

# Inside Out: An organisational map for primary violence prevention

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## Foreword

As I sit writing this foreword to the report of the Adelaide Hills Community Health Service *Inside Out Violence Prevention Project*, the Prime Minister Kevin Rudd has just released *Time for Action*, the major report of the National Council to Reduce Violence against Women and their Children.

Mr Rudd has announced that \$42 million will be allocated to tackle this issue. Importantly, \$26 million of this is dedicated to *primary* violence prevention - preventing violence *before* it occurs.

We are told as part of the announcement that nearly one in three Australian women experience physical violence and almost one in five women experience sexual violence over their lifetime.

We are also told that violence against women will cost the Australian economy around \$13.6 billion this year, rising to \$15.6 billion in 2021/22 if appropriate action is not taken.

Violence and abuse have immense impacts on the lives of so many women, children and others who are vulnerable and disadvantaged in our communities. This is indeed work which our service *must* undertake as part of our charter to maximise health and well being in our community.

We must provide an appropriate service response and I am convinced that the quality of our response to those whose lives are affected by violence and abuse will be in part determined by the quality of our workplace culture and interactions - and in particular, the level of respect contained in those interactions. This is not a new notion, and it should not come as a surprise that internal culture will affect the quality of organisational service responses.

Thus the focus of this Project on the 'inside' culture and the 'outside' response.

The Project has I believe, had a significant impact on our organisation and on our capacity to address violence and abuse as they impact on our clients. We will continue to take up the challenge and to work in support of the directions mapped out by the Federal Government announcement.

Jane Tassie  
Director, Adelaide Hills Community Health Service  
Chair, Inside Out Violence Prevention Project Reference Group  
May 2009

## Acknowledgements

The genesis of the *Inside Out Violence Prevention Project* lies with the Murray Mallee Community Health Service's *Respect Project*, the first whole of organisation violence prevention project in South Australia, probably Australia and maybe the world. Jan Brand, Carla Vicary and Viv Hazel generously shared the learnings and experiences of their project so that we could shamelessly pinch the idea.

I would also like to acknowledge the following people and organisations:

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The *Inside Out Violence Prevention Project Reference Group* (representing every program area of AHCHS) - for their direction and diversity of expertise. In particular, to Cathryn Marinos, community representative on the Reference Group for her insight, acuity and for bringing plain language to the table.

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Particular gratitude to David Adams, Co-Director of *Emerge*, Batterers Intervention Program, Somerville, Massachusetts and author of '*Why do they kill? Men who murder their intimate partners*', who generously organised the minutiae of site visits in Massachusetts and graciously shared his extensive knowledge and experience on my visit to the United States.

Staff and colleagues of AHCHS, alongside whom I have stood while they learnt about things that they didn't always want to know. Particular acknowledgement to the many staff (the ones I know about and those that I don't) who have past, present and personal experiences of this issue and who probably know more than they'd rather.

My profound thanks to the hundreds of women who have experienced violence and abuse, with whom I have worked, and all the others I have not, for their exquisite resilience, fortitude and capacity to change and enrich their lives.

I also acknowledge the people who use, have used and will use violence and abuse and the companionship of the many who don't. Without them, I would not be so compulsive and bloody minded about this work.

Fiona Meade  
Project Manager  
Inside Out Violence Prevention Project  
May 2009

## Executive Summary

The Adelaide Hills Community Health Service (AHCHS) is a primary health care service located in an inner country area of South Australia. AHCHS provides a range of services including home and centre based support services to older people, services specifically for young people, men, women, Aboriginal community members and children and families.

AHCHS along with the World Health Organization (WHO) recognises that violence and abuse are major contributors to ill health, chronic disease and the burden of disease on our society and health system.

The WHO has also recognised that whilst secondary and tertiary approaches to violence and abuse are vital and require ongoing implementation, primary prevention approaches (preventing violence before it occurs) are under-utilised even though they hold promise for reducing and ultimately eliminating the trauma and burden of violence and abuse.

*The Inside Out Violence Prevention Project* was undertaken over a period of two years between May 2007 and May 2009 and utilised a variety of primary prevention strategies to address the major Project goals.

The twin goals of the Project were:

- To build organisational capacity for addressing issues of violence and abuse, and
- To enhance a respectful organisational culture.

A Project Manager was appointed at 0.4 full-time equivalent (FTE) or 2 days per week, to implement Project initiatives. A Reference Group consisting of representatives from across the organisation and community provided oversight and promoted the Project.

This document details the range of organisational, workforce and communication strategies implemented, and highlights successes and limitations. It also assesses the capacity of the organisation to progress various Project initiatives within existing resources and identifies future opportunities if additional resources are allocated.

AHCHS is poised to capitalise on and to take a lead role in primary violence prevention in health. The work undertaken as part of the *Inside Out Violence Prevention Project* synchronises well with the recent release of the Federal Government's *Time for Action*, the report of the National

Council to Reduce Violence against Women and their Children. The government's substantial commitment to primary violence prevention in this report signals a new era in approaches to what the Federal Attorney General has described as *one of our most pervasive social problems*.<sup>1</sup>

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<sup>1</sup> *Time for Action to Reduce Violence Against Women and Children*  
Media Release, Office of the Prime Minister, Attorney General and Minister for the Status of Women, 29 April, 2009.

## Definitions

**Violence and abuse** are defined by the WHO as:

*The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.*

Violence is further categorised as follows:

**Child abuse:** Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

**Elder abuse:** a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. Such abuse is generally divided into the following categories: physical abuse, psychological or emotional abuse, financial or material abuse, sexual abuse, and neglect.

**Intimate partner violence:** any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviours include acts of aggression, psychological abuse, forced intercourse or other forms of sexual coercion, and various controlling behaviours. (The overwhelming burden of partner violence is borne by women at the hands of men.)

**Sexual violence:** any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

**Youth violence:** includes violence in gangs, in schools and by young people on the streets (young people in the *World report on violence and health* are defined as 10–29 years of age).<sup>2</sup>

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<sup>2</sup> *World Health Organization Report on Violence and Health*, WHO, Geneva, 2002.

## Introduction

Whilst serving as a reporting mechanism for the *Inside Out Violence Prevention Project*, this document is framed as a manual for use by community health services seeking to prevent violence. As such, it outlines the rationale for primary violence prevention and the range of organisational, workforce and communication strategies implemented throughout the course of the Project. It also highlights some 'shipwrecks and lighthouses'<sup>3</sup> encountered over the course of two years and comments on the potential for further work.

## Background

Violence is not a fact of life or an intrinsic characteristic of the human condition yet it is widely recognised as prevalent worldwide. The WHO estimated that almost 1.5 million deaths from homicide and suicide occurred globally in 2000.<sup>4</sup> Over 200,000 of those deaths occurred among young people, that is, 565 young people died every day.<sup>5</sup> An estimated 6-8% of elders reported abuse in 2000.<sup>6</sup>

In 2006, the Australian Bureau of Statistics (ABS) found that one in three women had experienced physical violence since the age of 15. One in five had experienced sexual violence and 16% had experienced violence by a current or previous partner.<sup>7</sup>

Intimate partner violence also contributes 9% to the disease burden in Victorian women under 45 years, making it the largest known contributor to the preventable disease burden in this group.<sup>8</sup>

Accurate figures are not available though it is widely acknowledged amongst violence intervention workers that an estimated 1 in 3 girls and 1 in 6 boys experience sexual abuse as children.

Australian Indigenous women are three times more likely to experience physical and sexual violence compared to non Indigenous women.<sup>9</sup>

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<sup>3</sup> *Let every shipwreck be your lighthouse*, expression attributed to Comedian, Tony Hancock, 1961.

<sup>4</sup> *World Health Organization Report on Violence and Health*, WHO, Geneva, 2002, p. 10.

<sup>5</sup> *Ibid.*, p.25.

<sup>6</sup> *Ibid.*, p.129.

<sup>7</sup> *Cited in Preventing Violence Before it Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, December 2007, p.24.

<sup>8</sup> *Research Summary: Key influences on health inequalities*, VicHealth, 2008, p. 5.

<sup>9</sup> *Women's experiences of male violence: findings from the Australian component of the international violence against women survey*, Research and Public Policy Series 56, Australian Institute of Criminology, Canberra, 2004.

Women with disabilities are 40% more likely to experience intimate partner violence than women without disabilities.<sup>10</sup>

Various studies have attempted to estimate the economic costs associated with violence and perhaps, more relevant for health professionals, the non-fatal health consequences and burden of disease.

A wide range of acute and chronic conditions have been linked to violence. These include cancer, ischemic heart disease, chronic lung disease, sexual and reproductive health problems and chronic pain syndromes.<sup>11</sup>

Some forms of violence are strongly linked to psychological consequences such as depression, anxiety, phobias, panic and psychosomatic disorders. Furthermore, the effects of violence frequently reverberate throughout a lifetime and therefore extend beyond the actual violent incident or incidences.

The WHO has identified that these findings have significant implications for the health of entire populations and contribute to overburdened health systems world-wide.<sup>12</sup> In Australia in 2002 - 2003, violence against women alone, was estimated to cost the economy \$8.1 billion.<sup>13</sup> The recently released national report *Time for Action*, predicts that violence against women and children will cost the Australian economy \$13.6 billion in this financial year alone.<sup>14</sup>

Violence is prevalent but not inevitable. Throughout human history and particularly in modern times, some forms of disease and injury have been radically reduced and in some cases eliminated by public efforts at prevention. Entire populations have been free of certain diseases that once plagued them. In Australia, we suffer far fewer child deaths from swimming pool drowning than we once did.

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<sup>10</sup> D. Brownridge, *Partner violence against women with disabilities*, 2006, cited in *Violence Against Women, Research Summary 4*, VicHealth, 2008.

<sup>11</sup> Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, The adverse childhood experiences (ACE) study'. *American Journal of Preventive Medicine* 1998;14(4):245–258.

<sup>12</sup> Andrews G, Corry J, Slade T, Issakidis C, Swanston H. Child sexual abuse. In: Ezzati M, Lopez AD, Rodgers A, Murray CJL, eds. *Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors volume 1*. Geneva: World Health Organization, 2004:1851–1940.

<sup>13</sup> Access Economics, 2004, cited in *Preventing violence and reducing its impact*, World Health Organization, Geneva, 2008, p.6.

<sup>14</sup> *Time for Action, The National Council's Plan for Australia to Reduce Violence Against Women and Their Children 2009-2021, A Snapshot*, March 2009.

Similarly, massive prevention efforts in the developed world focus on chronic diseases like diabetes, heart conditions and obesity. Causes for these conditions are known - *they* are therefore preventable. Causes, determinants, risk and contributory factors for violence and abuse are also known - *it* is therefore preventable.

## Primary Prevention of Violence

Levels of intervention in public health are commonly characterised in to primary, secondary and tertiary:

- Primary violence prevention aims to prevent violence before it occurs.
- Secondary violence prevention focuses on treating immediate injury and harm resulting from violent incidents.
- Tertiary violence prevention refers to a range of activity aimed at addressing the medium and long-term effects of violence and abuse and includes therapy and other rehabilitation efforts.

The WHO has noted that in developed countries, secondary and tertiary approaches to violence and abuse are widespread.<sup>15</sup> These approaches are critical to reducing the burden of disease and injury and require ongoing and strengthened implementation. Measures to stop violence occurring in the first place hold promise for eliminating violence and abuse, thereby reducing the demand and cost of secondary and tertiary approaches.

## AHCHS Inside Out Violence Prevention Project

In 2002, the Murray Mallee Community Health Service (MMCHS) launched a systemic change process to address violence prevention as a health priority. The *Respect Project* aimed to address issues of violence in relation to MMCHS clients and to develop a culture of non-violence within MMCHS.<sup>16</sup> In partnership with the University of SA, School of Social Work and Social Policy, an *Evaluation Report* was completed in 2006.<sup>17</sup>

In 2007, on the basis of the learnings of the *Respect Project*, AHCHS decided to implement a violence prevention initiative-later named the *Inside Out Violence Prevention Project*. The name reflected the intention

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<sup>15</sup> World Health Organization Report on Violence and Health; Summary, Who, Geneva, 2002, p.10.

<sup>16</sup> V. Hazel, J. Brand and C. Vicary, *One to 120 in 5 years; A population health approach to violence prevention in a rural primary health care service*, June 2006.

<sup>17</sup> D. Chung, T. Hand, S. Dixon, S. Sweeney, *Violence Project Evaluation*, August 2006.

to address violence and abuse both inside and outside of the organisation and thus the Project shared similar goals with the *Respect Project*.

The overall aim of the Project was to develop and implement a model for addressing the impacts of violence and for early intervention and violence prevention strategies. The Project goals were to enhance organisational capacity for addressing issues of violence in the community and to develop a respectful organisational culture. In May 2007, a Project Manager was appointed at 0.4 FTE (two days per week) for a period of two years.

Terms of reference were established for the Project and a Reference Group recruited from every program area within the organisation (refer Appendix 1). An initial project plan was devised and using an 'agile' approach to project management, planning progressed through many iterations.<sup>18</sup>

### Approaches to Violence Prevention

The *World Report on Violence and Health* defines a range of approaches to violence prevention activity through individual and relationship programs, community based efforts and societal approaches. As Project planning and activity progressed, a focus on community based approaches was adopted.

The principal aims of community based violence prevention activities are to raise public awareness of and debate about the issue and stimulate community action. As the *World Report* highlights, programs operating at the community or societal (primary approaches) levels are under-emphasised compared with those aimed at individual or relationship (secondary and tertiary approaches) factors.<sup>19</sup>

Organisational cultures have a potent role in influencing the behaviours of individuals and groups and play a role in violence prevention by modelling non-violent, equitable and respectful relations.<sup>20</sup>

It became evident that if we could enhance the capacity of the organisation to address issues of violence and model respect by using community based strategies - in the first instance, identifying the

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<sup>18</sup> R. Smith, *Search for the 'Holy Grail' of Primary Health Care Project Management*, Presentation to the Country Primary Health Care Conference June 2007.

<sup>19</sup> *World Health Organization Report on Violence and Health; Summary*, Who, Geneva, 2002, p.27.

<sup>20</sup> *Preventing Violence Before it Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, December 2007, p.43.

organisation as 'community' - we would greatly enhance our ability for individual and relationship approaches and open up opportunities for broader societal campaigns.

## Organisational Development

At a broad level the organisation provides a platform of infrastructure for primary violence prevention - a building block.

### Survey Profiling Baseline

One of the first tasks of the Project was to survey staff and volunteers to get a baseline profile of the level of knowledge and the range of activities and attitudes towards violence and abuse.

Survey results about beliefs, values and attitudes towards violence and abuse were encouraging and indicated supportive and receptive attitudes toward the aims of the Project. The results also indicated a strong majority were aware of issues of violence and abuse in their work which boded well for breaking the silence around violence and abuse and prevention efforts. General violence awareness training emerged as a critical aspect to support staff confidence and competence in providing a basic first response to clients and community experiencing violence and abuse.

The survey report made several recommendations related to:

- Violence awareness training for all staff,
- Exploring systems and supports to address the needs of staff addressing violence and abuse in their work,
- Auditing orientation materials, and
- Implementing a system of bullying and discrimination contact officers, and education and information sessions for staff and volunteers.

### Mapping Exercise

The Reference Group also audited current staff and team activity across AHCHS in relation to violence and abuse. An ecological model recommended by the WHO for understanding violence was used and

activity was mapped against factors considered determinant or contributory for gendered violence and abuse<sup>21</sup> (refer Appendix 2).

The mapping exercise revealed individuals and teams conducted a surprising amount of activity across a range of determinants or risk factors for violence. However, this work was delivered in isolation from other efforts and was not intentionally preventative of violence. It was therefore determined that mentoring of individuals and teams might enhance the intentionality and coordination of prevention efforts.

### **Data Management**

The WHO recommends enhancing capacity for collecting data on violence. Any credible public health activity requires measurement of the extent of the particular health problem being addressed. Reliable data on violence are vital for planning, monitoring and advocacy.

*Without information, there is little pressure on anyone to acknowledge or respond to the problem.<sup>22</sup>*

The Project attempted to establish baseline information on data collection about violence and abuse activity in order to profile the types of violence and abuse clients presented with and capture information about disciplines utilising the codes. (As with any form of data collection, the quality of the outcome can only be as good as the quality of staff input.)

A protocol for the preferred use of violence related codes was developed and staff education sessions were held to promote more accurate data collection with the intention of improving data quality about issues presenting to the health service.

Prior to this intervention only the Women's Health Team (two workers) were using these codes even though it was known that many staff were encountering these issues in their work and either not recording and/or not responding to them.

Twelve months on from the training and education, more areas of AHCHS were routinely using violence related codes and the organisation was capturing more data on violence and abuse.

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<sup>21</sup> *Population Reports: Ending Violence Against Women*, Center for Health and Gender Equity, Maryland, USA, 24 (4), December 1999, p. 8.

<sup>22</sup> *World Health Organization Report on Violence and Health; Summary*, Who, Geneva, 2002, p.5.

## Contact Officers

The National Occupational Health and Safety Commission defines occupational violence as:

*The attempted or actual exercise by a person of any force so as to cause injury to a worker, including any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk.*<sup>23</sup>

The National Health and Medical Research Council sub-categories of occupational violence are; internal to organisation, client related and random acts of violence.<sup>24</sup>

Occupational violence internal to the organisation includes violence between employees, and between employees and managers or employers. Examples include workplace bullying and conflict between workers.

One measure to address workplace bullying, harassment and conflict is to implement a system of contact officers. An equal opportunity contact person is a staff member appointed by the organisation to help other staff with any discrimination or harassment questions or problems before they develop.

Equal opportunity organisations recommend and routinely offer training for contact officers to address aspects of occupational violence internal to the organisation.<sup>25</sup>

In 2000, the organisation had a complement of 60 full-time equivalent (FTE) staff and 160 actual employees. There was one contact officer who had received no training in the role. Staff had little or no knowledge about the contact officer nor information about the role. In 2009, the organisation has 98 FTEs and 210 actual employees.

In 2007, six staff members were invited and supported to attend contact officer training provided by the Equal Opportunity Commission of South Australia (EOCSA) and subsequently recruited in to the role. Guidelines

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<sup>23</sup> NOHSC (1999) *Program One Report: Occupational Violence*. Paper discussed at the 51st Meeting of the Australian National Occupational Health and Safety Commission, 10 March 1999, Hobart, unpublished NOHSC papers.

<sup>24</sup> Muller 1997; Mayhew 2000b cited in *When it's right in front of you; Assisting health care workers to manage the effects of violence in rural and remote Australia*, NHMRC Commonwealth of Australia 2002. p.41.

<sup>25</sup>[http://www.eoc.sa.gov.au/site/eo\\_for\\_business/employers/employers\\_responsibilities/contact\\_people.jsp](http://www.eoc.sa.gov.au/site/eo_for_business/employers/employers_responsibilities/contact_people.jsp). Accessed February 2009.

were established for the role and a number of in-house information sessions were delivered to staff.

Printed information detailing the names and role of the contact officers is displayed on notice boards around the health service and included in the organisation's Orientation Package. A system for ongoing support and monitoring of the contact officer role was established and at the time of writing the contact officer system is undergoing its first review.

Throughout 2008, a number of other training and information sessions addressing occupational violence internal to the organisation, were sourced and offered to staff on multiple occasions. They included:

- Bullying information sessions delivered by the Working Women's Centre,
- Public Service Code of Conduct sessions delivered by the organisation's Employee Assistance Program providers,
- Complaints Procedure information sessions delivered by the AHCHS Director, and
- 'Nipping problems in the bud' training delivered by the EOCSA.

At the same time a *Protocol for Collaboration* outlining best practice in collaborative teamwork and conflict resolution was developed for the organisation and information sessions about it were delivered by the AHCHS Director.

A comparative analysis of data from the baseline and final evaluation surveys show staff reports of experiences of bullying decreased significantly from 23% to 12% in 2007 and 2009 respectively.

A decrease was also shown in staff reports of witnessing bullying from 40% to 13% across the same time frame. Similar decline was found in the categories of 'aggression' and 'abuse' in the workplace.

Further training undertaken in relation to other forms of occupational violence is addressed in the section on workforce development.

### **Systems Development**

Some initiatives were systematised to ensure sustainability beyond the life of the Project. A *Workforce Learning and Development Procedure and Framework* was developed and approved which routinely (annually) offers mandatory and voluntary staff development in a range of areas. The trainings listed in the 'Contact Officer' section as well as sessions on de-escalation of aggression, cultural awareness, violence awareness and diversity are included in the framework. Prior to this initiative these had only been offered ad hoc, if at all.

As already mentioned, the initial staff survey highlighted the needs of violence intervention workers and vicarious traumatisation (VT) as a priority. VT is described as a transformation in a worker as a result of working with clients' traumatic experiences. The full definition is:

*The inner transformation that occurs in the inner experience of the therapist [or other professional] that comes about as a result of empathic engagement with clients' trauma material.<sup>26</sup>*

It is related to, but not the same as, concepts such as emotional exhaustion, burnout, compassion fatigue, secondary traumatisation and counter transference.

A policy and a guideline document were developed and approved addressing VT, and a number of staff information sessions were conducted in house and delivered to staff of the Mt Barker Soldier's Memorial Hospital which is co-located with AHCHS.

Throughout the course of the Project other documents were developed including:

- Aggression Management Procedure,
- Zero Tolerance to Violent Behaviour Policy, and
- Workplace Bullying and Harassment Prevention Policy.

After consultation with administration staff materials outlining crisis and emergency referral services were compiled for use by reception staff when faced with a violence related crisis via telephone or in person. These materials were also incorporated in to the Staff Orientation Package and distributed as handouts at each Violence Awareness Training session.

## Workforce Development

Workforce development for violence prevention involves building the skills of workforces to implement primary prevention activity either opportunistically or more formally. It enhances the capacity of staff to influence attitudes and behaviours of clients and community in naturalistic contexts.<sup>27</sup> There is evidence that workplace training on various forms of

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<sup>26</sup> Z. Morrison, *Feeling Heavy; Vicarious trauma and other issues facing those who work in the sexual assault field*, Australia Centre for the Study of Sexual Assault, ACCSA Wrap No. 4, September 2007.

<sup>27</sup> *Preventing Violence Before it Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, December 2007, p.47.

violence and abuse has an effect on organisational culture, even when individual training has not been undertaken.<sup>28</sup>

### Violence Awareness Training

The baseline survey of staff confirmed workers not directly responsible for work with victims and survivors of violence and abuse, lacked confidence and skill in responding to disclosure, observation and evidence of the issue in the course of their daily work. Given the organisation's priority for violence prevention work, the decision was made to mandate general violence awareness training for all staff, regardless of their role within the organisation.

AHCHS provides services to the community across a broad range of areas including:

- Nursing
- Dietetics
- Occupational Therapy
- Physiotherapy
- Podiatry
- Early Childhood
- Speech Pathology
- Aged Care
- Dementia Care
- Palliative Care
- Home Help
- Paramedical Aid
- Health Promotion
- Administration
- Clinic car services, and
- Equipment Services

The organisation also has staff more directly responsible for work with victims and survivors of violence and abuse in Women's Health, Mental Health, Social Work and Youth Work.

Mandatory Violence Awareness Training aimed to foster common understandings of violence and abuse and to equip staff with the

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<sup>28</sup> Antecol, H & Cobb-Clark, D 2003, *Does sexual harassment training change attitudes? A view from the Federal level*, *Social Science Quarterly*, vol. 84, no. 4.

confidence and competence to provide a first response to disclosure, observation or evidence of violence and abuse.

An external consultant was commissioned to design and deliver the training. The one-day workshop promoted the WHO definitions of violence and abuse, best practice principles for work with victims and survivors of violence and abuse, and canvassed strategies and skills for providing a first response. These included validation techniques, information about rights, appropriate referral and de-briefing options.

Over 160 staff (86%) attended one of eight one-day workshops conducted between March 2008 and February 2009. Written evaluations on the day highlighted several important outcomes.

85% of participants rated their knowledge of violence and abuse as significantly improved by between 2 and 8 points on a scale of 1 to 10 (1=no knowledge and 10=excellent knowledge), following the training.

Over 70% of staff reported improved confidence and competence in providing an appropriate first response in situations involving violence and abuse, particularly those in roles not directly responsible for responding in the medium to long term.

*'Encouraged me to feel more confident in being faced with a situation I would have regarded as outside my realm of experience.'*

Of the staff that reported no increase in confidence, most reported more certainty about appropriate referral sources when needed.

Many staff had thought providing a first response to issues of violence and abuse involved much more than it actually does. This thinking appeared to lead to staff feeling fearful of addressing the issue with clients. The training focussed specifically on a first response involving listening, validating and referring appropriately.

Most reported relief they already had existing skills to fulfil this role and they would not have to solve the client's problem. When asked if they had learned something new from the training, many staff commented on this aspect.

*'It is not my job to fix the problem'  
'We can refer on and not take the load ourselves'  
'Clarification about our roles in certain situations'  
'How much to do and not to do'*

Choice of facilitator for the Violence Awareness Training for such a diverse staff group played a critical role in its success. When asked what they

liked most about the training a majority of staff provided overwhelmingly positive feedback about the facilitator.

*'All questions from group participants were answered with respect'  
'Very gentle, but interactive, everyone listened to and responded to respectfully'  
'Everyone felt their input was valued'  
'We didn't feel silly or stupid'*

When asked what they would have liked done differently, some staff commented the training was too long and they would have preferred a half-day or shorter session. This is attributable to two factors.

Firstly, some staff believe it is not their 'core business', for example they did not see it was part of their substantive role to respond to these issues. Largely for this reason, the Director or delegate attended the morning of every training to introduce the Violence Prevention Project and to outline the rationale for making the training mandatory, that is, violence prevention is an organisational priority and is therefore 'everybody's business'.

Secondly, a shorter training session would have suited staff within the organisation with a higher level of expertise around the issue. This is unfortunately a consequence of providing general awareness training across a diverse staff group and only applied to a small number of staff.

Other staff commented they would like further training in counselling responses. The decision was made that one day of training was adequate because of the organisational requirement to have all staff capable of providing a first response only, that is, the organisation did not require all staff to adopt an ongoing therapeutic or change management role in relation to victims and survivors of violence and abuse.

The final Project evaluation survey solicited information about changes to work practice as a result of violence awareness training. It revealed the main aims of the training were achieved.

*Over 90% of respondents reported increased awareness and over 80% of respondents reported improved confidence in providing a first response.*

## Diversity Training

Homophobic attitudes have been identified as a contributing factor to violence and abuse and the attitudes that support them.<sup>29</sup> Diversity training was mandated for all staff with a supervisory role within the organisation and an Adelaide based support service for newly identifying same sex attracted and transgender people were commissioned to design and deliver the one-day workshop.

The brief for the training was to foster some common understandings and definitions of Gay, Lesbian, Bisexual, Trans, Intersex/Same Sex Attracted (GLBTI/SSA) people; to explore myths, values and attitudes; to canvass responsible and sensitive service responses; to look at strategies for creating an accessible and welcoming environment and to celebrate diversity in the community and organisation.

Twenty-five people attended the training which was very positively received. Well over half the participants rated the content, the presentation and the relevance of the training as excellent. All participants reported feeling more able to respond sensitively to this population group.

## Mentoring Teams and Individuals

This was done throughout the course of the Project in both formal and opportunistic ways.

## Men's Health

There has long been a dearth of specific services for men in the Adelaide Hills region. In order to develop and implement some local men's health initiatives, a *Men's Health Worker Project* was funded part-time for a period of ten weeks in 2008.

*The Inside Out* Project Manager formally mentored the project worker on the reference group and opportunistically shared resources and information on training events related to violence and abuse.

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<sup>29</sup> B Pease, *Engaging Men in Men's Violence Prevention: Exploring the Tensions, Dilemmas and Possibilities*, Australian Domestic and Family Violence Clearinghouse, Issues Paper, No 17, August 2008, p.6

(Racism has also been identified as a contributing factor to violence and abuse and cultural awareness and sensitivity training was therefore also offered to all staff and will continue to be offered annually as required by the *Workforce Learning and Development Policy and Framework*.)

## Children and Families

Recent research by Buchanan has highlighted the need for the development of a knowledge base that combines infant attachment theory and feminist analyses of domestic violence. It is recognised perpetrators of domestic violence directly and indirectly undermine attachment between mothers and infants by rendering the mother physically and emotionally incapable of or unavailable for parenting.<sup>30</sup>

The research highlighted an opportunity for collaboration between the Children and Families Team and the Women's Health Team (which includes the Inside Out Project Manager) and involved mentoring members of the Children and Families Team in their learning around domestic violence.

The initiative culminated in the development of a pilot one-day workshop for mothers of small children called *Embrace: Mothering after domestic violence*. This work will continue to evolve and expand beyond the life of the Project.

## Communication and Education

The Project undertook a wide range of primary prevention activities which group under a heading that *VicHealth* has referred to as communications and social marketing. These activities aim to use a range of communication media to raise awareness of violence and address attitudes, behaviours and social norms that contribute to this problem.<sup>31</sup>

Some of the topics highlighted in the communication strategies utilised were controversial, particularly for staff, and afforded many rich opportunities for wider comment, discussion and debate. The final Project evaluation survey shows half of the respondents had an awareness of these strategies as initiatives of the Project.

The foyer of AHCHS provides space and opportunity for displays of information accessible by community members and staff. Many displays were created during the course of the Project on topics including; violence and violence prevention, Indigenous issues, sexual health, respectful relationships, gay and lesbian issues and materials produced by men's groups advocating action by men to stop violence.

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<sup>30</sup> F. Buchanan, *Mother and infant attachment theory and domestic violence: Crossing the Divide*, Australian Domestic and Family Violence Clearinghouse Stakeholder Paper, September 2008.

<sup>31</sup> *Preventing Violence Before it Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, December 2007, p.44.

A *10 Things Men Can Do To Stop Gendered Violence* poster was adapted for the service and posted in men's and unisex toilets in the building (refer Appendix 3).

Monthly *Updates* were sent electronically to all staff and posted on notice boards outlining initiatives, achievements and reflections on the Project. The *Updates* prompted, on occasion, ongoing correspondence and discussion between staff and the Project Manager.

The Project Manager routinely scanned the internet, mail lists and media for new research, reports, articles, discussion papers, government initiatives, consultations and training opportunities around violence, abuse and prevention. Relevant information was distributed to all staff either in hard copy or electronically.

Similar materials were also forwarded to targeted individuals, teams and disciplines where relevant, for example, publicity for an information session on voice loss and trauma in women was forwarded to speech pathologists.

On many occasions during the course of the Project, the Project Manager presented at the organisations' 'all of staff meetings'. These are opportunities for all staff to come together and share their professional expertise, practice and learning.

### **Privilege**

As a result of attendance at cultural awareness training, some staff were interested in pursuing further discussion and reflection about privilege. Here, privilege refers to the invisible and unearned advantages and benefits associated with culture, race, gender, class, professional status, sexuality, gender identity, age, ability and other factors.<sup>32</sup>

The Dulwich Centre's *Addressing Privilege Project* provided a model for discussion including some guiding questions for beginning conversations.<sup>33</sup> The Project Reference Group piloted two conversations about privilege and notes were taken on the content and process. The model was presented to an 'all of staff' meeting and the Project Manager met with each program area to extend an invitation and offer support to

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<sup>32</sup> *An invitation to talk about privilege*, Addressing Privilege Project, Dulwich Centre, Adelaide. <http://www.dulwichcentre.com.au>

<sup>33</sup> The Dulwich Centre is an independent, internationally renowned, Narrative Therapy Centre in Adelaide, South Australia. <http://www.dulwichcentre.com.au>

individuals and teams to form their own conversation groups about privilege (refer Appendix 4).

Academic Shawn Patrick has presented work with graduate counselling students addressing privilege<sup>34</sup>. One of the factors contributing to the positive outcomes of this work was anonymous participation.

With this in mind, an online discussion forum was created using a free provider with the intention of offering an in-house, anonymous means for staff to post messages about their reflections on privilege. The questions from the Dulwich Centre model were adapted and posted along with some beginning reflections.

### Queer Corner

In 2005, *Queer Corner; A Model for Raising Awareness of Issues Affecting Gay, Lesbian, Bisexual, Transgender, Intersex, Queer, and Same-Sex Attracted (GLBTIQS) People within Health and Community Service Organisations* was developed by staff of the Central Northern Adelaide Health Service. The Queer Corner model was evaluated in 2006 and found to be effective in fostering change in attitude, behaviour and practice among staff.

In order to address organisational norms that contribute to abuse and intolerance and to further our existing work in valuing diversity, the model was implemented across AHCHS.

It consisted of a series of over 50 brief emails for distribution to staff on a regular basis. The emails were authorised by the Director and sent to staff with electronic access fortnightly on behalf of the *Inside Out Violence Prevention Project*.

### Outcomes

Commonly in project work, efforts are made toward sustainability and embedding change organisationally. It is also common that the end of a project throws up opportunities, loose ends, challenges and future directions. The Inside Out Violence Prevention Project is no exception. The following section addresses the potential for some Project initiatives to be ongoing and assesses existing and potential capacity for this work. It also flags future possibilities in primary violence prevention work.

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<sup>34</sup> Shawn Patrick (Texas State University, USA), *Altering Relationships with Privilege*, Presentation to the 9<sup>th</sup> International Narrative Therapy and Community Work Conference, Adelaide, Australia, November 2008.

Opportunities to further systematise Project initiatives within existing resources can be explored. Consideration can also be given to establishing a Violence Prevention Action Group (VPAG) recruited from across the organisation and from community, with a dedicated focus on *action* to implement violence prevention strategies. The potential to dedicate some hours on an ongoing basis for carriage, further development and mainstreaming of violence prevention initiatives across the organisation is also worth exploring. Mainstreaming primary violence prevention work in the organisation dovetails well with recent Federal commitments in the report *Time for Action*.

### **Data management**

The work on data management made some inroads in to improving the organisation's capture of data on violence and abuse experienced by clients of AHCHS and in identifying change to staff practice in recording these issues.

Many staff, particularly those working in the homes of clients, encounter the issues first hand. Given the Project goal of fostering a 'whole of organisation' approach to addressing violence and abuse, many more staff could be recording these issues when and as they encounter them in their work.

Ongoing education and auditing of data would further the goal of making violence and abuse 'everybody's business' and the capacity of the Business and Information Support Team (BIST) to incorporate this in to existing workloads could be explored. In the absence of this capacity, additional resources for staff time could be considered.

### **Mentoring**

Mentoring activity undertaken in the Project with the Men's Health Worker Project and with the Children and Families Team, has produced quality improvement initiatives that address gaps in service provision, and have led to new and evolving work. As reported previously, both of these initiatives will persist beyond the life of the Project.

This work highlights the value of mentoring, by those with specialist knowledge, in furthering collaborative violence prevention and education. Mentoring could also address the coordination of more intentional violence prevention efforts with existing teams and programs which are addressing determinants and contributory factors for violence and abuse.

Some of these teams and programs were identified in the mapping exercise referred to elsewhere in this document and include Youth, Dietetics, Health Promotion, Mental Health, Social Work and Occupational Therapy. The capacity for this work within existing resources appears limited though additional resources would enable further development.

## Ongoing communication and education

In a major evidence review of prevention strategies, *VicHealth* identified that though few evaluations of these strategies exist, where they do, they have been found to work in influencing attitudes and behaviour.<sup>35</sup> The final Project evaluation survey identified around half of respondents had an awareness of the various communication and education strategies implemented.

There is some capacity for ongoing implementation of communication and education strategies though this would be limited to perhaps two or three initiatives per year by teams already engaged with violence prevention activity.

This would include the annual campaign for Sexual Health Awareness Week around respectful relationships by the Youth Team and White Ribbon Day activities conducted by the Women's Health Team in partnership with the Adelaide Hills Domestic Violence Action Group.

There is also room to explore the possibility of the emerging Men's Health area initiating and developing education strategies in relation to violence prevention.

Allocation of further resources would enable the engagement of teams and disciplines within AHCHS in violence prevention education thereby mainstreaming a 'whole of organisation' approach to the issue.

## Targeted Training Opportunities

Sourcing and targeting relevant training opportunities proved to be valuable in enhancing a 'whole of organisation' approach to violence and abuse and encouraging practitioners to consider these issues in the course of their work.

Many of the more general training offerings have been systematised primarily in the Workforce Learning and Development Policy and Framework.

There is capacity in the Women's Health Team and amongst senior management to source and circulate opportunities for discipline specific violence training. A Violence Prevention Action Group would also have a role in sourcing and hosting training events.

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<sup>35</sup> *Preventing Violence Before it Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, December 2007, p.48.

## Building Gender Equity

Work undertaken late in the Project involved exploring possibilities for enhancing gender equity both within the organisation and in service provision. Some of this work resulted in AHCHS negotiating and planning to host a two-day *Partnership Accountability* workshop for violence intervention staff of *Country Health SA*. The training is to take place in June 2009 (refer Appendix 4).

This work realised emerging possibilities for further efforts focused on equity in general as it relates to access, service provision and organisational culture. The work is specialised and requires additional resources if it is to be pursued and is also linked to the work on privilege undertaken in the project.

## Privilege Conversations

Despite expressions of genuine interest in beginning conversations about privilege, none took place formally. There is anecdotal evidence to suggest the demands of a busy health service preclude opportunities for groups to gather and reflect on the wider issue of privilege.

It is also known that conversations about privilege are necessarily personal and confronting, and there is evidence staff would prefer to participate in conversation groups of their own choosing (instead of their prescribed work groups).

The online privilege forum was not widely utilised and some staff reported electronic communication is not their preferred method and that time and priorities are a precluding factor in participating in face to face conversation groups.

Though the Project made minimal progress with the privilege initiative, evidence suggests there is an interest and potential benefit for the workforce and community in furthering this work. Exploring alternatives for sustaining conversations or making renewed efforts on existing ones would require ongoing, dedicated resources in the form of staff time and specialist knowledge.

## Queer Corner

The final Project evaluation survey revealed half of the respondents had an awareness of the *Queer Corner Program* as a Project initiative. The emails also prompted some staff to engage in intermittent correspondence and discussion with the Project Manager.

There is evidence of the effectiveness of this initiative in building awareness and influencing attitudes within the organisation which has resulted in the reduction of both deliberate and inadvertent homophobia. There is potential capacity within the Women's Health Team, the Business Information and Support Team or a VPAG to complete circulation of the remaining emails and any further editions of the program.

## Possibilities for the Future

Beyond advancing the existing Project initiatives, the pursuit of primary violence prevention for AHCHS and the community holds infinite possibilities. First among them is to shift the gaze of this work (which has to date been necessarily internal) externally towards partnership with the community.

Linking with state and national victim and survivor advocacy groups and establishing local versions of the same is a potentially powerful tool for raising awareness about violence and abuse and primary violence prevention.

Engaging men who have used violence and abuse and those who haven't in taking a stand against violence and abuse against women, children and other men has the potential to be valuable in creating long term, social change.

Targeting local community leaders and champions in sport, service clubs, schools and faith communities to participate in violence prevention activity can create a groundswell of support for change.

Social action campaigns and advocacy efforts for better legislation would marry 'tried and true' primary health care principles with the prevention of all forms of violence and abuse.

## Primary Prevention of Violence and Government Plans

Primary violence prevention work has potential to articulate with a wide range of state and national plans addressing life stage service provision. Applying a violence prevention lens to these plans and frameworks would result in a 'whole of government' movement toward reducing and eliminating violence and abuse in our community.

Some of these plans provide for secondary and tertiary approaches to violence and abuse but there are significant gaps and underutilisation of primary approaches in most, the notable exceptions being the recently released national plan *Time for Action* and the VicHealth *Framework*.

South Australian plans and frameworks include:

- Every Chance for Every Child – Making the Early Years Count. A Framework for Early Childhood Services in South Australia, 2003-2007, Department of Human Services, October 2003.
- *South Australian Women's Health Action Plan*, Child Youth and Women's Health Services, 2006.
- *Women's Safety Strategy*, Office for Women, South Australia, March 2005.

- South Australian Men's Health Strategic Framework, 2008 - 2012, SA Health, 2008.
- South Australian Youth Action Plan: South Australia's Policy Framework for Young People, 2005 – 2010, South Australian Office for Youth.
- *Our Actions to Prevent the Abuse of Older South Australians*, Office for the Ageing, Department of Families and Communities, November 2007.
- South Australia's Strategic Plan, 2004, Updated 2007.
- Strategy for Planning Country Health Services in South Australia, November 2008.

Interstate and National Plans include:

- Victorian Health Promotion Foundation, *Preventing Violence Before It Occurs. A framework and background paper to guide the primary prevention of violence against women in Victoria*, VicHealth, December 2007.
- *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children 2009-2021*, Australian Government Office for Women, Department of Families, Housing, Community Services and Indigenous Affairs, March 2009.

## Enablers

Senior management support for this work has been critical in both its reach and outcomes. Three out of six program managers were on the Reference Group for the Project and the Director of the organisation chaired the group. Their involvement, endorsement and promotion of Project initiatives lent considerable weight and credibility to the Project aims.

The breadth and scope of the Project was achieved with funding support for a Project Manager from Area Management initially and organisational management subsequently. Having a dedicated position for this work along with a two year time frame enabled the embedding of some important project initiatives and enhanced the quality and quantity of outcomes.

The Project partnered with the World Health Organization's *Violence Prevention Alliance* providing valuable learning around global work on violence prevention as well as international best practice primary prevention efforts.

This partnership also provided an opportunity for a study trip to the United States for the *Violence Prevention Alliance* Annual Meeting and a range of site visits to organisations involved in violence prevention work. These visits highlighted both what is possible and what is yet to be done in Australia to reduce and ultimately prevent all forms of violence and abuse.

Representation on the Reference Group from every program area in the organisation brought a rich and diverse range of expertise and support to the Project and Project manager. It contributed to 'whole of organisation' aspirations and provided direct and multiple communication channels to all staff. A community representative on the Reference Group helped 'ground' the group's process and Project initiatives in the 'real world'.

## Challenges

Primary violence prevention is a big, long, slow job and this is perhaps part of the reason why secondary and tertiary approaches are far more widespread. It is hard to justify funding, difficult to measure and only a very embryonic field of practice, particularly in Australia.

Primary violence prevention engages with the dense and diverse complexities of individuals, communities, cultures and societies. In the case of this Project, primary violence prevention aimed to penetrate the shell of organisational culture every bit as dense and diverse.

At a more focussed level, primary violence prevention seeks to interrupt and alter long established and entrenched attitudes, norms and behaviour that are violent, abusive, disrespectful or inadvertently supportive of all of these.

Evaluating this work is therefore an extremely inexact and fluid process. It is difficult to measure or to even know what to measure. It speaks to the expression:

*Not all that is measurable is valuable and not all that is valuable is measurable.*

Though the Project was able to deliver measurement on some initiatives as discussed above, the final Project evaluation survey revealed more amorphous and intangible results.

*'Well organised, valuable and important work'.  
[It] has been a fabulous project which has highlighted and supported the change in our workplace'  
'Much safer environment to work and empowered people to grasp an understanding of violence while being proactive about violence.'  
'It is a positive project'  
'This is important to making a healthy workplace.'*

The above comments suggest respondents struggled to be specific about the overall Project but considered it a good thing. Good things, including primary violence prevention, struggle to attract necessary funding worldwide. This Project was therefore a courageous endeavour on behalf of area and organisational management.

Engaging diverse groups was a major challenge throughout the Project and this was strongly evident during the course of the mandatory Violence Awareness Training. Typically, violence and abuse issues are secret, hidden, silent and private - indeed these are perpetuating factors. Unless it is right in front of us, most of us would prefer to ignore it. Health professionals in particular, confront powerfully competing demands and priorities every working day.

Some staff were and remain convinced; issues of violence and abuse are not part of their job. Each morning, in the opening round of the Violence Awareness Training day, it was common to hear comments like:

*'I'm here because I was told to be', or  
'I'm not sure why I'm here; it's not part of my job.'*

Yet importantly, many of those same staff reported in the closing round that participating in the training was extremely valuable for their work.

As late as the final Project evaluation survey, some staff still reported:

*'All of my clients are elderly so violence and abuse is not a problem in my work role', or  
'Most of my clients live alone so it is not an issue.'*

It is worth reiterating, primary violence prevention is a big, long, slow job. For some staff, the training day was the first time they had ever been required to reflect on issues of violence and abuse, either personally or professionally – this is progress.

Most importantly the majority of staff embraced the training and the opportunity it offered to learn and grow as a practitioner and support organisational efforts.

*'I feel privileged to be able to participate in this training and I'm so glad our organisation is addressing this issue.'*

## Conclusion

The *Inside Out Violence Prevention Project* is a bold and innovative initiative by a rural community health service that aimed to develop, implement and evaluate an organisational model for primary violence prevention and enhance a respectful organisational culture. It makes a modest and unique contribution to the field of primary prevention of violence, providing a map for other organisations to experiment with and explore.

The model highlights organisational, workforce and communication strategies where success is measurable, those that are not so easily measured and had mixed success and those immeasurables that show promise. This document also signposts some areas for further exploration and implementation. It is hoped others will use this document either in total or in part in efforts toward reducing and ultimately eliminating the pain, trauma exclusion and isolation wrought by violence and abuse.

## Useful Resources

World Health Organization, Violence Prevention Alliance

<http://www.who.int/violenceprevention/en/>

International Society of the Prevention of Child Abuse and Neglect (ISPCAN)

<http://www.ispcan.org/>

Amnesty International Campaign to Stop Violence Against Women

<http://www.amnesty.org/en/campaigns/stop-violence-against-women>

Close to Home, Domestic Violence Prevention Initiative (USA)

<http://www.c2home.org/>

The Men's Initiative of Jane Doe Inc, The Massachusetts Coalition Against Sexual Assault and Domestic Violence , (USA)

<http://www.janedoe.org/about.htm>

Aged Rights Advocacy Service (ARAS), Abuse Prevention Program (AUS)

<http://www.sa.agedrights.asn.au/prevent/home.html>

*Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*

<http://www.vichealth.vic.gov.au/en/Resource-Centre/Publications-and-Resources/Mental-health-and-wellbeing/Preventing-violence/Preventing-violence-before-it-occurs.aspx>

Time for Action, the report of the National Council to Reduce Violence Against Women and their Children and associated documents

[http://www.fahcsia.gov.au/sa/women/pubs/violence/np\\_time\\_for\\_action/Pages/default.aspx](http://www.fahcsia.gov.au/sa/women/pubs/violence/np_time_for_action/Pages/default.aspx)

B Pease, *Engaging Men in Men's Violence Prevention: Exploring the Tensions, Dilemmas and Possibilities*

[http://www.adfvc.unsw.edu.au/PDF%20files/Issues%20Paper\\_17.pdf](http://www.adfvc.unsw.edu.au/PDF%20files/Issues%20Paper_17.pdf)

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S. Patrick, *Altering Relationships with Privilege*, Presentation to the 9<sup>th</sup> International Narrative Therapy and Community Work Conference, Adelaide, Australia, November 2008.

B Pease, *Engaging Men in Men's Violence Prevention: Exploring the Tensions, Dilemmas and Possibilities*, Australian Domestic and Family Violence Clearinghouse, Issues Paper, No 17, August 2008.

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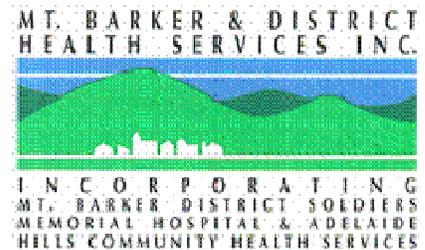
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## Appendices

### Appendix 1: Inside Out Violence Prevention Project Terms of Reference



# Inside Out

Violence Prevention Reference Group

## TERMS OF REFERENCE

### 1. Purpose

The Project Reference Group has been established to oversee and manage issues relating to the AHCHS Inside Out; Violence Prevention Project and provide support and direction for the Project Manager.

The group will provide feedback to Area Management and the AHCHS Senior Leadership Team and provide a mechanism for a cross section of acute and community health staff to facilitate the process of raising awareness of the project and the issues across the health service.

### 2. Membership

Director, AHCHS	Jane Tassie (Chair)
Project Manager	Fiona Meade
Consumer Representative	Cathryn Marinos
Line Manager, Project Officer	Jill Fishers
Rep Healthy Living Program	Michael Bebb
Rep Healthy Ageing Program	Lyndall Fowler
Reps Healthy Communities Program	Rosemary Badenoch
	Kerry May
Rep Business Information and Support Team	Tracey Ross
Rep Community Care Program	Rick Castle
Rep Mental Health Team	Sue Stockdale

### 3. Reporting

The Inside Out; Violence Prevention Reference Group reports to the AHCHS Senior Leadership Team and thence to Hills Area Health Service Management. The agenda and minutes of all Reference Group meetings shall be circulated to all members and made available to all AHCHS staff via the electronic distribution system.

#### **4. Meeting Frequency**

The Violence Prevention Reference Group will meet as required but not less than 6 times per year for the duration of the Project. Meetings will be held at AHCHS.

#### **5. Functions / Duties / Responsibilities**

Coordinate and endorse the development, implementation, evaluation and sustainability of the AHCHS Inside Out; Violence Prevention Project.

Provide context for AHCHS program areas as well as work together to achieve the goals of the Violence Prevention Project.

Provide a forum for discussion of issues arising through the Violence Prevention Program and provide recommendations to AHCHS Senior Leadership Team as appropriate.

Liaise with other committees or groups within and outside of AHCHS as required.

Provide group and individual support to the Project Manager to achieve the goals of the Project.

#### **6. AHCHS Inside Out; Violence Prevention Project**

##### **6.1 Project Aim**

To develop and implement a model for addressing the impacts of violence and for early intervention and prevention strategies.

##### **6.2 Project Goals**

To address issues of violence in relation to Adelaide Hills Community Health Service clients.

To develop a culture of non-violence within Adelaide Hills Community Health Service.

##### **6.3 Timeframe**

#### **7. Meeting guidelines**

##### **7.1 Agendas and minutes**

- Members are to forward agenda items to the Minutes Secretary

- Minutes are to be succinct and include
  - Key discussion points
  - Action to be taken
  - Who is responsible for the action
  - What time period is required for completion of the action
  - An Action Sheet - ie summary of actions in tabular form
- Timelines
  - Minutes will be circulated for comment within one week of the meeting
  - Suggested changes to be provided to the Minutes Secretary within one week
  - Agendas, draft minutes and meeting papers to be sent out a minimum of 3 working days before the meeting

## **7.2 Meeting follow up**

- Where a member has been asked to undertake a task and they are not able to attend the meeting to report back on the action taken, they are to provide the Project Manager with a brief written report (eg email) for the meeting

## **7.3 Meeting “etiquette”**

- Members are to make every effort to be punctual so that meetings can start at the designated time
- Members are to practice the usual means of good group process eg
  - Active listening
  - Open, honest, respectful communication
  - Constructive resolution of conflict
  - Members to share all information relevant to their approach to the discussion
  - Testing assumptions and inferences
  - Explaining reasoning and intent

## Appendix 2 - WHO Determinant and Contributory Factors for Gendered Violence

### Individual Determinants

- Belief in rigid gender roles and identities, weak support for gender equality
- Masculine orientation/sense of entitlement
- Male dominance and control of wealth in relationships

### Contributors

- Attitudinal support for violence
  - Witnessing or experiencing family violence as a child
  - Exposure to other forms of interpersonal or collective violence
  - Use and acceptance of violence as a means of resolving interpersonal disputes
  - Social isolation and limited access to systems of support
  - Income, education, occupation
  - Relative labour force status
  - Alcohol and illicit drug use\*
  - Poor parenting
  - Personality characteristics and poor mental health\*
  - Relationship and marital conflict
  - Divorce/separation
- \* denotes increased risk of perpetration only

### Community Organisational Determinants

- Culturally-specific norms regarding gender and sexuality
- Masculine peer & organisational cultures

### Contributors

- Neighbourhood, peer & organisational cultures which are violence-supportive or have weak sanctions against violence
- Community or peer violence
- Weak social connections and social cohesion and limited collective activity
- Strong support for the privacy of the family
- Neighbourhood characteristics (service infrastructure, unemployment, poverty, collective efficacy)

### Societal Determinants

- Institutional & cultural support for, or weak sanctions against, gender inequality and rigid gender roles

## Contributors

- Approval of, or weak sanctions against, violence/
- Ethos condoning violence as a means of settling interpersonal, civic or political disputes
- Colonisation
- Support for the privacy and autonomy of the family
- Unequal distribution of material resources

# 10

## THINGS MEN CAN DO TO PREVENT GENDER VIOLENCE

- 1 Approach gender violence as a MEN'S issue involving men of all ages and socio-economic, racial and ethnic backgrounds. View men not only as perpetrators or possible offenders, but as empowered bystanders who can confront abusive peers.
- 2 If a brother, friend, classmate or team mate is abusing his female partner –or is disrespectful or abusive to girls and women in general –don't look the other way. If you feel comfortable doing so, try to talk to him about it. Urge him to seek help. Or if you don't know what to do, consult a friend, a parent, a teacher or a counsellor. **DON'T REMAIN SILENT.**
- 3 Have the courage to look inward. Question your own attitudes. Don't be defensive when something you do or says ends up hurting someone else. Try hard to understand how your own attitudes and actions might inadvertently perpetuate sexism and violence, and work toward changing them.
- 4 If you suspect that a woman close to you is being abused or has been sexually assaulted, gently ask if you can help.
- 5 If you are emotionally, psychologically, physically, or sexually abusive to women, or have been in the past, seek professional help NOW.
- 6 Be an ally to women who are working to end all forms of gender violence. Support the work of women's centres. Attend 'Reclaim the Night' rallies and other public events. Raise money for community-based rape crisis centres and women's shelters. If you belong to a team or club or another community group, organise a fundraiser.
- 7 Recognise and speak out against homophobia and gay-bashing. Discrimination and violence against lesbians and gays are wrong in and of themselves. This abuse also has direct links to sexism (eg the sexual orientation of men who speak out against sexism is often questioned, a conscious or unconscious strategy intended to silence them. This is a key reason few men do speak out).
- 8 Attend programs, take courses, watch films, and read articles and books about multicultural masculinities, gender inequality, and the root causes of gender violence. Educate yourself and others about how larger social forces affect the conflicts between individual men and women.
- 9 Don't fund sexism. Refuse to purchase any magazine, rent or buy any DVD, subscribe to any Web site, or buy any music that portrays girls or women in a sexually degrading or abusive manner. Protest sexism in the media.
- 10 Mentor and teach young boys about how to be men in ways that don't involve degrading or abusing girls and women. Volunteer to work with gender violence prevention programs, including anti-sexist men's programs. Lead by example.

This poster was re-produced and adapted by the Adelaide Hills Community Health Services 'Inside Out' Violence Prevention project. The original was developed by MVP Strategies, a gender violence prevention, education and training organisation.

## Appendix 4 - “An Invitation to talk about Privilege”

# Inside Out

Violence Prevention

## An invitation to talk about privilege

### Background

The relations and practices of power that influence our lives are often invisible to us. If we do not proactively look at how relations of power operate to create advantages for some and deny these advantages to others, it can hinder our work as health workers.

You are invited to start conversations about privilege within your own workgroups using the model of the Dulwich Centre’s Addressing Privilege Project (see [www.dulwichcentre.com.au/privilege.htm](http://www.dulwichcentre.com.au/privilege.htm)).

Conversations about privilege involve reflection on the ways in which we enact our particular privilege and as such are highly personal. The risk of vulnerability and the potential for participants to be left in a place of shame is real. Establishing group rules, being concerned for the impact of the conversation on others and debriefing processes (including amongst the participants, with colleagues, line managers and EAP) will help to manage these risks.

The following questions will be a useful guide for early conversations. More guiding questions are available on the Dulwich Centre website and you can make up your own.

- What might distract us in this conversation?
- What concerns us about having this conversation?
- What rules do we need to feel safe having this conversation?
- What might concern a less privileged group about us having this conversation? (ie. indigenous, women, those with disabilities, gay and lesbian groups etc.)

A small group of Inside Out reference group members piloted some conversations in June and July and found them challenging and enlightening. Should you choose to engage in these conversations with others, please keep a record of them and forward to me so that our learnings can be added to the international Addressing Privilege Project hosted by the Dulwich Centre.

Fiona Meade  
August 2008

## **DOMESTIC VIOLENCE TRAINING**

### **PARTNERSHIP ACCOUNTABILITY\***

Accountability to women's experience of their partner's abuse and violence is concerned with addressing power imbalances and ensuring that the interactions are respectful.

Partnership accountability enables the development of processes that make it possible to:

- Challenge patriarchal practices and ways of thinking;
- Provides opportunity to acknowledge and discuss that each of us is of our culture;
- Identify and discuss behaviours that may inadvertently reproduce ways of being and thinking that might be experienced as dominating by co-workers

To establish a context that makes it possible to explore alternative and preferred ways of being and one that does not have us behaving in ways that deny the existence of power differences.

A context that encourages and promotes the acceptance of responsibility for dominating practices will be enhanced by the following factors:

- **Goodwill**  
Entering into the encounter with respect for the views of others and a commitment to seek ethical solutions that promote social justice.
- **Critical Self Appraisal**  
Recognition that we are of our culture and to avoid inadvertently reproducing unhelpful aspects of our culture, we need to be open to critiques from others.
- **Responsibility**  
Understanding that to accept responsibility for our actions gives an opportunity to explore new understandings, try new approaches and makes space for us to begin to appreciate the real impact of our behaviour on others.

\* Courtesy Dallas Colley, Domestic Violence Consulting and Training, 2008.