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Indigenous domestic and family violence, mental health and suicide

Kyllie Cripps

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Contents

About the cover artwork:

Artist: Linda Huddleston

Title: The journey towards healing

At the centre of the artwork is the Clearinghouse. The black half-circles are the people who come to the Clearinghouse for information about mental health and suicide prevention.

The waves of red, yellow and white dots surrounding the inner circle represent strength and healing.

The footprints represent the journey towards healing.

The red and white circles around the edge represent different programs and policies aimed at helping people heal.

The hands represent success and wellbeing.

Caution: Some people may find the content in this report confronting or distressing.

Please carefully consider your needs when reading the following information about Indigenous mental health and suicide prevention. If you are looking for help or crisis support, please contact:

13YARN (13 92 76), Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

The AIHW acknowledges the Aboriginal and Torres Strait Islander individuals, families and communities that are affected by suicide each year. If you or your community has been affected by suicide and need support, please contact Thirrili's **Postvention Suicide Support services** on **1800 805 801**.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe suicide and self-harm reporting. Please consider these guidelines when reporting on these topics.

1800RESPECT
NATIONAL SEXUAL ASSAULT, DOMESTIC FAMILY VIOLENCE COUNSELLING SERVICE

Summary

What we know

- Aboriginal and Torres Strait Islander people are overrepresented as both victims and perpetrators of domestic and family violence (DFV). This situation arises when 'people in positions of powerlessness, covertly or overtly direct their dissatisfaction inward toward each other, toward themselves, and toward those less powerful' (Cripps and Adams 2014:400).
- It has been found that, for Indigenous Australians, social and emotional wellbeing form the basis of good mental health. However, due mainly to a long history of trauma, cultural dispossession and forced displacement, suicide is a leading cause of mortality (Martin et al. 2023).
- Family members, especially women and children, are most at risk of being victims of DFV (Langton 2008). Responses to DFV have traditionally had a heavy reliance on the law and the criminal justice system (CJS). Laws provide victims with protection orders and recent law reform has contributed to more proactive policing and criminal charges to hold perpetrators accountable for their conduct (Douglas and Fitzgerald 2018; Nancarrow 2019).
- Current services are focused on responding to actual situations of violence and death. Equal priority should be given to preventing suicide, abuse, homicide and crime through the provision of services and programs to keep families safe and to improve their wellbeing.
- Across Australian jurisdictions, the implementation of several Indigenous frameworks to address issues have promise but work needs to be done to ensure that mental health is effectively integrated and programs are able to demonstrate better and more culturally safe outcomes. These frameworks have the potential, through increased partnerships, collaborative working relationships and information-sharing, to respond holistically to the complexity of DFV as it intersects with mental health and other related issues.

What works

- Responses provided by various agencies and organisations show evidence of the benefits of addressing issues to improve mental health. The AIHW has published articles on Indigenous mental health and its intersections with housing and homelessness (Allen and Clarke Consulting 2022), suicide prevention (Martin et al. 2023; Groves et al. 2022), connection to community (Dudgeon et al. 2022), and the connections between family, kinship and social and emotional wellbeing (Dudgeon et al. 2021). These publications enumerate best practices and models in mental health and suicide prevention and provide an evaluation of existing programs within Australia.
- Evaluations of Australian integrated domestic and family violence models indicate that they work:
  - when perpetrators are held accountable
  - where victims are given more targeted service responses
  - where there are methods to enhance agency accountability
  - where there are stronger relationships among participating agencies and clear delineations regarding responsibilities

  - when participating agencies build community knowledge and awareness around these issues to prevent future violence (ARTD Consultancy 2019; Flanagan et al. 2019; Mossman et al. 2019; Putt et al. 2017; Territory Families 2018).

- Further, when key stakeholders work in a coordinated manner to provide services to prevent and address DFV, they improve the safety of victims and their families through proper risk assessment, information-sharing and improved coordination. This is complemented by stakeholders receiving consistent training; building organisational and sector capability locally; and partnership strengthening (Cripps 2020).
- Exploring the evaluation of New Zealand's pilot model, the Family Violence Integrated Safety Response (ISR), reveals a program that is working and has been proven effective, which aims to provide for both immediate and longer-term safety and wellbeing needs of all concerned (Mossman et al. 2019). It is a model for best practice in terms of its design, implementation, and overall cultural acceptability and effectiveness.

What doesn't work

- Most literature implies that criminal justice responses do not achieve positive outcomes for Indigenous families and communities.

For example:

- Criminalising victims often misidentified as perpetrators (FVRIM 2021; AHRC 2020) exacerbates the experience of violence and abuse. There have been reports of women aiding their partners in committing breaches to orders to facilitate access to children or accommodation. These are arguably justifiable circumstances that do not require the criminalisation of women (Cripps and Habibis 2019; Nancarrow 2019).
- CJS responses remain irrelevant to the lives and contexts of Indigenous women (Jeffries and Bond 2014; Marchetti 2019; Nancarrow 2019). Often, a CJS response escalates violence against women and 'perpetuates violence against men' (Nancarrow 2009:17).
- Women report that CJS responses separate families and offers no resolution to the DFV or the broader contexts that contribute to the violence (Nancarrow 2009:17).
- Criminal justice reforms have been helpful in holding perpetrators accountable, yet reforms need to be more accommodating to the complexities of DFV and its intersections with mental health and suicide.

What we don't know

- The harms associated with DFV have been extensively researched and are well documented in both the Indigenous and non-Indigenous literature. However, how these harms intersect with mental health and suicide as potential precursors to and outcomes of DFV is an area that is still developing.
- Largely absent from DFV research, policy and program responses is how to target the significant number of men who attempt or die by suicide. This is especially the case where there are longstanding, cumulative and systemic problems involving persistent alcohol and other drug use, relationship conflict and interpersonal violence (Fitzpatrick et al. 2022). The ethical and political questions of responsibility, choice and agency are often left unresolved with the finality of death.

- Except for sporadic media reports and specific coroners' reports over the years, there is no research or literature that specifically explores the linking of sexual assault and suicide – despite the known prevalence of sexual assault and its associated harms (Eckermann et al. 2015; Guggisberg 2006, 2008, 2019).

1

Introduction

1 Introduction

Domestic and family violence (DFV) is recognised as a long-standing problem in Aboriginal and Torres Strait Islander communities. For more than 2 decades, through reports and inquiries, government policies, programs and services have attempted to address the complexity of this issue. While policy and program reforms have brought about positive outcomes for some DFV victims, they have also increased the vulnerability of Indigenous populations and resulted in a range of unintended consequences (Cunneen 2009; Douglas and Fitzgerald 2018; Larsen and Guggisberg 2009; Nancarrow 2019). This field has many examples where victims have been criminalised for acts that are, arguably, committed in self-defence or for breaching domestic violence orders for helping their abusive partners to access housing or to visit children. These circumstances lead women to reconsider going to the police.

Indigenous groups have advocated for the need for an alternative approach to the criminal justice response – emphasising, in its place, a holistic response that supports victims; holds offenders accountable; and is equally focused on the healing of families and communities in the aftermath of DFV (Robertson 2000; Wild and Anderson 2007). This holistic response is particularly important when mental health issues may have been part of the reason the violence occurred in the first place.

Two case studies

The two case studies below demonstrate these complexities.

- In the first case, a woman's continued exposure to both (a) excessive violence and abuse, and (b) her partner's mental health condition, affected and exacerbated her own mental health. Despite this, authorities expected her to care for her partner.
- The second case describes how a cycle of abuse and violence led Fionica to consider only one option out of her situation.

These are examples of the complexity that presents when DFV, with its resulting harm, intersects with mental health related issues. They also highlight the difficulties that families, communities and agencies confront while responding to such complex cases, where victims feel they have limited choices available to them. The stakes are high when lives are involved, as these cases demonstrate. There is a need for alternative approaches that give due regard to these lives and to the lives of those at risk.

Case study 1 – Jody Gore

In 2015, Jody Gore, an Aboriginal woman from Western Australia, fatally stabbed her former intimate partner, an Aboriginal man who suffered severe mental health problems. She had been on the receiving end of physical and verbal abuse from him for 20 years. The abuse was exacerbated by his misuse of alcohol and cannabis.

During her trial, she testified to being sworn at, kicked and punched, dragged by her hair, hit with rocks and hit in the face with a belt buckle. She treated her injuries herself. The scars on her body and mind are a reminder of the daily abuse she suffered. There were times when she did not call the police, knowing there were no services within proximity that could have helped her. She didn't want to get her former partner into trouble, given that he had been diagnosed with paranoid schizophrenia.

Many have asked her the question 'Why didn't you leave?' She says:

> The reason why is because you know the saying: when you're legally married, you say 'for better or for worse, in sickness and in health, through good and through bad, till death do you part'. And you stay with them because you love them. Also, you're patient. You think they will change. There's love and understanding and patience. It takes a long time, you know? (Tam 2022).

Government health services acknowledged her former partner's mental health condition yet relied heavily on Jody to support him even after they had separated, and despite knowing he directed his violence towards her. Jody's stabbing of her former partner is now recognised as an act of self-defence. At the time, however, the court proceedings failed to acknowledge the contextual complexity and – having established that Jody was simply in 'a bad relationship with incidents of violence' – sentenced her to life in prison (Douglas et al. 2020; Tam 2022). After 4 years in jail, following significant lobbying by human rights lawyer Associate Professor Hannah McGlade and others, Jody was released under a royal prerogative of mercy. Her sentence was commuted but her murder conviction stands (Douglas et al. 2021).

In interviews since her release, Jody has described both the weight of managing her ex-partner's mental health condition and the reality of the injuries that she had endured and could anticipate from him. At the same time (since 2009) she had provided care for her niece's 3 children and wanted to keep them safe – as well as to manage her own related illnesses. She has reflected on the systems that were unable to manage her ex-partner's condition, or to meet his basic needs for housing and food. If these had been available, it would have lessened his constant and ongoing reliance on her (Tam 2022).

Case study 2 – Death of Fionica

Fionica grew up in a strong family in a remote community. She attended school and achieved good results. At 14 she became involved with an older man, which impacted her schooling. Her family disapproved of the involvement and unsuccessfully tried to keep her away from him. Subsequently he assaulted Fionica and told her that if she did not become his girlfriend, he would hurt her family. During her family's renewed efforts to keep them apart, Fionica began self-harming and attempting suicide.

Various government agencies became involved and, together with her family, they agreed to send Fionica to boarding school in Queensland where she had no family, friends or other support. She became so depressed that for weeks she remained in bed all day and refused to attend classes; she was eventually sent home.

The next year she met another older man. He was the wrong skin and was violent towards her. Her family didn't like him. He had previous violence and intoxication offences and went to prison for breaching his parole. While he was in prison, Fionica went back to school and to counselling but stopped when he was released. Sadly, his violence continued and he crushed and broke her fingers, requiring a regional hospital visit. It was noted at the time that she was suffering from panic attacks.

When Fionica returned to her community from the hospital, the man arrived at her family's house in the early hours of the morning with a spear and axe. He said if she did not return home with him there would be war between their families the next day. She was so frightened that she called the police, but she was told there were no police on duty. She went back to the man, but it seems that, while he slept, she contemplated her options. She woke him to go buy her a Coke and, when he had gone, she slipped out and headed to the bush, where she took her own life (Northern Territory Coroners Court 2020).

The aims of this report

Through a desktop review of current and 'grey' literature, this report aims to highlight how the experience of DFV among Indigenous Australians is influenced by current law, policy, programs and services. It discusses research and/or programs where DFV intersects with mental health and/or suicide.

More specifically, the purpose of this report is to:

- gain an understanding of the existing evidence regarding Indigenous DFV and its intersections with mental health (if any)
- identify policies and frameworks that respond to domestic and family violence; improve Indigenous mental health; and help to prevent suicide and suicide-related behaviour
- enumerate current integrated services, and identify a model of best practice, if possible
- identify gaps in the literature and in policies and DFV integrated services
- provide recommendations for future DFV integrated models.

2

Background

2 Background

Naming and defining domestic and family violence

As Cripps and Adams (2014) note, naming and defining violence as it occurs within families 'has constituted one of the most extensive, ongoing and controversial issues in the discourse on familial violence' (2014:400).

This is an area that continues to evolve, because it is shaped by societal values, community expectations and the disciplines and professions involved in responding to the harms associated with violence. Law reforms have also played a significant role in defining terms, relationships and behaviours that constitute 'domestic and family violence' (and will continue to do so). In practice, this means that there is often variation within the literature in the terms used to describe domestic and family violence, and these terms are often used as umbrella terms to cover a range of violent behaviours.

Across all Australian jurisdictions, 'family' violence is now commonly understood to include all family relationships, inclusive of those who are 'relatives' according to Indigenous tradition or contemporary social practice. It may also include a person who has provided paid or unpaid care to someone – such as a person with a disability – who is dependent or partially dependent on that person (Blagg et al. 2018). The term domestic and family violence is now understood to include behaviours along a wide spectrum ranging from physical abuse at one end to cultural and or spiritual abuse at the other (Blagg et al. 2018; Cripps and Adams 2014). It is also inclusive of the most recent public debates recognising the influence of 'coercive control'. Coercive control is now understood as a pattern of behaviour which has the cumulative effect of denying victims/survivors their autonomy and independence by controlling, threatening or intimidating them (Moulding et al. 2021; Stark 2012).

This report applies the definition of domestic violence contained within the NSW Health policy directive 'Policy and Procedures for Identifying and Responding to Domestic Violence' (NSW Department of Health 2006:4).

In this directive, domestic violence is defined as:

> … violent, abusive, or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive, or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect upon children and young people and constitutes a form of child abuse.

It has also been widely accepted in most Australian states and territories, that the experience of Indigenous family violence encompasses a broad array of actions and relationships (that are not merely limited to intimate partner violence).

These include:

> Physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers, as well as self-harm, injury and suicide (Family Safety Victoria 2018:54).

As mentioned above, DFV includes psychological or emotional abuse, which is defined as:

> … actions that are used to threaten, intimidate, harass, belittle and humiliate someone else. It can include threats of violence or death toward a woman or to her children, family, friends, work colleagues or pets. It can also include isolating women from family and friends, yelling, damaging property, driving at excessive speed, making unfounded accusations of infidelity, interrogating someone and making threats of self-harm or suicide if the woman attempts to leave (COAG 2019).

Current literature recognises that the experience of DFV now also includes animal abuse (Coorey and Coorey-Ewings 2018). The spectrum of behaviours associated with DFV can be viewed using Figure 1, below:

Figure 1: Spectrum of behaviours constituting DFV

It was reported that, in 2014–15, almost 6 in 10 Indigenous women (57%) who experienced family and domestic violence were physically injured (ABS 2019a). In the same reference period, Indigenous women were 32 times more likely than non-Indigenous women to be hospitalised due to family violence (SCRGSP 2016). Furthermore, in 2016, Indigenous women were 21.2 times more likely to be imprisoned than non-Indigenous women (ALRC 2018).

In coroners' cases from Western Australia and the Northern Territory, Aboriginal youth victims' experiences of domestic violence and sexual abuse – compounded by their unaddressed mental health concerns – may have led them to see no other way out of their 'hopelessness' (WA Coroner 2019). The Western Australian State Coroner's investigation into the death of 13 children in the Kimberley region found that the victims had all experienced either domestic and/or sexual violence and/or alcohol abuse within their homes. If these 13 children had access to proper support their deaths might have been prevented (WA Coroner 2019; NT Coroner 2020).

When it comes to specific abuse categories (such as sexual assault), there is more DFV literature available in the non-Indigenous than in the Indigenous context (Tarzia 2021; Moulding et al. 2021; Humphreys et al. 2021). For instance, in the broader literature, it is noted that persistent victim-blaming contributes to a victim's sense of hopelessness. However, there is little to no research or literature that comments on this in the Indigenous context. This is despite the known prevalence of

sexual assault and its intersections with DFV (as reported by Breckendridge et al. 2015:4–5), and its associated harms – including recent coroner findings linking sexual assault with suicide (Eckermann et al. 2015; Guggisberg 2006, 2008, 2019).

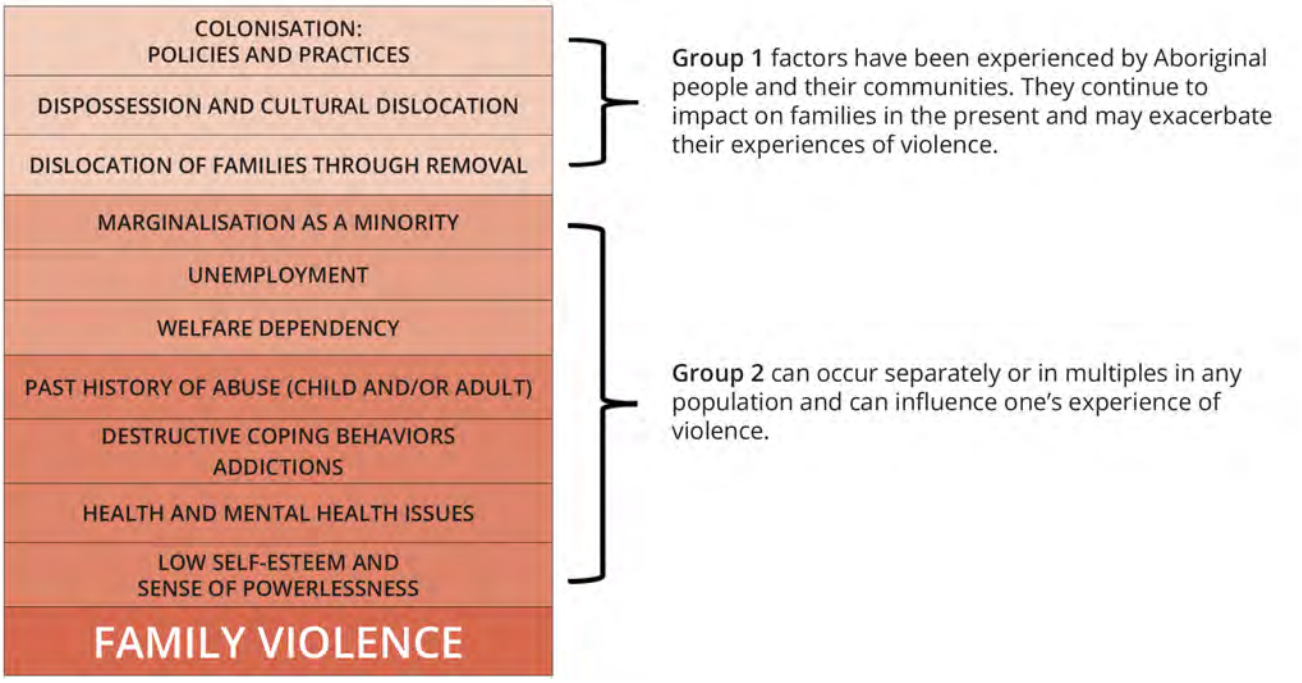
Understanding Indigenous violence in its historical and cultural context

There is a substantial international and national literature asserting that historical and intergenerational trauma is the accumulative emotional and psychological pain that develops over an individual's lifespan and across generations because of a group's collective trauma. This ongoing trauma originates from a history of community massacres; genocidal policies and practices; forced relocation; forced removal of children; and assimilative actions that prohibited the practice and handing-down of Indigenous cultures (Brave Heart et al. 2011; Evans-Campbell 2008, Menzies 2019). This trauma is reinforced by social marginalisation, as well as experiences of incarceration and racism. It is further compounded when individuals encounter domestic and family violence such that typical symptoms that can develop include a deep mistrust of self and others, including family; fear and anticipation of betrayal; shame and humiliation; suicide and risk-taking behaviour; as well as substance abuse (Atkinson 2002; Evans-Campbell 2008; Krieg 2009; Menzies 2019; Tilbury 2009).

The contexts in which the violence occurs and the circumstances and factors that lead up to the violence are best understood in intersectional terms (Blagg et al. 2018). A multitude of factors operate collectively to produce a violent event or a series of violent events, in an environment where power and control is held by the person exerting the violence (Blagg et al. 2018; Cripps and Adams 2014).

Figure 2 (below) illustrates the factors that come into play.

Figure 2: Intersecting factors leading to family violence



Source: Cripps 2004; Cripps and Adams 2014:405.

It is important to note that, when discussing violence with victims in the Indigenous community, their communication choices must be respected. The terms they use to describe their experience, or that of others, is a choice that is responsive to their circumstances and their sense of safety. Several Indigenous authors have written about the practice of 'Dadirri' or 'deep listening'. Victims willingly share their stories, in the language that is most comfortable for them, and practitioners are asked to listen deeply; connect with their story; appreciate and reflect on the silences; hear their pain; understand their grief; and respect their strengths.

If we fail to hear and give the time for the stories to be told, we miss crucial opportunities to build rapport and trust with victims and their families. But more than that, we may miss important information that could help ease their situation and/or save a life (Atkinson 2002; Ungunmerr-Baumann et al. 2022).

Understanding Indigenous mental health within the social determinants of health framework

In the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018–19, 24% of Indigenous Australians reported that they had been diagnosed with a mental health condition such as anxiety (17%) or depression (13%) (ABS 2019b). For both mental health conditions, females (21% and 16%) were more likely to report the condition than males (12% and 10%). In the same survey, 31% of Indigenous Australians reported experiencing 'high' to 'very high' levels of psychological distress.

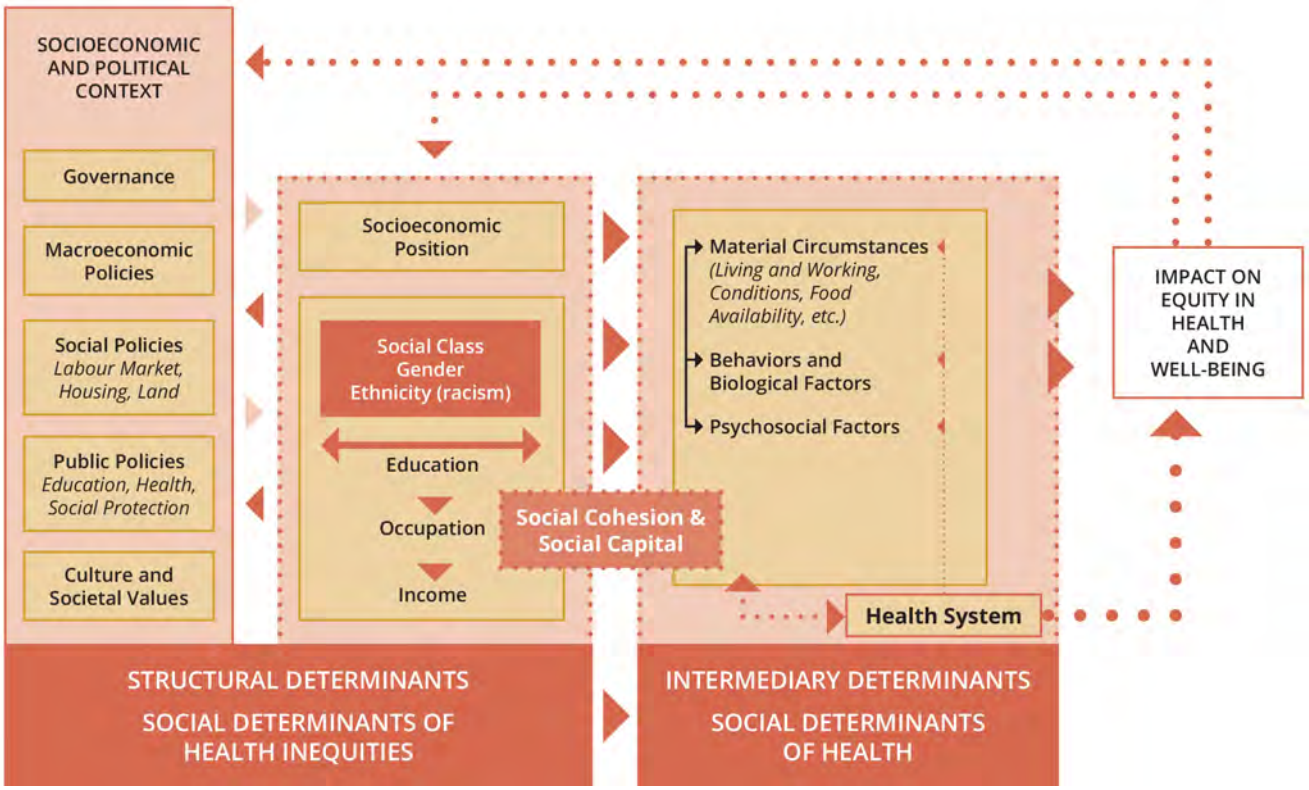
It has been found that psychological distress, as a contributor to mental ill-health (Kelly et al. 2009), is also a risk factor for suicide (PMC 2017). According to an Australian Human Rights Commission report (AHRC 2020), a major factor behind the high rates of suicides among Indigenous Australians was the lack of an early diagnosis – and that culturally appropriate responses could have helped prevent suicide (AHRC 2020).

Indigenous Australians hold a holistic view of good mental health that includes the social and emotional wellbeing (SEWB) of families, cultures, and communities around them (Martin et al. 2023). This is similar to the World Health Organization's definition wherein mental health is seen as a state that allows individuals to manage and cope with their stresses, work and live well within a community, build harmonious relationships and make decisions that shape their world (WHO 2022). For Indigenous Australians, good mental health reforms are those that include a recognition of their history of trauma, grief and loss; together with a cultivation of their cultural and spiritual wellness; and coupled with a belief in their capacity for self-determination. These are some of the principles outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and SEWB 2017–2023 (Commonwealth of Australia 2017). Gupta et al. (2020) conducted a review of programs and services that adopted the principles outlined in the framework and found successes and areas for improvements including that of investing in more 'proactive health-promoting approaches'.

Such an approach can be better understood using the social determinants of health framework as described by the WHO's Commission on the Social Determinants of Health 2008 (CSDH 2008). Put succinctly, one's overall health and wellbeing are determined by the interplay of various factors including the socioeconomic and political context, the individual's socioeconomic position and other material circumstances, behavioural, biological and psychosocial factors. Population groups are

'stratified according to income, education, occupation, gender, race/ethnicity and other factors; and these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants)' (CSDH 2008).

Figure 3: The WHO Social Determinants Framework



Source: Solar and Irwin 2010:6.

The framework emphasises the importance of implementing effective policies that will positively affect every individual's socioeconomic position, but notes that effective policies are only achievable if lawmakers consider both the structural and intermediary determinants of health and health inequities while enacting these laws.

An AHRC report (2020) emphasises the need to couple the framework with a strengths-based approach to bringing about structural reform. Merely focusing on the capacity for self-determination and community action will not be enough if structures continue to perpetuate a cycle of violence and discrimination, without provision for resources to support individuals (AHRC 2020).

It is relevant to mention that Australian health (and mental health) policies are grounded on the same framework discussed above. There are a good number of mental health initiatives for both non-Indigenous and Indigenous Australians: programs for Indigenous Australians are outlined and evaluated in the Indigenous Mental Health and Suicide Prevention Clearinghouse article *Connection to community* (Dudgeon et al. 2022).

Initiatives based on cultural continuity (which acts as a theory of self-determination) were found to reduce youth suicide, strengthen cultural identity and empower Elders (Dudgeon et al. 2022). However, implementation of such initiatives poses challenges when dealing with imprisoned Indigenous Australians who have been removed from their land, community and families (AIHW 2021a).

3

Methods

3 Methods

In acknowledging the breadth of the above DFV definitions, a comprehensive search was undertaken to capture traditional academic and evaluative research as well as available grey literature. The term 'grey literature' refers to research that is either unpublished or has been published in non-commercial forms.

To capture the appropriate material for this report, a staged approach was undertaken. In the first stage, a comprehensive search was undertaken for reviews, publications and evaluative studies between 2000 and 2021. Literature was retrieved through separate searches using the terms 'Aboriginal' or 'Torres Strait' or 'Indigenous' in combinations with family, domestic, violence, abuse, program, service, response, intervention, hospital, emergency, drug, alcohol, substance abuse AND combinations of 'mental health', 'suicide*', 'self-harm'. It should be emphasised that the search was limited to studies specific to Australia in the first instance and broadened to include international studies when search results were producing very limited Indigenous specific content.

The publications chosen most clearly demonstrated an awareness or consideration *to some degree* of the intersectional nature of Indigenous DFV, mental health, self-harm or suicide. This search was supplemented by following up on citations from the identified documents.

Examples of databases searched are detailed in Table 1.

Table 1: Search Databases

AGIS-ATSIS	JSTOR
APAIS-ATSIS	Lexis Nexis Medline (Ovid)
APAIS-HEALTH	ProjectMuse
ATSIHEALTH	Proquest
BIOMED	Psycinfo
CINCH-ATSIS	PubMed
CINAHL	Scopus
Family Studies Abstracts	Social work Abstracts
Family & Society Studies Worldwide	Violence and Abuse Abstracts
Family & Family ATSIS	Wolters Kluwer/CCH
Indigenous Australia	Westlaw AU
Indigenous Collection	Web of Science
Informit	

In total, about 85 articles, studies and reports were reviewed. (Refer to Appendix A for a more thorough description of the methodology used.)

4

Key issues

4 Key issues

There is an abundance of research on the impacts of DFV on mental health, but mostly on non-Indigenous populations. If included, current research makes limited mention of, or does not differentiate between, participants' Indigeneity.

DFV and mental health

There is a scarcity of scholarly research on the interaction between primary health care and mental health for Indigenous Australians in remote Australia (Carlin et al. 2022). Carlin et al. (2022) found that the most noted psychosocial stressors included recurrent family violence, drug and alcohol use, housing problems and family conflict, and that these were usually presented with mental ill-health, suicide or self-harm. They note that interviewed participants reported not receiving any formal therapeutic interventions and had limited engagement with SEWB workers (Carlin et al. 2022).

Despite widespread evidence in the general population of the co-occurrence of DFV and mental health harms, there is a lack of widespread engagement from mental health service providers in identifying or responding to DFV or with 'treating mental health as a symptom of abuse' (Humphreys et al. 2021:300; Nyame et al. 2013; Trevillion et al. 2016). Indeed, many victims struggle with a formal diagnosis of mental illness, expressing that this can feel that it ignores the violence and makes them the problem (Moulding et al. 2021). The subsequent fixation then by health professionals on treating symptoms such as anxiety, or depression as separate from the women's experience of DFV is reported to be unhelpful with some literature warning that it can be re-traumatising and damaging (Humphreys 2021; Moulding 2020; Sweeney et al. 2018).

Women

The literature in this field broadly highlights the destructive impact on women's mental health because of DFV (Moulding et al. 2021; Humphreys et al. 2021). Mental health conditions that have been specifically linked to DFV include depression, post-traumatic stress disorder (PTSD), suicidality, alcohol abuse, drug abuse, anxiety, self-harm, and suicidal feelings and thoughts (Moulding et al. 2021; WHO 2013). Studies have also shown that women who report past and current experiences of violence are almost 6 times more likely to experience psychological distress, with multiple forms of abuse increasing the severity of mental health problems (Moulding et al. 2021; Laing et al. 2010). Those who accessed mental health services mentioned the following difficulties: inconsistently-applied supports; limited working hours; time-consuming waits; high staff turnover; inaccessible centres; and lack of childcare. They mention that these challenges leave them feeling culturally unsafe, frustrated, and confused (AHRC 2020:424–425).

The following are some relevant statistics:

- In the period 2017–18, just over 2 in 5 Indigenous homicide victims were killed by an intimate partner, with Indigenous female victims more likely (89%) to be killed this way than Indigenous men (24%) (Bricknell 2020:12).

- In the 2014–15 National Aboriginal and Torres Strait Islander Social Survey, it was reported that for 63% of Indigenous women and 35% of Indigenous men who experienced physical violence, a family member was the perpetrator (ABS 2016).
- Indigenous women were 32 times as likely to be hospitalised due to DFV than non-Indigenous women (AIHW 2022b).
- A report for the 2022 Senate inquiry on missing and murdered women and children presented data from the AIHW National Mortality Database (NMD). It was reported that over the period 2006–2020, there were a total of 220 homicide deaths among Indigenous females across 5 jurisdictions in Australia representing 23% of all female homicide deaths during that period (AIHW 2022c).

Following an incident of DFV, many women describe losing their identities, their trust in others and their sense that the world is safe (Moulding et al. 2021). When coupled with experiences of degradation and humiliation that accompany acts of violence, especially sexual violence, the compounding impact on a victim's concept of self and bodily integrity can lead to severe psychological and health risks – including suicide and non-fatal self-harm (Guggisberg 2019:188; Boyd 2011). Guggisberg's research participants spoke of feeling helpless and of there being no way out of relationships. Guggisberg argues that suicidal ideation can be considered a form of resistance, representing a victim's radical attempt to escape the violence she is experiencing. Such ideations are not actualised but in worse case scenarios, the victims can become the offenders during an act of self-defence. Many cases of DFV are only discovered in hospital presentations for serious injuries or in police callouts where women themselves become the main perpetrators of serious assaults or homicides while trying to defend themselves (Morgan 2021).

The literature highlights that all forms of DFV are harmful and can detrimentally impact women's mental health. However, there has been an increased focus on the poorer outcomes that appear to be related to sexual abuse impacting women over their life course (Hamdullahpur et al. 2018). There is speculation that this is a more hidden and less spoken-about form of abuse. In these circumstances, victims feel an acute sense of betrayal and speak of this violence as being a multipronged attack that affects every element of a woman's body and mind: 'causing damage from the inside out' that is inescapable (Hamdullahpur et al. 2018; Tarzia 2021:289).

Many women have turned to substance use as a means of coping with the trauma and physical pain of violence (Williams et al. 2021). While many have been exposed to family substance use at young ages, some have been coerced into using drugs and alcohol as part of the abuse (Cripps and Habibis 2019; Williams et al. 2021). These women report the mixed results of turning to alcohol and other drugs. While they can help to relieve or numb the pain and help them forget their experiences, it can also contribute to feelings of low self-worth, shame and social isolation and increase stigma (Williams et al. 2021:1004).

Children

Children's exposure to violence and subsequent risk for mental health issues is also evident in the literature (Humphreys et al. 2021; Laing and Humphreys 2013; Menzies 2019). Two in 3 children who have been exposed to DFV, go on to experience sleep disturbances (which are a demonstrated early risk indicator for emotional and behavioural difficulties) and adult anxiety disorders related to PTSD (Menzies 2019; Insana et al. 2014). Twizeyemariya et al. (2017:319–320) support these findings in their examination of data from the Longitudinal Study of Indigenous Children. They found that more than 43% of Indigenous Australian children aged 6 to 10 years have 6 or more risk factors for mental illness in adulthood and that 23% are experiencing current psychological distress – with 41% of children exposed to domestic violence by age 10 (Twizeyemariya et al. 2017).

In 2020–21, emotional abuse (which includes exposure to DFV) was the most common type of substantiated harm (48%) experienced by Indigenous children (AIHW 2022a: Table S3.10). These children were the subject of substantiations of abuse and/or neglect at 7 times the rate of non-Indigenous children (AIHW 2022a).

Indigenous mothers do contact child protection authorities primarily to report cases and incidents of family violence and emotional abuse (AHRC 2020), but they hesitate at times for fear that children will be removed from their custody if authorities fail to appreciate the complexities of their situations. Decision-making in cases such as these are often led by risk frameworks with little attention paid to identifying and nurturing parental strengths. This can create additional stressors for parents involved with these systems.

Indigenous mothers also emphasise that they have utilised police as a source of support but have found response times tend to be slow. They are fearful of the consequences of reporting, which can at times prevent them from doing so (AIHW 2021b). Additionally, mothers report that access to services for children and youth tend to be limited or unavailable, and that language and cultural practices become barriers to an adequate response (AHRC 2020).

Evidence indicates a strong relationship between child sexual abuse and physical and psychiatric illness, including psychosis; mood disorders; PTSD; generalised anxiety disorders; and elevated rates of suicidality (Hamdullahpur et al. 2018). There also appears to be a link between sexual abuse and an increased risk of alcohol dependence, especially for those who have also experienced other types of child abuse including physical abuse and the witnessing of family violence (Hamdullahpur et al. 2018:1968).

Men

An Australian coronial study of suicides of men involved in interpersonal violence prior to their death found that 53% of men visited a health service at least once in the 6 weeks before their suicide (Fitzpatrick et al. 2022). Of these visits, 41% were related to mental health or alcohol and drug services, 27% were to an emergency department, and 20% to a primary care provider. In these health settings, the violence towards family members, including the threat of suicide, was primarily attributed to a transient situational or emotional crisis in which mental illness and/or alcohol or drug use were considered contributory factors. Treatment was focused on managing the crisis, primarily with medication. Fitzpatrick et al. (2022) found there was little evidence for the effectiveness of these interventions.

Fitzpatrick et al. (2022) indicate that almost 50% of men who had a history of violence had been in contact with the police at least once in the 6 weeks before their suicide. As primary responders to family and intimate partner violence and mental-health crises, police make important decisions about whether the criminal justice or mental health systems are the most appropriate pathways (Morgan 2021; Fitzpatrick 2022). Despite police involvement, it appears that none of the men in Fitzpatrick's sample received specific treatment or programs to address their violent behaviour. Their key focus was on managing the 'crisis' of their mental health or the criminality of their actions and exacting a consequence in some instances by way of a domestic violence order potentially further exacerbating the situation.

The complexity of men's emotional practices and the ways by which they externalise distress and anger during acts of violence and suicide have been made more apparent during coronial inquests and death reviews (Fitzpatrick et al. 2022). Coroners have identified several problems in risk assessment, patient discharge, follow-up and support, with a distinct lack of service integration between services that might enable holistic care (Fitzpatrick et al. 2022).

Current research evidence suggests that short-term mental health and criminal justice interventions may be insufficient to bring about substantive behavioural change in men. Since poor mental health or psychological distress may be exacerbated by alcohol and other drug (AOD) use, there is a clear need for interventions to be more holistic. This includes addressing the multiplicity of factors contributing to the given situation through access to well-resourced, targeted, integrated health and community services and DFV programs (Fitzpatrick et al. 2022; Chandler 2021; DV Prevention Council 2016). There must be a connection and, where appropriate, integration between targeted behavioural change programs and substance-abuse programs, and full evaluations regarding their effectiveness must be conducted.

While males are over-represented in the criminal justice system due to DFV, it is worth mentioning that men are likewise at risk to the experience of DFV. In 2021–22, 1 in 18 men have been subjected, since the age of 15, to some form of violence by a cohabiting partner (ABS 2023).

LGBTQIASB+

While LGBTQIA+ persons have DFV experiences similar to those of heterosexual-cisgender women, they are also subjected to threats to 'out' a partner's identity, undermine their gender, isolate them from the community or withhold their transition-related hormones (Bornstein et al. 2006; Donovan et al. 2020, Peitzmeier et al. 2019). Although they display high levels of agency and resilience, Indigenous LGBTQIASB+ persons experience discrimination and violence from non-family members and are at an even higher risk of family violence, assault, and harassment (Day et al. 2023). They may be hesitant to report forms of abuse and violence and may choose to not access health, mental health and suicide prevention services due to previous experiences with authorities and other first responders (Day et al. 2023).

DFV as a risk factor for suicide

Studies have shown that violent behaviour is a risk factor for suicide, irrespective of the presence of other mental health conditions, or of alcohol or drug use (Fitzpatrick et al. 2022; O'Donnell 2015; Scourfield et al. 2012; Stenbacka et al. 2012). In Victoria, postmortem toxicological profiles of Indigenous Australian suicides from 2009 to 2016 indicate that 40.6% contained alcohol;

42% contained illegal drugs; and 53.6 % contained pharmaceutical drugs. The primary interpersonal and contextual stressors identified in these suicides were conflicts with a partner (44.9%); conflicts with family members (43.5%); and experiences of family violence with a partner (36.2%) (where the deceased was either the perpetrator or the victim). It was likewise reported that 47.8% of those who died by suicide were separated from their partner (Coroners Court of Victoria 2020).

The relationship between mental illness, AOD use, violence and suicide are complex (Fitzpatrick et al. 2022; O'Donnell et al. 2015; Varshney et al. 2016). The relationship becomes much more complex when it is interlinked with criminal justice issues; socioeconomic issues including disruption in employment or unemployment related to violence; and family disruption (Fitzpatrick et al. 2022). The need to appreciate the context, interplay and cumulative effects of these factors with mental illness, AOD and violence is critical to understanding how violent situations happen and how they could have been prevented.

Fitzpatrick et al. (2022:1000) found that threats of self-harm were a common tactic of coercive control used by men to instil fear and exert power, often in the context of separation and custody battles. They also found that 'the act of suicide was directed towards specific ends, whether to punish, exact revenge, or lay blame and guilt upon partners, who the men believed had hurt or deserted them' (Fitzpatrick et al. 2022:1001). Coercive control is often used as a form of abuse by an individual with mental health conditions, which further exacerbates the problems experienced by their victims and children. Victims develop mental health conditions as well, and current mental health conditions are profoundly affected by further exposure to displays of coercive control.

DFV, criminal justice system and mental health

People who experience DFV rely on the police and the criminal justice system to keep themselves and their children safe. Protection orders (POs) issued by the criminal justice system provide some level of assurance that offenders will not be able 'to stalk, harass, assault, intimidate, go near or damage anything that belongs to the victim' (Cripps 2020). However, people with mental illness often report negative perceptions of police treatment (Morgan 2021). Police have broad discretionary powers, and their operational guidelines provide directions to officers on how to use those powers 'lawfully, ethically and efficiently' in complex situations including when encountering persons with mental illness in domestic violence contexts (Carroll 2023:1). Between 10% and 30% of Australian police time can routinely be spent in the management of people with mental illness, for a variety of reasons (Morgan 2021).

Research by Morgan (2021) found that a police officer's attitude and perception of people with mental illness will likely determine that person's fate. Police officers need to decide whether to use the criminal justice system or mental health services. These pathways lead to very different outcomes for people with a mental illness who have encountered the police. Despite an over-representation of people with mental illness in police custody and in prison (Ogloff et al. 2007), there is a lack of information in the literature on the decision-making process at the intersection of domestic violence and mental health (Morgan 2021). Further, the added complexity of race is also important, given the historical and contemporary relationships with police in Indigenous communities. Consider the coroners' report of the case of Roberta, discussed below.

Case study 3 – Roberta

Roberta and Lorenzo commenced a relationship in March 2016. Her family didn't approve of the relationship. By January 2017, Lorenzo had accused Roberta of cheating on him and had severely beaten her, punching and kicking her to the head and upper body. In February 2017 he was arrested and charged with aggravated unlawful wounding and was fined. The following month Roberta was with family and friends and, in what a judge referred to as a 'jealous home invasion', Lorenzo beat an elderly relative who sought to protect Roberta.

Lorenzo was sentenced to imprisonment for 4 years and 7 months (suspended after 2 years provided he remained under the supervision of a probation and parole officer for 18 months). The conditions of his parole required that he enter into a residential drug and alcohol program where no mobile phones were allowed, he was not to consume alcohol, and that he was to wear an electronic monitoring device.

According to records, Lorenzo participated 'extremely well' in the rehab programs, including a family violence program, although he was described as a 'quiet participant'. He was also participating in counselling to address his anger-management issues.

Yet despite these programs, Lorenzo was actively breaching parole conditions. From the moment he was released, he was pursuing Roberta on a mobile phone smuggled into the residential program. Once Roberta was located, Lorenzo consumed alcohol and his abuse of her recommenced. The fatal assault was the 7th time that Roberta's partner had abused her in less than 2 weeks. It was 5 days after Roberta had been told by police to 'stop calling us'. Acting Coroner Elizabeth Armitage summed up this case as one in which police failed to follow any of their procedures concerning domestic violence complaints and that their manner towards Roberta was rude and dismissive. But these actions and failures were not confined to the actions of police alone. The triple-zero call operator incorrectly classified Roberta's calls for help, and the parole officer tasked with supervising Lorenzo was oblivious to his breaches of parole conditions despite Roberta's clear and repeated reports to police that he was on parole and that he was wearing an electronic monitoring device.

The coroner in this case concluded that police 'did nothing to help her'. However, it would appear that neither did any of the programs or services that Lorenzo was engaged with. While he may have appeared to be actively participating, his subsequent actions told a different story (Northern Territory Coroners Court 2019, *Inquest into the death of Roberta Judy Curry*).

5

Policy context

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This section describes the key policies and frameworks that are dedicated to responding to both domestic and family violence, to improving Indigenous mental health and to preventing suicide and suicide-related behaviour.

National Plan on Violence against Women and their Children

The National Plan to Reduce Violence Against Women and Their Children 2010–2022 was released in February 2011. This plan, committed to by state and territory governments and led by the Australian Government, has been a shared commitment to drive responses towards ending and preventing violence against women (COAG 2016; COAG 2019). During the 12-year period of its operation, 4 3-year action plans were developed to drive implementation. While it has had its challenges – given the enormity of the problem – what has not waned is the various governments' ongoing commitment to tackling a problem that continues to plague our communities.

In October 2022, the Australian Government launched the new National Plan to End Violence against Women and their Children 2022–2032 (the Plan). Informed by extensive consultations with stakeholders, people with lived experience and Aboriginal and Torres Strait Islander communities, the plan seeks to align with healing journeys, the right to self-determination and agency (Fitz-Gibbon et al. 2022). The 2022–2032 National Plan described some key successes of the 2010–2022 National Plan, including strengthening service responses and establishing Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS), the 1800RESPECT helpline and the Stop it at the Start campaign.

The 2023–32 National Plan reports that women increasingly felt safer in their private and community environment. However, it also reported that the 2010–2022 National Plan had been unsuccessful in its goal of significantly reducing violence against women and children (DSS 2022). The new National Plan 'outlines the pathway to improvement in the domains of prevention, early intervention, response and recovery and healing' (DSS 2022:35). Most importantly, it mentions the development of a stand-alone First Nations National Plan (DSS 2022:42) to address the disproportionately higher rates of violence experienced by Aboriginal and Torres Strait Islander women and their children, which is expected to be available in 2023.

National Agreement on Closing the Gap

The National Agreement on Closing the Gap, a formal partnership between the Australian Government, state and territory governments, the Coalition of Aboriginal and Torres Islander Peak Organisations, and the Australian Local Government Association was signed in March 2019. It was built around 4 priority reforms: formal partnerships and shared decision-making; building the community-controlled sector; transforming government organisations; and shared access to data and information at a regional level. Through these 4 priority reforms, the government aims to close the gap in life outcomes between Indigenous and non-Indigenous Australians.

Most relevant to this current review is Target 13 which aims to reduce the rate of all forms of DFV against women and children by at least 50% by 2031. Target 12 is relevant, as it aims to reduce the rate of over-representation of Indigenous children in out-of-home care by 45%. This is pertinent,

given that witnessing DFV is recognised as a form of abuse and is presently acting as a significant driver of the current over-representation. These targets are ambitious, and not without their challenges given that in the broader Australian community, as was noted above, the first National Plan to Reduce Violence Against Women and Children was unable to significantly reduce violence. It will require resources and approaches that are geared to impact change at scale, across the country. Evidence that this is taking place is not widely available at the present time, largely given the COVID pandemic.

One further Closing the Gap target that is relevant to this report is Target 14, which aims for people to enjoy high levels of social and emotional wellbeing through a significant and sustained reduction in suicide within our population. This report has demonstrated the significance of DFV as a factor in the incidence of suicide, and the importance of integrated and sustained service-response systems. The critique above is equally valid here.

Australia is also moving towards a referendum to incorporate an Aboriginal and Torres Strait Islander Voice to Parliament. This is an important step forward for our nation: to imagine a better place for our families, our children, our grandchildren. It will ensure the voices of Indigenous Australians are heard, to assist governments to make better decisions and to achieve better outcomes including in this important space at the intersection of DFV and mental health. It is a step in the right direction for a better future.

The importance of integration approaches

Integration is critical to the success of the national and state-based plans and policies. There is significant overlap across these portfolios, given the intersecting nature of DFV. It is therefore paramount that clear governance structures and implementation plans, with specific commitments and resources, accountability mechanisms and reporting processes, are provided so that progress can be tracked. Zubrick et al. (2014) note that health and mental health systems are influenced by, and encompass, education; law and justice; human rights; and families and communities. As Zubrick et al. (2014:93) comment: 'coordinating policy inputs across multiple sectors to guide planning and services to address mental health and encourage interagency collaboration remains a complex and daunting task'.

Developments in law, policies and programs

Coercive control

There have been several propositions for law reforms related to coercive control that have come about due to the mishandling of specific cases in the past – sometimes due to a misidentification of victims and perpetrators. In these cases, police were unable to apply DFV policy and practice procedures when engaging with victims. Due to this, one law reform that was introduced was the extension of police powers to enable them to issue on-the-spot protection orders (Nancarrow 2019) to keep victims safe. However, this reform also heightened the victims' vulnerability, thereby leading to unintended actions on the part of the victims (Douglas and Fitzgerald 2018) – such as allowing the violent partner to breach protection orders in order to prioritise other needs (such as seeing the children or having a place to stay) (Nancarrow 2019). The DFV law reform's focus on separating families may be safe, yet it leaves victims vulnerable to homelessness and poverty, and opens them up to the risk of losing children to child protection systems (Cripps and Habibis 2019).

Co-location of specialist services

A note-worthy program born out of National Plan to Reduce Violence Against Women and Their Children is the co-location of community-based specialist domestic violence services at police stations (NSW Domestic Violence Death Review Team 2020). An evaluation of the pilot model in Nowra and Shoalhaven in NSW reveals numerous positive aspects including its potential to hold perpetrators accountable, ensure safety and provide empowerment for survivors of DFV. It also ensures police transparency and accountability (Mundy and Seuffert 2021). Mundy and Seuffert (2021) recommend a widened implementation trial across states and territories, and skills training to develop better intercultural and sensitivity practices.

Indigenous specialist courts

Another state-based policy that seeks to protect Indigenous defendants and their children is the development of Indigenous Specialist Courts, such as the Murri Courts in Queensland and Nowra Courts in New South Wales. They are responsible for the culturally appropriate processing and sentencing of Indigenous defendants and they are led by local community justice groups comprising Elders and respected persons (Radke and Douglas 2020). An ethnographic evaluative study of the Murri courts in Queensland showed therapeutic and transformative outcomes stemming from more appropriate child protection interventions (Radke and Douglas 2020).

6

Integrated responses, programs and models

6 Integrated responses, programs and models

Integrated responses can be seen as existing within 2 axes: 'horizontal' (integration of services between agencies and sectors at both service and agency levels), and 'vertical' (integration across different agency levels) (Wilcox 2010). Another way that integration has been conceptualised is by viewing it as a continuum that features several integrated service delivery models sharing the same outcomes (Potito et al. 2009). Integrated services include programs with formalised agreements between agencies, using words/phrases such as 'coordinated responses', 'partnerships', 'collaborations' and 'multi-agency', often drafted within a memorandum of understanding (Breckenridge et al. 2015).

Integrated responses to DFV are considered the 'gold standard' in Australia and internationally. They aim to provide support to women and children in the aftermath of violence; to hold perpetrators accountable; and to build community knowledge and awareness around these issues to prevent future DFV (ARTD Consultancy 2019; Flanagan et al. 2019; Mossman et al. 2019; Putt et al. 2017).

The Northern Territory's Domestic, Family and Sexual Violence Reduction Framework (DFSV) and the Alice Springs Model

An example of an integrated response framework is outlined in the Northern Territory's Domestic, Family and Sexual Violence Reduction Framework 2018-2028 (Norther Territory Government 2018). This framework outlines a 10-year strategy with an emphasis on reducing and preventing violence by:

- early identification of Territorians at risk of experiencing violence and provision of effective interventions
- outlining clear policy, information-sharing and funding models
- holding perpetrators accountable for their behaviour
- protecting the wellbeing of women, children and perpetrators and helping all who are affected to recover and thrive.

As the lead agency, the Northern Territory Council of Social Service (NTCOSS) works in partnership with expert DFV sectors, government agencies and other advocates to carry out the strategies and to implement the 3 major action plans in the framework. Action Plan 1 (2018–2021) focused on changing attitudes, intervening earlier and responding better. As of its last update, 71 out of the 78 actions were on track or completed. Action plan progress updates can be accessed here. In 2021, NTCOSS began discussions for Action Plan 2: Taking Stock, Evaluating and Reviewing and Building on What Works (2022 – 2025). A discussion paper posted for Action Plan 2 indicates that work is already under way to:

- identify strengths, gaps and opportunities across the service system
- monitor progress and evaluate initiatives including supporting the need to build capacity in the sector
- listen to and prioritise the voices of victims and survivors and to continuously support effective integrated, community-led service programs (Territory Families, Housing and Communities 2021).

An example of a specialist program that is aligned with the Northern Territory DFSV Framework is the Kunga Stopping Violence Program (KSVP), operating out of Alice Springs. It is one of the very few programs focused on the throughcare of Indigenous women on remand or serving sentences in the Alice Springs Correctional Centre. It has been running since 2014 and it works with 20 new women each year who have an history of alleged violent offending. The program engages with the women in prison and then provides responsive holistic case management for 12 months or longer following release. 'Holistic' in this instance means assistance with safety planning; medical treatment; employment; family reunification; legal assistance; and court support.

The program is voluntary and there is a significant focus placed on developing trusting relationships with the women during their period in prison in order to begin their healing work and to provide a strong ongoing foundation from which to work following release (Bevis et al. 2020). The importance of this program includes its unique understanding of and responsiveness to female perpetrators, who were often acting in self-defence. Many of these women also have untreated mental health issues; suicidal ideation; acquired brain injuries; and/or other disabilities from the violence they have endured.

An evaluation of the KSVP indicates that the program was client-focused and used a compassionate approach. The program provided effective trauma-informed training and is well-regarded in the Alice Springs community as it is able to provide support not only to those incarcerated, but to their families as well (Anderson 2021).

Queensland's Domestic and Family Violence Common Risk and Safety Framework (DFV CRASF)

In 2015, the Queensland Government Department of Child Safety, Youth and Women (DCSYW) contracted Australia's National Research Organisation for Women's Safety (ANROWS) to develop the Domestic and Family Violence Common Risk and Safety Framework, also known as the CRASF (DCSYW 2020), together with the tools and resources necessary for its effective implementation. The most updated version can be accessed here. The framework was developed for the use of all sectors that may encounter victim-survivors of DFV. It recommends the use of integrated service systems with responses for risk assessment and safety management. The framework provides 3 levels of tools, including a screening tool (Level 1) that can be used by professionals and first responders; a risk-assessment and referral tool (Level 2) that can be used by practitioners and specialist professionals working in the DFV sector; and a dynamic risk-assessment and safety-management tool (Level 3) to be used by high-risk multi-agency response teams.

As of 30 June 2022, the Queensland Government has conducted a comprehensive review of the CRASF and has emphasised that the risks of exposure to and experience of DFV on children must be recognised as distinct from the adult victim-survivor's or perpetrator's risks. Thus, new child-specific screening tools have been added, as well as methods for response.

As of 8 April 2023, the Queensland Government's website for community-led DFV action plans in Aboriginal and Torres Strait Islander communities indicated that both Hopevale Aboriginal Shire and Torres Strait Island Regional Councils were recipients of grants for the prevention of DFV. However, neither council's websites have yet reported on the progress of their programs for DFV. This may be due to the status of the program in its delivery (for example, whether it is in its establishment or implementation phase) or because funding has not yet facilitated a formal evaluation (as is often the case) (Productivity Commission 2020).

Critiques of current models

CJS-focused

The frameworks developed by the Northern Territory and Queensland governments seek to incorporate mental health services and aim to be responsive to mental health issues including suicide ideation. However, a review of the models show that this is far from clear. The 2020 AHRC report indicates that current frameworks have yet to demonstrate effective and positive outcomes, especially for Indigenous communities (AHRC 2020). At best, the 2 frameworks have focused on issues of violence against women and have merely 'responded' to justice-related issues. That being said, the Kunga Stopping Violence Program demonstrates a response model that respects the intersectionality of DFV with mental health.

One size fits all?

Other states and territories have similar models which have been critiqued for being heavily influenced by law and legal agencies resulting in an 'integrated criminal justice response' (Success Works 2009:10) instead of a fully integrated response system involving different government agencies and other organisations. The critique recognises that, on their own, CJS responses are unable to meet the multiple, differing and often competing needs of victims; perpetrators; their children; and the broader family and kinship groups impacted by DFV. Initiatives assume a universal experience of DFV, thereby adopting a 'one-size-fits-all' model (Fotheringham et al. 2021) that sometimes fails to consider the wellbeing of the targeted individuals and communities. In Cherbourg, Queensland, Indigenous men interviewed report that although the state provides SEWB services, these, together with suicide risk and violence prevention assessments, are not conducted in a culturally safe and informed manner (Blagg et al. 2018). While service users of the models report benefits in terms of meeting their immediate needs (Breckenridge et al. 2015, Zmudski et al. 2018), they likewise observe that the programs fail to consider the socioeconomic and cultural variability of the recipients (Cripps and Habibis 2019; Flanagan et al. 2019).

Administrative challenges

Agencies that work within these integrated frameworks are contracted externally and funded by the state for a maximum of 3 years. This poses a challenge in terms of program continuity and sustainability and may inhibit the integrated response model's long-term effectiveness (Cripps and Davis 2012; Cripps 2007; Cripps and Habibis 2019). Additionally, funding for integrated responses hardly consider the time, expertise, effort and administrative costs needed to run such operations (Breckenridge at al. 2015; Putt et al. 2017).

Information-sharing

A practice commonly shared by integrated service models is that of intra-agency information-sharing without the consent of at-risk victims, their family and kinship groups (Cripps 2020). According to Cripps, there are limited data available regarding the risks and benefits of information-sharing for Indigenous people in DFV situations. Similarly, Aboriginal and Torres Strait Islander communities should have access to and own their data (National Agreement on Closing the Gap: Priority Reform 4).

Appropriate representation

It is also important to note that, while most of the DFV frameworks across all states and territories in Australia indicate that these have been designed, delivered and evaluated through the involvement of Indigenous people, there is limited evidence supporting this claim (COAG 2016:98; Productivity Commission 2020).

Models for best practice

Two models are highlighted in this section:

- New Zealand's Integrated Safety Response to Family Violence (ISR) model
- Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council's (NPYWC) Uti Kulintjaku Watiku Project, based in Alice Springs.

Several other community-based Indigenous models have been evaluated and can be accessed through ANROWS Horizons Issue # 1 (Blagg et al. 2018).

New Zealand's Integrated Safety Response to Family Violence Model (ISR)

The ISR was introduced and piloted in 2016 at Waikato and Christchurch New Zealand. It was designed to look after the safety and wellbeing of victims and children affected by family or sexual violence. Its key features include funded dedicated staff and specialist services; risk assessment and triage systems; family safety plans; and case-management systems – all designed to reduce family violence, reoffending and revictimisation (NZ Police n.d.).

The ISR is a multiagency intervention that brings together the efforts of several groups and agencies – including but not limited to the police, Ministry for Children (known as Oranga Tamariki), Corrections, Justice, Social Development and Education; and other specialist family-violence non-government organisations and Maori services in the communities. It adopts a whole-of-family approach, whereby the agencies focus on both the perpetrator and on the other affected members of a family unit. Useful resources relevant to the ISR can be accessed here.

While evaluations of the ISR, more broadly, were consistent with Australian models, and supportive of integration for more holistic family support in the aftermath of violence, some recipients of the program in the Maori community felt that they were unheard and not actively involved in program development and its evaluations. Thus, ISR designers employed Maori people to help assess and improve the ISR model. Through this involvement, culturally appropriate approaches were slowly integrated into the model.

The ISR model may serve as an exemplar for best practice in the field. Consistent with Australian models, it:

- triages new episodes of DFV
- holds perpetrators accountable
- secures the safety and wellbeing of victims and children.

The model relies heavily on skilled case-management and information-sharing among organisations (Mossman et al. 2017). As reported in its evaluations:

- families reported feeling safer and better connected to their communities
- service providers reported improved workforce capability and processes (Mossman et al. 2017, Mossman et al. 2019).
- respondents reported significant reductions in family violence occurrences, compared with a matched control group not receiving the ISR.
- an 18% reduction in revictimisation was achieved in ISR sites, compared with control groups elsewhere in New Zealand.
- within a 5-year period, cost–benefit analysis of the reduction of family violence was rated at 3.2 times the investment made (Mossman et al. 2019).

The ISR model successfully proved that programs can address the intersectionality of violence and mental health. However, further evaluations as to refinements and/or improvements to the ISR model post-2019 are not yet available in New Zealand. The model is however, still in operation and has expanded into other districts.

The Northern Territory Uti Kulintjaku Watiku Project

The Uti Kulintjaku Watiku (Men's) Project in Alice Springs is an Anangu-led initiative by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) that began in late 2016 (Togni 2019). The program is headed by a community leader who encourages the use of storytelling and sharing among workshop attendees. Using a strengths-based approach, the leaders encourage men and young people to dialogue while practicing and respecting the Anangu culture. This then fosters, and builds the resilience of, all who participate and it enables them to learn skills that steer them away from violent behaviour (Togni 2019).

Alice Springs' Uti Kulintjaku Watiku Project serves as another exemplar for best practice, as integrates traditional healing practices with trauma-informed practices across its program areas. The evaluation of the project is a powerful demonstration of the effectiveness of the coming together of 2 cultural groups and disciplines. Storytelling was a key mechanism for teaching and learning the significance of personal stories to support Anangu healing and wellbeing. Visual representations and drawings were also important to share new concepts. This paradigm shift, which gave respect to the interplays of cultural knowledge and practices, created new ways to strengthen Anangu wellbeing and to prevent and reduce DFV.

Below are the reported key factors that support its success, as reported by Togni (2019).

- Uti Kulintjaku Iwara is a path to clear thinking which involves 4 core and interrelated components: firstly, thinking work; secondly, emotional work; thirdly, supportive work; and finally, iterative learning, reflection and evaluation. Relationships are central to this process and the implementation of learnings along the journey. It also supports Anangu engagement, leadership and learning.

- Privileging Anangu culture and language acknowledges and respects bi-cultural understandings. For issues such as DFV, respondents appreciated being able to communicate in one's first language. This, and using concepts to communicate not only words, is immensely important to sharing one's story in its truest form. (That is, not reshaping or retelling it in a form to suit a specific audience.)
- Creativity and energy are needed to develop innovative resources that build on strengths that inspire hope. In this field there is often a sense of diminished hope, given the extent and complexity of this problem – but at the community level in programs like this, there is a real sense that hope can be inspired through working together, drawing on the best of Anangu and Western knowledges and experiences to create the conditions for a better future. This is what is critical to the ongoing leadership of both men and women in this space.
- Continuity and leadership depends on a strong history and belief in culture and in knowledge; a track record in doing this work; and an ability to listen, understand and think clearly to find ways forward despite the challenges (especially short-term funding initiatives) (Togni 2019).

Four key developments and achievements have been reported as a result of the program:

- Proper representation of Anangu men's voice in violence prevention and in supporting young people's wellbeing.
- Building Anangu men's confidence and capacity to establish healthier intergenerational relationships.
- Developing more relevant resources, such as updated posters, to be used as educational and learning materials.
- Violence prevention through an emphasis on strengths and relationship-building (Togni 2019).

7

Identified gaps

7 Identified gaps

After a thorough desktop review, this report finds the following gaps in current policies, services and existing literature.

- How to target the significant number of men who attempt, or die by, suicide is largely absent from DFV research, policy and program responses. This is particularly the case where there is longstanding, cumulative and systemic problems involving alcohol and other drug use, relationship conflict and interpersonal violence (Fitzpatrick et al. 2022). The ethical and political questions of responsibility, choice and agency are often left unresolved with the finality of death.
- There is an absence of adequate social and public policies that recognise the intersections of DFV with (a) health in general and mental health in particular, and (b) the intergenerational trauma experienced by Indigenous groups brought about by systemic violence.
- With both co-located specialist services and Indigenous specialist courts, further evaluations are required to demonstrate a positive impact for all those involved. Evaluations to date have been limited in scope, being largely offender-focused, with few considering the impact for victims, children and other family and community members in the short, medium and longer term.
- There is an absence of fully integrated programs at the intersection of DFV, mental health and suicide, including specific plans and systems in place for administrative matters, organisational structuring, the most efficient methods for service delivery, and provisions for immediate clinical services.
- There is a lack of formal evaluations of DFV programs (Productivity Commission 2020; Cripps and Davis 2012) as well as literature on the impacts of DFV on the mental health of Indigenous populations. Furthermore, there is an absence of studies that incorporate cost–benefit analyses in their methodology.
- There is a lack of Indigenous research and studies focusing on the intersection of DFV and mental health services. Both the mental health and DFV spaces are littered with mental health plans, DFV and sexual violence plans, and alcohol and drug plans – but how these intersect with closing the gap has not been given attention.
- There is a lack of Indigenous research and studies focusing on the intersection of DFV and mental health in the context of the COVID-19 pandemic – particularly as many were isolated in their homes for extended periods. Further to this, prior to the pandemic many Indigenous communities were impacted by natural disasters including bush fires, and more recently flood events. Research is needed to appreciate how these exogenous shocks have impacted the incidence of and responses to DFV and mental health.

8

Recommend-ations for future policies and programs

8 Recommendations for future policies and programs

Policy reform

- Policy needs to be integrated between DFV and mental health as well as other social determinants that adversely impact the social and emotional wellbeing of individuals and families in the aftermath of violence.
- Policy responses need to appreciate and plan for complexity in these environments. Service responses must cater to the diversity and uniqueness of given situations so that those impacted by domestic and family violence at all its intersections are supported. For example, people with AOD problems, cognitive disabilities, acquired brain injuries and fetal alcohol spectrum disorders, or any combination of these, will have different experiences with violent behaviours and victimisation.
- Policy implementation needs to be adequately resourced locally, to drive integrated responses to local contexts so that they may be Indigenous-informed, trauma-informed and community controlled. This should factor in support for skills development and the back-filling of frontline roles.
- There is a need to review current DFV policy and its heavy reliance on law and order. Specifically, is it effectively meeting its purpose and/or creating unintended consequences for those experiencing violence? This is particularly the case with the misidentification of victims and perpetrators. It is also important to consider alternative pathways to justice when domestic and family violence intersects with mental health.
- Coroners and a recent state-based inquiry into police practice have also highlighted the inconsistency with which police DFV policy and practice procedures are applied when engaging with victims of violence. This results in further harm, including loss of life for victims of violence. Further research is needed to evaluate how widespread this problem is across Australian jurisdictions, with appropriate actions to improve police practice in this area.
- New law reforms (specifically related to coercive control) rely on consistency in training, policy and practice at all levels of policing, for the public to have confidence that the legal system can respond effectively. One missed step will diminish the value and power of such laws to prevent the type of violence it is trying to prevent. In all jurisdictions that proceed with these reforms, resources need to be available to raise awareness and improve education and operational policies and practices.
- There is likewise a need for continuous research to inform current policies and practices in the DFV and mental health space. Neither sector can afford to continue to work in silos when lives are at stake. Policies must include early intervention and preventive programs and be responsive to the diversity of Indigenous populations.

Enhancement of current integrated service responses

- In line with viewing integrated programs/models within a continuum, integrated service frameworks and programs need to be enhanced, bringing together different sectors and partners with Indigenous members of each community.
- Programs must identify and shape consistent, holistic care and trauma-informed support that is tailored to meet the needs of individuals and families experiencing DFV.
- Programs should be able to accommodate and respond to a range of issues, for example: physical injuries; management of mental health and trauma-related circumstances; housing and security upgrades; addressing the issue of AOD; and supporting children and their schooling.
- Additionally, the program or service response should aim to coordinate immediate, ongoing and after-care support services so that victims and family members are not overburdened with meeting the demands of various agencies. More specifically, future frameworks and programs should consider the following:
  - Risk assessment and management should form a fundamental component of therapeutic practice. This should be complemented with an assessment of protective factors as these factors can represent 'shields' to abuse or harm and can counter potentially identifiable risks (Guggisberg 2019:219).
  - Health-service clinicians should possess the skills to screen for, and facilitate, care for patients with alcohol, drug and mental health issues.
  - Therapeutic practice should also be offered in collaboration with the Aboriginal and Torres Strait Islander community-controlled health sector or a respected Elder within the community – subject to the consent of the individual receiving the care.
  - The 2020 AHRC report reiterated the importance of DFV shelters or refuges being safe places that can respond to women and children's diverse and intersecting needs – including alcohol and drug issues, mental health, housing, child protection and employment.
  - It is recommended that specialist services for both children and the youth be incorporated in future programs. This approach is similar to the Tangentyere Women's Family Violence Prevention Program which has, nested within it, integrated services responding to and preventing violence including specialist services for children. This approach is particularly important if we are to break the intergenerational, embedded cycles of violence, through trauma-informed culturally safe therapeutic supports for young people (AHRC 2020:139).
  - June Oscar has recommended (AHRC 2020) that since young people have intersecting experiences with socioeconomic disadvantage, emotional distress and substance abuse, 'youth services need to be far more holistic, proactive and integrated to be effective' (AHRC 2020:431).
  - Early intervention and preventive support given the experiences of children and young people needs to be available in locations across the country. Young people want access to gender-specific mental health services and programs that are facilitated by Indigenous staff who understand their circumstances and the nuances of confidentiality (AHRC 2020:432). Respecting these wishes is important: evidence from Canada (where Indigenous suicide rates have been equally high) shows rates have declined in communities where strong cultural connections, practice, and self-governance factors were present (AHRC 2020:432; Chandler and Lalonde 2008).

- Current referral pathways that include follow-up and ongoing support should be strengthened. Where there is a high record of client dropouts, an investigation of the reasons behind this should ensue, and immediate actions need to be set in place to address the dropout rate. Furthermore, when possible, tracer studies on program recipients should be conducted to assess future outcomes.

The importance of accountability and the need for evaluation studies

- To ensure accountability for individuals and organisations, current policies and programs need to be evaluated regularly. This is important where there is evidence of failure – including where laws have failed to be implemented or proper procedures have not been followed. This is essential for a whole-of-system accountability model to be enforced.
- Current models require support and resourcing in workforce development to evolve and improve.
- More importantly, these models need consistent evaluation to measure consistency of outcomes for communities. The New Zealand model may serve as the reference for how to evaluate in a culturally engaged and sensitive way. This ensures that integrated programs of the future can be appropriately responsive to critiques from its victims/families. It also fosters openness to continuously reform current program elements in their design and implementation phases (Cripps 2020). Evaluation should be seen as a continuous exercise, responsive to the time and space that is needed for lessons to be learned and for programs to be recalibrated as circumstances change locally.

9

Conclusions

9 Conclusions

Mental health, healing and trauma-informed practices that are centred around the individual, the family and the community should be at the heart of future integrated DFV service-response models. Blagg et al. (2018) recommended that intervention and prevention in the family violence arena be underpinned by a focus on social and emotional wellbeing – recognising that these policy areas are complex and overlapping. Such practices should include psychoeducational programs that address the use of suicide as a form of coercive control.

All state and territory jurisdictions are at various stages of implementing integrated DFV service-response systems. This shift has entailed law and policy changes and will continue to do so, particularly as coercive control laws come into effect across jurisdictions. It is imperative that these changes include regular evaluation mechanisms to ensure that any unintended consequences are being quickly identified and mitigated.

It is essential for policymakers and program developers to perceive wellbeing more holistically, since it can impact the wellbeing of the whole community. Thus, addressing Indigenous wellbeing within the larger contexts of DFV and intergenerational trauma is not just about the treatment of individual symptoms but should also be about the healing at the community level.

The recommendations in this review are a reflection of the strategies outlined in the National Plan to End Violence against Women and their Children 2022–2032. It is hoped that social and emotional wellbeing becomes the new indicator for good mental health. As described in the case studies in this report, when DFV intersects with mental health, lives are at stake in fundamental ways, it is therefore critical that engagement on this issue by all those involved is serious, committed and backed with resources. Our future generations deserve nothing less than a chance to live free of violence. This report is the start of a dialogue to improve policy, practice and professionalism in this space.

To reiterate, the case studies speak to the need for:

- understanding the intersection of DFV with mental health
- responsive institutions, policies and programs that appreciate context holistically.

When we fail to understand and be responsive, the cost is a life or lives lost. Thus, we must do better to prevent the unnecessary loss that we repeatedly see at this intersection.

Appendixes

Appendix A: Methods

In acknowledging the breadth of the above definitions, a comprehensive search was undertaken to capture traditional academic and evaluative research as well as available grey literature.

Grey literature is both informative and valuable, particularly in areas where there is a lack of scientific, academic or other formal evaluative studies. It plays an important role in the rapid and timely distribution of 'current' information on programs, policy and planning effects and so forth. While not necessarily being strictly evaluative in an academic sense, grey literature can provide considerable practical insights into current practice issues.

The term 'grey literature' refers to research that is either unpublished or has been published in non-commercial forms.

Examples of grey literature include:

- government reports
- policy statements and issues papers
- conference proceedings
- theses and dissertations
- research reports
- newsletters and bulletins
- websites
- fact sheets.

Stage 1

To capture the appropriate material for this report, a staged approach was undertaken. In the first stage, in line with instructions received from the AIHW Indigenous Mental Health and Suicide Prevention Clearinghouse, a comprehensive search for reviews and evaluative studies between 2000 and 2022 was undertaken. Literature was retrieved through numerous separate searches using the terms 'Aboriginal' or 'Torres Strait' or 'Indigenous' in combinations with: family, domestic, violence, abuse, program, service, response, intervention, hospital, emergency, drug, alcohol, substance abuse AND combinations of 'mental health', 'suicide', 'self harm'.

It should be reiterated that the search was limited to studies specific to Australia, in the first instance, but was broadened out to international jurisdictions when search results were producing very limited Indigenous specific content. (Examples of databases searched are detailed in Table 1.)

The sample of publications selected for this review is not definitive but selective. After initial culling via the search terms, approximately 100 documents were selected from these databases for further analysis as to relevance. Publications were chosen for relevance to demonstrating an awareness or consideration to *some degree* of information on the topic at the intersections of Indigenous DFV, mental health, self harm or suicide. Approximately 21 of the 100 documents appeared to contain evaluative studies; 9 were useful for plans/policies and advisories; and another 8 were to be used for programs/models. Based on relevance, the initial selection of 100 was further reduced to around 85 documents which form the basis of the results portion of this report. This search was supplemented by following up on citations from the identified documents.

Stage 2

Stage 2 of the literature search involved searching the grey literature. Numerous google searches were undertaken using the terms identified in Stage 1. This was complemented with searches of specific web-based clearinghouses, for example, the ANROWS Resources Database; the Closing the Gap Clearinghouse; the Indigenous Health Infonet and the international database MINCAVA.

Classification of studies

The titles and abstracts of the identified references were classified in a two-step process.

Step 1: Identification for exclusion

References were excluded if they

- were duplicates
- did not focus on domestic or family violence as defined earlier
- did not focus on Aboriginal and/or Torres Strait Islander people as either a primary focus or as an identifiable subset of the population
- were published before 2015 or dealt with programs from before 2015
- contained no discernible evaluative information on the topic or on programs/services relevant to the topic.

Step 2: Identification for further exclusion

1. The full article was scanned for quality and detail of information.
2. Using the same criteria as described above, if the fuller article did not meet the threshold for quality and/or quantity of information it was not included.

Appendix B: Policies and Frameworks

Name	Details	Key recommendations	Implementation
National Plan to Reduce Violence against Women and their Children 2010-2022	This Plan, committed to by state and territory governments and led by the Commonwealth, has been a shared commitment to drive responses towards ending and preventing violence against women (COAG 2016; COAG 2019). The central goals of the National Plan are to reduce violence against women and their children and to improve how governments work together, increase support for women and their children, and create innovative and targeted ways to bring about change.	The Plan contains 6 national outcomes, with strategies for achieving each of the outcomes: 1. Communities are safe and free from violence 2. Relationships are respectful 3. Indigenous communities are strengthened 4. Services meet the needs of women and their children experiencing violence 5. Justice responses are effective 6. Perpetrators stop their violence and are held to account	During the 12-year period it had four 3-year Action Plans to drive the implementation. The Plan also established: • Our Watch • Australia's National Research Organisation for Women's Safety (ANROWS) • the 1800RESPECT helpline • the Stop it at the Start campaign
National Plan to End Violence against Women and their Children 2022–2032	The National Plan puts in place a national policy framework to guide the work of governments, policy makers, businesses and workplaces, specialist organisations and family, domestic and sexual violence organisations and workers in addressing, preventing and responding to gender-based violence in Australia. It commits to a country free of gender-based violence – where all people live free from fear and violence and are safe at home, at work, at school, in the community and online. The vision is to end violence against women and children in Australia in one generation.	There are four focus areas, each of which have specific objectives: 1. Prevention 2. Early intervention 3. Response 4. Recovery and healing. The National Plan also outlines the development of an Aboriginal and Torres Strait Islander Action Plan, as well as the Australian Government's commitment to delivering a standalone First Nations National Plan.	The National Plan will be implemented through two 5-year Action Plans. These will detail specific Commonwealth, state and territory government actions and investment to implement the objectives across each of the four domains: prevention, early intervention, response, and recovery and healing.

Name	Details	Key recommendations	Implementation
The National Agreement on Closing the Gap	The Agreement is a formal partnership between the Australian Government, state and territory governments, the Coalition of Aboriginal and Torres Islander Peak Organisations, and the Australian Local Government Association. It was signed in March 2019.	There are 19 national socio-economic targets across 17 socio-economic outcome areas that have an impact on life outcomes for Aboriginal and Torres Strait Islander people. The Agreement also has four priority reforms: 1. Formal partnerships and shared decision making 2. Building the community-controlled sector 3. Transforming government organisations 4. Shared access to data and information at a regional level. Through these four priority reforms, the government aims to close the gap in life outcomes between Indigenous and non-Indigenous Australians.	Each party to the National Agreement has developed their own Implementation Plan and will report annually on their actions to achieve the outcomes of the Agreement. Plans have been developed and will be delivered in partnership with Aboriginal and Torres Strait Islander partners. Each Implementation Plan sets out how policies and programs are aligned to the National Agreement and what actions will be taken to achieve the Priority Reforms and outcomes, including information on funding and timeframes for actions.
Domestic, Family and Sexual Violence Reduction Framework 2018-2028 Northern Territory	This framework outlines a 10-year strategy with an emphasis on reducing and preventing violence by: • early identification of Territorians at risk of experiencing violence and provision of effective interventions • outlining clear policy, information-sharing and funding models • holding perpetrators accountable for their behaviour • protecting the wellbeing of women, children and perpetrators and helping all who are affected to recover and thrive.	Two out of 3 action plans have been developed and focus on: • changing attitudes • intervening earlier • responding better • taking stock • evaluating and reviewing • building what works	Work is under way to: • identify strengths, gaps and opportunities across the service system • monitor progress and evaluate initiatives including supporting the need to build capacity in the sector • listen to and prioritise the voices of victims and survivors and to continuously support effective integrated, community-led service programs.

Name	Details	Key recommendations	Implementation
Domestic and Family Violence Common Risk and Safety Framework (DFV CRASF) Queensland	The framework was developed for the use of all sectors that may encounter victim-survivors of DFV. It recommends the use of integrated service systems with responses for risk assessment and safety management.	The framework provides 3 levels of tools: • a screening tool (Level 1) that can be used by professionals and first responders • a risk-assessment and referral tool (Level 2) that can be used by practitioners and specialist professionals working in the DFV sector • a dynamic risk-assessment and safety-management tool (Level 3) to be used by high-risk multi-agency response teams.	There is no implementation information available.

Appendix C: Programs

Program	Program details		Evaluation	Evaluation details		Findings
New Zealand's Integrated Safety Response to Family Violence (ISR) model	Location(s)	New Zealand	Mossman et al. 2017 Mossman et al. 2019	Location	New Zealand	The evaluation found the following: • Families reported feeling safer and better connected to their communities • Service providers reported improved workforce capability and processes • Respondents reported significant reductions in family violence occurrences as compared to a matched control group not receiving the ISR
	Participants	Families		Participants	n/p	
	Duration	2016		Duration	n/p	
	Indigenous specific	No		Indigenous specific	No	
	Focus	Family and sexual violence		Focus	Outcomes	

Program	Program details		Evaluation	Evaluation details		Findings
Uti Kulintjaku Watiku Project.	Location(s)	Alice Springs	Togni 2019	Location	Alice Springs	The evaluation found the project helped with: • giving proper representation of Anangu men's voice in violence prevention and in supporting young people's wellbeing • building Anangu men's confidence and capacity to establish healthier intergenerational relationships • developing more relevant resources, such as updated posters, to be used as educational and learning materials Violence prevention through an emphasis on strengths and relationship-building.
	Participants	Men		Participants	Men	
	Duration	2016		Duration	n/p	
	Indigenous specific	Yes		Indigenous specific	Yes	
	Focus	DFV		Focus	Outcomes	

Program	Program details		Evaluation	Evaluation details		Findings
Domestic Violence Intervention Service (DVIS)	Location(s)	Shoalhaven NSW	Mundy and Seuffert (2021)	Location(s)	Shoalhaven NSW	The evaluation found the service provided: • immediate provision of emotional support and validation for victims in crisis • ease of access to in-depth information regarding policing and other justice system processes • a confident guide through the maze of government and community services and the legal system. Additionally, the co-location model assists in achieving immediate and longer-term safety, and confident advocacy for the rights and needs of survivors of DFV.
	Participants	DFV survivors		Participants	DFV survivors	
	Duration	1992-present		Duration	n/p	
	Indigenous specific	No		Indigenous specific	No	
	Focus	DFV survivors		Focus	Outcomes	
Kunga Stopping Violence Program (KSVP)	Location(s)	Alice Springs	Anderson 2021	Location(s)	Alice Springs	An evaluation of the KSVP indicates that the program: • was client-focused and used a compassionate approach • provided effective trauma-informed training • provides support not only to those incarcerated, but to their families as well.
	Participants	Women offenders		Participants	Women offenders	
	Duration	2014-present		Duration	n/p	
	Indigenous specific	Yes		Indigenous specific	Yes	
	Focus	Case management		Focus	Outcomes	

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Abbreviations

ABS	Australian Bureau of Statistics
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	alcohol and other drugs
ARTD	ARTD Consultancy
ATSI	Aboriginal and Torres Strait Islander
CJS	criminal justice system
CRASF	Common Risk and Safety Framework
CSDH	Commission on the Social Determinants of Health
DFV	domestic and family violence (also known as DV)
DFSV	domestic, family and sexual violence
DCSYW	Department of Child Safety, Youth and Women
FVRIM	Family Violence Reform Implementation Monitor
ISR	Integrated Safety Response
KSVP	Kunga Stopping Violence Program
LGBTQIASB+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Sistergirl, Brotherboy and other sexuality, gender and bodily diverse people
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NPYWC	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC)
NSW	New South Wales
NTCOSS	Northern Territory Council of Social Services
PMC	Department of the Prime Minister and Cabinet
PTSD	post-traumatic stress disorder
SCRGSP	Steering Committee for the Review of Government Service Provision
SDH	social determinants of health
SEWB	social and emotional wellbeing
WA	Western Australia
WHO	World Health Organization

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This report highlights how Indigenous Australians' experiences of domestic and family violence (DFV) are affected by current law, policy, programs and services. It discusses research and programs where DFV intersects with mental health and/or suicide and focuses on best practice and ways to improve outcomes for Indigenous Australians.

AIHW

Stronger evidence,
better decisions,
improved health and welfare