EVALUATION OF THE FAMILY DOMESTIC SEXUAL VIOLENCE PILOT PROGRAM IN ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES IN WESTERN AUSTRALIA

Interim Evaluation Report September 2024

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Acknowledgement

ECU acknowledges the people of the many traditional countries and language groups of Western Australia. It acknowledges the wisdom of Elders past, present and future and pays respect to the Aboriginal communities of today.

Terminology

Throughout this document the term Aboriginal is used to refer to both Aboriginal and Torres Strait Islander people.

Disclaimer

The information contained within this Report has been compiled from a variety of external sources and has not been subject to an internal independent verification. Although every care has been taken to ensure that the information and opinions are correct, the evaluation team specifically disclaim any responsibility for the use or interpretation of this report.

Abbreviations

Abbreviation	Definition
ACCHS	Aboriginal Community Controlled Health Service
ACCO	Aboriginal Community Controlled Organisation
AHCWA	Aboriginal Health Council of Western Australia
AHLO	Aboriginal Health Liaison Officer
AHP	Aboriginal Health Professional/Practitioner
ALO	Aboriginal Liaison Officer
AMS	Aboriginal Medical Service
BRAMS	Broome Regional Aboriginal Medical Service
DoC	Western Australia Department of Communities
CoP	Community of Practice
CPFS	Child Protection and Family Support
CQI	Continuous Quality Improvement
DYHS	Derbarl Yerrigan Health Service
FDV	Family and Domestic Violence
FDSV	Family, Domestic and Sexual Violence
ECU	Edith Cowan University
KEQs	Key Evaluation Questions
MOU	Memorandum of Understanding
NAHS	Ngangganawili Aboriginal Health Service
NGO	Non-Government Organisation
PAMS	Puntukurnu Aboriginal Medical Service
SWAMS	South West Aboriginal Medical Service
WA	Western Australia
YYAMS	Yira Yungi Aboriginal Medical Service

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1 Executive Summary

1.1 Overview

In 2022 the Aboriginal Health Council of Western Australia (AHCWA) received funding to undertake a pilot program (the Pilot) of Family, Domestic and Sexual Violence (FDSV) support services. This program was embedded into six Aboriginal Community Controlled Health Services (ACCHS) in metropolitan, regional and remote locations across Western Australia (WA). The FDSV Pilot was to build on and complement existing efforts to provide comprehensive services to Aboriginal communities and was part of the State government's commitment to work with Aboriginal people to strengthen Aboriginal-led family, safety and support responses to family violence. In 2023, the evaluation team from the Maladjiny Research Centre, Kurongkurl Katitjin (Edith Cowan University [ECU]) was awarded the contract to undertake a process and short-term outcome evaluation that would be conducted alongside the implementation of the FDSV Pilot program. The evaluation consists of an interim and final evaluation. This interim evaluation is based on analysis of data and relevant information collected since the Pilot program commenced in December 2022 - August 2024.

1.2 Interim Evaluation Key Findings

The FDSV Pilot has six ACCHS taking a leading role in acknowledging and responding to family violence in their community/ies. While each of the sites service delivery model differs, all are evidence of service design incorporating Aboriginal ways of working, with a focus on client centred, wraparound services that seek to heal and empower Aboriginal clients.

1.2.1 Enablers to service delivery

The interim evaluation identified some key factors that are supporting the Pilot program.

- Differentiation in the service delivery models across the six sites that reflect the different contexts from which the services are operating.
- Aboriginal staff /culturally competent staff working from a trauma-informed perspective and/or with good relationships with community.
- Use of tools/resources in ways that are effective and meaningful with Aboriginal clients.
- The ability of programs to access and refer internally to a range of culturally competent services that support client's/families physical and mental safety and wellbeing.
- A service environment operating from an understanding of the complexity of violence in Aboriginal families, including the role of trauma (collective and individual), and the need for collective healing and trauma informed activities/services.
- The importance accorded to advocacy especially for clients when engaging with mainstream services where there is less understanding about the types of violence impacting on Aboriginal families and best ways to respond.

- Strong engagement with community including co-design processes, awareness and education raising about FDSV, and communities as champions of the FDSV service.

1.2.2 Challenges

The interim evaluation identified some challenges from design to implementation, delivery and reporting. These included:

- Recruitment and retention of staff.
- Accessing appropriate training to enhance the capacity of existing and new staff.
- Defining the FDSV service particularly in response to clients in crisis.
- Establishing effective referral and triage processes within the ACCHS.
- Developing all relevant policies and procedures to ensure a secure service.
- Sourcing appropriate safety planning tools and other resources to utilise with clients.
- Gaining the trust and confidence of community.
- Gaining support and recognition from other stakeholders and external referrers.
- Designing and delivering services that respond to the cyclical nature of FDSV and the non-linear trajectory of changes in client's situations.
- Inconsistencies in project output reporting across all the grant recipient organisations.
- The types of outcomes that can be reasonably expected and reported on given the ways in which FDSV clients engage with services.

1.3 Recommendations

Based on the interim findings, recommendations for implementation prior to the final evaluation are:

1. **Program Logic:** Develop[1] and finalise a program logic for the Pilot.
2. **Service delivery map:** Develop[1] and finalise a service delivery map that identifies the elements to the Pilot program and captures the cyclical nature of the client journey.
3. **Continuous Quality Improvement (CQI):** Support services to complete CQI activities to help embed change into their current service.
4. **Reporting:** Introduce changes to the Pilot progress report template to address inconsistencies in reporting and enhance the site's capacity to demonstrate the impact of their service delivery model and community engagement strategies.
5. **Workforce Development:** AHCWA to consider developing a 'FDSV Workforce' for ACCHS including a workforce development strategy with a set training requirements and core competencies including requirement for FDV-Informed Practice Supervision Training for all Team Leaders.

[1]Work is already underway by AHCWA for the program logic.

2 Introduction

In 2022 the Aboriginal Health Council of Western Australia (AHCWA) received funding of $6.3 million to undertake a pilot of Family, Domestic and Sexual Violence (FDSV) support services in six Aboriginal Community Controlled Health Services (ACCHS) in metropolitan, regional and remote locations across Western Australia (WA). The FDSV funding is intended to build on and complement existing efforts to provide comprehensive services to Aboriginal communities by supporting the safety and wellbeing of Aboriginal people affected by FDSV and promote community safety. AHCWA is leading the capacity building and monitoring of the six ACCHS in the delivery of the Pilot program with a view to understanding the challenges, enablers and outcomes achieved through the service delivery models in each of the sites. The Pilot was contracted to commence from 1 November 2022 to June 2025 (noting an extension to the original Pilot timeline in May 2024).

In 2023, the evaluation team from the Maladjiny Research Centre, Kurongkurl Katitjin (Edith Cowan University [ECU]) was awarded the contract to undertake a process and short-term outcome evaluation that would be conducted alongside the implementation of the FDSV Pilot program. AHCWA and ECU are collating data and reporting to the Department of Communities on activities, outputs, process outcomes and short-term outcomes of the Pilot program.

3 Background

Rates of family violence experienced within Aboriginal communities is described as disproportionately high and shaped by the specific and historical context of colonialism, systemic disadvantage, cultural dislocation, forced removal of children and the intergenerational impacts of trauma.[1] As a result, it requires a distinct and tailored set of responses across multiple fronts led by Aboriginal communities and embedded in Aboriginal cultural values and ways of knowing and working.[2]

In July 2020, the Western Australian Department of Communities (DoC) launched *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* (Path to Safety), which provides a whole-of-government and community plan for reducing and responding to Family and Domestic Violence (FDV) over ten years.[3] Path to Safety has four focus areas:

1. Work with Aboriginal people to strengthen Aboriginal family safety
2. Act immediately to keep people safe and hold perpetrators to account
3. Grow primary prevention to stop family and domestic violence

4. Reform systems to prioritise safety, accountability and collaboration.

In December 2022, DoC launched the *Aboriginal Family Safety Strategy 2022-2032* as part of the State Government's response to Outcome 13 of the National Agreement on Closing the Gap namely:[4] [5]

That by 2031, the rate of all forms of family violence and abuse against Aboriginal and Torres Strait Islander women and children is reduced at least by 50 per cent, as progress towards zero.

The Strategy commits the State Government, Aboriginal people and the wider community to support Aboriginal-led responses to family violence. The commitment by Governments at both a state and national level, to support Aboriginal led responses to FDV in Aboriginal communities, has seen several initiatives funded, including the FDSV Support in WA ACCHS Pilot Program.

3.1 WA ACCHS FDSV Pilot Program

3.1.1 Aims

The WA FDSV ACCHS Pilot Program ('Pilot') aims to provide culturally appropriate case management and wrap-around support to improve the safety and wellbeing of Aboriginal women, men, children and families impacted by FDSV. Six ACCHS were funded to provide culturally appropriate support, engage with Aboriginal families, respond to family violence and its impacts, and connect Aboriginal families to support services.

3.1.2 Governance

AHCWA administers the funding to the Pilot sites and provides oversight through a Governance Committee. The Governance Committee includes a member from each participating ACCHS site, AHCWA and the ECU evaluation team. The Governance Committee set the direction for the Pilot program through a set of key performance indicators, monitors the evaluation, and tracks project outcomes. In addition, the Governance Committee provide advice and guidance to the ECU evaluation team on methods for this evaluation. Expertise and support to each of the sites is provided through the role of a dedicated FDSV Project Adviser based at AHCWA.

3.1.3 Sites

Following a formal expression of interest process, assessed by the Pilot program Governance Committee, the following Pilot sites were appointed in December 2022:

- Derbarl Yerrigan Health Service Aboriginal Corporation (DYHS)
- Broome Regional Aboriginal Medical Service (BRAMS)
- Nangganawili Aboriginal Health Service (NAHS)
- South West Aboriginal Medical Service (SWAMS)
- Yura Yungi Aboriginal Medical Service (YYMS)
- Puntukurnu Aboriginal Medical Service (PAMS)

3.1.4 Anticipated Outcomes

The following short and long-term outcomes were developed for the Pilot.

- Provision of culturally secure and holistic responses to FDSV including case management and wrap-around support.
- Services for Aboriginal people, delivered by Aboriginal people.
- Raising awareness of the harmful impact of FDSV in the community through culturally secure education.
- Provision of opportunities for healing and recovery.
- Clients experiencing or at risk of FDSV are assisted to enhance their safety.
- Increased perpetrator responsibility for abusive behaviours.
- Improved collaboration and coordinated service delivery to provide wrap around intervention to keep women and children safe and manage risks associated with FDSV perpetrators.
- Clients, including children and young people who have been adversely affected by family, domestic and sexual violence have the harmful effects of the violence reduced and have improved resilience and wellbeing.

3.1.5 Ethics

This evaluation has ethics approval from the Western Australian Aboriginal Health Ethics Committee (HREC1307) and Edith Cowan University (2024-05175 STROBEL).

4 The Evaluation

The overall purpose of the evaluation is to determine to what extent the six ACCHS have effectively embedded an FDSV program into their service, which is responding to the needs of women, men, children and families impacted by FDSV, and the key lessons learned. The evaluation consists of an interim and final evaluation. The interim evaluation focuses on assessing processes and is based on analysis of data and relevant information collected since the Pilot commenced in December 2022 through to August 2024. The final evaluation

report is to be submitted in June 2025. The final evaluation will examine the Pilot in its entirety and will include all findings from commencement through to June 2025.

4.1 Aims

- To explore the key enablers and challenges across the WA ACCHS Pilot program sites to improve the evidence base on and resources for the provision of specialist FDSV services in Aboriginal medical services and communities, in the areas of awareness raising/advocacy, safety planning case management and outreach.
- To better understand the unique aspects of the Pilot program – including service design and delivery and the geographical, socio-economic and cultural contexts in which they operate.

4.2 Evaluation Questions

The following key questions underpin the interim evaluation's data collection and analysis:

5. Were there any establishment challenges for the Pilot program?
6. How is the Pilot program being implemented?
7. What has been achieved to date?
8. What is the FDSV staff capacity to respond to those seeking support for FDSV?
9. What improvements could be made?

4.3 Interim evaluation method

The interim evaluation utilised a mixed methods approach.

4.3.1 Quantitative Data Collection

Data from the six ACCHS reporting on outcomes between December 2022-April 2023 and May 2023-November 2023.

4.3.2 Qualitative Data Collection

Online Surveys

An online survey was developed for use with the FDSV staff. The questions explore staff's experiences of working in an FDSV service and the challenges and facilitators of delivering the service. The aim of the surveys is to ensure all FDSV service staff are provided an opportunity to be a part of the evaluation. The surveys were undertaken in April 2024 and will be repeated in April 2025. A copy of the survey questions is provided in Appendix A.

Interviews

Qualitative interviews were completed with a selection of FDSV program staff at five of the six Pilot program sites. Interviews explored challenges and enablers to establishing and

implementing the FDSV programs, engagement with the community and some lessons learned since commencement of the programs. A copy of the interview questions and discussion prompts is provided in Appendix B.

Community of Practice Meetings

A member of the evaluation team attends the monthly Community of Practice (CoP) meetings provided by the AHCWA FDSV Project Advisor for staff and Team Leaders at each of the Pilot program sites. These meetings provide opportunities to hear from staff about the activities occurring at each of the sites, as well enabling discussion of aspects of the FDSV service delivery and the challenges, enablers, and lessons learned. The CoP meetings have also provided the evaluation team with opportunities to seek further insights from the sites.

4.3.3 Data analysis

Progress reports from the six ACCHS were aggregated and provided as summary data for each reporting period. Due to small sample size, results from the staff surveys were provided as descriptive data rather than analytically. Qualitative data from the interviews (recordings and notes) were examined for commonalities in experiences across the sites, in particular establishing and embedding the FDSV program in the ACHHS and within the community. Specific differences at each of the sites were also explored to provide insights into the context in which each program is delivered. This analysis provided the key themes and findings.

5 Key Findings

The following section provides the interim evaluation assessment of the Pilot program's processes and activities, focusing on the establishment and implementation of the services, the output data, and lessons learned to date. The interim evaluation is also concerned with exploring the unique aspects of the Pilot program to contribute to an evidence base of the importance of this approach to addressing Aboriginal family violence.

5.1 Program establishment

The six sites commenced their services between December 2022 and February 2023. There was a differing level of experience and capacity at the site organisations in terms of establishing or delivering FDSV services. Challenges included the time involved in ensuring the requisite staff, skills, and policies were in place.

FDSV teams were established as either part of an existing social and emotional wellbeing (SEWB) team or stand-alone program. For those programs integrated within a SEWB team the SEWB Manager also assumed the role of FDSV Team Leader. One site has been unable to establish an FDSV team and has subcontracted these services externally. One site had a pre-existing FDV service and has evolved this service for the Pilot based on previous learnings.

5.1.1 Staffing

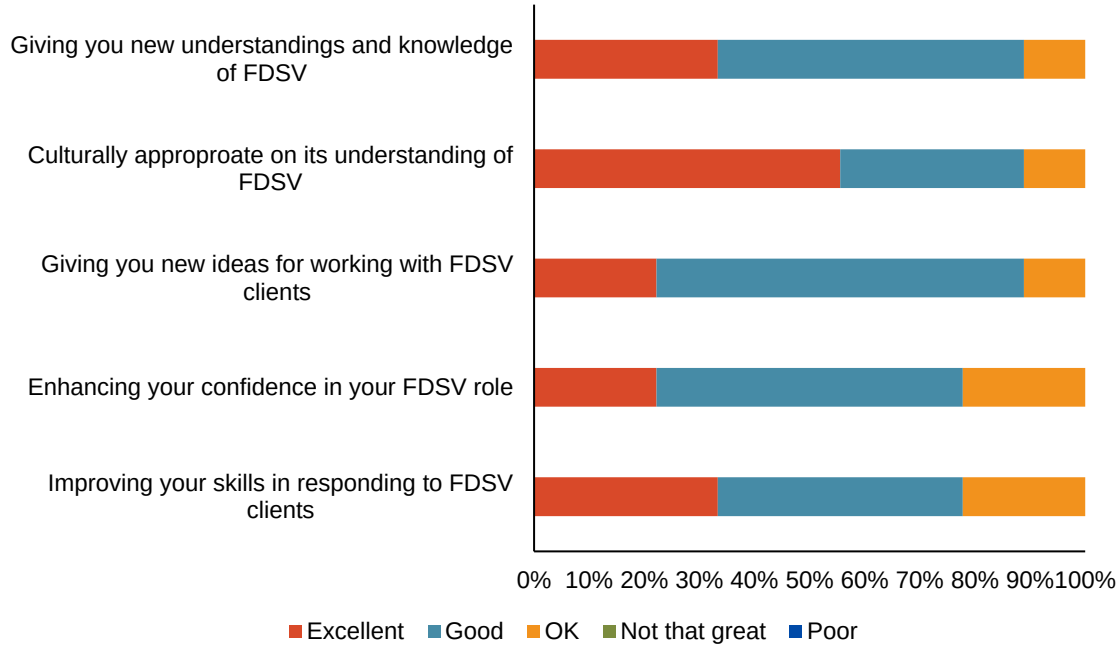
Staff recruitment and retention is an ongoing issue for organisations in regional and remote areas. Reasons for this included staff concerns about working in FDSV in small communities and the lack of housing in some sites. In addition to the standard requirements of working within an ACCHS, support services for FDSV requires additional specific skills to support the community. Some sites experienced identifying and retaining staff as an implementation challenge that persisted for some months and continues to be a challenge.

Five of the six sites identified a need for staff to access suitable training to undertake safety planning, and/or provide trauma informed FDSV service delivery. Sourcing suitable training for staff working in an Aboriginal community context highlighted a lack of readily accessible training. The training that was accessed and completed by seven FDSV staff across three sites were We Al-Li (n=6) and Safe and Together (n=3). Other training programs undertaken by staff included:

- DV-Alert eLearning Foundations
- DV-Alert First Nations

- CRARMF Comprehensive Training for Family Violence Specialists
- FDV-Informed Documentation
- Graduate Certificate Violence Responses.

For staff that undertook training and answered the staff survey, the majority felt that the training that was undertaken was either excellent or good (Figure 1). However, there were a number that felt training was okay indicating that perhaps alternative training is needed.



NOTE: Nine participants responded to the survey; missing n=4

Figure 1: Rating of training received

Staff surveys (n=11), progress reports and interviews with Team Leaders identified the ongoing need for training. With the following requested or planned for staff:

- Suicide Intervention Skills Training
- DART Group training – documentation, administration of risk assessment tools and safety plan, screening
- Safe and Together training
- Cert IV Mental Health for Aboriginal support workers
- FDV-Informed Practice Supervision for Team Leader
- Indigenous Mental Health First Aid
- FDV-Informed Documentation for Community workers
- Mandatory reporting requirements

5.1.2 Procedures and Policies

Sites experienced challenges in developing and embedding the range of procedures and polices required to support FDSV service provision and ensure the safety of all involved. Some sites needed or continue to need, support to develop these documents. Relevant policies and procedures that sites have completed or are progressing include:

- internal and external referral, intake and exit processes
- case management planning
- home visits risk management
- managing challenging behaviours
- incident management register
- privacy and confidentiality – internally in the health service and externally with community
- data collection and reporting systems – including establishing clinical items in the ACCHS record management systems.

5.1.3 Other establishment and early implementation challenges

Other challenges identified that impacted some or all site's FDSV program establishment and/or early implementation were:

- Defining what the FDSV service is and is not, especially the response to clients in crisis and working with perpetrators.
- Communicating that the service is not a crisis response but can still offer support services especially immediately after a crisis and having that message understood.
- Time involved in establishing relationships with relevant organisations and generating confidence and awareness of the service and processes for referrals, especially when the Pilot program is time limited.
- Accessing tools and resources that are suitable for working with Aboriginal clients. Some sites have adapted existing tools that appear to be working effectively.
- Gaining trust from the community.
- Establishing data collection processes.

5.2 Service Delivery

The FDSV service delivery model differs at each site and is shaped by local community needs, the local service system (both internally within the ACCHS and externally) and the community context. There are also commonalities across the service models. These include the importance of client centred, client-driven and flexible services that are confidential, responsive, non-judgemental and empowering. Also common across the sites is the importance of the ACCHS models of care and holistic concepts of health and wellbeing,

Aboriginal community governance as well as community engagement and support. Stakeholder relationships are important to all sites with common stakeholders including WA Police (WAPOL), women's refuges, other FDV services, crisis centres, emergency housing/accommodation services, child protection workers, and legal and court services.

There are a range of services delivered by the FDSV teams including: risk assessment and safety planning, informal and formal counselling, psycho-education, coordination of physical and mental health services from across the ACCHS, healing and therapeutic activities and groups, referrals and liaison with other service providers, advocacy and support to clients when engaging with the Police, Child Protection and Family Support (CPFS) and the courts, and practical assistance such as food and fuel vouchers, transport, mobile phones, temporary relocation to other towns and/or emergency accommodation. The sites also undertake differing degrees of community awareness raising and education about FDSV with some sites providing or sending FDSV staff to on Country and bush camps, healing camps and groups, weekly men's and women's support groups.

The following provides details of each sites service delivery model. This information is based on interviews with staff at the Pilot program sites, CoP meetings and progress reports.

5.2.1 Derbarl Yerrigan Health Service Aboriginal Corporation (DYHS)

DYHS is located in Perth with four clinics that provide services to 10,379 people in the region.

Staffing: Walbrininy Family Team, including the Team Leader, Aboriginal Support Worker and two full time Case Workers.

Program delivery: The FDSV team is located within the SEWB team at the main DYHS clinic located in East Perth and also provides outreach at the other clinics as required. Since commencing the FDSV service, the team identified a need to clarify and streamline the way in which clients were referred within the ACCHS. The approach has been refined over time to address the issue of people presenting to the service in crisis and clients not being suitably triaged/screened before referral to the FDSV team. After some time and consultations across the ACCHS, the resulting process is as follows:

1. GPs undertake an initial screening so that all referrals to the FDSV service/SEWB team come from a DYHS GP ensuring clinical governance in referral processes and the client journey. GPs at DYHS were provided training in FDSV screening.
2. GPs can refer the client to the SEWB team via *Communicare* clinical item "SEWB Referral" and follow with an Intramail – this is triaged by the counselling Team Leader, and referral is discussed at the Monday Intake Meeting.

3. Once the client is allocated to the FDSV team, the Team Leader:
    a. reviews the client file
    b. completes an FDSV triage with a summary for the caseworker
    c. enrols the client using the clinical item “FDSV Enrolment” and enters the summary in the “FDSV enrolment notes”
    d. Intramails the Case Worker to follow up with the client
4. The Case Worker follows up with the client for case management.
5. Clients who do not meet the criteria for the FDSV program are referred to other services within the DHYS or externally. The service does work with parents and children but the risks of providing services to perpetrators within the same clinic, means that DYHS does not work with these individuals and refers them to other services.

Strengths: Streamlined screening, triage and referral systems across the ACCHS suited to the workings of a busy metropolitan clinic. Utilising a continuous quality improvement approach to the FDSV service delivery model has seen an improved understanding across the ACCHS about what the service does and doesn’t provide, better engagement of the ACCHS clinical staff in screening and providing a FDSV aware service and enhanced clinical governance and service delivery for clients.

5.2.2 Broome Regional Aboriginal Medical Service (BRAMS)

BRAMS is located in Broome and provides services to 5112 people in the region.
Staffing: General Manager of Family and Community Services and the Integrated Family Violence Program with two Case Workers.
Program delivery: The Integrated Family Violence Program was focused on aligning with BRAMS other programs within the family and community services area. This included designing and refining referral and triage processes to achieve a support and case management approach and not a first response service. Within BRAMS the GPs, AHWs, nurses and other primary health staff are referring clients to the team and there are strong links with the SEWB team, maternal health and men’s and women’s healing groups. Referrals to the team is facilitated through BRAMS intake officer for all programs which directs clients to the FDSV team.

Service delivery is a client driven, case worker support model involving safety planning, information referral and advocacy to a range of other services within the BRAMS and in Broome (Police, courts, CPFS, accommodation and women’s refuge service) as well as provision of practical assistance (e.g. food, clothes, transport). There is a focus on empowering women to not accept violence and to know what’s available to them in Broome

and to be able to know what to do when they are in crisis. Building networks to develop and strengthen positive relationships for collaboration with other services in Broome and to increase referrals to the program with the FDV Team at the Broome Police, has been an important aspect of establishing the program.

In July 2024 the team decided to adjust its approach and establish a role for a full time Social Worker in the main primary health care clinic. In addition to providing external supervision to the two FDV Case Workers, the Social Worker acts as the first point of contact in the primary health clinic for walk in referrals, as well as being able to provide primary health staff with expertise when needed on complex cases and assist patients with additional information, navigation and referrals to support services.

Strengths: A service delivery model that is bringing FDSV into the primary health setting. BRAMS person-centered and culturally safe models of care are embedded in the FDSV service delivery model. There is Aboriginal mentorship of non-Aboriginal staff who are considered to be working in ways that are aligned to an ACCHS and developing trust among clients. Steadily increasing referrals since the program commenced suggest an increasing awareness and confidence in the service from the community and stakeholders.

5.2.3 Nangganawili Aboriginal Health Service (NAHS)

NAHS is located in Wiluna and provides services to 796 people in the region.
Staffing: SEWB Manager, an Aboriginal Social Worker, Social Worker and two Psychosocial Support Workers.
Program delivery: The FDSV program is located within the SEWB team. The focus is on working with individual clients and with families and at the community level. Even before commencing the pilot program, there was a focus on co-design and the need for community support in the service. Since the Pilot program officially commenced engagement with community has extended to awareness raising about the service and educating community about naming family violence, preventing/de-escalating violence and encouraging victims to seek support. Formal referrals for the team come from the NAHS biomedical clinic, NAHS aged care service, Wiluna Police, DCP, mental health services, and correctional services.

Initially the presentations were predominantly crisis related and there has been a focus on communicating that the service is not set up or able to provide for crisis response or intervention. The service is also focused on advocating and asserting the needs of clients with other services in the town who lack a trauma informed approach and are perceived by community as culturally unsafe.

Strengths: Formally establishing an FDSV service in the ACCHS has enabled a formal and public recognition and response to family violence that in turn has been a catalyst for increased community awareness and discussion about FDSV. This has resulted in increased referrals and members presenting to the clinic prior to crisis as well as after a crisis and filing for VRO's and initiating safety planning. Gaining the support of the community for the FDSV service and actively working with community to educate and raise awareness about family violence. The team is comprised of very experienced staff with strong connections and trust within the community that is critical to the effectiveness of the service.

5.2.4 South West Aboriginal Medical Service (SWAMS)

SWAMS is located in Bunbury and provides services to 4076 people in the region.

Staffing: Social Worker - FDV and Community Support Worker – FDV

Program delivery: A family violence role at SWAMS existed before the Pilot program and this has continued with an expansion of services and staff to other regional areas (Katanning and Narrogin, Busselton and Collie). The team has had many recruitment challenges and is currently comprised of a Social Worker - FDV and Community Support Worker – FDV. The staff work alongside the SEWB and mental health teams accessing their counselling services, social worker and other supports where required. While the service had several policies and procedures already in place at the commencement of the Pilot program, the decision to pursue White Ribbon accreditation meant a need to develop numerous additional policy and procedural requirements. At the time of writing, the accreditation process is ongoing, and a decision taken by the ACCHS to employ a policy writer to support the team.

The service delivery is a case management approach, involving multifaceted work that varies according to client's circumstances. The service works with many families involved with child protection and attend the Multi Agency Case Management meetings involving CPFS, WAPOL, Health, Housing, Justice, Education and Victim Support to support and advocate for clients. These meetings are an important way to facilitate shared information and multi-agency safety planning.

Like other Pilot program sites, the service faces many challenges due to the limited support services available in the area, especially accommodation for high-risk clients. It has also been focused on managing its service delivery boundary for clients in crisis and is unable to offer services or programs to perpetrators.

Strengths: SWAMS has a strong presence in the Bunbury community with a lot of trust and confidence in the service – that extends to the FDSV Team. Over time, the experienced non-Aboriginal team member has developed ongoing relationships with many women based on a high level of trust. The focus of the service is helping women to be stronger in themselves.

5.2.5 Yura Yungi Aboriginal Medical Service

YYMS is located in Halls Creek in East Kimberley, and provides services 1843 people in the region.

Staffing: SEWB Manager and two FDSV Support Workers

Program delivery: The FDSV team are within the SEWB team. Service delivery is dependent on clients' needs and involves crisis intervention, counselling, case management, yarning, referral, and assistance to access other services such as Centrelink, Department of Transport (driver's licence), Department of Education, child and family services. The staff also host and attend on-Country camps, fishing trips, weekly cook ups, and men's and women's groups, which are aimed at raising awareness of domestic violence and strategies for working to change violent behaviour. The groups are also focused on developing mentoring relationships between older and younger community members.

A focus on community engagement and awareness raising includes hosting regular education sessions with community leaders to provide information on how to access support when required, both in Halls Creek and other communities experiencing increasing violence-related incidents. There has also been a focus on building relationships and networks with other services to develop rapport, strengthen partnerships to increase support to clients, and support mainstream service providers engagement with families – especially those involved in CPFS. As a result, the FDSV service is getting increasing numbers of formal referrals from Anglicare, Key Assets and Department of Communities.

Strengths: The staff are from the community and have a deep understanding of the issues impacting families. The increasing trust in the staff is evident in consistent numbers of attendees to weekly group meetings and activities, and the invitations to address community gatherings and to deescalate situations before they become violent. The service has adapted the *Preston Path* tool for use with men to provide a culturally appropriate tool for engaging men to recognise and address patterns of violence. This is having good results and men are regularly attending the sessions aimed at discussing and working on their violence. Increased numbers of women are also engaging with the service.

5.2.6 Puntukurnu Aboriginal Medical Service (PAMS)

PAMS is located in Newman, has a clinic in Jigalong in the Pilbara and provides services 5385 clients in the region.

Staffing: Director of Community and Family Health

Program delivery: The FDSV service delivery model involves provision of generalist SEWB services, community awareness activities, and specific FDSV services developed for the pilot program. PAMS subcontracts to a specialist and holistic FDV support service, the Newman Women's Shelter, to provide these services. Community awareness activities are focused on addressing the underlying causes of violence by increasing awareness and promoting culturally sensitive gender specific education through community events and activities that indirectly address FDV. Due to the subcontracting of service provision by PAMS to Newman Women's Shelter the interim evaluation has not assessed this service delivery model. As part of the final evaluation interviews with stakeholders will occur and additional information on this service will be provided.

5.3 Outputs

To identify Pilot program outputs to date, the interim evaluation utilised the six sites progress reporting data and consolidated the data. Table one provides the consolidated data from the progress reports submitted between December 2022-December 2023

Table 1: Key performance indicators for all sites, December 2022—December 2023

#	Process outcomes	Dec 2022 – Apr 2023	May 2023 – Dec 2023
1	Total number of staff employed or contracted under the Pilot	12 (1-4 staff/site)	19 (0-6 staff/site)
2	Proportion of staff who are Aboriginal (Total staff who are Aboriginal / Total number of staff)	35% (0%-100% staff/site)	51% (25%-100% staff/site
3	Total number of clients/families supported by the Pilot[1]	194 (7-66 referrals/site)	497 (33-154 referrals/site)
4	Total number of formal and informal (e.g. self/family) referrals of clients[2]	Total: 194 Formal n=19; Informal n=58; Uncategorised n=117)	385 (Formal n=187; Informal n=198)
5	Total number of encounters provided.[3]	583 (5-303 encounters/site)	1820 (68-483 encounters/site)
6	Total number and type of advocacy undertaken on behalf of clients.[4, 5]	184 (3-110 events/site) Advocacy activities delivered included: 1. Writing letters 2. Setting up meetings with services 3. Attending meetings alongside clients 4. Working with institutions to reinstate licences.	704 (22-293 events/site) Advocacy activities delivered included: 1. Case management 2. Court support 3. CPFS meeting support 4. Crisis intervention 5. Accommodation and travel support 6. FDSV specific counselling 7. Referrals for FDV perpetrator support, alcohol and other drugs, and legal support 8. Support services for communication/utility, child developmental services, employment and skills, rehabilitation, midwife, childcare and early childhood, and physical and mental health 9. Police and legal system advocacy 10. Women's support services

7	List of the type of activities provided to support clients/families.	1. Informal and formal counselling 2. Crisis intervention 3. Emergency relief and evacuation supports 4. Case management 5. Risk assessment and safety planning 6. Brief interventions, early intervention and prevention sessions 7. Yarning 8. Psychoeducation 9. Introduction to new FDV case worker 10. Liaison, referral and advocacy 11. Attending meetings with clients 12. Court support 13. Group work 14. Food, including food bank boxes 15. Overnight accommodation 16. Transport and financial assistant with transport 17. Assistance with money management and Centrelink 18. Removalists assistance 19. Housing maintenance	1. Case management 2. Risk assessment 3. Safety planning 4. Counselling 5. Brief interventions, early intervention and prevention sessions 6. Yarning 7. Psychoeducation 8. Liaison, navigation, coordination, referral, advocacy 9. Practical assistance 10. Art therapy groups 11. Crisis intervention and accommodation 12. Psychosocial Support 13. Family Violence Restraining Order application assistance 14. Court support 15. Food and fuel vouchers 16. Mobile phones 17. Transport including safety drive outs 18. Alcohol and other drugs support
8	Total number of perpetrators or people using violence accessing the pilot services.[6]	17 (0-9 perpetrators/site)	10; (2-8 perpetrators/site)
9	Total number of encounters* by the ACCHS with perpetrators or people using violence.[7]	24	59
10	Total number of formal and informal (e.g. self/family) referrals of perpetrators or people using violence.[8]	17 (Formal n=6; Informal n=2; Uncategorised n=9)	47 (Formal n=38; Informal n=9)

11	Total number of group workshops/sessions with perpetrators or people using violence.[9]	9	30
12	List of the type of activities provided.[10]	1. Assistance behaviour change support 2. Counselling 3. Psychoeducation 4. Crisis intervention 5. Case management 6. Brief interventions, early intervention and prevention sessions 7. Yarning 8. Liaison, referral and advocacy 9. Safe space group 10. Practical assistance	1. Counselling 2. Psychoeducation 3. Liaison, referral and advocacy 4. Practical assistance (e.g., smart rider to attend sessions) 5. Crisis intervention 6. Case management 7. Solution-focused brief intervention 8. Yarning 9. Early intervention and prevention sessions 10. Assistance to access other services 11. Education sessions
13	Total number and type of external services engaged in wrap around services for clients/families.	38 (0-13 services/site) (no services provided)	1. Women's refuges/shelters 2. Family violence programs 3. Childcare centres 4. Housing services 5. Aboriginal corporations 6. Healing services 7. Legal aid 8. Police units 9. Community Mental Health 10. Medical services (Hospitals, Clinics) 11. Men's shelters 12. Aboriginal legal services 13. Department of Communities (Child Protection, Housing) 14. Multi-agency case management 15. Community coordinators 16. Early diversionary support 17. Mental health services

14	Total number of referrals to external services by the ACCHS.[11]	54 (0-26 referrals/site)	140 (3-50 referrals/site)
15	Total number and type of community activities related to raising awareness of FDSV and/or the related services[12, 13]	19 (0-10 activities/site) Types of community awareness activities delivered: 1. Maternal mental health service sessions 2. Participation in community group events with other ACCOs 3. Partnering with a Women's Health promotion initiative through a travelling coffee van 4. Horse riding event for youth in collaboration with other agencies 5. A camp 6. Group sessions 7. Family yarns 8. Shark Cage education 9. Integrated into consultations by other programs e.g. SEWB	58 (4-24 activities/site) Types of community awareness activities delivered: 1. 16 Days in WA events (community BBQ, World AIDS Day, DYHS children party, National Awareness Month, Mental Health Week) 2. NAIDOC events (Mirrabooka, Midland) 3. Odd Socks Day (DYHS sites) 4. Women's Health Week (DYHS events) 5. Regular social media awareness 6. Group discussions 7. Co-design groups 8. Men's sessions (Individual and group) 9. Family yarns 10. Bush camp 11. Conversations with Elders and community members 12. FDSV focus group sessions 13. FDSV group camp 14. Clothing market days 15. Cultural community meals 16. Happy Hangout Hour 17. Staff talks/presentations (Elder Abuse Week, Young Mum's and Bub's Group, Young Mothers Djin Djin Mart) 18. Planning events (16 days of activism) 19. White Ribbon Silent March (Bunbury, Busselton) 20. Group Education Sessions 21. Weekly Programs (Men's Group, Women's Circle) 22. Community Events (Service Provider Expo, White Ribbon Day event, Community Christmas party) 23. FDSV team support (Men's Group weekly activity, White Ribbon Day event)

16	Total number and type of community activities related to co-design of the services.	22 (0-15 activities/site) Types of co-design activities include: 1. Meetings with external services e.g. women's refuge, men's outreach service, mothers group 2. Group consultations 3. Camp 4. Family yarns 5. In-depth yarns with Elders 6. Discussions with SEWB staff and clients 7. Attendance at community events 8. Engagement of a university researcher to support the facilitation and documentation	36 (1-21 activities/site) Types of co-design activities include: 1. External stakeholder meetings 2. DV-Alert First Nations 2-day training 3. Meetings with Department of Health and Department of Communities 4. DART group launch evening 5. AFSP community reference group meeting 6. Internal staff meetings (screening tools, presentations, in-services) 7. Planning for Djook Yarning program with Wungenging Aboriginal Corporation 8. Pampering session 9. Housing Workshop 10. Centre for Women's Safety & Wellbeing FDV Code of Practice consultation workshop 11. Sexual Violence Prevention & Response Strategy workshop 12. Committee with Maternal Child Health Team (develop Child Safe Workplace) 13. Group sessions for feedback collection Regular visits to Ringers Soak Community (response to violence-related incidents)
17	List of the policies, procedures and related documents put in place to support the program within the ACCHS	Provided as summary in Section 5.1.2	Provided as summary in Section 5.1.2

NOTES: 1. It is ambiguous whether services reported number of individuals or families supported; 2. No services reported uncategorised referrals for December. Majority of uncategorised referrals are self-referrals; 3. One service only provided number of encounters in hours. It has been assumed that one hour is one encounter for this service; 4. Some services noted that their advocacy occasions count included referrals for FDSV short-term counselling, perpetrator, and AOD support; 5. Once servie did not provide KPI data and one service did not provide types of advocacy; 6. Only two services offered, and reported, perpetrator services in reporting period 1; 7. Three services reported encounters in reporting period 1; 8. Four services reported referrals of perpetrators in reporting period 1; 9. Only one service reported group sessions with perpetrators, however they note that this count was for two clients engaged in 30 individual sessions of short-term individual counselling; 10. Two services did not provide type of activity; 11. One service included referrals made by their subcontractor; 12. Services reported number of activities differently from reporting period 1. 13. One service did not provide type of community activities. One service was not counted as they listed types of activities, but number was unclear. **Definitions:** Advocacy: Represents the client to progress their case. Advocacy work may be internal within the service. Advocacy work may be conducted in person, online, by telephone, via letters or other forms of engagement; Encounter: One encounter is one session of engagement. This may be of short duration (minutes) or long duration (hours). It can be a formal or informal interaction, and it may occur in different formats e.g. face to face or telephone.

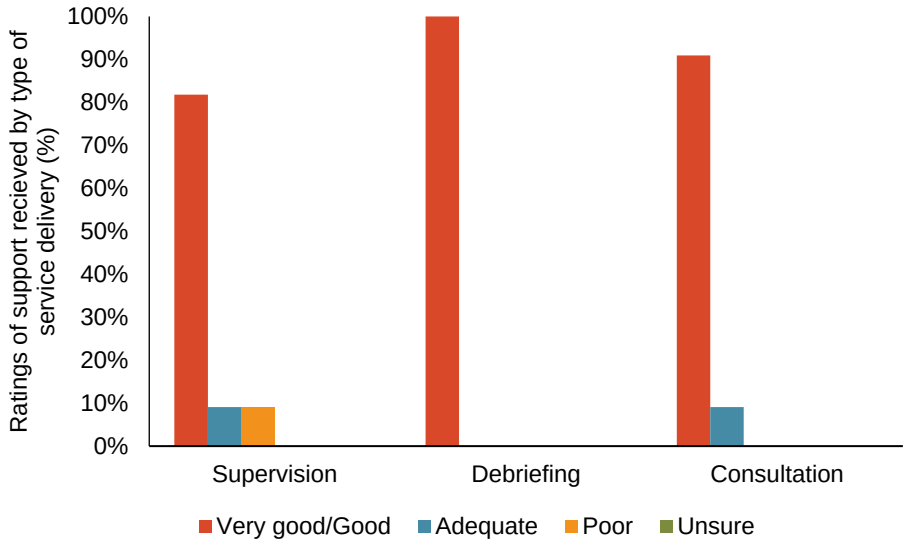
5.4 Staff capacity

The following are the key findings from the FDSV Pilot sites staff surveys, which explored staff perceptions of their skills, capacity, confidence, and their views of the FDSV service. Thirteen staff from four of the six services participated in the survey (Table 2). Overall, the views and experiences of staff are largely similar with a clear message that while staff are confident in their role, they want training to enhance their skills and capacity. This finding is also supported in the interviews with Team Leaders and Managers who noted the specialist skills required to work in FDSV and the importance of staff shifting their mindset from working in a SEWB context to FDSV, which involves a different way of working with clients to ensure safety.

Table 2: Demographic characteristics of participants.

	n	Total (%)
Gender		
Female	12	92.3
Male	1	7.7
Cultural Identification		
Aboriginal	2	15.4
Non-Aboriginal	11	84.6
Education		
Cert IV or below	2	15.4
Diploma	2	15.4
Bachelor Degree	4	30.8
Postgraduate Degree	4	30.8
Missing	1	7.7
Employment status		
Part time	2	15.4
Full time	10	76.9
Missing	1	7.7
Job Title		
Mobile Outreach	1	7.7
FDV Support Worker	2	15.4
Social Worker (1 FDV specific)	4	30.8
FDSV Case Worker	3	23.1
Team Leader	1	7.7
Missing	2	15.4
Time in role		
< 3 Months	2	15.4
< 6 months	3	23.1
6 – 12 months	3	23.1
1-2 years	1	7.7
> 2 years	3	23.1
Missing	1	7.7

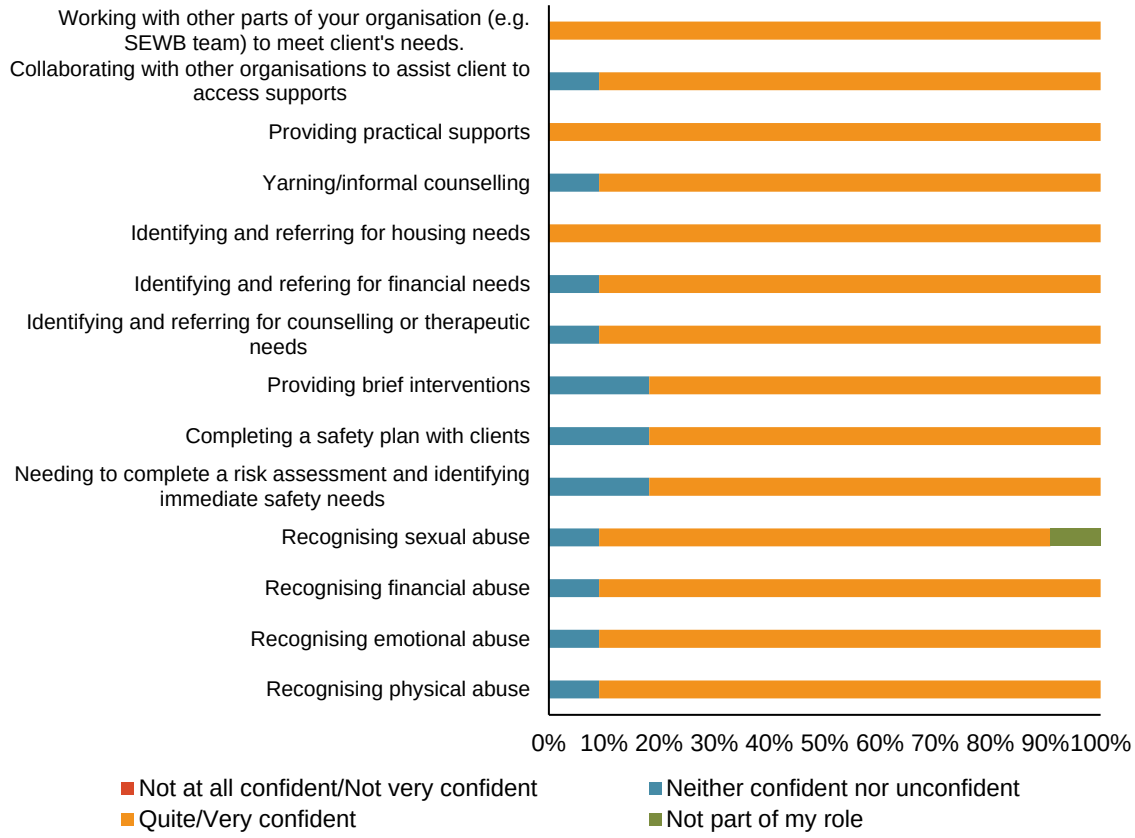
Of the participants that responded (n=10) all felt their role and responsibilities were clearly defined. Half of the staff were new to their role (50%; 6/12), a third had experience in similar roles (33%; 4/12) and 17% (2/12) had a lot of experience in their role. In addition, nearly all staff felt that the supervision, debriefing and consultation they received was very good or good (Figure 2).



NOTE: Eleven participants responded to the survey; missing n=2

Figure 2: Ratings of support received in their role by type of service delivery

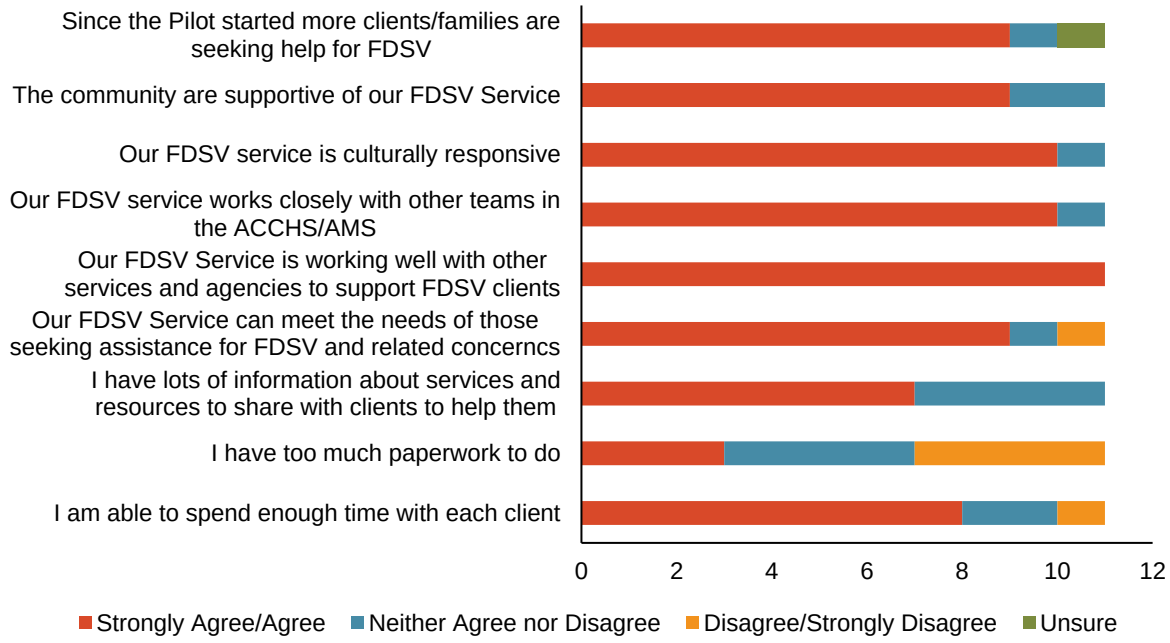
Overall, staff were very/quite confident undertaking a range of tasks related to their FDSV role (Figure 3). All participants were able to identify and refer for housing needs, provide practical supports and working with other parts of their organisation to meet client's needs.



NOTE: 11 participants responded to the survey; missing n=2

Figure 3: Confidence in undertaking tasks related to role

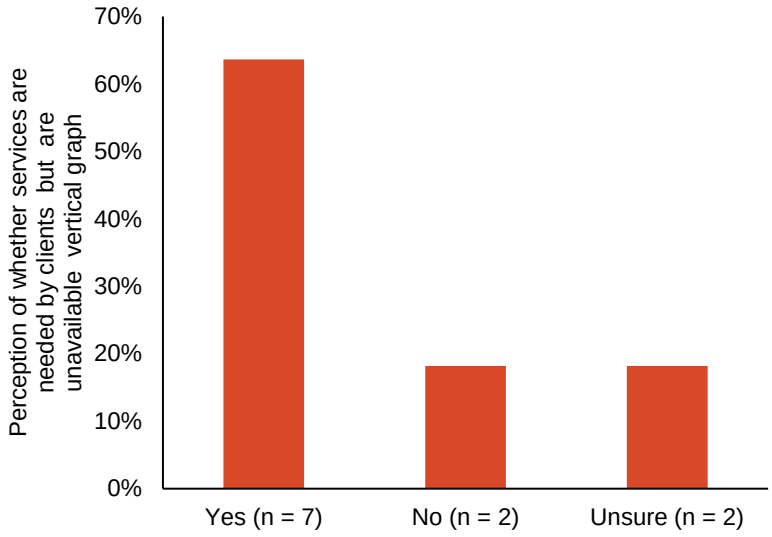
Staff surveys highlighted positive responses regarding engagement with the services by clients and the extent of community support as well as vies on the cultural appropriateness of serve delivery and collaboration across the ACCHS. Overall, they suggest FDSV services that are aligned to community needs and working well within the ACCHS model of care and integrated service delivery (Figure 4).



NOTE: 11 participants responded to the survey; missing n=2

Figure 4: Agreement with statements regarding their service and clients

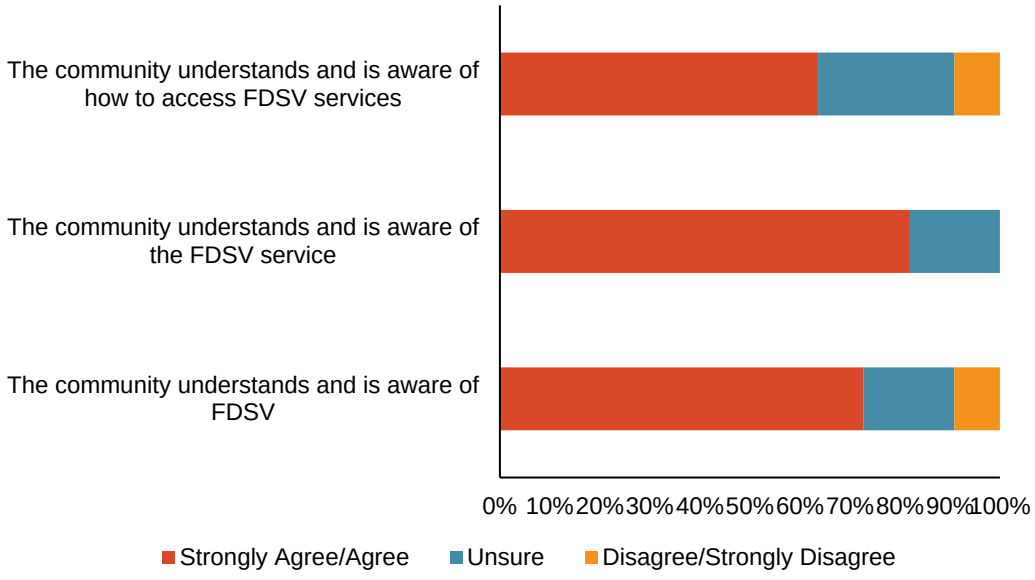
Most (64%; 7/11) FDSV workers identified that their clients needed additional specific services but couldn't access them (Figure 5). These services included permanent, temporary and emergency housing, crisis accommodation, perpetrator programs, counselling for children <10 years old, easy accessible rehabilitation, easy accessible food vouchers, a women's drop in centre, and drug rehabilitation.



NOTE: 11 participants responded to the survey; missing n=2

Figure 5: Perception of whether services are needed by clients but are unavailable

Figure six suggest that there remains work to be completed to ensure the community is aware and understands how to access a FDSV service (Figure 6).



NOTE: Eleven participants responded to the survey; missing n=2

Figure 6: Perception of community understanding of FDSV and FDSV service

Additional comments that were provided as part of the survey included:

- *Since starting here three weeks ago I can see the positive impacts this FDSV pilot is making. The clients I have met are very appreciative of the support and services we provide and seem to be more empowered afterwards*
- *There is a Great Need of a Crisis accommodation in Wiluna.*
- *Our clientele group are involved with lots of services which makes it difficult to support appropriately.*

5.5 Qualitative feedback

Interviews were conducted with Team Leaders and some staff members at five of the six Pilot program sites. The following quotes provide some reflections on changes among the community that staff have identified since the commencement of the FDSV programs.

"At the start we had no traction with the community. But once community saw some action with individuals, there was some word of mouth that the service is really helping people"

"The way we do it, they understand it's for the better."

"The Elders are really thankful."

"First they told us 'it's none of your business', but it's all of our business, you can't ignore it, and the community is starting to understand that."

"Many in the community seeing and being our parents' violence – growing up with that we need to break the cycle and who better to do that than us – local Aboriginal people – because we know the community, we know the experiences and we get that respect, and we know how our people heal from the trauma."

The following provides a snapshot of one of the FDSV service Pilot sites since their program commenced. Information and reflections are taken from the interview with the Team Leader. A long term FDV worker and advocate, the Team Leader regards the changes associated with the introduction of the Pilot program as remarkable in terms of the community's change in attitudes and response.

Before this pilot started, domestic violence was not spoken about openly. The term was taboo. Women experiencing FDSV would present to our clinic, our SEWB service, the police and DCP but would often not feel safe to speak about the violence that they were experiencing.

In our first conversations with community members, just the mention of this service felt controversial. Along with the many requests we received to start this pilot, people also expressed concerns that we would be breaking up I and 'getting in the middle' of relationships.

Understandably, my team began this pilot with much trepidation. I am happy to say that we are not receiving this type of feedback any longer. In the short time that it has been implemented, the changes have been surprising. For the first time women are specifically self-referring for FDSV.

Increasing numbers of women are help-seeking prior to an incident occurring (as well as during and after an incident). Family members are now calling on behalf of their loved ones and are actively engaging in safety planning. Women are calling police themselves to request 72 hour Police Orders. Men are requesting support for their own use of violence for the first time. Women, men and children are requesting new types of support not requested before such as help to obtain restraining orders, complete REDRESS paperwork and to receive specialist counselling for past trauma. We have even had phone calls where family members have organised their own evacuation. They then call our team for further assistance and advice.

Feedback from yarning groups suggests that women feel that they can more easily say no to the violence and that men are starting to understand that they cannot use violence as easily because women have options they have not had before.

5.6 Outcomes Assessment

The following summarises the interim evaluation's assessment of progress made towards the Pilot program's anticipated short-term outcomes.

Table 3: Interim Evaluation Outcomes Assessment

Anticipated Short Term Outcomes	Interim Assessment	Details/Comments
Provision of culturally secure and holistic responses to FDSV including case management and wrap-around support	✓	*Unique program facilitating tailored service design and delivery in six ACCHOs, resulting in FDSV services that each respond to the needs, contexts and nuances of the communities involved and the local service system/landscape. Avoiding a one size fits all approach to service design and leveraging the trust and confidence Aboriginal people have in their ACCHOs.* *Provision of client-led, case management services that work with individuals but also families and understand both the need and how to deliver a culturally secure and holistic FDSV service.* *Understanding by staff that safety planning is highly specialised and needs to take account of the community context and cultural factors at play in the community/clients lives.*
Provision of a response that is place based and in context	✓	

Services for Aboriginal people, delivered by Aboriginal people	✓	*A mixture of Aboriginal and non-Aboriginal staff involved in FDSV service delivery, non-Aboriginal staff in some sites have long established relationships to the community, other sites are offering staff mentoring and culturally safe workplaces.* *Some sites are providing jobs for local people and utilising their community knowledge and trust in the community as an integral part of the program/service design and delivery.* *Local knowledge of staff employed at some sites is an important factor to the trust and confidence community have in the service and the effectiveness of the service model response to FDSV.* *Careful recruitment of non-Aboriginal staff at some sites who understand importance of adhering to the ACCOs models of care and cultural safety protocols.*
Raising awareness of the harmful impact of FDSV in the community through culturally secure education	✓	*At some sites there is dedicated awareness raising among community through the use of appropriate methods such as On country trips, bush camps with Elders, incorporating discussion of FDSV into weekly men's and women's meetings, community cook-ups hosted at the health service, art therapy groups, children playgroups and other opportunities where community are present such as Football events.*
Provision of opportunities for healing and recovery	✓	*Some sites providing healing camps, other providing healing activities such as Art groups, cooking, and/or a safe space to talk, connect, and heal from trauma.* *Service design at most sites embeds a recognition and response to the impact of trauma on family violence and the central role of a holistic healing program to respond to FDSV.* *Some sites providing psychoeducation and counselling to clients.*

Clients experiencing or at risk of FDSV are assisted to enhance their safety	✓	*Case management approach that includes appropriate safety planning once a client is out of a crisis situation, as sites are not set up to provide immediate crisis response but work with clients after the crisis and capacity build clients to be able to better manage crisis situations.* *Evidence that staff are utilising safety planning that is mindful of the community context including limitations imposed by remote locations with few or no services and small communities. Training in safety planning has been provided to support staff at some sites.*
Improved collaboration and coordinated service delivery to provide wrap around intervention to keep women and children safe and manage risks associated with perpetrator of FDSV	✓	*Evidence of sites developing and implementing internal and external processes and relationships to achieve effective collaboration and coordinated service delivery. Across the health service with SEWB teams, GPs, nursing staff, maternal and child health teams, counselling staff, and externally with WAPOL, other FDV services, courts, women's refuges/safe houses, CPFS, housing and accommodation services. Evidence of networking and effective advocacy by the sites with other FDV services and organisations that can facilitate wrap around support. In some sites there is well defined wrap around service provision provided via such things as Multi Agency Case Management meetings.*
Increased perpetrator responsibility for abusive behaviours	Initial steps	*Currently two sites are working with perpetrators. Male staff employed at two sites.* *Evidence of culturally appropriate tools for engaging men to recognise and address patterns of violence and effective engagement of community members through Men's groups, and men linked with SEWB teams. Focus at one site on capacity building men from the community to mentor and support others.*

6 Summary

Family violence in Aboriginal communities takes many forms. It can be intimate partner violence but can also be broader. Other forms of violence include children and young people, lateral violence, abuse of Elders and intra-family violence. There are many factors that underpin family violence in Aboriginal families and communities such as cultural, historical, familial. The awareness and knowledge of the complexity of these factors and how they manifest is important to understand how to respond to families and their needs. The FDSV Pilot programs at five of the six ACCHS sites are evidence of the importance of this knowledge and understanding how service design and delivery can support families. The FDSV Pilot is also evidence of the importance of situating this program within the ACCHS to ensure families can access culturally safe, holistic and trauma informed services.

In some sites this has meant that these issues are being openly discussed with and by members of the community, and that where previously community members did not explicitly present for FDSV reasons - many now are. For those who are working in and with these communities – many for a long time, this shift is regarded as a very important change. It is contributing to raising awareness about FDSV, increasing community understanding of the importance of not tolerating violence and not treating violence as 'private business' or 'shame' and to support people to access help.

Relationships with community are critical to the FDSV services, not just as clients – but relationships with Elders and community leaders are equally important as a source of knowledge, for co-design of services and activities, and for enhancing awareness of FDSV. Relationships with community also facilitate community members being proactive in supporting action against FDSV and encouraging the use of the FDSV service. Local knowledge of staff employed in the FDSV Pilot sites and their relationships with community – especially in remote sites, is also critical to the trust and confidence community have in the service and the way in which FDSV is responded to.

The Pilot is an example of the importance of variation in an FDSV service delivery model and the role that context plays in the design and delivery of services. The different ways in which each ACCHS approaches its FDSV service delivery is in part dependent on existing strengths of each of the services/sites– and the differences in the service environment in which they are operating both internally and externally.

6.1 Pilot Program Strengths

6.1.1 Located in ACCHS

The ACCHS are uniquely positioned to offer a range of services within the one setting and provide FDSV clients a holistic and wrap around support service. Other unique characteristics and strengths of the Pilot programs resulting from their location within an ACCHS include:

- culturally appropriate models of care
- Aboriginal governance overseeing the programs
- culturally safe service provision
- trauma-informed therapeutic services and activities with a focus on healing for the individual and the family where possible, including on-country camps, art, and yarning circles
- staff with connection to and knowledge about cultural values, kinship and familial networks and obligations.

6.1.2 Unique service design

Differentiation in the service delivery models across the six sites reflects the need for services that can respond to the different contexts from which the services are operating. This variation is further evidence of the fact that a one size fits all approach to service design is not suitable when working with Aboriginal communities in regional, remote and metropolitan areas. Comparing two sites such as DYHS (a metro location) and NAHS (a remote community location) shows there are particular differences in what people want from their service, how it can respond and the types of supports it can provide.

6.1.3 Culturally appropriate ways of working

Knowledge of local contexts is critical to the delivery of services and the everyday practices of staff. Many of the sites have employed staff who have or are developing good FDSV skills, but also insights into the intricacies of local community issues, beliefs and cultural practices that can impact and underpin family violence. Tools and resources utilised by the sites vary and are responsive to the community's needs, ways of learning about FDSV and behaviour change. Some sites are developing or modifying tools and resources for use with clients to ensure they are appropriate. A good example is the use of Preston's Path at YYAMS. This visual tool is reported by the FDSV staff as effective in engaging men/perpetrators to reflect on their abusive behaviour, identify goals and strategies for behaviour change. Staff report that is assisting men to recollect strategies for behaviour change as well as reflect on their progress.

6.1.4 Advocacy

The Pilot program sites are playing a critical role in working to have many mainstream services respond in more appropriate and safe ways for Aboriginal women and to better understand their needs and the nature of FDSV in Aboriginal communities. This involves advocating for clients with organisations and service providers that aren't trauma informed and do not have staff adequately trained to provide culturally safe services.

6.1.5 Engagement with the community

Through co-design of the service and /or education and awareness raising, the Pilot programs are having positive impacts in the community. Staff have expressed surprise at how willing many in the community are to engage and support the service and to talk about violence.

6.2 Pilot Program Challenges

- Recruitment and retainment of appropriate staff.
- Sourcing suitable and accessible training for staff working with FDSV in Aboriginal contexts.
- Developing procedures, polices and processes that formalise ways of working and embed safety for all involved.
- Ensuring service delivery models are defined and documented and can be passed on and not reliant on individuals.
- Managing community expectations of the FDSV service – especially for many sites that are not able to provide a crisis response service. Many clients are constantly dealing with crises and are coming to the services during a crisis when the Pilot sites are not set up to respond to these situations. The sites are focusing on capacity-building clients to educate and develop their skills for better management in a crisis and are continually safety planning with clients to respond to the different situations they find themselves.
- Safety and risk management in remote communities. Some programs are operating in locations with limited or no services and resources for ensuring women's safety. Crisis intervention in small and remote towns is also very difficult and presents its own risks. Often the safest option is to support the victim-survivor to leave yet leaving safely can be very tricky. Not only do services need to safety plan for the individual or family that they are evacuating, but they also need to safety plan for the family that remain who might be blamed by association as well as the staff involved. Other challenges relate to ensuring

women's confidence can be maintained in small communities, and women learning to trust they can be forthcoming and disclose what is occurring.

- Building trust with clients and stakeholders - against the backdrop of a time limited Pilot. Trust involves ensuring people feel they can rely on a service longer than a year.
- Much of the systemic advocacy involved in dealing with an unsafe service landscape for Aboriginal clients is not explicitly funded under the Pilot program and yet plays a critical role in improving the FDSV service delivery for Aboriginal families.
- It is difficult to always capture the progress that is made in FDSV service delivery and reflect the gains at an individual client level in a short time. Progress reporting doesn't necessarily capture the nuances and complexities of FDSV work, which can be gradual and non-linear in nature and not always easily measured.

7 Recommendations

The interim evaluation identified some lessons learnt from which the following recommendations were drawn. These are put forward for consideration in the remainder of the Pilot program.

1. **Program Logic:** Develop[2] and finalise a program logic for the Pilot.
2. **Service delivery map:** Develop[2] and finalise a service delivery map that identifies the elements to the Pilot program and captures the cyclical nature of the client journey.
3. **Continuous Quality Improvement (CQI):** Support services to complete CQI activities to help embed change into their current service.
4. **Reporting:** Introduce changes to the Pilot progress report template to address inconsistencies in reporting and enhance the site's capacity to demonstrate the impact of their service delivery model and community engagement strategies.
5. **Workforce Development:** AHCWA to consider developing a 'FDSV Workforce' for ACCHS including a workforce development strategy with a set training requirements and core competencies including requirement for FDV-Informed Practice Supervision Training for all Team Leaders.

[2]Work is already underway by AHCWA for the program logic.

8 References

1. Department of Social Services. Aboriginal and Torres Strait Islander Action Plan 2023–2025 Canberra: Commonwealth of Australia, 2023:29.
2. Tulich T, May S, Blagg H, et al. Understanding the role of Law and Culture in Aboriginal and Torres Strait Islander communities in responding to and preventing family violence: ANROWS 2020.
3. Department of Communities. Path to safety: Western Australia's strategy to reduce family and domestic violence 2020 – 2030. Perth: Government of Western Australia, 2020.
4. Department of Communities. Aboriginal Family Safety Strategy 2022–2032. Perth: Government of Western Australia, 2022.
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9 Appendices

9.1 Appendix A: Staff online survey questions

The following survey seeks your reflections on your FDSV role and involvement in the FDSV Pilot. This survey is part of an independent evaluation of the FDSV Pilot that is being conducted by a team at Edith Cowan University.

By completing this survey, you are consenting to the information you provide being utilised by the evaluation team in their assessment of the FDSV Pilot. The survey is anonymous, and your answers will only be seen by the evaluation team.

Do you identify as

O Male

O Female

O Other

O Prefer not to say

Are you

O Aboriginal

O Torres Strait Islander

O Both

O Neither

Please indicate education you have completed

O Postgraduate Degree

O Bachelor Degree

O Diploma

O Certificate IV or below

O Other (Please provide details) _____

O Prefer not to say

Where are you currently employed?

O DYHS

O NAHS

O BRAMS

O YURA YUNGI

O SWAMS

O PAMS

O Prefer not to say

Employment status

O Full time

O Part Time

O Casual

How long have you been in your current role?

O Less than 3 months

O Less than 6 months

O Between 6-12 months

O Between 1-2 years

O More than 2 years

Please provide your job title

_____

Is your role and responsibilities clearly defined?

O Yes

O No

O Prefer not to say

How would you describe the supervision, debriefing, consultation and support you receive in your role as part of the FDSV team**?**

O Very good

O Good

O Adequate

O Poor

O Unsure

How would you rate your level of experience for your role?

O New to this type of role

O Have experience of similar roles

O Have a lot of experience in this type of role

Please indicate how confident you feel in recognising aspects of FDSV?

	Not at all confident	Not very confident	Neither confident nor unconfident	Quite confident	Very confident
Physical abuse					
Emotional abuse					
Financial abuse					
Sexual abuse					

Please indicate how confident you feel in identifying and meeting clients' needs?

	Not at all confident	Not very confident	Neither confident nor unconfident	Quite confident	Very confident	Not part of my role
Risk assessment and identifying immediate safety needs						
Safety planning with clients						
Providing brief interventions						
Identifying and referring for Counselling or therapeutic needs						
Identifying and referring for financial needs						
Identifying and referring for Housing needs						
Yarning / informal counselling						
Providing practical supports						
Collaborating with other organisations to assist client to access supports						
Working with other parts of your organisation (eg SEWB team) to meet clients' needs						

Please indicate the extent to which you agree or disagree with the following statements

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Unsure
I am able to spend enough time with each client						
I have too much paperwork to do						
I have lots of information about services and resources to share with clients to help them						
Our FDV service can meet the needs of those seeking assistance for FDV and related concerns						
Our FDV service is working well with other services and agencies to support FDV clients						
Our FDV service works closely with other teams in the ACCHS/AMS (e.g SEWB)						
Our FDV service is culturally responsive						
The community are supportive of our FDV service						
Since the Pilot started more clients/families are seeking help for FDSV						

Are there specific services that your FDSV clients need but can't access in your community/town/region?

O Yes (Please provide details below about what types of services)

O No

O Unsure

Please select from the following to indicate how you rate the understanding and awareness of FDSV and your service in the community/ies with which you work?

O There is a **very good understanding and awareness** of FDSV and the FDSV service and how to access it

O There is **some understanding and awareness** of FDSV and the FDSV service and how to access it

O There is **limited understanding and awareness** of FDSV and the FDSV service and how to access it

O There is **not a lot of understanding and awareness** of FDSV and the FDSV service and how to access it

O Unsure

Please select which of the training provided by AHCWA that you have attended.

O We Al-li Trauma Informed Care and Practice Workshop

O Safe and Together

O None of the above

How would you rate the training in terms of the following

	Excellent	Good	OK	Not that great	Poor
Improving your skills in responding to FDSV clients					
Enhancing your confidence in your FDSV role					
Giving you new ideas for working with FDSV clients					
Culturally appropriate in its understanding of FDSV					

Giving you new understandings and knowledge of FDSV					

Would you like to access other training/further training for your role?

O Yes

O No

O Unsure

If Yes – Please tell us what sort of training you think you need?

_____

Please tell us if there are other resources or supports that could assist you in your role?

_____

If there is anything else you would like to tell us (this might be about FDSV in your community, your FDSV service, the FDSV pilot, the support from AHCWA, or your role) please provide your comments below.

_____

Thanks for completing our survey

9.2 Appendix B: Interview questions / Discussion prompts

Interview Questions

- What is unique about the FDSV program at this site/ACCHs?
- How has the service model been designed / what was the process – was it a co-design process with community? Through staff at the ACCHS? Extension of existing program? Other?
- What are the referral pathways to the service?
- Does the FDSV program work with community in any ways other than through referrals?
- What other services are you mostly working with?
- What have been the challenges in getting the service going and working well?
- What's working well with the service?
- How have community responded? Have there been noticeable changes in – disclosures, presentations specifically for FDSV, help seeking, conversations about FDSV? Other?
- How are you record keeping actions/ establishing evidence base of the FDSV program outputs/outcomes?
- Capacity building of staff – have there been any issues? Are there future needs for staff?
- What do you see occurring over the next 12 months / remainder of the pilot?
- Anything else you would like to discuss about the FDSV Pilot?