women aged 15-44 years in Victoria.

Health justice initiatives are underpinned by a social determinants approach to healthcare which recognises the impact of social factors such as family violence and legal access upon individual health outcomes. Health justice initiatives are an integrated approach of healthcare, comprising health, legal and welfare professionals working collaboratively to provide legal assistance to vulnerable people within the healthcare setting. Health justice initiatives serve to redress health inequities exacerbated by limited access to adequate supports, by co-locating legal support within existing healthcare services.

The healthcare system is recognised as an important avenue for the disclosure of family violence, leaving health care practitioners ideally placed to identify signs of violence. Additionally, evidence presents health professionals as a major group consulted by patients for legal advice on how to proceed in a family violence situation. It follows that by implementing health justice initiatives that locate legal services in a healthcare setting that is familiar to patients, accessibility to appropriate supports will be boosted.

The integration of legal within healthcare will also facilitate opportunity for broad system change and for expansion of professional practice across a multidisciplinary team through knowledge exchange and professional development opportunities. It is hoped that through this model, lawyers, health practitioners and clinical administration staff will work together to significantly improve legal and health outcomes for some of the most vulnerable groups of women experiencing family violence such as CaLD women.

Commencing in December 2014, *inLanguage, inCulture, inTouch* initiated as an activity seeking to redress these legal access inequities experienced by CaLD women in a family violence situation. Supported by grant funding from the Victorian Legal Services Board, the overarching goal of *inLanguage, inCulture, inTouch* was the delivery of a health justice partnership (HJP) model providing wrap-around health and legal services to CaLD women experiencing family violence in the South Eastern region (SER) of Melbourne, Victoria.

Evaluation of *inLanguage, inCulture, inTouch* shows that the project has successfully achieved identified objectives of:

1. Successful replication of an existing inTouch legal centre model to Dandenong Magistrates' Court catchment area;
2. Establishment of a health justice partnership model; and
3. Development of a comprehensive training package to increase capacity of health professionals in cultural competency, family violence, and the legal referral pathways.

Evaluation of the *inTouch legal centre model to Dandenong Magistrates' Court catchment observed:-*

- Provision of social and legal support to a total of 234 clients at Dandenong court during the 2 year project.

- Provision of legal assistance to 99 clients at the Legal Centre outpost at Dandenong Magistrates' Court, who altogether sought advice for 180 separate legal and social support concerns.
- Provision of a further 21 secondary client consultations at the Maurice Blackburn Dandenong office outpost.
- Provision of culturally appropriate support, including advocacy for translation and interpretation services for a client base representing over 11 different cultural groups.
- Strong partnership engagement to raise the profile of the integrated model and generate new referral pathways with various stakeholders at Dandenong Magistrates' Court, including judicial officers, law enforcement, Court Users, and the legal fraternity in the SER
- Observation of a self-reported decrease in stress levels for interviewed clients, after receiving legal support from the inTouch in SER Legal Centre.

Evaluation of the *establishment of a health justice partnership model* observed:-

- Identification of implementation barriers and enablers via a dual-layered Monash Health consultation process with staff based at Dandenong Hospital.
- Review of internal hospital policies and procedures on family violence to facilitate whole-of-organisation screening and referral procedure.
- Provision of legal assistance to 34 new clients from the Dandenong Hospital outpost.
- Provision of opportunities to expand professional practice through delivery of legal education on the HJP model, referral pathways and case study scenarios to 47 hospital staff.

Evaluation of the development of a training package to increase capacity of health professionals in family violence and CaLD observed:-

- Pilot development, testing and refinement of training package in response to comprehensive staff feedback.
- Delivery of 15 training sessions at the Dandenong Hospital location, reaching in excess of 500 health professionals in a range of medical specialties.
- Embedding of the health professional training into the Monash Health continuous improvement training program calendar.
- Adaptation of the training into three different delivery modes (face-to-face, online, flexible face-to-face) to facilitate accessibility to a broader cross-section of staff.
- A significant shift in self-reported knowledge and skills for training attendees, observed through post-training evaluation of 255 survey participants.
- Delivery of a further five training session to reach 139 Maternal and Child Health Nurses and Coordinators servicing the South Eastern region.

These objectives were buttressed by the development of significant and enduring project partnerships that demonstrated strong support for the shared project goals. Partners' commitment was observed through provision of strategic guidance and committee membership, assistance with operational implementation, access to networks and linkage opportunities, probono support including infrastructure access and joint event opportunities. Partners reported that while project sustainability beyond the funding period was a concern, the project represented a worthwhile and necessary endeavour.

The evaluation was informed by a realist approach, an approach that examines the nature of successful interventions. Accordingly, the evaluation documented the outcomes but especially observed the processes that underpinned and guided activity.

There is a paucity of research solely examining the experiences of CaLD women in a family violence situation in Australia, and the quality of interventions available to redress inequity. This evaluation is contextualised as contributing to innovation and continuous quality improvement of family violence initiatives for CaLD groups, and more specifically, the efficacy of a wrap-around health justice partnership as a means of promoting more equitable legal access for CaLD women.

This is likely to offer social equity benefits by fostering cultural awareness and gender equality within society, and best practice on a professional level for program participants.

Report Overview

In 2013, InTouch Multicultural Centre Against Family Violence was the recipient of a grant from the Victorian Legal Services Board. The grant has a primary aim of increasing collaboration and capacity within both the health and legal sectors, through the establishment of a health justice partnership to increase access to support services for CaLD women in Victoria who are experiencing family violence. This grant has enabled the project '*InLanguage, inCulture, InTouch: an integrated model of support CaLD women for experiencing family violence*' to deliver the following three objectives:

- Establishment of a health justice intervention at the major clinical setting of Dandenong Hospital, Victoria;
- Expansion of an existing Legal Centre to the Dandenong Magistrates' Court setting to meet legal needs for CaLD victims of family violence in the South Eastern region of Melbourne;
- Delivery of health professional training sessions to develop practitioner skills in cultural competency and confidence to identify and respond to signs of domestic violence.

The following is an evaluation report of the activities comprising '*InLanguage, inCulture, inTouch: an integrated model of support CaLD women experiencing family violence*'.

Section One of this report comprises a brief literature review of the salient issues to provide context and theory for the implemented project. Key themes observed in the relevant literature are:

- Prevalence and causality of family violence;
- Health impacts upon women experiencing family violence;
- Marginalisation and the experience of CaLD women in situations of family violence;
- Barriers of access to integral support services such as legal assistance;
- The health system and family violence; and
- Victorian policy and program environment pertinent to the delivery of the project.

There is a paucity of systematic research solely examining the experiences of CaLD women in a family violence situation in Australia; consequently, the literature review has drawn upon both local and international peer-reviewed and grey literature.

Section two commences with an outline of applied evaluative methodologies; the latter half of the section comprises an analysis of the data findings for each of the three project aims.

Section three of the report seeks to inform future models of health justice interventions for women from CaLD backgrounds who are experiencing family violence, through the identification of critical elements of success of this project.

Case studies are interspersed throughout the report. They represent typical cases observed through the project lifetime. These case studies highlight the diversity and complexity of individual client cases and support the impetus for tailored responses to address the particular needs of CaLD women experiencing family violence.

Section One: Theory and Context

1.1 Prevalence and causality of family violence

Domestic or family violence is the intentional use of violence, threats, intimidation or force to control or manipulate a family member.[2] Family violence can occur in any familial relationship including across generations, de-facto and same-sex relationships, as well as 'family-like' relationships such as carer relationships. Whilst men and women can both experience family and partner violence, the prevalence for males is not as great, with men more likely to experience violence at the hands of a stranger.[3]

Recent global estimates suggest that one third of women globally experience intimate partner violence and non-partner sexual violence: the Australian Bureau of Statistics found that about 17% of all women in Australia aged 18 years and over had experienced physical or sexual violence by a partner since the age of 15.[4] This equates to around 1.48 million women. It is important to note that measurement of prevalence of family violence in Australian society is problematic – a great deal of family violence goes unreported or is hidden, and data measurement is often inconsistent across agencies and organisations or not routinely collected.

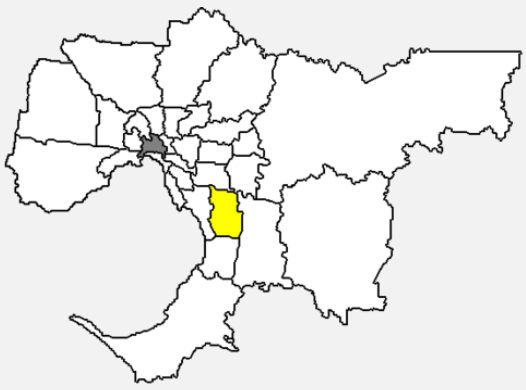
Although family violence is found across all cultures, ages and socio-economic groups, women marginalised by culture are more vulnerable to family violence (discussion at 1.4 below).

It is challenging to draw conclusions on the nature and extent of family violence in CaLD communities due to limited research undertaken on this group. Some studies indicate that women from CaLD backgrounds experience family violence at a higher rate[5] when compared to the general (mainstream) population, whereas other studies have found that CaLD women experience lower levels of family violence in comparison to the general population[6] with support networks found in ethnic communities acting as a protective factor in some situations.

Despite limitations on the research on prevalence and impacts for this group, what is clear is that women from CaLD communities are more likely to experience inequitable access to fundamental supports in situations of family violence, including limited access to legal services.

The situational focus for this project is the City of Dandenong, located in the South Eastern region (SER) of Melbourne, Victoria. The City of Dandenong has a diverse community with different

Figure 1. City of Greater Dandenong



- Population: in excess of 135,600 residents
- 30877 women residing in the City of Dandenong were born overseas
- Over 170 community languages spoken
- 55% from non-English speaking backgrounds
- 14% have limited English fluency
- Top ten non-English speaking countries of birth: Vietnam, India, Sri Lanka, Cambodia, China, Afghanistan, Bosnia, Greece, Mauritius, Philippines

From the findings of the 2011 Census, Profile of Victorian Municipalities. www.greaterdandenong.com, Accessed 8 Oct 2016

[2] See Definitions for formal definitions adopted by this report.
[3] Australian Bureau of Statistics, *Personal Safety, Australia, 2012.* Cat. No. 4906.0. Canberra: ABS.
[4] Ibid.
[5] CJ O'Donnell, A Smith and JR Madison (2002) 'Using demographic risk factors to explain variations in the incidence of violence against women' *Journal of Interpersonal Violence*, 17(2) 1239-1262 in A Morgan & H Chadwick (2009) 'Key issues in domestic violence' Research in Practice Summary Paper No.7, Australian Institute of Criminology. http://www.aic.gov.au/publications/current%20series/rip/1-10/07.html Accessed 22 Sept 2016
[6] J Mouzos & T Makkai (2004) 'Women's experiences of male violence: Findings from the Australian component of the international violence against women survey' *Research & Public Policy Series No. 56*, Australian Institute of Criminology. http://www.aic.gov.au/media_library/publications/rpp/56/rpp056.pdf Accessed 22 Sept 2016

cultures, religions and languages represented in its citizenry. It is the highest new settlement region in Victoria, welcoming approximately 2700 newly-arrived people each year (Figure 1).

In the City of Greater Dandenong, Victoria Police recorded a comparatively high rate of 1453 family violence incidents per 100,000 residents in the year 2013/14. Children were present at 475 of these incidents. The rate of family violence incidents in the City of Dandenong has increased by 183% in the past ten years.[7] The Victorian Magistrates Court and Children's Court of Victoria counted a total of 50,208 intervention order applications finalised during 2013/14. In the City of Dandenong, 3,265 intervention order applications were finalised by the Dandenong Magistrates' Court,[8] making the Dandenong Magistrates' Court the busiest court in the State of Victoria for Family Violence Intervention orders.

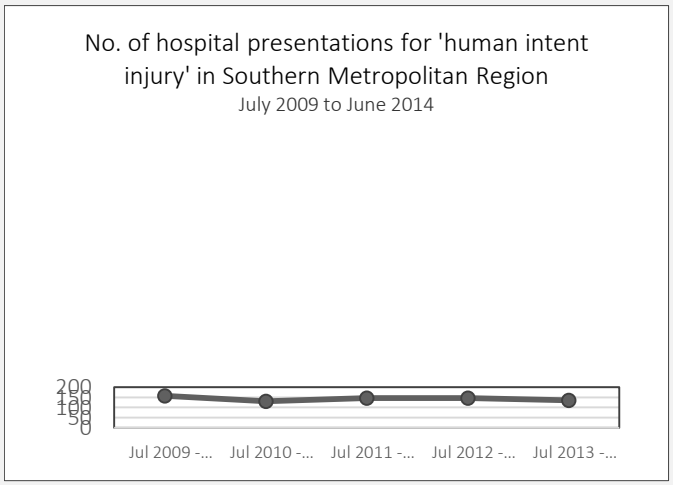


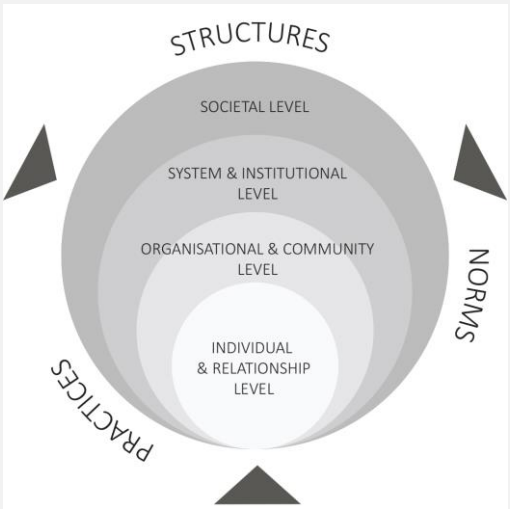
Table 1. Number of total presentations for human intent injury

Family violence also continues to be responsible for a large proportion of services delivered by hospitals in the South Metropolitan[9] region of Victoria. According to data from the Victorian Family Violence Database, hospital presentations for family violence incidents have remained at a consistently high rate (Table 1).[10] Two thirds of patients presenting for a human intent injury of either 'Child neglect, maltreatment by parent, guardian' or 'Maltreatment, assault by domestic partner' were female.

Although most men are not violent, 95% of all victims of violence experience aggression from a male perpetrator.[11] It is widely accepted that experiences of violence are gendered.[12] The key characteristic present in family violence appears to be gender norms and beliefs surrounding male dominance and superiority.

More recently, the socio-ecological model[13] has evolved as a helpful way of observing the interplay of gender inequality with intersectional issues at societal, community and individual levels (Figure 2). This more expansive explanation of causality proposes that social norms, practices and structures that support inequality intersect with factors at the individual, organisational, institutional and social levels, thus leading to family violence. A robust framework for conceptualising family violence like the socio-ecological model has informed early interventionist activity such as *inLanguage*,

Figure 2. Socio-ecological model of violence against women
(Based upon Our Watch, ANROWS & VicHealth (2015): 21)



[7] Crime Statistics Agency (2016) 'Family Incidents' https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents. Accessed 12 Sept 2016
[8] A family violence intervention order protects a person from a family member who is using family violence by specifying conditions to stop a person from using family violence. If these conditions are broken, they can be charged with a criminal offence. Family violence includes emotional and financial, emotional and sexual abuse, as well as physical violence. See www.legalaid.vic.gov.au for more information.
[9] Includes Bayside, Frankston/Peninsula and South East Melbourne catchment.
[10] Victorian Family Violence Database (2014) RCFV Victorian Emergency Minimum Dataset data - July 2009 to June 2014. http://www.rcfv.com.au/Report-Recommendations. Accessed 26 Sept 2016
[11] Australian Bureau of Statistics (2013) Personal Safety, Australia 2012, Cat. No. 4906.0, ABS, Canberra.
[12] Studies by the United Nations, European Commission, World Bank and World Health Organization all locate the underlying cause for violence against women in the social context of gender inequality.
[13] L Heise, (1998) Violence against women: An integrated ecological framework. *Violence Against Women*, 4(3): 262-290

inCulture, InTouch. The project has also understood and applied prevailing understanding of the key drivers for violence against women, namely:

1. Tolerance for violence against women
2. Limits to women's independence in public and private life and control of decision making
3. Rigid gender roles and stereotypes
4. Male peer relations that normalise disrespect, aggression and violence towards women.[14]

The literature emphasises that these drivers can be further exacerbated by other factors such as experience and exposure to violence, anti-social behaviours such as harmful use of alcohol and condoning of violence (in general).[15] This model has been reflected in health professional education and principles of professional practice adopted for this project.

1.2 Health impacts upon women experiencing family violence

In a public health context, family violence has been named as a foundational cause, or 'determinant' of health, alongside adequate access to legal support. The social determinants of health are "the conditions in which people are born, grow, live, work and age"[16] and are the underlying factors that guide health and wellbeing of the individual. A determinants approach reconceptualises the understanding of 'health' as holistic wellbeing and not just the absence of infirmity. The existence of family violence as a social determinant is therefore connected to overall health outcomes for the individual.

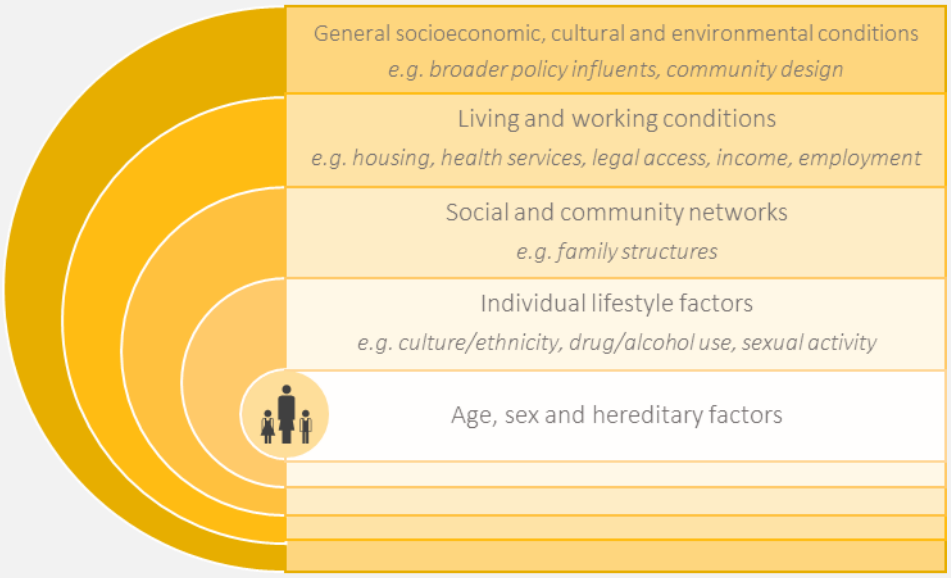


Figure 3. Factors that influence our health

There is ample evidence to demonstrate diminished mental health[17,18] and poorer physical health outcomes[19,20] for women experiencing family violence;[21] the World Health Organisation has described the levels of violence experienced by the world's women as a 'global public health problem of epidemic proportions, requiring urgent action.'[22]

[14] Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth (2015) *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, Melbourne, Australia
[15] Our Watch, ANROWS & VicHealth (2015)
[16] World Health Organisation (2016) 'What are social determinants of health?' http://www.who.int/social_determinants/sdh_definition/en/ Accessed 6 Sept 2016
[17] J Archer (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin*, 126: 651–680
[18] JM Golding (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14: 99–132
[19] E Cassell & A Clapperton (2015) Hospital-treated assault injury among Victorian women aged 15 years and over due to intimate partner violence (IPV), Victoria 2009/10 to 2013/14. *Hazard*, 79: http://www.monash.edu/__data/assets/pdf_file/0017/372302/haz79.pdf . Accessed 12 Sept 2016
[20] D Walsh (2008) The hidden experience of violence during pregnancy: a study of 400 pregnant Australian women. *Australian Journal of Primary Health* 14(1): 97–105
[21] For a comprehensive treatment of health outcomes for women experiencing family violence, see M. Lum On, J. Ayre, K. Webster, L. Moon (2016) *Examination of the health outcomes of intimate partner violence against women*: State of knowledge paper. Sydney: ANROWS.
http://media.aomx.com/anrows.org.au/160324_1.7%20Burden%20of%20Disease%20FINAL.pdf Accessed 12 Sept 2016
[22] World Health Organization (WHO) (2013), London School of Hygiene and Tropical Medicine and South African Medical Research Council, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, http://apps.who.int/iris/handle/10665/85239 WHO, Geneva, 2013. Accessed 7 Sept 2016

Studies have found that women experiencing partner violence of more severity tend to have a higher likelihood of developing psychological problems.[23] Family violence is also a high risk factor for diminished physical health outcomes. In 2004, the Victorian Health Promotion Foundation found that intimate partner violence is the leading contributor for ill-health, death and disease for women aged 15-44 years in Victoria.[24] A recent five-year study of Victorian public hospital data found that 3,794 hospital-treated injury cases were for women experiencing intimate partner violence. 11% of the women were pregnant at the time of seeking treatment. [25]

There is some research available supporting the finding that children are also directly and indirectly affected[26] safety,[27] development[28] and overall wellbeing[29] at risk in a situation of family violence. These impacts are significant when considering that a quarter of Australian children and young people have witnessed or been exposed to acts of violence against their mother.[30] A further concern is the finding that notes the potential for boys to perpetrate acts of family violence later in life, modelling the abuse they witnessed in childhood.[31]

Family violence impacts flow beyond the family unit and into society, for example into productivity,[32] housing instability,[33,34] and employment instability.[35] Violence against women has also been quantified as a significant economic burden to Australian society: the greatest economic burden of $13.9 billion being borne by those experiencing violence themselves with a further $7.8 billion burden attributed to national, and State and Territory government expenditure across health, administration and social welfare.[36]

Case Study 1: Fatima's Story

Fatima, her husband Hussein and their children arrived from Afghanistan leaving behind their family and community. They had few social supports other than a couple of uncles and found living in Australia difficult. They struggled to survive on little money and Hussein was unable to secure work due to lack of formal education and language barriers.

Hussein started to have frequent angry outbursts and increasingly controlling behaviour. He began to monitor Fatima's whereabouts, becoming increasingly suspicious of her. Fatima made friends with other Afghan women but as her independence increased so did the emotional and verbal violence from Hussein.

Fatima was referred to inTouch by the Social Work team within the Antenatal Ward at Dandenong Hospital. At the first trimester of pregnancy visit, Fatima disclosed to her treating practitioner that her husband had hit her. On examination she had bruising on her back and was very fearful in her manner. Fatima's treating practitioner made a compulsory notification to Child Protection and Child Protection requested that Hussein leave the home, which he did voluntarily.

Initially Fatima was happy with this outcome but soon she became distressed as members of her overseas family and the Australian community criticised her for taking action against her husband. She became ostracised from her community and stopped taking calls from her family. The situation was further complicated as Hussein was the primary visa holder and Fatima was not sure of her rights in this situation.

Prior to her follow-up medical appointment, an InTouch lawyer met with Fatima at the hospital. Through the interpreter, the lawyer explained to Fatima that their service was free, and provided information and advice regarding the law in Australia in relation to family violence. Fatima was unaware that family violence and also rape was illegal within marriage, and subsequently disclosed further incidents. Fatima wanted the violence to stop and she also wanted her husband to return to the home.

inTouch assisted Fatima to apply for a family violence intervention order prohibiting her husband from committing acts of family violence but permitting him to remain in the home. The husband was referred to a trauma specific counselling service, which he engaged with. The inTouch Legal Centre also liaised with Fatima's Child Protection worker throughout the process. Soon after the intervention order was made, Child Protection agreed it was safe for the husband to return to the home.

Fatima was very happy with the outcome and reported that she felt safer in her home.

Applying a public health lens to family violence serves to capture the many dimensions of the problem, in order to develop multisectoral responses that reflect a socioecological model. The value of a

[23] A Holtzworth-Munroe, N Smutzler, N, & E Sandin, E. (1997). A brief review of the research on husband violence. Part II: The psychological effects of husband violence on battered women and their children. *Aggression and Violent Behavior*, 2: 179– 213.
[24] VicHealth (2004) *The Health Costs of Violence: Measuring the burden of disease caused by intimate partner violence*. Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/media-and-resources/publications/the-health-costs-of-violence. Accessed 12 Sept 2016
[25] E Cassell & A Clapperton (2015)
[26] D Indermaur, (2001), 'Young Australians and domestic violence' in *Trends and Issues in Crime and Criminal Justice*, no. 195, Australian Institute of Criminology. See http://www.aic.gov.au/media_library/publications/cfi-pdf/cfi008.pdf Accessed 21 Sept 2016
[27] JL Edleson (1999) 'Children's witnessing of adult domestic violence'. *Journal of Interpersonal Violence*, 14(4):839–870.
[28] World Health Organisation (2002) World Report on Violence and Health, Geneva, World Health Organization
[29] G Bedi G & C Goddard C (2007) Intimate partner violence: What are the impacts on children? *Australian Psychologist* 42(1): 66–77
[30] D Indermaur, (2001)
[31] Ibid
[32] PwC (2015) *A High Price to Pay: the economic case for preventing violence against women.* PricewaterhouseCoopers, accessed 10 Jun 2016
[33] Pavao, J., J. Alvarez, N. Baumrind, M. Induni, R. Kimerling (2007) 'Intimate Partner Violence and Housing Instability' in *American Journal for Preventive Medicine*, 32(2):143-146
[34] Pattavina, A., K.M. Socia, and M. J. Zuber (2015) 'Economic Stress and Domestic Violence: Examining the Impact of Mortgage Foreclosures on Incidents Reported to the Police' in *Justice Research and Policy*, 16(20): 147-164
[35] Bell, H. (2003). Cycles within cycles: Domestic violence, welfare, and low-wage work. *Violence Against Women*, 9, 1245-1262
[36] PwC (2015) Ibid.

multisectoral response lies in its ability for key stakeholders to collaborate to address health issues through the identification of shared goals across individual, community, system and societal levels to impact health outcomes.

Research into collaboration on health improvement is still in its infancy and reviews are not yet able to demonstrate conclusive evidence of efficacy.[37] Interventions that seek to address the underlying causes of ill-health such as family violence and legal access, in addition to having an immediate impact upon safety and provision of support, have the potential to lead to improved health and wellbeing outcomes in the longer term for women and their children.

1.3 Marginalisation and the experience of CaLD women in situations of family violence

By the year 2010, approximately six million people in Australia were born overseas and almost four million of these were born in a country where English was not the main language.[38] Women who migrate arrive at disproportionate disadvantage to that of immigrant men in areas of social status and basic human capital resources.[39] Research supports the finding that immigration affects women's understanding of family violence, access to resources and responses to family violence. Their experience of family violence can be further intensified as they are affected by social isolation of the immigration experience, reducing their ability to develop effective management strategies to combat a family violence situation.[40]

Earlier (international) literature highlights the complexity of the cultural overlay in a woman's ability to respond in a situation of family violence. For migrant and refugee people who also identify as lesbian, gay, bisexual, transgender, queer or intersex, the complexity of experience is further amplified as notions of gender, family and power can be rooted in a traditional cultural framework. Another common cultural barrier identified is the expectation that a woman must 'keep the family together' and maintain family violence as a private matter, a common belief of collectivist cultures.[41] With these beliefs still persisting in some communities, the preservation of family and community can transcend the concern of individual safety of women and their children.[42]

In the Australian setting, there is only limited scholarship on the specific experience of CaLD women in a family violence. [43] Of the research available, a number of additional barriers and difficulties are identified that impact a CaLD woman's ability to disclose family violence, find assistance, access support services and leave a family violence situation.[44,45]

Personal barriers include:

- Language barriers;
- Lack of support structures and/or isolation from extended family;
- Lack of knowledge and familiarity with support services;
- Lack of awareness of rights and family violence laws in an Australian context;
- Cultural differences, e.g. around what constitutes 'family violence';
- Social stigma and shame surrounding separation, divorce, etc.;
- Fear of losing children and extended community support networks;

[37] National Collaborating Center for Methods and Tools (2013). *Multisectoral partnerships for health improvement*. Hamilton, ON: McMaster University. http://www.nccmt.ca/resources/search/177

[38] M Kully & L Pejoski. (2016) *Australia unbound? Migration, openness and population futures.* Australian Government Department of Immigration and Border Protection. http://www.border.gov.au/ReportsandPublications/Documents/research/migration-population-futures.pdf Accessed 10 Octover 2016

[39] H Bui & M Morash (1999). Domestic violence in the Vietnamese community: An exploratory study. *Violence Against Women*, 5, p. 774 as cited in E Erez, M Adelman, & C Gregory (2009). Intersections of immigration and domestic violence: Voices of battered immigrant women. *Feminist Criminology*, 4, 32−56.

[40] N Ghafournia (2011) Battered at home, played down in policy: Migrant women and domestic violence in Australia. *Aggression and Violent Behavior* (16):207–213

[41] MR Yoshioka & DY Choi (2005), 'Culture and interpersonal violence research: paradigm shift to create a full continuum of domestic violence services'. *Journal of Interpersonal Violence*, 20(4): 513–519.

[42] H McGlade (2012), Our greatest challenge: Aboriginal children and human rights, Canberra: Aboriginal Studies Press; Nash, ST (2005), 'Through black eyes: African American women's constructions of their experiences with intimate male partner violence'. *Violence against Women*, 11(11): 1420–1440.

[43] S Tually, D Faulkner, C Cutler, & M Slatter. (2008). *Women, domestic and family violence and homelessness: A synthesis report.* Adelaide: Flinders Institute for Housing, Urban and Regional Research. Accessed 19 Oct 2016. https://www.dss.gov.au/sites/default/files/documents/05_2012/synthesis_report2008.pdf

[44] Domestic Violence Victoria (2016) 'Diverse communities and family violence'. http://www.dvvic.org.au/index.php/understanding-family-violence/diverse-communities-and-family-violence.html. Accessed 22 Sept 2016

[45] R Flory (2012) *Whittlesea CALD Communitiess Family Violence Project, Scoping Exercise Report*. Whittlesea Community Futures and Whittlesea Community Connections: Melbourne

- Limited access to resources impacting upon ability to exercise choice;
- Community pressure to remain with abusive partner;
- Mistrust of authorities (sometimes arising from pre-migration experiences);
- Perceived complications caused by secondary visa applicant status.

Systemic barriers:

- In-eligibility for supports due to visa status;
- Real complications caused by secondary visa applicant status;
- Communication barriers between women and service providers, e.g. agency staff, application forms in languages other than English.

Recently, anecdotes of the experiences of women from CaLD communities and the range of key workers that interacted with them were collected by the Multicultural Centre for Women's Health based in Victoria, Australia. Their accounts detailed that even within the category of 'culturally and linguistically diverse' there were differing experiences of violence and consequently, different barriers to seeking support (see Figure 4). [46]

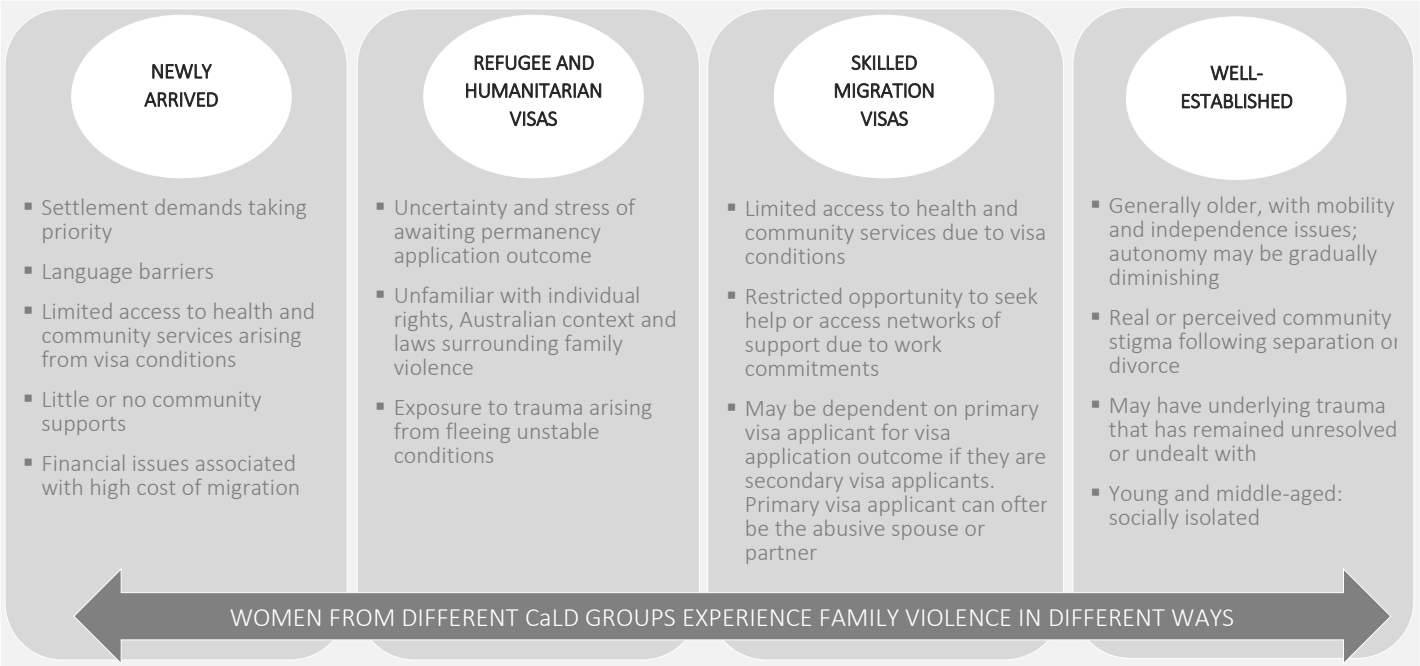


Figure 4. Issues, barriers and experiences that may be associated with different groups of CaLD women experiencing family violence. (Based on C Poljski (2011))

Thus, while whole-of-population prevention strategies have been effective in addressing family violence, for CaLD women, the literature highlights the need for *culturally appropriate* and flexible strategies that specifically recognise the complexities of violence perpetrated against different groups of women. Given this intersectionality of gender, sexual identity, cultural factors and immigration status, there is need for interventions that are multifaceted, adaptable, and that can also be tailored to individual need.

Failure to address this complex social need with culturally appropriate strategies that address access inequalities to fundamental supports such as legal assistance, will contribute to continued marginalisation and longer-term impacts for women and children and broader society.

[46] For a detailed overview of immigrant and refugee women in Australia and their experiences with family violence, see C Poljski (2011) *On Her Way: Primary prevention of violence against immigrant and refugee women in Australia*. MCWH: Melbourne

1.4 Access to justice for CaLD women who are experiencing family violence

The law provides a "framework for the resolution of a broad range of problems central to individual and society welfare"[47]. Legal access is a further key determinant[48] of health: legal problems can influence a number of social conditions for the individual, which can in turn impact upon health outcomes. Underscoring its importance, the United Nations has declared legal access to be a strategic goal of its 2030 Agenda for Sustainable Development.[49] Evidence supports a finding of improved health outcomes for those who receive individualised advocacy[50] across both phases of legal access, that is, of initial approach to institutions and authorities for help, and actual progress through the legal system. Internationally, legal help-seeking continues to be at the centre of advocacy in family violence policy. The opportunity for the legal profession to raise awareness and address the legal rights of vulnerable or disadvantaged groups including CaLD women experiencing family violence,[51] is a unifying theme observed across the literature.

Internationally, the issues surrounding minority access to justice are supported by a plethora of literature substantiating the significant barriers encountered across societal and cultural, as well as institutional domains. The experience of CaLD women in particular, contradicts the fundamental assumption that western institutions permit equal access to justice systems.[52] In the Australian setting, research into adequacy of legal access for CaLD groups has been limited, although the available data suggests underrepresentation of CaLD communities in the legal system, possibly arising from the range of barriers to effective engagement.

Case Study 2: Elaha's story

Elaha is a Hazara refugee. When Elaha was a child her family fled to Iran to escape the war. At the age of 12 years old, she ws abducted and forced to marry her abductor. Elaha was repeatedly raped throughout her 12-year marriage to her husband. She became pregnant and gave birth to their son. She was also subject to physical violence and verbal abuse.

In 2013, Elaha, her husband and son migrated to Australia, where unfortunately the violence continued. Elaha finally fled the home following an incident where her husband assaulted their son. Elaha went to the police who applied for a family violence intervention order on behalf of her and the child.

An inTouch lawyer represented Elaha at the Dandenong Magistrates' Court and negotiated with the husband's lawyer. The husband consented to a final intervention order excluding him from the home for a period of 12 months.

Elaha's son suffered trauma as a result of witnessing and being a direct victim of family violence. He expressed a strong wish to have no contact with his father. Elaha's position was complex: she was subjected to extended family and community pressure as she was told the father "has a right" to his son.

The husband brought family law proceedings in the Federal Circuit Court against Elaha seeking parenting orders to spend regular time with their son, however the child remained vehemently opposed to any contact.

The inTouch Legal Centre acted for Elaha in the family law proceedings, with an InTouch lawyer preparing her response and affidavit and appearing for her at Court. Elaha was also accompanied by her inTouch caseworker who provided emotional support. Recognising that it was stressful for Elaha to be at Court, InTouch arranged for her to use the safe room at Court. This also meant that she would not be required to be in the proximity of her husband.

Interim orders were made requiring the preparation of a family report to assess the child's wishes and make recommendations. At the following court hearing, final orders were made whereby the son lived with Elaha and he could spend time with his father if and when he expressed a wish to do so. The husband was ordered to attend a men's behavioural change program and parenting course.

The inTouch Legal Centre continues to support Elaha. inTouch will also assist Elaha to apply for an extension of the intervention order.

Elaha clearly feels empowered by the court process; it heard her son and addressed the violence against them.

[47] Christine Coumarelos, Pascoe Pleasence and Zhigang Wei, "Law and Disorders: Illness/Disability and the Experience of Everyday Problems Involving the Law" (Justice Issues Paper 17, Law and Justice Foundation of New South Wales, 2013).
[48] Wendy Parmet, Lauren Smith & Meredith Benedict, "Social Determinants, Health Disparities and the Role of Law" in Elizabeth Tobin Tyler et al (eds), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 21.
[49] United Nations (2016) Sustainable Development Knowledge Platform. https://sustainabledevelopment.un.org/?menu=1300 Accessed 22 Oct 2016
[50] Chapter 1. Parmet, W.E, JD., L. A. Smith MD MPH and M.A. Benedict JD MPH (2011) 'Social determinants, health disparities and the role of law in Tobin Tyler, E. and E. Lawton (2011) *Poverty, Health and Law: Readings and Cases for Medical-legal Partnership.* Carolina Academic Press: North Carolina
[51] J Beqiraj and L McNamara (2014) *International Access to Justice: Barriers and Solutions*. Bingham Centre for the Rule of Law Report. http://www.ibanet.org/Document/Default.aspx?DocumentUid=7FCF610E-BEA8-4E06-99B1-B89C34A87BCD
[52] Goodman L A, Epstein, D (2008) *Listening to Battered Women: A survivor-centered approach to advocacy, mental health and justice*. Washington DC: American Psychological Association

In 2010 InTouch consulted widely with migrant and refugee women and service providers in Victoria, Australia, to specifically understand the barriers to the justice system encountered by women experiencing family violence. The report titled, '*I Lived in Fear Because I Knew Nothing*'[53] found that generally, CaLD women who *sought* legal support were confronted by several barriers (Figure 5). Internationally, barriers to access for legal supports (often referred to within the scope of 'formal help-seeking' or 'formal supports') has been growing as a field of inquiry in recent years. In the United Kingdom, key barriers for black, Asian and minority ethnic women experiencing family violence included referral fatigue, fear of engaging with a solicitor, fear of service provider discrimination (real and perceived) and inflexibility of legal aid support. This cohort of family violence survivors were consequently one and a half times less likely to seek out statutory services.[54]

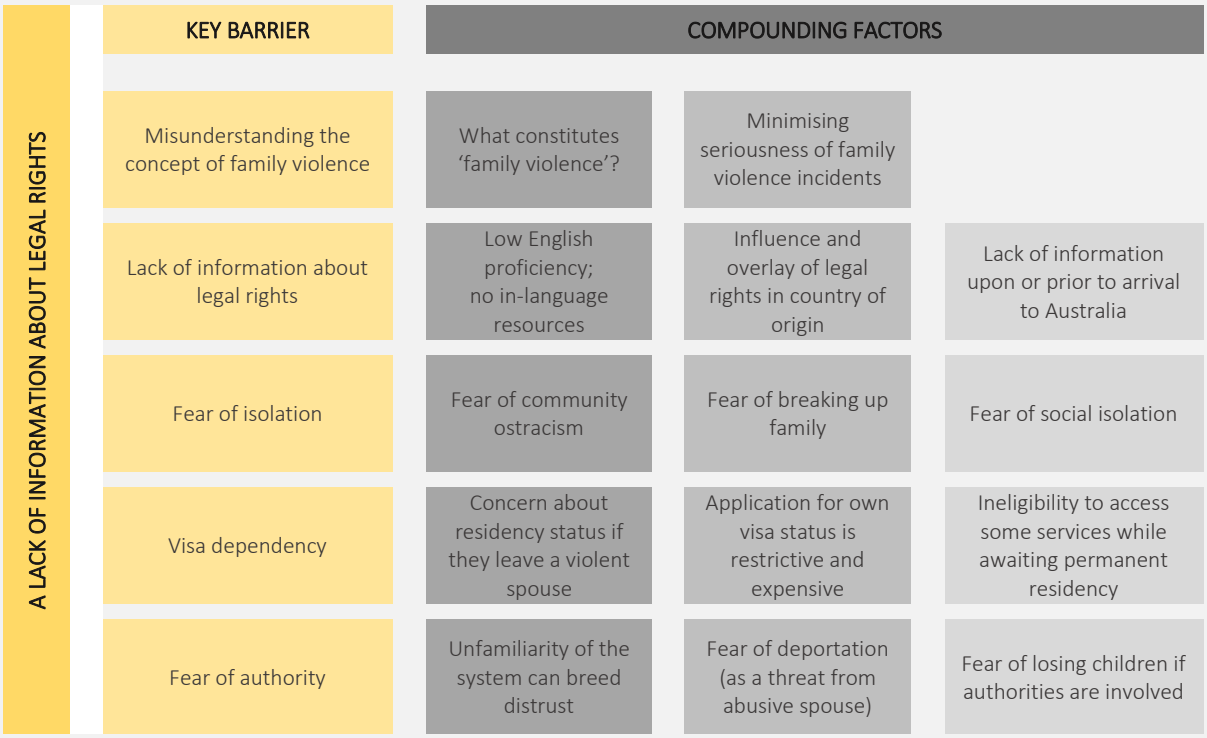


Figure 5. Barriers experienced by CaLD women experiencing family violence when seeking information about their legal rights. (Based on findings from InTouch (2010))

In Canada, similar experiences have been chronicled by community leaders of immigrant women including: lack of culturally and linguistically appropriate services, limited coordination and portability of services, and discriminatory practices embedded in service delivery.[55] Community leaders recommended increased cross-sector collaboration as a means of addressing the structural barriers inhibiting legal access for immigrant women, and boosting the rates of legal services utilised during episodes of intimate partner violence (when compared to a mainstream population).[56]

Data examining the help-seeking behaviours of women experiencing family violence indicates that formal help-seeking is a process, rather than a one-time event, supporting the need for greater awareness of the potential barriers across the help-seeking cycle.[57] As migrant and refugee women in Australia *progressed* through the justice system, *I Lived in Fear Because I Knew Nothing* found that the cohort

[53] InTouch Multicultural Centre Against Family Violence (2010) *I Lived in Fear Because I Knew Nothing: Barriers to the justice system faced by CaLD women experiencing family violence.* http://apo.org.au/resource/i-lived-fear-because-i-knew-nothing-barriers-justice-system-faced-cald-women-experiencing Accessed 25 Oct 2016

[54] Legal Services Commission (2009) *Report on Black, Asian and Minority Ethnic (BAME) Women, Domestic Abuse and Access to Legal Aid*. Legal Services Commission, Domestic Abuse Access to Justice Series.

[55] Guruge, Sepali; Janice Humphreys (2009) Barriers affecting access to and use of formal social supports among abused immigrant women. *Canadian Journal of Nursing Research*, 41(3): 64-84

[56] I Hyman, T Forte , J Du Mont , S Romans & M M Cohen (2006) Help-seeking rates for Intimate Partner Violence (IPV) among Canadian immigrant women, *Health Care for Women International*, 27(8): 682-694

[57] LB Cattaneo, J Stuewig, LA Goodman, S Kaltman, M Dutton, M (2007) Longitudinal helpseeking patterns among victims of intimate partner violence: The relationship between legal and extralegal services. *American Journal of Orthopsychiatry*, Vol 77(3):467-477

was once again marginalised by barriers including: inadequate engagement with law enforcement, resourcing constraints around legal representation and inadequate access to support services. Many women reported that their experience of being further marginalised by the legal system had impacted upon perceived longer-term psychological recovery from the ordeal of abuse and contributed to a sense of disempowerment.

In recent times in Australia, understanding of the experience of CaLD women's access to justice has been advanced further by research undertaken by the Judicial Council on Cultural Diversity.[58] Nation-wide consultations with over 120 migrant and refugee women living in Australia[59] revealed that a positive court experience will also have ripple effects for the broader community. CaLD women who were extended equitable access and subsequently experienced a positive and supported court process were likely to share this experience with other women in their community. Conversely, those who were poorly supported in the process were liable to advise others not to engage with the legal system. A positive court experience was also associated with improved healing from the trauma of family violence, and accessibility of court and court processes was the highest indicator of satisfaction for women, moreso than the actual outcome of court proceedings.

Furthermore, professional and skilled interpreters were seen to facilitate communication not only for CaLD women accessing the court system, but also supported smooth court processes overall by minimising risk of miscommunication.

Acknowledging its limitations, the cumulative evidence so far provides further impetus for the integration of legal, health and human services and especially for the development of effective referral practices between such services. If implemented effectively, an integrated service model can provide a means to secure early intervention and potentially thwart the escalation of violence and or abuse for women in situations of family violence.

1.5 The health system and family violence

Evidence increasingly recognises the medical system as an important avenue for the disclosure of family violence,[60,61] leaving social and health care practitioners ideally placed to identify signs of violence. Disclosure is any conversation where the person experiencing family violence reveals information about the abuse occurring to another individual. Interviews with survivors of partner abuse have shown that health professionals are a major group to whom women want to disclose violence. Where strategies such as the provision of specific patient screening questions were incorporated in the healthcare consult, identification rates were significantly increased.[62]

Disclosure to a sympathetic health professional or clinical social worker can be pivotal in securing the longer-term safety of women experiencing family violence. The health professional can confidentially listen, potentially advise and can function as a referral point to mobilise the services and sources of support to meet need. The health sector can play a vital role in preventing violence against women: early identification of the problem can reduce its consequences and decrease the likelihood of further victimisation of CaLD women.[63]

[58] Inaugurated in 2014, the Judicial Council on Cultural Diversity (JCCD) was endorsed by the Council of Chief Justices with the aim of promoting equitable access to justice by assisting Australian courts, judicial officers and administrators to respond to changing (cultural needs) of society.
[59] JCCD (2016) *The Path to Justice: Migrant and Refugee Women's Experience of the Courts*. Canberra: Judicial Council on Cultural Diversity
[60] C Garcia-Moreno (2015) The health-systems response to violence against women, *Lancet* 385 (9977):1567–1579
[61] GS Feder MHutson, J Ramsay, AR Taket (2006) Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Arch Intern Med*, 166(1):22-37
[62] J Waalen,, MM Goodman, AM Spitz, R Petersen, LE Saltzman (2009) Screening for intimate partner violence by health care providers: Barriers and interventions. *American Journal of Preventive Medicine*, 19(4):230-237
[63] P Easteal, (1996) *Shattered dreams: Marital violence against overseas-born women in Australia*. Canberra: Australian Government Publishing Service

Qualitative studies[64,65] conducted overseas have examined the spectrum of responses received by women experiencing family violence when disclosing to a social or healthcare professional. Positive responses following disclosure identified by the peer-reviewed literature included health professionals believing a woman's account, validating her experience and provision of emotional support. A positive response was attributed to better psychological health benefits for the patient disclosing the abuse, [66,67] Contra-distinctly, women who received a negative response following disclosure were less likely to disclose family violence or seek help in future instances. [68]

Of the negative responses explored in the research, perhaps the most alarming response was the advice for a woman to leave an abusive relationship. One American study reported that two-thirds of health care providers who advised a woman to leave an abusive relationship did not accompany their advice with appropriate safety

Case Study 3: Kim-Ly's Story

Kim-Ly was born in Vietnam and came to Australia as a refugee 20 years ago. Kim-Ly and her husband, Trang were married in a religious ceremony. The marriage was not registered and they lived in a de-facto relationship. They had four children ranging from the age of 18 to four years of age. Trang was an alcoholic – when he was intoxicated he was verbally and physically abusive towards Kim-Ly in the presence of their children.

Kim-Ly and Trang purchased a house in joint names some years ago, and separated shortly thereafter with Trang excluded from the home by the police pursuant to a family violence intervention order.

For the past ten years, a pattern developed with Trang re-entering the home when the intervention order expired. After a few months of co-habitation, tensions would arise and violence would occur, the outcome being police attendance and Trang's removal, with reinstatement of a further twelve month intervention order.

In early 2015, Trang had re-entered the home after the expiration of yet another Intervention Order. Tensions began to rise soon after and during an argument Trang punched Kim-Ly repeatedly in her arm causing severe bruising. Kim-Ly was holding their four year-old child at the time. Frightened, an older child rang the police who attended the home and issued a Safety Notice excluding Trang from the home.

Kim-Ly attended the Dandenong Magistrates' Court the following Monday morning as requested by police. She was identified as a woman from a culturally and linguistically diverse background by the Court Applicant Support Worker and was referred to the inTouch case manager and duty lawyer in attendance at the Dandenong Magistrates' Court.

In a consultation with the InTouch lawyer and case manager, Kim-Ly undertook a risk assessment. Through this process the InTouch case manager and lawyer gained a rich source of information about Kim-Ly's relationship with Trang, the pattern of behaviour, her values, the dilemmas she faced and the repeated risk to her safety and that of the children.

Kim-Ly's case involved a property settlement dispute with her husband Trang; this was discussed the next day at the inTouch Direct Service Team case allocation meeting. Kim-Ly was subsequently assigned a Vietnamese caseworker to provide her with ongoing cultural and emotional support as well as safety planning and she was referred to the inTouch Legal Centre for assistance with the property settlement.

In the months that followed, Kim-Ly had several conferences with the InTouch lawyer at the Maurice Blackburn offices in Dandenong, a more convenient location for Kim-Ly. Through ongoing support from her inTouch caseworker and the lawyer, Kim-Ly felt confident to participate in property mediation with Trang. Trang agreed to be removed from the title of the home in return for a small payment. The inTouch Legal Centre prepared and filed the appropriate court documents and did the conveyancing, removing Trang from the title.

Kim-Ly was delighted with the outcome. She no longer feels obliged to let Trang back into the home, putting an end to the cycle of violence.

[64] KM Sylaska & KM Edwards (2014) Disclosure of intimate partner violence to informal social support network members: A review of the literature. *Trauma, Violence, & Abuse*, 15(1):3-21

[65] S Othman, C Goddard and L Piterman (2014) Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence*, 29(8) 1497–1513

[66] KM Sylaska & KM Edwards (2014) Op. cit.

[67] AL Coker, KM Watkins, PH Smith& HM & Brandt (2003). Social support reduces the impact of partner violence on health: Application of structural equation models. *Journal of Preventive Medicine*, 37, 259–267

[68] K Bosch & MB Bergen (20060 The influence of supportive and nonsupportive persons in helping rural women in abusive partner relationships become free from abuse. *Journal of Family Violence*, 21: 311–320

planning.[69] This is particularly concerning given that the increased risk of femicide occurs when a woman returns to an abusive relationship, after having left for a short period.

Women generally did not find the option of 'leaving' to be a helpful response either. A large-scale Victorian-based study of pregnant women experiencing violence reported that information and referral options were mainly geared to women who were ready to leave an abusive relationship. For those women who did not want or were not yet ready to leave, offers for assistance were duly rejected. The authors of that particular study propose this shortcoming to be indicative of a "predominantly crisis intervention-oriented" family violence support system that is "not meeting the needs of women wanting to stay in their relationships". The study went on to propose that social or healthcare professionals should view the disclosure dialogue as "the first step in a long walk to safety."[70] This reinforces women's expectations that social and healthcare practitioners become skilled in making opportunities available for them to raise experiences of violence,[71] and for women to retain the option to choose their own path without fear of judgement, as active agents of their own lives.

For CaLD women, disclosure can be a complex process. The - albeit limited - literature examining the reluctance of CaLD women to disclose abuse to a health professional can be attributed to a number of factors such as: fear, time constraints of service provider, language barriers religious beliefs, extended family pressure or shame.[72] Where literature examined attitudes to disclosure of violence across a broad population group, it tended to consolidate the cohort into one homogenous group, making it difficult to exclusively extract the evidence-based conclusions on adequate health professionals responses for CaLD women.[73]

Critically, a recent literature review of three major Australian health care publications found multicultural health research as 'limited and uneven'; impacting upon the research base available for equitable policy making, service development and health care interventions and implementation for CaLD populations. The paucity of effective interventions to engage CaLD health consumers is concerning given the diversity of cultures represented in the Australian population. There is thus considerable scope for understanding cross-cultural factors impacting upon disclosure, and subsequent practice development, to ensure that CaLD women experiencing family violence are able to receive safe, appropriate and positive responses from health care professionals.

Recent evidence has also seen the role of the healthcare expand to that of 'non-legal adviser'. In 2011 the Legal Australia-Wide (LAW) survey[74] canvassed the views in excess of 20,000 respondents across Australia. The survey found that respondents sought the advice of their healthcare professional for over one quarter of their legal problems. Generally, health professionals were the first port of call to advise on personal injury or health-related problems confronted by the respondents. Health or welfare professionals were also the second-most frequently consulted advisers for crime problems including assault, sexual assault and domestic violence. The vast majority of problems raised for informal legal advice from a healthcare professional were rated as having a 'severe' or substantial impact on the everyday lives of respondents.

The LAW survey went on to advocate for the investment in formal training to enhance practice for healthcare professionals who operate in this 'gateway' role as 'non-legal adviser'. Where this is to be formally embedded into a position or role, the LAW survey supported the provision of additional

[69] DS Morse, R Lafleur, CT Fogarty, M Mittal and C Ceruli (2012) "They told me to leave": How health care providers address intimate partner violence. *Journal of the American Board of Family Medicine*, 25(3): 333-342
[70] D Walsh (2008)
[71] GS Feder MHutson, J Ramsay, AR Taket (2006) Women exposed to intimate partner violence: Expectations and differences when they encounter health professionals: A meta-analysis of qualitative studies. *Arch Intern Medicine*:166(1):22-37
[72] Nora Montalvo-Liendo (2009) Cross-cultural factors in disclosure of intimate partner violence: an integrated review. *Journal of Advanced Nursing*, 65(1), 20–34
[73] Ibid.
[74] Christine Coumarelos et al (2012) Legal Australia-Wide Survey: Legal need in Australia. Law and Justice Foundation of New South Wales. http://www.lawfoundation.net.au/ljf/site/templates/LAW_AUS/$file/LAW_Survey_Australia.pdf

resources alongside agency and service linkage to support expanded professional practice for healthcare professionals.[75]

The application of 'culturally competent' principles to healthcare practice has the potential to strengthen the efficacy of healthcare consultations. Cultural competency, or cultural responsiveness is the ability to work effectively with people from diverse cultural backgrounds. This includes appropriateness of behaviours, attitudes, policies and practice tools, and encompasses individual workers, systems and organisations interfacing with and supporting each other for improved efficacy.[76] The aim of cultural competency is to foster constructive cross-cultural interactions.

[75] Ibid.
[76] National Health and Medical Research Council (2006) *Cultural Competency in health: A guide for policy, partnerships and participation*. NHMRC: Canberra. https://www.nhmrc.gov.au/guidelines-publications/hp19-hp26. Accessed 23 Sept 2016

In the Australian setting, access of health services by CaLD women is lower than compared to mainstream groups; one particular barrier noted is a lack of awareness among health service providers of what constitutes effective cross-cultural service provision. Consequently, there is only a small base of health-oriented interventions that have sought to understand the needs of CaLD health consumers by intentionally studying culturally competent practices.[77] Available research observes the need for treating health professionals to undergo cultural competence training as a means of building awareness of cultural diversity and confident engagement with persons of diverse cultural backgrounds.

Cultural competence training can include: acquiring an understanding of migration experiences, confidence in working with interpreters,[78] understanding the voice of the CaLD consumer,[79] availability and awareness of an organisational cross-cultural framework[80] and provision of information to facilitate consumer awareness such as in-language resources.

Where cultural competency training was undertaken by treating social and healthcare professionals, international studies have found a general improvement in patient care and enhanced communication with CaLD health consumers.[81] CaLD health consumers with a culturally-competent health professional also reported increased uptake in social and health care services.[82] Bilingual culturally competent health workers or overseas qualified health professionals have been identified as further elements of successful health interventions that deliberately seek to engage the health care needs of CaLD groups.[83,84]

A coalescence of factors including the prevalence of family violence, its negative health impacts and the expansive role of the healthcare professional, in combination with the interlinked nature of health and legal problems, highlight the need for well-coordinated and joined up health and legal services (Figure 6). Additionally, it will enhance accessibility to legal recourse for population groups generally considered at a disadvantage when it comes to issues of access, such as people from CaLD backgrounds.

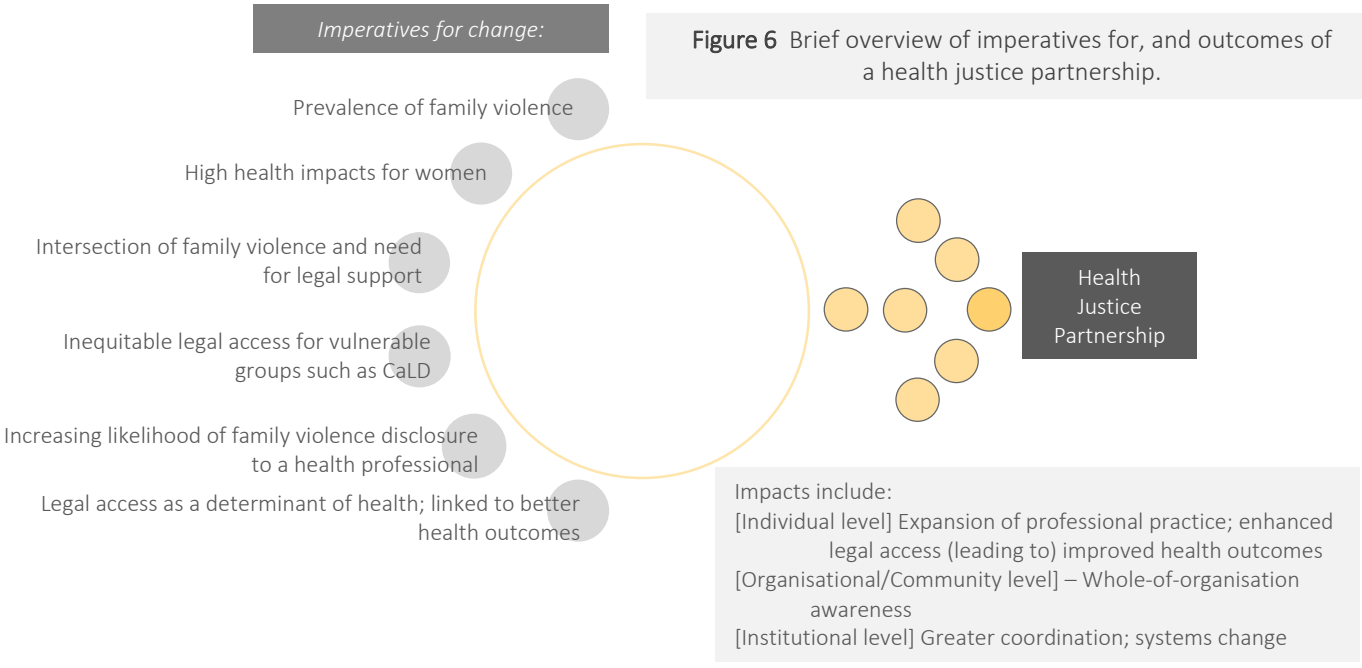


Figure 6 Brief overview of imperatives for, and outcomes of a health justice partnership.

[77] P Garrett, HG Dickson, A Klinken Whelan and L Whyte (2010) 'Representations and coverage of non-English speaking immigrants and multicultural issues in three major Australian health care populations.' *Australia and New Zealand Health Policy*, 7(1).
[78] A Bischoff , T Perneger , PA Bovier P.A. et al. (2003) Improving communication between physicians and patients who speak a foreign language. *British Journal of General Practice*, 53, 541–546.
[79] M Leininger (1991) Leininger's acculturation health care assessment tool for cultural patterns in traditional and non-traditional life ways. *Journal of Transcultural Nursing*, 2(2), 40–42.
[80] New South Wales Health (2001) Guidelines for the production of multilingual health resources by area health services, NSW Health Department and NGOs funded by NSW Health. *NSW Health Policy Statement 2001/99*. NSW Department of Health, Sydney
[81] M Truong, Y Paradies, N Priest N (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*
[82] TL Fisher, et.al. (2007) Cultural leverage: interventions using culture to narrow racial disparities in health care. *Med Care Res Rev; 64(5 Suppl):243S-82S*
[83] S Henderson (2011) 'The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review.' *Health and Social Care in the Community*, 19(3): 225-249
[84] L Chenowethm, Y-H Jeon M Goff & C Burke (2006) Cultural competency and nursing care: an Australian perspective. *International Nursing Review* 53, 34–40

1.6 The intersection of health and justice for CaLD women experiencing family violence

Health justice partnerships[85] (HJPs) are an integrated approach of healthcare. HJPs comprise health, legal and welfare professionals working collaboratively to provide legal assistance to vulnerable people within the healthcare setting.

Models of HLPs vary in design and delivery but essentially comprise four core activities[86]:

1. Provision of legal assistance in the healthcare setting;
2. Transformation of legal and health institutions;
3. Influence and broader policy change; and
4. Prevention of 'health-harming social conditions' through health trend analysis and identification of patterns of systemic need.

HJPs provide wrap-around services to health consumers or clients from a singular referral point, supporting improved efficiencies and opportunities for more effective program delivery. In the process, HJPs share information and expand professional practice across its multidisciplinary team.

Health justice initiatives are underpinned by a social determinants approach to healthcare which recognises the impact of social, economic and political factors upon individual health outcomes. HJPs are also based on the understanding that some medical complaints may in fact require legal remedies, and that individuals are more likely to disclose these concerns to a trusted health professional, rather than a lawyer.[87] HJPs are located in a clinical setting that is familiar and accessible to health consumers: the integrated model aims to address health inequities exacerbated by limited access to legal assistance, particularly for disadvantaged and/or vulnerable population groups including CaLD women.

While the movement is still in its infancy in Australia, HJPs currently exist in some form in over 290 sites across the United States (US), including hospitals and health centres, with a further 126 legal aid agencies operating an on-site HJP.[88] In 2015 these partnerships resolved over 15,000 legal issues ranging from health insurance, immigration, housing, employment entitlements and family violence. Measured outcomes included improved health for the chronically ill,[89] a reduction in stress levels[90] and a reduction in healthcare spending for high-use, high-need patients.[91] A majority of HJPs reported that they had capacity to meet demand for patients' needs.

Looking more specifically at how US HJPs have grappled with the issue of family violence, the latest survey[92] by the US National Center for Medical-Legal Partnerships[93] found that 15% of all HJPs surveyed actively targeted their services to women experiencing domestic abuse and 77% of HJPs received referrals for issues of 'personal and family stability'. HJPs reported inconsistent screening for health-harming civil legal needs, with the exception of family violence. Almost half of all US HJPs regularly screened for family violence, demonstrating raised collective awareness of the scale of the issue.

Although some legal services have had a presence in Australian healthcare settings, HJPs are relatively nascent in Australia. Health Justice Australia, the national advocate for HJPs gives the current number of health justice partnerships in operation at just 20.[94] There is limited data to determine the efficacy

[85] Also referred to in the literature as 'medico-legal partnerships', 'advocacy health alliances' and 'multidisciplinary practice'.
[86] E Lawton, M Sandel, S Morton, L Ta, C Kenyon and B Zuckerman (2011) 'Medical-Legal Partnership: A new standard of care for vulnerable populations' in Tobin Tyler, E. and E. Lawton (2011) *Poverty, Health and Law: Readings and Cases for Medical-legal Partnership*. Carolina Academic Press: North Carolina: pp 71-93; National Center for Legal Partnerships (2016) 'The Four Ways Medical-Legal Partnership Combats Health-Harming Social Conditions'. http://medical-legalpartnership.org/mlp-response/ Accessed 11 Oct 2016
[87] Health Justice Australia (2016) 'What are health justice partnerships?' https://healthjustice.org.au/what-are-health-justice-partnerships/ Accessed 12 Sept 2016
[88] National Centre for Legal Partnerships (2016) 'Partnerships across the US'. http://medical-legalpartnership.org/mlp-response/ Accessed 11 Oct 2016
[89] Robert Pettignano, Sylvia B. Caley, and Lisa R. Bliss (2011) Medical-legal partnership: Impact on patients with sickle cell disease. *Pediatrics*, 128(6): 1482-8
[90] Anne M. Ryan, Randa M. Kutob, Emily Suther, Mark Hansen, Megan Sandel (2011) Pilot Study of Impact of Medical-Legal Partnership Services on Patients' Perceived Stress and Wellbeing. *Journal of Health Care for the Poor and Underserved*, 23(4): 1536-1546
[91] Jeffrey Martin, Audrey Martin, Catherine Schultz, and Megan Sandel (2015) 'Health Affairs: Treating high-need, high-use patients with MLP'. Health Affairs Blog. http://healthaffairs.org/blog/2015/04/22/embedding-civil-legal-aid-services-in-care-for-high-utilizing-patients-using-medical-legal-partnership/ Accessed 5 Oct 2016
[92] National Center for Medical-Legal Partnerships (2016) *The State of the Medical-Legal Partnership Field*. Washington, DC: National Center for Medical-Legal Partnerships http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf. Accessed 11 Oct 2016
[93] The US National Center for Medical-Legal Partnerships is the auspicing body for HJP research, resource development and innovation in the US. Its focus includes systems change to grow medical-legal partnerships and reach communities in need.
[94] Health Justice Australia (2016) 'Where is my local HJP?' https://healthjustice.org.au/ Accessed 12 Oct 2016

of the model in addressing the barriers to legal needs for women experiencing family violence in the Australian setting. However, the evaluation of *Acting on the Warning Signs* (AOTWS), a recent partnership between the Royal Women's Hospital and Inner Melbourne Community Legal[95] to deliver a healthcare-based HJP in Victoria, Australia, provides early positive evidence. Surveyed clients reported positive support for the services offered by the AOTWS legal clinic and reported a sense of empowerment that arose from having increased their knowledge about family violence service and support options.

The project was limited in its engagement of CaLD women (as this group was not singled out for categoric study) leaving a gap in understanding how adequately the AOTWS HJP met the legal access needs of this group.

An important component of the HJP model is the ability to raise awareness and upskill health professionals about negative health influents such as family violence, and to build health professional confidence to initiate a positive discussion when they observe signs of family violence in a patient. In 2015, US HJP partnerships facilitated training for over 15,000 health professionals, assisting them to have greater understanding of social determinants (not limited to family violence) and to build confidence and practice in identifying patients who would benefit from an HJP intervention. [96] The AOWTS extended family violence awareness training to over 120 health professionals at the Royal Women's Hospital, engaging mainly with nurses, midwives and social workers in the maternity, neonatal and women's health clinical areas. Demonstrating the opportunity for the expansion of professional practice enabled by the HJP model, surveyed health professionals reported:

- Marked positive change in their understanding of the warning signs exhibited by a patient that would prompt suspicion of family violence;
- Improved comfort to ask patients about family violence during a healthcare consult;
- Increased confidence to refer to family violence supports and services (although this did not necessarily translate into increased frequency of referrals following training);
- Improved health professional understanding of intervention orders.

Finally, whilst the AOTWS HJP intervention found an increased confidence in asking about family, there was a slight decrease in the confidence of health professionals in discussing family violence with *CaLD women*, signifying the need for continued learning in this area.

Emerging cases point to the HJP model as innovative in its alignment of legal and healthcare to address the social determinants of health for vulnerable groups with poorer access to legal assistance.[97] Despite these promising preliminary findings, there is a need to continue building the empirical base of evidence to understand the critical success factors of the HJP model, and in particular understand whether the legal health needs of CaLD women experiencing family violence are more readily met by a co-located legal/health service.

1.7 Victorian policy and program context

This project commenced in 2014, alongside amplified discourse about the prevalence, impacts and effects of family violence. This heightened public awareness was initiated mainly through the effective campaigning of Rose Batty, mother of Luke Batty, who was tragically killed by his father in an act of family violence. Rose's appointment as Australian of the Year in 2015 also served to continue to raise the profile of domestic violence to the national agenda.

[95] K Hegarty, C Humphreys, K Forsdike, K Diemer, S Ross (2014)
[96] National Centre for Legal Partnerships (2016) 'Impact at a glance. http://medical-legalpartnership.org/mlp-response/ Accessed 11 Oct 2016
[97] Summarised in T Beeson, et al (2013) *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*. The National Center for Medical-Legal Partnership: http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf Accessed 22 Oct 2016

1.7.1 Royal Commission into Family Violence (Victoria)

A Royal Commission into Family Violence was initiated by the Victorian Government. Its Terms of Reference were direct – an inquiry into how Victoria's response to family violence can be improved through the provision of 'practical recommendations'[98]. Among other aspects of inquiry, the Commissioners were required to investigate how agencies and community organisations could better integrate and improve coordination efforts. Wrapping up in 2016, the Commission made a number of recommendations of relevance to this particular intervention including:

- Improvement of the capacity of universal and specialist services to respond to CaLD experiences of family violence;
- Allocation of funding for family violence interpreters in the Magistrates' Court setting;
- Provision of Victoria Police training and practical guidance on use of interpreters;
- Resourcing of Victorian hospitals with the ability to develop and coordinate a whole-of-hospital family violence response;
- Implementation of routine screening for family violence in all public antenatal care settings.

1.7.2 Victorian Action Plan to Address Violence Against Women and Children 2012-2016

The Victorian Action Plan to Address Violence against Women & Children[99] is a key policy document for the Victorian context. It outlines the Victorian government's approach to reducing violence against women and children with planned action framed around 'prevention', 'early intervention' and 'response' to drive long-term social and community change.

Planned activity around early intervention has a focus on the identification of at-risk and vulnerable women and children and the minimisation of the impact of violence upon their lives. Strategies include the strengthening of hospital responses and the development of skills of service professionals to identify and manage the safety of women and children who are considered to be at-risk.

The policy directive urges a coordinated and integrated approach by government and other agencies to support planned activity.

1.7.3 Monash Health

Acknowledging the cultural diversity of its target population, the *Monash Health Strategic Plan 2013-2018* is purposed to "deliver quality, patient-centred health care and services that meet the needs of our diverse community." As a service, Monash Health is committed to the provision of services that accommodate diverse cultural and language needs as stated in its Consumer Rights and Responsibilities.[100] Innovation and strategic partnerships are also key principles of the *Monash Health Strategic Plan 2013-2018*, with the outcome of facilitation of 'seamless' healthcare journeys for health consumers.[101]

Monash Health has a strong commitment to addressing family violence within the healthcare setting, with activities including long-standing existence of relevant domestic-violence oriented internal policies, and a commitment from executive leadership. The South East Centre for Sexual Assault (SECASA) has also provided generalised domestic violence training and development across Monash Health sites, with a focus upon sexual assault in the intimate partner relationship. To reflect this existing work undertaken (and minimalize duplication), a SECASA representative has been invited to be a part of the Monash Health Working Group for this health justice partnership project.

[98] A Chernov (2014) Royal Commission into Family Violence (Victoria) – 'Terms of Reference'. http://www.rcfv.com.au/MediaLibraries/RCFamilyViolence/UploadedDocs/Terms-of-Reference.pdf
[99] State of Victoria (2012) Victoria's Action Plan To Address Violence Against Women & Children 2012-2015. Victorian Government: Melbourne
[100] Monash Health (2016) *Monash Health Consumer Rights and Responsibilities* http://www.monashhealth.org/page/rights_and_responsibilities . Accessed 10 Oct 2016
[101] Monash Health (2013) *Monash Health Strategic Plan 2013-2018* http://www.monashhealth.org/page/Strategic_Plan Accessed 12 Sept 2016

Monash Health incorporated a specific health justice partnership deliverable within its Statement of Priorities 2015-16 to "strengthen the response of

Case Study 4: Jasleen's Story

Jasleen arrived in Australia from India on a student visa in 2013 with Jasleen as the main applicant and her husband as dependent. They had been married for several years during which time Jasleen experienced severe violence. Her husband was extremely coercive and controlling; she had suffered various trauma as a result of the violence, including miscarriage. Jasleen finally built up the courage to separate from her husband and made a report to the police. This was successful and she was granted a 12 months intervention order.

The intervention order was due to expire so Jasleen attended Dandenong Magistrates' Court, whereupon she became a client of InTouch. Despite the fact that the husband had breached the Order on numerous occasions, the police did not assist Jasleen in applying for an extension. Jasleen felt increasingly isolated and was unsure how to proceed.

At Dandenong Court, Jasleen was assisted by an inTouch case worker and lawyer. She disclosed that her husband has breached the intervention order on numerous occasions, but she had never reported this to the police. In her experience, the police in India were likely to dismiss her reports by encouraging her to return to her husband; this experience of law enforcement had influenced her inaction. The inTouch lawyer advised Jasleen of police processes in the Australian context and assisted her to make an intervention order application against her husband. This was subsequently successful.

Jasleen's case was discussed at InTouch's case allocation meeting and a case worker from Jasleen's cultural background was assigned to her. With transportation provided by her InTouch caseworker and assistance from an interpreter, Jasleen made a statement at a local police station. As a result, Jasleen's husband was charged. The matter went to the Criminal Court and he received bailed conditions, including that the he not enter the suburb where Jasleen lived.

However, when released, Jasleen's husband continued to enter the suburb and harass her. He was sentenced to a period of imprisonment and then sent to a Detention Centre. As the dependent on Jasleen's student visa, his visa was cancelled and he is likely to be deported back to India.

As the husband is a high-risk recidivist, inTouch sought a longer intervention order than the usual 12 months. Throughout the ordeal Jasleen received numerous phone calls from her husband's family both in Australia and India. The nature of the phone calls varied from threats to harm her and her family in India to being apologetic and persuasive, seeking to influence reconciliation between the couple. On few occasions, her husband also called her from the Detention Centre saying he was sorry and promising to change. Jasleen was distressed. Her caseworker referred her to a psychologist for support.

inTouch was successful in the application and the Magistrate ordered Jasleen's intervention order be extended by a period of five years – an excellent result.

inTouch Legal Centre is currently assisting Jasleen to apply for a divorce and is corresponding with her husband regarding the parties' joint bank accounts. The divorce is of symbolic importance for Jasleen, as the husband refuses to acknowledge that the relationship is over and considers Jasleen "his" for life. The law in the client's country of origin remains fault-based; Jasleen was surprised and grateful that under Australian law she did not need to prove fault in order to be granted a divorce.

health services to family violence."[102] Inclusion of the *inLanguage, inCulture, InTouch* project as a specific deliverable for Monash Health ensured regular activity monitoring and reporting to the Victorian Department of Health and Human Services on the progress of the partnership.

1.7.4 Victorian Legal Services Board

The Victorian Legal Services Board set a priority theme of 'Legal and Health Partnerships' for the 2014 round, in view of the growth of the health justice partnership model in the US. InTouch was awarded a grant to establish a partnership between community legal services and health settings with a focus on the vulnerable group of CaLD women.

[102] Department of Health and Human Services (2015) *2015-16 Statement of Priorities.* Victorian Government: Melbourne https://www2.health.vic.gov.au/about/statements-of-priorities/monash-health-2015-16-statement-of-priorities

Section Two: Evaluation Findings

2.1 Project and evaluation overview

inTouch was the lead organisation for this project. inTouch recently piloted a Legal Centre model dedicated to the Sunshine Magistrate's Court catchment; *inLanguage, inCulture, inTouch* extended this legal model to the South Eastern region (SER), locating an outpost at the Dandenong Magistrates' Court, with the aim of supporting CaLD women experiencing family violence in the Court's catchment area. *inLanguage, inCulture, inTouch* also delivered an integrated health and legal model ('health justice partnership' – HJP) with a range of health, legal and family violence partners including Monash Health, Jean Hailes *for Women's Health*, and legal firms Maurice Blackburn and Lander & Rogers (Appendix One).

- The inTouch Legal Centre established an outpost at Dandenong Magistrates' Court (DMC). The service provided legal services to CaLD women experiencing family violence, advice, risk assessment, referral and on-going casework in a holistic model comprising case manager and lawyer integrated consultations.
- Monash Health clinical staff received training in best practice approaches to maintaining cultural sensitivity and relevance in working with CaLD clients, identifying family violence within a cultural context, and in effective referral processes. Additionally Maternal Child Health Workers in the Southern region received similar training on identifying , responding appropriately and referring.
- CaLD health consumers who disclosed experience of family violence were referred through Monash Health Dandenong Hospital site into the HJP to receive legal service support in the forms of risk assessments, safety planning, legal navigation and literacy, migration status, referrals and advocacy, to ensure the best possible legal outcomes.

2.1.1 Project goal and objectives

The overarching goal of *inLanguage, inCulture, inTouch* was the delivery of a health justice partnership (HJP) model providing wrap-around health and legal services to CaLD women experiencing family violence in the South Eastern Region (SER) of Melbourne.

Project objectives:

1. Successful replication of an existing inTouch legal centre model to Dandenong Magistrates' Court catchment area;
2. Establishment of a health justice partnership model;
3. Development of a comprehensive training package to increase capacity of health professionals in cultural competency, family violence, and the legal referral pathways.

2.1.2 Evaluation

The aim of the evaluation is to evaluate the implementation of a HJP model in creating wrap-around services to CaLD women experiencing family violence in the southeast region of Melbourne.

The evaluation framework was developed by Jean Hailes *for Women's Health* with guidance from a senior academic with high-level evaluation expertise in particular for projects focusing on marginalised groups. Evaluation activity was progressed by an external evaluator with experience in research and health-oriented projects.

The evaluation was underpinned by the guiding principles and approaches of collaboration, capacity building, engagement, equity, empowerment and advocacy.

2.1.3 Project history

In 2012, InTouch established an in-house Legal Centre. It is a registered Community Legal Centre, receiving its accreditation with the National Association of Community Legal Centres in April 2014. As the first legal service of its kind in Australia, it is the only multidisciplinary family violence practice in Australia that provides integrated support services to cater specifically (and exclusively) for the legal needs of migrant and refugee women. Its unique model was developed around the concept of 'therapeutic, culturally sensitive lawyering' which allows women from CaLD backgrounds experiencing family violence to be supported by social workers and lawyers simultaneously within a trusted environment. All referrals to the inTouch Legal Centre are required to address the essential client demographic criteria of 'CaLD'[103] to qualify for case management and legal assistance.

To establish the in-house Legal Centre, in January 2013 inTouch piloted its Legal Centre service in the Sunshine Magistrates' Court catchment area, following the formation of strong partnerships with the Sunshine Magistrates' Court, community legal centres in the region, Victoria Legal Aid, as well as a number of pro-bono legal firms and barristers. Again, this legal service is only for CaLD women who are experiencing or at-risk of experiencing family violence

In September 2014, inTouch received grant funding from the Victorian Legal Services Board to expand its operation through the replication of its Legal Centre model to the South Eastern Region (SER) of Melbourne. Expansion to this new catchment would occur with the establishment of a health justice partnership (in partnership with a South-East based health service) and a Legal Centre outpost which provided direct legal assistance using the integrated Legal Centre model. The grant also supported the delivery of health professional training in the areas of cultural competency and family violence. The project would be implemented across two years, formally concluding on 30 November 2016.

In addition to implementation outcomes from the Sunshine-based Legal service, establishment of the HJP was informed by learnings from a study tour undertaken by the inTouch senior leadership team. The Tour comprised of site visits to HJPs and healthcare sites in the US and Canada as well as attendance at the National Medical-Legal Partnerships Summit and National Conference on Health and Domestic Violence. Learnings from the study tour were presented at a grant recipients' forum coordinated by the Victorian Legal Services Board. Senior inTouch leadership also consulted with key project workers of *Acting on the Warning Signs*, a joint HJP partnership between the Royal Women's Hospital, Victoria and Inner Melbourne Community Legal Centre.

The *inLanguage, inCulture, inTouch* project was conceptualised as comprising three phases:

Phase One. Key activity - Establishment
– Explored potential partnerships – Establishment of Memoranda of Understanding, referral pathways, information sharing protocols – Engagement an evaluator and ethics approval – Establishment of committee structures and terms of reference
Phase Two. Key activity – Training
– Training resource development – Identification of potential training sites and approach to healthcare providers – Seeking formal training accreditation – Training rollout (family violence risk factors for CaLD and cultural competency)
Phase Three. Key activities – Implementation and Monitoring
– Establishment and operation of legal outpost at Dandenong Magistrates' Court – Extension of service to Monash Refugee Health Clinic site and Dental Services – Implementation, monitoring and refinement of health justice partnership model at Monash Health Dandenong Hospital.

[103] See Definitions for formal definitions adopted by this report.

2.1.4 Project governance

inLanguage, inCulture, inTouch was guided by the establishment of several inter-related strategic and implementation structures with diverse membership representation to reflect the broad expertise and skill-sets required to guide the project (Appendix Two – Committee Membership).

First tier strategic oversight was provided by the Health Justice Partnership Advisory Committee. Its terms of reference include overseeing the quality and direction for the project via quarterly project meetings. Membership comprised executive and senior management level representation from all project partners as well as high-level experts from project-relevant organisations.

Second tier oversight was provided by the Monash Health and InTouch Health Justice Working Party. This committee was responsible for operational decision-making for rollout of the HJP at the Dandenong Hospital site. Working Party membership comprised of senior members of Monash Health Allied Health, clinical operational staff from the Dandenong Hospital site, a senior representative from the Monash Health Refugee Clinic, legal and health project representatives from inTouch, Jean Hailes *for Women's Health* and the South Eastern Centre Against Sexual Assault (SECASA). This Group met on a monthly basis to consider project implementation and monitoring.

Third tier oversight was provided by inTouch, via an internal project team that convened on a monthly basis to oversee the deliverables across the entire project (i.e. for each of the three project objectives.) The Internal Project Committee was convened in the second year of the project; its role and purpose included project monitoring, communications, budgetary considerations and issues management.

A total of 26 committee meetings were held. The Health Justice Project Advisory Committee meetings had the highest attendance rate of 74%, demonstrating strong commitment for collaboration at the higher strategic level. The inTouch Project Team meeting had an attendance rate of 73% for all five of its meetings, with **all** Monash Health and InTouch Health Justice Working Party members present at 54% of scheduled meetings.

The project evaluator was also invited to participate at each of these committee fora to provide evaluation updates and discuss evaluation implementation.

Additional committee engagement for *inLanguage, inCulture, inTouch* included:

- Delivery of a Legal Centre/ Health Justice Partnership Prospectus Workshop to the Health Justice Partnership Advisory Committee. This Workshop was convened with the aims of enhancing partnerships and development of a funding and sustainability strategy following the conclusion of the project in November 2016.
- Attendance to several workshop sessions facilitated by the Victorian Legal Services Board for its group of grant recipients of the 2014 funding round. The aim of these workshops included: raising partnership awareness, knowledge exchange and capacity building. The workshops were attended by members of the inTouch Internal Project Committee.

2.1.5 Project partnerships

inLanguage, inCulture, inTouch formed a number of significant partnerships across legal and health sectors, a key success factor for this project (discussed in more detail at 2.3 below); key project partners included Monash Health, Jean Hailes *for Women's Health*, Maurice Blackburn and Lander & Rogers. Detailed description of key project partners and their respective contribution to the project are also outlined at 2.3 below.

Broadly, project partners collaborated with *inLanguage, inCulture, inTouch* through the provision of:

- Operational implementation of the project
- Strategic guidance (Committee membership)
- Expertise and advocacy
- Networking and linkage opportunities
- No-cost access to office infrastructure for legal outposts
- Administrative support
- Probono representation of clients of the HJP
- Formal project evaluation
- Access to referral pathways
- Advocacy for HJP course as an undergraduate coursework option

2.2 Evaluation approach

This program was designed to evaluate best practice, place-based, family violence service provision in CaLD settings. Enhancing understanding in this area is likely to have long-term, practice benefits for program staff such as promoting innovation and best practice in intervention design and implementation. Short-term, individual benefits were not anticipated as a result of participation in this evaluation.

The evaluation was informed by a realist approach. Realist evaluation is an approach that examines the nature of successful interventions. Specifically, realist evaluation asks – under what contexts and for which groups interventions work, and how? The principles of realist evaluation stem from qualitative principles such as the systematic collection and analysis of data, iterative theory development, seeking alternative cases and explanations and strong reflection processes.[104]

As this project aimed to enhance the understanding of family violence initiatives in CaLD settings, the evaluation is contextualised as contributing to innovation and continuous quality improvement of such programs. This is likely to offer social equity benefits by fostering cultural awareness and gender equality within society, and best practice on a professional level for program participants. Extending existing understandings of best practice family violence prevention is beneficial to the ongoing consolidation of an evidence base of theoretical models to inform violence prevention research and practice, especially for CaLD women given the limited evidence base in this area.

Like the *Acting on the Warning Signs* pilot, this pilot project foresaw limited client growth in the initial establishment stages. Accordingly, the data obtained is descriptive only and does not lend itself to statistical transferability.

2.2.1 Evaluation methodology and activities

This project captured quantitative and qualitative data. Qualitative data included de-identified surveys and structured interviews.

Evaluation Phase 1: Project Formation involved:

1. Dissemination of partners' self-assessment using the VicHealth partnerships analysis tool at project commencement – all project partners

Evaluation Phase 2: Establishment of the inTouch Legal Centre in the South Eastern region (SER) – involved:

1. Design and implementation of pre- and post- semi-structured interviews/surveys with clients accessing the Dandenong Magistrates' Court inTouch Legal Centre service
2. Identification of referral pathway processes with the legal fraternity in the SER
3. De-identified case studies of client interaction with Dandenong Magistrates' Court inTouch Legal Centre service

[104] Wong, G., Greenhalgh, T., Westhorp, G., & Pawson, R. (2012). Realist methods in medical education research: what are they and what can they contribute? *Medical Education*, 46(1): 89-96

Evaluation Phase 3: Capacity building of the health sector to participate in the legal-health services – involved:

1. Design and rollout of health professional workshops to assess learning needs in relation to identification of CaLD women experiencing family violence and referral mechanisms for legal assistance
2. Development of a training package for health professionals working in acute and community sectors, informed by workshop learnings and covering areas of cultural competence, family violence and legal referral processes.
3. Implementation of post-training evaluations to determine impact upon skills and knowledge in key learning areas.

Evaluation Phase 4: Provision of a client-centered approach – involved:

1. Design and implementation of pre- and post- semi-structured interviews/surveys with clients accessing the HJP at the Dandenong Hospital outpost.
2. De-identified case studies of client interaction with the HJP

Evaluation Phase 5: Project outcomes– involved:

1. Interviews with key workers to evaluate 'expansion of practice' indicators, quality of partnership collaborations, process modifications and barriers and enablers of the HJP model and implementation of the inTouch Legal Centre in SER at project commencement, mid-way and conclusioon
2. Dissemination of partners' self-assessment using the VicHealth partnerships analysis tool at project conclusion – all project partners

Evaluation Phase 6: Final report:

This evaluation report will report project outputs and outcomes following the above evaluation framework.

2.2.2 Ethics

Ethical clearance for *inLanguage, inCulture, inTouch* was provided by the Swinburne University Human Research Ethics Committee.

This research study took into account the sensivity of the subject matter – i.e. family violence within CaLD communities but the study did not involve a direct discussion of family violence with the research participants. Interviews and focus groups were designed to elicit information about processes and program implementation such as the processes associated with implementing and maintaining intervention strategies. Qualitative interviews did not elicit the disclosure of individual case information and did not involve the collection of any personal or sensitive information.

2.3 Evaluation Phase 1: Project formation

inLanguage, inCulture, inTouch commenced its project journey by identifying key stakeholders and potential project partners. Following introductory sessions which included the consideration of stakeholder engagement parameters, terms of partnerships were assented to and partnerships commenced. *inLanguage, inCulture, inTouch* formalised four key and six additional project partnerships across legal and health sectors; these partnerships generated significant value for the project and were a key success factor for this project. Table 2 below outlines partnership contribution to the project.

Table 2. Partnerships matrix

Key Project Partners	
Monash Health	Memorandum of Understanding guided partnership activity which included: ▪ Operational implementation of the project - HJP ▪ Strategic guidance (Committee membership) ▪ Expertise and advocacy ▪ Networking and linkage opportunities ▪ Administrative support (year one)
Maurice Blackburn	▪ Strategic guidance (Committee membership) ▪ Expertise and advocacy ▪ Networking and linkage opportunities ▪ No-cost access to office space for Dandenong outpost ▪ Launch event venue access
Lander & Rogers	▪ Strategic guidance (Committee membership) ▪ Expertise and advocacy ▪ Probono legal assistance for MOU development or agreements between parties ▪ Assistance with development of referral pathways ▪ Probono representation of clients of the HJP
Jean Hailes for Women's Health	▪ Design and delivery of health professional training sessions (year one) ▪ Strategic guidance (including through Committee membership) ▪ Formal evaluation of the project including final evaluation report

Additional Project Partners	
Victoria Legal Aid	▪ Strategic guidance (Committee membership) ▪ Networking and linkage opportunities
Monash University	▪ Joint event sponsorship ▪ Advocacy for HJP course as an undergraduate coursework option ▪ Strategic guidance (Committee membership) ▪ Networking and linkage opportunities
Dandenong Court	▪ Linkage to Court Users network ▪ Office space for Dandenong Legal Centre service
Casey Cardinia Community Legal Centre	▪ Referral pathways ▪ MOU
Monash Springvale Community Legal Centre	▪ Referral pathways
WAYSS (formerly Westernport Accommodation & Youth Support Services)	▪ Referral pathways

Partnership engagement was gauged at mid-point and conclusion of the project utilising the VicHealth Partnership Analysis Checklist. This Checklist is used by organisations to reflect and assess engagement, with the ultimate aim of strengthening partnerships for ongoing effectiveness. Monitoring of partnership efficacy is an important project activity, particularly given the multisectoral nature of *inLanguage, inCulture, inTouch's* project partners.

Following socialisation of the partnerships analysis activity at a HJP Advisory Committee, The VicHealth Partnership Analysis Checklist[105] was disseminated by the evaluator via the inTouch Chief Executive Officer. Completed Checklists were collated by an InTouch project coordinator and provided to the evaluator for analysis.

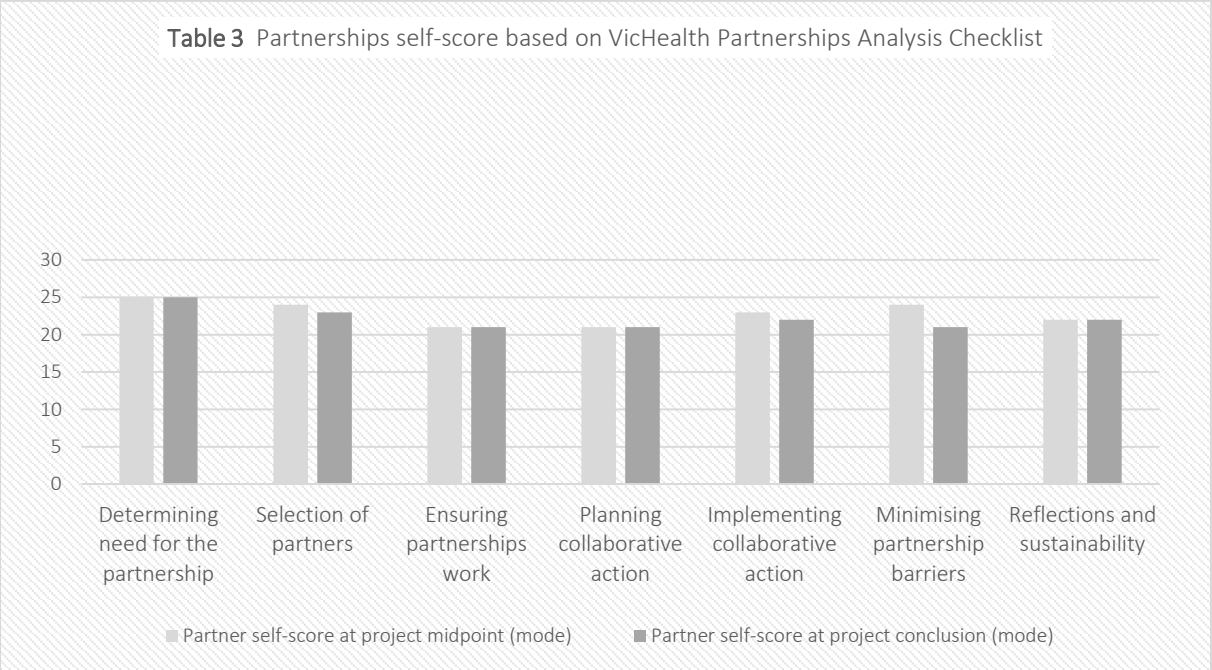
The Checklist aggregates scores across seven aspects of partnership engagement:

- Determining partnership need;
- Selection of partners;
- Preliminary assessment of partnership efficacy;
- Planned collaboration;
- Implementation;
- Barrier minimisation; and
- Reflections and partnership sustainability.

In round one of the Checklist, partners of *inLanguage, inCulture, inTouch*, eight responding partners assigned the partnership generally high ratings across each aspect of partnership engagement, attaining the Checklist rating that 'a partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.'

For round two, this overall high rating for each of the aspects was repeated with the exception of one of the responding seven project partners, which resulted in a mid-range partnership assessment of 'moving in the right direction but it will need more attention if it is going to be really successful'. The parameters of this partnership had been altered during the course of the project, possibly accounting for this shift (Table 3 below).

Table 3 Partnerships self-score based on VicHealth Partnerships Analysis Checklist



The consistently strong ratings assigned by project partners suggest that engagement was a sustained effort evidenced across the project lifetime. Sustainability was a concern for project partners, who identified limited resources available to progress the work of the partnership. Checklist findings showed there seemed to be less focus on a planned approach to collaboration; in spite of this, partners

[105] Available from https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool

saw the need for the partnership, there was an identified goal, and the benefits of engaging in the partnership or the project outweighed the costs of commitment.

Evaluation Phase 2: Establishment of the inTouch Legal Centre in the South Eastern region

inLanguage, inCulture, inTouch was successful in establishing a Legal Centre outpost to service the legal needs of CaLD women residing in the catchment area of Dandenong Magistrates' Court (DMC).

A number of outputs were evidenced towards fulfilling this project deliverable.

- Establishment of several referral pathways with the legal fraternity based in the SER.
- Provision of legal assistance to clients at the Legal Centre outpost at DMC.
- Provision of secondary client consultations at the Maurice Blackburn Dandenong office outpost.
- Provision of culturally appropriate support, including advocacy for translation and interpretation services for a diverse client base.
- Strong partnership engagement to raise the profile of the integrated model at Dandenong Magistrates' Court with various stakeholders including judicial officers, law enforcement, Court Users, and the legal fraternity.

Originally the model for the legal outpost was for it to receive referrals from the inTouch Direct Service team and local community legal centres, and consult with clients at the Maurice Blackburn Dandenong outpost. In November 2015 the legal service was extended to a duty solicitor service at Dandenong Magistrates' Court every Monday (Table 4).

Table 4 Model iterations of inTouch Legal Centre in SER (servicing DMC catchment area)

Model iteration	Advantages	Limitations
1) *'Original model'* Maurice Blackburn office outpost; referrals from the inTouch Direct Service Team and local community legal centres.	▪ Dedicated office space ▪ Convenience of an additional legal service location for inTouch clients who were unable to attend Central inTouch offices	▪ Limited number of referrals
2) *'Coordinated model'* DMC outpost; establishment of an inTouch duty lawyer at DMC every Monday; case manager consults with client, then lawyer consults with client (Maurice Blackburn office outpost available for follow-up consultations.)	▪ Linkage to relevant DMC networks, e.g. Court Users meetings ▪ Dedicated office space (confidential appointments away from other court users) ▪ Clients able to see an inTouch lawyer on the same day their matters were heard at DMC	▪ Consultations took longer as the client was unable to have both the case manager and lawyer in attendance at the same time due to confidentiality reasons
3) *'Integrated model'* DMC outpost; establishment of an inTouch duty lawyer at DMC every Monday; dedicated DMC office space with both lawyer and case manager present at client consultations. (Maurice Blackburn office outpost available for follow-up consultations.)	▪ Linkage to relevant DMC networks ▪ Dedicated office space ▪ Enhanced practice development opportunities ▪ Cancels the need for client to repeat her story as both professionals are present at consult	▪ Questions of confidentiality –legal advice was received from Julian Burnside QC prior to implementing this model (see 2.4.3 Legal Professional Privilege)

2.4.1 The integrated model

Characteristic of the realist approach, strong reflection processes and model iterations resulted in the successful establishment of the 'integrated model' as the optimal model for the inTouch Legal Centre in the SER.

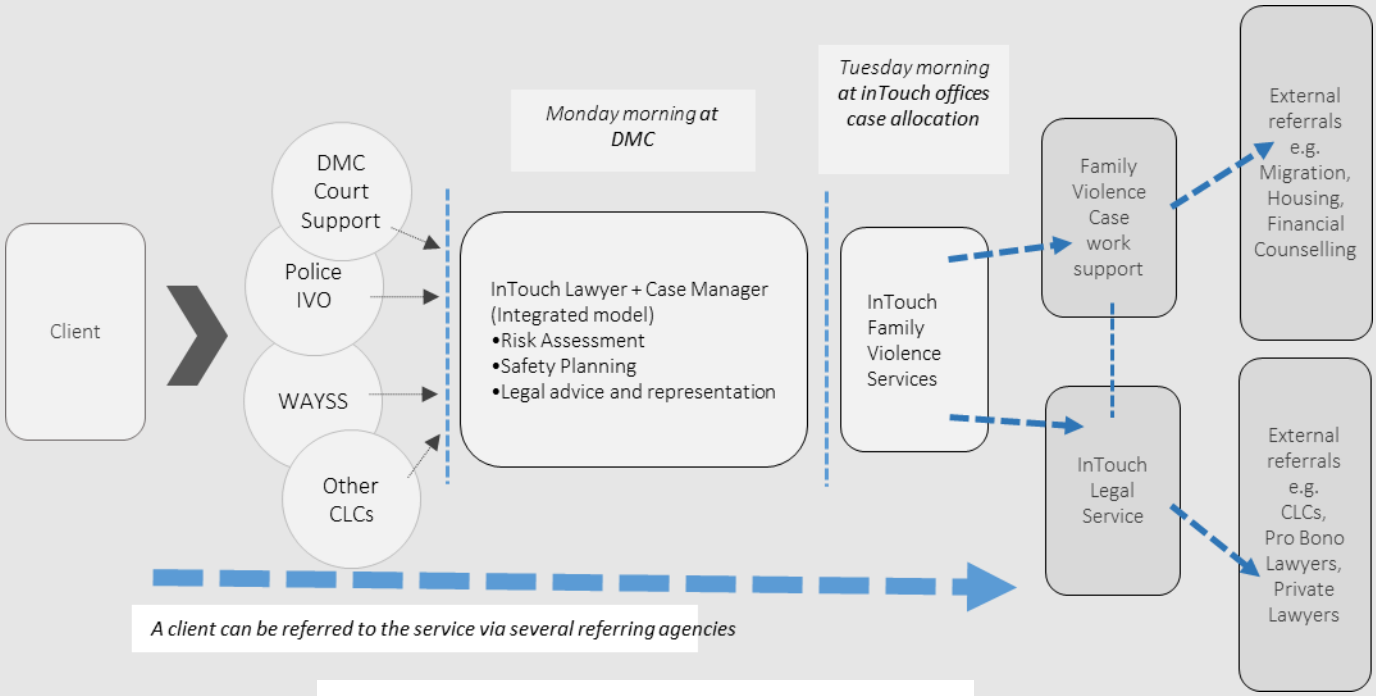


Figure 7 The integrated model – inTouch Legal Centre in SER

The integrated model consisted of a dedicated inTouch duty lawyer in attendance at DMC every Monday, working alongside an inTouch caseworker (Figure 7). Monday is the traditional day for police applications for intervention orders brought on behalf of people experiencing family violence. The Duty Solicitor met with CaLD women who were the subject of police intervention order applications together with the inTouch case manager, in a dedicated office provided by DMC. Consultations took up to one hour and typically included a risk assessment of safety by the case manager, followed by the lawyer providing legal advice and representation. An interpreter was booked for the consultation if the client required it.

The inTouch lawyer was trained in cultural competency, and skilled in the 'empathetic lawyering' style which seeks to understand the client and exercise empathy and compassion during the consultation. The inTouch case manager was from a CaLD background and also spoke a language other than English.

If the client was identified as requiring ongoing legal assistance, the client was referred to the inTouch Legal Centre and an appointment was arranged for the lawyer to meet with the client at the outpost located in the offices of Maurice Blackburn Dandenong. Appointments were arranged and interpreters booked for attendance at this outpost. inTouch was able to utilise the facilities at Maurice Blackburn's offices including a well-appointed interview room, a receptionist, and administrative support services such as photocopy machines and faxes. Similarly, for ongoing casework, the client was referred to the inTouch Family Violence Services for support.

2.4.2 Referral pathways and raised service awareness

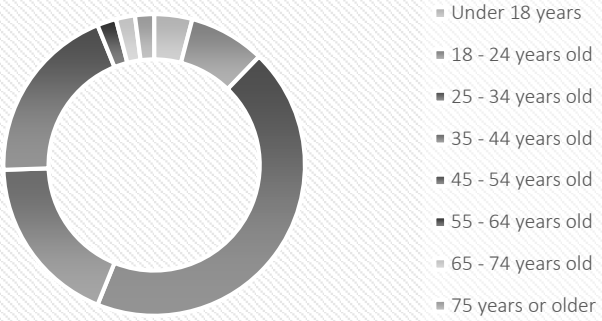
Several referral pathways were established for this service. Pathways processes include:

- Legal fraternity: Victoria Legal Aid (Dandenong) office and Casey Cardinia Legal Service (Memorandum of Understanding established with Casey Cardinia Legal Service)
- DMC: regular referrals via the DMC Court Support Worker (of intervention order applications)

A number of additional networking opportunities were undertaken by the inTouch Legal Centre team to raise awareness of the service including:

- Regular Court Users' meeting attendance
- Attendance at the Court Users' introductory session initiated by the DMC Magistrates.

Table 5 Age group of clients attending inTouch Legal Centre in SER



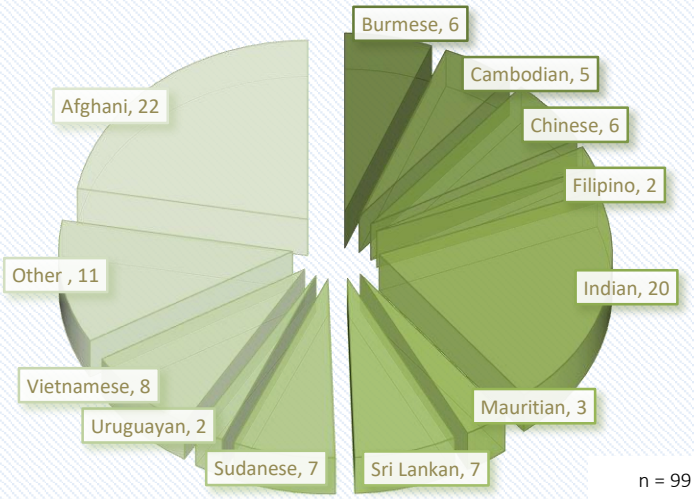
It is then not surprising to note that the vast majority of referrals to the service came from the Dandenong Magistrates' Court Support Worker, potentially an outcome of engaged stakeholder relations for this project.

A further outcome was recognition of inTouch as an agency available to directly assist women in the Southern region of Melbourne who are experiencing family violence, by featuring the Legal Centre in the Southern Melbourne Family Violence Support Service Matrix 2016. This Matrix was developed by the Integrated Family Violence Coordinator at WAYSS and features a further 15 other local agencies supporting victims of family violence in the region.

2.4.3 Referral data

Referral data was extracted from the inTouch Legal Centre in SER case file database and provided to the evaluator in de-identified form. All clients who accessed the service during the project period were included in the evaluation. Client demographics and type of legal issue/s supported were included in the data analysis.

Table 6 Cultural identity of clients assisted by inTouch Legal Centre in SE



A total of 234 clients were provided social and legal support at Dandenong court during the 2 year project. With the addition of duty lawyer , 99 client referrals were received via the inTouch Legal Centre in the South Eastern Region since its commencement in October 2016 with a further 21 appointments at the Maurice Blackburn Dandenong office outpost (these also included secondary consultations). Consultations were typically open/shut cases or for women seeking advice only. Translation and interpretation services were requested in 45 of the 99 cases with over 11 different cultural identities represented in the Legal Centre client base.

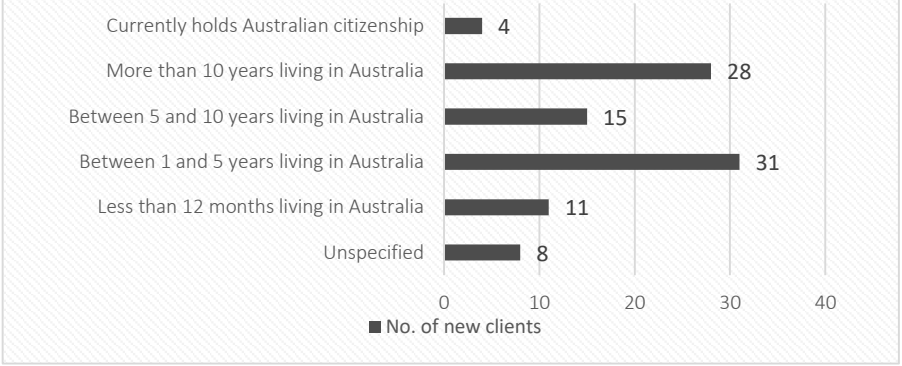
The typical client of the inTouch Legal Centre in SER at DMC was a female aged between 25 and 34 years old and from either Afghanistan, India or Vietnam. She had resided in Australia for between one and five years and usually had one or more children aged eighteen years or less. She required an interpreter to assist in her legal consultation (Tables 5 – 7).

91 separate issues were raised in consultation with the inTouch lawyer and case manager across the areas of:

- family law
- children's matters
- property
- divorce
- spousal maintenance; and
- child support.

These were in addition to the 92 cases which required family violence legal assistance. So, each client would bring an average of two concerns to be addressed in consultation with the inTouch lawyer and case manager.

Table 7 New clients of inTouch Legal Centre in SER - Time spent living in Australia



The potential for broader family impacts were significant; the 99 new clients of the inTouch Legal Centre in SER shared a total of 160 children between them.

2.4.4 Legal professional privilege and the integrated model

In establishing the inTouch Legal Centre in SER, a dilemma regarding confidentiality or 'legal professional privilege' arose.

Lawyers and case managers have different ethical and professional obligations. Case managers are contractually mandated to report to Child Protection[106] if they form the view that a child is at risk of serious harm and, they must report to the police if they hold a reasonable belief that a child under 16 has been sexually abused (unless they have a reasonable belief for not doing so.) Lawyers are exempt from both requirements.[107] They are bound by their client's legal professional privilege; a lawyer cannot disclose confidential communication with a client without the client's consent – the exception being a lawyer may disclose confidential information in order to avoid the probable commission of a serious crime or to prevent imminent serious harm to a person (usually the client).[108]

A conflict may arise if a client makes a disclosure in the presence of a case manager and lawyer; the case manager is obliged to disclose and the lawyer is bound not to disclose.

inTouch adopted the approach that the safety of women, children and community is paramount. Believing that the integrated service model of lawyer and case manager working side by side as the optimal client-focused model of care, it submitted a discussion paper to the Law Institute of Victoria Ethics Committee, seeking advice on this perceived conflict of professional responsibilities.

While this was under consideration, the inTouch Legal Centre in SER applied the coordinated model of client care with each professional (lawyer and case manager) seeing the client separately.

[106] Please see section 184 of the *Children Youth and Families Act 2005* (Vic)
[107] Please see section 199 of the *Children Youth and Families Act 2005* (Vic) and section 327 of the *Crimes Act 1958* (Vic).
[108] (See Rules 9.2.4 and 9.2.5 of the Legal Profession Uniform Law Australia Solicitor's Conduct Rules 2015).

Pro-bono concise and practical legal written advice was provided by a Queen's Counsel on the issue. The advice received was that the integrated model should proceed. However, if at any time during the consultation "the lawyer thinks the client is about to refer to a matter which would be reportable, they should ask the case manager to leave the room while the lawyer explores the issue."

1. If there *was nothing reportable*, the case manager could return to the consultation.
2. If there *was something reportable*, the lawyer would ask the client whether they would like it to be reported, explaining that whilst the lawyer will not report it without permission (legal professional privilege), the case manager would be obliged to report it.

This advice was adopted and operationalised by the inTouch Legal Centre in SER as it was seen as empowering the client to make her own decisions about disclosure and reporting.

Furthermore, whilst inTouch lawyers would strongly recommend to a client that she act protectively and work with the case manager to report, in the event that a client elected not to disclose,[109] to mitigate risk to both organisational and client confidentiality, the InTouch Legal Centre in SER would close its file and refer the matter to another lawyer off site. The case manager would continue their work with the woman, ensuring that her safety, risk assessment and case management continued as chief priority.

This assurance on the practicalities of operationalising an integrated model within the confines of differing responsibilities on confidentiality was critical; in addition to ensuring client's confidentiality needs and rights were maintained. This model is currently the only Community Legal Centre in Australia within a Family Violence Crisis service, therefore setting the benchmark for implementing a model of this kind.

2.4.5 Client surveys

Five clients who accessed the inTouch Legal Centre in SER were invited to participate in a survey to explore how well the service was doing in meeting their legal and health needs.[110] An inTouch worker conducted the survey interviews and de-identified interview responses were provided to the evaluator for analysis. Each participant was asked the same questions upon entry and exit from the Legal Centre service:

Questions asked upon entry into and exit from the project:

1. Would you have known how to find lawyers to assist you?
2. Could you afford to engage lawyers to assist you in this matter?
3. What are your legal or health related concerns right now?
4. On a scale of 1 to 5 how stressed or worried do you currently feel?

Five clients participated upon entry to the service; four of the five were able to be contacted for exit survey interviews.

Upon entry:

- None of the women had any knowledge of how to locate a lawyer or legal service to provide assistance in their situation.
- Four indicated they would not have been able to afford to engage lawyers to assist them; the fifth client indicated that she 'did not know' if she would have been able to afford legal support.
- Safety (of self and children), property concerns, intervention orders and navigation of the Australian legal system were legal health concerns identified by participants. The health concerns included depression, emotional health, stress and 'health' broadly.
- All five participants assessed their stress at a level of 4 'high'.

[109] This is very rare and has not happened at InTouch.
[110] See 2.1.8 for Ethical considerations undertaken by this research study.

Without this program would you have known how to find lawyers to assist you?

> *"No – very hard I don't know where to go. Without you I don't know what I would have done so glad to have met you. I tell all my friends. Asian women don't know where to go."[Participant B]*

> *"No. I tried to get help in the past but no one would help me" [Participant D]*

Upon exit:

- Legal concerns changed to 'nothing at the moment' for three clients; one was still proceeding with divorce and property matters. Health matters identified included diabetes and 'none at all'. One participant divulged that a counsellor was helping her and she was feeling much better.
- All demonstrated a reduction in perceived stress with responses ranging from 'rarely stressed' to 'sometimes stressed'.

What are your legal or health related concerns right now?

> *"In the past I couldn't get legal help though I tried. I wanted to get my husband's name off the house and I also wanted to process the divorce. To be honest, I don't know where I would be without my faith given all the terrible things that have happened by my husband." [Participant D]*

2.4.6 Case study

Mai's Story

Background

Mai had been subjected to long term and severe physical, sexual and emotional abuse throughout her 20 year marriage which resulted in a profound deterioration to her mental health. When Mai disclosed to her GP that her husband had threatened to kill her if she divorced him, her GP put her in touch with a family violence support service which resulted in the removal of her husband by police.

Mai divorced her husband and agreed at mediation to a financial settlement, splitting their combined assets. As a result of the settlement Mai could not afford to remain in the family home where she lived with her children, one of who has a disability requiring extensive care. Her mental health deteriorated rapidly leading to her admittance into a mental health facility.

InTouch intervention

Mai was referred to inTouch Legal Centre by a psychiatrist at a mental health facility where she was receiving treatment following the property settlement.

Mai had previously been referred to another Community Legal Centre, but was advised they could not assist her because she did not meet the eligibility guidelines. When inTouch lawyers met with Mai she appeared confused and distressed, and had limited English skills. She instructed that she had not wished to settle on the terms reached at the mediation. It appeared that the settlement was not fair or equitable given the contributions Mai had made in supporting the family throughout the marriage, both financially and emotionally.

Mai was placed in a difficult position whereby she was ineligible for legal aid funding as it was a property matter, but could not afford a private lawyer. The inTouch Legal Centre was able to retain a private law firm to act probono for Mai, and explore whether the property settlement which she had purportedly agreed to could or should be challenged.

The private firm and the inTouch Legal Centre co-case managed Mai's legal needs. After review of the client's case, it appeared unlikely that she would be able to challenge the property settlement due to various factors such as: the evidence suggested that throughout the property settlement mediation process Mai had had emotional and legal support and it was determined that she had fully understood the process. The evening after her inTouch lawyer advised her of this, Mai was re-admitted into hospital whilst her legal proceedings were still afoot. The inTouch Legal Centre are continuing to provide legal support to the client in consultation with her treating practitioners, so as to minimise further risk to Mai's mental health.

Even though Mai did not achieve the legal outcome she was hoping for, the legal intervention and holistic support provided by inTouch team informed Mai of her legal rights and enhanced her understanding of legal procedure so she could make an informed decision.

2.4 Evaluation Phase 3: Capacity building of the health sector to participate in the legal-health services

inLanguage, inCulture, inTouch was successful in facilitating opportunities to build health sector capacity to participate in legal health services.

Staff at the Dandenong Hospital site received training from Jean Hailes *for Women's Health*[111] and inTouch, on best practice approaches to maintaining cultural sensitivity and relevance in working with CaLD clients, identifying family violence within a cultural context, and in effective referral processes.

Whilst Dandenong Hospital staff were chosen as the principal target audience for this activity, other healthcare professionals were also engaged including Monash Health's Refugee Clinic and Maternal and Child Health Nurses supporting the South East Region.

2.5.1 Capacity-building project achievements

From August 2015 to October 2016, a number of outputs were evidenced towards fulfilling this project objective:

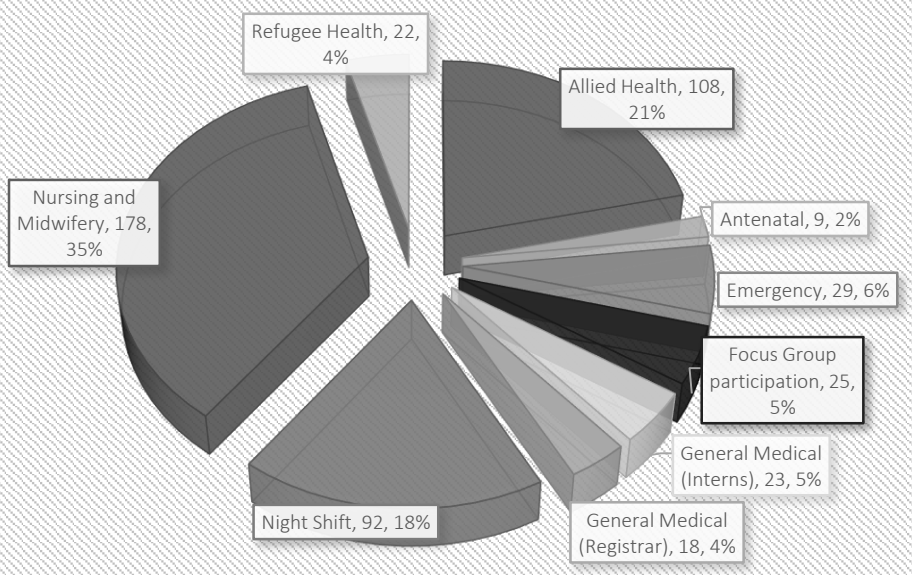
- Completion of a comprehensive needs assessment utilising a quantitative survey tool with health professionals at the Dandenong Hospital location;
- Facilitation of a focus group to further inform training needs;
- Data analysis and identification of the barriers and enablers to program implementation of HJP;
- Development of pilot training materials and post-training evaluation processes;
- Delivery of a (pilot) training package to the Social Work Department at Dandenong Hospital;
- Testing and refinement of pilot training package, following staff feedback;
- Development of pre- and post-training evaluation mechanisms to assess change in family violence knowledge, screening and referral processes and awareness of the HJP and legal outpost at Dandenong Hospital;
- Identification of health professional training delivery options, including workplace face-to-face training for both day and night shift staff, online family violence training module and combined face-to-face and online training;
- Collaboration with Monash Health learning development coordinators to identify specific training session opportunities and needs;
- Identification, design and delivery of health professional training sessions for maternal and child health nurses servicing the broader South-Eastern region;
- Regular activity reporting to the Monash Health and InTouch Health Justice Working Party.

[111] Jean Hailes *for Women's Health* facilitated training sessions during year one of the project.

2.5.2 Raising health professional capacity to participate in legal health services for CaLD women

A total of 15 training sessions were delivered at the Dandenong Hospital location, reaching in excess of 500 health professionals – doubling the original training goal. Training was particularly well-attended by staff in Nursing and Midwifery and Allied Health staff. High attendance was also observed by the night shift staff group (Table 8) who were offered tailored night-time training to accommodate availability and access for this group.

Table 8 Health specialties of Monash Health attendees of HJP family violence training for health professionals



A further five training sessions were delivered to Maternal and Child Health Coordinators servicing the South-Eastern region; a total of 139 Maternal and Child Health Coordinators received this training. Delivering training to coordinators had the potential for learnings to be disseminated further, to Coordinators' respective Maternal and Child Health Nurse teams.

2.8.1 Reflecting health professional learning needs

The final training package was shaped by a comprehensive needs analysis, focus group (Appendix Three) and pilot training process. The needs analysis was conducted in the form of a survey; responses were received from 180 Monash Health staff. The focus group included 25 participants from a range of disciplines, including staff from Medicine, Nursing, Allied Health, Midwifery, Social Work, Administration/support and Interpreters. The resulting pilot training package was further refined by feedback derived from post-training evaluation. The workplace based training was deliberately flexible, based on staff availability and learning needs (see Appendix Four for training core competencies).

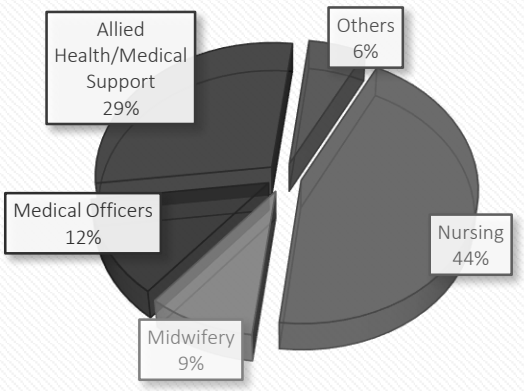
A range of content modalities were incorporated into the training package such as case studies, quiz, statistical data, news items, research and evidence based study findings.

Pre- and post-training evaluation surveys were implemented for each training session delivered, to assess change in health professional knowledge, confidence and understanding in the core competency areas. The evaluation questions invited participants to rate skills and knowledge in relation to the following topics prior to and after attending trainings session:

1. Knowledge of what constitutes family violence;
2. Family violence in CaLD communities;
3. Identification, responding to and referring CaLD victims of family violence;
4. inTouch's HJP with Monash and referral to the Dandenong Hospital legal outpost.

A total of 255 staff evaluation surveys were received (Table 9 – medical specialties of respondents).

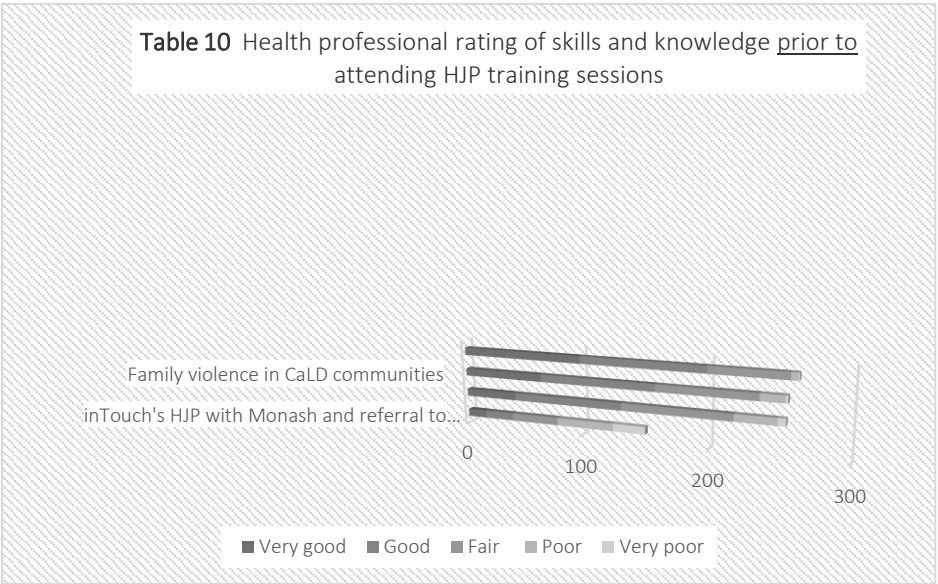
Table 9 Pre- and post-training evaluation respondents by medical specialties



Key findings included:

- Prior to training, 85% of survey participants assigned a positive rating to their skills and knowledge in the four training areas.
- The two areas that health professionals rated to be the most deficient prior to training were: knowledge of the HJP and Dandenong Hospital outpost and the identification, response and referral to CaLD family violence victims.
- Prior to training, Allied Health survey participants rated their knowledge of CaLD (family violence and identification and response) as 'fair' or 'poor'. Post-training evaluation demonstrated a strong shift in knowledge – with the exception of one survey participant, all Allied Health staff acquired knowledge and skills in the previously deficient areas.
- Pre-training, Nursing and Midwifery tended to assign a high rating to their knowledge and skills in the areas of family violence, family violence in CaLD, identification and response to CaLD victims; however, had less knowledge of the HJP. (At the time of Nursing and Midwifery undertaking their training, the HJP had been in operation for three months.) Following training, all Nursing and Midwifery participants positively rated their knowledge of the HJP.
- The training area that demonstrated the least shift in staff knowledge was 'what is family violence', suggesting staff already had an existing understanding of this topic area.
- Initially, 135 staff had assigned negative ratings of either 'poor' or 'very poor' across each of the training topic areas. Following the training, only one staff member had rated their knowledge as 'poor' (this was for the topic area of 'Identifying, responding and referring CaLD victims of family violence').

Table 10 Health professional rating of skills and knowledge prior to attending HJP training sessions

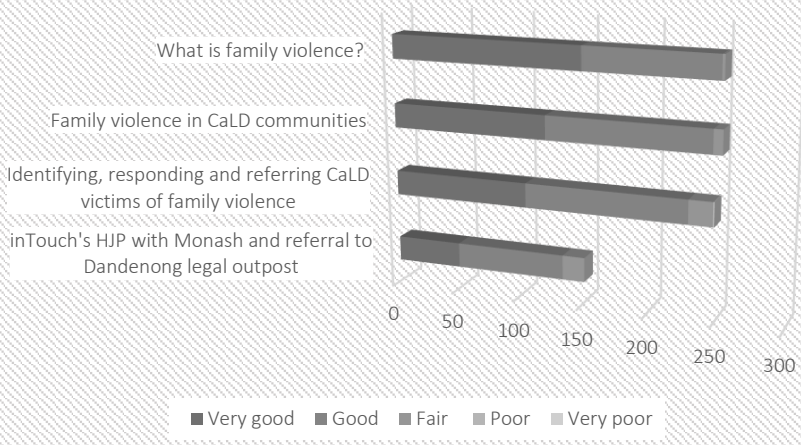


- This equated to a 99% change in staff skills and knowledge into positive ratings (fair/good/very good) after receiving training.

Overall, following the training sessions, evaluation data demonstrates an increase in health professional knowledge for each of the topic areas (Table 11).

Whilst strong knowledge development was evidenced as an outcome of delivering the training, it is not known if this was translated into increased screening or referrals as this data was not captured as part of this evaluation.

Table 11 Health professional rating of skills and knowledge after attending HJP training sessions



Staff were also invited to submit suggestions for strengthening the training program. 44 responses were received; of those:

- More than half suggested longer training sessions;
- 14% requested the inclusion of more case study material;
- 5 respondents requested the inclusion of more interactive material, such as video clips.

Further suggestions included the inclusion of more material on CaLD sensitivity, legal processes and specifically, the inTouch HJP.

2.5 Evaluation Phase 4: Provision of a client-centred approach

inLanguage, inCulture, inTouch was successful in establishing a formal health justice partnership, to provide a client-centred approach for access to justice from a healthcare setting.

Following a considered partnership engagement process, the HJP was implemented in partnership with Monash Health; a formal Memorandum of Agreement guided project activity. Dandenong Hospital was selected as the delivery site for this model due to the broad cultural diversity of its patient population.

The following limitations are identified with this component of the evaluation:

- Some elements of referral data were not provided per Monash Health patient medical confidentiality protocols. As a result, client/patient demographics on age, cultural identity and children are not available.
- It could not be determined if staff referring had participated in the HJP training as referral tools did not include training and development as a field option.

2.6.1 HJP project achievements

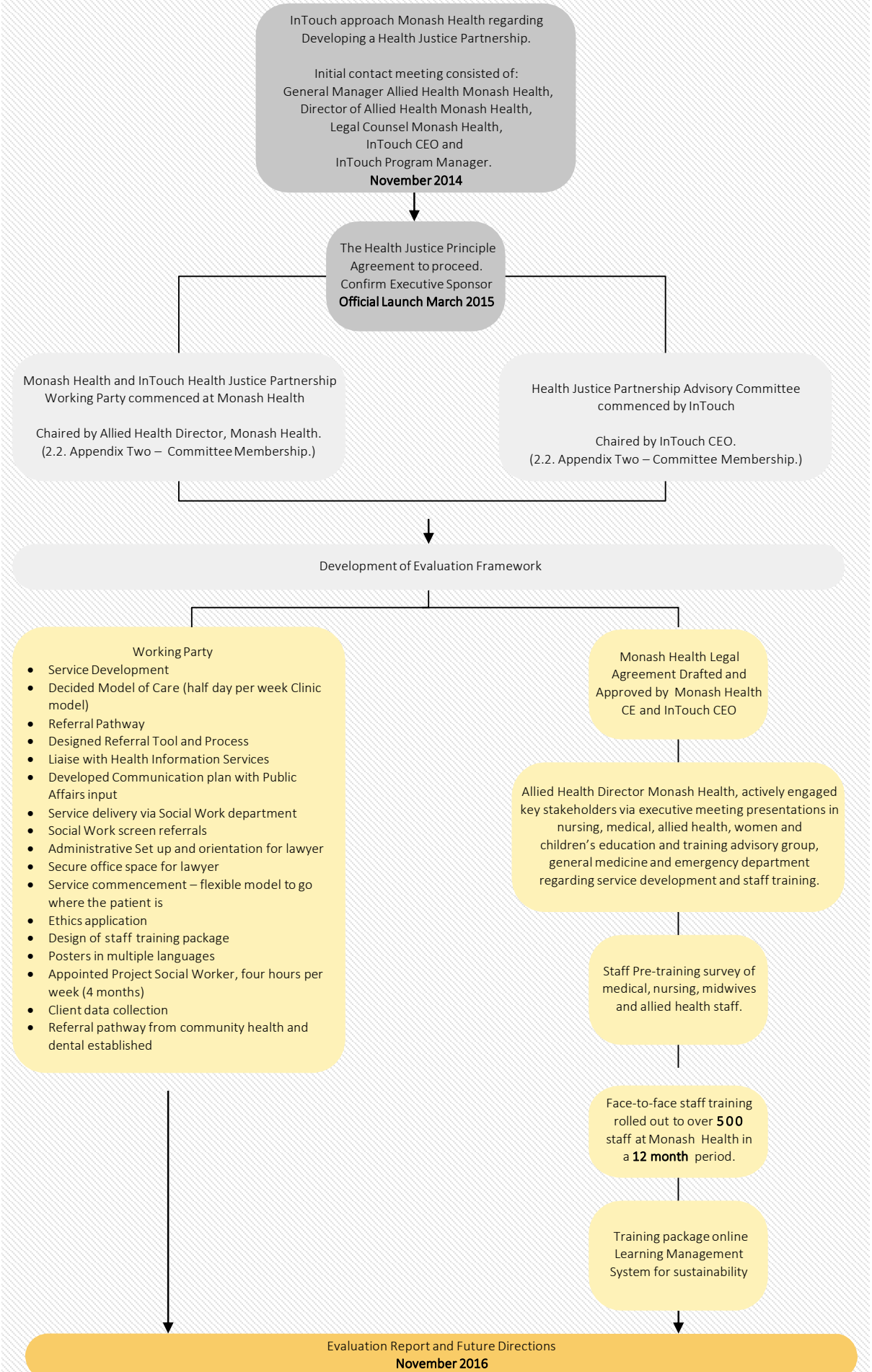
The Monash Health and InTouch Health Justice Working Party included key workers from Monash Health and inTouch Multicultural Centre Against Family Violence, and was responsible for operationalising the HJP. In recognition of the significance of both the project and the partnership, Monash Health also resourced short-term Project Worker support to assist project implementation. From June 2015 to November 2016, the Monash Health and InTouch Health Justice Working Party:

- Established a regular forum for HJP workers to monitor project deliverables and implementation;
- Undertook a preliminary consultation with Monash project representatives to consider critical elements of success in program inception, design and implementation;
- Initiated a review of internal hospital policies and procedures on family violence response and referrals;
- Informed the development of an HJP-specific Communications Plan to raise awareness for the service across Monash Health sites (and the Victorian health sector more broadly);
- Facilitated opportunities for the project to assess health professional learning needs (survey, focus group), and to trial a pilot training package;
- Adapted the training into three different delivery modes (face-to-face, online, flexible face-to-face) to facilitate accessibility to a broader cross-section of staff.
- Engaged with hospital learning development coordinators to coordinate training opportunities for staff;
- Supported the delivery of a training package for health care workers to build their understanding of family violence, particularly in understanding the experience of women from CaLD backgrounds;
- Developed an HJP-specific protocol including: referral procedures, ongoing communication pathways between health professionals and lawyer, patient/client care plans, relevant forms, e.g. referral, risk assessment and client consent forms;
- Explored possible office locations and established a dedicated office for legal service use;
- Formalised a referral tool for health professionals to systematically identify women experiencing family violence and refer them to the HJP;
- Established a data capture strategy linked to existing administrative processes;
- Fostered strong inter-professional processes (i.e. between HJP lawyer and Monash Health staff) for knowledge sharing and opportunities to expand professional practice;
- Facilitated the provision of legal support to hospital patients and staff through the HJP model;
- Identified opportunities to expand the HJP model to other Monash Health settings (i.e. Refugee Health Clinic and Dental Services).

The project was also identified as a specific deliverable within the Monash Health Statement of Priorities 2015-16, the Statements of Priorities being the key accountability agreement between Monash Health as a Victorian public health services and the Minister for Health. This signified that activity undertaken towards the HJP was regularly reported to the Victorian Department of Health and Human Services.

Figure 8 outlines the health justice partnership development process between Monash Health and inTouch.

Figure 8 Health Justice Partnership Development Process: Monash Health and InTouch



2.6.2 The client health journey

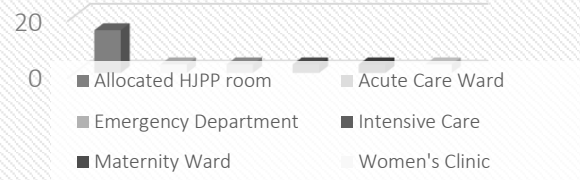
HJP is the integration of a legal service within a healthcare setting. This HJP streamlined the referral processes for services and supports for CaLD women experiencing family violence. On a weekly basis a dedicated inTouch lawyer attended Dandenong Hospital to meet with CaLD women who had experienced or were at risk of experiencing family violence. Women were identified either by a referring health professional or self-referral. (In the latter project stages, the HJP service also became available to Monash Health staff.)

The inTouch lawyer was trained in cultural competency, and skilled in the 'empathetic lawyering' style which seeks to understand the client, and exercise empathy and compassion during the consultation. Consultations varied in length, depending on the extent of issues raised by the client/patient. Legal assistance included on-site intakes, advice, assessment for further legal and family violence support through inTouch or referrals to partner agencies. An interpreter was booked for the consultation if the client requested (and pending translator availability).

Like the inTouch Legal Centre in the SER, if the client required ongoing assistance, the case was referred to the inTouch Legal Centre and an appointment was arranged for a lawyer to meet with the client at the outpost located in the offices of Maurice Blackburn Dandenong or once more at the Dandenong Hospital location. Usually this was the same lawyer the client had met with previously, encouraging case continuity and opportunity to build client rapport. If required, interpreters were booked for attendance at this outpost also. Similarly, for ongoing casework, clients were referred to inTouch Family Violence Services for further support.

A dedicated office was provided to the lawyer for the purposes of the HJP, however upon observing the challenges presented to some women in accessing the clinic (particularly if undergoing medical treatment), the lawyer adopted the flexible approach of making ward-based consultations where requested and appropriate.

Table 12. Location of HJPP consultations at Dandenong Hospital



34 new client cases were opened from the HJP established at Dandenong Hospital. 31 of those were referred to the HJP service via the referral pathway established for the project (via the Social Work Department); the remaining cases were referred via the inTouch Legal Centre in the SER based at DMC. Nearly half the clients received a legal consultation while undergoing or recovering from treatment in a hospital ward (client/patients were seen in Emergency, Maternity, Acute Care, Intensive Care and Women's Clinic). Anecdotally it is understood that some of these women were receiving treatment arising from injuries sustained in a family violence incident.

The HJP also facilitated opportunities for Monash Health staff to engage with the inTouch lawyer. The inTouch lawyer provided legal education on the HJP model, information about referral pathways and case study scenarios to a total of 47 hospital staff (midwives, allied health professionals and community and refugee health workers).

2.6.3 Referral pathways

A specialised referral tool was developed for implementation, with referrals into the service proceeding through the Social Work Department. Development of the referral tool was labour-intensive as it had to progress through several layers of hospital bureaucracy (management, senior management, legal) before being formally adopted as hospital process. Delays resulted in the service commencing with an

informal referral pathway in place: the Social Work Department discussed potential cases with the inTouch HJP lawyer who then advised if the cases met HJP inclusion criteria. The referral pathway was promoted in training sessions delivered as part of the HJP project.

During the latter project stages, further referral pathways were established through the Refugee Health Clinic and Dental Services to extend the service to these different patient groups and boost HJP referral numbers (Figure 9).

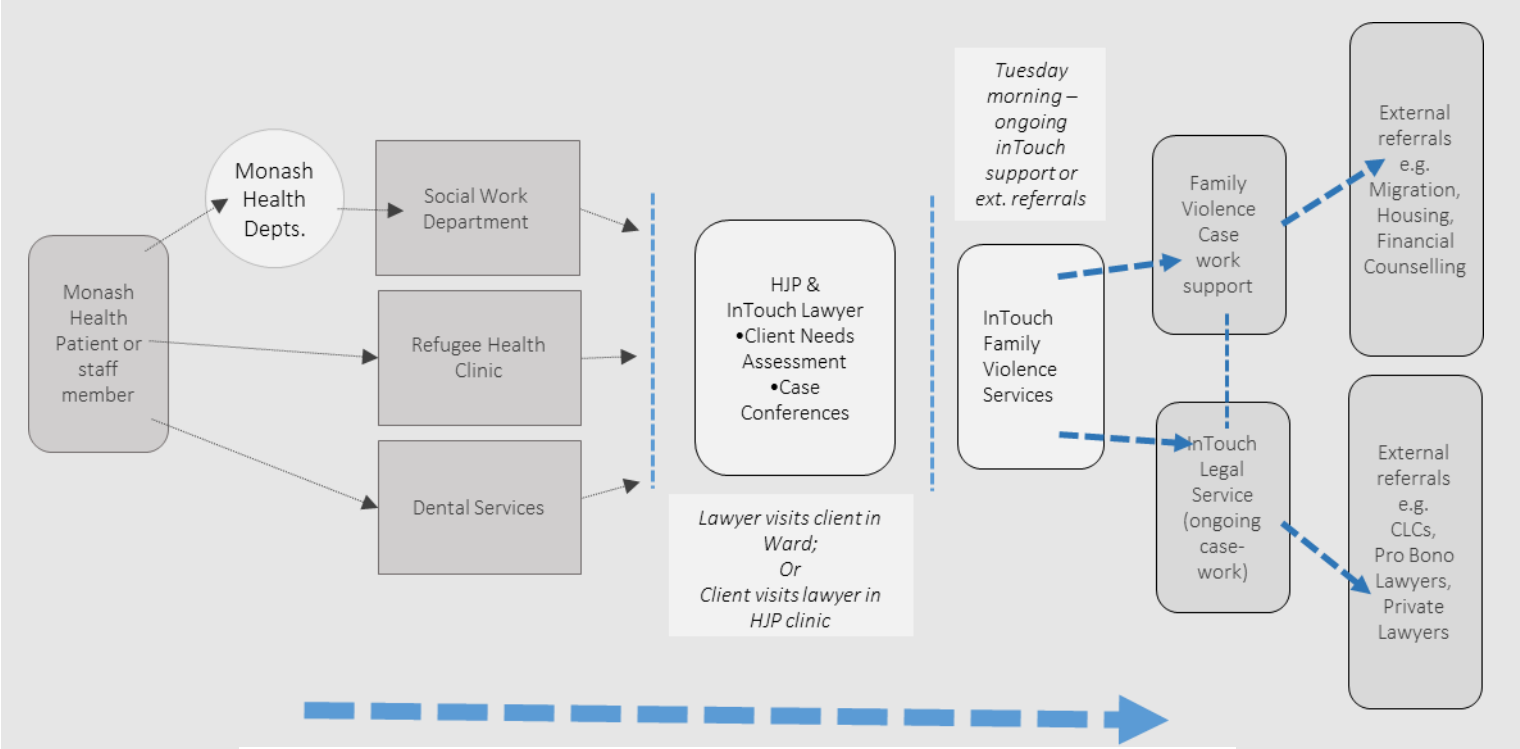


Figure 9 Health Justice Partnership – inTouch Legal Centre co-located at Dandenong Hospital

2.6.4 Broadening HJP service awareness

A broad communications plan for the HJP was developed by inTouch (with input from the Monash Health and InTouch Health Justice Working Party) with an objective of building the HJP project profile.

A key component of the communications plan was government relations, to raise awareness of the project with relevant state and Federal government members.

A number of communication channels were accessed to promote the project (Table 13). Through this combination of press (online media), event, HJP promotional and practitioner-targeted opportunities, an audience of approximately 1m was potentially made aware of the HJP.

Table 13 Communications Plan for HJP project promotion

Communication channel	Audience	Reach
inTouch Health Justice Partnership Model Launch, March 2015	▪ Victorian Legal Services Board ▪ Private legal firms ▪ State and Federal government representatives ▪ Community agencies ▪ Foundations/philanthropic trusts ▪ Division of General Practitioners ▪ Key project partners	120
Age online newspaper article '*Lawyers in hospital to help family violence victims'* March 2015	▪ Age online readership	606,000 (readership)
Onsite HJP promotional material i. HJP posters in 6 community languages plus English ii. Electronic screen promotion at 10 Monash Health sites for a two-week cycle in March 2016	▪ Monash Health patients, visitors ▪ Monash Health staff	Not provided
Department of Health and Human Services Newsletter 'Health Vic.' feature article October 2016	▪ Administrative, medical and allied health staff working within the Victorian health sector	300,000
Feature article in the Development Report of the Victorian Legal Services Board July 2016	▪ Past, current and potential grant recipients of the Victorian Legal Services Board	400

The HJP was also promoted at various events such as the Vulnerable Children's Seminar, the South Eastern Regional Legal Assistance Forum Group and the Victorian Healthcare Association Forum on system-wide responses to family violence, reaching a further audience of 378 community, government, legal and healthcare professionals.

2.6.5 Client surveys

Five clients who utilised the service at Dandenong Hospital were invited to participate in a survey to explore how well the HJP service was doing in meeting their legal and health needs.[112] An inTouch worker conducted the survey interviews and de-identified interview responses were provided to the evaluator for analysis. Each participant was asked the same questions upon entry and exit from the HJP service:

Questions asked upon entry into and exit from the project:

1. Would you have known how to find lawyers to assist you?
2. Could you afford to engage lawyers to assist you in this matter?
3. What are your legal or health related concerns right now?

[112] See 2.1.8 for Ethical considerations undertaken by this research study.

4. On a scale of 1 to 5 how stressed or worried do you currently feel?

Four clients participated upon entry to the service; the same four clients participated in exit survey interviews also.

Upon entry:

- Only one woman did not have any knowledge of how to locate a lawyer or legal service to provide assistance in their situation. Remaining participants identified Legal Aid, internet search or friend as potential avenues to attain legal access.
- All four women indicated they did not have the financial resources to engage legal support.
- Legal concerns were: 'everything', or 'getting into trouble with police or immigration', providing a violent partner access to a newborn child with an intervention order in place and property concerns.
- Health concerns were: depression, stress and pregnancy.
- Participants rated their stress from 'sometimes stressed' [2] to 'always stressed' [5].

What are your legal or health-related concerns right now?

> *"Health: I'm so low, really down, I'm trying to keep my stress down because I'm pregnant. Legal: I'm concerned about getting into trouble with the police and immigration because I did something really wrong. That is my biggest concern."*

Upon exit:

- The only legal concern named was an intervention order; the other women stated they no longer had any legal concerns.
- Upon exit, stress was still apparent for participants although to a lesser degree. The highest stress rating following access to the HJP service was 'sometimes stressed' [3].

How stressed or worried do you currently feel?

> *"2- Rarely stressed. My husband has left the country. Before that it was a very stressful time for me but now things are much better… My health has improved a lot. The legal education I received was very informative.*"

2.6.6 Case Study

Thiri Aung's Story

Background

Thiri Aung and her partner were newly-arrived refugees when she was referred to the inTouch Legal Centre by by a Monash Health midwife after disclosing family violence; she was 4 months pregnant with her sixth child at the time. An InTouch lawyer first met with Thiri Aung in the antenatal clinic following one of her scheduled pregnancy appointments.

Some months prior to referral into the HJP, Thiri Aung had been seriously assaulted by her current partner. Her teenage daughter had telephoned the police who in turn issued a safety notice excluding the husband from the home. An interim intervention order was also made by the Dandenong Magistrates' Court and Child Protection became involved. The family did not have a support network in Australia and the husband was rendered homeless.

This situation was extremely distressing for Thiri Aung – she was suffering from anxiety and depression as well as gestational diabetes brought on by the pregnancy. Thiri Aung did not support the Intervention order application made by the police: she could not understanding why her husband could not return especially when she was unwell with her pregnancy and needed support.

It was challenging to engage with Thiri Aung as she was very wary of strangers and authority following her pre-migration experiences with authority figures in her country of origin. Her recent experience with police and Child Protection was a further barrier to engaging with her and she was traumatised and confused about the legal process in general.

In view of these barriers, the first meeting with Thiri Aung at Dandenong Hospital took nearly two hours with the inTouch Lawyer focusing on building rapport and gaining the client's trust. With the support of a female interpreter, the inTouch lawyer advised Thiri Aung about Australian law in respect of family violence, as well as the different options for protection from violence, including intervention orders which would still permit the husband to live in the home but prohibited him from committing further acts of family violence. After receiving this advice, Thiri Aung was open to engaging with inTouch. Where she had initially advised that she did not want an order in place at all, following legal advice, she instructed that she would support an intervention order conditional to her husband remaining home.

After the initial appointment at the hospital, the inTouch lawyer accompanied Thiri Aung to Court. Meetings were held with a Department of Health and Human Services (DHHS) representative, the police, the husband's case manager and the community lawyer who assisted him. inTouch's involvement resulted in establishing linkages between the relevant case stakeholders – something that had not been achieved before. This had the effect of opening up communication channels between DHHS, the husband's case manager and Thiri Aung and her husband (who both had limited English proficiency).

inTouch's involvement in this case marked a turning point for the client where her voice was listened to by DHHS, the police, and, in turn, the Magistrate. The matter was able to be finalised on the basis that the husband could return home with a family violence intervention order in place prohibiting family violence, for a period of 12 months.

Thiri Aung mentioned that she would have never accessed any legal intervention if it had not been offered at a health setting; it was difficult for her to get around and she would never have been able to access legal appointments herself. She was grateful that the lawyer could meet her at an environment that was comfortable and familiar. Thiri Aung was positive about the court outcome; she had less anxiety and stress and reported being happier. Her husband's behaviour had improved markedly since returning to the home.

Thiri Aung advised that though she was initially regretful that the police had become involved, she was now grateful and she felt safer in her home.

2.6 Evaluation Phase 5: Project Outcomes

Three rounds of semi-structured interviews were conducted with key workers involved in implementation of the inTouch Legal Centre in SER component and provision of the client-centred HJP model at Monash Health. The aim of these interviews was to evaluate 'expansion of practice' indicators, quality of partnership collaborations, process modifications and barriers and enablers (see Appendix Five for key worker interview questions). The interviews were focused on developing a preliminary understanding of the cultural and situational appropriateness of the Health-Justice Partnership project overall. The evaluator undertook each key worker interview. Key workers included strategic leaders responsible for project oversight, managers and key operational staff responsible for direct service delivery at the coalface.

Purposive sampling was conducted with the qualitative data, with responses categorised into the four themes for these interviews. The following summary tables were compiled from the semi-structured interview responses collected at:

1. InTouch Legal Centre in SER – project mid-point and conclusion of project (Table 14)
2. Client-centred HJP model at Monash Health – project commencement, mid-point and conclusion of project (Table 15)

Where relevant, quotes from some of the participating key workers are included.

These interviews were never intended to measure outcomes for clients, but are instead focused on implementation considerations for the project, from the key worker perspective.

The themes raised here will be considered in more detail at Section Three: Discussion.

Table 14 Key worker interviews - inTouch Legal Centre in SER

Evaluation themes	Project mid-point	Project conclusion
Expansion of practice	▪ Ample opportunities for expansion of practice for the professionals involved; **information and knowledge exchange** was specifically mentioned as an outcome. ▪ Increased awareness and value of respective roles: "*I've been a practitioner for many years, but this is the first time working as a lawyer with a caseworker. It's a revelation! I'm watching [the case manager] working with the client and I think that I'm thinking about things holistically, but she's the one with the expertise that can see things that I don't see…vulnerabilities that I can't see and I don't have the expertise or skillset to observe or to address."*	▪ **Professional attitudes** identified as barrier to widespread implementation of the integrated legal model; **professional development** for lawyers may be **helpful in influencing acceptance for inter-professional collaboration.** ▪ Workers observed **limited community understanding of rights** held by women from some CaLD communities. ▪ Professional culture was recognised as a barrier but the model provided opportunity for system change: *"The **cultures of a law service and a welfare service are very different**."*
Quality of partnership collaboration	▪ **Court User meetings** were identified as a **good starting point for facilitating stakeholder collaboration** with various stakeholders represented at this forum ▪ The inTouch Legal Centre in SER team generally perceived **support for the new model**, e.g.*…Police was supportive of more duty solicitors working on behalf of women, it makes it quicker for them to progress through their workload."* And acknowledged that change was still a process for other Court Users who were adjusting to the new inTouch service	▪ **Regular meetings with the Court Support Worker were helpful** in providing background information about cases and case referrals. This demonstrated the strong linkage and referral opportunities that had been fostered by DMC. ▪ Project stakeholders remained supportive of the project and provided **broader engagement and capacity building opportunities** beyond DMC.
Process modifications	▪ **Need for a systematic way of allocating CaLD clients**; the current process was *ad hoc* ▪ The integrated way of working was advantageous for clients: *"**Clients don't need to go to ten different services and get confused**."* ▪ **Scaling up the model** would strengthen the work of the service by providing more service continuity. ▪ **Culture should be reflected in all layers of the service**: *"I would like to see more lawyers from CaLD communities…I think it is important."*	▪ The **key workers developed in their roles** and new way of working. This had changed from caution about the lack of continuity permitted by a half-day service, to confidence in utilising the networks of other resources to support clients: ▪ There were challenges posed by implementing the coordinated model and support for the integrated model.
Barriers and enablers	▪ DMC **infrastructure limitations**. Key workers described situations where the inTouch lawyer was seated between the intervention order applicant (CaLD woman) and the respondent (person responsible for inflicting harm); due to Court crowding ▪ **Sustainability** was a **key concern**, even at early stages of implementation. ▪ **Client-centric practice empowered women** to choose, even if the client acted contrary to advice provided. ▪ **Longer length of time allocated to client consultations** set the service apart from other Community Legal Centres.	▪ **Court policies around interpreters were a barrier** for hearings where Court policy is to only appoint one interpreter for both parties. ▪ Difficulties of retaining interpreters from ethnic communities with smaller population groups (who may know applicant/respondent). ▪ Integrated model **raised community understanding of family violence**: *"I have enjoyed explaining how Australian law works, so they have this knowledge and then can pass this onto their children too."* ▪ Workers built **trust in the legal system**: "*Women are given the chance to have a conversation with a lawyer, **they are hopefully being listened to** and as a result do not feel alienated by the system…if they need to call the police in future again, then they can do so confidently and comfortably."* ▪ Tender was out for DMC redevelopment which could potentially improve the way the service functioned within DMC. ▪ **Organisational flexibility and support**, contributed to successful implementation: *"I have a CEO who is supportive and an organisation behind me that enables me to consider all the factors and make the best decision to proceed around the ethical issues that we have to address."*

Table 15 Key worker interviews - Client-centred approach to justice (HJP) and delivery of health professional training

Evaluation themes	Project commencement *(Focus group undertaken to inform implementation)*	Project mid-point	Project conclusion
Expansion of practice	Practice barriers or identified opportunities to expand: ▪ Difficulty doing social work like family violence when you are a nurse ▪ Hard to find private moment with patient due to multiple patient workload ▪ No training, don't know questions to ask; don't have confidence to ask. ▪ Sustained education into annual training calendar. ▪ Provision of specific screening questions ▪ Lack of awareness of family violence policy ▪ Use induction, orientation to make staff aware of relevant policies	▪ Opportunity to **build individual staff capacity** and in turn organisational capacity – *"the fact that so many people attended indicates that there was a gap there…It looks like we were ready for the opportunity and we embraced it."* ▪ **Heightened awareness of family violence** among staff. ▪ Stakeholder relations; build internal support for the project with key people. ▪ Family violence is now seen as **'everybody's business'.** Lots of discussion around wards. ▪ Greater **awareness of inTouch's** work evident when staff speak to CaLD patients. ▪ Identified **need to "consider how we support staff** by way of debriefing" **post-disclosure**.	▪ **More understanding about 'why people don't leave** abusive relationships', e.g. more awareness of increased risk of death for women at times when she returns to relationship following brief departure. ▪ Increase in **project implementation, management** skills and **generating executive level support** for HJP project staff. ▪ More awareness and empathy that for recent **migrants, family violence** is **not the primary issue**; other issues take priority.
Quality of partnership collaboration	▪ Need for linkage. Need to refer to external agencies as there are no in-house services ▪ Lack of resources - such as time, expertise, access to Social Work Department.	▪ **Opportunities to educate** staff on CaLD and family violence arose from the partnership. ▪ Strong **committee attendance** by partners. ▪ Comprehensive **partner planning**. ▪ Tension between SECASA and the project. SECASA has historically provided family violence training to Dandenong. ▪ Need for **partner organisations to have a greater understanding of hospital culture**, bureaucracy, policy, procedures, etc. ▪ Need to build inTouch's understanding of hospital policy, procedures, culture, etc. ▪ Challenges of merging two fields for multisectoral health work. ▪ Builds **links between acute and community** sectors, where linkage has been limited.	▪ **Connection to other networks and opportunities**, e.g. the Health Justice Connect network (CEO engagement and HJP forum presence) and Strengthening Hospital Responses to Violence (Ballarat). ▪ Potential for more collaborations with appointment of Hospital Family Violence Coordinator to streamline and coordinate family violence activity across the hospital (outcome following Royal Commission recommendation)

Table 15 Key worker interviews - Client-centred approach to justice (HJP) (continued)

Process modifications	▪ On-site legal post. ▪ Opportunistic disclosure rather than specific screening. ▪ Need for after-hours social workers (particularly in emergency depart). ▪ Asylum seekers don't get a bed; consult with refugee nurse recommended. ▪ Sexual violence protocols. ▪ Feedback loop: No feedback from referrals/not sure if actioned ▪	▪ **Part-time resourcing of project lead/support** is necessary for all future partnership projects. ▪ **Policy review** for relevant Monash policies ▪ **Referral pathway** flowchart. ▪ **New referral form** with formal sign-off processes, excluding it from medical records. ▪ Adaptation to a patient-centred approach – **seeing patients in wards** and HJP office. ▪ Changing from locating HJP in community, to advocating for the HJP to be co-located in hospital, with community referring on. ▪ Social Workers involved in implementation have now adopted HJP as part of their practice. ▪ **Secondary consultations** now offered at hospital site also. ▪ Change of evaluator and training delivery at project mid-point impacted training and evaluation activity. ▪ Establishment of **regular update meetings** with all project partners by mid-point of HJP.	▪ Expansion of HJP to Refugee Health Clinic site. ▪ Extension of HJP access to Monash Health staff ▪ Adding the element of legal education to provide staff with more access to the HJP lawyer in an informal way.

Table 15 Key worker interviews - Client-centred approach to justice (HJP) (continued)

Barriers and enablers	▪ Privacy. Inability to screen the female patient as partner was present or family were present at all times. ▪ Time: Need to complete physical assessment, no time for a family violence assessment ▪ Need to build rapport over a number of encounters. ▪ Can't refer to social work at night (need to hold patient overnight for social work to see in the morning. ▪ Language barriers, cultural barriers, fear of separation. ▪ No interpreters. ▪ Incorrect information given to patients (e.g for spousal visa holders and deportation)	Barriers ▪ Operational staff received **no communication about HJP** or their involvement prior to its commencement. ▪ Staffing – **need for clarity of roles** and responsibilities. ▪ Practicalities of finding an office space. ▪ Monash Health **ethics** – navigating organisational requirements. ▪ Referral form development was impacted by change of legal personnel (no continuity) ▪ **Lack of a dedicated project officer** or project lead impacted continuity and individual workloads of staff with existing full workloads (risk of stagnant activity) Enablers ▪ **Flexible training opportunities** e.g. night-time training for night-shift workers ▪ Approachable and accessible lawyer. ▪ Recognition that HJP required organisational change; **high-level executive support was instrumental to influencing cultural change**. ▪ Having the HJP there is an enabler. ▪ Aligning HJP to Monash Health policies, approaches and programs. ▪ **Organisational champions** that embrace and promote the initiative (across all hospital levels – operational, support staff, higher exec. and whole departments) ▪ Inclusion of the activity as a deliverable in Monash Health Statement of Priorities with reportable activity obligations to DHHS. ▪ **Strong organisational knowledge** facilitated access to human resources required to deliver the project. ▪ Ensuring staff understood project aims and staff benefits encouraged support for project. ▪ *"Knowing how much the intervention saves in the long-term – generational effects, emotional impact, trauma, jail time – it is a far more effective intervention and more cost-effective approach."* ▪ Intersectoral approach to working, to meet complex need.	Barriers ▪ Initial caution about capacity led to **slow promotion**, impacting referral numbers. ▪ Clean Wall policies were a barrier in erecting advertising material for the HJP. ▪ Need for more higher-level Monash Health communication to flow to on-the-ground workers. ▪ Language – **access to the right interpreters**. ▪ Barrier and incidental learning: Bringing about **change to a conservative and established health system**, especially when some departments experience immediate pressures **can be challenging**. ▪ When women aren't in the frame of mind to willingly acknowledge the violence. ▪ **Capacity to continue** the service. Enablers ▪ "**Staff are patient-centred** and want to have something else in their toolkit to offer women in vulnerable situations." ▪ HJP aligns very well with professional intent of some health specialisations (e.g. social work, midwifery) ▪ **Issues' prominence on the national agenda** – "permission to talk about the issue has made the timing right for the project." ▪ Looking at the **social determinants of health** at a higher level and how vulnerable people fit within that context. ▪ Royal Commission into Family Violence recognition of the need to address the CaLD experience of family violence. ▪ Lawyer flexibility with locations, times, days to consult with patients/clients. ▪ Translation of promotional posters into community languages.

Section Three: Recommendations for future models

inLanguage, inCulture, inTouch sought to redress legal access inequities experienced by CaLD women in a family violence situation through the delivery of a health justice partnership model. The model provided wrap-around health and legal services in the South Eastern region of Melbourne Victoria with key objectives comprising:

1. Replication of an existing inTouch legal centre model to Dandenong Magistrates' Court catchment area;
2. Establishment of a health justice partnership model (within an existing healthcare site);
3. Development of a training package to increase capacity of health professionals in cultural competency, family violence, and legal referral pathways.

Derived from evaluation learnings and supporting the principle of continuous quality improvement, the following provides some key recommendations within each of the three project objectives to inform future project design of similar activities.

3.1 Replication of an existing inTouch legal centre model to Dandenong Magistrates' Court catchment area

- There was significant value in implementing the integrated model, in particular opportunities presented for expansion of professional practice and streamlined service provision.
- Planned implementation of the integrated model should revisit the issues of legal professional privilege and develop procedure and practice approaches following counsel advice.
- To maximise awareness and referral to the service, significant partnership engagement is necessary. Optimally this should commence early on in the establishment phase.
- Partnership engagement should be layered, with engagement strategies for Court Users, judicial officers, law enforcement and broader legal fraternity, as well as cross-sectorally with organisations which can provide ongoing support options for clients.
- Project establishment phase should explore suitable outpost locations with private offices that can facilitate confidential casework consultations.
- Institutional support for services tailored to CaLD groups is instrumental; policies should reflect complex need and diversity – in particular translation and interpreter services which have the dual effect of enabling cross-cultural communication for client, and supporting streamlined court communication and proceedings.
- Implementation of a HJP should consider these policies; if these are deemed impractical, consideration should be given to advocating for policy change to reflect demonstrated need/best practice.
- A positive court experience should be reinforced by reflecting values of compassion and sensitivity within procedures and professional attitudes towards family violence victims. This would enhance support and accessibility of court and court processes for women.
- Widespread implementation of an HJP can be supported through sector-wide professional development on the value of working in a multisectoral model.

3.2 Establishment of a health justice partnership model

- The HJP evidenced need for sustained system change. Linkage to the authorising policy environment - overarching policies and accountability mechanisms - serves to integrate the activity into the whole and provides impetus for regular activity and monitoring.
- High-level executive support is key to influencing the success of initiatives that involve whole-of-organisational change. Strategy to intentionally obtain executive level project support should precede any activity or project implementation.

- Organisational champions are instrumental in garnering support, raising awareness and sustaining activities for HJPs. Champions should be identified and engaged cross-organisationally – key operational staff, learning development coordinators, executive level staff and whole departments can play a vital role in raising organisational support for HJPs.
- Legal education conducted in a semi-formal style provides a forum for staff to raise individual points for clarification. Lawyer accessibility in this way serves to further expand professional practice and build service support. The presence of a consistent legal practitioner further aids building of staff rapport and project awareness.
- A dedicated project lead who can advance project deliverables and avoid 'stagnant activity' is necessary to implementing projects that involve broad system change such as the HJP. The project lead should have the qualities of being able to navigate legal, community organisation and hospital administration and bureaucracy. The lead should also be able to foster effective partnerships with key workers within these different professional environments and workplace cultures.
- Data collection for HJP and data sharing between HJP project partners should be preceded by developing an understanding of organisational ethical and confidentiality procedures. Whilst data sharing would be advantageous in obtaining a clear picture of client utilisation of service, ethical requirements and medical confidentiality should guide all activity therein.
- An adaptable project model involving elements such as flexible consultation locations will further enhance accessibility for CaLD women experiencing inequitable legal access.

3.3 Development of a training package to increase capacity of health professionals in cultural competency, family violence and the legal referral pathways

- Training should retain the characteristics of being time and location flexible, accessible to all staff and delivered in multiple modalities to maximise engagement of staff in professional development opportunities.
- Where possible, family violence training should pursue accreditation with relevant professional institutions, to further incentivise training attendance and completion.
- Training on the specific needs of CaLD women experiencing family violence is an identified professional development need, highlighting a need for health professionals to demonstrate culturally competent practice with CaLD patients. Training sessions should be embedded in the hospital professional development calendar for sustained opportunities for knowledge to be built in this area.
- Strong operational committee engagement is a critical success factor towards furthering project activity. There is need for a clarification of roles and responsibilities within this forum to ensure activities progress and there is accountability for specified project action items.

3.4 Conclusion

Family violence is a pervasive social problem: women and children across Australia are being impacted in significant and increasing numbers, with complex and extensive consequences for overall wellbeing and long-term health. In Victoria, intimate partner violence is the leading contributor for ill-health, death and disease for women aged between 15 and 44 years, and in the City of Dandenong it continues to be responsible for a significant number of violent incidents, hospitalisations and intervention order applications.

Family violence and lack of legal access comprise two key social determinants of health: by virtue of experiencing these, the health outcomes of the individual are immediately weakened. Relevant literature depicts a heightened vulnerability for CaLD women experiencing family violence, including at key junctures such as when seeking access to justice or the healthcare system and when engaging with health professionals. Critically, what the literature highlights more than anything is the paucity of

research into the understanding of the CaLD experience and family violence. Given the greater barriers evidenced by CaLD women, failure to address access to healthcare and legal supports in an equitable way risks trapping this group in a cycle of further marginalisation and exposure to continued harm.

Health justice partnerships are an integrated approach of healthcare comprising health, legal and welfare professionals working collaboratively to provide legal assistance to vulnerable people within the healthcare setting. HJPs are underpinned by a social determinants approach to healthcare, recognising the impact of social factors such as family violence and legal access upon individual health outcomes.

inLanguage, inCulture, inTouch applied an innovative HJP model towards seeking to redress the legal access inequities experienced by CaLD women in situations of family violence with a focus upon the legal/health needs of CaLD women in the South Eastern region of Victoria. The major cultural identities of the client population group serviced by the model reflected the major cultural identities of residents of the City of Dandenong region, suggesting that the model has positively engaged with its intended target audience.

Evaluation of *inLanguage, inCulture, inTouch* demonstrates that the project successfully achieved its identified objectives. Drawing from both quantitative and qualitative data, the evaluation was informed by a realist approach that examined the critical factors for successful implementation of this intervention. Thus, the evaluation of project objectives was focused solely on process implementation outcomes with a view to enhance understanding of best practice intervention design and implementation.

- The inTouch Legal Centre in SER has provided legal and casework consultation opportunities for women from a range of cultural groups who are experiencing family violence. This integrated model has had outcomes including expansion of professional practice, reduction of stress levels in clients and access to various referral pathways arising from strong partnership engagement. The experiences of women like Elaha, Mai, Thiri-Aung and others illustrate the complexity of health and legal issues experienced by CaLD women, as well as underscore the need for tailored interventions that address the barriers to legal access experienced by CaLD women in situations of family violence.
- The introduction of the HJP in partnership with Monash Health has expanded legal access opportunities for CaLD women and streamlined support service access, through the integration of a legal service within healthcare setting. The HJP has initiated a broad whole-of-organisation change process and has fostered strong inter-professional processes for collaboration, knowledge exchange and development.
- The HJP has also positively impacted health professional knowledge about family violence and CaLD through tailored learning opportunities for Monash Health staff and Maternal and Child Health Nurses servicing the target region.

A key driver of this activity has been strong partnership engagement. Several project partners have contributed to the project in a range of specialised ways such as strategic guidance through committee membership, operational implementation, access to referral pathways and networking and linkage opportunities. Surveys and interviews with stakeholders, partners and staff have yielded valuable data, contributing to evaluator observations about project sustainability, barriers to implementation and quality improvement. Partners have demonstrated enduring project commitment and sustained effort across the project lifetime.

Short-term, individual benefits or impacts were not assessed as part of this evaluation; there continues to be a gap in wider understanding of the efficacy of employing a health justice model to respond to legal access inequities for women experiencing family violence in Australia.

The health justice movement is a relatively nascent phenomenon to Australia and this evaluation acknowledges the work of Health Justice Australia in elevating the value of the health justice partnership initiative to promote broader awareness and acceptance for HJPs. Whilst this project directly contributes to the collective understanding of innovative design features and critical success factors of health justice/family violence initiatives for CaLD women, the need remains for further funding to support research into the *efficacy* of such interventions. It is suggested that impact evaluation of health justice interventions consider the inclusion of indicators that observe:

- Health outcomes of individuals who access the service;
- Legal and other outcomes of particular cases;
- Organisational impacts;
- Professional practice expansion opportunities; and
- Policy change at the institutional level (and perhaps beyond).

Ideally, a funded impact evaluation would elicit data to inform the cost-benefits of employing a health justice model that integrates a legal service within an existing healthcare site. Importantly, it would also extend the evidence base in the little-focused field of inquiry of CaLD women and their experience of family violence in an Australian context and especially, how they engage with relevant support services and agencies.

The evaluation has observed model iterations across each of the three project objectives; implementation has demonstrated positive early signs of model efficacy, however, without deeper data capture and analysis, it is difficult to know how transferable this model is. Given the momentum that *inLanguage, inCulture, inTouch* has generated it would be premature to discontinue this endeavour.

Appendices

Appendix One – Key Project Partner Descriptions and Partnership Matrix

inLanguage, inCulture, inTouch formed a number of significant partnerships across legal and health sectors, a key success factor for this project. Key project partners were Monash Health, Jean Hailes *for Women's Health* and legal firms Maurice Blackburn and Lander & Rogers.

Monash Health provides integrated healthcare to one quarter of Melbourne's population. The organisation employs more than 14,000 staff to provide care across the lifespan from newborns and children, to adults, the elderly, their families and carers. Monash Health's geographical scope covers 2,312km^2 across the south-east of Melbourne, covering 1.344 million Victorians of diverse cultures and ethnicities residing in nine local government areas.

Jean Hailes *for Women's Health* is a national not-for-profit organisation dedicated to improving the knowledge of women's health throughout the various stages of their lives, and to providing a trusted world-class health service for women. Jean Hailes combines research, clinical care and practical education for women and health professionals and is an accredited provider of high-level education to the Royal Australian College of General Practitioners.

Maurice Blackburn is Australia's leading social justice law firm. Its track record spans around 100 years of effective advocacy in issues of civil liberty and social justice, underpinned by a philosophy of seeking to treat every client with sincerity and respect. Maurice Blackburn has grown to become a national firm with over 30 offices throughout Australia employing more than 1000 legal professionals. Many of Maurice Blackburn's legal professionals also hold leadership roles in legal associations and reform groups, representing the interests of clients and the community.

Lander & Rogers is a leading independent Australian law firm operating nationally from Melbourne, Sydney and Brisbane. Lander & Rogers is a trusted advisor to many publicly listed and private Australian companies, Australian subsidiaries of global companies as well as all levels of government. It has seven areas of practice, covering a range of industry sectors; it prides itself in providing sustained excellence and exceptional client service. Lander & Rogers has a significant firm-wide probono program focusing on access to justice, social inclusion and community service work. Its community work is diverse including assisting not-for-profit organisations or foundations, community groups, humanitarian and/or aid organisations and environmental groups at a local, national and international level.

Appendix Two – Committee Membership

Health Justice Partnership Advisory Committee

Membership: Executive and senior level managers of project partners and relevant project-related organisations

Meeting frequency: Monthly

Strategic focus

Chair:	Maya Avdibegovic,	inTouch Multicultural Centre Against Family Violence
Elizabeth Becker		inTouch Multicultural Centre Against Family Violence
Roshan Bandary		inTouch Multicultural Centre Against Family Violence
Dr Mandy Deeks		Jean Hailes for Women's Health
Helen Fatouros		
Rhonda Garad		Jean Hailes *for Women's Health* (year one)
Linda Gyorki		Inner Melbourne Community Legal Service (year one)
Vicky Kyritsis		inTouch Multicultural Centre Against Family Violence
Fiona McAlinden		Monash Health
Paula Piccinini		inTouch Multicultural Centre Against Family Violence
Associate Professor Hannah Piterman		Monash University
Professor Leon Piterman		Monash University
Carol Quayle		Monash Health
Joanna Renkin		Lander & Rogers
Leanne Sinclair		Victorian Legal Aid
Steve Walsh		Maurice Blackburn

Monash Health and inTouch Health Justice Partnership Working Group

Membership: Senior level managers of Monash Health, clinical staff, inTouch project team, Jean Hailes, SECASA and Monash Refugee Clinic senior manager

Meeting frequency: Monthly

Operational focus for Monash Health HJP

Chair:	Fiona McAlinden	Director, Allied Health
Jess Bermudez		Social work
Katie Catchlove		Social Work (project Admin. for Monash Health – temp.)
Rhonda Garad		Jean Hailes *for Women's Health* (year one)
Dana Kiley		Deputy Director of Nursing, Dandenong
Penny Lording		Acting Senior Manager, Social Work
Jacquie McBride		Manager, Refugee Health
Carolyn Worth		Manager, South Eastern Centre Against Sexual Assault
Carol Quayle		Manager, Social Work
Elizabeth Becker		inTouch Multicultural Centre Against Family Violence
Roshan Bhandary		inTouch Multicultural Centre Against Family Violence
Paula Piccinini		inTouch Multicultural Centre Against Family Violence
Claire Sullivan		inTouch Multicultural Centre Against Family Violence

inTouch Health Justice Internal Project Committee

Membership: inTouch project team

Meeting frequency: Monthly

Operational focus; project monitoring, communications, budgetary considerations and issues escalation

Chair:	Maya Avdibegovic,	CEO, inTouch Multicultural Centre Against Family Violence
Elizabeth Becker		inTouch Multicultural Centre Against Family Violence
Roshan Bhandary		inTouch Multicultural Centre Against Family Violence
Karen Iatrou		inTouch Multicultural Centre Against Family Violence
Vicky Kyritsis		inTouch Multicultural Centre Against Family Violence
Paula Piccinini		inTouch Multicultural Centre Against Family Violence
Claire Sullivan		inTouch Multicultural Centre Against Family Violence

Appendix Three – Health professional training – Focus group learnings

Dandenong Monash Hospital

31/02/2015

Aim: A focus group was held with the aim of identifying current practice, barriers and enablers, in the screening and referral of women experiencing family violence (FV) at the Dandenong Monash site.

Participants

25 participants from a range of disciplines (allied health, management, medical and nursing, physiotherapy, interpreter service) and departments (Emergency, mid-wifery, ante/post natal care, in-home visiting service and social work) attended.

Staff recommendations

- Implement a whole of organisation approach to FV
- Raise staff awareness of FV policy and procedures
- Embed training in FV and the Health Justice project, across disciplines and across departments (Include in induction and continuous professional development training)
- Training to include a broader understanding of the indicators of family violence
- Resource staff to screen and refer women experiencing violence (time, training, job description)
- Train staff delivering home based care in FV screening and referral
- Build the capacity of staff across departments to screen, manage and refer women experiencing FV
- Create promotional material/resources on for FV in accessible places where women partners and family are not present
- Develop culturally competent approaches to dealing with overseas born women experiencing family violence
- Build effective partnerships with specialist FV agencies
- Create a community of practice within the organisation to support FV practice
- Develop confidentiality practices to ensure the safety of women disclosing FV

Appendix Four – Health professional training – Core competencies

Core competencies for participants undertaking health professional training were:

- Sound understanding of the nature and prevalence of family violence;
- Able to identify, respond and refer women experiencing family violence;
- Understand their role as outlined in Monash Health policies on family violence and disclosure;
- Describe the legal options available;
- Discuss the challenges of family violence in a multi-cultural context including cross cultural communication.

Appendix Five – Schedule of interview questions – legal and health professionals (Key Worker Interviews)

This semi-structured interview is focused on developing a preliminary understanding of the cultural and situational appropriateness of the Health-Justice Partnership project. This evaluation seeks to explore the contextual suitability and efficaciousness of the Health-Justice Partnership project in meeting the needs of CaLD women experiencing family violence in the south-east region.

1. What has been your experience of program implementation [for this project overall]?

2. Have there been specific challenges or opportunities that have arisen as a result of implementing/maintaining this program?

3. Have you needed to adapt any aspects of the program to suit the unique needs of your community groups/clients?

4. How has this program been used in conjunction with other programs?

5. Has this program influenced any local partnerships?

6. Has here been any development of partnership between settings and sectors?

7. a. Has this program influenced significant change within the context of the community you are working with?

b. (If yes) Which factors made this possible?

8. Conversely, has a lack of interest in this program inhibited adaptive change within the community group participating at your site?

9. Can you think of any changes in resources, programs and/or policies that have affected the implementation or maintenance of the program at your site?

10. Can you think of any changes in resources, policies or programs that have had a direct influence on or relationship to the program?

11. Have adaptive changes occurred to the program itself throughout the implementation stage or afterwards?

12. What has been your experience of communication and feedback loops between project partners?

13. Have there been particular barriers or facilitators in seeking to engage staff and clients in this prevention initiative?

14. Have you gained increased skills through your participation in the project?

15. In concluding this interview, are there any suggestions you have about changes or future directions for this program or other programs in this area?

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