BOLD THINKERS DRIVING REAL-WORLD IMPACT

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Australian Nurse-Family Partnership Program

Growing Stronger Families, funded by the Australian Government

BOLD DELIVERS
FINAL REPORT

ANFPP NATIONAL PROGRAM CENTRE
Intimate Partner Violence Adaptation Project

Image Description: Newbord peacefully laying in doctors arms after birth.

Contact: Brooke Dickson
Phone: +61 7 3891 4181
Email: info@anfpp.com.au

Growing Stronger Families
Funded by the Australian Government

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Image Description: Babies feet in mothers hand (top left), baby laughing (bottom left), baby holding onto mum while being carried (right).

FIGURES

Tables

Image Description: Infant baby cheekily smiling with their tounge out.

ACKNOWLEDGEMENTS

The Australian Nurse-Family Partnership Program National Program Centre (ANFPP NPC) acknowledges the traditional custodians of the lands and waters on which we live and work. We pay respect to elder's past, present and future.

We further acknowledge that Aboriginal and / or Torres Strait Islander people and community are diverse and dynamic and continue to evolve and develop in response to historical and present social, economic, cultural and political circumstances. Diversity includes gender, age, languages, backgrounds, sexual orientations, religious beliefs, family responsibilities, marriage status, life and work experiences, personality and educational levels [1]

The implementation of the Australian Nurse-Family Partnership Program is funded by the Department of Health through the Indigenous Australians' Health Programme. The Australian Nurse-Family Partnership Program DFV Component has been made possible by funding provided by the National Indigenous Australians Agency (formerly part of the Department of Prime Minister and Cabinet) through the Indigenous Advancement Strategy Safety and Wellbeing grants as part of the *National Plan to Reduce Violence against Women and their Children 2010-2022*.

[1] *Commonwealth of Australia. (2013). National Aboriginal and Torres Strait Islander Health Plan 2013- 2023. Canberra, Australia: Commonwealth of Australia.*

PREFACE

The Australian Nurse-Family Partnership Program Domestice and Family Violence Component has been made possible by funding provided by the Department of Prime Minister and Cabinet from under its Safety and Wellbeing grants as part of the National Plan to address violence against women and children.

This work has been adapted from the Nurse-Family Partnership® Program Intimate Partner Violence Intervention. We are grateful to the support and guidance provided by Dr Susan Jack one of the principle investigators for her ongoing support, input and generosity of her time and materials to ensure alignment to the researched intervention. Along with Dr Jack, Debbie Sheehan and Gail Radford-Trotter our NFP International consultants have also provided wonderful support to the project and direction along the way.

Particular thanks to the steering committee members Dr Mark Wenitong, Tracey Dillon, Professor Boni Robertson, Aunty Anne Leisha, for providing cultural guidance, sharing their experience and inputs to help shape and ensure alignment to the context that the program is working in. Further to this, a special thanks to Ashlee Donohue for her guidance on the adaptation requirements and support to deliver education to the staff.

This component has been developed to support nurses and family partnership workers identify and respond to the issue of domestic and family violence (DFV) and is intended to fit seamlessly into the current Australian Nurse-Family Partnership Program. To support us in achieving this goal, we appreciate and give thanks the support and inputs provided by ANFPP staff who participated in the staff needs activities to outline from a practice point of view what they required to scaffold the amazing support they offer their clients.

Brooke Dickson
Australian Nurse-Family Partnership Program Intimate Partner Violence Project Manager

ACRONYMS & ABBREVIATIONS

Abt	Abt Associates
ACT	Australian Capital Territory
ANFPP	Australian Nurse Family Partnership Program
ANFPP-NPC	Australian Nurse Family Partnership Program National Program Centre
ANKA	ANFPP National Knowledge Access (Project)
CEO	Chief Executive Officer
DFV	Domestic and Family Violence
EPDS	Edinburgh Post-Natal Depression Screening
FGD	Focus Group Discussion
FPW	Family Partnership Worker
IPV	Intimate Partner Violence
NFP	Nurse-Family Partnership (USA)
NHV	Nurse Home Visitor
NNVAWI	Nursing Network on Violence Against Women International
NPC	National Program Centre (formerly Support Service)
NS	Nurse Supervisor
NSW	New South Wales
NT	Northern Territory
PM&C	Department of Prime Minister and Cabinet
QLD	Queensland
QCDFVR	Queensland Centre for Domestic and Family Violence Research
SA	South Australia
SEWB	Social and emotional wellbeing
STAR	Strengths and Risks Framework
UC	University of Colorado
USA	United States of America

Family Partnership Worker	For this report Aboriginal Community Worker (ACW) role and the Aboriginal Family Partnership Worker (AFPW) will be referred to as Family Partnership Workers as their role within the context of the ANFPP is the same.

EXECUTIVE SUMMARY

The Australian Nurse-Family Partnership Program Intimate Partner Violence (ANFPP IPV) Adaptation project (the Project) commenced in July 2016 and concluded in December 2019. This report summarises the purpose, objectives and the outcomes achieved by the Project over this period.

The purpose and objectives of the ANFPP Intimate Partner Violence Adaptation Project were to:

- **Understand the cultural and service delivery context, changes and adaptations required and remaining true to Nurse-Family Partnership program Intimate Partner Violence intervention.**
- **Integrate a Domestic and Family Violence (DFV) component into the ANFPP core curriculum and upskill all roles in the new content.**
- **Evaluate the impact of the adapted education.**

The intended project outcomes and benefits for the project were for ANFPP staff to be able to identify and support clients experiencing DFV and for the ANFPP Nurse Supervisors (team leaders) to be able to support their staff as they undertake this aspect of their work. Further to this, the Project sought to strengthen referral pathways and enhanced interagency support for clients and families within the ANFPP.

The project was broken down into 6 phases with a degree of overlap expected. These phases and their relationship are outlined in Figure 1.

ANFPP IPV PROJECT PHASES

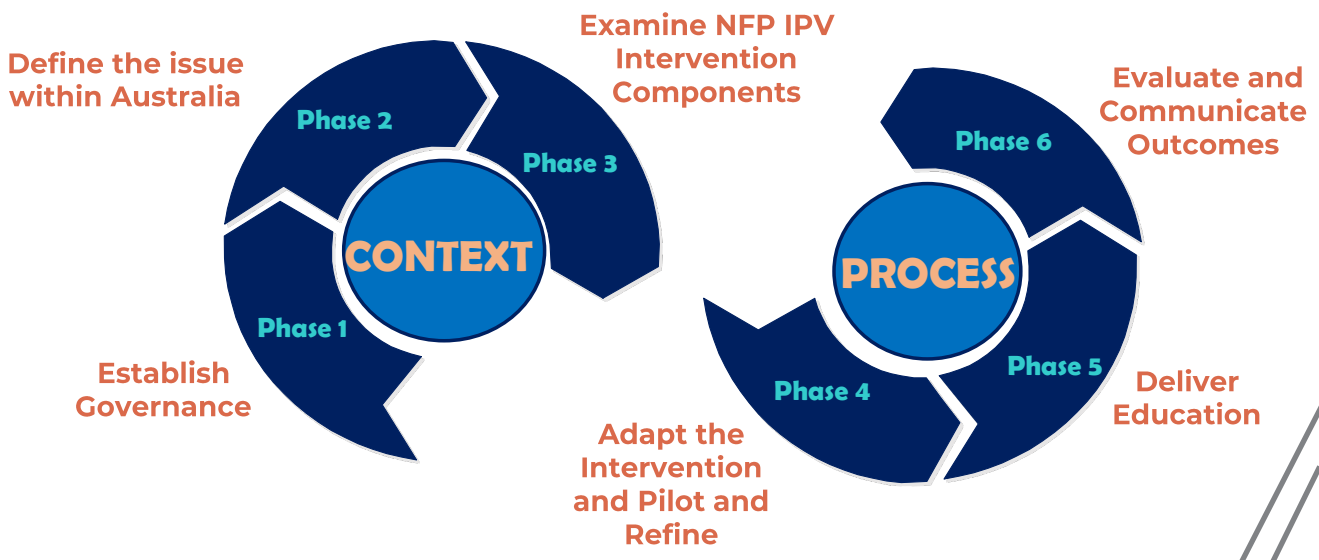


Figure 1 - Project Phases

The table below outlines the original NFP IPV Intervention and the outcome of the ANFPP DFV component.

Table 1: ANFPP adaptations of the NFP IPV intervention

NFP IPV Intervention (5 Original Components)	**ANFPP DFV Component**
NFP IPV Education for Nurse Home Visitors and Supervisors: a. E-learning modules for self-study and team-based discussion b. In-person workshop (1 day) c. System navigation team meeting education module	ANFPP have converted the first 3 modules into a structure suitable for the ANFPP online learning environment. Module four was a team-based learning which was used for introduction for Teams (this was covered in the team-based education delivery). Module 5 is on the Danger Assessment tool which is not being used within ANFPP. In-person education has been incorporated into ANFPP unit 2 education System navigation was incorporated into the introduction section within the ANFPP online learning environment and reinforced during the face to face education
Manualized intervention + NFP IPV clinical pathway; facilitators and corresponding nurse instructions to guide work in four areas: safety planning, increasing awareness of the health effects of IPV, self-efficacy, and social support.	ANFPP domestic and family violence pathway and manual are available through the online learning environment. The domestic and family violence pathway and associated yarning tools and guides have been embedded into the home visit guidelines and is part of the home visit resources. These resources are all available in the ANFPP online learning environment.
Site readiness checklist to support NFP supervisors implement the novel innovation into their implementing agency and current workflow.	The site readiness checklist has been embedded in this manual and has been recommended to be incorporated as part of the implementation package should there be a further role out of new ANFPP sites.
Guidelines for reflective supervision	A Nurse Supervisor domestic and family violence manual which incorporates guidance for reflective supervision and supporting staff has been provided to all NS and incorporated into NS education.
Clinical coaching and support	Ongoing monthly roles specific Community of Practice meetings provide opportunity to discuss implementation challenges and learnings. Site support visits have also provided domestic and family violence education activities with site teams.

KEY PROJECT ACTIVITIES

Critical success factors for this project included:

- Developing a program with a foundation based on client-led content delivery and strengths-based approaches. Much of the literature in the domestic and family violence space encourages the client to have control of decisions. The delivery of ANFPP is informed by the NFP client-centred principles.
- Using a trauma-informed approach in working with clients.
- Using training and educational resources and tools that can be adapted to local practice context.
- Understanding the baseline and staff needs associated with the content to be adapted and then embedded in practice.
- Applying a team-based approach to care alongside ongoing support from a team leader and the provision of safety and well-being supports for staff.
- Promoting cultural support and safety (including through an Indigenous identified role.)
- Hiring and engaging staff with previous work experience working with clients who have experienced domestic and family violence.
- Understand the environment and context the program is working in and examining the relationship between existing and new content.

FIGURE 2

KEY PROJECT ACTIVITIES: A SUMMARY OF THE COMPLETED ACTIVITIES DURING THESE PHASES

Lessons Learnt during this project include:

- Identify evidence-based literature– limited literature available in this space, this project could contribute to that space
- Considerations of climate in program where trying to introduce new content - consider what else the staff have to learn at the same time
- Concurrent projects that could have an impact – delays in project with dependencies have an impact
- Limitations of local tools – states and territories have differing frameworks
- Clear purpose and how to tailor content
- Communication to staff about the project
- The importance of terminology
- Additional and ongoing support of staff

KEY RECOMMENDATIONS

The top key recommendations have been identified as a result of this project. These recommendations could support future implementation of new content into the ANFPP. They are also applicable more broadly to programs looking to incorporate Domestic and Family Violence elements into their work.

The key recommendations are:

- **Ensure that the program is ready for new content to be incorporated & consider any other projects happening within the program.**
- **Identify and respond to the support needs of current staff, including staff members' ability to contextualise the content to the local client and workplace context.**
- **Recognise the importance of networks, clear referral pathways and strong relationships with clients to the successful introduction of new content.**
- **Provide opportunities for refreshers and check-in following implementation of new content, with attention given to staff safety.**
- **Incorporate support for inter-site learning and sharing of information.**

Image Descriptoin: A toddler smiling while holding an infant in her lap. The infact is happy and has his face turned twoard the face of the toddler.

PROJECT BACKGROUND

The purpose and objectives of the ANFPP Intimate Partner Violence Adaptation Project were:

The key recommendations are:

- **Understand family and intimate partner violence in the Australian Aboriginal and Torres Strait Islander context. This understanding informs the necessary adaptation of the existing NFP IPV education and supports to meet the cultural and service delivery context of Australia, whilst remaining true to the principles of the NFP model.**
- **Integrate this adaptation into the existing ANFFP education to nurse home visitors and develop a new education package to meet the position requirements of the Family Partnership Worker role.**
- **Train all ANFPP staff at partner organisations.**
- **Evaluate the impact of the adapted education and supports on site staff capabilities to support their clients who are experiencing violence in their intimate relationships.**

This project was established in July 2016 for completion in December 2019 and involved the adaptation of the NFP IPV intervention to the Australian Aboriginal and Torres Strait Islander context. Initially the intervention was to be implemented as a standalone education module but for long-term sustainability the IPV education module was embedded in the ANFPP core education.

The focus of this work was to look beyond screening to not only identify if the issue was occurring but also to determine how to respond appropriately to support the client. Feder et al (2009) outlines significantly less effort has been given to developing interventions aimed at reducing IPV or its consequences compared with the emphasis on universal screening.

The strategic goal of this project is to:

> ***Provide education and support to Australian Nurse-Family Partnership teams to effectively respond to Intimate Partner Violence (IPV) in Indigenous communities and [in time] reduce the incidence of IPV and / or its consequences for families participating in the ANFP Program.***

1.1 NURSE-FAMILY PARTNERSHIP® PROGRAM BACKGROUND OF THE INTIMATE PARTNER VIOLENCE INNOVATION

The ANFPP is a licenced adaptation of the Nurse-Family Partnership (NFP) program, the information in this section provide a context of how the NFP IPV innovation came about.

To set the context the Nurse-Family Partnership® NFP a licensed program. It is an early intervention program that aims to improve the quality of life for parents and child Improving self-efficacy, promoting attachment and supporting economic self-sufficiency through the three program goals. The program approach differs from many other approaches as it finds and builds on the strengths of both home visiting team and client to facilitate behavioural change.

The ANFPP program goals include:

- Improving Pregnancy Outcomes
- Improved Childhood Development
- Improved Parental Life Course

Experiences of IPV among young women are common and significantly impact their physical, mental, and reproductive health outcomes across the lifespan. Within health and social care settings, complex familial, social, cultural, structural and political factors influence how health care professionals recognize, and then respond, to individuals who have experienced family violence. Awareness of the need to develop interventions to address IPV within the context of the Nurse-Family Partnership (NFP) program emerged in the first trial of the program, conducted in Elmira, New York [United States (US)] (Eckenrode et al, 2000), it was established that in nurse-visited households where the mother reported moderate to severe levels of IPV, the beneficial program effect of reducing state-verified rates of child abuse and neglect was not found.

However, subsequent evaluations of NFP, in both the US (Olds et al, 2004) and the Netherlands (Meidoubi et al 2013), have reported reductions in IPV exposure among nurse-visited women, suggesting that there may be practices embedded within the way that NFP is delivered that could be further enhanced to support women and children experiencing family violence.

Since NFP was not specifically designed to respond to adolescent girls and young women exposed to IPV, one of the first steps was to determine the extent to which this home visitation program provided education and clinical guidance to nurses to address this issue in their clinical practice. In 2006, a web-based survey of 283 NFP nurses and supervisors in the United States found that 72% of respondents reported that the presence of IPV in the home made delivering the NFP program somewhat or very difficult and that almost 40% of nurses expressed that they did not have sufficient knowledge and skills to adequately address IPV (Jack et al, 2012). To address these educational and clinical gaps, a team of researchers from Canada and the United States was formed to develop, pilot and evaluate a nursing intervention to identify and respond to IPV among women enrolled in the NFP program.

A formative process was used to develop the NFP IPV intervention. To identify core components of the intervention, a qualitative case study was conducted in four NFP implementing agencies in the United States to

1) understand the problem of IPV as it is experienced by the women enrolled in NFP and described by NFP nurse home visitors and supervisors;

2) identify women's needs and requests for intervention through the NFP program;

3) analyse the current practices nurses use to identify and then address the needs of women exposed to IPV; and

4) analyse the strategies and organizational policies that exist to support abused women and children in the community *(Jack et al, 2012)*.

To ensure that the intervention reflected current evidence-based practices as well as the principles of the NFP program, four data sources were used to develop the final NFP IPV intervention:

1) the results of the case study which informed the content and structure of the clinical pathway, including a multi-faceted approach to assessment, and the IPV education provided to nurses and supervisors;

2) existing evidence to augment assessment techniques, responses to IPV disclosures and intervention procedures;

3) the NFP-client centered principles and attention to NFP nurse competencies;

4) adaptation and adoption of several existing NFP facilitators and nurse instructions (Jack et al, 2017).

The resultant NFP IPV intervention consisted of five related components:

1) a comprehensive educational curriculum to support nurse home visitors develop the knowledge and confidence to address IPV in practice;

2) a manualized intervention, along with a clinical pathway providing guidance for assessment and developing tailored intervention plans informed by a client's level of risk, readiness to address safety, and mental health and substance use experiences, and then a series of facilitators to use in practice to promote safety planning, increase a client's level of awareness of the health effects of violence, to enhance self-efficacy and to promote social connection.

From 2011-2015, this intervention was evaluated in a cluster-based randomized clinical trial at 15 sites in eight US states to determine the effect on maternal quality of life (Jack et al, 2019). In this trial, improvements in quality of life and reductions in experiences of IPV from baseline to 24 months postpartum were measured in both groups and there were no statistically significant differences between the groups.

One possible reason why the augmented NFP program was not more effective than the standard program was that it could be that the standard NFP program, given the potency, outcomes such as quality of life and IPV to such an extent that the augmented practice model did not provide any incremental benefits.

Qualitative process data collected during the trial also provided insights that there were limitations in the implementation of the intervention, and that a low level of fidelity to the intervention may have reflected the complexity of the intervention as well as challenges related to safely addressing IPV within a home environment. However, the results from the evaluation of the NFP IPV education completed by nurses and supervisors demonstrated positive results among nurses. In comparing NFP nurseswho received the IPV education to controls, there were large clinically and statistically significant increases in knowledge and confidence to initiate discussions about women's experiences of violence and then to respond to disclosures of IPV.

These findings, taken together with the finding that no harm to clients was demonstrated in the trial, compelled the US National Service Organization to move forward with providing this requested educational support to NFP nurses. In the US, the NFP education has been further adapted and is now available through a series of optional e-learning modules to all nurse home visitors and supervisors.

More broadly internationally, there is ongoing work to further enhance and adapt the IPV education and intervention. The intervention has been embedded into the Canadian NFP visit-to-visit guidelines and core education, and outcomes related to maternal experiences of IPV are being measured as part of the British Columbia Healthy Connections randomized controlled trial (Catherine et al, 2019) and nurses' experiences of the education and their responses to IPV explored in the adjunctive process evaluation study (Jack et al, 2015).

Similarly, work to culturally adapt and evaluate the acceptability of the IPV education and intervention is being currently conducted in Northern Ireland and Norway, and was informed the development of an IPV intervention which was as part of the ADAPT project with eight Family Nurse Partnership sites in England.

Image Description: Close up of a happy infants' face .

1.2 OVERVIEW OF THE PROJECT

The implementation plan for this project was divided into six phases as outlined in the project plan, see Table 1. The progression between phases was not linear as individual activities were not reliant on completion of other phases.

Table 2 - Project Phases

Item	Description	Timeline
Phase 1 **Governance**	Outline governance structure in project plan. Confirm Steering Committee Terms of Reference (TOR) and establish meeting schedule. Identify evaluation methodology.	~ Nov 2016
Phase 2 **Define problem with Australia**	Conduct environmental scan including staffing needs assessment, organisational situational analysis, national and state policy and screening tool situational analysis.	~ June 2017
Phase 3 **Map Adaptation Requirements**	Define cultural adaption methodology, content and contextual adaptations to the intervention materials and resources. Identify data and tools required to evaluate effectiveness of the education and support components. Consider STAR framework incorporation into the education delivery approach. Identify the FPW education requirements.	~ Jan 2018
Phase 4 **Adapt intervention (Inc. Piloting)**	Translation of information gathered in previous phases into an adaptation of NFP IPV intervention including: • Education module (with six components including online learning module, workshops, 3-6 month follow up teleconferences and team meetings) • Manualised intervention including a clinical pathway, home visit facilitators and nurse instructions • Supervisor guidelines for reflective supervision • A site readiness checklist • Clinical coaching and consultation Develop the FPW stream of domestic and family violence education. Pilot completed education in twosites – gather baseline information, education of staff, review feedback post education and update education for all streams. Collaborate with Workforce Development team to incorporate DFV education elements within core curriculum education.	
Phase 5 **Deliver Education**	Deliver domestic and family violence unit of education to 13 remaining sites.	~ Dec 2018
Phase 6 **Evaluate**	Evaluate effectiveness of education with pilot sites and sites from Phase 5. Commence delivery of ANFPP core curriculum with domestic and family violence elements included.	~ Jun 2019

The intended project outcomes and benefits for the project were:

- ANFPP staff (Nurse Home Visitors, Family Partnership Workers and Nurse Supervisors) are able to identify and support clients and families experiencing domestic and family violence in a culturally safe way.
- Nurse Supervisors are able to support staff who are providing care to clients with complex needs.
- Improved ANFPP education including embed domestic and family violence education in the curriculum for long-term sustainability.
- Strengthened referral pathways and interagency support for clients and families within the ANFPP who experience domestic and family violence.
- Clients experiencing domestic and family violence receive effective support from NHV's and FPW's
- Children of clients experience less exposure to domestic and family violence.

1.3. ANFPP HEALTH SERVICES

The adaptation of the intervention was led by the ANFPP NPC and the education was provided to ANFPP staff working in 13 partner organizations (Table 2) across four states and two territories

Table 3 - ANFPP Partner Organisations 2019

ANFPP Partner Organisations		
Northern Territory	2017	Danila Dilba Health Service
	2016	Top End Health Service – NT Government
	2017	Wurli-Wurlinjang Health Service
	2009	Central Australian Aboriginal Congress (CAAC)
Queensland	2009	Wuchopperen Health Service (WHS)
	2016	Institute of Urban Indigenous Health (IUIH) - North
	2017	Institute of Urban Indigenous Health (IUIH) - South
New South Wales	2017	Durri Aboriginal Corporation Medical Service
	2017	Greater Western Aboriginal Health Service
	2009	Wellington Aboriginal Corporation Health Service (WACHS)
ACT	2017	Winnunga Nimmityjah Aboriginal Health and Community Services
Victoria	2017	Rumbalara Aboriginal Co-operative
South Australia	2017	Nunkuwarrin Yunti of South Australia

Image Description: A close up of a mum placing her hands around her pregnant belly in the shape of a heart.

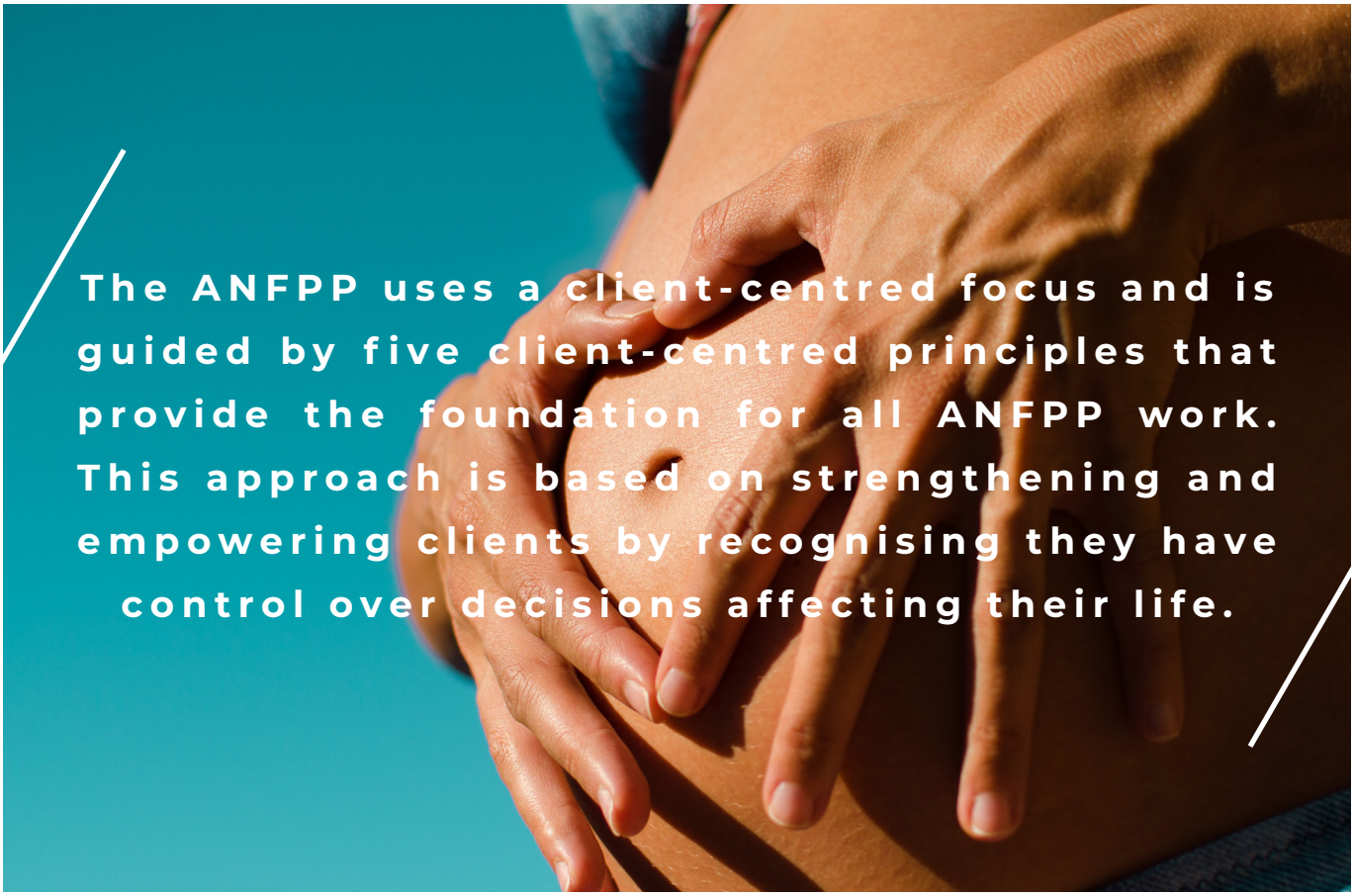


FIGURE 3
ANFPP CLIENT-CENTRED PRINCIPLES

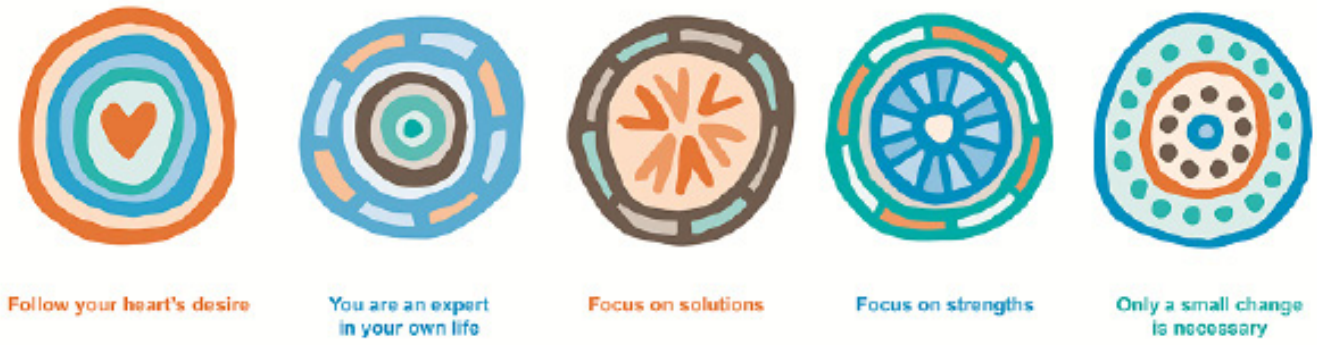


Image Description: ANPP Client-centred principles (from left to right): Follow your hearts desire, you are an expert in your own life, focus on solutions, focus on strengths, and only a small change is necessary.

SUMMARY OF ACTIVITIES

At the commencement of the project in 2016, four partner organisations were delivering ANFPP across four sites. During the life of the project the ANFPP conducted a scale up to 11 partner organisations, delivering the program to 13 sites as outlined in Table 2

In addition, during the period the program developed a data collection system *(called ANKA)*, adjusted core education delivery and completed a project tofurther define the FPW role. While the concurrent ANFPP projects created challenges for the IPV project all contracted Key Performance Indicators *(KPIs)* and deliverables were met.

2.1. PROGRAM ACHIEVEMENTS

Table 4 – Key Performance Indicators

Activities	Contract KPI	Due Date	Completed Date	Status
REPORTING PERIOD				
Interim Progress report and unaudited expenditure report – 1		27.01.2017	27.01.2017	Completed
Interim Progress report and unaudited expenditure report – 2		28.07.2017	28.07.2017	Completed
Audited expenditure report		28.09.2017	28.09.2017	Completed
Adapted intervention designed	✓	31.12.2017	31.12.2017	Completed
Interim Progress report and unaudited expenditure report – 3		29.01.2018	29.01.2018	Completed
Training Materials		30.06.18	30.06.2018	Completed
Interim Progress report and unaudited expenditure report – 4	✓	31.07.2018	31.07.2018	Completed
Audited expenditure report		28.09.2018	28.09.2018	Completed
Supplementary Training sessions	✓	31.12.2018	12.02.2019	Completed
Interim Progress report and unaudited expenditure report – 5		29.01.2019	29.01.2019	Completed
IPV training module incorporated into core curriculum	✓	30.06.2019	05.03.2019	Completed
Interim Progress report and unaudited expenditure report – 6		31.07.2019	31.07.2019	Completed
Audited expenditure report		30.09.2019	30.09.2019	Completed
Final Report		15.01.2020	15.01.2020	Completed
Final Audited Expenditure Report		15.01.2020	15.01.2020	Completed

2.2. PHASE 1 – ESTABLISHING GOVERNANCE

The Governance structure was defined in the project plan, and the Steering Committee Terms of Reference (TOR) were developed in collaboration with key advisors who provided cultural governance and technical quality assurance over the Project.

On 1 November 2016, the inaugural Steering Committee meeting provided an opportunity for key stakeholders to gain a detailed understanding of the Project, the NFP and ANFPP. The committee members were able to meet and to learn about each person's experience and expertise.

The Steering Committee consisted of:

- **ANFPP Leadership Group champion - Dr Mark Wenitong**
- **ANFP National Program Centre Workforce Development Manager - Aurora Bermduaz-Ortega**
- **ANFP National Program Centre Director– Karen Harmon**
- **ANFP National Program Centre IPV Project Manager – Brooke Dickson**
- **NFP IPV lead - Dr Susan Jack, School of Nursing, McMaster University, Canada**
- **NFP International consultant - Debbie Sheehan, NFP National Service Office, USA**
- **Representative from Department of Prime Minster and Cabinet**
- **Representative from Commonwealth Department of Health**
- **Australian IPV/Indigenous Family Violence expert – Professor Boni Robertson (research)**
- **Australian IPV/Indigenous Family Violence expert – Tracey Dillon (programmatic)**

Table 4 outlines the steering committee meetings held throughout the project and the key outcomes of each of these meetings. They were held in alignment to project activities.

Table 5 - Steering Committee Meetings

Steering Committee Meetings		Key Outcomes
1	1 November 2016	Finalisation of project plan, project initiation documentation
2	18 May 2017	Presentation of findings from staff needs assessment, environmental scan and literature review
3	5 December 2017	Review and discussion of domestic and family violence clinical pathway and manual
4	4 April 2019	Discussion and review of project evaluation methodology
5	1 November 2019	Presentation and discussion of project evaluation findings.

2.3. PHASE 2 – DEFINING THE PROBLEMS IN AUSTRALIA

The NFP program model was 'not designed specifically to respond to women exposed to IPV'*(Jack, 2015)*. Therefore, the initial development phase of the NFP IPV intervention involved defining the problem, conducting a needs assessment of nursing staff and determining the baseline data to be collected by program staff.

As we built upon this foundation work in Australia, we sought to identify and understand local contextual challenges that would need to be addressed during the process of adapting the NFP IPV education and intervention for the ANFPP program.

The following contextual issues were identified:

- The program model in Australia included Indigenous Family Partnership Workers (FPWs). The FPWs work closely with NHVs to deliver the ANFPP in a culturally safe way. FPWs expressed their need for training and recognised their training needs may differ from Nurse Home Visitors.
- Domestic and family violence occurs in the context of an Indigenous experience of violence which has been noted as having a relationship with 'the disruption and distress attributable to colonisation, dispossession and the removal of Indigenous children from their families'(Cripps K, 2012). This can impact on the education staff needs of ANFPP teams.
- The uniqueness of the organisational environment where ANFPP staff deliver the Program, with associated impact on the training and support needs of ANFPP teams who respond to violence.
- Australian policies and legislation on issues such as mandatory reporting differ in Australian states and territories.
- The current methods of data collection regarding intimate partner violence needed an immediate review. This included the identification and implementation of suitable screening and assessment tools.

STAFF NEEDS

To assess staff educational and support needs across ANFPP roles a survey was devised. The survey aimed to learn how staff supported clients impacted by domestic and family violence, to determine levels of expertise, and learn from reflections on their experiences. The survey contained questions and scenarios giving the NSs, NHVs, and FPWs the opportunity to respond.

The survey results gave the project information on what was needed to facilitate engagement with support services, highlighted strengths and challenges for staff working in their communities and common areas to build knowledge, skills and confidence. The assessment process identified that the term Intimate Partner Violence *(IPV)* did not reflect the terminology used in community and the term Domestic and Family Violence *(DFV)* was adopted within ANFPP.

From November 2016 to the end of February 2017, a consultative needs identification process was undertaken to identify ANFPP staff educational needs for addressing domestic and family violence in their work with clients. This was conducted with the teams at the four sites delivering ANFPP at that time *(CAAC, IUIH North, WACHS, WHS).*

Role-specific surveys were developed and conducted. The survey data was analysed, themed, collated, and reported back to staff as a basis for further discussions at site visits. The site visits consisted of focused group discussions to clarify and elaborate on survey results and were concluded with a scenario-based client journey mapping activity to understand service connections and referral pathways.

SUMMARY OF KEY STAFF NEEDS SURVEY FINDINGS

- **Identified baseline of where staff are positioned in their approach to domestic and family violence and where further and more in-depth discussions were required.**
- **Responses demonstrated the depth of understanding and skills utilised when addressing domestic and family violence. The strategies identified to support clients were consistent across all sites and roles.**
- **Participants identified different understandings of attitudes surrounding the domestic and family violence. Sexual violence was regarded as a likely issue for some clients but one that remains hidden.**
- **Domestic and family violence was most commonly identified by direct disclosures to ANFPP staff. FPWs were more likely to say they witnessed domestic and family violence or were the first to know about or recognise it, through their knowledge of the family or the community.**
- **FPWs highlighted challenges and strengths related to their role as members of the community.**
- **Identified discrepancies between the supports and referral pathways available outside ANFPP and the awareness of these pathways amongst staff.**
- **ANFPP staff have a good understanding of factors that prevent clients from engaging with support services. FPWs cited more practical barriers such as transport, childcare and costs.**

- **The understanding and awareness of support available within their organisation was consistent.**
- **Significantly, all staff reported the work of supporting client and colleagues in situations of domestic and family violence has an impact on their own health and wellbeing.**

ENVIRONMENTAL SCAN

The purpose of the environmental scan was to supplement the ANFPP staff needs activity which focused on current practice, knowledge and skills in addressing domestic and family violence. The environmental scan report provided a situational analysis and was more narrowly focused on the environments where ANFPP practices.

The environmental scan:

- **Identified the domestic and family violence environment at the system, programmatic and service levels, and strategic policy and legislative frameworks in Australia, at state and territory and national levels.**
- **Provided a resource to inform the design of domestic and family violence training, in alignment with the ethos and scope of ANFPP.**
- **Detailed relevant support identified through consultation with staff and other experts.**
- **Outlined the implications for the ANFPP Intimate Partner Violence (IPV) Project to consider when designing education content and skill development knowledge and practices for addressing and responding to clients experiencing domestic and family violence.**
- **Supported identification of local community led initiatives to best support clients as the ANFPP program does not work in isolation in community.**

LITERATURE REVIEW

A Literature Review was conducted by Queensland Centre for Domestic and Family Violence Research (QCDFVR) to provide insights and considerations about domestic and family violence in Aboriginal and Torres Strait Islander populations; how to identify and respond to family violence in a home visiting context; and an understanding of the adaptation of evidence-based content for a culturally competent adaptation.

The implications from the literature outlined that the ANFPP training curriculum would benefit from specific content on the following topics:

- **Understanding how views of family relationships, obligations and sense of connectedness may differ, and giving consideration to the diverse family and kin structures of Aboriginal and Torres Strait Islander populations.**
- **The definition of domestic and family violence and theories about its causes. domestic and family violence is differentiated from other types of violence by the relationships between those using violence and those who experience the violence and the impacts extend beyond the people immediately involved.**
- **The constraints and barriers on Aboriginal and Torres Strait Islander women may also vary as it may be difficult for them to leave their homes and communities given their connections to kin.**
- **The legacy of colonisation, policies and practices, institutional racism, and their effects on intergenerational trauma.**
- **Understanding barriers to reporting domestic and family violence – generally, and specifically for Aboriginal and Torres Strait Islander populations.**

The adaptation process identified that much of the published processes outlined in the health care literature has been designed for acute care in hospital settings. In this context, women would often have a short-term engagement with a health care provider and the primary focus was on crisis management. In contrast, the NFP IPV intervention had been designed for a home visitation program, a primary health care context where staff develop and nurture a therapeutic relationship with clients and their families over a two- and half-year period,

2.4. PHASE 3 – MAP ADAPTION

The literature review identified that limited research was available that explored cultural adaptation processes for an evidence-based health program designed for delivery to Aboriginal and Torres Strait Islander people. In response, the Project looked more broadly to international literature for approaches to cultural adaptations. A session on *Adaptation of the Nurse-Family Partnership Program Intimate Partner Violence Intervention of the Australian Setting* was presented in Melbourne at the Nursing Network on Violence Against Women International (NNVAWI) conference in October 2016. The session reviewed a range of methodologies to determine the most appropriate for realising the Project outcomes. The evidence-based methods identified formed the basis of the adaptation process.

While ANFPP is not a specific specialist family violence prevention / early intervention program, the lessons from domestic and family violence programs have been helpful in directing this project. In Australia the health field is taking measures to educate staff in identifying and responding to domestic and family violence. The domestic and family violence component for ANFPP is not about screening to identify and then referring on, it is about understanding relationships, and the client's support needs, and working with the client to keep her and her baby safe. ANFPP does, however, provide an opportunity to work across the spectrum from prevention, early intervention, through to crisis management, so staff must understand what the client needs might be at each of these levels.

The focus of the domestic and family violence component has been to align with the partner organisations delivering ANFPP, and their approach to supporting specific client groups identified through the staff needs report. Partner organisations have the best community knowledge for addressing family violence. The education provided to ANFPP staff aims to strengthen their knowledge and support for clients experiencing domestic and family violence.

The domestic and family violence education uses multiple teaching and learning strategies to increase learners' knowledge and skills and introduces a number of innovation resources along with discussions on how they can be applied in practice. , employed in different component consists of various elements including:

Education Teaching and Learning Strategies:

1. Introduction to the domestic and family violence intervention. Completion *(independently or through team meeting discussions)* of the NFP e-learning modules:
   a) Introduction to the NFP IPV Intervention b) Characteristics of an Abusive relationship c) Responding to a client disclosure and teams were encouraged to complete d) Identifying IPV as a group.

   Note: During this project the NFP e-learning modules were accessed but these have since been adapted for the ANFPP online learning environment and include
   a) Introduction to the ANFPP Domestic and Family Violence (DFV) Component
   b) Characteristics of an Abusive Relationship and
   c) Responding to a disclosure and staff are recommended to attend DV-Alert education as well.
2. Completion of a team meeting activities focused on "system navigation" strategies following engagement in the education. These activities includes (site visits, guest speakers) to help staff navigate local networks and partner community organisations; as well as to be able to provide anticipatory guidance when referring clients to these agencies.
3. Team based education workshops upskill staff understanding of domestic and family violence and how to apply the ANFPP DFV pathway in practice at their site.

Learning and Practice Resources Provided:

1. ANFPP domestic and family violence pathway to guide decision making in practice as well as a corresponding manual to provide guidance on how to apply the pathway in practice.

2. Yarning tools, and guides for use, to use on home visits when applying the tailored intervention.

3. Nurse Supervisor manual, which includes a "site readiness" checklist to ensure that the implementing organisation is prepared to integrate the domestic and family violence intervention into current workflows. The manual also provides guidelines for reflective supervision.

The adaption work also included the development of a series of 'yarning tools', for use by home visiting team members during their interactions with clients. The yarning tools *(YT)* sit within the ANFPP home visit guidelines.The YT have been designed in a generic style and each addresses a specific topic for discussion with the client, such as Healthy Relationships or What is domestic and family violence? Each YT is accompanied by a guide (for staff use) explaining its intended purpose, use, and how it can be adapted for local context.

The opportunity exists for staff to exchange the generic YT with a local versionwith the same intention, allowing for further local contextualisation.

The project connected with the broader international NFP programs going through the process of incorporatingg the NFP IPV innovation *(Northern Ireland, England, Canada and Norway)*. The international community shared approaches and encouraged a strong emphasis on fidelity to the original design of the NFP IPV intervention.

Adaptation issues within the broader international NFP community are identified in Table 5 below along with the ANFPP's approach to addressing these issues:

Table 6 - Adaption Issues

ADAPTATION ISSUE	ANFPP APPROACH	IPV PROJECT OUTCOME
Sustainability of Education	The education will be built into the core curriculum for all roles and a train the trainer approach will be utilised to ensure all ANFPP educators are able to deliver the content. An ANFPP educator will be allocated to ensure content stays relevant and in line with state/ territory and National policies and procedures.	ANFPP IPV project manager is now also ANFPP Workforce Development and Education Lead and is able to ensure the ANFPP Education team are upskilled to deliver the ANFPP domestic and family violence content and content is up to date. Lesson plans and facilitator guides have also been created as part of the project.

ADAPTATION ISSUE	ANFPP APPROACH	IPV PROJECT OUTCOME
Assessment process	Assessment processes for identifying risk/safety need to be both evidence-based and appropriate for the system context for ANFPP. **Challenge:** The Danger Assessment used within the NFP pathway is currently only a validated tool for North America (there is potential opportunity to work with DA designer to validate for Australia). The Environmental Scan identified that each state/territory utilises a different risk assessment framework/tool which is often multi agency and very few have a weighted overall risk score to support the tailoring of safety planning.	Each site to use their local state risk framework in place of DA tool to identify threat and support safety planning and will also support those located where an integrated care arrangement is in place to ensure common language is used in supporting clients. Currently using state / territory based tools.
Measurement of outcomes	Challenge: Need to distinguish between clinical tools and tools to measure outcome and consider the burden on clients.	Align with measures identified within STAR framework around stages of change and how this will be captured in the ANKA system
Implementation evaluation	The quality of implementing the innovation and this evaluation will need to align with the approach used by the international societies to inform an NFP global / generic approach to adaptations of NFP innovations, potential for inclusion in a broader NFP paper in the field of implementation science.	ANFPP IPV project evaluation approach created with support of IPV project steering committee
Referral pathways	Consider mandatory reporting requirements and where these fit within the pathway.	Service navigation activity within education to support referral out of the program and to strengthen local networking of services.
Trauma and Violence Informed Care	Dr Kelsey Hegarty identified at the ANROWS WITH study presentation *(Hegarty, 2017)* where they used a trauma and violence informed care approach that education alone is not enough, there is also a need for governance, leadership and systems to ensure education provided to staff can be impactful for clients and work within existing organisational structures. **Challenge:** The IPV innovation provides opportunity to embed a trauma informed care approach within ANFPP and the organisations delivering ANFPP. There is a need to ensure we work within legal and organisational systems to support women.	The NPC team have completed a 2 day workshop with Judy Atkinson to understand trauma informed care from an Australian Indigenous worldview. The NPC team is also building mindfulness activities into ANFPP education more broadly

2.5. ASSESSMENT TOOLS

The NFP IPV pathway identified two mental health tools not currently used with the ANFPP (e.g. the PHQ-9 and the GAD-7). The ANFPP education team recommended using the Edinburgh Post-Natal Depression Screening (EPDS) as the mental health screening tool. The EPDS was selected because it is in current use within ANFPP and thereforestaff are familiar with it. This was confirmed with the NFP international consultant and the pathway was adjusted to reflect this.

A risk assessment review showed that the tools currently used in Australia align with the Danger Assessment tool being used by the NFP. The Danger Assessment tool is not currently validated for Australia. The project suggested state / territory based tools to be used in Australia and the committee did not object to this plan. Table 6 below outlines the difference between the Danger assessment Tool and the state/territory tools. This was shared in a brief to the CEO's for consideration and to seek agreement for use by the ANFPP team in their services.

Table 7 - Risk Assessment Tool Review

Danger Assessment Tool	NT/SA DFV Risk Assessment Framework	NSW DVSAT
20 questions (ask the client directly) some questions weighted higher (1 to 5 where 5 is high) and considers the last 12 months. The questionnaire is used in with a 12-month calendar to identify incidence.	59 questions (only ask the client what you don't already know) with various weightings (1 to 5 where 5 is high) and looks over the last month or in the past ever.	25 questions (ask the client directly) with no weighting and doesn't specify a timeframe however does outline some professional judgement considerations.
Results: <8 – Variable danger 8-13 – Increasing danger 14-17 – Sever danger 18+ – Extreme danger	Results: 0 – 23 – Standard 24 – 44 – Medium Risk 45 + – High Risk	Results: Yes, to less than 12 questions – at threat Yes to 12 or more questions – high threat

Question (weighting) and the equivalent questions asked in Australian tools		
Q1 (1)	**Q4 & Q30 (4/5)**	**Q2 & Q8**
Q2 (5)	**Q18 & Q19 (3/1)**	**Q18 (askes about access)**
Q3 (4)	**This question not covered**	**Q11**
Q4 (4)	**Q20 (1)**	**Q13**
Q5 (3)	**Q2 & Q5 (2/4)**	**Q4**
Q6 (3)	**Q5 (5)**	**Q1**

Q7 (3)	**Has questions about past arrests**	**Similar to Q6 but ask if charged with breach**
Q8 (2)	**Q48 (1)**	**Q23**
Q9 (2)	**Q55 (4)**	**Q24**
Q10 (1)	**Q54 (5)**	**Q3**
Q11 (1) & Q12 (1)	**Q21 (4) drugs and alcohol are asked in same question**	**Q15 drugs and alcohol are asked in same question**
Q13 (1)	**Q15 (3)**	**Q10**
Q14 (1)	**Q58 (2)**	**Q7 & Q8**
Q15 (1)	**Similar to Q51 but not the same**	**Q20**
Q16 (1)	**Q12 (4)**	**Q16**
Q17 (1)	**Q9 & Q44 (both 5)**	**Q21**
Q18 (1)	**Q29 (5)**	**Asked in professional judgement section**
Q19 (1)	**Q56 (4)**	**Q9**
Q20 (1)	**Q35 (2)**	**Not asked but professional judgement would be used.**

After discussion with partner organisations, the recommendation by the project was for sites to use the current state / territory-based tools. This would support common language for referral processes beyond ANFPP, as some sites were working toward integrated systems. The use of these tools within the DFV pathway also supported staff to frame and support discussions around mother and child's safety in the context of DFV.

Queensland and the Australian Capital Territory do not have risk assessment frameworks in place and the Victorian common risk assessment framework does not include a weighted calculation of risk factors (although this tool is under review). The project worked with these sites to determine the most suitable tool for their context. The danger assessment tool was also an option for these sites.

The Danger Assessment Tool had previously been adapted to suit the needs of an Indigenous population in Alberta, Canada and therefore the Project made contact with Dr Jacqueline Campbell, the Danger Assessment developer. Dr Campbell indicated she was open to exploring how the tool could be used in the Australian context, if sites were interested in this type of research activity, however there wasn't an appetite for this type of activity at this time.

2.6. DATA COLLECTION IDENTIFIED

As ANFPP were in the process of developing a bespoke data collection system for client and program information (ANKA) there was opportunity to design the data collection fields. As with the broader ANFPP the NFP provided a data form outlining the fields for IPV data collection. This was reviewed along with the ABS data collection fields for domestic and family violence to inform the ANKA DFV data collection.

The process of data collectionin ANKA that aligns with the domestic and family violence pathway has been identified in Figure 5 and further mapping of the various fields and their content can be seen in Annex 4. Currently not all ANFPP sites collect data through the ANKA system; three sites use Communicare as their client information system (CIS). Due to the development of the ANKA system it is not possible to update the ANFPP data collection fields within Communicare. A plan is in place for the sites using Communicare to transition to ANKA, but the transition has not occurred during this project's timeframe. For the purpose of identifying a disclosure the data from the Communicare system has used both a disclosure and a referral after a home visit as a proxy measure for a disclosure. Data from the three sites who use the Communicare (CIS) is outlined in Table 7.

Table 8 - Communicare DFV data

Year	Client Disclosures recorded	Referrals	No further action	Already has referral in place when starting program	Referral after home visit
2015	3	0	1	2	11
2016	7	4	1	2	12
2017	15	8	5	2	2
2018	23	10	5	8	1
2019*	11	7	2	2	6

** until September 2019*

This table also identifies from the disclosures how many then have referrals.

The project began in July 2016 and there was increased discussion about domestic and family violence with site staff through the staff needs activity. This correlated with an increase in the recording of client disclosures from the three sites who use Communicare data collection. These sites previously had a client relationship form to complete as part of the ANFPP which asked questions about the client's relationships and safety in those relationships. It is possible the increased awareness of domestic and family violence caused staff to be more aware and comfortable discussing this topic with clients. The broader discussion occurring nationally during this period may also be a factor. The total number of clients is difficult to show over a year as, due to the nature of the program, the ANFPP doesn't have a fixed number of clients in a specific time frame. This data only reflects those clients who chose to disclose their experience.

The project worked with the ANKA development project to create fields for domestic and family violence data collection, Figure 2 and Annex 3 outlined this process and the associated fields where data is collected. Since May 2019 data collection has been available in the ANKA system and staff have provided feedback on how the data collection is working for them. One area considered in the education but not the data collection was when the client is using violence. The ANKA system development process is working to identify how new fields can be added to capture a client'suse of violence.

Table 8 summarises the data that have been collected in the ANKA system. A number of factors should be considered when interpreting these data. Firstly, due to the site scale-up discussed earlier, not all ten sites identified as using ANKA were seeing clients over the full period. Secondly, the 2017 and 2018 data are due to the onboarding of one of the new sites into ANKA.

The ANKA domestic and family violence data identifies that sites are having discussions about domestic and family violence with their clients, if the client chooses to disclose then this is recorded and if the client or family member wants a referral to a domestic and family violence support service then they are provided. Anecdotally, staff have indicated in site support discussion the issue of clients disclosing and then not wanting a referral. Please note that due to changes in the ANKA system there are likely more referrals than indicated in the data here – these are being addressed within the ANKA project.

Figure 4 - ANKA Data Collection

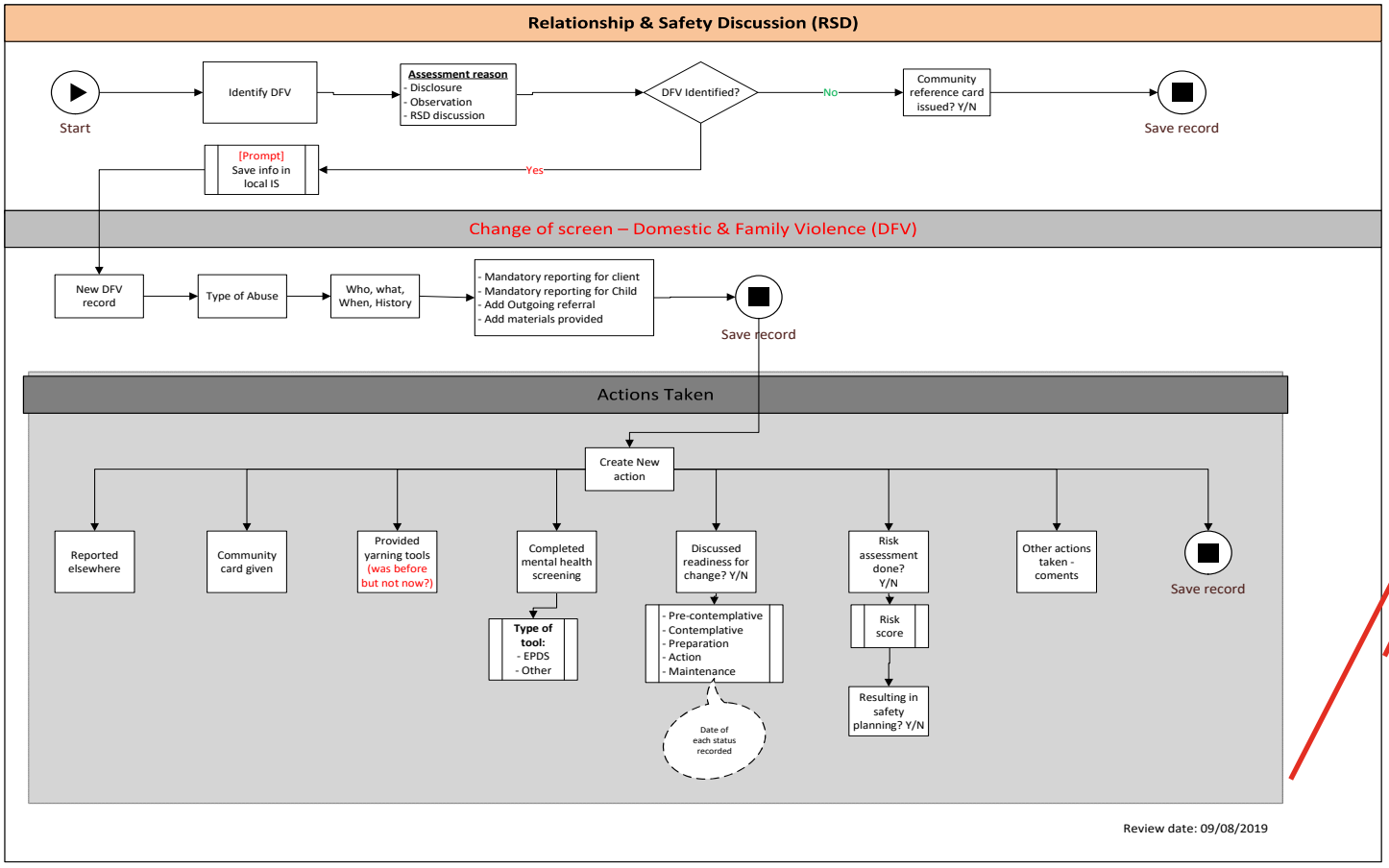


Table 9 - ANKA DFV data

Year	Client Disclosures recorded	Referrals	Referrals for client	Referrals for other family members
2017		48	34	14
2018		30		
2019*		49		
Totals	186			

** until September 2019*

2.7. PHASE 4: ADAPT THE INTERVENTION

The project appointed Ashlee Donohue to the role of curriculum developer support. Ashlee is an Aboriginal woman from the Dunghutti Nation, a DFV prevention educatorand advocate.Ms Donohue reviewed the NFP IPV materials, and made recommendations as to the adaptions required. She noted the NFP content was of a high calibre with relevant content for our client group.

The key changes for ANFPP were:

- To adapt language used throughout to reflect the cultural norms, terminology and sensibilities of the Australian language.
- To enhance the safety planning considerations for women and families living in rural and remote communities in Australia
- To change the names and content of the client stories for the "readiness to address safety" section to reflect client settings and issues in Australia
- To remove the recommendation to use the Danger Assessment as the risk assessment tool and replace it with the local state / territory risk assessment tool to support consistent language with referral agencies.
- To identify current mental health challenges experienced by client, to remove reference to use the PHQ-9 and GAD-7 and replace with the EPDS
- *To include content that reflects that marijuana use as a drug that has an influence on the occurrence of violence.* *(This was not included in the original NFP IPV materials)*

> *(The education and pathway)* have made me feel like I can do my job a bit better, in a more relaxed way

Table 10 - NFP IPV adaption to ANFPP DFV component

NFP IPV Intervention (5 Original Components)	ANFPP Domestic and Family Violence Component
NFP IPV Education for Nurse Home Visitors and Supervisors: a. E-learning modules for self-study and team-based discussion b. In-person workshop (1 day) c. System navigation team meeting education module	ANFPP have converted the first 3 modules into a structure suitable for the ANFPP online learning environment. Module four was a team-based learning which was used for introduction for Teams (this was covered in the team-based education delivery). Module 5 is on the Danger Assessment tool which is not being used within ANFPP. In-person education has been incorporated into ANFPP unit 2 education. System navigation was incorporated into the introduction section within the ANFPP online learning environment and reinforced during the face to face education.
Manualised intervention + NFP IPV clinical pathway; facilitators and corresponding nurse instructions to guide work in four areas: safety planning, increasing awareness of the health effects of IPV, self-efficacy, and social support.	ANFPP domestic and family violence pathway and manual are available through the online learning environment. The domestic and family violence pathway and associated yarning tools and guides have been embedded into the home visit guidelines and is part of the home visit resources. These resources are all available in the ANFPP online learning environment.
Site readiness checklist to support NFP supervisors implement the novel innovation into their implementing agency and current workflow.	The site readiness checklist has been embedded in this manual and has been recommended to be incorporated as part of the implementation package should there be a further role out of new ANFPP sites.
Guidelines for reflective supervision	A Nurse Supervisor domestic and family violence manual which incorporates guidance for reflective supervision and supporting staff has been provided to all NS and incorporated into NS education.
Clinical coaching and support	Ongoing monthly roles specific Community of Practice meetings provide opportunity to discuss implementation challenges and learnings. Site support visits have also provided domestic and family violence education activities with site teams.

Along with adapting the narrative to suit the Australian Aboriginal and Torres Strait Islander context, the Project considered the presentation of information and how this could influence the comprehension of key concepts. As a result, the Project contracted Gilimbaa, an Indigenous graphic design company, to provided design support. The Gilimbaa team had provided design support to ANFPP on previous occasions.

Gilimbaa have designed a range of visual elements to complement the yarning tools which are used with clients. This undertaking was a joint activity with the ANFPP home visit guideline review project, and forms part of the long-term integration of the domestic and family violence component into the ANFPP core curriculum. The domestic and family violence specific yarning tools and handouts are located within the ANFPP home visit guidelines.

A pilot session, trialling the adapted content and delivery methods, was held during Unit 2 education in September 2017 *(where the face-to-face element is embedded within the ANFPP core curriculum)*. This group of trainees did not have the opportunity for pre-learning activities. The education team suggested that theses activities be incorporated into the face-to- face delivery. Feedback from the pilot education indicated the content was too much for one day. Additionally, it identified the importance of pre-learning (knowledge acquisition) activities as a foundation for the education, and the need for face-to-face delivery to focus on practical implementations, specifically how to identify and respond to domestic and family violence during ANFPP home visits.

The lessons from the international NFP IPV RCT were shared during this phase and the importance of the Nurse Supervisor role was identified. If the Nurse Supervisor *(team leader)* did not understand the domestic and family violence pathway content or its application in practice, then the team did not apply the pathway regularly within their home visits, as intended. Suggestions to support application in practice included ensuring staff had key materials with them at all visits and team leads had skills in reflective supervision *(reflective / clinical practice discussions)*. It was important that Supervisors had the necessary skills to support staff with clients experiencing violence, including supporting staff to walk alongside their client's decisions. With this knowledge the Project ensured the education delivery began with the NS.

2.8. PHASE 5: EDUCATION

To deliver the new education content a package was developed to upskill current ANFPP staff and to ensure sustainability and consistency of domestic and family violence education. The education commenced with the Nurse Supervisor role followed by site specific sessions. The timing of these sessions was negotiated with each site and a member of the ANFPP education team along with Ashlee Donohue conducted each session. The education was also embedded within the core curriculum.

The Nurse Supervisor training included the Nurse Supervisor from each partner organisation's ANFPP team. The Program Manager from TEHS attended to ensure the specific needs of their communities would be supported. The purpose of this training was to provide the nurse supervisors with the skills and information necessary to implement the domestic and family

violence pathway within their teams. The nurse supervisors were also present for their site-based education sessions;having already completed their nurse supervisor domestic and family violence education, they were able to support the tailoring of the education and ensure relevance for their local organisation.

ANFPP Nurse Home Visitors and Family Partnership Workers were trained on location at their respective sites, in order to reduce disruption to their work and to provide an opportunity for other members of the organisation to attend the training if interested; however, no sites took up this opportunity. Providing education on-site gave the educators an opportunity to understand the local setting and tailor education delivery.

Overall, education sessions were held for ANFPP partner organisations in four states and two territories, including 11 Aboriginal controlled services and one health department (TEHS). Approximately 50% of the staff trained identify as Aboriginal and Torres Strait Islander. One partner organisation had their domestic and family violence education training in February 2019 to accommodate staff changes at the site. A catch-up education session was conducted for the few staff who had completed their core education before the curriculum was modified by this Project, but were not present for the initial site-based domestic and family violence education. A total of fourteen sessions were provided with 108 ANFPP staff trained. Since the beginning of 2019 all new ANFPP staff complete domestic and family violence as part of the core curriculum, 30 staff were trained in this way at the time of this report.

Image Description: A pregnant mother standing about her childs cot in a nursery.

2.9. PHASE 6: EVALUATION AND COMMUNICATION

The evaluation approach was designed with the support and input of the IPV project steering committee and was endorsed out of session. The table in Annex 4 outlines the overall mixed methods design and key questions. This design also took into consideration the approach used for the NFP IPV RCT and the activities being conducted by the international NFP teams implementing the NFP IPV intervention. implementing the NFP IPV intervention.

Table 11 identifies the project objectives, which phase of the project this objective was achieved and what did the evaluation activities identify for each of these objectives. These objectives were outlined in the initial project proposed by the funder.

Table 11: Project Objectives Key Findings

Project Objective	Objective Achieved	Key Findings / Learnings
1. Understand family and intimate partner violence in the Australian Aboriginal and Torres Strait Islander context. This understanding informs the necessary adaptation of the existing NFP IPV education and supports to meet the cultural and service delivery context of Australia, whilst remaining true to the principles of the NFP model.	Phases 1, 2, 3 & 4	• Considerations of program climate where trying to introduce new content (e.g. readiness, impact of concurrent projects, staff experience) • Comprehensive understanding of common cultural contextual factors, and variable factors across sites • Staff are experts in their local community and cultural contexts • Strong alignment of identified cultural and service delivery context with client-centred principles and trauma-informed approach
2. Integrate this adaptation into the existing ANFFP education to nurse home visitors and develop a new education package to meet the position requirements of the Family Partnership Worker role.	Phase 4	• Purpose of education must be clear • Existing local tools have limitations • Staff are experts in feasible local solutions including tailoring content, appropriate terminology • Importance of regular and open communication with staff about the project • Education content now embedded within the core curriculum • Domestic and family violence education is delivered to all new ANFPP staff with the expectation that responding to domestic and family violence disclosures is standard practice within an ANFPP home visit
3. Train all ANFPP staff at partner organisations.	Phase 5	• Additional and ongoing support of staff is important
4. Evaluate the impact of the adapted education and supports on site staff capabilities to support their clients who are experiencing violence in their intimate relationships.	Phase 6	• Achievement against domestic and family violence education objectives (see below) • Critical success factors and recommendations identified (see report)

There was a slight misalignment between the project objectives and the specific evaluation objectives. Although the evaluation was done early in the project process, the evaluation outline was established after the project had already begun. The evaluation focus more closely on the educational aspect and the experience of the content for staff as outlined in objective 4 in the table above.

Broadly, the evaluation aimed to answer the following:

- **Did the ANFPP domestic and family violence education components support implementing staff to be competent in identifying and responding to clients experiencing domestic and family violence?**
- **Did staff increase their knowledge and ability to support ANFPP clients experiencing domestic and family violenceto stay safe?**
- **Were the ANFPP partner organisations able to connect with local resources to support ANFPP clients experiencing violence, in order to help those clients, take actions to improvetheir and their child's safety?**

The evaluation included pre and post-training surveys and face-to-face focus groups. Due to staff turnover the pre and post surveys cannot be correlated to specific learners; therefore, group norms for the specific roles have been used to determine a change in understanding and confidence in their ability to supporting clients experiencing domestic and family violence.

The focus groups were conducted in specific role groups to ensure the domestic and family violence pathway and education met the needs of each role within the ANFPP home visit team.

Interview questions were developed to match the evaluation objectives. Table 12 identifies the key topics explored through the focus group discussions about the how the project supported staff in practice and what can be useful for future education adaptation and implementation in the ANFPP.

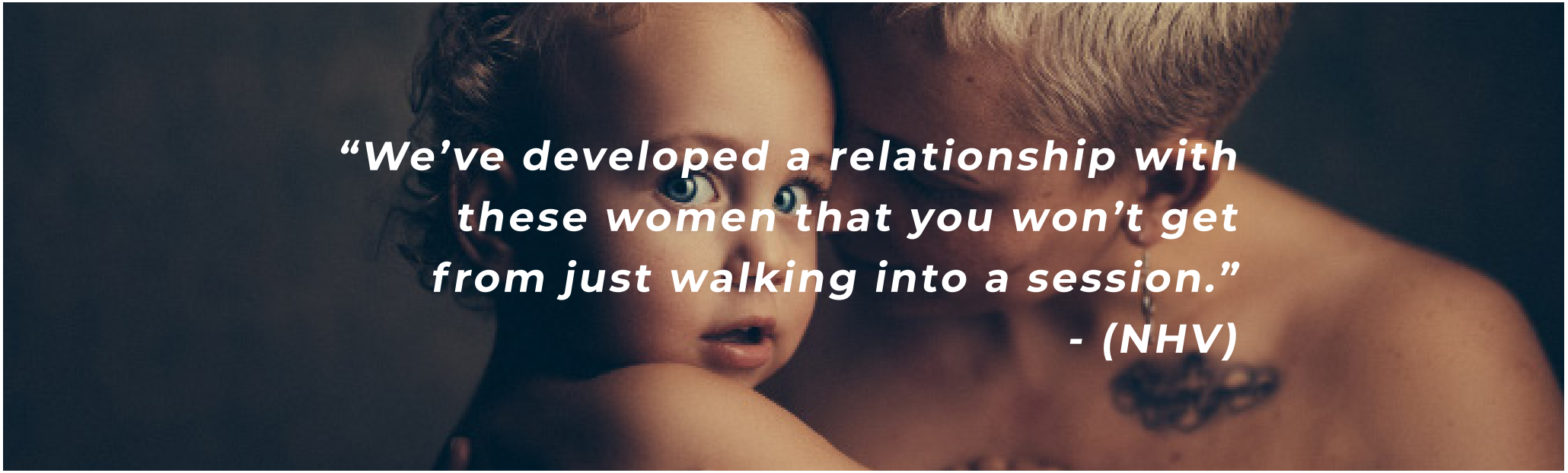
Table 12 - Achievement against intended Outcome / Benefits

Intended Outcomes / Benefits	Evaluation Findings
1. ANFPP staff (NHVs, FPWs NSs) are able to identify and support clients and families experiencing DFV in a culturally safe way	• Overall, the surveys identified that staff feel better able to support their clients (including identifying, responding, and supporting) after the education • Most staff felt the education and resources helped (capability and confidence) with assessing and identifying domestic and family violence by helping open discussions safely, identifying client risks and appropriate actions to take, and empowering clients with choice • Qualitatively, there was a mix of perspectives regarding the education and pathway's impact on practice overall – some indicated there was no change, others indicated it has helped to open discussions and understand the client's perspective and choices • Factors contributing to the extent of impact include previous domestic and family violence education and experience, ANFPP role and the local cultural context • Staff generally used one or more of the tools in their practice, but also felt some tools were not appropriate for their local site-specific cultural context (e.g. language, terminology) • Staff described using the tools as guides and frameworks (rather than rigid adoption) - this approach was determined to be most helpful for enabling objective, natural conversation and drawing out sensitive information when working with clients • At sites that had used the pathway to support and prioritise disclosure, participants felt it supported safe discussions in a less confronting way, and also provided an opportunity to educate the client • Challenges in applying the education and pathway included the fear of shame and consequence in small communities, supporting mums who did not want a referral or did not want to disclose, and the risk of disengagement • Where the pathway was used for responding to and planning support for their clients, staff felt it helped clients to feel less overwhelmed, maintain client engagement, and provide practical strategies for planning around domestic and family violence patterns • Summary of identified successes for embedding education and application of domestic and family violence pathway in practice: ◦ Provides a framework for safe, objective and focused discussion for both client and staff ◦ Flexibility to use the pathway as a guide over time (and adapting it to local and individual context) ◦ Focus on staff role of safety and support and not 'policing', helps maintain client engagement ◦ Enables education of client (domestic and family violence, risks, relationships, options, strategies) and empowerment ◦ Opportunities to support client's family and friends (in addition to the client) ◦ A good additional and relevant resource for our clients and work

Intended Outcomes / Benefits	Evaluation Findings
2. Nurse Supervisors are able to support staff who are providing care to clients with complex needs	• Team-based approach and ongoing active support from a team leader for the domestic and family violence component identified as critical by FPWs and NHVs • Most FPWs and NHVs interviewed indicated they felt well supported by their NS • Staff across both new and established sites identified a range of benefits for working in a partnership arrangement (FPW and NHV) as part of implementation of the domestic and family violence component
3. Improved ANFPP education including embedded domestic and family violence education in the curriculum for long-term sustainability	• An Indigenous identified role is critical for education delivery • Face-to-face training is a preferred mode for receiving domestic and family violence education • Personal stories shared by the lived experience Aboriginal facilitator were relevant, motivational, engaging, relatable • Education content helpful, important, relevant, relatable, met expectations / needs • Those with less professional domestic and family violence experience indicated they got significant learning out of the workshop, while other staff with more domestic and family violence experience felt it was a good refresher • Education resources (introductory document, workshop manual, workshop workbook) not generally used or referred to as part of practice (after the education was workshop delivered) • Future education should increase focus on practically adapting the content and tools to local variable factors, supporting local staff needs and contexts, and ensuring all resources and tools were accessible from one location • Staff indicated that though the domestic and family violence education and pathway are helpful, integrating this component into ANFPP is not possible without an existing strong provider-client relationship, ongoing support, a team approach, experience, measures for staff safety, understanding local context, and establishing links to other local supports and services
4. Strengthened referral pathways and interagency support for clients and families within the ANFPP who experience domestic and family violence	• Three newly established sites indicated they have engaged or opened up additional referral pathways since the training. • Most staff and sites indicated the domestic and family violence education and pathway has not significantly impacted on how they refer their clients (to date), and that they continue to work collaboratively with their existing established referral networks and contacts • Access to local referral supports (e.g. crisis accommodation) remains a challenge across many sites

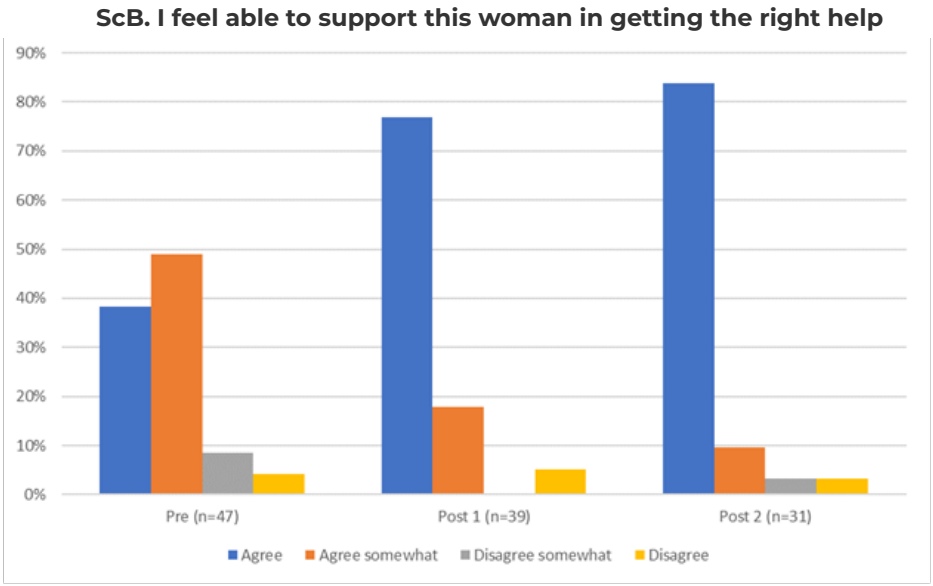
Intended Outcomes / Benefits	Evaluation Findings
5. Clients experiencing domestic and family violence receive effective support from NHVs and FPWs	• Across most sites, the pathway and tools have been well received by clients (as reported by staff) • Clients have identified (to staff) increased knowledge of domestic and family violence, associated risk factors, strategies to manage it, and an openness to safe discussions • Disengagement remains an ongoing challenge and risk due to the fear of shame and negative consequences of a client discussing and disclosing domestic and family violence to staff
6. Children of clients experience less exposure to domestic and family violence	• Whilst the evaluation identified that the embedded education and application of the domestic and family violence pathway in practice provides opportunities to support a client's family and friends, this objective has not yet been fully evaluated at this time • In time, the embedding of the domestic and family violence component may demonstrate a broader impact on domestic and family violence in the communities ANFPP serves

Image Description: A close up of a mother holding her child from the shoulders up, without clothes.



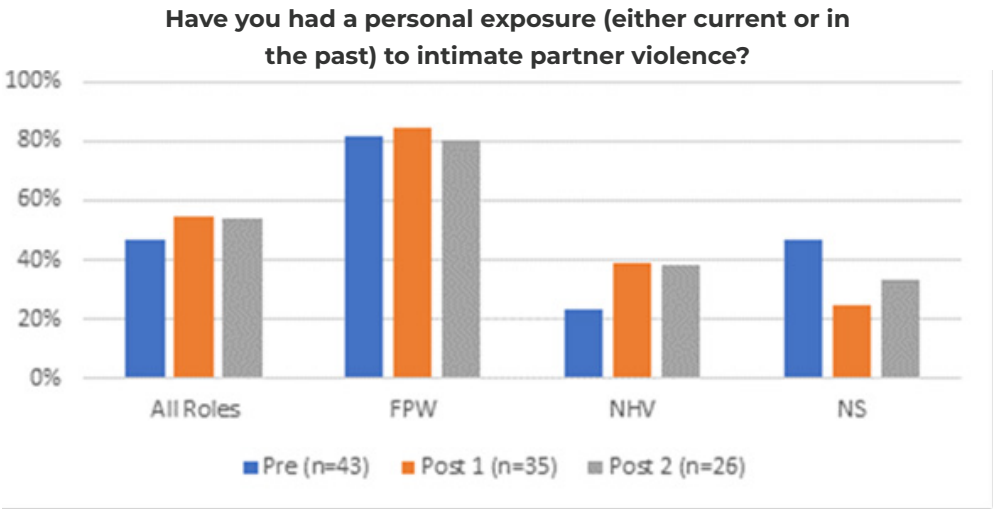
With the focus of the project aligning with a foundational overarching competency for ANFPP staff is to ensure the mother is able to nurture and protect her child from harm. Within the pre/post survey staff were presented with a scenario and a series of questions. Staff were asked to respond in way that would reflect either your current practice or your hypothetical response to the scenario. Figure 5 outlines an example of how the education provided created a change in staff's response to one of the questions regarding supporting clients, overall there was a significant majority of respondents that agreed or agreed somewhat for all of the surveys. There was a 7% increase from pre to post 2 surveys of respondents that answered agree or agree somewhat, and a 46% increase of respondents who answered agree.

Figure 5 - Staff Response to Supporting Clients Get Help



The findings from the pre / post survey and the focus group discussions were presented in a report format to the steering committee. Discussion with the steering committee regarding these finding identified an interest to understand the staff's personal exposure and the impact this may have. Figure 6 below outlines for the staff who participated in the individual survey's personal exposure. It is important to note that due to staff turnover the staff in the pre survey are not necessarily the same staff in each of the post surveys. There was a relatively high response (compared to the number of responses in Figure 5) to this question which demonstrates that staff felt safe to disclose this type of information in this format. The overall data from the pre/post survey indicated that for the FPW role this is more of an issue. This has been taken into consideration in Nurse Supervisor and team support education offered more broadly in ANFPP education.

Figure 6 - Personal Exposure of Staff to Domestic and Family Violence



The data collection within the ANKA system was intended to replace the need foran implementation log, which was the method used by other NFP teams implementing the NFP IPV intervention. This log was used in the RCT to determine how staff applied the pathway in practice, however, due to delays in the ANKA project, the data collection element was not available for staff use in time for the domestic and family violence education role. This makes it difficult to determined how the pathway was used in practice following the education. However anecdotally through site support activities the project identified that some teams did not fully apply the pathway in practice.

The next section lessons learnt highlights the findings from the various evaluation activities along with findings from activities conducted during the Project.

Image Description: Mum holding her wrapped baby and kissing his chin.

LESSONS LEARNED

3.1. PROJECT IMPLEMENTATION

- *Identify evidence-based literature* - to support cultural adaptation of an intervention developed within another NFP context (e.g. the USA) to meet the needs of the ANFPP and the Aboriginal and Torres Strait Islander context as well as implementing domestic and family violence education within the ANFPP. domestic and family violence specific services provided the majority of the literature that framed this Project. This created some challenges in translating information for the home visiting context, where the program is delivered within a health organisation. Many of the principles and considerations of how to work with clients were drawn into the adaptation and education materials.
- *Considerations of climate in program where trying to introduce new content* – this was a significant time of change for ANFPP with scale up (3–13 sites) and a new data collection system (ANKA) being built and other education projects being implemented. Although the project was able to buffer the impact of these changes it did create significant extra work and impacted timelines for some elements of the project. It also meant re-doing some elements of work and stakeholder engagement. For example, the ANKA data collection element was not able to be launched at the same time as the education delivery.
- *Concurrent projects that impact* – The FPW role review and definition project was completed in 2019, after the domestic and family violence education adaptation and roll out was completed. However, the IPV project was cognisant of the FPW role review project and process, and incorporated elements as it was able. In response to the role review, the ANFPP education was modified so that both NHV and FPW roles now attend the same sessions; the IPV project responded by factoring this into the education approach. The focus groups ensured an opportunity still remained for the FPW staff to highlight what they felt their needs were and to identify any further recommendations.
- *Concurrent projects that impact* - The Home Visit Guidelines (HVG) project was closely linked to the IPV project content. The HVG project changes had an impact on the IPV project, however the project manager ensured they understood the changes in the dependent projects to ensure minimal impact. Timely changes were made as necessary to meet IPV project Key Performance Indicators. The domestic and family violence materials are now embedded within the HVG to ensure the domestic and family violence materials are used as part of standard ANFPP practice.
- *Concurrent projects that impact* – the transition of the online learning environment for ANFPP created a challenge for the Project, until the platform was determined by ANFPP in 2019 the Project was unable to convert the NFP IPV online modules. In the interim the Canadian NFP kindly provided access to ANFPP staff to the NFP versions. While the content was relevant for ANFPP there were challenges using the North American content and staff connecting with this material. The feedback from the use of this material did provide some guidance to the ANFPP adaptation of the online modules.
- *Limitations of the risk assessment tools* – In Australia the literature indicatesthat risk assessment tools are best used by aspecialist role. The NFP IPV use the Danger Assessment tool, which has an online learning and certification aspect and provides specific training. This tool is used broadly across Canada and USA by a variety of roles that are not domestic and family violence specialists. In

contrast, Australia lacks a standard national Risk Assessment Tool, and the Project's recommendation was therefore for sites to use the risk assessment tool in standard use in their state. The Project also recommended that all sites participate in further education on their particular risk assessment tool. While information was provided on how to access this external education, the rate of uptake and completion of this training at the site level is not known. Barriers to the uptake of training may include the service delivery impact of the extra offline time required and the financial costs to sites. In addition, the availability of tools and training varies between states. For QLD and ACT teams this training was not readily available as they do not have state specific risk assessment tools. The NSW DVSAT provides a reference guide on its use, but no specific external training. Complexities such as these and the variation between sitesmade it difficult for the NPC to provide any specific, national support for the use and implementation of a risk assessment tool.

- *Clear expressed purpose and site-specific tailoring of tools* – Discussions with ANFPP partner organisation CEOs identified some sites already had extensive domestic violence services. Concern was expressed about how these teams would work together on domestic and family violence support. Reassurance was provided indicating the domestic and family violence education component was not to replace any of these services and could enhance usage and connection of clients to these services. The approaches to support clients within the context of ANFPP home visiting focus on mother and child safety and how ANFPP teams would work alongside existing services for the best outcomes for clients. It was important to be clear that the domestic and family violence Pathway is a guide and can be tailored for each client's specific needs; it operates within the context of ANFPP and does not replace local requirements.

- *The importance of terminology* – once in practice the domestic and family violence pathway was reviewed at various points with both teams who were implementing the tool, and new staff completing the core curriculum. Through review with site teams it was clear that the terminology 'Relationship and Safety Discussion' did not work for the action associated. This discussion is used in place of a screening tool and used a case finding approach. Once domestic and family violence exposure is identified with a client this activity does not need to be repeated as the staff move into a different area of the pathway. Review with staff who were actively using the tool identified confusion about the 'relationship and safety discussion' as staff are required to continually have discussions with the client regarding relationships and safety. This activity was renamed 'universal assessment of safety' in line with the original NFP IPV pathway to reflect that it is conducted with all clients and the frame of the discussion is around client and child safety.

- *Communication to staff about the project* – this project ran over a three-year period, with some ANFPP sites not on-board when the project began. The Project provided updates at the national conferences, at regular national meetings and at community of practice forums but these did not repeat what had been previously presented. During the service implementation process for new sites, there was not the opportunity to provide this background information to ensure that all staff coming into the ANFPP understood that this was an enhancement.

- *Additional and ongoing support of staff* – it has been identified that staff require ongoing support for working with clients experiencing domestic and family violence beyond the provision of the initial education. While the ANFPP conducts regular communities of practice where staff share challenges and successes, it was identified in the focus groups that ongoing support was needed tailored specifically for this area. In Canada, as part of the Canadian Nurse-Family Partnership Education pilot project conducted in Ontario, the NFP teams received a full day of IPV training as part of the NFP core curriculum, which was then followed up with another full-day of in-person training to discuss and review their experiences implementing the IPV intervention into practice, and to develop strategies to support ongoing implementation and delivery.

3.2. TRANSLATIONAL LEARNINGS

The lessons learnt for programs considering including domestic and family violence content within their program are outlined below. These lessons were derived from various sources and could be utilised by other programs considering incorporating DFV education into their context.

Critical success factors for the implementation of the ANFPP DFV component include:

- **A program with a foundation based on client-ledcontent delivery and strength based approaches. Much of the literature in the DFV space encourages the client to have control of decisions. The delivery of ANFPP is built on the client-centred principles**
- **Using a trauma-informed approach in working with clients.**
- **Understanding the baseline domestic and family violence knowledge and experience of staff and the associated staff needs**
- **Training and educational resources and tools that can be adapted to local practice context**
- **Team-based approach with ongoing support from a team leader.**
- **Cultural support and safety (including through an Indigenous identified role)**
- **Staff with previous experience working with clients who have experienced domestic and family violence**
- **Implementation of staff safety and well being strategies alongside domestic and family violence content.**
- **Clear understanding of local service systems (availability, capacity, suitability for clients, coordination.)**
- **Clear understanding of local cultural context (family and kin structures, cultural obligations and 'norms.')**
- **Established links and networks to other relevant local domestic and family violence supports and services within and beyond the team's organisation.**

RECOMMENDATIONS

A range of key lessons inform the recommendations. They focus on increasing the appropriateness, effectiveness and sustainability of future education and implementation of the Domestic and Family Violence component. Recommendations from the evaluation include:

1. Ensure program is ready for new content to be incorporated into curriculum and be considerate of any other projects / activities occurring within the program that may be interdependent.

2. Provide additional support for adapting and localising Domestic and Family Violence component resources and tools, including increased focus on use of the pathway and tools as guides, supporting implementation in small communities, linking to local DFV supports.

3. Provide opportunities for refreshers after 6 - 12 months of initial training.

4. Provide follow-up support post workshop and at regular intervals based on site needs (this could be in the form of a phone call).

5. Provide additional staff safety initiatives for FPWs (Aboriginal and / or Torres Strait Islander staff) (based on the additional challenges of their relationship to community).

6. Provide professional development opportunities and support tailored to individual and site needs (including additional targeted training and development to supplement the Domestic and Family Violence component, cultural competency).

7. Identify needs, plan and implement appropriate support at site level (in context of ANFPP, identify support programs) for male partners and other people that use violence (With consideration for the additional resources and changes required to support existing staff and the program).

8. Support opportunities for inter-site learning and sharing, including experiences, case studies (what worked well, what didn't work well).

CONCLUSION

The DFV component was the first major enhancement to the Australian Nurse Family Partnership Program (and more broadly the NFP program). While the timing of implementation may not have been ideal within the wider context of the ANFPP, the program has benefited greatly from the opportunity the project provided toincorporate DFV specific education.

The ANFPP Domestic and Family Violence component currently consist of:

1. Three online modules completed as part of the introduction learning for ANFPP
2. Introduction document inclusive of service navigation activities
3. Domestic and Family Violence Pathway and Manual (consisting of the background and evidence base for the Domestic and Family Violence pathway)
4. Domestic and Family Violence face to face education within ANFPP core curriculum education (approximately 1 day of content spread over 2 days of delivery)
5. Ongoing opportunity for topic discussion in monthly role specific Community of Practice meetings.

As the content for the pathway is embedded with the core curriculum this content will be reviewed as part of the review and update process for all ANFPP education.

The staff have identified that there was a need for the domestic and family violence education and have appreciated the content and improved support structures. Clients have demonstrated that they feel safe to disclose their experience of domestic and family violence to ANFPP staff and ANFPP staff have referred clients to services specifically designed to support this need. Staff have shared they feel better able to support their clients.

These outcomes reflect the initial strategic goal of the project for ANFPP teams to effectively respond to domestic and family violence in Indigenous communities. The education content is now embedded within the core curriculum. Domestic and family violence education is delivered to all new ANFPP staff with the expectation that responding to domestic and family violence disclosures is standard practice within an ANFPP home visit. In time this may demonstrate a broader impact on domestic and family violence in the communities ANFPP serves.

REFERENCES

Catherine, N.L.A., Lever, R., Sheehan, D., Zheng, Y., Boyle, M.H., McCandless, L., Gafi, A., Gonzalez, A., Jack, S.M., Tonmyr, L., Varcoe, C., MacMillan, H.L., Waddell, C. , & for the British Columbia Healthy Connections Project Scientific Team(2019). The British Columbia Healthy Connections Project: findings on socioeconomic disadvantage in early pregnancy. *BMC Public Health19*, 1161 https://doi.org/10.1186/s12889-019-7479-5

Cripps, K., & Davis, M. (2012). *Communities working to reduce Indigenous family violence (Brief 12).* Canberra: Indigenous Justice Clearinghouse.

Eckenrode, J., Ganzel, B., Henderson, C.R. Jr., Smith, E., Olds, D.L., Powers, J., Cole, R., Kitzman, H., Sidora, K. (2000) Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence. *JAMA,* 284, 1385–1391.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R. (2009).How far does screening women for domestic (partner) violence in different healthcare settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. Health Technol Assess,13(16),1-113.

Hegarty, K., Tarzia, L., Rees, S., Fooks, A., Forsdike, K., Woodlock, D., Simpson, L., McCormack, C., Amanatidis, S. (2017). Women's Input into a Trauma-informed systems model of care in Health settings (The WITH Study) Final report (ANROWS Horizons 02/2017). Sydney: ANROWS.

Jack, S.M., Ford-Gilboe, M., Wathen, C.N., Davidov, D.M., McNaughton, D.B., Coben, J.H., Olds, D.L., Macmillan, H.L., & NFP IPV Research Team (2012) Development of a nurse home visitation intervention for intimate partner violence. BMC Health Serv Res 12, 1952. https://doi.org/10.1186/1472-6963-12-50

Jack, S.M., Sheehan, D., Gonzalez, A., Macmillan, H.L., Catherine, N., Waddell, C., & for the BCHCP Process Evaluation Research Team (2015). British Columbia Healthy Connections Project process evaluation: a mixed methods protocol to describe the implementation and delivery of the Nurse-Family Partnership in Canada. BMC Nurs 14, 47 https://doi.org/10.1186/s12912-015-0097-3

Jack, S.M., Ford-Gilboe, M., Davidov, D., MacMillan, H.L. & NFP IPV Research Team (2017), Identification and assessment of intimate partner violence in nurse home visitation. J Clin Nurs, 26, 2215-2228. Epub 18 Dec 2016, doi:10.1111/jocn.13392

Jack, S.M., Boyle, M., McKee, C., Ford-Gilboe, M., Wathen, N., Scribano, P., Davidov, D., McNaughton, D., O'Brien, R., Johnston, C., Gasbarro, M., Tanaka, M., Kimber, M., Coben, J., Olds, D.L., MacMillan, H.L.(2019) Effect of Addition of an Intimate Partner Violence Intervention to a Nurse Home Visitation Program on Maternal Quality of Life: A Randomized Clinical Trial. JAMA, 321(16), 1576–1585. doi:10.1001/jama.2019.3211

Mejdoubi, J., van den Heijkant, S.C., van Leerdam, F.J., Heymans, M.W., Hirasing, R.A., Crijnen, A.A. (2013) Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. PLoS One,8(10), e78185. Published 21 Oct 2013. doi:10.1371/journal.pone.0078185

Olds, D.L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D.W., Henderson, C.R. Jr., Hanks, C., Bondy, J., Holmberg, J. (2004), Effects of nurse home-visiting on maternal life course and child development: age 6 follow-up results of a randomized trial, Pediatrics, 114,1550–1559.

Annex 1 – Project Risk Matrix

CATEGORY	LEVEL	SCORE	DESCRIPTION
Likelihood (L)	Rare	1	May occur only in exceptional circumstances
	Unlikely	2	Could occur at some time
	Possible	3	May occur at some time
	Likely	4	Will probably occur in most circumstances
	Almost Certain	5	Expected to occur in most circumstances, almost inevitable
Consequences (C)	Minor	1	Routine procedures sufficient to deal with the consequences
	Low	2	Would threaten an element of the function
	Moderate	3	Would necessitate significant adjustment to the overall project
	High	4	Would threaten goals and objectives; require close management
	Critical	5	Would stop achievement of functional goals and objectives
Risk Level (R)	Critical Risk	15-25	Most likely to occur and prevent achievement s of objectives, cause unacceptable cost overruns or schedule slippage
LxC=R	High Risk	10-14	Could substantially delay the project schedule or significantly affect technical performance or costs, and requires a plan to handle
	Medium Risk	6-9	Requires identification and control of all contributing factors by monitoring conditions and reassessment at project milestones
	Low Risk	1-5	Normal control and monitoring measures sufficient

REF	RISK	RESPONSIBLITY	L	C	R	IMPACT	CONTROL / MITIGATION STRATEGY
1. PROJECT MANAGEMENT							
1.1	In order to realise KPIs A.5 – 6 the project schedule is premised on the expectation that the ANFPP NPC contract with the Department of Health will be extended beyond the existing contract end date of 30 June 2018.	DFV Project Manager/ National AN-FPP Program Manager	2	3	Medium	May need to work with another contractor.	*All aspects of the project processes are documented and for sustainability beyond the life of this project the long term goal is that the ANFPP DFV education will become integrated within the ANFPP core curriculum.*
1.2	Commonwealth funding for the ANFPP and NPC ceases at 30 June 2018 and there is no provision for the +1 +1 extension.	DoH/PM&C	2	4	Medium	The Project deliverables cannot be completed and implemented with ANFPP sites. Investment is lost.	*Ensure open engagement with both funding partners.*
1.3	*Steering Committee members unavailable*	IPV Project Manager	3	1	Low	A lack of cultural leadership to guide adaptation process. May require staff extra time to update Steering Committee members out of session.	Ensure that notice is given well in advance of the meeting to ensure availability and provide an update close to the time of the meeting. The NPC team and ANFPP Leadership Group are also available as a resource for the project to ensure cultural adaption meets the requirements of the ANFPP program.

REF	RISK	RESPONSIBLITY	L	C	R	IMPACT	CONTROL / MITIGATION STRATEGY
2. EDUCATION							
2.1	Nurse Family Partnership education materials not available within the ANFPP IPV Adaptation Project timeline to provide guidance in the adaptation process / education resource development.	IPV Project Manager	2	1	Low	The material from NFP will provide the evidence base for the decision around the adaptation. The impact for the Project will be an increased workload in the education development as it will be more than adaptation required, rather creation.	The NFP has already been provided the v3.0 NFP IPV Intervention (May 2015) clinical pathway which is the key document the NFP IPV education is based on. The environmental scan document will identify the Australian situation that the ANFPP DFV education will need to be based on, which will be a product of this Project. The Project is also working closely with the NFP IPV Intervention Developer who is providing guidance to the Australian development process.
2.2	Changes to the ANFPP delivery model or scope of the program (eg. different at risk populations) have implications for the IPV Adaptation Project.	IPV Project Manager/ National ANFPP Program Manager/ Workforce Development & Education Manager	3	3	Medium	The existing Project scope and funding allocation cannot be easily modified to accommodate a change to the existing ANFPP delivery model.	The ANFPP IPV Adaptation Project is working closely alongside the NPC Workforce Development and Education team during the life of the project to ensure currency of education delivery approach.
2.3	Staff retention rates are low.	IPV Project Manager/ Workforce Development and Educa-tion Manager	3	2	Medium	The increased and ongoing education of new staff. No definitive measure of long term IPV education attainment/knowledge.	The IPV education will be integrated into the ANFPP core curriculum minimising the need to provide independent education sessions.

REF	RISK	RESPONSIBLITY	L	C	R	IMPACT	CONTROL / MITIGATION STRATEGY
2.4	Identification method for disclosure in a clinical environment is focused predominantly on mandated screening tools (state/territory specific).	IPV Project Manager/ Workforce Development and Education Manager	3	2	Medium	Reliance on only using a screening tool may limit client disclosure and/or impact the client relationship with the ANFPP team.	ANFPP staff understand the methodology and have confidence in a cross-collegial approach to identifying clients experiencing IPV, whilst still meeting mandatory reporting requirements.
2.5	Introduction of new innovations that are linked to ANFPP IPV module (e.g. STAR, home visiting guidelines)	PV Project Manager/ Workforce Development and Education Manager	5	2	High	If IPV education component is rolled out in isolation of new innovations that have DFV as an element will create confusion for staff delivering the program and could impact on client outcomes.	Work closely with the WDE team to ensure that new innovations are worked on collaboratively and potentially
3. DFV EDUCATION COMPONENT ROLE OUT							
3.1	Poor team cohesion between NHV and FPW in delivering the program to clients.	IPV Project Manager/ Workforce Development and Education Manager	3	2	Medium	Poor teamwork will impact the success of the DFV education module on delivering positive outcomes that rely on a strong therapeutic alliance between the NHV and FPW and the client.	Strengthen the use of the 'How's it going between us' facilitator within the current ANFPP education for reflective practice and build on the learnings of this activity for the Project. When adapting the IPV intervention ensure that the modelling approach is woven through the education.

REF	RISK	RESPONSIBLITY	L	C	R	IMPACT	CONTROL / MITIGATION STRATEGY
3.2	Personal and professional biases influence the success of the DFV education module. (this risk is once the content is being used by staff at implementing sites)	DFV Project Manager/ Workforce Development and Education Manager	3	4	High	Staff previous exposure to family and/or domestic violence could influence their therapeutic relationship in supporting clients and/or result in vicarious trauma impacting on staff health and wellbeing and capacity to deliver program content.	Identify biases at time of recruitment through behavioural interview style questions, emphasis on the five client-centred principles. Ensure clear boundaries of individual roles are established. Use scenarios in the education to outline these. Encourage reflective supervision to unpack any influencers and ensure education for Nurse Supervisors is inclusive of these approaches to how to respond to issues.
3.3	Poor navigation of the cultural and clinical/ therapeutic responsibilities by staff.	DFV Project Manager/ Workforce Development and Education Manager	2	4	Medium	If the DFV education module is not culturally appropriate it could have significant impact on staff and/or clients and cause client and/or staff retention issues, and ultimately program outcomes.	Utilise a cultural adaptation methodology to ensure cultural safety is inherent in the education module. A Cultural update to the education is more broadly occurring within the ANFPP education and the Project will ensure that the DFV education component integration will harmonise with this effort.

REF	RISK	RESPONSIBLITY	L	C	R	IMPACT	CONTROL / MITIGATION STRATEGY
3.4	Pilot results don't take into account the non-homogeneity of the multiple sites (Work Force Study results) and/or identify incongruences between organisational processes and government policy and state/territory legislation.	IPV Project Manager/ Workforce Development and Education Manager	2	3	Medium	If the DFV education is not culturally appropriate for the location it could have significant impact on clients and cause client and staff retention issues and impact vicarious trauma. Creates challenges for the Project in relationship management with organisations for the best results of the project and the ANFPP staff and clients.	The environmental scan, inclusive of the staff needs analysis and the organisation situational analysis will support the education development to be orientated to support staff at any site within the country and to understand how to identify local impacts, issues and make therapeutic adjustments accordingly.
3.5	Organisations (and/or local services) do not have appropriate therapeutic support measures/services in place for staff to access support if this education results in resurfacing of past or current personal experiences of DFV and/or trauma. (e.g. Employee Assistance Scheme).	IPV Project Manager/ Workforce Development and Education Manager/ Service Planning	2	3	Medium	Vicarious trauma for staff could impact their ability to work in a therapeutic relationship with the client, which could also impact staff and client retention.	Conduct pre-education workshops with staff to promote early adopters, self-recognition their own experiences and methods to dealing with these in a therapeutic way personally and with client's experience DFV. Ensure that organisations are aware of the how the ANFPP fits within their organisation and the referral pathways that will support delivery of the program and support of staff

Annex 2 - Approach To Applying Recommendations and Evidence

This table synthesised the information from the Environmental Scan reports and the literature review used to inform the process.

Themes	Environmental Scan Recommendation	ANFPP IPV approach	Evidence supported from literature (the following statements are directly lifted from the literature review– references are available with the literature review)
Trauma Informed Response/ care / approach	Clearly define trauma informed approach in ANFPP context	ANFPP Unit 1 is currently under review and incorporating further cultural contextualisation. The IPV project is participating in this process to ensure the understanding of the historical context/policy and how intergenerational trauma could also have an impact in DFV where those who are traumatised may have difficulties in their intimate relationships.	For Aboriginal and Torres Strait Islander populations, there is a strong relationship between their social, political and economic circumstances, as well as colonial history, and the health of individuals. The effects of this history have been transmitted through the generations; trauma is a rational response to distress created by these unacknowledged or ignored events, and this hopelessness and grief is transferred intergenerationally. An example provided in the literature by NSW education centre against violence (ECAV) on how they address this was: The history of Aboriginal and Torres Strait Islander peoples is taught at the beginning of the course, as some Aboriginal and Torres Strait Islander people are unaware of their history given its traumatising nature and the reluctance of Elders and other community members to speak of these events.
	Issues related to children who observe or live in a home with DFV	Children can be a motivator for change, the ANFPP IPV innovation will develop facilitators for staff to engage clients in discussion to understand the impact that violent situations can have on children and their developing brains, even if not physically involved in the violence.	The safety of a woman and her children must be the centre of any strategies to respond to family violence. Aboriginal and Torres Strait Islander women can be quite concerned about the involvement of Child Safety and their children being removed, and this is an important issue of which ANFPP staff need to be aware.
	Develop skills to recognise trauma and how to work with clients	The approach used broadly across the ANFPP with clients focuses on the client-centred principles and the elements of culture safety outlined in the literature are already embed within the program: The approach used broadly across the ANFPP with clients focuses on the client-centred principles and the elements of culture safety outlined in the literature are already embed within the program: 1. Family partnership role supports borrowed trust 2. ANFPP is a relational program so development of a relationship is vital 3. With 64 visit opportunities across the life of the program and visits duration is at least an hour the program provides ability to not rush 4. ANFPP is implemented within services that provided other programs to Aboriginal and Torres Strait Islander women	IPV has been found to limit the effectiveness of home visiting programs in improving outcomes for mothers and children from economically disadvantaged and culturally and linguistically diverse background. Four key concepts important for cultural safety: 1. borrowed trust (relying on the opinions of kin as to whether the service is culturally safe); 2. establish the relationship first (build a relationship with the Aboriginal and Torres Strait Islander person before asking personal questions); 3. come at it slowly (ask for information gently, take time or have a conversation rather than anticipating immediate responses); 4. people similar to the Aboriginal and Torres Strait Islander woman are attending the service.
	Vicarious trauma – awareness of self and others	Build on elements that are already within ANFPP education e.g. Identify vicarious trauma to ensure understanding of how IPV might affect staff and teams. The IPV innovation also includes clinical coaching and consultation following the education to support embedding practice and provide support for issues	For the training of Aboriginal Community Workers in family violence, it may then be important to consider the composition of the staff conducting the training and consider acknowledging the personal trauma histories of workers as well as discussing the legacy of colonisation and intergenerational trauma.

Themes	Environmental Scan Recommendation	ANFPP IPV approach	Evidence supported from literature (the following statements are directly lifted from the literature review– references are available with the literature review)
	Adapt forthcoming COAG conceptual Framework for Trauma within an Aboriginal and Torres Strait Islander context	Once defined and available will determined how to incorporate elements. ANFPP WDE team have conducted 2-day workshop with Judy Atkinson to look at trauma more deeply and how this can be incorporated into approaches used in education delivery.	The context of family violence in Aboriginal and Torres Strait Islander populations is so important to consider, as it is only by acknowledging and addressing these contexts that truly effective programs can be developed and implemented.
Defining and identifying DFV	Formally adopt DFV rather than IPV for Australian context	The difference between these 2 terms will be unpacked and how to differentiate the different types of violence within DFV in the education as the clinical pathway is specific to IPV.	The term also recognises the diversity of violence experienced by Aboriginal and Torres Strait Islander people, which includes the perpetration within a family of different types of violence such as physical, psychological, social, emotional, sexual, cultural, spiritual, and financial.
	Adapt Duluth Wheel inclusive of institutional violence	This is under consideration, a document on how to adapt the wheel was provided and will look to Canadian experience of adapting the tool for their indigenous population. Implementing sites also encouraged to adapt the wheels to be presented in a more meaningful way to their client group, some sites have already done this before the IPV project started as the Duluth Wheels have been a part of the ANFPP materials since the program began in Australia.	The collectivistic nature of such populations may not match well with the assumptions and individualistic nature of the power and control wheel and the Duluth model.
	Identify how staff can sensitively enquire about community norms, terminology and attitudes around DFV	FPW role will be critical in understanding this and in educating and supporting nurses in how and when to approach the topic of DFV with clients. For FPW role education it will be important for them to understand what has been taught to the NHV's and why, so they can work in a partnership to best support their clients.	There is increasing evidence that health care professionals are well positioned to identify IPV and provide early interventions.
	Embed localised understanding of role of family and community	A self-directed checklist activity has been created for staff to complete between unit 1 and 2 of education to understand local setting. It may also provide an opportunity for staff to meet with other local service providers and identify what works for them locally.	Sensitivity to communal values and practices may highlight that approaches such as Duluth and the Power and Control Wheel, based on individualistic values, are not relevant to many Aboriginal and Torres Strait Islander women's situations. Therefore, these frameworks may not assist service providers to offer services that assist women and reduce family violence.
	Focus on understanding behaviours and attitudes rather than specific types of DFV	The education will include an understanding of the historical, intergenerational trauma and past policies that have an impact on behaviours and attitudes in this space, this is likely to build into education already provided in ANFPP Unit 1 education.	It is important to be aware of the context of this violence, as knowing the various reasons and risk factors for family violence will ultimately make any responses to family violence more successful. Workers can be aware of these risk factors in their daily interactions with women and children, and these risk factors can be incorporated into the program to reduce violence.
	Risk indicators inclusive of financial, goal to home transitions, alcohol, weapons, brain injury, strangulation and social media use.	This information will support the decision for which risk assessment tool is chosen as part of the IPV clinical pathway. Currently different states/territories have differently tools and the environmental scan report has a table outlining the elements – the project will need to determine if/how this element of the clinical pathway will align with state/territory requirements. Another element in this decision process is which risk assessment tools have been designed for Aboriginal and Torres Strait Islander people, the Victorian CRAF may provide guidance.	This type of assessment is specialist work and requires specific knowledge and skills. However, all workers can gain benefit from being informed about risk assessment and understanding how risk assessments are used and the importance of responding when the outcome of that risk assessment identifies that women and children are at significant risk. People engaging in risk assessment need to be culturally competent, that is workers should have an awareness of their own beliefs and biases, knowledge of Aboriginal and Torres Strait Islander women's values and cultural practice and the ability to use culturally appropriate interventions.

Themes	Environmental Scan Recommendation	ANFPP IPV approach	Evidence supported from literature (the following statements are directly lifted from the literature review– references are available with the literature review)
Developing Knowledge and skills in educating clients	Embed cycle of violence spiral	This tool (Walker, 1979) can be useful to guide discussions with clients, it doesn't have to focus on their individual situation it could be a discussion about something they observe and can be used in the IPV clinical pathway as a tool for discussing universal assessment of safety. The ANFPP DFV manual will also unpack how this is represented in client relationships.	The training of health care providers needs to include information and skill development on the practical use of assessment procedures and tools in order to increase rates of identifying women and children experiencing violence.
	Even if DFV is not an immediate issue for client, introduce topic	This is incorporated as part of the universal assessment of safety within the clinical pathway and if no disclosure of violence the discussion is repeated at 8 weeks postpartum and when child is 16 months. Situations change for clients so asking throughout the program provides various opportunities, allows client to know it's a topic that can be discussed, allows for relationship to develop and client to feel safe to discuss.	As many women are more likely to be in frequent contact with health workers while pregnant than at any other time in their lives, this represents a unique opportunity to screen and refer pregnant women and it has been suggested that domestic violence during pregnancy occurs more frequently than health conditions that are routinely screened for in the antenatal period but there needs to be ongoing assessment of risk as pregnancy is not the only time of risk for women, there are also risks postpartum.
	Develop facilitators to 'plant the seed' even if DFV is not an immediate issue		
	Provide information on difficulty and risk of leaving a relationship.	This is an element within the education and roles plays will unpack how staff can discuss this with clients. Further to this staff having a detailed understanding of the local setting and support available will support these conversations with clients. The education will also support staff to work with the client when she doesn't want to leave the relationship as well.	Aboriginal and Torres Strait Islander women may not be able to leave as they may have to take care of their children, due to their connection to kin or as there may not be available support agencies
	Include safety planning prompts – understanding lethality and using appropriate safety planning tools	This will be done as part of the IPV clinical pathway and potentially might also be included within the ANKA system. Some state/territory risk frameworks include safety planning so what is taught in ANFPP will need to align with local requirements.	It is essential to tailor safety plans to woman's level of risk as well as her readiness to address safety.
	Frame education on health relationships, strong families and healthy parenting	ANFPP works from a strengths-based approach and the element of healthy relationships and parenting education with clients are included within the ANFPP IPV facilitators to use with clients. These discussions are also supported in the universal assessment of safety discussions early on in the Clinical IPV pathway. Healthy parenting is also a topic extensively covered more broadly with the ANFPP education between staff and clients and their families.	The loss of traditional roles and status for Aboriginal and Torres Strait Islander men, and their consequent feelings of powerlessness compared to men in mainstream society, may lead Aboriginal and Torres Strait Islander men to regain power by exercising control over women and children through family violence however traditionally relationships were often on an equal standing.
Communication and non-judgemental responses	Communication skills to lead discussions and sensitively enquire about attitudes and beliefs about DFV	The face to face education will unpack and practice approaches for how to communicate in a non-judgemental way. This will be combined with motivational interviewing (MI) techniques as there will need to be a slight adjustment to MI approaches in an IPV situation as it is the woman's response that she can work on as it is not her behaviour to change.	Programs needed to be offered continually, contain repetitions in content and be offered orally and visually and Culturally sensitive practices include having regard for women's business (with the inclusion of discretion), use of the local language and pictorial representations. Any work with Aboriginal and Torres Strait Islander women should ultimately be based on an empowerment model, so as not to replicate the lack of power women may be experiencing in their violent relationships.
	Adapt behaviour change principles and motivational interviewing		

Themes	Environmental Scan Recommendation	ANFPP IPV approach	Evidence supported from literature (the following statements are directly lifted from the literature review– references are available with the literature review)
Listen to instincts and body language and being attuned to somatic responses and symptoms in self and client	The discussions with staff highlighted that education needed to unpack what to do with a gut feeling that something is wrong for a client. FPW's also indicated that this was where NHV's needed to value the FPW input. This will be important for ANFPP staff to work as a team and discuss concerns with one another.	There was no evidence identified in this area.	
	How to build and maintain trust and retain engagement	The IPV clinical pathway incorporates this element by ensuring that the 1st activities are about supporting relationship development. This is also aligned to the STAR framework as well and any specific questions are not asked until there has been an opportunity to develop a relationship.	Questioning about IPV should not take place at the first visit, there should be plenty of warning that such questions will be asked, and disclosure is more likely to be enhanced when there is an ongoing relationship between the health provider and the mother.
	Understand that DFV is a long term chronic issue	Education will include supporting staff to work with the client's decision and that changes in this area can take time for clients as there are many factors affecting their decision. The Education will also unpack that the risk of harm can be heightened just after separation.	NFP IPV Intervention Developer indicated verbally that it takes an average of 7 times for clients to permanently change their situation – so it is likely that a client may not change her situation within the life of the program but her understanding of her situation may change. There also needs to be continued support for any program or service, recognising that change will be slow and will require healing across generations.
	Include boundary-setting for all staff roles	This is already an element of ANFPP education and this will be reinforced in the ANFPP IPV education as DFV is an emotive area and how staff can identify and work within boundaries. The ANFPP IPV innovation also includes approaches to reflective practice form both perspectives of the Nurse Supervisors and NHV/FPW to unpack issues.	There was no evidence identified in this area.
Partnership and brokerage skills and practice	Develop service navigation skills and practice for all staff Build capacity of staff to partner and link to services and networks Referral paths inclusive of family centred healing programs	To support these areas an extensive self-directed staff checklist activity has been created to ensure that staff are aware of: local setting (community & organisation) services (e.g. police, DV service, legal) local network meetings local legal and reporting requirements (including mandatory) These topic areas have been included within the checklist along with local cultural element: understanding kinship system, identifying local owners and elders	The nature of the service system will differ in diverse communities, with more available services in urban areas as compared to regional and remote areas. Responding to family violence may be offering referrals. However, women must be made aware of who may have access to their information. If their name is provided to an Aboriginal and Torres Strait Islander service, this may compromise the privacy and confidentiality of the woman.
			Holistic responses that address the issues for women, children, and men, however the safety of women and children must always be the priority. Reconstituting family ties is central to family violence responses. Any responses to family violence must pay attention to the familial and wider kinship networks involved in or affected by family violence, as well as the impact of colonisation and other traumatic events on the origins of this violence

Themes	Environmental Scan Recommendation	ANFPP IPV approach	Evidence supported from literature (the following statements are directly lifted from the literature review– references are available with the literature review)

Supporting documentation and reporting	Documentation training and technical support systems and in line with National Data collection	There was no evidence identified in this area	NFP IPV is based on March of Dimes protocol
			Where documentation is inclusive of:
			• Result of conversation and specific information or resources provided
			• In cases where disclosure has been made, document:
			  • Frequency and severity of past and present
			  • Location and extent of injuries and subsequent issues
			  • Referrals made and outcomes
			  • Safety planning discussed
			  • Follow –up
			  • Record direct quotes from client
			  • Measurements of any physical abuse

	Mandatory reporting requirements	There was no evidence identified in this area	Each state and territory varied in its mandatory reporting requirements.

Image Description: Mum holding her baby against her head and smiling.

RECOMMENDATIONS

Annex 3 - Data Collection Items

Initial DFV Identification Record

- Assessment Date
- Phase
- Stage
- Assessment Reason (Disclosure, Observational Risk Indicators, Relationship & Safety discussion)
- Was DFV Disclosed? – Yes/No
- Was community ref. card issued? Yes/ No

Actions Taken

- Created date
- Reported elsewhere (Y/N)
- Community Card given (Y/N)
- Completed Mental Health screening (Y/N)
- Discussed Readiness for change (Y/N)
- Readiness type: Pre-Contemplation; Maintenance; Action; Contemplation; Preparation
- Readiness stage date
- Risk Assessment done (Y/N)
- Resulting In Safety Planning (Y/N)
- Risk Score

Initial DFV Identification Record

- Assessment Date
- Phase
- Stage
- Assessment Reason (Disclosure, Observational Risk Indicators, Relationship & Safety discussion)
- Abuse Type (Stalking; Physical; Emotional; Sexual violence; Financial; Digital (e.g. Social media); Controlling; Threats; Verbal; Other)
- Living with the person
- Relationship with the person
- Afraid of that person
- History of abuse
- Previous abuse date
- Mandatory reporting completed (client) Y/N
- Mandatory reporting completed (child) Y/N
- Add outgoing referrals (radio button only – not an attribute)
- Add materials provided (radio button only – not an attribute)

Outgoing referrals Data collection items

- Referral Date
- Phase
- Stage
- Referral within service (Y/N)
- Referral related to (Child wellness check, DFV discussion, EPDS discussion, Client activity, Client profile, STAR discussion, DANCE Discussion)
- Referral for (Client, Child, Father, Partner, Family)
- Referral followed-up (Y/N)
- Referral type (recommended, supported, initiated)
- Referral Category
    - Employment Or Education
    - Early Childhood
    - Environmental health
    - Domestic violence
    - Drug Or Alcohol
    - Primary Care Services
    - Crisis support
    - Other
    - Smoking
    - Housing
    - Social
    - Primary Care Services (Health Assessment MBS 715)
    - Child and Family Health Service
    - Mental Health
    - Primary Care Services (Other)
    - Environmental Health (Other)
    - Child Protection Services
    - OT / Speech

Annex 4 - Evaluation Design Overview

Outcome	Evaluation question	Indicator/s	Data collection method	Data collection tool	Sample	Ethics and consent process	Who will collect this data?	When will this data be collected?	How will this data be analysed? By Whom?
Staff identify an increase their knowledge and ability to support ANFPP clients experiencing violence in their intimate relationships Linked to project outcome 1 and 2	ANFPP Staff have the capacity and improved ability to respond to clients experiencing intimate partner violence in their relationships	% of staff with increased knowledge and application (as identified in survey responses)	Pre/post education survey (new sites) Staff needs survey – pre/post (established sites) currently conducted through survey monkey	Survey through online platform	All staff participating in the ANFPP IPV education	Staff will be de-identified down to role and site. Detailed information provided at beginning of survey, staff consent indicated in completion of survey with a short paragraph which will explain how the information will be used	Project manager	Before any IPV education, shortly after receiving IPV education and approximately 6 months post IPV education.	Simple quantitative analysis Either project manager or external data specialist

Outcome	Evaluation question	Indicator/s	Data collection method	Data collection tool	Sample	Ethics and consent process	Who will collect this data?	When will this data be collected?	How will this data be analysed? By Whom?
ANFPP partner organisations were able to connect with local resources to support ANFPP clients experiencing violence Linked to all project outcomes	Questions 1-11 from acceptability and feasibility will be explored, key questions include: What were the ANFPP staff's experiences? (Worked well/ challenges/ how did they overcome)How did NS's support application of innovation? Were ANFPP staff able to refer clients to necessary services?	Intended and Unintended effects	Site based teams and (potentially) role based focus group discussions (at site location) Feedback provided by site staff throughout the project	Focus group discussion and Yarning circles Referral data from ANKA system	All ANFPP site staff	Ethics approval Site CEO approval for staff time Consent form	External evaluator	Early 2019 (after/ towards the end of implementation logs completion)	Thematic Analysis by External evaluator

Outcome	Evaluation question	Indicator/s	Data collection method	Data collection tool	Sample	Ethics and consent process	Who will collect this data?	When will this data be collected?	How will this data be analysed? By Whom?
ANFPP IPV education elements supported imple-menting staff to be competent in support-ing and responding to clients experi-encing violence in their intimate relationships Linked to project outcomes 1 and 3	To what extent did ANFPP staff use the inno-vation in Practice? Identify ability of staff to identify if IPV is an issue for a client and then the measures that staff implement-ed to sup-port the client	% of com-pletion of log by ANFPP staff ANKA Reports	Implemen-tation log identifying which elements of the clinical pathway were used with clients, 1 log per client. Potentially PDF form format Focus group discussions ANKA data	Implemen-tation log and ANKA	All sites and all staff over a period of 9 months (potentially 400 logs) 1 log per ANFPP client	Clients will not be identifiable and staff will be identifiable (could use staff coding) Informed Consent is gained when client join the ANFPP with regards to data collection	ANFPP Site staff	Once education has been received and seeing clients for a period of 9 months	Simple quantitative analysis Either project manager or external data specialist

Abt Associates
Level 2
5 Gardner Close
Milton, Brisbane QLD, 4064
Australia
Tel: +61 7 3114 4600

Abt Associates
Euston House
24 Eversholt Street
London, NW1 IAD
United Kingdom
Tel: +44 (0)20 8133 9977

Abt Associates
55 Wheeler Street
Cambridge, MA 02138-1168
United States
Tel: +1 617-492-7100

Abt Associates
4550 Montgomery Avenue
Suite 800 North
Bethesda, MD 20814-3343
United States
Tel: +1 301-347-5000

Abt Associates
Level 4
33 Ainslie Place
Canberra, ACT 2601
Australia
Tel: +61 2 6188 4192

Abt Associates
180 Maiden Lane
Suite 802
New York, NY 10038
Tel: +1 212 779-7700

www.abtassociates.com

Brooke Dickson
info@anfpp.com.au
P: +61 7 3891 4181