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Final Report

LGBTIQ+ Family Violence Perpetration Research Project

Prepared for the Department of Social Services

By Queerspace Research - The Centre for Family Research and Evaluation

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A division of

Acknowledgements

CFRE respectfully acknowledges the Kulin Nation as Traditional Owners of the land where we deliver our services. We acknowledge Aboriginal and Torres Strait Islanders as the first people of Australia. Sovereignty was never ceded, and they remain strong in their connection to land, culture and in resisting colonisation.

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Glossary

Brotherboys – Brotherboys are Indigenous transgender people with a male spirit, whose bodies were considered female at birth. Brotherboys choose to live their lives as male, regardless of which stage/path medically they choose. Brotherboys have a strong sense of their cultural identity*.

FV – family violence – behaviour towards a family member that is abusive, threatening, coercive or otherwise controlling of the family member and causes them to fear for their own safety and wellbeing or those of another person, or behaviour causing a child to be exposed to the effects of those abusive behaviours*.

Intersex – Intersex people are born with physical sex characteristics that don't fit medical and social norms for female or male bodies*. Note that many intersex people do not identify as LGBTQ+.

IPA – intimate partner abuse

IPFV – Intimate partner and/or family violence

IPV – intimate partner violence

LGBTIQ+– lesbian, gay, bisexual, trans, intersex and queer

MSM – men who have sex with men

PV – partner violence

Risk and Protective Factors: These are types of correlates. They are factors associated with increased probability of an adverse, or favourable outcome, respectively.

Sistergirls – Sistergirls are Indigenous transgender people with a female spirit, whose bodies were considered male at birth, who have a distinct cultural identity and often take on traditionally female roles within the community, including looking after children and family. Many Sistergirls live a traditional lifestyle and have strong cultural backgrounds. Their cultural, spiritual, and religious beliefs are pivotal to their lives and identities*.

TGD – trans and gender diverse. Includes people who identify as non-binary.

Transgender – Transgender people have gender identities and expressions that differ from their assigned sex at birth (for example, someone who was assigned male at birth and is transgender may be female, genderqueer, non-binary, agender, or any other gender that is not male). Transgender is often used as an umbrella term, either on its own or as part of the larger term 'trans and gender diverse' but may also be used as a gender in and of itself*.

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* The definitions for Brotherboys, Sistergirls, Intersex, Transgender, and family violence were borrowed from Sistergirls/Brotherboys NT, the Intersex Human Rights Association, Transgender Victoria, and the Victorian Family Violence Protection Act of 2008, respectively.

Executive Summary

Background

National and international studies have found that family violence (FV) in lesbian, gay, bisexual, trans, intersex and/or queer (LGBTIQ+) relationships occurs at rates similar to, if not higher than heterosexual relationships. LGBTIQ+ populations face unique and intersecting vulnerabilities, including that: the impacts of abuse are compounded by discrimination and stigma experienced in a community context; intimate partner and family violence remains largely invisible in LGBTIQ+ communities due to myths that LGBTIQ+ people do not, or cannot, experience abuse; LGBTIQ+ communities are far less likely than the general population to find support services that meet their specific needs; and, many services are unable to support the unique needs of LGBTIQ+ people impacted FV (Commonwealth of Australia 2019).

Given the poor understanding of what effective interventions might look like for LGBTIQ+ people using or experiencing violence, gaining a better understanding of the risk factors associated with violence is a key step in the development of effective, targeted and nuanced interventions. The findings and recommendations from this project highlight the complexity of the issue and the need address individual, institutional and societal risk factors in order to develop interventions that are targeted, effective and affirming of the identities of participants.

Purpose

The purpose of this research was to develop a better understanding of the risk and protective factors associated with LGBTIQ+ family violence in order to build effective interventions for LGBTIQ+ people using violence.

queerspace/drummond street services (ds) delivers specialist family violence services for LGBTIQ+ people, including therapeutic work and case management support. This provided ds unique client and practitioner data to explore, alongside the literature around LGBTIQ+ people's use of violence.

Note that within this report, risk and protective factors are being discussed in terms of their correlation or co-occurrence with family violence; they should not be assumed as causal given their relationships to one another are often complex.

Key Learnings

Broad key learnings that emerged from this research project are:

1. LGBTIQ+ family violence is a complex issue, and people should be listened and responded to in a way that recognises diversity of experiences and knowledge

2. Primary prevention efforts which challenge structural hierarchies including patriarchy, racism, colonialism, and ablism; and increase awareness of LGBTIQ+ family violence would be useful in addressing many of the risk factors
3. Capacity building with the LGBTIQ+ sector to respond to family violence, and with the mainstream family violence sector to respond to LGBTIQ+ people and families, should be prioritised concurrently to ensure people have services they feel safe to approach

We have much further to go in establishing a body of research around LGBTIQ+ family violence and effective interventions to reduce or end it. Remaining open to new learnings about what LGBTIQ+ family violence may look like, and what might work in addressing it, is important in ensuring assumptions do not eclipse opportunities for change.

Methodology

Over the course of the research project, four different data sources were explored, which were triangulated midway through the project, and informed the fifth step in the project, the development of the pilot intervention.

1. A rapid literature review was conducted to provide a picture of the existing evidence for family violence risk factors and interventions with LGBTIQ+ people.
2. Twelve practitioners took part in focus groups and/or interviews. Interview questions covered risk and protective factors, and triggers or points of escalation for LGBTIQ+ FV, with an emphasis placed on those using violence (See Appendix A for the Discussion Guide). Coding and analysis were done inductively and deductively using NVivo.
3. A client file data audit was conducted using files of 52 clients who had used or experienced violence and who had consented to having their data used for research. The file audit tool included 84 fields. After completing the audit, those whose files did not provide sufficient relevant information to populate at least 40% of the fields were omitted, leaving 47 case files.
4. Seven clients took part in individual interviews, some of whom had used violence, and some of whom had experienced violence. Again, questions explored risk and protective factors for family violence, as well as triggers/points of escalation (See Appendix C for Discussion Guide). Coding and analysis were done inductively and deductively using NVivo.
5. Pilot interventions were developed and trialled in a community setting for LGBTIQ+ women, trans & gender diverse people who has used family violence, with affected family members also engaged as part of an integrated service response. Twenty-two clients took part in the program. The pilot program outcome evaluation included pre/post questionnaires, attendance and completion data, and client focus groups. Practitioners also developed two de-identified case studies to illustrate the complexity of the work. Because a small number of people took part in the trial, and

the evaluation was limited, more work is needing to evaluation this program going forward to generate robust learnings.

Findings

Across the literature, practitioner interviews, and client file audit data, there was a great deal of consistency in the themes that emerged. The following table summarises the findings from the literature, practitioner interviews, and client file audit regarding risk and protective factors for LGBTIQ+ family violence. The main themes for use and experiences of family violence which emerged included experiences of abuse, mental health, substance use, social and material resources, relationship factors including gender roles, intersectional marginalisation, and service access. Note that most factors could have risk or protective impacts, depending upon the circumstances of the person. For example, material resources instability could increase risk, and material resource security could be protective. Each theme within the findings which emerged from at least two of the data sources is discussed below.

	Literature	Practitioner	Client Audit
Past Abuse	✓	✓	✓
Adult Abuse	✓	✓	✓
Substance Use	✓	✓	✓
Physical Health		✓	
Mental Health	✓	✓	✓
Relationship Factors	✓	✓	✓
Gender Roles	✓	✓	
Social Resources/ Community Support	✓	✓	✓
Financial Resources	✓	✓	
Minority Stress	✓	✓	✓
Intersectional Marginalisation	✓	✓	
Access To services	✓	✓	✓

Past & Adult Abuse

Childhood experiences of violence were identified in the three data sets as a risk factor for experiences and/or use of family violence later in life. Previous experiences of abuse were discussed in the literature, for example in previous relationships or at other points in the same relationship. The practitioner data suggested previous experiences of family or intimate partner violence and sexual abuse as an adult were risk factors for both the use and experiencing of family violence.

Substance Use

Substance use came up as a risk factor and/or point of escalation for violence throughout the data. The literature indicates that alcohol plays a role in psychological and/or physical violence in intimate lesbian and gay relationships. In the practitioner interviews and focus groups, alcohol or other drug misuse was the single most frequently cited risk factor for LGBTIQ+ family violence. The client data showed that while personal drug and alcohol abuse were mentioned by only one quarter of those in the use of violence group, half of the experiences of violence group described alcohol or other drug abuse by their partner as a trigger for an instance of abuse. This suggested that those using violence may underreport their substance use.

Mental Health

Within the literature about LGBTIQ+ family violence, several mental health issues were associated with either the use or experiences of family violence. These included low self-esteem and anxiety as risk factors for experiences of family violence, and less secure attachments, greater psychological distress, low self-esteem, stress and disordered personality characteristics as risk factors for the use of family violence. From the client data, the use of violence was associated with high rates of mental health distress, and depression in particular. There were higher levels of other mental health disorders, like Borderline Personality Disorder and Autism Spectrum Disorder among those who had used violence in comparison with those who experienced violence.

Relationship Factors & Gender Roles

The broad theme of relationship factors was another that emerged across all three data types. In the literature, this largely pertained to the degree of accommodation and/or control being used by partners, as well as the extent to which they each maintain their own autonomy within the relationship. Unequal distributions of power, and stereotypical enactments of gender roles in relationship were the subthemes within "relationship factors" as per the practitioner interviews and focus groups. The examples provided of power discrepancies included differences in financial capacity, age differences, one partner or family member being a carer for the other and having control over immigration status. In any

of these cases, the person afforded less power might be more vulnerable to family violence enacted by the person holding more power.

In addition to what was discussed above around structural factors, the changing roles during the transition to parenthood were raised, as often these were related to how gender operated in the family. Often the parent who was the primary carer for the infant was more vulnerable to experiencing family violence, where a working parent might be in a position of greater power over them. The client data audit identified the birth of a child as a period of increased risk for family violence among LGBTIQ+ people. Unequal distribution of labour and of caring responsibilities were highly correlated with family violence, and financial control was integral to parents' experiences of abuse.

Social & Material Resources/Community Support

A lack of social and/or material resources was prominent throughout the data as being associated with risk of LGBTIQ+ family violence. The literature highlighted the socioeconomic disadvantage faced by TGD people, including lack of access to education and employment, and increased risk of homelessness, and the vulnerability to experiences of family violence it represented. The practitioner interviews and focus groups recognised these challenges, and also raised the significant implications of social resources and community or lateral violence. Social isolation was identified as a risk factor for family violence, as well as a tactic of abuse which then put people at risk for ongoing or future family violence.

The lack of awareness and recognition of LGBTIQ+ family violence in comparison with heterosexual cisgender family violence, and its resulting invisibility, was also identified as an area for individual and collective capacity building in order to minimise risk. Similarly, the client data showed that those who experienced LGBTIQ+ family violence were almost twice as likely as those who used violence to be isolated from family of origin.

Minority Stress

Experiences of discrimination and the internalisation of that discrimination, often referred to as minority stress, were raised across the three sources of data. In the literature, this included the findings that internalised homophobia was frequently associated with the use of violence among women who have sex with women and men who have sex with men, with researchers suggesting internalisation of negative beliefs about oneself may serve as barriers to one's establishment of healthy relationships. Internalised homophobia has also been correlated with experiences of violence in intimate partnerships among lesbian and bisexual women.

Minority stress has also been discussed in terms of the impact of heteronormative expectations of gender roles. Subscription to hegemonic masculinity has been associated with the use of family violence among gay and bisexual men. Similarly, stereotypical

masculinity was raised in both practitioner and client interviews as being associated with patterns of use of family violence in intimate partnerships.

Intersectional Marginalisation

From the literature, trans and gender diverse people, who exist at the intersection of sexual and gender minorities, experience higher rates of intimate partner violence than do their cisgender counterparts, and transwomen may be particularly at risk. Those who identify at other intersections may also face increased risk in association with structural and other challenges. LGBTIQ+ people with disability, those who are Indigenous or from culturally, linguistically, and religiously diverse communities, and elders may experience multiple layers of discrimination and have less access to safe and appropriate services, and the violence they experience may be less visible. Practitioners discussed the relationship between systemic violence, including on the basis of race, ethnicity, disability, indigeneity, or other identities, and the use or experiencing of family violence. The material disadvantage often associated with marginalised identities were also referenced in terms of family violence risk.

Access to Services

The literature, practitioners and clients each identified lack of access to safe, appropriate and responsive services as a factor contributing to risk for LGBTIQ+ people experiencing family violence, particularly where a particular person's identity existed at the intersection of multiple forms of marginalisation.

Interventions for LGBTIQ+ people who use violence

In terms of interventions for LGBTIQ+ people who use violence, there was very little available research, whether about mainstream interventions applied to these cohorts, or about specialist LGBTIQ+ interventions. Even in the context of cisgender heterosexual people who use violence, the effectiveness of existing interventions has not been consistently evidenced within the literature, which suggests simple adaptation may not be the best way forward.

Given the inter-relational nature of family violence, and a high level of risk associated with misidentification of LGBTIQ+ perpetrators, an Integrated Service Response (ISR) model was developed to allow for the management of dynamic risk. The model allows for one practitioner to work with the person using violence, supporting them to change their behaviour and address a range of co-occurring risks; while another worker supports those harmed by the violence through therapeutic case management and counselling. All work carried out by both workers is overseen by a practice lead who coordinates case planning meetings, supervises the work being carried out by each worker and ensures that the needs and safety of those harmed remain at the centre of all case planning and co-ordination. Key to this model is thorough assessment, safety planning, case management and ongoing case supervision meetings.

A group program was also delivered concurrently with the ISR model. The group program reflected many of the key learnings from the earlier data sets in this report, and was developed as a trauma-informed intervention, recognising that many people who use violence have also experienced violence. The program emphasised empowerment, building on the strengths of participants. The content included discussions of what violence and abuse look like, and promotion of non-violence in how people relate to others.

The evaluation of the pilot found that the concurrent individual and group supports were important to those using violence in getting the most benefit from the group content. The vulnerability and collective inquiry that were made possible through the group setting catalysed shifts in understandings of violence for the participants. As part of the individual work, practical supports and brokerage funds were key to promoting and maintaining the safety of those affected by violence. The ISR model allowed for thorough assessment and management of risk, particularly where there had been misidentification, or unclear presentation of families in terms of who was using violence. Longer term work would allow for learnings around the medium-term impacts on the use of violence by participants, and experiences of those being harmed.

Conclusions

Based on the triangulation of data from the literature review, practitioner and client interviews, client file audit and pilot project evaluation, the recommendations for interventions with LGBTIQ+ people who use family violence include the following:

- Services must be safe and appropriate for LGBTIQ+ people, and should use comprehensive assessment to get an understanding of the use and experiences of violence in a family, rather than making any assumptions based on identity; this may include capacity building for mainstream family violence sector and related systems, such as the police and the courts
- Programs should include supportive structures that help mitigate dynamic risk, through ongoing assessment and supervision
- The trauma histories of people using violence should be recognised, while not being allowed to serve as justification of the use of violence against others
- Programs are more effective when they are flexible based on the needs of the individual clients, or a group of clients; this may include having services available outside business hours
- Programs which are integrated within broader organisational or service systems may be more effective than those being provided in isolation. Family violence services should address, or be linked with services which address other challenges which may trigger or escalate violence, such as AOD, mental health, and material resource insecurity
    - Housing support including advocacy and brokerage, and case management support more broadly around material resource insecurity offer potential as they build clients' capacity to end their use of violence

- To mediate the impacts of social isolation, connection to community might be fostered through case management support and/or warm referral to other services
- Families expecting children or transitioning to parenthood are a high risk cohort, who could benefit from specialised primary prevention and early intervention strategies

What is clear from the data in this report is the lack of awareness of what family violence may look like in LGBTIQ+ families, whether among the general public, within LGBTIQ+ communities themselves, or within service systems. While the pilot intervention discussed in this report was limited in its scope, further evaluation of the program as it goes forward and builds its client base, and ongoing review and development could yield important learnings about effective intervention in this space.

Limitations

There are a number of limitations in scope and generalisability to consider when interpreting the findings of this report. These pertained to the context in which the research was carried out, the limited number of participants engaged in each stage of data collection, and difficulties obtaining consent. Key limitations identified included:

- Research was carried out within single organisation, limiting the diversity of client and staff demographics
    - Primarily white Australians of Western/Anglo-European descent
    - Largely based in the Melbourne metro area
    - Client base includes proportionately few cisgender men
- The numbers of participants in the different phases of data collection were relatively small
    - Twelve practitioners took part in focus groups/interviews
    - Seven clients took part in interviews
    - 47 cases included in client file audit
    - Four group program participants took part in focus group
    - Pilot program engaged 22 participants
- While intended components of the evaluation plan, data about changes in use of violence were not able to be collected, nor was change data more broadly from pre/post questionnaires

Given these factors, the experiences and voices of cisgender men, Indigenous people and People of Colour, and people living in rural/regional contexts were insufficiently represented in this report. Further evaluation of the pilot program discussed in this report, which addresses some of the gaps in the initial evaluation, would be useful in establishing more robust learnings.

Introduction

There is long-standing evidence in the literature as to the existence of family violence (FV) in lesbian, gay, bisexual, trans, intersex and/or queer (LGBTIQ+) families and communities (Jackson Heintz & Melendez 2006; Lindhorst, Mehrotra & Mincer 2010; Badenes-Ribera, et al 2016). However, there remain substantial gaps in our understanding of intimate partner and/or family violence when it occurs in these communities, including risk and protective factors, impacts, and effective supports and interventions. This has meant it has thus far not been possible to formulate an evidence-based framework for understanding LGBTIQ+ FV. To address one part of this gap, this paper aims to build on existing evidence for risk and protective factors for family violence in LGBTIQ+ communities, in order to inform the development of targeted interventions.

This document is the final project report for the LGBTIQ+ Family Violence Perpetration Research Project funded by the Department of Social Services. This paper has two main foci: risk and protective factors for LGBTIQ+ family violence; and family violence interventions for LGBTIQ+ people. Risk and protective factors were explored through a literature review, practitioner interviews, and a client file audit. Potential interventions were considered, also through the literature review and practitioner interviews, as well as client interviews and the evaluation of pilot interventions. This research has included practice-based data drawn from the practitioners and clients at queerspace, a peer-led LGBTIQ+ health and wellbeing program at drummond street services in the Melbourne metro area. Queerspace provides individual, couple, and family counselling, case management support, groups, and community engagement initiatives to promote the health of LGBTIQ+ communities, as well as training and capacity building for the service sector around work with LGBTIQ+ people. Since 2016, queerspace has provided specialist LGBTIQ+ family violence support, as the lead agency in the Victorian w/respect LGBTIQ+ integrated family violence service.

A public health approach

The drummond street services' approach to practice is based on a public health framework, which conceptualises programs and services across the spectrum of interventions from health promotion, to prevention, early intervention, treatment, and recovery. In order to prevent issues such as family violence, drummond street's approach emphasises interventions on the early end of the spectrum. Screening and assessment enable early identification and targeting of issues before they become more serious. An awareness of factors associated with health and wellbeing challenges people may face is useful in initiating support as soon as possible.

Something to note with regard to language around the public health approach is our use of the terms, "risk and protective factors". Some sources in the literature referred to these as "markers" rather than factors, or at times as "drivers". We have avoided the use of "drivers" given the implication that drivers are *causal* factors in the use of and experience of violence.

Throughout this paper, risk factors are explored as factors *associated* with the use of violence, rather than factors assumed to *lead to* the use of violence. It is quite probable that many LGBTIQ+ people will have experienced some of the risk factors described below, including trauma in childhood, as well as various coping strategies such as the subsequent use of alcohol or other drugs. The paper in no way implies that these people will therefore use violence.

Notes on language use

When not in the context of a particular source, the terms "experiencing violence," and "using violence" have been used in this report instead of "victimisation" (or victim/survivor) and "perpetration" (or perpetrator) in line with existing drummond street practice guidelines. drummond street policy[1] contends that it is often difficult, particularly upon first meeting clients, to form a comprehensive understanding of how power is operating in their relationship/s, and therefore to decide who may be "perpetrating" (using) or a "victim" of (experiencing) violence. It also recognises that there may be times when multiple parties are using and/or experiencing forms of violence in the context of intimate partner and family relationships.

Alternate language, including "using" and "experiencing" violence, was chosen in recognition that mainstream approaches to family violence may not adequately capture the complexities of LGBTIQ+ relationships and families, and the unique factors that impact LGBTIQ+ people's experiences and use of violence. Further, where not specified, all references to "use" and "experience" of violence are in reference to an intimate partner or family violence context, rather than the use of violence more generally. Where appropriate, however, within the review of the literature we have retained source terminology when referring specifically to its findings to be true to the paper's own conclusions about LGBTIQ+ FV. For example, it may not always be appropriate to assume that it is possible to equate what we mean by "use" of violence to "perpetration" as used in the original source, and vice versa for "experiencing" (or being a victim of) violence.

Likewise, while this paper is concerned with LGBTIQ+ FV across the acronym, sources reviewed in this paper often used less expansive language such as "same sex" partner violence or similar. Where appropriate, we have stayed true to the language used in the source paper to be clear about the generalisability of those findings.

[1] Policy here refers to drummond street's risk assessment procedures.

1. Literature Review

The first half of the literature review section of this report explores the academic and grey literature in reference to the risk and protective factors for family violence, with a focus on LGBTIQ+ specific research. Given the dearth of literature focussing distinctly on LGBTIQ+ use of FV it was not always possible to exclusively discuss risk factors in the context of the *use* of violence. Therefore, in practice, this literature review focuses on risk factors that were associated with either the use or experience of violence, or both. This exploration of correlates of family violence does not dismiss the role of structural hierarchies of power in fostering a social environment that condones and even promotes violence against certain people, by certain people. Rather, it aims to complement the work that has been undertaken and is still being undertaken around these issues, with learnings about what might make one person living in the context of such structural violence more susceptible than another to experiencing or more likely to use violence in their families and intimate relationships. The second half of the literature review section will explore interventions for LGBTIQ+ family violence.

The review does have further limitations. As it stands, given time and resource constraints, it is only a sample of available literature. The dynamics of LGBTIQ+ FV, such as what it tended to look like, or what tactics people using violence employed, while critical to explore, fell outside its scope. So too did "drivers" given these are understood to be causal factors in the use of LGBTIQ+ FV and cannot be established in the absence of rigorous research. It is important to note that there is a distinct lack of research in regard to protective factors, resulting in the bulk of this review focussing on risk factors. Likewise, the majority of the literature available is from outside Australia; it is largely American and Canadian. While every effort was made to highlight Australian research, it was necessary to review international literature given the limited body of research in general.

Search Protocol

For this rapid review, a search was conducted of the literature for articles from the year 2008 through 2018. Because of the limited available literature, several articles that were LGBTIQ+ specific from between 2000 and 2008 were included as well. SAGE Journals, JSTOR, and Google Scholar were used to explore the academic literature, and a combination of Google and Google Scholar were used for grey literature.

Risk and Protective Factors for LGBTIQ+ Family Violence

Prevalence

While the focus of this section of the literature review was on risk factors associated with the use, or experience, of violence, its prevalence amongst the LGBTIQ+ community was also considered in order to give further context. Prevalence rates of FV within LGBTIQ+

communities are varied throughout the literature (Edwards, Sylaska & Neal 2015). The inconsistencies in prevalence rates may be attributable to a range of identifiable methodological issues within existing research (Barrett & St. Pierre 2013; Edwards, Sylaska & Neal 2015) and make it difficult to gain an accurate understanding of the extent to which FV impacts LGBTIQ+ communities. However, many studies (Edwards, Sylaska & Neal 2015; NVACP 2016; Ireland et al. 2017) suggest that LGBTIQ+ people experience rates at least similar to or even higher than women in heterosexual relationships, prompting the need for further, validated research into this problem.

Prevalence rates are a key focus of much of the research and reviews of literature concerning LGBTIQ+ FV, yet it has been argued that offering prevalence rates with no further examination of the social context does not contribute to a greater understanding of LGBTIQ+ FV (Ristock 2011) and may serve to further pathologise LGBTIQ+ relationships (Lorenzetti et al 2014). While prevalence rates in general will not be discussed further, it is important to note that research has found that rates of FV vary for different identities within LGBTIQ+ communities.

For example, a common finding within the literature is that rates of FV experienced by bisexual-identifying people tend to be much higher than those who identify as lesbian or gay, and this is particularly true for women (Ireland et al 2017; Coston 2017). It has also been found that trans and gender diverse (TGD) people experience higher levels of FV than those who are cisgender (Leonard et al. 2012), with trans women experiencing the highest rates (Goldenberg et al 2018; Leonard et al. 2012). It should be noted that TGD people experience higher rates of sexual violence and general violence throughout their lifetime (Rymer & Cartei 2015), and it is likely that rates of violence are higher still for trans people of colour, including sistergirls and brotherboys (NACVP 2016; Riggs & Toone 2017). There is a distinct lack of research examining the ways and extent to which people with intersex variations are impacted by FV, however it is thought that prevalence rates are as high, if not higher, than people without intersex variations (IHRA 2009).

Risk factors

In order to develop effective, targeted prevention and intervention strategies for FV perpetration within LGBTIQ+ communities, it is essential to have an understanding of the factors that may increase a person's risk of using violence. It is also important to look at different risk factors across LGBTIQ+ identities and experiences. A notable characteristic of literature in the area of LGBTIQ+ FV, however, is the tendency to homogenise distinct identities within LGBTIQ+ communities, while also privileging some voices over others. This results in a saturation of research regarding the experiences of lesbian, gay and, to a lesser extent, bisexual people, making it difficult to gain insight into the experiences of people who do not fit within those identity categories, such as TGD people (Guadelupe-Diaz & Jasinski 2017; Yerke & DeFeo 2016) or those with intersex variations – for which no literature was found. This means there is limited data available regarding the risk factors that are more pertinent to these distinct communities and identities reflected by the LGBTIQ+ acronym.

It is important to contextualise what research is available by considering that people who have experienced trauma in their childhood or throughout their lives may cope using behaviours that are often understood to increase risk of adverse health and wellbeing outcomes. 'Risk factors' then, should be understood in the context of a person's particular experience, as the same behaviour, use of substances, for example, may have protective effects against family violence for one person, and increase risk of harm by family violence for another (Hill et al. 2012).

Mental health

Within the literature, poor mental health has been identified as a risk factor for LGBTIQ+ and non-LGBTIQ+ FV (Hill et al. 2012; Edwards, Sylaska & Neal 2015; Miller & Irvin 2017). Edwards, Sylaska & Neil (2015) found, in their critical review of the literature on IPV in sexual minority populations, that low self-esteem, attachment anxiety, and psychological health problems were associated with experiences of IPV, and less secure attachments, greater psychological distress, low self-esteem, more stress, and disordered personality characteristics were associated with use of IPV.

Several authors discuss the relationship between FV and depression for men, finding that men who have experienced FV are more likely to report depressive symptoms than men who have not experienced FV (Kimmes et al. 2017; Ireland et al. 2017). Research also shows that LGBTIQ+ people experience mental health issues at higher rates than non-LGBTIQ+ people (Katz-Wise & Hyde 2012), suggesting that mental health as a risk factor for FV is particularly noteworthy for people in LGBTIQ+ communities.

Childhood experiences of abuse

A common finding throughout the literature, and one that is shared for cisgender heterosexual FV (Capaldi et al. 2012; Lorenzetti et al. 2014), is that experiencing childhood abuse is a significant risk factor for both experiencing and using FV in adulthood (Hill et al. 2012; Ireland et al. 2017; Kimmes et al. 2017; Lorenzetti et al. 2017). Some contend that exposure to family violence as a child may influence a person's perception of violence, increasing the likelihood that they will view the use or experience of violence as an appropriate or expected relational pattern (McRae et al. 2017).

To contextualise this finding, it is important to consider that marginalised populations may experience childhood violence and trauma at higher rates than others (Allen Mallett, Tedor & Quinn 2019, Zou & Anderson 2015). For example, in their paper exploring risk factors for intimate partner abuse (IPA) for African American lesbian women, Hill et al. (2012) draw on research indicating higher rates of childhood sexual trauma for lesbian women as well as for African American women, contending that experiences of childhood sexual abuse may therefore increase risk of experiencing as well as using violence in adult intimate relationships. Further literature suggests that lesbian and bisexual women have greater chances of experiencing childhood sexual abuse (Levahot, Molina & Simoni 2012; Rausch 2016), while the same is true for TGD people (Kussin-Shoptaw, Fletcher & Reback 2017). In an Australian context, Brown (2004) points out the significant impact that child sexual assault

can have on the psychological and emotional wellbeing of sistergirls, such that experiencing child sexual assault can often lead to mental health issues. Not only is childhood abuse itself associated with the use and experiencing of family violence, but as already discussed, mental health challenges, to which childhood abuse is often linked, are also risk factors for family violence in and of themselves.

Substance Use

A significant risk factor for use and experience of FV is substance use (Baker et al. 2013). There is a breadth of literature linking substance use to FV within a heterosexual context (Lewis et al. 2017) as well as within LGBTIQ+ communities (Hill et al. 2012; Lewis et al. 2012; Chong, Mak & Kwong 2013; Kelley et al. 2014; Edwards, Sylaska & Neal 2015; Wu et al. 2015; Kimmes et al. 2017; Lewis et al. 2017). For example, Kelley et al. (2014) found alcohol use to be associated with IPV perpetration among men who have sex with men (MSM), while Lewis et al. (2017) found alcohol use to be a correlate of women's IPV perpetration. Lewin et al (2012) found that sexual minority women who experienced physical and nonphysical IPV were more likely to use recreational drugs and alcohol. They contend that, "the consistent finding that alcohol plays a direct role in psychological and/or physical violence emphasises the part that identification and treatment of alcohol use and related problems should play in addressing problems of relationship violence among lesbian women" (Lewis et al. 2017, p. 117).

Substance use as a risk factor is particularly salient when addressing FV in LGBTIQ+ communities, as it has been documented that members of these communities may use substances at a higher rate than those who do not identify as LGBTIQ+ (Kelley et al. 2014; Lewis et al. 2012; Langenderfer-Magruder et al. 2016; Lewis et al. 2017). For example, sexual minority men are more likely to use marijuana, cocaine, and heroin compared with heterosexual men (Kelley et al. 2014).

Social & material resources

Low socioeconomic status and low levels of educational attainment have been identified within the literature as risk factors for experiencing and using LGBTIQ+ FV (Balsam & Szymanski 2005; Hill et al. 2012; Milletich et al. 2014; Edwards, Sylaska & Neal 2015). These risk factors are particularly salient for trans and gender diverse people, who, as a result of various forms of systemic discrimination, are more likely to have difficulty maintaining employment, and are at higher risk of experiencing homelessness and incarceration (Goldenberg, Jadwin-Cakmak & Harper 2018; Papazian & Ball 2016). TGD young people face higher levels of housing instability, often as a result of violence within the home, and may be relying on a partner or lover for accommodation including rental support. If the young person is experiencing violence in the relationship, they may not report or seek help for the abuse due to a fear of homelessness (Goldenberg, Jadwin-Cakmak & Harper 2018; Papazian & Ball 2016).

Within the literature, financial abuse enacted against TGD people is a common theme, with research suggesting that people using violence may restrict or withhold finances necessary for a person's gender affirmation, as well as other essential resources (Yerke & DeFeo 2016;

Guadelupe-Diaz & Jasinski 2017). It is important to note that, as limiting or controlling access to resources is a common dynamic of FV, communities that are afforded less access to resources — as a result of homophobia, transphobia and/or sexism — may face increased and unique risks for family violence (Goldenberg, Jadwin-Cakmak & Harper 2018).

Previous/concurrent experiences of family violence

A risk factor for use of physical aggression that was found within the literature is previous or concurrent experiences of FV (Edwards & Sylaska 2013; Lewis et al. 2017). In their research into predictors of women's same-sex violence perpetration, Milletich et al. (2014) found that the risk of using physical aggression increased for women who had experienced psychological aggression from their partner. The authors argue that women who used physical force in response to psychological abuse were attempting to resist the perceived power imbalance in the relationship.

On the contrary, when reviewing risk markers found in the literature for men and women's same-sex IPV, Kimmes et al. (2017) found that the strongest risk marker for perpetration of physical partner violence was perpetration of psychological abuse. However, in line with Milletich et al. (2014), the second strongest risk marker for perpetrating physical partner violence was being a victim of psychological abuse. Nonetheless, a limitation of this research is that it was not made clear whether the psychological abuse (perpetrated or experienced) occurred within a previous relationship or a current one. Therefore, it was not possible to ascertain whether the authors were contending that psychological abuse perpetration and/or victimisation in a previous relationship was a precursor to physical abuse perpetration in a later relationship, or whether the two were co-occurring in the same relationship. Another similar finding was that perpetration of psychological abuse by a partner within a same-sex relationship is likely to progress to perpetration of physical abuse by the same partner (Chong, Mak & Kwong 2013).

Relationship factors

Some relationship factors were identified within the literature as potential risk factors for using and experiencing FV. For example, Milletich et al. (2014) found that in lesbian relationships, fusion — defined as "the blurring of boundaries between peoples in which they sense a loss of self as an individual" (Milletich et al. 2014, p. 654) — was a risk factor for perpetrating IPV. The authors contended that women who perceive their partners to be either too dependent or independent may use violence as a means of mediating levels of relationship fusion. This finding has been echoed elsewhere, with relationship fusion being related to an increased prevalence of violence within lesbian relationships (Hill et al. 2012; Badenes-Ribera et al. 2016). Other relationship factors such as accommodation and dominance have also been linked with perpetration, with mixed findings. For instance, some authors contend that high levels of dominance and domineering behaviours in a relationship were associated with perpetration (Chong, Mak & Kwong 2013). In contrast to this, Milletich et al. (2014) found that dominating behaviours were not associated with partner violence (PV), yet presented the finding that high levels of accommodating behaviours may be

associated with fusion, "which may in turn increase a context conducive to the perpetration of PV" (p. 661). It was unclear whether the authors were contending that partner violence was more likely to be perpetrated by the person who is displaying accommodating behaviours or by another partner, therefore this data should be interpreted cautiously.

Heteronormative understandings of gender

Heteronormative understandings of sex and gender have been identified within the literature as a risk factor for FV within LGBTIQ+ relationships. In their discussion of "rigid and traditional interpretations of gender" (p. 178), Lorenzetti et al. (2017) argue that traditional notions of masculinity serve to reinforce the subordination of genders who are perceived to be weaker, or, in the case of homosexual men, masculinities that are perceived to be weaker (Lorenzetti et al. 2017).

Normalised gender roles and hegemonic masculinity have elsewhere been identified in the literature as FV risk factors for MSM (Kay & Jeffries 2010; Goldenberg et al. 2016; Stephenson & Finneran 2017). Kay and Jeffries (2010) contend that, by failing to conform to compulsory heterosexuality, gay men challenge hegemonic masculinity and are therefore positioned as subordinate by society. The use of IPV in this context may be an attempt to reassert dominance and "oppose their subordinate position" (p.417). Goldenberg et al. (2016) has also identified a lack of clear gender roles within gay male relationships as a precursor for conflict, particularly in terms of domestic role negotiation. Goldenberg et al. (2016) theorise, for example, that some gay relationships may be defined by a struggle to "be the alpha" and leader of the household. This in turn can increase risk of perpetrating or experiencing IPV. This is supported by research which shows that power imbalances within a relationship, particularly in terms of decision-making, is a risk factor for LGBTIQ+ FV more broadly (Katz-Wise & Hyde 2012; Potter, Fountain & Stapleton 2012; Chong, Mak & Kwong 2013; Sanger & Lynch 2018).

Minority Stress

Another risk factor that was identified and expanded upon within the literature was that of minority stress - referring to the various impacts that marginalisation has on members of stigmatised groups (Carvahlo et al. 2011; Lewis et al. 2012). Minority stress may refer to external forces, such as discrimination and harassment, or internal responses to those forces. Internal responses can include stigma consciousness – referring to the extent to which people from marginalised or oppressed communities expect to be stigmatised and experience discrimination (Carhalho et al. 2011) – sexual identity concealment and internalised homophobia. Throughout the literature, where minority stressors were measured, internalised homophobia was frequently associated with use of FV (Carvahlo et al. 2011; Edwards & Sylaska 2013; Kelley et al. 2014; Milletich et al. 2014; Kimmes et al. 2017; Lewis et al 2017). Some researchers theorise that internalised homophobia may contribute to low self-esteem and feelings of powerlessness, and that those can in turn impact a person's ability to establish healthy relationships (Carvahlo et al. 2011; Milletich et al. 2014).

To a lesser extent, internalised homophobia has also been linked to victimisation potential (Carvahlo et al. 2011). For instance, it was found that women who have experienced abuse from a lesbian or bisexual partner may internalise negative beliefs about themselves and be more likely to remain in a violent relationship as a result (Balsalm & Szymanski 2005). Milletich et al. (2014) contends that women who self-identify as heterosexual but are in a relationship with a woman have increased levels of internalised homophobia and may therefore be more at risk of perpetrating violence. It was also found that some MSM are at an increased risk of having higher levels of internalised homophobia and perpetrating partner violence, likely due to heteronormative understandings of gender roles, in particular the adherence to strict notions of 'masculine' identity (Stephenson & Finneran 2017; Bartholemew et al. 2008). Oringher and Samuelson (2011) found that, in a sample of gay and bisexual men, those who demonstrated higher levels of conformity to masculine norms, specifically aggressiveness and suppression of emotional vulnerability, were more likely to perpetrate physical violence in their relationship than those who did not.

Sexual identity concealment and 'outness' were also identified within the literature as risk factors for perpetrating or experiencing violence, however findings were inconsistent and at times contradictory. Some authors found that higher levels of outness related to higher levels of perpetration (Edwards & Sylaska 2013; Edwards, Sylaska & Neal 2015) and others found that the more out a person was, the more likely they were to have experienced IPV (Carvahlo et al. 2011).

Intersectional marginalisation

It is essential to note that not all members of LGBTIQ+ communities face the same level of risk when it comes to experiencing or using FV. Prevalence data indicates that trans and gender diverse people experience FV at higher rates than cisgender people (LGBTIQ+ Domestic and Family Violence Interagency 2014; Goldenberg, Jadwin-Cakmak & Harper 2018; Yerke & DeFeo 2016) with trans women being the most at risk (Leonard et al. 2012). Julie Serano (2007), for example, argues that queer communities need to take seriously the prevalence of 'transmisogyny': "the majority of violence and sexual assaults committed against trans people is directed at trans women" (2007, p. 15). As she elaborates (2007, p. 14): "While trans people on the female-to-male (FTM) spectrum face discrimination for breaking gender norms (i.e., oppositional sexism), their expressions of maleness or masculinity themselves are not targeted for ridicule - to do so would require one to question masculinity itself." Serano thus argues that trans women occupy a unique position "at the intersection of multiple binary gender-based forms of prejudice: transphobia, cissexism, and misogyny" (Serano 2007, p. 12). Serano's concept of transmisogyny has been critiqued as universalising whiteness in its theory of gender and sexuality (Krell 2017), and therefore other factors which increase one's risk of violence should be considered alongside it. The limited research into FV experienced by TGD people suggests that trans women of colour experience the highest rates of FV and violence in general (NACVP 2016), and face greater barriers to accessing services, including discrimination and violence from police (Guadelupe-Diaz & Jasinski 2017).

There was no empirical research found examining the extent to which sistergirls and brotherboys are impacted by FV. Research from a mainstream context, however, tells us that rates of family violence within Indigenous communities are high, with Aboriginal women being 34 times more likely to be hospitalised as a result of family violence than non-Aboriginal women, and Indigenous men 27 times more likely than non-Indigenous men (AIHW 2019). The ongoing impacts of colonisation and racist government policies (Our Watch 2014), in conjunction with transphobia and transphobic violence, likely create unique and compounding risk for sistergirls and brotherboys. As one of the only articles found that explores the experiences of sistergirls states, "sistergirls occupy the unique position of being targets of misogyny, transphobia, and racism shaped by ongoing histories of colonisation" (Riggs & Toone 2017, p. 237).

LGBTIQ+ people from culturally, and linguistically diverse, and diverse faith backgrounds also face unique factors that serve to increase risk of FV, including isolation from family of origin and lack of appropriate service availability (Noto, Leonard & Mitchell 2014; Horsley 2015). It has likewise been identified that LGBTIQ+ people living with disabilities are at increased risk of experiencing FV (Ballan et al. 2014; NACVP 2016; Our Watch 2017) however this risk has not been explored sufficiently in the literature. Research into family violence generally tells us that people with disabilities are more likely to experience family violence than people without disabilities (Ballan et al. 2014) – suggesting that further exploration of the unique risks faced by LGBTIQ+ people living with disabilities is required.

Elder LGBTIQ+ people, particularly those with declining cognitive function, may be at particular risk for abuse; the prevalence of family violence used by carers is well-established. In addition, the discrimination they often face in aged care may fail to recognise their relationships at all, let alone family violence they experience, and may act as a barrier to help-seeking (Hafford-Letchfield Simpson Willis & Almack 2018; Harrison 2006; Kamavarapu et al. 2017; Mahieu Cavolo & Gastmans 2018).

Protective factors

In comparison to risk factors, protective factors are under-researched within literature examining LGBTIQ+ FV (Ireland et al. 2017). Despite this, the few sources that touch on this area point to the importance of identifying protective factors given their potential to reduce the risk of FV (Ireland et al. 2017). Protective factors that have been identified within the literature relate to themes of resilience, identity, social support and relationship quality (Lewis et al. 2012; Ireland et al. 2017).

Resilience

On the topic of resilience, Hill et al. (2012) argue that people who have experienced multiple and intersecting forms of oppression and trauma "possess many unique strengths and resiliencies that arise from having to face and overcome discrimination on a daily basis" (p. 410). They go on to discuss the potential benefits of drawing on resiliencies and coping strategies for the purpose of developing intervention and prevention approaches.

Social Supports

Others explore the importance of social supports, finding that having strong social supports can increase self-esteem (Beals & Peplau 2005) and psychological adjustment, thereby reducing the risk of FV (Lewis et al. 2012).

Relationship Quality

Relationship quality, which has been identified as a protective factor for heterosexual FV, has been recognised as being relevant for LGBTIQ+ FV (Ireland et al. 2017).

Identity

Lewis et al. (2012) propose the contested notion that identity operates as a coping mechanism – citing findings that lesbian identity predicts active coping (Bowleg, Craig & Burkholder 2004). However, there were conflicting findings that lesbian identity is associated with substance use (Kerby et al. 2005) and higher levels of depressive symptoms (Zea et al. 1999).

Overall, there is a distinct lack of empirical research into protective factors for LGBTIQ+ people using or experiencing violence – something that will need to be addressed given the role protective factors play in reducing risk of both experiencing and using FV.

Limitations identified within the literature

Despite the growing body of research examining LGBTIQ+ FV, methodological issues and research gaps contribute to an underdeveloped understanding of the nuanced dynamics and potential causes of FV within the distinct communities covered by the LGBTIQ+ acronym. Much of the literature is characterised by oversimplified constructions of LGBTIQ+ relationships and the forms that violence can take within these communities. One of the key limitations identified within the current terrain of LGBTIQ+ FV research is the narrow lens through which relationships within LGBTIQ+ communities are viewed and analysed (Edwards, Sylaska & Neal 2015). There are several factors that contribute to a simplified representation of LGBTIQ+ relationships in the literature. Firstly, much of the research reviewed focuses on the experiences of LGB identifying people, or people in "same sex" relationships (Guadelupe-Diaz & Jasinski 2017), offering limited insight into the experiences of trans and gender diverse people and people with intersex variations. This can also be said for much of the literature that claims to be examining violence within LGBTIQ+ relationships, whereby the T, I and Q are often overlooked (Yerke & DeFeo 2016).

Another significant limitation within the literature is the tendency for researchers to make assumptions about the composition of LGBTIQ+ relationships (Goldenberg, Jadwin-Cakmak & Harper 2018) by not gathering data relating to the gender and sexuality of the partner(s) of the participants in question (Barrett & St. Pierre 2013; Edwards, Sylaska & Neal 2015). Not only is it necessary to consider the many different and nuanced identities, genders and sexualities within LGBTIQ+ communities when undertaking research into FV, it is essential to have an understanding of who LGBTIQ+ people are in relationships with. Failure to have an

understanding of the complexities of LGBTIQ+ relationships and the different forms violence can take across the spectrum of genders and sexualities involved could have a significant impact on the ability to develop effective, targeted intervention strategies for people within these communities and their partners. For instance, the finding within literature that bisexual women are most likely to have FV perpetrated against them by men is one that warrants attention and has the potential to inform intervention strategies, and literature that includes TGD people in most cases neglects to specify the sexual orientation and gender identity of their partners (Brown & Herman 2015; Coston 2017)[2].

A further limitation that has been identified within the literature is that recruitment of participants has tended to focus on self-identification with the LGBTIQ+ acronym as opposed to sexual behaviour (Kimmes et al. 2017). For example, in such an instance, a man who had sex with men but did not identify as gay or bisexual would not be included in research that sought to understand FV within gay male relationships (Lewis et al. 2012; Milletich, et al. 2014; Kelley et al. 2014; Coston 2017). This means that some important experiences are missing from the existing research picture on LGBTIQ+ FV.

It should be noted that many of the samples within the research may also be unrepresentative of the broader LGBTIQ+ community (Barrett & St. Pierre 2013). Participants were often recruited through snowball sampling or via LGBTIQ+ events, health services or other LGBTIQ+ specific domains (Balsam & Szymanski 2005; Barrett & St. Pierre 2013; Goldenberg, Jadwin-Cakmak & Harper 2018). One of the implications of such sampling processes is that participants who are less connected to the community, and potentially less open about their sexuality, are likely to not be captured within research (Carvahlo 2011; Lewis et al. 2012). This could in multiple ways distort or skew data collection, including on risk factor measures such as internalised homophobia (Balsam & Szymanski 2005).

Another limitation within the literature is that the majority of participants in many of the studies were white and had at least some university education (Balsam & Szymanski 2005; Carvalho et al. 2011; Lewis et al. 2017). This is especially problematic given low socioeconomic status or educational attainment has been identified as a risk factor for LGBTIQ+ FV, while research also shows that people of colour experience higher rates of violence and face a higher prevalence of risk factors associated with FV, such as experiencing or witnessing abuse in childhood, substance use and discrimination and oppression (Hill et al. 2012; West 2012).

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[2] Available literature suggests that many bisexual cis and trans women experience violence at the hands of cis men (including straight-identifying men). As a result, it is important that this be understood as a factor in rates of both use and experience of violence in an LGBTIQ+ context, especially when designing appropriate interventions. As has been reiterated throughout this literature review, LGBTIQ+family violence is multi-faceted and complex and encompasses many sexualities and gender identities.

Gaps in research

Within the body of literature accessed and reviewed, there are several notable gaps that must be addressed. Firstly, there were very few empirical studies found that were published within Australia. In addition to this, there was a dearth of qualitative accounts, with most of the empirical literature utilising quantitative methodology. While quantitative methodology is valuable in exploring certain aspects of LGBTIQ+ FV, qualitative methods could completement these with exploration in depth of the complexities of family violence's presentations in LGBTIQ+ communities. The learnings from both methodological approaches could bolster one another in building capacity for service providers to appropriately design prevention and intervention programs.

As mentioned earlier, there are very few studies that explicitly mention protective factors for LGBTIQ+ FV, with no literature found that explores protective factors for these communities in depth. Further research into protective factors for LGBTIQ+ FV is warranted, and indeed required, in order to develop effective intervention strategies and promote community wellbeing.

There is also very limited research available that addresses trans and gender diverse experiences of FV. While there is a small amount of literature concerning the dynamics and risks factors associated with trans and gender diverse people's experiences of FV, there were only two studies mentioning the use of violence by trans and gender diverse people. One of these studies had a very small sample size of 5 participants (Brown 2007) and the other used anecdotal evidence gathered by a community network for trans people and their families (Cook-Daniels 2015). Further, there were also no studies found examining FV for people with intersex variations, which is a significant issue for a research body claiming to explore or understand "LGBTIQ+" FV.

Likewise, there is a lack of research focusing on the ways in which LGBTIQ+ people from culturally and linguistically diverse backgrounds experience FV – including those from refugee and migrant backgrounds living in Australia – and the specific risk factors that may impact people from these communities. Another significant gap is the lack of research into the dynamics and risk factors of FV for LGBTIQ+ Aboriginal and Torres Strait Islander peoples.

It is evident from the literature that LGBTIQ+ people face unique and complex risk factors for experiencing and using FV. LGBTIQ+ people experience higher levels of trauma as a result of factors such as childhood abuse, previous experiences of violence and structurally embedded homophobia and transphobia. In order to develop a nuanced understanding of LGBTIQ+ FV, it is essential to unpack the complexities of relationships within the LGBTIQ+ acronym, as well as the risk and protective factors that are present for people within these different communities. Research in this area has largely centred around the experiences of LGB people and has failed to capture the many relationship types and identities within LGBTIQ+ communities, resulting in an incomplete picture of LGBTIQ+ FV.

LGBTIQ+ Family Violence Interventions

The latter half of the literature review section of this report outlines the context in which LGBTIQ+ family violence interventions are delivered, and interventions themselves are reviewed. The context is important to consider, as it raises some of the reasons mainstream interventions may not be appropriate or effective in addressing LGBTIQ+ family violence.

Context

Lack of safe, appropriate services

Available literature shows that problems with service access provision for LGBTIQ+ people experiencing and using FV are multiple and varied depending on the type of support accessed. Many LGBTIQ+ people report being afraid of accessing specialist or mainstream family violence services due to:

- a lack of culturally sensitive intake/reporting, including inadequate systems for accounting for gendered and sexual diversity, and poor data collection (Aleksandrs & Phillips, 2015; Fileborn, 2012);
- a fear of, and experience of discriminatory responses and stigma from staff (Aleksandrs & Phillips, 2015; Ard & Makadon, 2011; Calton et al., 2016; Fileborn, 2012; GLHV, 2015; Leonard et al., 2008; VGLRL, 2015);
- a lack of safe, inclusive and culturally appropriate housing/accommodation (Aleksandrs & Phillips, 2015); and
- a lack of suitable referral options (Aleksandrs & Phillips, 2015; VGLRL, 2015).

As an alternative to presenting to mainstream family violence services, many LGBTIQ+ people may instead turn to LGBTIQ+ specific community organisations. However, as noted by the Safe Steps and No to Violence joint submission to the Victorian Royal Commission, there are also issues for those accessing help from these services due to a lack of training in and knowledge of family violence dynamics and impacts among staff (Aleksandrs & Phillips, 2015, p.40-41, 47). This lack of understanding was highlighted in 2008 in the National LGBTI Health Alliance Submission on the National Plan to Reduce Violence Against Women and Children, which discussed that the impacts of family violence were compounded for LGBTIQ+ people "due to a poor understanding of the issues and a lack of appropriate responses" (National GLBT Health Alliance, 2008). More recently, recommendations from the Victorian Royal Commission into Family Violence also recognised serious gaps in research and service provision for LGBTIQ+ people experiencing domestic violence (State of Victoria 2016, p. 151). This reinforces reports from service providers (both mainstream and LGBTIQ+ specific) of a widespread need for resources and guidance to facilitate working with this population, including integrated models, culturally sensitive training, and awareness-raising about the dynamics and impacts of FV for LGBTIQ+ people (Constable et al., 2011; ACON, 2014; Aleksandrs & Phillips, 2015; GLHV, 2015).

Research also reinforces that LGBTIQ+ victims are reluctant to engage law enforcement for help (Constable et al., 2011; Calton et al., 2016; Donovan & Hester, 2011; VGLRL, 2015). Lack of safe access to services and poor service responses from police increase the risk of LGBTIQ+ people experiencing and using FV and create extra barriers for overcoming and addressing violence within LGBTIQ+ communities.

Unpacking the victim/perpetrator binary

A pertinent critique of the application of mainstream FV perspectives to LGBTIQ+ FV is the reliance on the victim/perpetrator dichotomy. From available literature on LGBTIQ+ FV, this long-held binary view is problematic when it comes to developing effective interventions for people within LGBTIQ+ communities, particularly interventions for people who use violence (Ireland et al. 2017; Hill et al. 2012; Carvahlo et al. 2011; Balsam & Szymanski 2005). Ireland et al (2017) in their Australian study, point to the need for "*perpetration to be examined alongside victim potential*" (p. 108). It may be helpful to consider the ways in which perpetrators may have a history of victimisation, including that LGBTIQ+ people may be at greater risk of experiencing childhood abuse, which in turn has been identified as a risk factor for LGBTIQ+ FV perpetration (Hill et al. 2012; Ireland et al. 2017). In order to effectively address the use of violence by an LGBTIQ+ person, it is important to develop an understanding of the ways in which that person may have had violence used against them.

Bidirectional violence in an LGBTIQ+ context

As illustrated above in the review of the literature about risk factors, LGBTIQ+ people who use violence may also have had violence used against them within the context of a relationship. Within a mainstream and heterosexual context, a woman's use of violence is often explained through a frame of self-defense or resistance, particularly given evidence showing that many women who kill do so in the context of having been victim to prolonged coercive control (Belknap et al. 2012). However, particularly within an LGBTIQ+ context, this may not reflect the complexity of FV dynamics; the ability to enact violence is not determined based solely on a person's gender. Oliffe et al. (2014) contend that in some cases, physical LGBTIQ+ partner violence can be bidirectional and normalised within the relationship. Many authors contend that within LGBTIQ+ relationships, violence is used and experienced in a range of ways, including as bidirectional violence, and that the binary of victim/perpetrator is one that warrants further attention (Cannon et al. 2015; Longobardi & Badenes-Ribera 2017; Richards et al. 2017).

Several studies in this review found that rates of reporting for both victimisation and perpetration were higher than rates of reporting for either one independently of the other, though findings like these must be viewed critically, as there is a methodological risk that perpetrators under-report their use of violence (Balsam & Szymanski 2005; Carvahlo et al. 2011; Edwards & Sylaska 2013; Milletich et al. 2014). In addition, people experiencing violence often take responsibility for their partner's abusive actions, while those using violence often claim their partner was violent against them. This adds a layer of complexity to interpretation of

findings of FV research, particularly for those in LGBTIQ+ relationships, in which misidentification of the person using violence is very common (Jordan et al. 2019).

It is not our intention to claim that all, or even most LGBTIQ+ FV is bidirectional — to do so would serve to undermine the legitimacy of the experiences of those being harmed, and their voices should be held at the forefront of FV work. However, it would appear from the literature that viewing LGBTIQ+ FV through a simplistic victim/perpetrator lens may obfuscate its complexities.

Interventions

Given the poor understanding of what works to address FV in the general population, it is no surprise that there is a dearth of literature providing evidence for effective interventions for LGBTIQ+ people and communities, or indeed reviewing any such interventions at all, whether mainstream or LGBTIQ+ specialized (Calton Bennett Cattaneo & Gebhard 2016). Compounding the problem is that there is a lack of awareness of what abuse in LGBTIQ+ relationships might look like – from the general public, within LGBTIQ+ communities and from mainstream service providers. Therefore, in developing interventions for the LGBTIQ+ community, a number of issues need to be taken into account:

Misidentification. One of the challenges in providing appropriate services to LGBTIQ+ people affected by FV is institutional misidentification of individuals as "victim/survivors" or "perpetrators" (Little 2008). For example, a survey investigating the current state and provision of "batterer intervention programs" in the U.S. found that in one program, so many of their LGBTIQ+ court mandated clients were incorrectly charged that the provider formed a group specifically for those individuals (Dalton 2008). This has also been identified as a problem in the Australian context (Aleksandrs & Phillips 2015). Further, myths about LGBTIQ+ FV, and associated minimisation of violence between people of the same sex or gender, may also contribute to first responders failing to identify abuse as well as correctly identify those using it (Vickers 1996; Little 2008).

Even in cases where use of violence in a particular situation is identified, appropriate interventions may not be available, as the vast majority of existing and available programs have been designed for heterosexual men who use violence against women. While some of the risk and protective factors for use of violence may be shared with cisgender heterosexual men and LGBTIQ+ people, there are unique factors at play in LGBTIQ+ people's use of, and experiences of violence that must be accounted for in interventions if they are to be effective in the short and longer term (Edwards Sylaska & Neal 2015). For example, even within LGBTIQ+ communities there are challenges related to recognition and identification of abuse. Structural oppression and limited historical rights and recognition of LGBTIQ+ relationships are just some factors contributing to denial of FV within LGBTIQ+ communities. Often, it is feared that if abuse within LGBTIQ+ relationships is talked about or acknowledged, LGBTIQ+ relationships and identities will be further delegitimised or stigmatised (Coston 2017; Ristock 2012; Lorenzetti Wells Callaghan Logie & Koziey 2014). Leading up to the marriage equality plebiscite

in Australia, for example, there was pressure not to talk about family violence within the LGBTIQ+ community, for fear of its impact on the plebiscite outcome (Wade, 2017).

Using and Experiencing Violence. Another complicating factor in appropriately addressing LGBTIQ+ FV is how frequently individual histories include experiences of both using violence and having violence used against them. The LGBTIQ+ population has higher rates of childhood abuse than the general population does, and previous experiences of violence and abuse are associated with increased risk of using FV (Friedman et al. 2011; Edwards & Sylaska 2013; Milletich Gumienny Kelley & D'Lima 2014). Some existing models for FV may essentialise the role of 'perpetrator', failing to recognise people's histories of trauma and violence they may have experienced, and therefore may not adequately reflect the nuanced dynamics of FV as they occur in many LGBTIQ+ relationships. This includes the fact that so many people who use violence have experienced violence themselves, and the increased rates at which LGBTIQ+ people experience violence. This essentialisation may also lead practitioners to take on a paternalistic, practitioner-as-expert role in the therapeutic relationship. As Augusta-Scott and Dankwort (2002) put it, "the concern here is that an intervention model based on victim/victimiser opposites may in fact structurally resemble the symmetrical, adversarial… relationship that has been regarded as one of the major instigators of domestic violence." (p. 792)

Theoretical Framework. Another consideration when developing interventions appropriate to LGBTIQ+ people is what theoretical framework will or should underpin the work undertaken. Many existing, (heterosexual) FV interventions, most notably Duluth-based models, focus on FV as an exercise in power and control, with a specific focus on male privilege given the gendered nature of men's violence against women. The assumption that what drives FV violence in an LGBTIQ+ context is the same as that which drives FV in heterosexual relationships may be inappropriate or irrelevant to many LGBTIQ+ people – particularly when focused on a normatively understood gender lens, or male privilege only, as opposed to other axes or privilege or oppression (Rizza 2009). Further, while LGBTIQ+ people are sometimes included in Duluth-based programs, the literature has tended not to examine the effectiveness of those programs on use of violence by LGBTIQ+ participants. A great deal more research is necessary to build a comprehensive understanding of what culminates in FV in LGBTIQ+ relationships, families, and communities.

Trauma. As trauma has been well established as a key risk factor for the use of violence (Machisa et al 2016; Montgomery et al 2019), interventions recognising and addressing trauma could also offer potential for use with LGBTIQ+ people who use violence (Hill et al. 2012; Rausch 2016). This is particularly so, given LGBTIQ+ people have been shown to have experienced higher rates of trauma than the general population (Roberts et al. 2010; Roberts et al. 2012; Ross et al. 2014; Burns et al. 2015; Cohen et al. 2016). While their research pertained to women in general, rather than specifically LGBTIQ+ women, Van Dieten, Jones and Rondon (2014) have reviewed several trauma-informed intervention programs that women charged with perpetrating FV have been referred to. Among these was Beyond Violence, an evidence-

based, manualised curriculum that addresses multiple risk factors for violence, including experiences of trauma. Promisingly, evaluation of the program, carried out by Kubiak et. al. (2012) was able to demonstrate reductions in mental illness symptoms for participants including anxiety, depression and PTSD, as well as unhealthy anger styles. Given that mental health challenges including anxiety, depression, and experiences of trauma have been established as risk factors for family violence, this suggests potential indirect impacts of the program on future experiences and/or use of violence (Hill et al. 2012; Edwards et al. 2015). Another trauma-informed violence prevention program, based on relational theory and incorporating strengths-based and CBT strategies, aimed to foster women's personal and social resources as protective factors against future violence (Gehring et al. 2010). The researchers found that this program was associated with reduced recidivism among participants. Overall, trauma-informed interventions such as these may offer potential in informing the development of targeted interventions for LGBTIQ+ FV.

Intersecting Marginalities. Finally, while detailed information about and evaluation of Indigenous interventions into FV is lacking in the literature, such programs tend to recognise the violence people have been subject to, and have an emphasis on healing and holistic support (AAV, 2008). This approach, given the trauma histories of many LGBTIQ+ people (Wawrzyniak & Sabbag 2018; Zou & Andersen 2015), could be of value in development of LGBTIQ+ FV interventions. An Australian scoping study of Australian, Canadian and New Zealand Indigenous family violence interventions found that the essential elements of successful programs included community 'buy in' and ownership of programs, a holistic approach, meeting of cultural needs, support for the healing of those who have used violence, and education around family violence issues (Gallant et al. 2017). Whilst their specific experiences may differ, LGBTIQ+ communities and Indigenous communities each face additional intersecting layers of systemic violence. Indeed, Gallant et al. (2017) wrote, *"The intersectional dimensions of gender, race or culture and class also play out across the spectrum of the ecological framework and offer an important frame within which to understand the complexities of family violence"* (p. 3). The parallel structures of power-based hierarchies impacting LGBTIQ+ communities mean that there is potential value in learning from behaviour change approaches that are being trialled within First Nations communities, including but not limited to community engagement approaches that take into consideration the impact of trauma.

When it comes to addressing LGBTIQ+ FV, reliance on a rigid gendered binary can be inappropriate and unhelpful. The gender binary has been recognised as a social construct within feminist, queer, trans and other postmodern scholarship (Butler 2002; McPhail 2004; Monro 2007). It and other binary categorisations of difference, moreover, inform the social hierarchies and power differentials that are instrumental in the establishment and maintenance of power inequities. It is therefore essential that the gendered binary be considered for critique in knowledge-building, prevention and intervention efforts to address LGBTIQ+ FV (Krell 2017; Weber 1998).

It has elsewhere been noted, for example, that a failure to interrogate the gender binary may limit the potential to address violence in all its manifestations and intersections, notwithstanding race and settler-colonialism. As Monture-Okanee (1992), a Canadian Indigenous scholar puts it, "the violence of racism often echoes in a silenced world. What I do not understand is violence in its definitions as merely 'against women'." (p. 193) The valuable contributions of feminism in problematising the gender binary might therefore be utilised alongside intersectional approaches and perspectives to build a truly inclusive and effective response to FV.

Discussion

It is evident from the literature that LGBTIQ+ people face unique and complex risks for experiencing and using FV. In order to develop effective interventions for LGBTIQ+ people who use violence, it is essential to have a nuanced understanding of the complexities of relationships within the LGBTIQ+ acronym, as well as the risk and protective factors that are present for people within these communities. Further, research in this area has largely centred around the experiences of lesbian, gay and bisexual (LGB) people and has failed to capture the many relationship types and identities within LGBTIQ+ communities, resulting in an incomplete picture of LGBTIQ+ FV. What is clear from the literature, however, is that LGBTIQ+ people experience higher levels of trauma as a result of factors such as childhood abuse, previous experiences of violence and structurally embedded discrimination. Because trauma is well established as a risk factor for violence, trauma-informed approaches merit attention from researchers as potentially valuable in designing and testing specialised interventions

A critical examination of the functionality of FV interventions, and indeed our understanding of FV itself within LGBTIQ+ communities may offer an opportunity for substantive development of alternative models that are not simply adaptations of existing and contested understandings and interventions, but that are LGBTIQ+ FV-specific from the ground up. With that in mind, the following key learnings from the literature could help inform LGBTIQ+ family violence interventions:

- Services must be safe and appropriate for LGBTIQ+ people, and should use comprehensive assessments to get an understanding of the use and experiences of violence in a family, rather than making any assumptions based on identity; this may include capacity building for the mainstream family violence sector and related systems, such as the police and the courts
- Services should be trauma-informed, recognising that while someone may have used family violence, they may also have been harmed by violence
- Services would benefit from bringing a curiosity to their work in exploring how power may be enacted in different ways, and whether violence may, in some cases, be multi-directional

- Programs which are integrated within broader organisational or service systems may be more effective than those being provided in isolation
- Programs may be more effective when they are flexible based on the needs of the individual or group of clients
- People using violence may be more effectively engaged in programs which use strengths-based approaches, and work with them collaboratively, recognising that they are experts in their own lives
- Practitioners should take care to avoid using coercive tactics to change participant behaviour in their role as practitioners; this may create dynamics which mirror those of family violence
- Family violence services should address, or be linked with services which address other challenges which may trigger or escalate violence, such as AOD, mental health, and material resource insecurity
- Program content should include exploration of social hierarchies, intersectionality and structural violence

2. Practitioner Interviews

From the literature, there are clear gaps in existing understandings of LGBTIQ+ family violence. There was little research specifically focused on family violence as it appears in LGBTIQ+ contexts versus in heterosexual relationships. In the research that is available, it is often unclear what risk and protective factors are associated with the use of family violence, and which with experiencing it. There have also been very few studies investigating the effectiveness of family violence interventions specifically for LGBTIQ+ people. What research is available has largely been carried out in North America; very little is specific to the Australian context.

To begin to fill in the gaps, interviews and focus groups were conducted with practitioners from queerspace at drummond street services. Practitioners interviewed were those delivering the With Respect LGBTIQ+ Family Violence Program in Melbourne, which delivers a range of family violence initiatives and interventions, ranging from prevention, through early intervention to tertiary interventions for people using and experiencing violence, and recovery services. Practitioners were therefore uniquely equipped to provide observations of LGBTIQ+ family violence and its risk and protective factors, as well as triggers for violence, strategies used by those causing harm, and sequencing of violence as they presented in urban Victoria, Australia. This was also an opportunity to test assumptions which could be made based on literature about heterosexual relationships or based on inferences from indirectly related learnings.

Methodology

Three focus groups and five individual interviews were conducted with twelve practitioners from queerspace, across the With Respect service and queerspace's LGBTIQ+ alcohol and other drug (AOD) service. Interview questions covered risk and protective factors, and triggers or points of escalation for LGBTIQ+ FV, with an emphasis placed on those using violence (See Appendix A for the Discussion Guide). The 30-60-minute sessions were recorded as audio files, transcribed, and the qualitative data was coded thematically using NVivo software. The themes were identified through a combination of deductive methods using those identified from the literature, and inductive methods as additional themes emerged from practitioner statements. Cross-coding was carried out to ensure consistency.

This section will explore the risk and protective factors identified through the practitioner interviews and focus groups. The risk factors are grouped into individual factors, those associated with families of origin, relationship factors, and community, social & structural factors. However, this is not to suggest that individual, family, or relationship factors exist in isolation; they should be understood to impact upon, and be influenced by, one another and broader contextual factors.

Risk factors

The factors clustered around four main themes including individual (both historical and current); family of origin; relationship; and community, social or structural factors.

Individual factors

Historical risk factors that emerged included trauma, childhood abuse, experiences of injustice, insecure attachment, and experiences of FV or sexual abuse as an adult. Trauma was a frequently referenced risk factor, with practitioners in six of the focus groups and interviews discussing the relationship between trauma and both using and experiencing FV.

AOD misuse or challenges

This was the single most frequently cited risk factor for FV, with 31 mentions across the eight interviews or focus groups. While all practitioners recognised that alcohol and other drugs could escalate or trigger violence, those who work in the AOD service discussed violence and AOD use as inextricably linked and emphasised that effective interventions must address AOD use as well as violence. When people are feeling controlled by a family member or partner, they may seek to reclaim control by making reckless choices which can risk harm to themselves, such as risky substance use or sex. For people struggling with addiction, intimidation and violence were sometimes used as means of obtaining money to purchase drugs. Some practitioners talked about drugs being used as a tactic or as part of a pattern of abuse, as an excuse for violence or as a considerable risk factor relating to sexual assault in communities that often mix drugs and sex.

Material insecurity

Practitioners discussed the ways in which socioeconomic status and access to material resources can relate to the use or experience of violence for clients. The stress associated with poverty and homelessness was identified as a risk for FV, but in addition, being in a rooming house or supported housing situation as a result of housing instability exposed people to discrimination by staff, as well as physical and sexual assault by other occupants. People were often more likely to use substances as a means of coping with current and/or historical trauma while living in rooming houses, which is itself a risk factor for FV. Practitioners mentioned clients who started doing sex work while living in these types of settings and struggling financially, which could put them at risk of abuse by their clients, particularly for trans women.

One practitioner identified financial stress as having a significant impact on a persons' behaviours, judgements and the ways in which they engage with other people and their greater surrounds. Another practitioner discussed the ways that poverty and social exclusion throughout a person's life can shape a person's ideas about who they are which can relate to the way they think about and use violence, both generally and within families and intimate relationships. One discussed that when people feel a lack of control over their own lives, for example because of structural factors such as poverty or lack of employment, they may seek control inside the relationship.

Substance use was identified as a significant factor for clients who were experiencing poverty or homelessness and the combination of financial stress and substance use was identified to be a risk factor for the use or experience of violence. It was identified that people who are less financially or socially secure are more vulnerable to remaining in a relationship where violence and controlling dynamics are being used against them, particularly when their partner holds more economic or social resources.

Experiences of family violence or sexual abuse as an adult

Practitioners identified previous experiences of FV or sexual abuse in adulthood as a trauma experience and risk factor for both experiences and use of FV. This theme emerged in five of the eight focus groups and interviews. One practitioner identified that people who have been responding to violence in their lives often have a fragmented internal framework or sense of self and present with a high level of shame. Another practitioner commented on their experiences working within the prison system, identifying that every person who they worked with had a history of violence in their families and/or relationships. Three practitioners discussed the impact of sexual abuse throughout a lifetime, with one practitioner speaking to the ways that people may use violence in resistance of a lifetime of abuse enacted against them. Another practitioner spoke of the ways that experiencing sexual assault can lead to isolation and increase vulnerability to experiencing violence.

Experiences of injustice

Experiences of injustice emerged as a theme in three focus groups and interviews, with two practitioners identifying anger and the use of violence as correlated with someone's experiences of societal injustice or unfairness. One practitioner discussed the ways that addressing a person's anger without exploring the underlying factors relating to injustice they have experienced has the effect of concealing elements of that person's broader narrative, which are essential to understanding their use of violence. Injustice was also discussed in relation to family narratives, for instance where a family have fled their home country due to war and violence and have come to Australia where they have been forced to navigate racist and discriminatory systems and workplaces.

Childhood abuse

Childhood abuse was discussed in four of the focus groups and interviews, with one practitioner contending that people who use violence have almost invariably had experiences of violence as a child. One practitioner discussed the impacts of childhood sexual abuse in terms of memory and cognitive processes and identified experiences of childhood sexual abuse as very often correlating with the use of violence for women who are involved in the justice system. Childhood abuse was identified as having lasting impacts on a person's ability to make social connections and their understanding of how to operate within intimate relationships. One practitioner talked about clients feeling a lack of control in their lives as an effect of violence from their families of origin, which could make them more vulnerable to using or experiencing family violence.

Insecure attachment

Attachment refers to patterns or styles of relating to others which reflect the coping responses of infants to their caregivers' styles of interaction with them (Bowlby 1997). Secure attachment refers to the patterns associated with having a caregiver who has represented a secure base from which the infant could interact with their environment, which insecure attachment refers to patterns associated with having a caregiver who has not consistently met the infant's needs (Ainsworth & Bell 1970). Two practitioners discussed insecure attachment in relation to a person's use or experience of violence, with one practitioner relating shame and jealousy to insecure attachments. Practitioners discussed the risk of people getting into unhealthy relationships when they don't value themselves, which sometimes involves poor attachment.

One practitioner mentioned the fact that early neglect or experiences of violence may impact people's capacity for empathy and compassion. This may limit their insight or investment in relationships. Practitioners gave example of clients who were in dysfunctional or abusive relationships because of difficulty in identifying what is appropriate in healthy relationships, or because of inability to identify abusive behaviours within relationships.

Health factors

Within the health factors theme, both mental and physical health came up as risk factors. Practitioners discussed mental and physical health factors as exacerbating vulnerabilities in the people who are experiencing or using violence, as well as sources of stress which may trigger or escalate violence. Trauma experienced by clients was widely identified as a risk factor for either the use or experiencing of family violence.

The combination of fear, insecurity and substance use was an example of factors that might precipitate violence. Having poor self-esteem, and therefore a limited capacity to determine what is appropriate and healthy in relationships, was noted as putting someone at risk for being in dysfunctional and abusive relationships. Stress related to insecurity about the stability of the relationship was also identified as a risk factor for FV.

One practitioner noted that in trying to stay removed from feelings, people often harm themselves. When they are no longer able to hold that harm in themselves; when it becomes so unbearable, they may at that point enact harm on others.

Shame

One practitioner talked about deep and acute experiences of shame from being persecuted on intersectional bases including race or trans identity. They discussed how people who have such experiences, as well as abuse in their family or relationship, may have shame about that as well and may hide or defend those abusive relationships. This represents a barrier to help seeking, as well as a point of vulnerability to abuse.

Another practitioner mentioned a client who would face transphobic hostility, drink until they couldn't suppress the feelings any longer, and lash out physically at the next transphobic verbal attack. Another practitioner discussed homophobic experiences a client

had had while living in a rural area, and his resulting reluctance to reach out for support relating to FV.

Practitioners identified some themes relating to the ways in which TGD clients have used violence in their relationships. A theme that emerged related to TGD clients using identity politics to shame and control their cisgender partner or utilising discourse surrounding oppression and privilege to maintain control in the relationship. An example of this may be when a TGD person silences and undermines a cisgender partner on the basis that they are afforded more privilege within a cisnormative society. Another practitioner discussed the use of coercive control in intimate relationships by TGD people as being in response to the lack of control afforded to them within society due to hierarchical cisnormative structures.

Family of origin

The subthemes which emerged relating to people's experiences in their families of origin included being the target of, and witnessing abuse, and being isolated from the family of origin.

Target and witnessing of abuse

This theme was raised in five of the focus groups and interviews. Practitioners spoke about TGD clients experiencing psychological and physical abuse from their family of origin, with some emphasis on the use of violence by siblings. Other forms of violence experienced by TGD clients in their family of origin include: family members encouraging TGD people to suicide, deliberately using incorrect pronouns, deliberately withholding hormones or other items required for someone's gender affirmation and isolation or excommunication from family. One practitioner shared valuable insight about the risk of TGD young people having to source hormones off the street as their parents would not support their transition, putting the young person at significant increased risk.

Another practitioner gave an example of a client who faced violence from his family in response to his coming out as gay. In one case he was almost killed, and family members would subsequently suggest he should have been killed. Similar examples were given relating to instances where clients from families where gender and sexual diversity were not culturally supported have faced increased violence and shame within their family of origin.

Isolation from family of origin

Practitioners discussed that often their clients are isolated from, or do not have, a family of origin. This leaves them with fewer support options when they were experiencing FV, and in cases of not having a family of origin, leaves them at a disadvantage in terms of developing healthy relationships.

Relationship factors

Among the risk factors within this theme were unequal distributions of power and stereotypical understandings of gender roles.

Unequal distributions of power

This was one the most commonly referenced relationship factor identified as a risk for FV. One form this took was lack of autonomy, which might be emotional dependency, reliance on a partner for financial or housing security or immigration processes, being controlled by a partner, and having a partner who is also a carer.

Financial capacity discrepancies were also frequently mentioned. Practitioners discussed the fact that people who are not financially stable and are experiencing violence may feel they have no choice but to remain in the home and/or the relationship. The person who brings the most money into the household can sometimes use this to justify disproportionate control over the household finances, or as a means of undermining a person's ability to contribute meaningfully to the household or family.

Age differences and social capital were seen as factors in the unequal distribution of power. Where one partner has greater social and financial capital, they are better able to undermine their partner's ability to reach out for support from the community in response to the violence, adding to their capacity to control the partner.

Stereotypical understandings of gender roles

In terms of TGD people experiencing violence in relationships, dynamics that were identified included sexual abuse, erasure of the client's gender identity by their partner, transphobia from cisgender partners and the playing out of heteronormative misogynistic violence. In one example, the partner with more stereotypically masculine gender expression was doing things that resembled masculine patterns of FV; the partner with more stereotypically feminine gender expression was using less physical violence but was using more emotional abuse. Other examples were given around people who had recently transitioned to parenthood and gender stereotypes playing out in other ways relating to people's roles and key nurturer or provider.

Community, social or structural factors

Social isolation and lateral violence

Within this theme, the most common risk factor was social isolation. Examples of this included people moving away from friends or family to be with their partner, people's friendships deteriorating because of their controlling partner, having a history of trauma and subsequent difficulty relating to building and maintaining social ties, and a person undermining community or friends' perceptions of their partner.

Practitioners discussed the ways that TGD people who are in heterosexual relationships and not connected with the queer community may be at greater risk of violence or exposure of their gender identity from their cisgender partner. It was identified that TGD people may be more likely to be trapped in a cycle of violent relationships, or more likely to stay in violent relationships as they believe, or have been made to believe, they will not find another partner. Times of transition, such as surgery, were identified as being a point of escalation of violence in relationships.

Lateral violence, or violence from within community, was also identified as a risk factor by several practitioners. This has taken the form of policing by the community, a "call-out culture", the politics of queer and need to be "a good queer" and fetishization or erasure of certain members of the community. Being subject to lateral violence often leads people to isolate themselves, or be isolated from, their communities. It may also cause individuals distress, cause greater internalised stigma or shame, and act as a barrier to help-seeking around family violence.

Community collusion

Community collusion with the violence, or ignorance of what FV looks like within LGBTIQ+ contexts, was another identified factor. The partner responding to violence is often labelled the perpetrator of abuse and subjected to misguided accountability processes. Some people who have caused harm may be more likely to be held to account by the community if they are a person of colour, or if they are physically larger. Friends and community members, or even the person responding to violence, may also take the violence less seriously than they would if the relationship followed the commonly understood form of a cisgender man abusing a cisgender woman, minimising abuse to the point that it is not recognised as such.

Service & systems access

A number of structural and systemic considerations were discussed by practitioners in relation to the experiences of TGD people. Practitioners discussed the interconnection between societal transphobia and socioeconomic status or class, identifying that TGD clients may be less financially and socially supported and afforded less social privilege. It was identified that there is a lack of safe access to FV services for TGD people, both for those who are experiencing violence as well as those who are using violence. The lack of access to services was of particular concern for trans femme people, who face higher rates of sexual assault and murder.

Intersecting marginal identities

Themes relating to intersecting identities and experiences were raised by several practitioners. One practitioner shared insight into the ways in which a person who is using FV, may also be experiencing violence from the community due to their race, ethnicity, faith, disability, or other identity and may concurrently be the target of ongoing discrimination or violence. Several practitioners spoke to the importance of understanding the ways in which people can face multiple and intersecting forms of oppression and violence and that their use of violence is inextricably linked to and informed by their greater social context. It was acknowledged that for many people, risk of harm can be exacerbated by intersecting barriers to accessing support, whereby a person may be navigating multiple and complex social, emotional or physical difficulties in accessing help that is easily accessible to others.

Racism and white privilege were brought up frequently during the focus groups and interviews. Racism was discussed as a form of systemic violence impacting upon a person's risk of using violence. Practitioners talked about the internalised shame that results from

racist discrimination within LGBTIQ+ communities, where people of colour are often either invisible as legitimate potential romantic or sexual partners, or they are fetishized or otherwise objectified in romantic and sexual relationships.

Colonialist discrimination

Practitioners discussed the ongoing structural violence Indigenous people are responding to, which, like interpersonal violence, may contribute to people's use of or experiences of violence. Indigenous people are subject to consistent punitive surveillance, contributing to growing frustration and lack of belonging in community. Intergenerational trauma is continuously re-enacted and Indigenous people are often excluded from participation in society and are scrutinised in a way that white people are not. Practitioners shared examples of the misidentification of clients as using violence by police, and the colonialist bias they believed impacted upon their assessment of the violence.

Protective factors

Formal or informal supports around family violence

The most frequently referenced protective factor in the focus groups and interviews was clients accessing support around FV. Practitioners primarily discussed the ways in which engaging in counselling can assist clients to identify and recognise violent dynamics within relationships. Practitioners identified that counselling sessions can offer a space where a client experiencing violence can reflect on relationship dynamics and discuss potential concerns with a practitioner who affirms their experience. Psychoeducation within counselling was identified as being protective for clients in terms of supporting them to develop an understanding of FV dynamics, and the ways in which they or their partners behaviours could be causing harm.

Practitioners identified the importance of addressing co-occurring issues such as mental health, AOD and employment services, whether through additional supports or family violence services themselves, particularly in cases where comorbidities have triggered or escalated violence.

Personal and interpersonal insight or self-awareness

The second most frequently identified protective factor that was discussed by practitioners was personal insight or self-awareness, in terms of a person learning to identify their feelings, triggers, and the impact of violence. One practitioner discussed the ways that learning to recognise true feelings can help a person act protectively, for instance a person recognising that it is fear that they feel, rather than guilt or shame. The recognition of trauma was discussed, and the ways in which a person can go through processes of understanding how their trauma can influence their relationships and how they relate to the world.

Interpersonal awareness was discussed in relation to people developing the ability to identify in their partner/s or family member/s patterns of escalation and be able to recognise

when they may be at risk of harm. In terms of the use of violence, practitioners discussed the process of engaging in active self-reflection as allowing a person to understand the harm they may be causing someone and to make changes to their behaviour or relationship. It was identified as protective to be able to recognise behaviours as violence; being able to identify what is happening and where a person may have transgressed boundaries to cause harm to their partner/s. Having insight into triggers for their use of violence and having the self-awareness in any given moment to know that they are at risk of acting violently, was also identified as protective for people who are using or have used violence. Practitioners spoke of the development of strategies to lessen the likelihood of someone using physical violence, including leaving the house when they know they are beginning to experience a feeling or emotion that tends to precede violent action, such as anger or anxiety.

Material resources

Having material resources was identified as a protective factor by practitioners in four of the focus groups. It was seen as protective when a person has the financial means to leave a dangerous or potentially dangerous situation, for example by taking a taxi, or booking a hotel room, or booking a flight. Having the financial resources to be able to afford lawyers to support throughout legal processes may act as a protective factor, although it was noted that this is also a means of enacting harm whereby the person using violence may have the financial resources to do further harm through using the legal system. Practitioners also identified protective effects associated with having access to safe, stable accommodation.

Community connection

Practitioners identified community connection as an important protective factor for LGBTIQ+ people using or experiencing violence. One practitioner discussed the ways in which connecting with a community and engaging in community activities such as picnics, barbecues and film nights can be protective for a person who has experienced violence within a relationship. They made the point that it may not be necessary for someone to physically attend events, mentioning the benefits of engaging in an online capacity. Several practitioners identified that having support networks and being connected to communities of support are protective for people using or experiencing violence.

Having friends was also identified by three practitioners as being a protective factor for people experiencing and using violence. One practitioner spoke about how having a friend who can provide a safe place for a person to go and who regularly checks in on their wellbeing is beneficial for clients and can be a protective factor in terms of FV as well as suicide.

Understanding and awareness of family violence

Understanding and awareness of FV was identified as a protective factor by practitioners and was spoken about generally in relation to engagement in counselling or other FV support. One practitioner discussed the ways in which becoming aware of the dynamics of FV is beneficial for clients who blame themselves for violence that is being enacted against

them. Through unpacking the internalisation of blame narratives, a person is able to identify that they are not the cause of their own harm and that the person using violence is the one who needs to take responsibility for their actions.

Family

One practitioner discussed the ways in which having a sense of stability within the family and having experienced modelling of respectful relationships may provide a person using violence with a base from which they can navigate how to move towards changing their behaviour within relationships. Another practitioner commented that family may function as a protective element of a person's support network.

Changes in substance use

A protective factor that was identified was reducing substance use, with two practitioners discussing the ways that reducing or ceasing substance use can allow a person to have greater clarity and provide space for self-reflection. One practitioner identified that reducing substance use can allow both people using violence and people experiencing violence the space needed to recognise violent or controlling dynamics and invest time and energy into changing those behaviours.

Legal action

Two practitioners discussed the protective qualities of people who are experiencing violence taking out Intervention Orders, identifying that taking this step can help clients feel empowered and can increase a person's trust in the police. This is incredibly important for a person from LGBTIQ+ communities, as not only is there a history of police mistreatment of people from LGBTIQ+ communities, LGBTIQ+ FV has generally not been well responded to by police officers.

Pets

Having a pet was identified as a protective factor by one practitioner, who spoke of an instance where, for one couple, the process of caring for their dog helped to stabilise their relationship. It was also identified that having a pet can be a protective factor for people who are considering suicide, with clients reporting that having an animal has, at times, been the only thing keeping them alive.

Understanding or appreciation of relationship equity

One practitioner spoke about the protective impacts associated with supporting a person to understand respect and equity in relationships. Discussing the need for deconstructing mythologies surrounding notions of ownership, control and coercion and exploring and building radical responsibility in relationships.

Triggers and points of escalation

Common factors which triggered and/or escalated family violence were discussed to better understand some of the dynamics of the violence being enacted and to assess key areas and

timings for intervention. The themes that emerged from this discussion included: substance use, seeking support, changes in family structure or circumstances, transition, coming out, stress related to material insecurity, health, lateral violence, internalised homophobia and gender dysphoria, trauma recall or flashback, and time of the week or year.

Substance use

Alcohol and other drug use was identified as a trigger ten times over the course of the eight focus groups and interviews, making it the single most frequently cited trigger for FV escalation. This included AOD use that made someone more likely to use violence, less aware of their use of violence, or as an excuse for their use of violence. Some of the practitioners described AOD as always being involved in cases of violence among their clients; with one describing AOD and FV as inextricably linked. Gay men were identified by many practitioners as particularly likely to be affected by AOD when using FV.

Support seeking

While practitioners commonly identified support seeking as a protective factor, it was also identified as a potential point of escalation of violence. Even in cases where the partner using violence suggested the person they were harming seek counselling, as part of psychological abuse strategies to make the person being harmed believe the violence was their fault, or that it was not really happening, when this support was actually sought by the person being harmed, the person using violence shifted to discouraging the support, suggesting the person being harmed was beyond help. Another example given was that when a person experiencing violence began to change the way they responded to their partner, acting with more agency, or challenging the partner's abusive behaviour, this was often associated with an increase in the intensity of the abuse.

Changes in family structure or circumstances

Partners moving in together, having a baby, separating, or beginning new relationships were cited as potential points of escalation or triggers for FV. Practitioners named examples in which these factors contributed directly or indirectly to an escalation in conflict or violence:

- Transition to parenthood: Practitioners stated that the person who does not give birth to a new baby, often feels left out or ignored by their partner, which can trigger or escalate violence.
- Moving in together: Moving in together may lead to one or more people in the family being isolated, or to a sense that a person's autonomous space has been eroded.
- Separation: The period following separation was also identified as a trigger for or point of escalation of violence. In cases where the separated partners continue co-parenting, the partner using violence may use the children as a means of harming the other partner by undermining their relationship with the children, or by using violence against the children themselves.

Gender transitions

The point of transition, either socially or medically, was identified as a trigger or point of escalation for FV amongst TGD people as was coming out to family or a partner. Accessing medical transition services or going through administrative processes associated with social transition, and experiencing barriers or delays in the process, could be experienced as structural violence, and act as a trigger for the use of violence.

Stress related to material resource insecurity

Practitioners discussed how violence often escalated during periods of increased stress around material security. Getting evicted from a home, and fear of homelessness, combined with financial concerns like the costs of moving, were examples of circumstances that were followed by an increase in violence. Also discussed were the implications of such changes and stressors on a person's sense of control over their lives.

A lack of access to education or employment were seen as additional risks for controlling dynamics within a relationship.

Health

The health of the person using or responding to violence was raised as a stressor that could trigger or escalate violence. This included health issues within the family context more broadly, such as that of in-laws or extended family which could raise issues for a person that might trigger or escalate their use of violence.

Lateral violence

Practitioners discussed the political "call-out" culture within queer communities, which includes policing of other community members. There is often pressure on communities and individuals to be representative of "the good queer" which contributes to the minimisation or concealment of violence. Particularly in cases where the person primarily responding to violence is understood within the community to be the person using violence, this can exacerbate social isolation of individuals or families affected by FV and limit opportunities for people to reach out for support. This response can leave the person responding to violence more vulnerable, and/or trigger or escalate a person's use of violence.

Trauma recall or flashback

Flashback to a traumatic experience was identified as a trigger for the use of violence. The practitioner discussed the anxiety and fear elicited by the flashback as contributing to the violent response.

Time of the week or year

One practitioner discussed the significance of the day of the week or time of year in terms of escalation of violence. The practitioner had noticed a clear pattern of increased violence approaching over the weekend, when they had less access to their regular support services and there was often an increase in the use of AOD. There was a similar pattern around public

holidays, when there might be a week or two over which the client wouldn't have access to the practitioner supporting them. The vulnerability associated with that lack of access, or anticipation of the lack of access, was discussed as a main factor in that escalation.

Strategies and tactics

Key themes relating to the specific nature of LGBTIQ+ FV perpetration that were identified by practitioners will be explored below. Themes related to manipulation of heteronormative understandings of FV, retaliatory or mutual violence, sexual abuse or manipulation, targeting gender or sexual identity, social isolation and AOD.

Manipulation of heteronormative understandings of family violence

This was the most frequently occurring theme relating to tactics of enacting harm and related to the ways in which people using violence manipulate systems and communities, generally to create a false narrative around their partner being abusive. In five of the focus groups, practitioners gave examples of instances where people using violence have manipulated heteronormative and cisnormative perceptions of FV to their advantage, either through presenting as a victim to services or police, calling out their partner as abusive in their community, or utilising identity narratives around maternity and innocence to make people believe that they could never be possible of enacting harm. This may have been by taking advantage of perceptions by police of people of colour, people larger in stature or physically stronger, other masculine gender expression as perpetrators of violence. Cases were also identified in which a person was able to position themselves as a victim merely by being the first person to call the police or apply for an intervention order, because of the limited understandings of LGBTIQ+ family violence within the criminal/legal systems.

Retaliatory or multidirectional violence

Instances of retaliatory or multidirectional violence were identified by some practitioners, whereby one partner in a relationship may use violence to respond to violence that is being used or has been used by another partner. Retaliatory violence also presented as a theme in relation to violence in the family of origin, where the family member who instigated violence positions themselves as victim once the client responds.

Retaliatory violence was discussed by some practitioners in relation to who held power within a relationship, with the person who holds power generally instigating violence and the other person responding. Practitioners identified instances where the person instigating violence may then claim to be the victim of violence once the other person responds. Practitioners identified that sometimes it is less clear who is instigating violence, and that power within relationships can shift and there are instances where a person is causing harm to their partner but is also having harm caused to them by their partner.

Two practitioners shared insights into the ways that different types of violence can be used multidirectionally and concurrently, for instance where one partner is using emotional and psychological abuse and the other is responding with physical violence.

Sexual abuse or manipulation

Practitioners discussed sexual violence in the context of a relationship, including coercion, non-consensual aggressive sex and rape. Sexual abuse or manipulation was identified in five of the focus groups, and at times explored further. One practitioner discussed AOD use; and dissociation, or detachment from reality often associated with a trauma response, during sex; and the implications of these in terms of negotiating active consent. Also discussed were the ways that a person can shut down or hyper-sexualise their partner's desires for intimacy, effectively shutting down their sexuality and causing shame.

Targeting gender or sexual identity

Practitioners identified tactics relating to undermining or shaming someone's gender or sexual identity. This included discussing the ways in which TGD people may experience violence in the forms of threats to 'out' them, speaking about their body in a way to erode their confidence or policing their gender expressions. It was also identified in one focus group that bisexual people may face biphobia and violence targeted at their sexuality by non-bisexual partners.

Social isolation

Practitioners discussed ways in which people using violence can intentionally isolate their partner/s and family members from their social networks, communities and families. This included preventing someone from seeing their friends or family, monitoring their movements, or telling them that no one will believe them if they talk about the violence in the relationship.

Three practitioners discussed the ways that people using violence can mobilise LGBTIQ+ communities to enact lateral violence on a person, perhaps through telling everyone that their partner is using harm or triggering a call out that results in the community closing ranks on the person who is experiencing violence.

Patterns or sequencing of violence

Practitioners identified patterns or sequencing of violence relating to shifts between the use of violence and experiencing of violence, the extension of violence to other family members, instances where adolescents began to use violence as well as patterns of multiple abusive relationships within families.

Shifts between use of violence and experiencing of violence

In half of the focus groups and interviews, practitioners discussed the ways in which someone's use of violence in the context of FV may be preceded by having violence used against them in other circumstances. Practitioners identified that often people who come to be defined as perpetrators have at some stage in their life been victims. One practitioner spoke of the ways that a person's trauma history and triggers may result in them unintentionally controlling a partner, and another practitioner identified instances where a

person who has received violence in relationships throughout their life may become aware that they are using violence against a partner in later relationships.

Extension of violence to other family members

Two practitioners discussed how dynamics of violence can involve or extend to wider family. This was identified in relation to multiple people using physical violence within a family unit in a cyclical manner, for instance when a person uses violence against a sibling while experiencing violence used against them by a parent. Also discussed was the ways in which family members can be drawn in so that they are colluding with a person using violence.

Patterns of being in a series of abusive relationships

In two of the focus groups practitioners identified cases where they have had clients who have been in a string of abusive relationships in their adult life. One practitioner shared insight into the impact that previous violent relationships had on a client's later relationship in terms of their level of anxiety within the relationship and emotional and psychological dependence.

Discussion

The knowledge and experience practitioners have accumulated throughout their work helped to embellish our understanding of the risk factors as drawn from the literature. While many of the findings were consistent between the literature and the practitioner data, there were several novel considerations introduced in the latter. Practitioners were particularly able to add value to explorations of client interactions with, and impacts from, family violence services and supports. Practitioners were also able to speak to the impacts they have observed of structural violence on the experiences of LGBTIQ+ people who have used or been harmed by family violence.

From the findings of the practitioner interviews, there are a number of points to consider in the development of interventions:

- As AOD use was indicated as a trigger or point of escalation of violence, support around AOD use could be helpful in reducing the frequency or severity of violence
- Housing support including advocacy and brokerage, and case management support more broadly around material resource insecurity could build clients' capacity to end their use of violence
- Given that weekends and public holidays are high risk periods, having services available outside of business hours may be important in providing the most benefit to clients
- Program content should be trauma-informed, and therapeutic support around people's experiences of trauma should be part of the work, as needed
- The trauma histories of people using violence should be recognised, but should not be allowed to serve as justification of the use of violence against others

- Because of poor understandings of LGBTIQ+ family violence in the systems which respond to it, services should remain curious in their approach with new clients and use comprehensive assessment to establish how and by whom violence is being used
- To mediate the impacts of social isolation, connection to community might be fostered where needed through case management support and/or warm referral to other services
- Program content should include discussion about what constitutes abuse, and what respectful relationships, including consent, might look like
- Lateral violence may be important to address as part of initiatives for the primary prevention of LGBTIQ+ family violence
- Families expecting children or transitioning to parenthood are a high risk cohort, who could benefit from specialised primary prevention and early intervention strategies

3. Data File Audit

In the client data file audit, the aim was to gather further data surrounding client experiences, to test the learnings from the literature and practitioner interviews and focus groups. The hope was to gain a better understanding of how a wide range of factors impacted upon people's experiences or use of violence, which were not well differentiated in the data up to that point. Some examples of this include, how people tend to relate to one another in their relationships, specific mental health challenges, personal or family transitions, and past experiences of violence.

Audit Methodology

queerspace clients who had experienced or used family violence were identified using a client records management system report which indicated family violence markers, including family violence recorded as either a current alert or as a presenting need. As such files audited may not necessarily have been based on FV experienced in the client's current relationship; they may have experienced or used violence recently or historically but spoken about FV as a key reason for engaging the service at the point of intake. Clients were selected only if they had provided consent at the point of intake for the use of their data for research and evaluation purposes. Case files including case notes, intake, risk assessments, and other assorted files were read by the research team to initially confirm the availability of material to complete the audit. These files were then used to ascertain the presence of a risk factor.

Cases were removed that had less than 40% of fields available, this resulted in removal of 3 clients who had insufficient information. A total of 47 clients remained, with 25 who had experienced violence and 22 who had used violence. Note that cases were not matched as partners or family members across the Used and Experienced Violence groups.

There were 84 fields (see Appendix B) that included information on demographics and potential risk factors on topics including: family of origin, the personal/individual, the relationship, intimate partner family violence, identity, experiences accessing support and social and community factors. Options for completing the audit included:

- the information was found and the factor was present;
- the information was found and the factor was absent;
- the information was not found; or
- the factor was not applicable to this client.

Additional notes were taken on clients when relevant.

A limitation of the audit was that many of the data points were not recorded fields within the database; as such, the absence of information does not definitively confirm that a given factor was not present, just that it was not captured. For example, if a client's parents had alcohol or substance use issues and it was not raised in the provision of service, it would not

be recorded as a risk factor. This highlights the potential to improve our understanding of risk factors by formalising their capture within our client records infrastructure. On average, 37% of fields across the clients were not mentioned explicitly in files as either occurring or not occurring.

Results

Demographics

Age, Education, Employment, Nationality, Aboriginal or Torres Strait Islander and Disability

The average age of clients who had experienced violence was 42 years, the average age of those who had used violence was 37 years. Across both groups, the youngest client 24 years of age, and the oldest was 60. Clients who experienced violence were 4.5 times more likely to have a tertiary education than the group of clients who has used violence. 72% of all clients were born in Australia. Of those who had used violence, 2 were of Aboriginal or Torres Strait Islander background and 3 had a disability.

Table 1
Demographics for Clients using or experiencing violence

	Age	Tertiary Education	Employed	Australia as Country of Birth	ATSI	Disability
Experienced Violence	41.64	72% (18)	44% (11)	68% (17)	0	0
Used Violence	36.91	36% (8)	41% (9)	77% (17)	2	3
Average across both groups	39.28	55%	43%	72%	2	3

Gender and Sexuality

The majority of people in our sample were cis females (57%) who identified predominately as lesbian (32%), in both the Used Violence or Experienced Violence groups (See Table 2 and 3). Note that in the general client population of queerspace, 40% of clients are cis females. Lesbian is the most common sexual orientation in both the queerspace general population and the audit sample. Because the pilot programs specifically did not engage cis men, it is unsurprising that there are proportionately more women in the sample than in the general queerspace population.

Table 2
Gender for clients using or experiencing violence

	Female	Male	Trans Female	Trans Male	Non-Binary

Experienced	54%(13)	16%(4)	16%(4)	0%(0)	12%(3)
Used	64%(14)	5%(1)	5%(1)	5%(1)	5%(1)

Table 3

Sexuality for clients who had used or experienced violence

	Lesbian	Gay	Bisexual	Queer	Other	Questioning	Hetero -sexual
Experienced	28%(7)	20%(5)	12%(3)	20%(5)	16%(4)	4%(1)	0%(0)
Used	36%(8)	9%(2)	18%(4)	14%(3)	14%(3)	5%(1)	5%(1)

Partner's Gender

Partners of the clients involved in the audit were most commonly female (See Table 4).

Table 4

Gender for clients' partners who had used or experienced violence

	Female	Male	Trans Female	Trans Male	Non-Binary
Partner of those who experienced violence	12	6	1	2	2
Partner of those who used violence	17	2	1	0	1

Risk Factors

The analysis revealed key risk factors pertaining to a number of areas including relationship, personal, family of origin, and support. The results have been organised by each area and risk factor and are then summarised through identifying notable differences and similarities between the Used Violence and the Experienced Violence group.

Relationship

Birth of a Child

5 clients (one from the Used Violence group and four from the Experienced Violence group) had children under 10. All but one mentioned tension beginning or escalating after the birth of a child. In the one case where tension was not mentioned as beginning or escalating after the birth of the child, the current partner had psychologically abused the child in their relationship and the previous partner had left the family. As such, all clients with young children mentioned the interrelation of transitioning to parenthood and partner tension or conflict. Two of the four clients also mentioned physical violence beginning or escalating after the birth of a child.

Roles and Responsibilities

Unequal distribution of household labour or caring responsibilities was a common risk present in the clients audited. Half of applicable respondents described an unequal distribution of household labour occurring in their relationship. Those who experienced violence more commonly, mentioned an unequal distribution of household labour and commonly referenced financial control as integral to their experience of abuse. Approximately one third of clients who were carers, whether for children or adults, mentioned an unequal distribution of caring responsibilities.

Table 5

Roles and responsibilities for clients who had used or experienced violence

	Heteronormative Understandings of Gender Roles	Unequal Distribution of Household Labour	Unequal Distribution of Caring Responsibilities
Experienced	20% (5)	36% (9)	32% (8)
Used	27% (6)	23% (5)	32% (7)

Power and Dominance in Relationship

The majority of clients who experienced violence (72%) mentioned their partner's dominance within their relationship. Power imbalances in decision making was mentioned by 60% of those who experienced violence, and power struggles within the relationship by 44% of those who experienced violence. It was determined that, of all the clients in the Used Violence group, only one did not display dominance in their relationship. The presence of dominant traits was unable to be determined for 9 clients in this group, with the remainder clients (= 12) all showing signs of dominance in their relationship.

Table 6

Power and dominance relationship traits for clients who had used or experienced violence

	Dominance Within Relationship	Partner/s Dominance within Relationship	Power imbalances in decision making	Power Struggling within Relationship
Experienced	0% (0)	72% (18)	60% (15)	44% (11)
Used	55% (12)	23% (5)	36% (8)	23% (5)

Relationship Dynamics

Those who experienced violence were 7.9 times more likely to express instances where they have accommodated the needs or wishes of partners over their own, and 4.7 times more

likely to experience relationship fusion with their partner than those who used violence. Both groups showed high rates (68%) of low relationship satisfaction. The majority of clients had recently separated from their partner or had an impending separation. Several clients had mentioned the separation as leading to the onset of abusive events.

Table 7

Relationship dynamics for clients who had used or experienced violence

	Accommodating Behaviours	High levels of fusion	Low relationship satisfaction	Recent Separation	Impending Separation
Experienced	44% (11)	32% (8)	68% (17)	64% (16)	24% (6)
Used	9% (2)	9% (2)	68% (15)	50% (11)	23% (5)

Personal

Drug and Alcohol Use

There were high rates of drug and alcohol abuse. 60% of those who experienced family violence mentioned their partner's abuse of drugs or alcohol. This was commonly mentioned as a precipitating factor for an incident of violence in the relationship.

Table 8

Alcohol and drug use history for clients who had used or experienced violence

	Personal Alcohol Abuse	Personal Drug Abuse	Partner or Family Member's Alcohol Abuse	Partner or Family Member's Drug Abuse	Partner's Abuse of Drugs or Alcohol
Experienced	20% (5)	16% (4)	40% (10)	48% (12)	60% (15)
Used	27% (6)	23% (5)	18% (4)	14% (3)	14% (3)

Mental Health

Those who used or experienced violence in their relationship had high rates of mental health distress. Both those who used violence and those who experienced violence had high rates of trauma history, suicidal thoughts, depression and PTSD, with those who used violence displaying slightly higher rates in all but PTSD, which was roughly equal.

Those who experienced violence had substantially higher rates of anxiety symptoms (80% compared to 56%). Clients who experienced violence commonly mentioned these symptoms in relation to the fear of a reoccurrence of violence or anxiety around the legal, financial or household complications following separation. A recent or impending separation was

recorded for 90% of clients who had experienced violence and presented with anxiety symptoms.

Other mental health factors identified included six clients experiencing Borderline Personality Disorder (2 in the Experienced Violence and 4 in the Used Violence group) and three with Autism Spectrum Disorder (all from Use Violence group).

Table 9
Mental health of clients who had used or experienced violence

	Trauma History Mentioned	Suicidal Thoughts	Anxiety Symptoms	Depressive Symptoms	PTSD	Other MH Factors
Experienced	56% (14)	44% (11)	80% (20)	52% (13)	24% (6)	40% (10)
Used	64% (14)	50% (11)	56% (12)	59% (13)	23% (5)	59% (13)

Family of Origin

Family of Origin Violence and Abuse

Both groups had experienced similar rates of childhood physical, emotional or sexual abuse. While national prevalence rates of physical child abuse are estimated between 5-10% (AIFS, 2017), comparatively the groups of those who experienced or used violence showed much higher rates of childhood abuse (24-32%). Between 12-14% had experienced childhood sexual abuse. In addition, 32% of those who experienced violence and 41% of those who used violence had experienced family violence in their family of origin. Rates of child abuse or violence within family of origin were slightly higher for the group who used violence (see Table 11).

Table 10
Family of origin violence and abuse for clients who had used or experienced violence

	Childhood Abuse (Physical, emotional or neglect)	Childhood Sexual Abuse	Violence within Family of Origin
Experienced	24% (6)	12% (3)	32% (8)
Used	32% (7)	14% (3)	41% (9)

Experience of Violence in Other Relationships

It was common for either group to have experienced violence in past relationships, but only the Used Violence group had mentioned using violence in past relationships. Both those who

used or experienced violence had experienced a similar level of violence in former relationships. Those who experienced violence were also more likely to be experiencing violence in other contexts. This may have been in the workplace, in their share homes, or in public spaces, as a few examples.

Of those who had used violence, 18% stated that they had used violence outside of an intimate relationship. These were all women who indicated a continual use of violence beyond the context of an intimate relationship. The majority of those who had used violence only mentioned using violence within a relationship. For most clients however, it was not possible to confirm if they had or had not used violence in other contexts or in past relationships.

Table 11

Experience of violence in other relationships for clients who had used or experienced violence

	Experienced violence in former relationships	Used violence in former relationship	Used violence in other contexts	Currently experiencing violence in other contexts
Experienced	36% (9)	0% (0)	4% (1)	32% (8)
Used	36% (8)	32% (7)	18% (4)	14% (3)

Support

Social Support

Both those who experienced and used violence had similar rates of community connections and social support. Those who were in the Experienced Violence group were 1.8 times more likely to be isolated from their family of origin than those who had used violence.

Table 12

Social support rates for clients who had used or experienced violence

	Strong Community Connections	Limited/No Community Connections	Good Social Supports	Supportive Family Relationships	Isolated from Family of Origin
Experienced	24% (6)	16% (4)	64% (16)	32% (8)	40% (10)
Used	23% (5)	23% (5)	59% (13)	46% (10)	27% (6)

Experiences Accessing Services

Approximately one third of clients mentioned negative experiences accessing other services, such as mainstream family violence services, health services, housing services, and counselling services, among others. Although there were similar rates of positive and negative experiences accessing services between the two groups, those who experienced violence were 3.9 times more likely to express reluctance to access services than the group

who used violence. Those who had experienced violence more commonly mentioned a reluctance to engage law enforcement.

Table 13
Experiences accessing services for clients who had used or experienced violence

	Negative Experiences Accessing Services	Positive Experiences Accessing Services	Reluctance to Access Services	Reluctance to Engage Law Enforcement
Experienced	36% (9)	8% (2)	28% (7)	28% (7)
Used	32% (7)	5% (1)	9% (2)	18% (4)

Minority Community Experiences

Those who Experienced Violence were more likely than those who Used Violence to express identity shame and concealment. Additionally, this group commonly mentioned expectations of or experiences of identity-based discrimination, harassment or prejudice. Almost half of those who had experienced violence had expressed an expectation of discrimination, or experiences of discrimination or homo/trans/bi-phobia.

Table 14
Minority community experiences for clients who had used or experienced violence

	Identity Shame	Identity Concealment	Expectation of Discrimination	Experiences of Discrimination	Experiences of Harassment	Experiences of Homo/trans/bi-phobia	Experiences of Racism
Experienced	28% (7)	12% (3)	48% (12)	44% (11)	32% (8)	48% (12)	8% (2)
Used	4.5% (1)	4.5% (1)	18% (4)	32% (7)	18% (4)	18% (4)	4.5% (1)

Summary

The file audit has shown differences in the presence of particular factors from those who have used or experienced violence, indicating potential risks (or effects) of family violence for LGBTIQ+ people. There were also similarities across both groups which suggests there are general risks associated with family violence occurring in LGBTIQ+ relationships and families. This audit was limited by its oversampling of lesbian couples and under-sampling of other groups within the LGBTIQ+ acronym.

Used Violence Group

The most common risk factors identified in the Used Violence group were mental health distress, suicide ideation, history of trauma, child abuse, family violence in family of origin,

using violence in previous relationships, dominance in the relationship, and drug and alcohol abuse.

Mental Health and Wellbeing

The Used Violence group showed high rates of mental health distress with particularly high rates of depression. There was also a higher presence of other mental health disorders within this group, predominately Borderline Personality Disorder and Autism Spectrum Disorder that were not present at similar rates in the Experienced Violence group. The majority of clients also had a history of trauma and had experienced family violence or child abuse during childhood at a slightly higher rate than the experienced violence group.

Context of Violence

The Used Violence group had a high incidence of suicide ideation, being present for half the group, which was only slightly larger than the experience violence group (44%). This could suggest that the use of harm by the individual can extend to self-harm, further research on this area would be of interest in order to explore this.

One-third of clients in the Use Violence group had professed to using violence in a previous relationship and one-fifth of clients mentioned using violence in other contexts. This suggests that for certain people the use of violence was not limited to intimate relationships, whilst the majority had only mentioned using violence in a relationship.

Differences in Reporting of Behaviours

While partners/family members were not matched between the Experienced and Used Violence groups, the differences in incidences of particular behaviours recorded from the Used Violence group and the Experienced Violence group were still notable. Dominance was a common trait of those who used violence in their relationship. Just over half of the clients in the Used Violence group presented with traits of dominance in their relationship, however a much higher rate of the Experienced Violence group mentioned the experience of their partner's dominating behaviours in the relationship.

Drug and alcohol abuse were also common with those who used violence. Personal drug and alcohol abuse were mentioned by about one-quarter of the clients in the Used Violence group. However, approximately half of the Experienced Violence group mentioned alcohol or drug abuse by their partner as a trigger to an incident of violence or abuse.

Both dominant behaviours and drug and alcohol abuse are identified here as risk factors for the use of violence. Those who used violence described lower rates of these behaviours than the those who experienced violence described of the partners who had used violence against them. This may suggest that either those who use violence are not disclosing this information, or it may be that in the groups there was an actual lower rate of drug and alcohol abuse and dominant behaviour than for the partners of the Experience Violence group. For the latter, this could reflect the type of individuals who are both using violence *and* who are seeking help through drummond street's services.

An additional example of discrepancy is in the recorded rates of their partner's use of violence. For the Used Violence group, 41% had mentioned incidents where the partner used violence against them, however only 4% of the Experience Violence group were identified as using violence in their relationship.

Experienced Violence Group

Overall, this group presented most commonly with anxiety symptoms, isolation from their family of origin, was more likely to experience violence outside of their relationship, and within their relationship they were more likely to use accommodating behaviours or experience fusion or power imbalances with their partner. They also commonly expressed identity shame and a reluctance to access services (including law enforcement) or had negative experiences accessing services. The Experienced Violence group also had a much higher level of education attainment than the Use Violence group.

Mental Health and Wellbeing

The majority (80%) of those who experienced violence had symptoms of anxiety that were most commonly mentioned as being generated by feeling fear around the reoccurrence of violence or abuse, or the issues they were confronted with following the dissolution of the relationship (i.e. child caring/visitation arrangements, financial instability, securing housing, or legal disputes). Almost all (90%) of those experiencing anxiety in this group had a recent or impending separation with their partner.

Relationship Dynamics

Those who were experiencing violence were vulnerable to experiencing violence in other contexts with one third of those currently experiencing violence outside of their relationship. Within their relationship, this group was almost 8 times more likely to be using accommodating behaviours than the Used Violence group. Power imbalances in decision making were mentioned by the majority of those who had experienced violence, and power struggles within the relationship were mentioned by almost half of those who had experienced violence. Those who experienced violence were also more likely to experience fusion with their partner and experience isolation from their family of origin.

Barriers to Accessing Support

The Experienced Violence group expressed an overall reluctance to access services. They commonly mentioned negative experiences in accessing services and were also more likely to mention a reluctance to engage law enforcement. This group also mentioned identity shame and concealment, experiences or expectations of discrimination, and experiences of homo/trans/bi-phobia at a higher rate than the use violence group. These elements may act as barriers for accessing both formal and informal support.

Both Groups

In both groups there were similarities in the incidence of risk factors. This included high rates of:

Trauma. This included past experiences of family violence in their family of origin, child abuse, PTSD diagnosis and approximately one third of both groups had experienced violence in a previous relationship.

Mental health issues. There were high rates of mental health issues in both groups with similarly high rates of depressive symptoms and suicidal thoughts.

Unequal roles and responsibilities. Unequal distribution of labour was mentioned commonly in both groups as well as an unequal distribution of caring responsibilities. Both types of unequal roles and responsibilities were mentioned by about one third of clients.

Low relationship satisfaction. Relationship dissolution (impending or current) was mentioned by the majority of clients.

Tension following the recent birth of a child. Almost all clients who had children under 10 (= 4 of 5) mentioned tension beginning or escalating after the birth of a child. Two of the four clients who mentioned tension at this time also mentioned violence beginning or escalating after the birth of a child. This audit was limited by a low number of clients participating who had young children.

Negative service experiences. Experiences or expectations of discrimination, as well as negative experiences accessing services, were common amongst the clients.

4. Client Interviews

Having reviewed the academic and grey literature relating to family violence interventions, explored with practitioners their observations about risk and protective factors for family violence, and explored client data via the file audit, the voices and perspectives of clients themselves were important to include in ensuring that the other data accurately reflect their experiences and intervention needs.

Methodology

To allow for in-depth insights, interviews were conducted. Clients of queerspace who were appropriate to interview, based on their current level of safety, were identified by practitioners, and provided with basic information about the research before being asked if they would like to be contacted by the research team with further information. Seven clients consented to participation after being provided with a plain language statement outlining the purpose of the research, as well as the risks and benefits of participation. Four interviews took place face to face at drummond street services' Carlton office, and three were conducted over the phone. Audio was recorded, transcribed and coded using NVivo. Participants were provided with $50 gift cards in recognition of their time. All client cases were still open at the time of the interview, and as such they had access to their queerspace practitioner in the event they needed to debrief about the interview content. The discussion guide (see Appendix C) for the interviews was informed by the literature review and practitioner interview/focus group findings. The themes from the interview data, identified deductively from the discussion guide, as well as inductively based on client responses, included the dynamics of violence, including the forms it took, patterns or sequencing of violence, triggers or points of escalation, and forms of resistance to violence; community or lateral violence; individual risk and protective factors; and structural factors.

Participants

Among the participants, one was a trans-intersex bisexual person, one was a nonbinary pansexual person, one was a lesbian-identified ciswoman who had been in a relationship with a transman, and the others identified as queer or gay ciswomen who had been in relationships with other ciswomen.

Findings

Risk Factors

All of the risk factors raised by the clients had been identified within the literature, practitioner interviews, and client file data included in this paper. The interviews add value by validating some of the findings which were more heavily represented in the practitioner

interviews than in the literature review, such as rigid adherence to gender norms, and pregnancy or the transition to parenthood.

Table 15

Risk factor by Number of Individual Mentions and Number of Participants

Risk Factor	Number of Individual Mentions	Number of Participants
Rigid Adherence to Gender Norms	15	4
Material Resource Insecurity	12	6
Isolation or Lack of Support from Family of Origin	10	5
Mental Health Vulnerability	10	3
Previous Experiences of Violence	8	6
Pregnancy or Young Children	8	2
AOD	5	3
Internalised Stigma	4	2

Rigid adherence to gender norms

This theme was raised fifteen times across four interviews and was discussed in the context of violence in families of origin and intimate partnerships, and by housemates. One participant had experienced violence by her father in response to her expressing her femininity:

> *Well, I think the father abuse was [about] my gender. I started appearing to be girly and queer. So trying to beat it out of you, make you a man. I'm intersex, so I fluctuate between male and female, and sometimes I appear more female, sometimes I appear more male. I had surgeries [I didn't consent to] as a child, mostly because of the fears of my father.*

Within intimate partnerships, this consisted of the working partners taking up normative patriarchal roles. It included having active social lives while their partners who were the primary carers for their children were cut off from friends and family, having financial control and decision making power, and expecting their partners do most of the household labour. In one case, the person was a trans man with a masculine gender expression, while in the other case, the person had carried the baby and had a more feminine gender expression.

> *I look at our families of origin right, and the dads f***ed off every weekend to go fishing or sailing or golfing. Like, it seems to be quite reasonable for men to take hours and hours and hours of time, whereas I think, 'What did my mum do?' She looked after us all the time. Like all the time, I can't even remember that she even left the house without us... Did she? Probably not, right? So again, his expectations of what*

was reasonable were based on that model, whereas mine were based on the, hang on, we're parents, we share.

Material resource insecurity

This theme came up twelve times across six interviews. In terms of abuse by housemates, participants spoke of their vulnerability to abuse by virtue of limited financial resources. Their financial situation forced them into living situations where they had no power. One participant spoke to the interconnectedness of systemic discrimination and material resource insecurity; they didn't have access to legitimised forms of employment, and/or housing unless they passed as cisgender men, for example.

There was also a theme among the participants who were primary carers for their children, of coming from a family with little money, and having ex-partners who were higher income earners and/or who came from wealthy families:

> *I guess I've grown up always being dependant - being taught that women are dependent on men for money. I think that I have a lot of fear around that as well, like I can't autonomously manage by myself; I don't have that confidence. [It] is making me more vulnerable to him and his threats, and maybe more dependent on him and beholden to him.*

Isolation or lack of support from family of origin

Isolation or lack of support from one's family of origin came up ten times across five interviews. This pertained both to their vulnerability to abuse to begin with, and their ability to access informal supports to address and/or end the violence. One woman spoke about her mother's lack of support, first around her coming out as a lesbian, and then around her choice to leave her relationship. Another spoke of the abuse she faced from her father and other family members when she was growing up and to the present, as well as the sense that her friendships were one-sided, leaving her with no genuine supports. A participant who had used violence spoke to the social isolation they experienced and the interconnectedness between this and their use of violence. Several participants referred to the person using violence cutting them off from friends and family, or to the vulnerability to abuse they experienced by having tenuous connections with their community.

Mental health challenges

There were ten mentions of mental health challenges as a risk factor for family violence across three interviews. One participant described her ex-partner's need for psychological assistance, and yet the outcome was that her partner managed to manipulate the court system into requiring the participant herself to get psychiatric clearance to get access to her children. Another participant described the mental health of their ex-partner and family members who had used violence against them as terrible, and a contributing factor to the violence.

Previous use/experiences of violence

This came up eight times across six interviews. In four of the six cases, this referred to violence witnessed or experienced in the family of origin as a child or young person.

> *My childhood was violent from the get go; I can't even imagine not having a violent childhood. It affected my relationships as a kid, in terms of how I engaged with authority figures, teachers. It influenced me wanting to do creative stuff as a form of escape. Yeah, it dictated how I walked down the street, it dictated everything.*

In one case, it referred to a person who used violence in his intimate relationship as an adult using violence against his family members when he was younger:

> *He's used [violence] in his family of origin as a teenager. That's only come out recently, like his sister said to him that she feels really, sort of, scarred by the way he treated her as a teenager, and his whole family. I think he was very abusive towards them. And I think that came out in our couples counselling stuff, that actually his abusive behaviour towards me wasn't only about me, it was old stuff about rejection and family of origin things.*

In another case, it referred to the emotionally violent behaviour in a range of different types of relationships throughout adulthood of a person who had used violence in an intimate relationship.

Pregnancy or young children

Pregnancy and the transition to parenthood were discussed as risk factors eight times between the two interviews with participants who had children. Where violence did emerge during or after the transition to parenthood, those experiencing violence spoke about being more accommodating of their partner to keep the children safe. Participants spoke about how pregnancy kept a person in a relationship for longer once it had become violent, where they otherwise might have left. They also spoke around the way that having children changed the relationship dynamics and positioned one person to take on a more traditional female role in the family, making them vulnerable to isolation from friends and family, and vulnerable to financial control.

> *Having children is the main thing [that allowed violence to happen], because it's almost like you invite in a forced inequality. So, there's quite a lot of layers, but essentially the - I call it the heteronormative vortex, I don't know if I've coined that term - but it's about the sets of behaviours that are then expected of you and what you expect of your partner as a parent. And when you are in a relationship like mine where you look straight, and one of you wants to be straight, then those become almost impossible to fight against. So, I got sucked in, sucked down, by all of that. And I think that that inequality perpetuated the violence. Not perpetuated... I think it created the conditions for it. Yeah, I don't think the conditions would have... I don't think there would have been violence if we had been more equal, like we were before we had kids.*

Alcohol and Other Drug use

This came up five times across three interviews. The first participant discussed the interconnectedness of AOD use, homelessness, poverty, and illegal employment, and the vulnerability it created in the use or experience of violence. Another spoke to the impact of addiction to alcohol and other drugs on their parents' and partners' ability or motivation to address their own mental health or relationship issues, contributing to violent behaviour.

Internalised stigma

Internalised stigma refers to the absorption and application to oneself of stigmatising assumptions and stereotypes from one's social and/or structural context. Internalised stigma was raised four times over two interviews. Participants spoke about how the use of violence against them, often seemed linked to a person's struggles with their own identity and internalise homophobia or transphobia. When one participant was asked whether an abusive partner was connected with LGBTIQ+ community, she responded, *"No, not at all. He calls them all losers and freaks."*

Structural/systemic factors

Structural/systemic factors are inter-related with risk factors which could be categorised as having impacts on a more individual level. However, because the implications of structural factors in developing interventions may in some cases be a bit different, for example in suggesting a need for sector-wide capacity building, or primary prevention activities, versus provision of specific forms of therapeutic case management support, we have separated structural factors into their own theme. The number of mentions, and number of participants discussing each subtheme are laid out in Table 3.

Table 16

Structural/Systemic factor by Number of Individual Mentions and Number of Participants

Structural/Systemic Factor	Number of Individual Mentions	Number of Participants (out of 7)
Limited understandings of family violence	20	7
Hierarchies of power	20	5
Impacts of formal supports	45	7

Limited understandings of family violence

The impact of poor understandings or awareness of LGBTIQ+ family violence, or indeed family violence in general, was raised twenty times, and came up in all of the interviews. Two participants identified the invisibility of forms of violence which weren't physical within the legal and service systems as major barriers to accessing support.

It's hard to be taken seriously. It ended up being my word against hers, and that was devastating to me. It took a lot for me to come out and say what I needed to say, and not to have it taken seriously, or get told that you know "What's your proof?". Yet if it's a heterosexual relationship and I experienced a quarter of what I experienced in this relationship a lot of things would have been done. We would have been heard. Certainly, intervention orders would have been in place immediately, and a lot of things like that.

Five participants discussed their own limited understandings of violence, including how different forms of violence are connected:

I didn't really see it for ages. Like, I just had no idea it was really happening until I rang, until friends said to me, 'You need to ring the hotline'. And I said, 'Oh, yeah, well I'll ring them and they'll say it's not happening,' and I rang them and they said, 'You need to go to family court.' I was [shocked].

I guess I didn't really know much about it prior to experiencing it and now it's much broader and it's much deeper, and I have a much greater understanding of all the kinds of family violence that are possible than I ever did before.

I think before, I thought about physical, sexual and emotional abuse as related, but still as quite separate things. I understood that they occurred together, I guess they were co-morbid. I didn't understand their relationship, more than that, the connection of my attitudes and violence occurring. I had bad attitudes and I was violent. I didn't understand that one allows for the other to exist.

Hierarchies of power

Social hierarchies of power, including binaries such as man/woman, straight/queer, cisgender/transgender, white/non-white came up twenty times across five interviews. One participant discussed the transphobic and anti-intersex discrimination she faced throughout her life, and the complex ways in which this made her more vulnerable to family violence, including her being stuck in a cycle of AOD use, poverty, and insecure housing. Another discussed the fact that her mother was a woman of colour who faced racist and xenophobic discrimination, which limited the family's ability to gain financial security when the participant was growing up. Her family of origin, while loving and supportive, had limited financial resources to offer around her leaving the relationship and pursuing full parenting responsibility for her child. One participant identified that normative Western ideas of what queer identity and coming out should look like were imposed on her by her partner, who put pressure on her to be out in a particular way, in spite of what felt uncomfortable and/or unsafe for the participant:

Throughout the relationship, she was pushing me to come out to my mum, and my family. My mum is absolutely supportive, she knows I'm gay. I've never [brought] a boy home. I would always bring women home. We've never really spoken about it. Never really felt the need that we had to. It's just the relationship that we have. As long as we love each other and support each other, no matter what. It wasn't good enough for

[my ex-partner]; she thought that I needed to sit [my mum] down, take her through everything, come out to her. Not only her, but my entire family.

The participant discussed that if she had done what her ex-partner had been trying to pressure her to do, it would damage her relationships with her mother and the rest of her family of origin, isolating her from sources of support.

Three of the five participants who referenced social hierarchies of power discussed the significance of patriarchy and the power differential implicit in the man/woman binary. This was discussed in the context of people's families of origin, housemate relationships, and intimate partnerships. In one case the entitlement associated with masculinity of a person who used violence was complicated by his internalised transphobia. Another participant talked about their experience of intersectional marginalisation, and the profound impact this had on all facets of their life:

I happen to sit at the intersection of many different things and there's not many people like me. And when I have, when there are people like me that have been visible, they have all killed themselves. To me my survival rate is zero because when I've come across people that at least tick four of the boxes which I fill, um, yeah they all have died. So, the discrimination that I experience on a very regular basis affects me every single day and every minute of my life.

Impacts of formal supports

The significance of formal supports was raised 45 times, and by every interview participant. This was discussed in terms of the services themselves, and their availability to those who needed them. All of the clients who were interviewed had received LGBTIQ+ specialist counselling support through queerspace/drummond street services, and all mentioned the importance and benefit of that support. Two participants named their counsellors as the primary, or indeed only, people they could consistently approach to talk to about things that were difficult, with one sharing, *"I don't have a lot of friends, and counselling is the main avenue of emotional release and understanding, a comfortable place."* A person who had accessed services around their experiences of violence described the novelty and value of a service system caring about LGBTIQ+ family violence:

This might sound weird, but what's new is that people actually care. Like, I don't know, I'm [in my thirties], so a good portion of my life was just like, this is acceptable, and this is how it is. It's never going to change. Whereas now, it's like, 'Oh right, there are people that can call it what it is and say that it's wrong.' And they will agree with you, and it's not you just making it up and feeling uncomfortable. So that's good. I guess that's the new thing is that, yeah, it's like actually a thing that people are talking about and acknowledging as actually wrong.

However, a major limitation that was raised was that there was limited funding available for specialist, and even mainstream services, which meant having to wait a long time for a service, or having less frequent access than would be ideal, or getting turned away from a service altogether. For example, a participant who had received a flexible support package

talked about barriers to access they attributed to bureaucracy. They also expressed that, *"my counsellor, I wish I could see her way more than I do, but I know that having to funnel support through…government funding is really f***ing hard."* Another participant spoke at length about their experiences in trying to access housing support:

> *I contacted all the services in urban Victoria. I was either fobbed off to somebody else, or I was dismissed, and even the one service out of all services that said they could help physically, and only one service out of all of them actually gave me contact with a case worker, an advocate I can physically talk to, face to face, personally. [The others] would say, "No, you don't need to [come in]; we can just do this over the phone." But there's gotta be some humanity here, and there wasn't, so I was constantly for six weeks, navigating the system, only to be let down, and then having to go back home to this horrid person as well, who didn't want me there.*

One participant talked about how the lack of integration within the family violence service system amounted to inaccessibility:

> *There was an analogy that I heard about a family violence victim survivor, whatever the terminology is, it's like a woman with a ball of red wool and she gives the end of the wool to someone like you, you know, a researcher, and the researcher says, "Well actually, I know about this stuff, but I can't help you with this because I'm a researcher; I'm not a clinician; I'm not a lawyer; I'm not a doctor; I'm not a family violence specialist, so go over there to that person". So you take your ball and you give it to [the next person]…It went on, and then you've got a spider web of wool.*

Conclusions

The insights from client's own understandings of the use and experience of LGBTIQ+ family violence are invaluable to consider alongside other data sources for the development of interventions. The considerations for intervention development which emerged from the client interviews are laid out below:

- Critical exploration of social hierarchies including racism, sexism, and heteronormativity, and their impacts on individuals and their relationships to others should feature as a major theme in program content
- Case management support and/or brokerage should be available as needed for people using violence and/or affected family members engaged with the service
- Therapeutic support, including around AOD and mental health challenges, should be part of the work as needed, or warm referral should be made to the appropriate services
- Program content should foster a greater awareness of how our thoughts and feelings are shaped by our experiences, including experiences of harm, and build skills in changing how we respond to those thoughts and feelings

- Collective learnings around what constitutes family violence should be a major theme of program content, and awareness raising around LGBTIQ+ family violence could be an important primary prevention strategy
- Child safety remains an important consideration as part of risk assessment, and families expecting children or transitioning to parenthood are a high risk cohort, for whom targeted early intervention strategies should be developed
- Greater integration of individual services within the family violence service system is important in reducing barriers to service access, especially for LGBTIQ+ people who face additional barriers related to their identities or relationship forms
- Demand far outstrips funded LGBTIQ+ specialist service availability; further funding could ensure improved access and improve health outcomes for this cohort.

Discussion

This discussion will cover first the initial triangulation of data, which focused on risk and protective factors for LGBTIQ+ family violence, followed by the intervention data triangulation. Finally, recommendations for ongoing program delivery, and additional interventions which could be impactful, will be discussed. The pilot intervention will be laid out following this discussion, as its design, development, and delivery were informed by consideration of the learnings from the data to this point.

Risk and protective factors. In triangulating the risk and protective factor data from the literature review, the practitioner interviews, and the client file audit, there was significant consistency across many themes (as can be seen in Table 16). Further, the data from practitioner interviews and the file audit support the finding from the literature that experiences and use of LGBTIQ+ FV may shift over the course of a relationship, or of one's lifetime. There were, however, some novel findings in each of the practitioner interviews and the file audit. The finding that the literature is somewhat limited in its ability to capture the complexity of people's experiences, responses, and choices in their behaviours, was reflected within the data from practitioners and clients, where it was identified that there is a need to explore the ways in which a person using violence may have also experienced violence.

Table 17

Risk factors present across the three types of data sources

	Literature	Practitioner	Client Audit
Past Abuse	✓	✓	✓
Adult Abuse	✓	✓	✓
Substance Use	✓	✓	✓
Physical Health		✓	
Mental Health	✓	✓	✓
Relationship Factors	✓	✓	✓
Gender Roles	✓	✓	
Social Resources/ Community Support	✓	✓	✓
Financial Resources	✓	✓	
Minority Stress	✓	✓	✓
Intersectional Marginalisation	✓	✓	
Access To services		✓	✓

While the risk and protective factors discussed throughout this paper are often conceptualised as individual factors, the findings demonstrate that there is interconnection between these and the context in which they occur. An important consideration which emerged across the three data sources was the impact of structural discrimination related to hierarchies of power. The literature discussed the impact of marginalisation, discrimination and harassment on stigmatised groups, as being associated with the use of violence as well as experiences of violence in family and intimate relationships. Specifically, internalised homophobia, shame about being in an abusive queer relationship, and conformity to dominant gender norms were associated with use and/or experiences of violence among LGB people.

Intersectional marginalisation was also discussed, including the intersection of feminine identity with gender diversity, as well as that of LGBTIQ+ identity with disability, or with First Nations or culturally and linguistically and/or multi-faith identities, and the unique factors that may be associated with increased risk of family violence at those loci. Practitioner

interview and focus group data acknowledged and explored the ways in which a persons' experiences of oppression and marginalisation interact with and inform their experiences of violence within families or relationships. Practitioners identified the ways in which racism and white privilege can play out within LGBTIQ+ communities, as well as the broader community, and the significant impacts this can have on the way a person may negotiate systems and relationships. From the client data audit, those who experienced violence were more likely to express identity shame and concealment, as well as an expectation of discrimination in approaching services. Those who used violence and those who experienced violence commonly cited having had, or anticipating, negative experiences accessing services. The presence of this theme across the three types of data clearly illustrates the significant impact of structural violence and discrimination on people's vulnerability to, and experiences of LGBTIQ+ family violence. This suggests the potentially significant impact of wide-reaching, community and population-targeted health promotion and primary prevention strategies which foster more inclusive culture and resist hierarchies of power which allow violence to continue.

The broad theme of relationship factors was another that emerged across all three data types. In the literature, this largely pertained to the degree of accommodation and/or control being used by the partners, as well as the extent to which they each maintain their own autonomy within the relationship. However, these studies failed to specify whether these characteristics were associated with the use of violence, experiences of violence, or both. Unequal distributions of power, and stereotypical enactments of gender roles in relationship were the subthemes within "relationship factors" as per the practitioner interviews and focus groups. The examples provided of power discrepancies included differences in financial capacity, age differences, one partner or family member being a carer for the other, and having control over immigration status. In any of these cases, the person afforded less power might be more vulnerable to family violence enacted by the person holding more power.

In addition to what was discussed above around structural factors, the changing roles during the transition to parenthood were raised, as often these were related to how gender operated in the family. Often the parent who was the primary carer for the infant was more vulnerable to experiencing family violence, where a working parent might be in a position of greater power over them. The client data audit identified the birth of a child as a period of increased risk for family violence among LGBTIQ+ people. All clients with children under twelve mentioned tension or conflict in the relationship increasing during the transition to parenthood. Unequal distribution of labour and caring responsibilities were also highly correlated with family violence, and financial control was integral to parents' experiences of abuse. While the cohort of clients in this study was small, with 47 clients altogether and only 5 with children under 10, these findings suggest that primary prevention strategies promoting respectful and equitable LGBTIQ+ relationships, particularly around high risk periods such as the transition to parenthood, could be helpful in disrupting the establishment of unequal power distribution within families before those relationships became abusive.

Social and material resource scarcity or discrepancy were prominent throughout the data as being associated with risk of LGBTIQ+ family violence. The literature highlighted the socioeconomic disadvantage faced by TGD people, including lack of access to education and employment, and increased risk of homelessness, and the vulnerability to experiences of family violence it represented. The practitioner interviews and focus groups recognised these challenges, and also raised the significant implications of social resources and community or lateral violence. Social isolation was identified as a risk factor for family violence, as well as a tactic of abuse which then put people at risk for ongoing or future family violence.

The lack of awareness and recognition of LGBTIQ+ family violence in comparison with heterosexual cisgender family violence, and its resulting invisibility, was also identified as an area for individual and collective capacity building in order to minimise risk. Similarly, the client data showed that those who experienced LGBTIQ+ family violence were almost twice as likely as those who used violence to be isolated from family of origin. In terms of access to formal supports, one third of clients across the use of violence and experiences of violence groups had had negative experiences accessing services. However, those who experienced violence were almost four times more likely than those who had used violence to be reluctant to approach services. Again, the client data audit cohort was small with 47 client files included, but when the three data sources are taken together, they highlight the need for capacity building across service sectors in responding appropriately and supportively to LGBTIQ+ service users, as well as the need for resources and support services addressing financial distress available alongside family violence services. Community level interventions around health promotion and primary prevention which increase collective understanding of what constitutes respectful, as well as abusive relationships, could be valuable.

Substance use came up as a risk factor and/or point of escalation for violence throughout the data. The literature indicates clearly that alcohol plays a role in psychological and/or physical violence in intimate lesbian and gay relationships. In the practitioner interviews and focus groups, alcohol or other drug misuse was the single most frequently cited risk factor for LGBTIQ+ family violence. Interestingly, the client data showed that while personal drug and alcohol abuse were mentioned by only one quarter of those in the use of violence group, half of the experiences of violence group described alcohol or other drug abuse by their partner as a trigger for an instance of abuse. Services which provide family violence interventions might consider counselling support around any drug and alcohol challenges as part of the work, or warm referral to such services if there isn't capacity within the service. Primary prevention efforts targeting drug and alcohol use could also have an impact on family violence prevalence and could add value to their service by employing a family violence lens in their work.

Childhood experiences of violence were identified across the data sets, generally referring to experiences within the family of origin. The file audit data showed that women who use violence often have a history of childhood sexual abuse or violence. The practitioner data also supported the findings from the literature that people who have experienced FV in

previous relationships may be likely to use violence or have violence used against them in later relationships. The client data showed that those who used violence had experienced higher rates of childhood physical or emotional abuse or neglect, as well as violence within family of origin. Previous experiences of abuse were discussed in the literature, in particular with respect to the use of physical force by one woman in response to ongoing psychological abuse by a female partner. The practitioner data suggested previous experiences of family or intimate partner violence and sexual abuse as an adult were risk factors for both the use and experiencing of family violence. In the client data, it was common for those in both the use of violence and experiences of violence groups to have experienced violence in past relationships, but only those in the use of violence group mentioned having used family violence previously. This reiterates the insufficiency of simple concepts such as the victim/perpetrator binary in forming a comprehensive understanding of the complexity of people's experiences and use of violence. Increased access to trauma recovery services could be helpful to reduce family violence.

Within the literature about LGBTIQ+ family violence, a number of mental health issues were associated with either the use or experience of family violence. These included low self-esteem and attachment anxiety as risk factors for experiences of family violence, and less secure attachments, greater psychological distress, low self-esteem, stress and disordered personality characteristics as risk factors for the use of family violence. Practitioner interviews briefly mentioned insecure attachment as a risk factor for both the use and experiences of family violence, as well as experiences of trauma more broadly, though this featured to a lesser extent in this data than in the literature. From the client data, the use of violence was associated with high rates of mental health distress, and depression in particular. There were higher levels of other mental health disorders, like Borderline Personality Disorder and Autism Spectrum Disorder, among those who had used violence in comparison with those who experienced violence. Experiences of family violence were often associated with anxiety as a mental health issue. This is useful in illustrating that effective interventions around family violence may require wrap-around services which support clients across multiple intersecting challenges they are facing, to ensure the best possible outcome.

Novel risk factors within the practitioner data included medical health challenges for both the use and experiences of violence, and feeling out of control and having a limited capacity to manage conflict for the use of violence. The client data identified interesting differences in reporting around dominating behaviour, drug and alcohol use, and use of violence, as well as the significance of the birth of a child as a period of high risk for family violence.

Practitioners shared some valuable insight into protective factors, particularly for the use of violence that were not found within the literature. The protective factors that were identified in the literature were generally reflected in the practitioner data, however they tended to be framed differently. The literature identified themes of resilience; practitioners spoke to the protective value of a person finding ways to cope with their trauma. Within the

literature, a strong sense of identity was identified as protective and the practitioner data showed that identity was linked with community connection and personal insight. Practitioners elaborated on the protective nature of personal insight and awareness, with many identifying this as one of the most important protective factors for people to become aware of the impact of their violence and make changes. Practitioners identified support seeking around FV, as well as coexisting factors, such as mental health or AOD challenges, as being protective factors for both people experiencing violence and people using violence, while acknowledging that this is also a high-risk time for people who are having violence used against them. Having access to material resources was identified as a protective factor, along with having pets and having an understanding or awareness of FV dynamics.

Practitioners discussed the need for structural change around responses to social issues, such as poverty, unemployment and addiction, and the potential protective value of such changes. If people are able to see a path for themselves in the long term, including stable accommodation, employment, financial security, and access to medical services, this could mitigate many of the risk factors and triggers for violence.

Other content themes which might be useful as part of a program, based on the findings about risk and protective factors in this paper, include: respectful and equitable relationships, heteronormativity and its impact on family structures and roles, nonviolent communication and conflict management, self-reflection and awareness, and understandings of family violence. In order to deliver wraparound, holistic support to clients to best position them to make changes, therapeutic case management as part of an intervention could include financial literacy, brokerage funds, employment and/or housing support and advocacy, substance use, mental health, and connection to community.

Interventions. The intervention related findings are summarised in Table 17. Each of these findings will be discussed in this section, with respect to how it informed the intervention, and any evaluation findings regarding its impact within the intervention.

Table 18
Common themes present across the three types of data sources

Finding	Lit review	Prac interviews	Client interviews
Safe & accessible services	✓	✓	✓
Trauma-informed	✓	✓	✓
Curiosity/lack of assumptions about who is using violence	✓	✓	
Integration within broader systems	✓		✓
Flexibility of programs	✓		

Collaborative, strengths based practice	✓		✓
Non-coercive practice	✓		
Wraparound services, including AOD, mental health & material security	✓	✓	✓
Inclusion of social hierarchies in content	✓	✓	✓
Services offered outside business hours		✓	
Content to increase understanding of family violence		✓	✓
Pregnancy/transition to parenthood		✓	✓
Lateral violence		✓	

The importance of safe and accessible services has been consistently established throughout the data. As a peer-led service queerspace is well positioned to provide services which are responsive to the needs of LGBTIQ+ people, and which clients might feel less wary of approaching. The pilot program reflected this commitment to safety and access in their affirmative employment of practitioners with lived experience of LGBTIQ+ identity, and the options for clients of receiving outreach services or travel vouchers, depending upon their comfort level and/or ability to access the Carlton office of queerspace/ds.

One very clear learning from this paper is the fact that LGBTIQ+ people using violence have very often experienced violence themselves, whether in the form of family violence or otherwise. This hightlights the potential value of trauma informed approaches to practice, not only with those who have experienced family violence, but with clients who have used violence as well. Collaborative practice was identified as beneficial to engagement with people who used violence in the literature and in client interviews, and non-coercive practice was also discussed in the literature as important in work with people who have used family violence. These practice approaches and principles were important components of the pilot program across the individual and group work.

The significance of structural violence and discrimination in allowing violence to exist, and even condoning it, as well as its impact as a barrier to help-seeking, helps to form a picture

of what limitations on additional supports clients engaging with an intervention may or may not have access to. Social hierarchies of power were established across the literature, practitioner interviews and client interviews as deeply impactful in how people relate to one another and to service systems. The content for the group program as part of the pilot intervention was designed to dedicate some sessions specifically to these topics, but also to hold to the theme of social hierarchies of power across its entirety.

Flexibility of programs was suggested within the literature to be helpful in achieving positive outcomes for clients using violence, and wraparound services which help clients address additional challenges was emphasised across the data sources in this report. An important consideration in development and delivery of the pilot program, which is also central to queerspace/ds' practice model more broadly, was ensuring that the service was flexible in meeting the unique needs of the client. This flexibility could include the frequency of individual sessions, the nature of the work as more therapeutic or more practical, the range of case management activities carried out by the worker and the client, among others.

Lateral violence came up in the literature review and practitioner interviews, as impacting on people's risk for use and/or experiencing of violence, and the support available to them when they are being harmed. Awareness raising campaigns about family violence targeting LGBTIQ+ communities broadly could be impactful primary prevention strategies for reducing family violence. The WeDeserve project at queerspace/ds, which took place from mid-2018 to mid-2019, engaged trans and gender diverse communities in coproduction of a series of short films highlighting what respectful relationships look like for them. The project employed a TGD lived experience creative workforce to develop and produce the films, and targeted TGD community and family violence sector as part of a village appraisal process. These types of projects on a larger scale could be helpful in creating shift towards nonviolence for these communities.

While specialist transition to parenthood supports were outside the scope of the pilot interventions, this would be an important cohort to target with future initiatives, as the literature, as well as practitioner and client interviews suggested an increased risk during this time period. queerspace/ds are now undertaking a research project to further explore LGBTIQ+ family violence in the transition to parenthood, with a view to develop interventions and capacity building initiatives to address it.

Pilot Interventions

Introduction to the intervention

A pilot program was developed for and delivered to LGBTIQ+ women and gender diverse people who used violence. This program was funded by the Victorian Department of Health and Human Services and was delivered by queerspace in a community-based setting. The fact that queerspace/ds was funded to develop and deliver the pilot intervention, and to carry out the research project discussed in this report, allowed for added value across each of the two projects. In response to the limited knowledge base available about LGBTIQ+ family violence, the pilot program was based on an Integrated Service Response (ISR) model, which involved support by separate Therapeutic Family Violence Specialists being provided to the person using violence, and the person/people being harmed where safe and appropriate, with supervision and oversight by a Senior Practitioner. Note that drummond street also developed and delivered a prison based pilot program, funded by the Victorian Department of Justice and Community Safety, for women and gender diverse people who had used family violence. This was based on a similar model, but because it was not specifically for LGBTIQ+ people, it has not been explored as part of this report.

There were a number of key components of the program delivery. A comprehensive family violence risk assessment allowed for thorough exploration of what violence looked like in the families the program served, and ongoing assessments meant that practitioners were able to explore the use of violence and its dynamics, rather than making assumptions based on referral information. It allowed practitioners to work with those using violence and the people they had harmed in a dynamic way that managed risk and allowed practitioners to help people address their use of violence, while assisting those who had been harmed with recovery. Services for LGBTIQ+ participants in the program were delivered by LGBTIQ+ identified practitioners, and intake and introductory processes recognised and included LGBTIQ+ identities, for example by allowing people to self describe gender, and by including an option to introduce one's pronouns along with their names. The support provided within the ISR model included both individual therapeutic case management and a group program, delivered to those using violence concurrently with the individual work. Where affected family members were engaged with the service, they were provided individual therapeutic case management support only.

Therapeutic case management support

A key component of the intervention was individual therapeutic case management support delivered to participants. This reflected the importance of wraparound support to address co-occurring challenges such as material resource instability, mental health, and AOD misuse in promoting positive outcomes for people using family violence, as established in this report. A team of four staff contributed considerable time to individual work with participants over the course of the pilot, matching the skill set, gender and sexuality of the

team with the client's needs. Rather than being offered consecutively to the group program, the individual support was concurrent. The aim was to provide participants with the opportunity to unpack some of the issues that came up for them in the group each week, and to address their individual needs outside of the group format. The type of support provided included therapeutic counselling, case work and advocacy, including but not limited to warm referrals to sexual assault, AOD, legal or housing services, support with applications, and the provision of brokerage funds and/or letters of support.

Group program

A group program was delivered across 17 sessions to people who had been identified as using violence. The program reflected many of the key learnings from the data collected as part of this research project. For example, it was developed as a trauma-informed intervention, recognising that many people who use violence have also experienced violence. The program emphasised empowerment, building on the strengths of participants. The content included discussions of what violence and abuse look like, and promotion of nonviolence in how people relate to others. Group sessions were offered once per week, and were two hours each in length, with some running longer depending on how the group moved through the content, with each session delivered by two practitioners over a total of approximately 42-45 hours per group. The program was flexible to meet the needs of each participant. This included responsiveness to people's learning styles, cognitive abilities, and/or need for Auslan interpretation. The content emphasised the significance of structural hierarchies of power in the maintenance of an environment which enables particular forms of violence. It also took a collaborative, experiential approach to learning, rather than a didactic one. For the program outline, including session objectives, please see the Appendix F.

Attendance & completion rates

While there were only twenty-two participants, they showed significant interest and investment in the program and there were high rates of attendance, with a 73.5% attendance rate across individual and group sessions in the Futures Free from Violence program.

A total of eleven people took part in the group program for people who had used violence. Of those, there were four participants who were highly dedicated to the program, with two completing all sessions, and two missing only two of the 17 sessions. Two attended five sessions and one attended 7 sessions. Four participants attended only one or two sessions. The 73.5% attendance rate across the pilot program reflects the fact that, even where clients did not engage with the group program, individual sessions were extremely well attended.

As is discussed further in the client and staff focus groups, at the beginning of the group, there were larger numbers of participants, and there were differences among them in terms of readiness to take responsibility for their actions and make changes. Those who were not yet in a state of readiness for change dropped off, and the remaining group members spoke

to the value of having a smaller group of participants who were highly motivated to get as much as possible out of the program. Excluding those participants who did not continue with the group after 1 or 2 sessions, the rate of completion of at least 75% of the content for the group program was 57%.

Program evaluation

The evaluation of the pilot program included monitoring of attendance and completion rates; pre/post assessments of mental health and wellbeing, and relationship quality; focus groups with staff and clients to provide insights around program impacts, and development of case studies to illustrate how clients were supported through the pilot. Because of the pilot timelines, and because few affected family members wanted to engage within the ISR, assessment of changes in behaviour fell outside the scope of the evaluation for this report. Given the program is ongoing, measuring this impact in the short and medium term will remain a priority of the research team.

The pre/post evaluation questionnaires included in this phase of the evaluation included the General Health Questionnaire (GHQ12) to measure general health and wellbeing, and selected LSAC measures to measure social isolation, financial distress, and relationship quality at the point of intake and then again at the fourth and final session. Reductions in violence were to be measured using post reflective interview questions (for both those using and experiencing violence) carried out by practitioners at the final session, with follow up future interviews by the research and evaluation team for clients who consented to this process.

A number of clients engaged in the program did not consent to participate in the evaluation or for their data to be used for research and evaluation purposes. Of the sample of clients who did participate, a small sample (4) were highly distressed at their first session and were unable to complete a sufficient number of questions within the questionnaire for their responses to be included. As a result of these issues, there were not enough pre/post matched questionnaires to generate outcome data. Post reflective interviews have been limited to date given that the majority of clients who participated in the trial have continued to receive individual support. The research team will work with program staff to resolve some of these issues for the ongoing evaluation of the trial.

Staff focus group

A focus group was conducted with four program staff. The conversation included the unexpected aspects of the program context; the ISR in practice; the impacts of the program as a whole; and the value of offering group work alongside the individual therapeutic case management support.

Limitations of program context

Practitioners spoke to the importance of a service system which supports those who are engaged with it at every point. At this point, this is not the case in the service system within which the program was embedded:

> "We are working in a crisis space, and at an intervention level; it's a continuum. If we didn't have access to brokerage, we would be in real trouble. For some people we're working with, they're not even able to access the service system in ways that would support them. Often, we're looking at safe housing [because mainstream crisis supports were unsafe or unavailable to our clients]. The program was conceptualised based on the assumption that there would be services around us, so we had to deviate from the original idea."

This context necessitated much more crisis response work than was planned, which meant that there was less capacity in terms of the number of clients the program could serve. This highlighted how far the sector had to go to adequately meet even the crisis needs of LGBTIQ+ people who had used or experienced family violence. If this capacity were developed, it would support the work of interventions designed to effect behaviour change.

Value of an integrated service response

The ISR was developed based on the limited knowledge base that exists around LGBTIQ+ people's use and experiences of family violence. It recognised the need to be responsive to risk levels which may be complex to assess, and the fact that misidentification by the service system and by LGBTIQ+ people themselves was very common. Practitioners discussed how crucial to their program integrity it was to be able to provide support both to those using harm, and those being affected by that violence:

> "Something this experience has shown is that people show up for something they identify with. So if you say this is a program for people who have used violence in a relationship, a whole lot of people in the world will resonate with that in some way, and so we're opened that door for them, but that could include all kinds of different people. Some may be people who have been behaving abusively, others have been misidentified by the legal system, others have been convinced that they are violent by their abusive partners. Whatever door you open, the people running the program have to be prepared to hold space for all of that complexity and sort out what's going on in people's lives. In some ways, what matters is that there is a door open for people to come through. Once they are in, there is a wraparound response that can sort out what's going on and support them wherever they're at. If we didn't have an integrated service response, we wouldn't have been able to support some of those people at all. If we found, no, you're actually a survivor."

Impacts of program

While practitioners cautioned that conclusions about the impacts of a family violence intervention should not be drawn out without longer term contact with those who were harmed and those using violence, practitioners shared their observations about how the program seemed to be making a difference to the families it engaged:

> "I have had incredibly moving conversations with people I am supporting about things that have shifted for them, in terms of how they view their own behaviour, how they understand the impact of their behaviour on their partners, and I have every reason to

believe that change is occurring. But I would not say definitively that change had happened until we speak to the person using violence and the affected family member in a year's time, in three year's time, about what the change has been in their life as a result of the program. Only the affected family member can tell us whether there has been real change, and whether their everyday experience of choice and freedom has shifted."

"Certainly there are examples we can point to where, from the information we're getting from clients, and in line with my professional assessment and where I have seen significant change occur in the past, I can say, yes, I believe significant change is happening here."

Practitioners spoke to the importance of the therapeutic case management support in enabling change for clients. They provided a wide range of therapeutic, and practical supports to clients including around legal matters, homelessness and substandard housing, and access to other material resources. The interconnectedness of the family violence and co-occurring challenges in terms of potential for change was emphasised by practitioners:

"I am supporting someone living in their car. All their income is going to pay the mortgage and bills for the family home where they are not living, and where it would be terrible for everyone if they were to live, they are living on $20 per week. Even providing them with grocery money each week has been really impactful. They were getting to the point where there was so much pressure on them just to live, that was then going to put pressure on their partner to have them move back in, which would then put the partner, the children, and my client in danger. So it's all connected. If we couldn't address that immediate material concern, we couldn't address the safety problem. That's only one example but here are so many where a bit of material support and legal support, actually enables people to move toward greater safety."

Group work

While a significant component of the program as a whole was the therapeutic case management support being provided within the ISR, the concurrent group work allowed for important reflections and conversations for clients. Another major benefit of offering the group program was that it brought people through the door:

"Certainly, running groups was a huge part of engagement. Most people that we have in the program came through word of mouth; that's how things tend to operate in our community, not through seeing a flyer, but through networks of trust. A lot of people came because they heard there was a group. People said they had been waiting years to sit down in a room with others who had caused harm in relationships and have robust conversations about their behaviour, their relationships, and change. That's been echoed over and over again in the group and in individual work. I think there is a value that is placed on group work, and in working together in community; there is something about that shared experience."

Facilitators noted that participants who were not ready to move towards change dropped off from the group in the first few sessions, promoting a sense of safety and allowing vulnerability among those participants who remained. According to facilitators, clients were able to speak in a way that was very open, and they were willing to challenge themselves. One facilitator described how participants spoke of the group's progress:

> "It had been quite intense, with group hitting peaks for their learning at different times. It was moving for individuals during that time to see the group make that progress. One group member commented that at the beginning, some weren't ready to do the work, and their own sense of doing harm. They were there to give excuses for their behaviour and wanting to be supported in that. There was a natural drop off with these participants not getting what they were wanting. Those who remained were really ready to do the work."

Also discussed was the value of group work in allowing for a community approach to harm reduction and accountability:

> "They also were able to learn from each other; one person would give an example of something that they tried or that worked for them. If you can get people talking about behaviours they want to change in that public setting with peers who can hold them accountable, this can be a positive step towards change. If facilitation is highlighting issues with accountability, minimisation, blaming, etc., it [provides] opportunity for [the] whole group to hold people accountable, and this may be easier to hear than from someone in a position of perceived power or privilege."

According to facilitators, a strong sense of safety had been established among the group participants, allowing them to be vulnerable with each other and challenge themselves. In speaking about work around accountability, one facilitator said, "While that's a difficult space, they were able to work through difficult things together; [the group] had great strengths. They were able to speak in a way that was very open and willing to challenge themselves."

The facilitators discussed the importance of processing what had happened in the group in the individual therapeutic work. When doing work in both formats concurrently, the group provides some space to breathe, and also allows participants a sense of belonging, even when they are not physically in the room.

Client focus group

A focus group was conducted with four participants who attended the final session of the group program. The focus group explored the clients' perspectives on the concurrent individual and group work, the group program structure and content, and the impact of engagement with the pilot program more broadly.

Concurrent individual and group work

When asked about the importance of the individual work and the group work, to assess which of these components were more important in achieving the program objectives, clients clearly expressed the importance of combining the two components. Those who engaged consistently in the individual work, stressed that having the space to work through their individual needs and to further unpack themes raised in the group sessions, helped them to get as much as possible from the program. Participants made the following comments:

"I think it's imperative that they go together. The one on one can be quite intense. You get to recap what's happened in the group and speak about that. In the group, it gives you breathing space. Because you're working with other people, you get to have some space, and still be engaged, but not push yourself the whole time. My one on ones were quite structured. There was a part at the beginning that recapped the group, had a chat about where my head was at going forward, and then we were back in group again."

"Strongly recommend the two together. The group work is the most effecting therapy I've ever done. I've done a lot of therapy, and this was the most effective thing. But safety in the group is really important. The combination of the group with one on one support is really powerful."

Group Program Structure & Content

Participants all expressed how valuable the whole group discussion was in allowing collective inquiry around the topics of hierarchy, oppression & violence, consent, coercive control, respect, and accountability. Clients found that when role plays were acted out with the whole group able to engage, and with facilitators taking part, the process was much more valuable than when they were paired up and working independently:

"[It was less helpful] when they would pair us up and we had to dive into things ourselves. It was good to self-reflect, but It was always better to do that with support, in the circle. When there was a larger group, they couldn't do that as much."

"Role play was good too. Quite confronting, quite daunting; you're quite vulnerable. Obviously when you're being confronted so much with something it's triggering, where you want to look at shining a light on those areas you want to have a look at. We did it with each other, which was good, but most helpful was when it was with facilitators; they could pull us up on things where we had blind spots with. That was the most helpful."

In terms of the length and number of sessions, clients commented that having the sessions between 6 and 9PM didn't feel like enough:

For me, the only negative was, some nights we would be really on a roll, and then it was like, time's up, the night ended. Right when you were really at the point of a poignant, important conversation, to have that shut down doesn't really allow it to roll over to the next week and keep that fluid conversation going again. For me, the program could go an extra hour.

Clients had the sense that between 17 and 20 sessions was likely a fairly good number to ensure that there was time to establish rapport and really engage with the work. They also commented that a smaller group size was much more conducive to work than larger group sizes:

"I also find that the smaller the group, the most we learned. The deeper we could dive. In larger groups we had to split in half to do those activities. When people didn't turn up, that's when we had the most in depth conversations."

"I would say, half a dozen participants, that would be max."

Impact of Engagement with the program

Clients all spoke to the significance of their engagement with the program. All of them found that they had a new awareness of their behaviour, a new motivation and the tools to make effective change. One client noted how the learnings from the program impacted upon how she noticed abusive behaviour that was all around her as she moved through the world:

"I didn't have much of an understanding of abuse, what abuse was. For me, I was mortified that someone would find me abusive, find me controlling, minimising someone's feelings, I never attached that to abuse. Now, I'm getting a really good understanding of what that is. Now I see it everywhere, in the workplace in the home, in the pub. That's good and bad. I don't like to see that all the time, but it was really helpful to know exactly what this thing looks like, to explore it a bit and the background to it."

"Exploration of different behaviours and background into why some of those present, really having a look at it, an inquiry into those things. The group was a slow burn; once we all got into it, there were some really inspiring things that came out of it. I was interested in why something presents the way it does, and then the beauty of that inquiry coming into fruition is that we could all think about a better way of dealing with things."

"Collective inquiry offered an opportunity for exploration of how experiences…I was walking very skeptically, and it was like, Oh shit! That relationship [among group members and facilitators] helps build the experience until it's ripe, and then you realise something. The group work is powerful in that sense. Especially when it's done so safely and patiently. I can't speak more highly of the process. It's the best thing I've ever done."

"I feel a lot better. I've gotten the opportunity to start a dialogue with myself that makes sense, because it's with other people. Bounce ideas off others, gain insight into the intricacies of abuse. I have regained trust in myself that I am capable of knowing, learning, changing. I have been given that opportunity to change. I can't be more grateful to everyone in this program, because it's just completely changed everything for me."

Case studies

The following de-identified case studies were prepared by one of the Therapeutic Family Violence Specialists to depict the complexity of the experiences of clients the program supported. They illustrate how the program responded to the individual needs of clients.

Cassie

Cassie is a cisgender, lesbian woman in her late twenties. Cassie was referred to the Futures Free from Violence (FFFV) program by her criminal defence lawyer. This lawyer was representing Cassie in family-violence related matters and believed that Cassie's participation in FFFV would reflect well on her and indicate to the magistrate that Cassie was engaged in taking responsibility for the impacts of her behaviour.

Cassie was arrested and charged after an incident in which Cassie smashed some of her girlfriend Sasha's property at the home that they shared. As well as criminal charges, this incident resulted in an Intervention Order (IVO) which included exclusion provisions, obliging Cassie to leave the home, making her homeless.

On entering the program, Cassie and Sasha were engaged as part of the Integrated Service Response model, with separate therapeutic family violence specialists working with each party, overseen by the practice lead. They each attended two individual assessment sessions with their practitioners. Cassie expressed high levels of shame and remorse about her behaviour, anxiety and suicidal ideation.

Through a rigorous assessment process, it became clear that the long-term dynamic of Cassie's relationship with Sasha was one in which Sasha used aggression, intimidation, threats and emotional abuse to achieve coercive control over Cassie's life. The incident that lead to Cassie's arrest positioned Cassie as the only person using violence within the relationship, oversimplifying the complex power dynamics and use of violence in this case. Like many victim/survivors of abuse, Cassie had for a long time blamed herself for the abuse she experienced and experienced very low self-esteem. Cassie's arrest and criminal charges, especially the way that she was spoken to by the police, her lawyer and her magistrate, compounded her feelings of self-blame and shame and encouraged her to see only herself as the problem.

Due to a high number of cases like Cassie's, where a victim/survivor had been misidentified by their community or the criminal justice system as the only perpetrator, FFFV practitioners created a separate group program for people who had used physical force in response to long term abuse. Participants came into this group identifying themselves as "perpetrators"

and experiencing extremely high levels of shame often coupled with suicidal ideation. Through group and individual sessions, participants were given space to recognise their common experience of also being abused. This group became an invaluable space for mutual support and healing.

Sasha, who was not yet sufficiently ready for change, was supported by her practitioner in individual work only.

Cassie's ability to participate in the group was severely hampered by life circumstances resulting from her experience of abuse, especially homelessness. Having been identified by the Criminal Justice system as a perpetrator, Cassie could no longer access family violence support services such as Safe Steps or Berry Street. Meanwhile, Sasha continued to use threatening and harassing communication, including threats to kill, to isolate Cassie from friends and community, prevent her from staying in work and exacerbate her self-blame and self-loathing.

A vital early stage in the work with Cassie was supporting her to believe that she was someone who deserved to be supported at all. In tandem with this work of healing, Cassie's individual worker supported her with intensive family violence case management. For example, Cassie's worker supported her to take out an IVO against Sasha and to report breaches of the order when they occurred; wrote a professional assessment of Cassie's situation for her magistrate and supported her during her court proceedings; purchased emergency accommodation for Cassie on more than one occasion after she was turned away by housing services; and provided direct financial aid for groceries and transport. Difficulties with securing housing ultimately drove Cassie to move back in with Sasha for a period, during which Cassie's support worker provided her with intensive, daily support with safety planning, risk management and negotiation. Because Sasha was still engaged in individual support with another FFFV practitioner, the senior practitioner was able to monitor the safety of the couple through the two practitioners.

Working closely with Cassie, her worker was able to advocate for her to be returned to the social housing register, a process which required agreement from both Sasha and from the Department of Health and Human Services. Throughout this period, Cassie was provided with individualised therapeutic support, largely over the phone, focussed on understanding intimate partner violence, recognising warning signs, negotiation, fairness and responsibility.

About her experience with FFFV, Cassie said: "*I've been accessing support services for over ten years and I've never had an experience like this. You treated me not like a client, but like a human being. You actually listened to what I needed most and did a lot of work to make it possible. I really believe now that I'm going to be ok.*"

Willow

Willow is a non-binary transgender person who is attracted to people of all genders (bi+ or pansexual). Willow self-referred into the Futures Free from Violence (FFFV) program after hearing about it through networks of trust within the LGBTIQ+ community. Willow had been

told by more than one former sexual partner that their behaviour was controlling and abusive, but expressed feeling unable to understand exactly what they had done wrong or how to change.

Willow entered the program expressing high motivation to change their behaviour. However, they also entered with a profound sense of hopelessness about their capacity to change, symptoms of depression and significant suicidal ideation. Willow described having experienced major barriers to accessing supports to address their mental health and their use of violence. Services that Willow had previously accessed had either not understood Willow's experience as a transgender person, or colluded with their violent behaviour, or both.

At the time that the program began, Willow was experiencing homelessness after being suddenly evicted from a shared housing situation by other residents who did not feel comfortable after learning about Willow's past abusive behaviour. Willow's transgender status made it extremely difficult for them to access housing services or to find a job. Being Assigned Male at Birth (AMAB), Willow was also unable to access mainstream family violence support services even though they are also a survivor of family violence.

Willow's FFFV case manager supported them to find secure housing and stable employment through LGBTIQ+-affirmative organisations. Willow later described these as essential preconditions for them to meaningfully participate in FFFV: *"While I was worrying every day about how to get money or where to sleep, I could never properly engage in a process of change that involves being emotionally vulnerable. I had my guard up all the time. Now I feel like I can open up and things are starting to shift in my relationships."*

Willow participated in the FFFV 17-week group program for queer women and trans and gender diverse people who have used violence or behaved abusively in an intimate relationship. Willow also received intensive individual counselling and case management. By the end of their time in FFFV, Willow expressed that they felt more aware of how they tended to coerce and control partners and of the impact of this behaviour. They also expressed high motivation to continue the work of accountability, electing to receive ongoing individual counselling with a practitioner specialising in behaviour change.

In reflecting on their time in the FFFV program, Willow stated that they found the combination of individual and group work invaluable: *"There are things that I could not have learned about myself if I didn't hear them from other people with similar experiences to me. At the same time, there are things that came up in the group that I needed to explore more and the time with my individual counsellor was essential for that."*

Willow also emphasised the way that the program reduced their isolation and encouraged them to believe that change is possible: *"Overall, it was so important to me to feel seen and supported in this process of change by other trans people including transgender practitioners. It was also very profound for me to interact in a group setting with other people who had behaved abusively and be treated like a human being... but at the same time know that the*

facilitators were there to make sure we did not collude and supported each other to be accountable."

"Many other people have responded to my behaviour by cutting me out and isolating me socially. These practitioners are the only people who have ever made me feel like they really understood my experience and really believed that I could change, and I don't know if I would have made it to today without them. I can only hope that programs like this continue and are made available to more people in the future."

Summary of evaluation findings

The evaluation of the pilot was limited by the small number of participants, as well as the fact that consent was not given by many for participation in research and evaluation. However, the preliminary learnings suggest the value of incorporating some key elements indicated in the data included in this report.

The pilot interventions were delivered by LGBTIQ+ identified practitioners in keeping with the practice values of queerspace/ds, including being inclusive and responsive to the needs of the communities being supported. From the client focus group, the participants felt a deep sense of safety and support in the group program, which facilitated their learning and reflection. This suggests that provision of programming by specialist LGBTIQ+ services may be beneficial to clients, and that further benefit to clients may be possible with capacity building within mainstream services.

The facilitation of the group program was trauma-informed, collaborative and non-coercive in approach, in response to the data suggesting the value of these to work around the use of family violence. Clients spoke to the value of having practitioners with lived experience of LGBTIQ+ identity in fostering a space where they could feel safe to discuss, and reflect on ending harm they had caused. They also noted the skills of practitioners in identifying, and supporting them to hold themselves accountable for even the most subtle ways that power and violence may have been operating in their language and interactions with one another during role plays and group discussions.

From the data in this report, social hierarchies of power are profoundly significant in allowing and sustaining violence, including family violence. The content of the group programs reflected this by not only having sessions focused on power structures, but by incorporating a structural lens across the program. The helpfulness of increased understandings of violence was also raised within the practitioner and client interviews. One of the most significant impacts for clients of the group program was the discussion and increased awareness of how social hierarchies of power shape our relationships to others and to ourselves, and this gave clients a sense that they could move towards change. The adaptation of the program to further focus on this content seemed to be effective in fostering awareness of abusive behaviour, both around and by participants.

The findings across the data triangulated within this report indicated the importance of flexibility in program delivery for individual clients. The interventions were therefore

designed to be flexible to participant needs, including with the provision of individual and/or group work, as appropriate, as well as the diverse advocacy and support activities. The therapeutic case management activities and brokerage funds allowed for clients to fully participate in the program, and to improve the safety of themselves and their family members. Some clients for whom the group was not appropriate were able to be engaged in individual work which supported them to make choices in moving towards nonviolence. This client-centred approach seems to have met the support needs of individual clients.

What has been very clear from this report is that effective intervention into LGBTIQ+ family violence is poorly understood. The intervention that has been developed and implemented around this project of knowledge-building about LGBTIQ+ use of family violence has been relatively small in scope and is in its early stages. However, the initial findings suggest the value of this type of specialist intervention, particularly given the dearth of available services for this cohort. Further knowledge building will be prioritised as part of the ongoing development, delivery, and evaluation of the program.

Limitations

There are a number of limitations to consider when interpreting the findings of this report. These pertained to the context in which the research was carried out, the limited number of participants engaged in each stage of data collection, and difficulties obtaining consent.

With the exception of the literature review, the data collection which informed this research was carried out with queerspace staff and clients. The data was therefore limited to the demographics of queerspace staff and client base, which is largely women and gender diverse people, and also primarily white people of Western/Anglo-European descent. The experiences and perspectives of cisgender men in LGBTIQ+ communities featured less than did those of women and gender diverse people. Further research which targets queer and trans Indigenous people and People of Colour (QTIPoC) would be valuable in centring those experiences and further exploring how intersectional forms of oppression impact upon LGBTIQ+ use and experiences of family violence. The vast majority of our staff and clients are based in the Melbourne metro area. There could be additional factors to consider in developing interventions targeting rural/regional communities which would not have been reflected in queerspace staff and client data. While we did identify that families in the transition to parenthood and with young children were particularly at risk for family violence, children were not interviewed as part of the research and evaluation project. This decision related to considerations of appropriateness and safety; it does not reflect the value of children's voices in this space.

The practitioner interviews engaged twelve individuals, and the client interviews only seven. The pilot program engaged only twenty-two participants, and only four took part in the group program focus group. The client file audit included only 47 cases. The diversity of experiences captured through these exercises is therefore limited to a small number of perspectives. While the evaluation was intended to include changes in violent behaviour from the perspectives of both those who had used violence, and their affected family members, it was not possible to gather this data due to low numbers of affected family members being appropriate or willing to engage, and the fact that for some participants, the work is ongoing. Also included in the evaluation plan was assessment of change in mental health distress levels, financial distress, social isolation, and relationship quality. However, there was insufficient data to yield findings because of high levels of distress at first session for many of the clients, some not giving consent to participate in research and evaluation, and some questionnaires being incompletely filled out or pre/posts unmatched.

Conclusions

Based on the triangulation of data from the literature review, practitioner and client interviews, client file audit and pilot project evaluation, the recommendations for interventions with LGBTIQ+ people who use family violence include the following:

- Services must be safe and appropriate for LGBTIQ+ people, and should use comprehensive assessment to establish an understanding of the use and experiences of violence in a family, rather than making any assumptions based on identity; this may include capacity building for mainstream family violence sector and related systems, such as the police and the courts
- Programs should include supportive structures that help mitigate dynamic risk, through ongoing assessment and supervision
- The trauma histories of people using violence should be recognised, while not being allowed to serve as justification of the use of violence against others
- Programs are more effective when they are flexible based on the needs of the individual or group of clients, including having services available outside business hours
- Programs which are integrated within broader organisational or service systems may be more effective than those being provided in isolation. Family violence services should address, or be linked with services which address other challenges which may trigger or escalate violence, such as AOD, mental health, and material resource insecurity
    - Housing support including advocacy and brokerage, and case management support more broadly around material resource insecurity could build clients' capacity to end their use of violence
- To mediate the impacts of social isolation, connection to community might be fostered where needed through case management support and/or warm referral to other services
- Families expecting children or transitioning to parenthood are a high risk cohort, who could benefit from specialised primary prevention and early intervention strategies

With ongoing delivery, development and evaluation of programs for LGBTIQ+ people who use violence, further learnings are likely to be generated to the benefit of the clients engaged in this program, as well as LGBTIQ+ communities across the country.

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Appendix

A) Practitioner Interview and Focus Group Discussion Guide

RISK FACTORS/CORRELATES

What did you notice were some of the commonalities among those who used violence? What did you notice were some of the commonalities among those who experienced violence?

PROTECTIVE FACTORS

With cases where violence is present, what did you notice helped minimise the violence?

With cases where violence is present, what did you notice helped end the violence?

With cases where violence is present, what did you notice helped them cope with the violence?

DYNAMICS

With clients you see who are experiencing or using violence, what does the violence look like?

- What were some of the specific behaviours or strategies employed by those who used violence?
- Were multiple people in the family involved in the use of or experiencing of violence? What did that look like?
- How often do you see retaliatory violence (e.g. if two people were using violence against each other, did one appear to be the 'primary' aggressor?)

What have you noticed are triggers for IPFV? Or have you noticed any patterns to the violence? (e.g. seemed to occur after xyz events/feelings/experiences)

What have you noticed are points of escalation for the violence? (e.g. unemployment? pregnancy? New birth? Recent separation?)

If one of your clients was using or experiencing violence, when did you fear they or their family member/partner were most in danger?

B) Client File Audit Tool

Fields:

- Age
- Education attainment
- Income
- Country of birth
- ATSI
- Disability
- Gender identity
- Sexual identity
- Partner's gender and sexuality
- Supportive family relationships
- Violence within family of origin
- Isolated from family of origin
- Childhood abuse physical emotional or neglect
- Childhood sexual abuse
- Witnessed parental FV
- Witnessed FV within the home
- Had to leave home due to violence
- Kicked out of home
- Experienced violence in former relationships
- Perpetrated violence in former relationships
- Perpetrated violence in other contexts
- Currently experiencing intimate partner violence
- Currently perpetrating intimate partner violence
- Currently experiencing violence in other contexts
- Currently perpetrating violence in other contexts
- Suicidality or suicidal ideation
- Suicide risk alert
- Anxiety symptoms and diagnosis
- Depressive symptoms and diagnosis
- PTSD
- Other mental health factors identified
- Identified trauma history
- Care seeking behaviours
- Dependence and tendency to depend on others
- Alcohol abuse
- Other family member/s alcohol use
- Drug abuse
- Other family member/s drug use
- Partner drug or alcohol problems
- Seeking support for AOD
- Other family member seeking support for AOD
- Low relationship satisfaction
- Dominance within relationship
- Partner/s dominance within relationship
- High levels of fusion
- Accommodating behaviours
- Partner/s accommodating behaviours
- Power imbalances in decision making
- Power struggling within relationship
- Heteronormative understandings of gender roles
- Unequal distribution of labour
- Unequal distribution of caring responsibilities
- Pregnancy
- Recent birth of a child
- Tension began/escalated after birth of child
- Violence began/escalated after birth of child
- Recent separation
- Impending separation
- Recent marriage
- Recent cohabitation
- Violence used against them in previous relationship/s
- Used violence in previous relationship/s
- Violence used against them in current relationship/s
- Using violence in current relationship/s
- Difficulty naming/identifying FV
- Identity shame
- Relationship shame
- Identity concealment
- Relationship concealment
- Expectation of discrimination
- Experiences of discrimination
- Experiences of harassment
- Experiences of homo/trans/biphobia
- Experiences of racism
- Strong community connections

- Limited/no community connections
- Good social supports
- Out about gender/sexual identity
- Fear of people within community knowing about FV
- Lateral violence from/within community
- Negative experiences accessing services
- Positive experiences accessing services
- Reluctance to access services
- Reluctance to engage law enforcement

C) Client Interview Questions

Risk Factors

Identity

How do you and your partner(s) or family feel about each other's identities (whether sexual, gender, cultural, religious, racial, etc.)? How do you show that to one another?

Are you connected to an identity-based community (such as an LGBTIQ+ community, religious community, cultural community, etc.)? What is your relationship with that community like?

If you or your partner/family member is going through transition, do you/they have access to the resources/services you need (inc. medication, surgery, counselling, administrative gender change, etc.)? How have you supported each other? How have you felt about it?

Early Life and Family Experiences

What was it like growing up in your family? What were your parents or guardians' relationships like? What do you see as your role in your relationship/family? Your partners' or family members'? How are those roles determined?

What role has violence played in your life, past or present? (including in or outside the home)

Discrimination

How have any of your identities impacted the way you've been treated (by individuals, communities, or societal structures)?

What have your experiences been like when trying to get support or services? How do you expect them to be?

Health

How is your/your partner(s)/family members' physical or mental health? If you act as carers for one another, what is that experience like?

Material Security

How have money and other material resources impacted upon your life and experiences?

Protective Factors

What are some of your self-care or coping strategies? Who do you talk to about things that are bothering you, or that you are finding hard to manage?

How has accessing services affected your relationship?

How has your knowledge of what intimate partner violence can look like had an impact on your experiences?

D) Client Focus Group Questions

Futures Free from Violence

1. What did you find valuable about the program?
2. What did you think could be changed or improved about the program?
3. What did you think about the structure, in terms of the number of sessions and length?
4. What activities did you find particularly helpful?
5. Were there any activities you found less helpful? What made them less helpful?
6. Were there any things you learned or otherwise got out of the project which you did not expect?
7. Have you noticed any changes to the way you feel, or your actions/choices?
8. What are your thoughts on the value of the group and individual work? Are both important? To what extent did they support one another?

E) Staff Focus Group Questions

1. How were affected family members engaged in the service? How was safety considered during these processes?

2. What were some of the concerns raised by clients about engaging with the service and sharing their experiences?

3. Were there changes in clients' level of risk from their assessments over the course of engagement with the service?

4. Which client groups were reached by the program? Were there any groups you were not able to engage?

5. Which clients, or groups of clients have experienced change, and what was the nature and extent of the change(s)? What has helped you to reach this conclusion?

6. Were co-occurring issues addressed through therapeutic case management? What were the outcomes of this support?

7. What processes did the team use to ensure client and/or family goals were reflected in the individual work?

10. Did client articulation of their use of violence and/or level of accountability shift over the course of their engagement with the service?

12. What do you think were the key benefits of the ISR?

13. Were there any unintended impacts of the ISR or or FFfV more broadly?

14. Were there any unintended consequences in terms of child protection outcomes for clients who have engaged in the program?

15. How can the engagement of clients be improved?

F) Program Outline & Session Objectives

Session Zero: Introductions and Consultation

The purpose of this session is to allow facilitators to learn more from participants about what they would like from this group program. This first session allows for participants to introduce themselves, meet other participants and develop a group/participant agreement.

Session One: Understanding ourselves and the stories of family, community, and society

To understand ourselves and how we are influenced by our relationships, the communities we grow up in and the broader ways that society thinks and operates, and to look at how our thoughts feelings and behaviours are connected to each other.

Session Two: The Four Pillars

Introduce and explore with participants Ellen Pence's Four Pillars framework. Foster & build awareness of how structures allow, produce, and condone violence.

Session Three: Entitlement Beliefs and Hierarchy

Explore societally embedded hierarchies with participants, and their interactions with these. Support participants to draw connections between hierarchies and entitlement beliefs. Identify how this may have impacted upon their own families and lives.

Session Four: Exploring Relationship Myths and Values

Explore critically how societal expectations can shape our concepts of normal, desirable, or ideal relationships. Develop understandings of the types of relationships we want for ourselves, and how these concepts might shape relationships differently.

Session Five: Exploring Strong Emotion

Reflect on how strong emotions, like anger, insecurity, and jealousy, can be useful, or may not be useful. Identify our existing strategies for managing less useful strong emotions, and build upon those by considering new strategies.

Session Six: Negotiation in Relationships

Explore understandings of negotiation in relationships, and how each of us has come to these. Identify how we negotiate with others to have our needs met, and what gets in the way of fair negotiation.

Session Seven: Coercion and Control

We aim to explore and gain a greater understanding of coercion and threats and their impact.

Session Eight: Non-controlling Behaviour and Negotiation

Identify situations in which we have been emotionally abusive to achieve a desired outcome. Practice recreating those situations, and collectively identify respectful actions we have been able to use, as well as actions to be improved upon.

Session Nine: Respect for Ourselves and Others

Reflect on our values and strengths, and consider how we stand up for those values in our lives, past and present. Consider how we might apply these experiences and skills to new contexts, and how we can stand up for the rights of others the way we have stood up for our own.

Explore the use of emotional and sexual abuse to harm partners and how this harm (and the threat of further harm) enable coercive control and result in an ongoing limitation of a partner or family member's freedom. Explore what respect means to participants and how it might look to centre autonomy, choice and consent in an intimate, family or sexual relationship.

Session Ten: Abuse as a Barrier to Respectful Relationships

Explore the context, objective, and impact of our harmful behaviours in relationships, and any ways they might reflect, or share commonalities with harm we have experienced. Identify nonviolence and respectful alternatives to our harmful behaviours.

Session Eleven: Finding Calm Ground

Explore strategies for reminding ourselves of our positive experiences and achievements, and reconnecting with important goals for the future. Create individualised Mood First Aid boxes based on the activities that resonated most with us.

Session Twelve: Attuning to the Needs of Children

Build collective awareness of how violence affects children's lives. Consider how we can support children to heal.

Session Thirteen: Exploring Accountability

In this session we we explore:

- What does honesty and accountability mean to participants, and to people connected to them?
- What would it mean to have honest relationships with ourselves in order to have accountability in our relationships with others?
- What does accountability in relationships lead to?
- What does it mean to be in relation with others without accountability?
- What could make the violence stop?
- What could prevent further violence?
- Who/What does the person doing harm care about?

Session Fourteen: Denying, Minimising, Justifying, Blaming

Explore denying, minimising, justifying, and blaming in the context of hypothetical scenarios. Start to think about this in the context of our own lives and relationships.

Session Fifteen: Practicing Honesty and Accountability

Explore denying, minimising, justifying, and blaming we may have engaged in in our relationships with others. Identify ways we would like to change how we might respond in a similar situation in the future.

Session Sixteen: Working together to End Violence

Consider how we might all engage with efforts to end violence, in terms of our own behaviour, our families, our communities, and society.

Session Seventeen: Graduation

Reflect on learnings from the program, and think about where to from here.