Mothers in Mind

Independent Evaluation 2016 - 2017

THE UNIVERSITY OF MELBOURNE

Mothers in Mind®
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children's protection society

Acknowledgements

The Mothers in Mind Evaluation Final Report has been prepared by members of the research team at the University of Melbourne. The primary author of this report was Larissa Fogden.

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Research Team

Professor Cathy Humphreys
Dr Margaret Kertesz
Larissa Fogden
Department of Social Work, University of Melbourne

For further information

Professor Cathy Humphreys and Dr Margaret Kertesz

Department of Social Work at the University of Melbourne

E cathy.humphreys@unimelb.edu.au

E mkertesz@unimelb.edu.au

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Executive Summary

1.1 Background

The Children's Protection Society (CPS) provides support services to vulnerable families and children living in the North East Melbourne metropolitan area. In 2016, CPS started to run Mothers in Mind, a group program for mothers and young children who have experienced family violence and separated from the perpetrator. This program was developed by the Child Development Institute in Canada, and has been evaluated over a number of years in Canada.

In early 2017, CPS contracted Department of Social Work at the University of Melbourne to carry out an evaluation of the Mothers in Mind (MIM) program, to include programs run in Term 3 2016, Term 4 2016, Term 2 2017 and Term 4 2017. The program due to run in Term 4 2017 was cancelled.

1.2 Evaluation aims

The aims of the evaluation were aligned to the MIM program logic:

1. To evaluate the extent to which the Mothers in Mind intervention changes mothers' understanding about the impact of DFV on attachment and parenting, and reduces emotional dysregulation and stress;
2. To assess the effectiveness of the Mothers in Mind program in improving mother-child relationships;
3. To identify how well the Mothers in Mind program fits within the Victorian service delivery system and how it should be adapted for this context.

> *[MIM] has put my life in the right direction, but there will never be a magic fix. There will always be things to work on.*

1.3 Methodology

The evaluation drew on a number of research methods, including a range of validated scales measuring program and client outcomes, a demographic survey, a client satisfaction questionnaire and post-group interviews with participants and CPS staff. With the exception of the interviews, all data collection conformed with the evaluation tools developed for MIM by the Child Development Institute, to ensure comparability with Canadian data and future Victorian data.

The findings from this evaluation are constrained by two factors.

1. The research team relied on data already collected by CPS for the two 2016 programs in consultation with the Child Development Institute. However, between the 2016 and 2017 program cycles, CDI revised its data collection tools and replaced the

validated scales used in 2016 with a new set of scales. This limits the degree of comparability between the program cycles.

2. The number of participants in each group, and therefore in the sample as a whole, is very small. The groups consisted of seven, six and five women respectively; demographic data is available for 16 women.

These constraints mean that the evaluation findings are not generalisable, and conclusions should be treated with caution. They form a basis of comparison for future evaluations, and are an indication only of MIM's effectiveness.

1.4 Findings

- MIM is reaching its target population – women who have experienced domestic or family violence (DFV), who are no longer living with the perpetrator of violence and who have children under four years old. This appeared to be due to a rigorous assessment process at intake.

> *It brought back a little bit of who I was and I haven't been able to feel that in a good seven years.*

- Mothers noted a positive change in their relationship with their children after participation in MIM, and attributed this to being better able to understand their children's behaviour and respond appropriately. Levels of emotional closeness did not change significantly where this was measured.
- The 2017 group was mostly a well-educated and articulate group of mothers, and those interviewed were able to describe what they had learned about the impact of DFV on their children and their parenting.
- While the mothers had a good understanding of child development and parenting strategies, MIM boosted their confidence in their parenting and ability to put boundaries in place for children's behaviour.

> *I think coming out of the program, with all those things we've used there about being fun and caring and understanding and just gentle, it's really helped.*

- The self-care component of each session and the take-home quotations were powerful tools in encouraging mothers to view themselves with greater compassion. Mothers re-learned the importance of small self-care actions in boosting their self-confidence, which in turn improved parenting confidence.

- Mothers' feelings of isolation before and after MIM were at concerning levels, but were alleviated during the program by:
    - the opportunity to connect with other mothers with similar experiences.
    - the warm engagement between facilitators and mothers, both in a group context and on a one-to-one basis, which allowed mothers to talk about their feelings and the challenges in their lives.

> *The phone calls during the week – I know towards the end I couldn't answer them because I was very busy, but just knowing someone is calling to see how you're going and stuff, it's kind of like – well, damn. That's what I've wanted my whole life.*

- In its current form, MIM has limited capacity to assist participants on an individual basis with external factors causing stress, anxiety or depression.
- MIM was seen by some mothers as a catalyst for further change in their lives, a step in the right direction.
- The positive impacts of participating in the MIM program continued to be felt six months after completing the program.

1.5 Issues identified by participants and facilitators

Participants were generally happy with the program and would recommend it to other mothers. However, both participants and facilitators raised some practical issues.

- The group venue needs to be large enough to allow children active play. The room at the Heidelberg site was a little small.
- Mothers found it difficult to focus on adult discussions when their children were very close by, due both to the distraction and to the concern that children hear distressing subject matter. An extra facilitator could help with the children or individually support mothers as needed. The MIM session guide recommends one facilitator for every two mothers.

> *I've [now] seen these other mums and they still have their days . . . but it was like, look how far they've gotten in just a year or two years. It gave me so much hope that…it's going to be okay.*

- Morning sessions are most appropriate for this age group of children, who tend to nap in the afternoon.
- A small proportion of participants came from culturally and linguistically diverse backgrounds, with some extra challenges in terms of engagement and language.
    - Normal parenting styles from the participant's culture should be identified during the pre-group assessment period.

    - During sessions, extra support should be provided as appropriate with language or reading problems.

- Group participants at different stages in their journey away from domestic or family violence may have different support needs. Facilitators need to take changes in support needs over time into account when managing disparate groups.
- Recruitment issues
    - Referrals to MIM have tended to arrive shortly before each group's commencement, causing difficulties in engaging and assessing potential participants in time.
    - Recruitment has been most successful in maternal and child health services where workers were aware of the importance of mother-child work in DFV contexts, and within the NEMC-FS alliance, where professional relationships with CPS staff are presumably strongest.
    - A recruitment strategy communicating the target population, the need for assessment and actively "selling" the program to services may be necessary to promote timely referrals.
    - Recruitment problems for the Term 4 2017 program were exacerbated by the provision of the better-resourced Children and Mothers in Mind program.

1.6 Recommendations

The data collected from this small sample of mothers and program facilitators, and in particular their comments about their experiences of MIM, lead to the following recommendations.

1. That a component is added to the program to allow mothers time (separate from their children) to learn more about DFV and its impacts and to engage with their own trauma issues.

2. That session content is delivered with flexibility to ensure that the content remains relevant and resonant for women at different stages in their journey away from violence.

3. That casework capacity is built in to the facilitator roles so that mothers and children are supported in dealing with:
    - external stressors such as housing, court processes, contact arrangements between father and children, or social isolation;
    - child-specific issues.

4. That program planning makes MIM relevant and engaging for mothers from culturally and linguistically diverse backgrounds. This could include:
    - discussions during the assessment process of parenting norms within the participant's culture;

- provision of extra support as appropriate to help with language or reading difficulties.

5. That facilitators continue to be highly skilled in DFV issues and child and family casework, and become very familiar with the program. Ideally, facilitators should gain experience of running the program repeatedly over time to build these skills.

6. That one facilitator is present for every two mothers, as recommended in the MIM session guide.

7. That the program is run in a larger space, with room for children to play separately from their mothers, and with the possibility for active play.

8. That program sessions are held in the morning so as not to clash with afternoon naptimes for young children.

Background to the Research

1.1 The Children's Protection Society

In early 2017, the Children's Protection Society contracted the University of Melbourne (Department of Social Work) to carry out an evaluation of Mothers in Mind, a group program for mothers and young children who have experienced family violence and separated from the perpetrator.

The Children's Protection Society (CPS) is a child welfare organisation that has provided support services to vulnerable families and children since 1896. Since the mid-1980s, CPS has turned its focus towards providing an array of support services to families living in the North East Melbourne metropolitan area. These support services include Intensive Family Services, Fathers programs, Mentoring Mums, ChildFIRST, Therapeutic Services, Professional Development and Education and innovative early education and care programs.

The overarching vision of CPS is that all children and young people thrive in resilient, strong and safe families and communities. Its mission is to nurture, support and strengthen the life chances for vulnerable children, young people and families. CPS has shown great commitment to contributing to the evidence base of a wide range of interventions to support families and children and has over the years become the site for several large research and evaluation projects. This commitment to best practice is in line with the CPS values, which emphasise hope, integrity, leadership and accountability to the community.

CPS works closely with nine other family service agencies in north east Melbourne, as well as DHHS Child Protection, in a partnership known as the North East Metropolitan Child and Family Services Alliance (NEMC-FS). The purpose of the NEMC-FS Alliance is to provide a high quality, integrated and culturally responsive system of support for vulnerable children and their families living in the north-east Melbourne area.

1.2 Domestic and Family Violence in Victoria

Domestic and family violence (DFV) has a profound ecological impact upon the Victorian community and broader human service systems. DFV directly affects one in five Victorian women over the course of their lifetime (Australian Bureau of Statistics, 2013). Furthermore, over half of women who had experienced perpetrated by their partner have children in their care at the time of the violence (Cox, 2015). The Royal Commission into Family Violence (State of Victoria, 2016) and the Victorian Government Department of Health and Human Services' *Roadmap for Reform: Strong Families, Safer Children* strategy (DHHS, 2016) have provided opportunities for the child and family service system to re-examine their services and identify areas for improvement in the pursuit to prevent neglect and abuse, intervene early and secure better futures for children. Family violence is a common issue within this geographical region in which CPS operates, with 2015-2016 data reporting that 234 incidents of family violence on average were reported to the police every week (Women's Health in the North, 2016). CPS has recognised the need to provide targeted support to both victim/survivors and perpetrators of family violence and implemented a range of evidence-based interventions for mothers, fathers and children.

1.3 Domestic and Family Violence and the Mother-Child Relationship

Research indicates that domestic and family violence (DFV) can reduce the quality of the relationship between a mother and her child (Hooker, Kaspiew & Taft, 2016). Perpetrators of violence use a variety of tactics to directly and indirectly undermine mothers, with the aim of reducing women's confidence in their ability to parent effectively, and isolating mothers from their children (Holt, Buckley & Whelan, 2008; Humphreys, 2011). Directly, perpetrators may physically attack mothers, leaving them incapacitated and physically unable to respond to their child's needs (Humphreys, 2007). Indirectly, perpetrators may constantly criticise or humiliate women and their parenting, often in front of their children, or otherwise manipulate children in ways that further undermine her parenting (Thiara & Humphreys, 2017). Children who have been exposed to DFV often exhibit aggressive, attention-seeking and oppositional behaviours, causing further parenting challenges for mothers who may already be struggling with their own mental health (DHHS, 2013). Attachment theory provides insight into understanding the effect upon children when the mother-child relationship is undermined by perpetrators of violence. Forming a secure attachment to a primary caregiver during infancy is crucial to an infant's brain development, psychological, social and emotional growth, lifelong sense of security and ability to create and maintain meaningful relationships (Buchanan, 2008). Mothers who have experienced DFV may have difficulty responding to the needs of their children, making it difficult for these attachment bonds to form.

> *I didn't really understand how [DFV] would affect my relationship with the kids…just learning about that has helped me manage it a lot better with the kids' behaviour and reinforces the fact that I can't really take things to heart. I overlook some of their behaviour sometimes to get through because they're just responding to the stimulus that they're given and the stress and the exhaustion and everything that they're put under.*

There is emerging evidence that interventions that focus on strengthening the mother-child relationship after separation from perpetrators of violence may help to reduce the long-term effects of exposure to family violence for both mothers and children (Hooker, Kaspiew & Taft, 2016). After separation, the mother-child relationship continues to be affected by the 'absent presence' of the perpetrator, that is, the perpetrator's actions continue to impact mothers and children even he is no longer physically present in their lives (Humphreys, 2011). When mothers have the opportunity to participate in interventions that assist them in strengthening their relationships with their children, re-establishing themselves as parents away from the control of the perpetrator and rebuilding their confidence as parents, they can reduce the effect of this 'absent presence' and improve outcomes for both themselves and their children (Thiara & Humphreys, 2017).

1.4 Mothers in Mind

Mothers in Mind (MIM) is a relationship-based early intervention group program for mothers and children, developed in Canada by the Child Development Institute. Informed by principles of trauma-informed practice and attachment theory, the focus of the 10-week group program is to intervene early in the lives of children whose mothers have experienced family violence or other hurtful experiences, to improve child outcomes and reduce the number of children and families requiring intervention from DHHS Child Protection. The ten-week program is designed to strengthen mother-child relationships, enhance parenting skills, reduce parenting stress and improve parenting self-efficacy. Throughout the program, mothers learn specific strategies for parenting and stress management, increase their knowledge of child development and engage in reflection with skilled facilitators and other mothers. Children attend weekly two-hour MIM group sessions with their mothers.

The goals of MIM are to:

1. Reduce mothers' stress and uncertainty related to parenting;
2. Provide the opportunity for women to learn from other mothers who share similar "mothering experiences" and difficulties related to managing traumatic histories;
3. Support the positive development of mother-child relationships;
4. Provide a sensitive, safe environment for women to express their concerns and challenges related to parenting; and
5. Respond to the socio-emotional needs of children exposed to family violence.

1.5 Current Interventions for Women and Children

Services responding to women and children experiencing DFV have predominantly focused on offering interventions at times of crisis, such as the lead up to separation from perpetrators of violence (Diemer, 2012). The current service response has been criticised for failing to offer appropriate interventions in the period following separation, leaving women vulnerable and isolated during the critical time of rebuilding their lives after violence (Hooker, Kaspiew & Taft, 2016). Mothers and their children are often treated separately during this time, through interventions such as individual counselling, rather than through joint therapeutic work. One popular intervention in services includes parenting skills programs, which can be insulting when offered to women who have managed to continue parenting through violence. Being offered a parenting program as intervention may further reduce mothers' confidence in their ability to parent effectively and deter them from seeking out other forms of support (Humphreys, Thiara, Sharp & Jones, 2015).

Research suggests that services should offer interventions based on attachment theory and trauma-informed practice, where mothers develop their understanding of attachment, increase their understanding of the child's experience of violence and how this manifests in their child's behaviour and improve their response to their child's needs (Hooker, Kaspiew & Taft, 2016). These interventions are more effective when they involve mothers and children together, rather than when mothers and children are treated separately (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Liebermann, Ippen & Horn, 2006). Providing spaces where mothers and children can work together allows mothers to learn

and practice ways of being a parent in a safe and supported environment, through communicating openly, addressing feelings and creating boundaries for behaviour (Humphreys, Thiara, Sharp & Jones, 2015). Providing interventions in the form of group work is particularly beneficial in reducing the social isolation often experienced by women who have experienced DFV, as it creates opportunities for women to connect with others, both skilled professionals and women in similar circumstances (Flannery, Irwin & Lopes, 2000).

> *I felt like I was robbed from being a mum. . . . I'm gaining that connection back, but I'll never get that time [again].*

As of 2018, Mothers in Mind is one of the few interventions in Australia that is attachment-based, trauma-focused and involving both mothers and children. This evaluation report contributes to the developing work in the area of strengthening the mother-child relationship in the aftermath of DFV and addresses this gap in the current service system.

1.6 The implementation of Mothers in Mind by CPS

In April 2016, and prior to the commencement of the Mothers in Mind program, staff from across CPS participated in a two day in-house training workshop conducted by Dr Angelique Jenney, then Director of Family Violence Services at the Child Development Institute (CDI), now Wood's Homes Research Chair at the University of Calgary. This training specifically addressed the following topics:

1. Understanding the program logic and development of MIM
2. MIM program objectives
3. Eligibility criteria and assessment
4. Program components and service delivery
5. Clinical skills required by MIM facilitators (e.g. self-reflective practice)
6. Information pertaining to trauma informed practice and the impact of violence and trauma on toddlers
7. Impact of violence and trauma on parenting
8. Risk and protective factors
9. Identifying moments of connection and disconnection
10. Gender roles, mother blaming, gendered inequality
11. Information regarding Infant and toddler mental health and development, attunement and attachment, and
12. Adaptations of the model and program evaluation.

The training was supplemented by case studies and role plays to ensure that all participants were familiar with content and had experience in delivering each element of the program.

After the training was completed CPS selected MIM facilitators from this pool of trained staff. All selected staff members had extensive experience in the delivery of therapeutic group programs with vulnerable and at risk mothers and their children, and both workers had significant experience working with families affected by family violence. All staff members had also been involved in the development, implementation and evaluation of supported playgroups for vulnerable families. The facilitators also had access to the team from the CDI in Canada through regular videoconferences to prepare for the group, undertake reflective practice during the group and review the outcomes post group.

To determine eligibility of the participants for all groups, the facilitators undertook a comprehensive assessment of the women and children referred to the program. As part of the assessment each family met with the facilitators prior to the group starting, as part of a two-hour assessment process which included a face to face interview with mother and children and psychometric testing. The assessment also included family violence risk assessment and safety planning. During the assessment phase, the mothers were given a space to share their story and get to know the facilitators. They were also provided with information regarding what to expect from the group. Upon completion of the group the participants completed post-test psychometrics and questionnaires to ascertain the efficacy of the intervention.

Evaluation methodology

The MIM evaluation was designed to follow the MIM program logic provided by CPS (Appendix 1), and aimed to:

1. evaluate the extent to which the Mothers in Mind intervention changes mothers' understanding about the impact of DFV on attachment and parenting, and reduces emotional dysregulation and stress;
2. assess the effectiveness of the Mothers in Mind program in improving mother-child relationships; and
3. identify how well the Mothers in Mind program fits within the Victorian service delivery system and how it should be adapted for this context.

Table 1. Sources of data used to inform the Mothers in Mind Evaluation Project

	Term 3 2016	Term 4 2016	Term 2 2017	CPS Staff
Pre-MIM Parent Assessment				
- Initial phone screening tool	√	√	√	
- Demographics form	√	√	√	
- Parenting Survey (PS)	√	√		
- Tool to Measure Parenting Self Efficacy (TOPSE)	√	√	√	
- Social Support Scale (SS)			√	
- The Patient Health Q. for Depression and Anxiety (PHQ-4)			√	
- Self Compassion Scale (SC)			√	
- Raising A Baby Scale (RAB)			√	
- The Parental Cognitions and Conduct Toward the Infant Scale (PACOTIS)			√	
Post-MIM Parent Assessment				
- Parenting Survey (PS)	√	√		
- Tool to Measure Parenting Self Efficacy (TOPSE)	√	√	√	
- Social Support Scale (SS)			√	
- The Patient Health Q. for Depression and Anxiety (PHQ-4)			√	
- Self Compassion Scale (SC)			√	
- Raising A Baby Scale (RAB)			√	
- The Parental Cognitions and Conduct Toward the Infant Scale (PACOTIS)			√	
Program Assessment				
- Group Fidelity / Integrity Checklist			√	
- Trauma Informed Practice Scale (TIPS)			√	
- Client Satisfaction Questionnaire	√	√	√	
Interviews				
- Interviews - 1 month post-program			√	√

- Interviews - 6 months + post-program	√	√	√

The evaluation took a mixed methods approach, using multiple data sources. In order to ensure that evaluation data would be comparable with Canadian data and with future data collected in Victoria, the data collection tools posted on the Canadian MIM website were used (and adapted for Australian conditions where necessary). These consisted of a demographic survey, phone screening tool (referral information), and a range of validated scales (see Table 1). Using statistical analysis software (SPSS), paired sample t-tests were conducted in order to track changes over the course of intervention. In addition, semi-structured interviews were conducted with participants and staff facilitators to obtain context and a deeper understanding of any changes indicated in the validated scales. Program fidelity was assessed through a checklist administered twice during the 2017 group program. Detailed descriptions of these tools can be found in Appendix 2.

To be eligible for the program evaluation, women had a child between three months and four years, had experience of DFV and were no longer living with the perpetrator of violence. Mothers who participated in the evaluation received a $25 Coles/Myer gift voucher at each of the three stages of data collection (pre-group scales, post-group scales and interview).

The *Mothers in Mind* Evaluation Project was approved by the University of Melbourne Research Ethics Committee. A number of strategies were used to ensure that participants were not put at risk by the research and felt safe and supported.

Findings

1.7 Referral Sources

Between July 2016 and April 2017, the Mothers in Mind program received 30 referrals.

There were several referral sources:

- Maternal and Child Health Nurses referred eight mothers. One of these nurses referred two mothers, while the rest referred one mother each. Three of these nurses were Enhanced Maternal and Child Health Nurses, who referred one mother each.
- Overall, nine referrals came from agencies within the North East Metro Child and Family Services (NEMC-FS) Alliance:
    - CPS referred five mothers. Three referrals came from Family Services Team workers and two referrals came from Therapeutic Services Team workers.
    - Kildonan UnitingCare referred two mothers. One referral came from the Families First program, while the second referral came from Integrated Family Services.
    - Berry Street referred one mother, through Integrated Family Services.
    - Anglicare referred one mother through their Beyond the Violence group program.
- Of the four referrals from agencies external to the NEMC-FS Alliance:
    - Two referrals came from workers at Martina Women's Refuge.
    - Two referrals came from AOD Counsellors at Uniting Care ReGen.
- Two referrals came from workers at the now defunct North East Melbourne Services Connect
- Two referrals came from DHHS Child Protection Services.
- Five mother referred themselves to the program. It is not known where they heard about Mothers in Mind.

All mothers were referred to the program because they had experienced domestic and family violence. Additional reasons for referral to MIM included:

- Mothers were experiencing mental health issues (8 referrals)
- Mothers were experiencing social isolation (8 referrals)
- DHHS were involved with mother and children (8 referrals)
- Mothers had had hurtful experiences (other than DFV) in the past (6 referrals)
- Mothers were experiencing substance use issues (5 referrals)
- Child was demonstrating developmental concerns (2 referrals)
- Mothers were experiencing issues related to grief and loss (2 referral)
- Mothers were from culturally and linguistically diverse (CALD) backgrounds (1 referral)

Of these 30 referrals, 12 mothers did not go on to attend the program:

- Facilitators decided that two of these referrals were inappropriate for MIM, as mothers and their children were living separately at the time of referral
- Two mothers did not feel ready to engage in a therapeutic program
- One mother had prior commitments on the same day as the program
- One referral came too late to complete the assessment process before the program started
- Data was not collected on why the remaining six referrals did not become participants.

1.8 Participant Characteristics

The mothers participating in MIM were aged 22-45, with a mean age of 32. Two-thirds of the 21 children who attended with them were aged 0-2. Nine children attended Term 3, 2016, six children attended Term 4, 2016 and six children attended Term 2, 2017.

Families lived in the northern suburbs - seven participants lived in City of Whittlesea, four lived in Banyule, four lived in Darebin, one lived in Hume and one lived in Nillumbik. The location of one participant was unknown as she was living in a refuge.

Table 2. Participant demographics, (n = 16 unless otherwise stated).

Country of birth			**Highest level of education**		
Australia	12	75%	High school	3	19%
Afghanistan	1	6%	TAFE	5	31%
New Zealand	1	6%	University	7	44%
Scotland	1	6%	Unknown	1	6%
Syria	1	6%			
			Relationship status		
Number of years in Australia			Separated	7	44%
Since birth	12	75%	Single, never married	4	25%
6-10 years	3	19%	Married/defacto/partnered	3	19%
Unknown	1	1%	Divorced	1	6%
			Unknown	1	6%
Ethnicity					
Anglo-Australian	10	63%	**Age of mothers (22-45 years)**		
Middle Eastern	1	13%	20-29	6	38%
Mixed	2	6%	30-39	9	56%
European	1	6%	40-49	1	6%
Pacific Islander	1	6%			
UK	1	6%	**Child age (n=21)**		
			0-12 months	6	29%
English as first language			Two years old	8	38%
Yes	14	88%	Three years old	5	24%
No	2	12%	Four years old +	2	10%
Income source			**Involvement with Child Protection**		
Govt assistance	12	75%	Current involvement	3	19%
Wages/salary	2	13%	Previous involvement	9	56%
Child support	1	6%	No involvement	4	25%
Private Income plus govt	1	6%			
			Living arrangements of children		
Annual income			Children live with mother	16	100%
$10-19 999	5	31%	Children have lived away from mother in past	2	13%
$20-29 999	4	25%			
$30-39 999	2	13%			
$40-49 999	2	13%			
$50-59 999	1	6%			
Unknown	2	13%			

All but two mothers spoke English as their first language. Four mothers (25%) were born overseas (one each born in New Zealand, Afghanistan, Scotland and Syria). Of the four mothers born overseas, three had lived in Australia for a period of 6 and 10 years, two were Australian citizens and one was a permanent resident. The citizenship status or number of years in Australia of the fourth mother born overseas is unknown. The mothers from Afghanistan and Syria spoke English as an additional language.

Three quarters of the mothers relied on government pensions, earning between $10,000 and $39,999 per year. They were comparatively well educated, with twelve having gone beyond school to start or complete university or TAFE studies., five had a range of educational experiences. Only three mothers indicated that they had not completed high school.

All mothers were living apart from the perpetrator of violence while completing the Mothers in Mind program. Three mothers were living with new partners. All children lived with their mother at the time of the program. Nine mothers had been previously involved with Child Protection and three mothers were involved with Child Protection at the time of the program. Two mothers indicated that their children had lived away from them in the past, due to Child Protection involvement.

Past hurtful experiences:

All mothers identified that they had experienced some form of abuse since the age of 18, with 100% of participants indicating that they had experienced psychological abuse and 87% reporting physical abuse. Many mothers had experienced neglect or abuse as children (see Table 3). All mothers who responded had experienced two or more types of abuse.

The majority of mothers (75%) felt that their children had been exposed to DFV, while three were certain they had not been. One mother was not sure.

Table 3. MIM participants who had experienced neglect or abuse in the past (n = 15)

Experiences of childhood neglect	5	33%
Experiences of physical abuse		
Within the last 12 months	9	60%
From birth-18 years old	7	47%
Since 18 years old	10	67%
Experiences of sexual abuse		
Within the last 12 months	2	13%
From birth-18 years old	5	33%
Since 18 years old	8	53%
Experiences of psychological abuse		
Within the last 12 months	14	93%
From birth-18 years old	6	40%
Since 18 years old	15	100%
Exposure to family violence		
Within the last 12 months	4	27%
From birth-18 years old	5	33%
Since 18 years old	4	27%

1.9 Pre- and Post-Group Parent Assessment Tools

In 2016, the assessment tools used before and after the program comprised the Parenting Survey, measuring parental competence, attachment and isolation, and the TOPSE, which measures parenting self-efficacy. In 2017, the Parenting Survey was replaced with several scales measuring social support, depression and anxiety, self-compassion, parenting knowledge in relation to infants and toddlers, and parental cognition and conduct towards children. (These are set out in Table 1.)

2016: Parenting Survey

Nine participants from the two 2016 groups (n = 13) completed the Parenting Survey. This measure was removed from the evaluation tools package in 2017 by the Child Development Institute.

When analysing total mean scores at baseline, mothers were divided into two groups: those who attended less than five sessions (n=3) and those who attended five or more sessions (n=6), to see if there were any differences in scores between groups.

Table 4. Pre-MIM Parenting Survey: total mean scores, measuring Parental Competency, Attachment and Isolation, n = 9

	All (N = 9) **Mean** (SD)	< 5 sessions attended (N = 3) **Mean** (SD)	5+ sessions attended (N = 6) **Mean** (SD)
Parental Competency	**29.7** (6.04)	**29.3** (8.50)	**29.8** (5.42)
Attachment	**12.8** (1.79)	**13.3** (.58)	**12.5** (2.17)
Isolation	**19.4** (4.61)	**17.3** (6.51)	**20.5** (3.62)

Findings from the Parenting Survey indicate that prior to beginning the MIM program, mothers felt both somewhat uncertain about their ability to parent effectively, and very socially isolated. Although the average score related to parental competency (29.7) was not high enough to be considered clinically concerning (occurring for scores 35 or higher), this score still reflects some level of uncertainty and stress related to parenting. These scores were similar regardless of whether mothers dropped out of MIM (29.3) or completed the program (29.8). Scores on the Isolation subscale (19.4) were much higher than the threshold score for concern (a score of 11 or higher), indicating severe feelings of isolation for mothers. Mothers who completed the MIM program had greater feelings of social isolation (20.5) than those who dropped out of the program (17.3), although both scores are in the clinically concerning range.

On a positive note, prior to beginning the MIM program, mothers also felt somewhat close to their children, and felt somewhat able to understand their child's feelings or needs (M = 12.8). This average score was not considered clinically concerning (requiring a score of 16 or higher). Mothers who went on to complete the MIM program indicated that they felt slightly closer to their children (12.5) than those who dropped out before completion (13.3), but this score difference is only small.

Table 5. Parenting Survey: Paired samples t-tests comparing Parental Competency, Attachment and Isolation total mean scores pre- and post-MIM, n = 4

	Pre-MIM **Mean** (SD)	Post-MIM **Mean** (SD)	Mean difference
Parental Competency	**29.3** (6.85)	**28.3** (8.06)	- 1.0 *
Attachment	**12.0** (2.58)	**13.0** (6.73)	+ 1.0*
Isolation	**19.5** (4.20)	**15.3** (5.74)	- 4.2*

*p >.05

Paired-samples t-tests were conducted for participants who completed the Parenting Survey both pre- and post-MIM (n=4). These tests found that scores changed on the Parental Competency subscale (t(3) = -.38, p = .731), the Attachment subscale (t(3) = 1.00, p = .31)

and the Isolation subscale (t(3) = 1.62, p = .204), however, these changes were not statistically significant.

Participant total mean scores decreased on the Parental Competency subscale (29.3 pre-MIM to 28.3 post-MIM) indicating that after completing Mothers in Mind, participants felt slightly more confident in their ability as parents. Scores also decreased on the Isolation subscale (19.5 pre-MIM to 15.3 post-MIM), suggesting that mothers felt considerably less socially isolated, although it must be noted that average scores were still above levels of clinical concern (a score of 11 or higher).

On the Attachment scale, post-MIM scores (13.0) were slightly higher than pre-MIM scores (12.0), indicating that participants perceived themselves as less emotionally close to their children after completing MIM than they had prior to beginning MIM. However, neither score is clinically concerning. This finding contrasts with the Emotion/Affection and Empathy/Understanding dimensions of the TOPSE (Table 6) and is contradicted by participant interview statements. The groups completing these two scales only partially overlap, and the sample sizes are too small to make firm deductions about this discrepancy.

2016 and 2017: Tool to Measure Parenting Self-Efficacy (TOPSE)

Eleven participants from across the three groups (n=18) completed the TOPSE. Two additional participants partially completed the TOPSE, however, their responses were excluded from analysis as they were missing more than 25% of data.

Again, when analysing total mean scores at baseline, mothers were divided into two groups: those who attended less than five sessions (n=3) and those who attended five or more sessions (n=8), to see if there were any differences in scores between these groups.

Table 6. Pre-MIM TOPSE total mean scores measuring seven dimensions of parenting self-efficacy, n = 11

	All (N = 11) **Mean** (SD)	< 5 sessions attended (N = 3) **Mean** (SD)	5+ sessions attended (N = 8) **Mean** (SD)
Emotion and Affection*	**18.1** (2.26)	**19.0** (1.73)	**17.8** (2.43)
Play and Enjoyment*	**16.9** (2.12)	**18.7** (2.31)	**16.3** (1.75)
Self-Acceptance*	**15.2** (2.86)	**17.3** (2.52)	**14.4** (2.67)
Learning*	**18.0** (2.76)	**17.0** (5.20)	**18.4** (1.60)
Empathy and Understanding*	**17.4** (2.54)	**18.7** (2.31)	**16.9** (2.59)
Control*	**13.5** (3.64)	**11.0** (3.61)	**14.4** (3.42)
Discipline*	**14.4** (4.30)	**16.7** (4.16)	**13.5** (4.28)

*All TOPSE subscales have a total possible score of 20.

Prior to beginning MIM, mothers felt fairly confident in their ability to show emotion and affection towards their children (18.1), to engage in play (16.9), to try out new parenting strategies (18.0) and to provide an empathetic and understanding response to their child (17.4). Mothers were less confident in their ability to parent effectively (Self-Acceptance =

15.2), to stay calm when their child displayed difficult behaviours (Control = 13.5) and to put discipline and boundaries in place with their children's behaviour (14.4).

Scores were slightly higher on all subscales completed prior to the beginning of the program for mothers who dropped out early, except for the subscales related to Learning (17.0) and Control (11.0). These higher scores indicate that mothers who dropped out early were overall more confident in their parenting ability than those who completed MIM. However, mothers who dropped out early indicated that they felt less able to stay calm when their child displayed difficult behaviour (11.0) compared to those who went on to complete the program (14.4). Given the small sample size, further data is necessary to determine whether this difference is valid.

Table 7. TOPSE: Paired samples t-tests comparing pre-MIM and post-MIM total mean scores across the seven TOPSE dimensions, n = 6

	Pre-MIM **Mean** (SD)	Week 10-MIM **Mean** (SD)	Mean difference
Emotion and Affection*	**18.0** (2.00)	**18.2** (1.94)	+ 0.2 **
Play and Enjoyment*	**17.0** (1.26)	**17.5** (3.39)	+ 0.5 **
Self-Acceptance*	**14.3** (3.14)	**17.0** (1.55)	+ 2.7 **
Learning*	**19.0** (1.26)	**18.5** (2.07)	- 0.5 **
Empathy and Understanding*	**17.0** (1.67)	**18.0** (2.10)	+ 1.0 **
Control*	**14.2** (3.82)	**12.5** (4.97)	- 1.7 **
Discipline*	**14.5** (4.28)	**16.7** (2.42)	+ 2.2 **

* All TOPSE subscales have a total possible score of 20.
** p >.05

Paired-samples t-tests were conducted for participants who completed the TOPSE both pre- and post-MIM (n=6). As with the Parenting Survey, these tests found that scores changed on all subscales: Emotion and Affection (t(5) = -.54, p = .611), Play and Enjoyment (t(5) = -.49, p = .646), Self-Acceptance (t(5) = -2.33, p = .067), Learning (t(5) = .52, p = .624), Empathy and Understanding (t(5) = -.97, p = .377), Control (t(5) = 1.04, p = .347) and Discipline (t(5) = -2.29, p = .071). Again, these changes were not found to be statistically significant.

Participant total mean scores considerably increased on the Self-Acceptance subscale (14.3 pre-MIM to 17.0 post-MIM) and the Discipline subscale (14.5 pre-MIM to 16.7 post-MIM), indicating that after completing MIM, mothers felt more confident in their ability to parent and to put boundaries in place for their children. Participants rated themselves highly on the Emotion and Affection subscale (18.0 pre-MIM to 18.2 post-MIM), the Play and Enjoyment subscale (17.0 pre-MIM to 17.5 post-MIM), the Learning subscale (19.0 pre-MIM to 18.5 post-MIM) and the Empathy and Understanding subscale (17.0 pre-MIM to 18.0 post-MIM). These consistent ratings between the beginning and end of the program can suggest that either participating in MIM reinforced participants' feelings of self-efficacy across these dimensions, or, that MIM had no effect on how mothers felt about their parenting across these areas.

Participant total mean scores decreased on the Control scale (14.2 pre-MIM to 12.5 post-MIM), suggesting that after completing MIM, mothers felt less able to respond calmly when

their child was displaying difficult behaviour. This finding contrasts with the decrease in Parent Hostile-Reactive Behaviours (PACOTIS, Table 8) and is contradicted by interviewed participants who stated that they felt better able to manage their children. The groups completing these two scales only partially overlap, and the sample sizes are too small to make firm deductions about this discrepancy.

2017: SS, PHQ-4, SC, RAB and PACOTIS

Pre-MIM, all participants from the Term 2, 2017 group (n=5) completed the Social Support Scale (SS), the Patient Health Questionnaire for Depression and Anxiety (PHQ-4), the Self Compassion Scale (SC), the Raising a Baby scale (RAB) and the Parental Cognitions and Conduct Towards the Infant Scale (PACOTIS). Three participants completed these measures both pre- and post-MIM. Baseline scores were not analysed by session attendance, as the attendance rate of this group was high and the sample size was too small to allow any conclusive findings. (Table 8)

Paired-samples t-tests found that although participant total mean scores changed on all 2017 measures from pre-MIM to post-MIM, these changes were not statistically significant: SS ($t(2) = 1.25$, $p = .343$); PHQ-4 ($t(2) = -1.31$, $p = .321$); SC ($t(2) = -1.91$, $p = .197$); RAB ($t(2) = 1.50$, $p = .272$); PACOTIS ($t(2) = 1.58$, $p = .255$).

Participant total mean scores slightly decreased on the Social Support scale (23.3 pre-MIM to 21.7 post-MIM), indicating that participants levels of social isolation decreased after completing MIM. Despite this decrease, post-MIM scores were still high, supporting findings from other sources of data that feelings of social isolation persist for mothers even after being involved in the ten week program.

Table 8. SS, PHQ-4, SC, RAB and PACOTIS scales: Paired samples t-tests comparing pre-MIM and post-MIM total mean, n = 3

	Pre-MIM **Mean** (SD)	Week 10-MIM **Mean** (SD)	Mean difference
Social Support Scale (SS)	**23.3** (3.51)	**21.7** (2.08)	-1.6*
The Patient Health Questionnaire for Depression and Anxiety (PHQ-4)	**2.3** (1.15)	**4.3** (3.51)	+ 2.0*
- Anxiety	**1.3** (.58)	**2.0** (1.00)	+ 0.7*
- Depression	**1.0** (1.00)	**2.3** (2.52)	+ 1.3*
Self Compassion Scale (SC)	**34.3** (6.66)	**41.7** (12.58)	+ 7.4*
- Self-Kindness	**7.0** (3.00)	**7.3** (2.08)	+ 0.3*
- Self-Judgment	**4.0** (2.00)	**5.7** (2.08)	+ 1.7*
- Common Humanity	**7.0** (3.00)	**7.7** (2.08)	+ 0.7*
- Isolation	**4.3** (2.08)	**6.3** (2.52)	+ 2.0*
- Mindfulness	**7.7** (2.52)	**8.0** (2.00)	+ 0.3*
- Over-Identification	**4.3** (2.08)	**6.7** (2.08)	+ 2.4*
Raising A Baby (RAB)	**47.7** (7.50)	**44.7** (8.14)	- 3.0*
The Parental Cognitions and Conduct Towards the Infant Scale (PACOTIS)			
- Perceived Parental Impact	**19.7** (21.78)	**32.3** (16.26)	+ 12.6*
- Parental Hostile-Reactive Behaviours	**30.3** (10.50)	**23.7** (9.50)	- 6.6*

** p >.05*

Scores on the PHQ-4 increased on both the anxiety and depression subscales from pre-MIM to post-MIM. These findings indicate that participants experienced more anxiety in the two weeks before the end of the program (2.0, or, More days than not) compared to the two weeks before the start of the program (1.3, or, Several days). Mean scores also indicated an increase in depression in the two weeks before the end of the program (2.3, or, More days than not) compared to the two weeks before the start of the program (M = 1.0, or, Several days).

Scores on the Self Compassion scale indicate that participants' levels of self-compassion increased after completing MIM. Participant scores remained highest on the subscales measuring Self-Kindness (7.0 pre-MIM to 7.3 post-MIM), Common Humanity (7.0 pre-MIM to 7.7 post-MIM) and Mindfulness (7.7 pre-MIM to 8.0 post-MIM), indicating that

1. mothers came into the program being kind to themselves, seeing failure as part of being human and remaining mindful when things went wrong, and
2. participation in MIM amplified levels of self-compassion in these particular areas.

Participant scores increased on the subscales measuring Self-Judgment (4.0 pre-MIM to 5.7 post-MIM), Isolation (4.3 pre-MIM to 6.3 post-MIM) and Overidentification (4.3 pre-MIM to 6.7 post-MIM), suggesting that after completing MIM, mothers showed greater compassion

towards themselves when they made mistakes and felt somewhat less alone when they felt they had failed.

Participant total mean scores showed little change on the RAB scale (47.7 pre-MIM to 44.7 post-MIM). These scores show that prior to beginning MIM, the 2017 group of mothers already had a high level of understanding of child development, and that completing MIM did not have a significant effect on their child development knowledge.

Scores on the PACOTIS showed that after completing MIM, mothers felt more confident in their ability to respond to their children's needs, demonstrating a considerable increase in understanding of how their behaviour affected their children's behaviour (9.7 pre-MIM to 32.3 post-MIM) and a decrease in responding to their children with hostile or reactive behaviours (30.3 pre-MIM to 23.7 post-MIM).

Six-month follow-up

Two mothers from the Term 2, 2017 group completed the TOPSE, SS, PHQ-4, SC, RAB and PACOTIS scales at three time points: before commencing the MIM program, during the last session of MIM, and six months after completing MIM.

Table 9 indicates that for these two mothers six months on, scores remained at the levels similar to those at the completion of MIM on the Emotion and Affection, Play and Enjoyment, Self-, Learning and Empathy and Understanding scales of the TOPSE, suggesting that MIM either reinforced participants' pre-existing feelings of parenting self-efficacy across these dimensions, or that MIM had little effect on the mothers' confidence in their ability to parent. Participant total mean scores increased on the Control and Discipline scales, indicating that these two mothers continued to feel more confident about their ability to put boundaries in place for their children even six months after completing MIM.

Social Support scores remained similar pre-MIM, post-MIM and six months on and indicate that MIM has little effect on social isolation in the short-term and the long-term. Scores on the PHQ-4 also remained similar, further indicating that MIM had little direct ongoing effect on these mother's experiences of depression and anxiety.

I think for me, [MIM] gave me that self-confidence back and the encouragement to not feel guilty and negative. To just wake up and go because I deserve it and I can do it.

Scores on the Self Compassion scale remained highest on the subscales measuring Common Humanity, Isolation, Mindfulness and Over-Identification six months after completing MIM, suggesting that when these mothers made mistakes, they showed compassion towards themselves. Of note, scores on the Isolation subscale continued to improve during the six months post-program (6.5 at the completion of MIM, to 7.5 six months on), suggesting that mothers felt somewhat less alone when experiencing feelings of failure. These findings are not in line with mothers continuing to indicate high levels of social isolation six months after MIM, and would require a larger sample to infer meaning from these changes. Regardless, for these mothers, maintaining these high levels for the six months following the program is very positive, considering their initial scores pre-MIM on these scales.

Scores remained similar on the scales measuring Self-Kindness (5.5 pre-MIM, 7.0 post-MIM, 6.0 six months on) and Self-Judgment (5.0 pre-MIM, 6.0 post-MIM, 6.0 six months on). These scores indicate that six months after completing MIM, mothers continued to show compassion towards themselves to at least at the same level as when they finished MIM.

Table 9. TOPSE, SS, PHQ-4, SC, RAB and PACOTIS scales: comparing pre-MIM, Week 10 MIM and Six-months post-MIM total mean scores, n = 2

	Pre-MIM **Mean** (SD)	Week 10 MIM **Mean** (SD)	6 months Post-MIM **Mean** (SD)
Tool to Measure Parenting Self-Efficacy (TOPSE)			
- Emotion and Affection	**18.0** (.00)	**17.5** (0.71)	**17.5** (0.71)
- Play and Enjoyment	**18.0** (.00)	**18.5** (2.12)	**18.0** (2.83)
- Self-Acceptance	**17.0** (1.41)	**17.0** (1.41)	**17.5** (2.12)
- Learning	**17.5** (0.71)	**17.5** (3.54)	**16.5** (3.54)
- Empathy and Understanding	**18.0** (.00)	**17.0** (1.41)	**17.5** (2.12)
- Control	**15.0** (2.83)	**15.0** (.00)	**16.5** (0.71)
- Discipline	**16.0** (2.83)	**17.5** (0.71)	**17.5** (0.71)
Social Support Scale (SS)	**21.5** (2.12)	**20.5** (0.71)	**21.0** (1.41)
The Patient Health Questionnaire for Depression and Anxiety (PHQ-4)	**2.0** (1.41)	**2.5** (2.12)	**2.0** (2.83)
- Anxiety	**1.0** (.00)	**1.5** (0.71)	**1.0** (1.41)
- Depression	**1.0** (1.41)	**1.0** (1.41)	**1.0** (1.41)
Self Compassion Scale (SC)			
- Self-Kindness	**5.5** (2.12)	**7.0** (2.83)	**6.0** (1.41)
- Self-Judgment	**5.0** (1.41)	**6.0** (2.83)	**6.0** (.00)
- Common Humanity	**5.5** (2.12)	**8.0** (2.83)	**8.5** (2.12)
- Isolation	**5.5** (0.71)	**6.5** (3.54)	**7.5** (3.54)
- Mindfulness	**6.5** (2.12)	**8.0** (2.83)	**8.0** (2.83)
- Over-Identification	**5.5** (0.71)	**7.0** (2.83)	**7.5** (2.12)
Raising A Baby (RAB)	**44.0** (5.66)	**40.0** (1.41)	**40.5** (0.71)
The Parental Cognitions and Conduct Towards the Infant Scale (PACOTIS)			
- Perceived Parental Impact	**23.0** (29.7)	**39.5** (14.85)	**42.3** (6.11)
- Parental Hostile-Reactive Behaviours	**22.0** (11.31)	**23.5** (0.71)	**17.3** (4.62)

Participant total mean scores again showed little change on the RAB scale (44.0 pre-MIM, 40.0 post-MIM, 40.5 six months on), suggesting mothers' retained their high levels of knowledge regarding child development six months post-program.

Finally, scores on the PACOTIS showed that after completing MIM, the two mothers who completed questionnaires continued to demonstrate a high level of confidence in their ability to respond to their children's needs. Mothers' scores reflected a further increase in understanding how their behaviour has a direct effect on their children's behaviour (23.0 pre-MIM, 39.5 post-MIM, 42.3 six months on) and a decrease in responding to their children with hostile or reactive behaviours (22.0 pre-MIM, 23.5 post-MIM, 17.3 six months on). Interestingly, for these mothers in particular, scores measuring parental hostile-reactive behaviours did not change pre-MIM to immediately post-MIM. The significant improvement in these scores six months after completing MIM (23.5 post-MIM to 17.3 six months on) may instead indicate a decrease in external factors affecting stress levels, which may in turn have decreased mothers' likelihood of responding to their children with hostile or reactive behaviours. Further data is required to determine this.

1.10 Program Assessment Tools

2017: Group Fidelity and Integrity Checklist

The checklist was completed by the evaluator twice during the Term 2, 2017 program, at sessions six and nine. In both sessions, the facilitators fully adhered to the session structure, including preparation, free play time, welcome circle, Talk Play and Connect time, the goodbye circle and a debriefing discussion after the families left. Trauma-informed practice content was integrated into discussions with mothers as appropriate, either in the group or on a one-to-one basis. The warm, relaxed atmosphere of the group was striking and facilitators made good connections with mothers and children, both in a group and an individual context.

2016 and 2017: Trauma Informed Practice Scale (TIPS)

Three participants from the Term 2, 2017 group (n=5) completed all three TIPS subscales of MIM program (for details see Appendices 2 and 3). These measured participant perceptions of staff respect for participants' Agency and Autonomy, staff help in Strengthening Parenting, and Cultural Responsiveness and Inclusivity.

Participants selected the highest possible response (3 = Very true):

- on 12 items of the Agency subscale (total of 15)
- on 4 items of the Parenting subscale (total of 5)
- on all items of the Cultural Responsiveness and Inclusivity subscale (total of 8).

Table 10. Responses to TIPS (Agency) and TIPS (Parenting) subscales, %.

	Somewhat true	Very true
Agency		
Staff respect the strengths I have gained through my life experiences.	33%	67%
In this program, I have had opportunity to connect with others.	67%	33%
I have had opportunities to help other survivors of abuse in this program.	67%	33%
Parenting		
The program provides opportunities for children to get help dealing with the abuse and hardships they may have experienced or been affected by.	67%	33%

These results suggest that that participants felt that overall that the MIM program and facilitators respected their agency and autonomy, was culturally responsive and inclusive and that participation in MIM helped to strengthen their relationships with their children.

The four items where participants were not in complete agreement can be seen in Table 10.

2016 and 2017: Client Satisfaction Questionnaire

Ten mothers from across the three groups (n=18) completed the Client Satisfaction Questionnaire. Five of these mothers took part in the Term 3, 2016 session, two mothers participated in Term 4, 2016 and three mothers participated in Term 2, 2017. Table 11 shows that all mothers were extremely or somewhat satisfied with the MIM program and would recommend MIM to other mothers. All mothers also completed at least some of the goals they had identified at the beginning of the program.

Table 11. Overall satisfaction with Mothers in Mind program across all groups.

	Term 3, 2016 (n = 5)	Term 4, 2016 (n = 2)	Term 2, 2017 (n = 3)	Total (n = 10)
Satisfaction with MIM				
- Extremely satisfied	100%	50%	33%	70%
- Somewhat satisfied	-	50%	67%	30%
Would recommend MIM to other mums	100%	100%	100%	100%
Goals				
- Completed all goals	80%	50%	33%	60%
- Completed some goals	20%	50%	67%	40%

Mothers identified the following as aspects they liked most about participating in MIM:

- Receiving support from facilitators with expertise in family violence
- Getting to know other women who had experienced family violence
- Learning new parenting strategies
- Getting books to take home at the end of each session
- The planned activities for children

Three mothers identified aspects they didn't like about participating in MIM:

- Experiencing difficulties understanding what the other mothers were saying (CALD participant)
- Sometimes feeling triggered by content
- The session time was inconvenient – (Term 4, 2016 participant, when the sessions were scheduled from 1pm-3pm)

Mothers noticed the following changes in their relationship with their child after completing MIM (See Table 12):

- Feeling better able to understand their child's behaviour
- Feeling better able to identify their own reactions to their child's behaviour
- Feeling able to respond more positively to their child
- Feeling closer to their child
- Feeling more confident in their role as parent

Table 12. Perceived changes in parenting after attending Mothers in Mind.

	Term 3, 2016 (n = 5)	Term 4, 2016 (n = 2)	Term 2, 2017 (n = 3)	Total (n = 10)
Noticed positive change in relationship with child	100%	100%	100%	100%
Felt that attending group made them a better parent	100%	100%	100%	100%

Mothers felt that attending MIM made them a better parent because:

- It gave them the opportunity to regularly share how they were feeling with others
- They learnt more about their children
- They learnt new parenting strategies
- They learnt about the importance of taking time out for themselves
- They learnt that support and help was available
- They learnt more about themselves
- It increased their confidence in their parenting ability

Mothers suggested the following changes for improving MIM in future:

- Having some time during the session where children and mothers are separated so that mothers can focus on the discussion
- Holding sessions outside in warmer weather
- Running MIM in the morning rather than the afternoon
- Providing more parenting information around feeding, toilet training etc

I didn't really understand how [DFV] would affect my relationship with the kids…

1.11 Participant Interviews

Post-program interviews: Five mothers agreed to be interviewed after completing the Mothers in Mind program. Three of these mothers had completed the Term 2, 2017 group and were interviewed one month after completing the group. Another mother, from the Term 4, 2016 group, was interviewed eight months after completing the group. The other mother, from the Term 3, 2016 group, was interviewed 12 months after completing the group. Although these two mothers were not interviewed until well after completing the group, their responses have been analysed alongside the post-program interviews with the mothers from the Term 2, 2017, which were conducted one month after completing MIM. Interviews took place from July-August 2017.

Six-month follow-up interviews: Three mothers from the Term 2, 2017 agreed to be interviewed six months after completing the Mothers in Mind program. Two of these mothers were the same mothers who had been interviewed immediately after completing the Mothers in Mind program, while one mother had not been interviewed before. For the purposes of analysis, only these interviews have been utilised to inform findings regarding the longer-term impacts of MIM for mothers. Interviews took place in December 2017.

Improvement in Mother-Child Relationship

All mothers who took part in interviews post-program could describe at least one way in which participating in MIM had positively impacted their relationship with their child.

New ways of responding to children were suggested in the group, and mothers who said that they had previously smacked, yelled at or ignored their children when they expressed difficult or triggering behaviour, stated that MIM had taught them to take a deep breath, speak calmly to their children and try to understand what they need.

> "I think coming out of the program, with all those things we've used there about being fun and caring and understanding and just gentle, it's really helped."

[My child] is very good when I treat him friendly, because I can tell that when I'm angry and don't pay attention to him that much that he becomes angry and doesn't listen.

> "I'm more calm with [my child] – I don't snap. Like, I used to say 'shut up', you know, because I was used to hearing my ex say that to her."

Mothers also stated that they played more with their kids since completing MIM, and that this had also made them feel closer to their children.

> "Before, I didn't take time with them or play with them. Kids like to play with their mum and dad and this is very enjoyable for me also. Sometimes when I play with them, all my stress and other troubles go."

Six months on, the three mothers continued to describe the ways in which participating in MIM had helped to strengthen their relationship with their children. They specifically identified that learning about the impact of DFV on children has continued to change their responses to their child's behaviour in the long-term.

> "I didn't really understand how [DFV] would affect my relationship with the kids…just learning about that has helped me manage it a lot better with the kids' behaviour and reinforces the fact that I can't really take things to heart. I overlook some of their behaviour sometimes to get through because they're just responding to the stimulus that they're given and the stress and the exhaustion and everything that they're put under."

One mother, who had previously expressed that she sometimes felt triggered by the similarities between her child and her ex-partner, stated that the content of the group, as well specific strategies taught by the group facilitators, had helped to change the way she responded to her child:

> "…having that validated, that it's okay to feel that way but the child's not doing it on purpose, that was really helpful…I don't feel as kind of triggered."

Improvement in Parenting Self-Efficacy and Stress Levels

All mothers who participated in interviews felt that they had more confidence in their parenting ability after completing MIM. A number of mothers attributed this increase in confidence to the way that MIM had reminded them to take time out for themselves. Mothers mentioned that in an effort to be a 'good mum', they had been putting the needs of their children ahead of their own and that this had affected their self-confidence, and consequently, their parenting. With the support of the facilitators, and session content focused on self-care, mothers began to implement some of the self-care strategies they had learned and described the impact this had.

> "One specific week it was about learning to take time for yourself, even if you had your child around, just learning to do small things, like

The program, especially the [facilitators]…they gave me self-confidence again. Like, you are a mum. You are a woman. You deserve to be happy. You deserve to look after yourself. You deserve to smile. You deserve all the positives and good things. So, I started to feel like I deserve all that and that I can do it. It's hard, but I can.

> having that warm shower, you know, doing your hair after it. It's just so small and it's so funny but it's like I feel guilty for doing those things, so to hear that was like – you know what? I'm going to dry my damn hair today."
>
> "It brought back a little bit of who I was and I haven't been able to feel that in a good seven years."

Participating in the self-care component of every session also helped mothers to feel better able to remain calm when they felt stressed.

> "Every day I have new struggles but now it's less, not like before. I try to have a deep breath and listen to my calm side, not like respond straightaway to the stressful thing and shout and whatever, just take a moment and have a deep breath and remember all the positive things."

Mothers also received self-care quotes to take home each week, which many placed in prominent places around their house so they could view them regularly.

> "All these [self-care quotes] help – especially sometimes I take them down and read them again. They're very powerful and inside, words can calm you down."
>
> "I have them all and I keep them in a nappy bag because when I change [my child], I always read the different quotes".

Interviewed mothers also said that talking with other mums helped to normalise what they were feeling, which in turn reduced stress levels.

> "Everything I'm feeling and going through is normal. I'm not wrong."

Six months after completing the program, responses from the three interviewees indicated that because of what they had learned and practised during MIM, they continued to make time for self-care during their daily routine. The mothers described using the time when their child is asleep or at childcare to go for a walk, listen to music, put on make-up etc.They also described incorporating self-care into their daily routine by engaging in activities that are enjoyable for both mother and child.

> "Sometimes she doesn't have a nap, and that's fine because we'll go for a drive, we'll go to the park and go for a walk, so we're doing something together…I've noticed my attitude shift and it's like "no, you need to have that five minutes." And it doesn't mean being separate [from my child]. I remember learning that in the group."

Mothers indicated that they continued to use and remember the self-care quotes that had been provided to them during the program.

I think some of the daily sayings were really helpful. The one about the waves, that comes back to me when I'm feeling stressed or things are stressful.

Parenting in the context of DFV

The mothers interviewed from the 2016 groups did not feel that their parenting or their young children had been affected by the violence they had experienced. Only the mothers interviewed from the 2017 group could describe the ways that DFV had impacted their parenting.

> "I was constantly being triggered and it wasn't helpful at all. But [MIM] helped me to recognise that. I've done work on myself and changed my behavioural response."

> "I felt like I was robbed from being a mum. I felt like I was a nanny… like I was mothering his and his mother's child. I'm gaining that connection back, but I'll never get that time."

Social isolation

Most of the mothers who were interviewed post-program stated they found it helpful to meet and talk to other mothers who not only had experienced domestic and family violence, but who also had children under the age of four.

> "It was good for me to know that not everyone has a house with a white picket fence kind of life."

It was nice to have a chat to some of the other women and just hear what they've been through and what they're still going through and realise that there are other people that share the same feelings and have shared the same road or a similar road to you.

Talking with other mothers was also identified as particularly beneficial for participants who had recently left a violent relationship. One mother, who had ended the violent relationship two months before joining MIM, described this.

I've [now] seen these other mums and they still have their days – we all have our days – but it was like, look how far they've gotten in just a year or two years. It gave me so much hope that…it's going to be okay.

However, one mother, who was from a culturally and linguistically diverse background, found it difficult to engage with the other mothers during sessions:

> "Two of them were the same age as my son, but there was not much openness or sharing [between mothers]".

Six months on, interviewed mothers held differing views of their experiences of talking to the other mothers in the group. While it was helpful for some to talk to others who had

experienced DFV, others found it difficult when women would recount their experiences to the group.

> "Although we were there with the shared experience, it wasn't necessarily helpful to hear each other's experiences…no one was necessarily actually hearing each other's stories and it could be really tough."

Other responses also indicated the difficulty of building relationships with other mothers after being socially isolated due to DFV.

> "I remember being nervous the first time I came in. I was pretty much an emotional wreck and I was very silent, I think, for the first three times. [Before the group] I hadn't been around more than two people at once for a long, long time."

Several mothers suggested that a longer group program may have made it easier for mothers to build more trusting and lasting relationships with one another, possibly reducing social isolation in the longer-term.

Social supports

Eco-maps were constructed during interviews to get a sense of what supports were in place for participants post-MIM. Only supports that were identified as helpful to participants were included in the eco-map below.

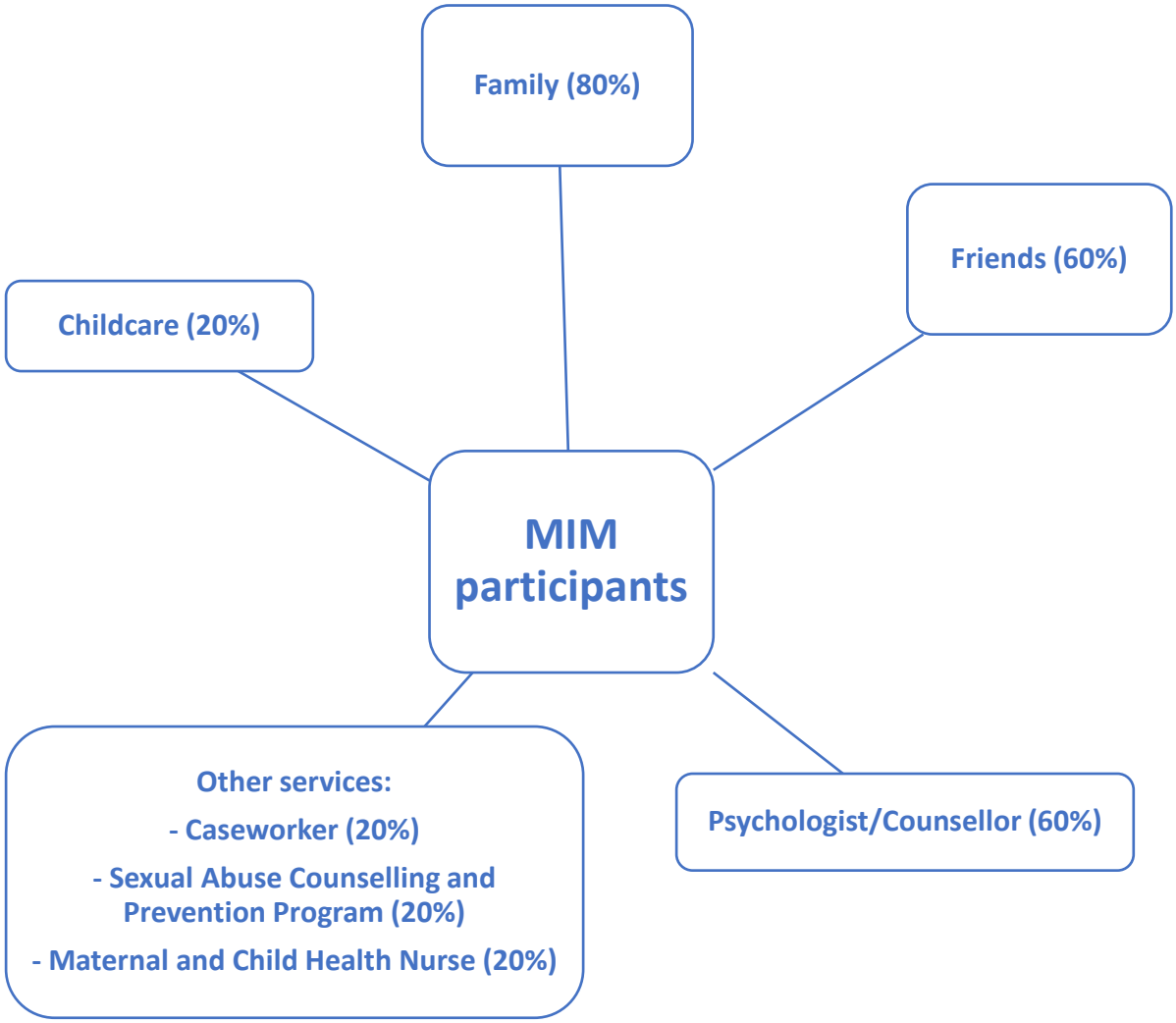
Family was the greatest source of support for participants post-MIM, with four mothers stating that they had at least one family member they turned to support, and some mothers having up to four family members they regularly confided in.

After family, participants were likely to turn to their friends or to professional counselling for support. Three mothers described having at least one close and supportive friend. Two mothers saw a psychologist in addition to the support she received from her friends. One mother did not turn to her friends for support, but to a psychologist whom she saw regularly.

Some participants received support from other services, such as a caseworker, a counsellor through CPS' Sexual Abuse Counselling and Prevention Program, or a Maternal and Child Health Nurse that was seen regularly. One mother also received support from the staff at her son's childcare.

Most mothers had at least two places or people they could turn to for support. However, one mother whose family lived overseas, did not speak to her family regularly and did not have any close friends. She was not connected to any services that were supportive and did not have anyone on her eco-map.

Table 13. Social Support Ecomap post-program, n=5.



The mothers interviewed six months on from the Term 2, 2017 group indicated the same three sources of support: family (100%), friends (100%) and a psychologist/counsellor (100%). One mother also identified her GP as a source of support. All mothers stated that they felt satisfied with the level of support they had at the time of the interview.

Relationship with facilitators

Every interviewed mother stated that one of the reasons they attended sessions each week was because they had a good relationship with their group facilitators. Mothers mentioned that they valued the expertise of the facilitators, and the support they provided both during the sessions and during the weekly follow-up phone calls.

> "The phone calls during the week – I know towards the end I couldn't answer them because I was very busy, but just knowing someone is calling to see how you're going and stuff, it's kind of like – well, damn. That's what I've wanted my whole life."

Six months on, mothers continued to remember their positive experience of the program as directly related to their relationship with the facilitators.

> "I think the facilitators make the program in terms of how they deliver the content and whether people feel safe within that space as well."

Mothers spoke of the loss they felt at the end of the group and their desire for ongoing support from the MIM facilitators once the group had ended.

> "I guess the sad thing is that you go through that program and you kind of build up this relationship, this trust with them…it's a shame that then, those two, can't personally provide ongoing support."

In the six-month follow-up interviews, mothers identified the need for facilitators of the MIM program to have specialist skills in childhood trauma and DFV in conjunction with group work facilitation skills. All mothers spoke of one facilitator in particular, who had a wealth of skills and experience in developmental trauma and working with children and who was able to provide mothers with valuable and practical strategies. Mothers felt that this facilitator was able to make the content of the program relevant to their particular situations, which further positively impacted their experience of the program.

> *Particularly for women who are really vulnerable at the time, or feeling really alone in their experience, the content isn't enough. The content, the way it is delivered, and having someone who is really experienced, that's able to make sure it becomes relevant.*

Overall impact of MIM

Although the topics covered throughout the program were not new for many of the mothers, they acted as an important reminder of actions they could be taking to improve their relationship with their children.

> "It's all stuff you've read, heard, know that you should do anyway…[but] it doesn't make it any easier to get in your brain."

Overall, mothers were glad that they had participated in MIM and felt that the program had acted as a catalyst for further change in their lives:

> "[MIM] has put my life in the right direction, but there will never be a magic fix. There will always be things to work on."

> "I honestly could say right now that if I didn't come and do this program or I didn't grow the balls to finally push myself to do something I would probably be extremely depressed, I probably wouldn't have thought to have looked for a house, I would have no motivation. This was my motivation starter…I know I have my daughter and she is also the reason I move on, but the group really was the push."

> "I think for me, [MIM] gave me that self-confidence back and the encouragement to not feel guilty and negative. To just wake up and go because I deserve it and I can do it."

During the six month follow-up interviews, mothers continued to indicate that participating in MIM had a positive impact on their parenting and their relationships with their children, but were able to reflect on several aspects of the program.

Mothers would have liked more information about the nature of DFV, and felt that theydid not get a chance to discuss this during the program.

> "We didn't get to highlight what family violence really is."
>
> "The only other thing I'd say is maybe just a bit more about family violence. What it actually is as well, not just only about the physical stuff, but the underlying emotional."

Some of the mothers identified the need for DFV psychoeducation as being not for themselves, but for some of the other mothers in the group who were earlier in the process of separation from their violent ex-partner. These comments about women in the group being at different 'stages' in the process of separation led to a wider discussion about appropriateness of MIM for mothers at different stages. Interviews indicated that mothers who completed the program one or two years after separating from their violent ex-partner, felt that they were already familiar with much of the program content, and sometimes felt like the group was focused on the experiences of mothers who were earlier in the process of separation than they were.

I feel like in comparison [to other mothers], I had gone along that road a little more in terms of protecting my children, that engagement with them, what we do around feelings.

> "[Another mother] and I were kind of fairly similar in that we had got through that crisis year and now we were really in the day-to-day…and I guess because I have done a lot of that there was a fair bit of repetition."

Mothers who were further along in the process of separation indicated that facilitator support was the most important aspect of the group, and that this support was the reason they returned. Mothers who were earlier in the process of separation indicated that, while they appreciated the facilitator support, they also benefited from learning the content of the program and having the opportunity to talk to mothers in similar situations.

1.12 Staff Interviews

Recruitment and Assessment

For all groups, the majority of referrals came through in the week preceding the first session causing stress levels to rise for facilitators who were carrying their own caseloads as well as trying to organise times to meet with potential participants to conduct the pre-MIM assessment:

> "There was very little room for any cancellations. This is a demographic of people that have a lot on, and they might forget, or they're just having a bad day or whatever. It just felt very difficult to have a time where the client was available, the baby was having a good day, we [the facilitators] were both available, you know, all the logistics…some of our referrals were right down to the line and it was like, my gosh, we've got to get this done before group starts."

Several suggestions were made during interviews with facilitators regarding how to improve the recruitment process:

- Creating a frequently asked questions sheet about MIM so that potential referral sources are more aware of what kind of referrals are appropriate, and what kind are not appropriate.
- Setting a date two weeks prior to the first session of MIM where referrals stop being accepted.
- Making potential referral sources aware that participants need to undergo an assessment before joining the group.

Facilitators found the assessment process helpful in allowing them to assess the suitability of potential participants and get to know the mothers and their children. A key issue for all facilitators related to the amount of information about past trauma history elicited from mothers during the assessment period:

> "One of my questions was: do we need to know about the violence? We don't really need to know about the violence unless the mum feels like it's impacted her parenting. And if we do start the conversation and we ask probing questions about the violence, then is that setting up the group space as a space to talk about the violence, rather than a space to talk about how the parenting's been impacted?"

> "It's up to the mum about what they share with us but you know, some of the women we had in our group had complex, complex backgrounds with childhood neglect and trauma and sexual abuse and really significant family violence and a lot of that isn't directly addressed again in the group."

Overall, facilitators felt that the assessment interview should be shorter, and that questions about past trauma history should be limited and only be asked in relation to finding out more information about parenting. Facilitators also felt that specific questions needed to be asked about mothers' cultural backgrounds and the impact of this on parenting.

> *. . . towards the end she was using less of that language, so less of the 'He's being naughty' and more understanding 'He's having some big feelings' and walking him through it whilst being beside him.*

Client outcomes

All facilitators observed positive changes in the relationships between the mothers and children in their group:

> "The difference between the mum who was on her phone, didn't respond to her child at all in week one and week two, to week eight or nine, when she went up to her child, kissed him on the head and had this big smile on her face, that's an example [of a change in mother-child relationships]. Also, a mum who appeared to be disconnected from her child in the beginning, but then was freely choosing to play with her child towards the end – that was really lovely."

> "There was a mum who you could see was frustrated with her child's behaviour and didn't really know what to do with that, it was particularly challenging. At the beginning, the language she used around her child's behaviour was really negative and really blamed the child and his way of managing these really big emotions. But then towards the end she was using less of that language, so less of the 'He's being naughty' and more understanding 'He's having some big feelings' and walking him through it whilst being beside him".

> "We had a little girl and she said to us "would you like to see me hug my mum?". She was this sassy little girl, nearly three years old, and we were like "yes! I'd love to see that!". And she was jumping on her mum and her mum was laughing and it was just really beautiful. The little one had picked up on the idea that connection and affection were really important in this space."

Overall, facilitators felt that mothers responded positively to the group, but agreed that many of the mothers were familiar with the concepts being discussed:

> "I think they engaged well. A lot of them were already doing some of the stuff that was suggested, which was helpful."

Facilitators felt that the following points should be considered when running MIM again in future:

- Holding sessions in a bigger space so that there was more space for children to run around and to make it easier to hold conversations away from 'little ears'.
- Having three facilitators rather than two so that facilitators could step out of the room to support mothers as needed, without leaving one facilitator alone to run the session.
- Holding the group in the morning rather than the afternoon.

Discussion

1.13 Is MIM reaching its target population?

The Child Development Institute defined the target population of the Mothers in Mind program as "women who have experienced significant trauma, often beginning in childhood, with current or historical child welfare involvement" (Child Development Institute, n.d.), with children under four years old. In Victoria, CPS has focussed on women who have experienced family violence. The rigorous assessment process has ensured that women only progressed to attending the group if they met MIM's eligibility criteria.

Information from the Demographic Form indicates that CPS MIM is serving its intended population. Of the 16 women who participated in the groups under evaluation, all had children under four, although two siblings over four also participated. All had experienced two or more types of trauma (neglect, physical, sexual or emotional abuse, or exposure to DFV). Three quarters of the women had current or previous involvement with Child Protection. While the women were not well off, mostly relying on government assistance as their sole form of income, they were well educated, with 75% of women having completed TAFE or university. Facilitators reported that participants were familiar with many of the concepts introduced during the group.

> *This was my motivation starter…I know I have my daughter and she is also the reason I move on, but the group really was the push.*

While it does appear that MIM is reaching its target population, it is unknown whether there is a particular time post-separation from a violent ex-partner where this program is most beneficial. The eligibility criteria ensured that all women who participated in MIM had left the relationship before participating in the program. However, women ranged from being one month to two years out of a violent relationship, highlighting the challenge for facilitators of keeping the content of the program relevant and resonant for women in these vastly different stages.

The six-month follow-up interviews indicated that mothers who were further on in the process of leaving a violent relationship experienced some discomfort being in the same group as mothers who were earlier in the process. These mothers described feeling worried about the other mothers, and feeling triggered by hearing about some of the experiences that mothers were going through that were similar to what they had already been through, for example, experiences with the Family Law Court. On the other hand, one mother who was very early in the process of separation found the experience of talking to the mothers who were further on in the process beneficial, as she felt that these mothers provided her with guidance and made her feel less alone in her experience. Therefore, participating in a group with woman at a range of stages in the post-separation process appears to be most helpful for women early in this process, but runs the risk of alienating women at a later stage in the process.

Findings from both the post-group and six month follow-up interviews with mothers also suggested that the content of MIM sessions was helpful for mothers early in the process, while this content was already familiar to mothers who were at a later stage in the process. Mothers at this later stage desired support beyond the content and social interaction with other mothers, and it was these mothers who gained the most benefit from the interaction

with facilitators. These changes in support needs over time are derived from a very small sample and require further testing. They are nevertheless important considerations for facilitators when running similar groups with women.

1.14 Did Mother-Child Relationships improve?

Mothers felt somewhat close to their children both before and after the program, and felt fairly confident in showing affection and empathy, and playing with their children. Those who completed the Client Satisfaction Questionnaire noted a positive change in their relationship with their children, through increased confidence, a better understanding of children's behaviour and their own reactions and their ability to respond more positively to their children. In some cases, facilitators reported that these changes were observable as the group progressed.

Before, I didn't take time with them or play with them. Kids like to play with their mum and dad and this is very enjoyable for me also. Sometimes when I play with them, all my stress and other troubles go."

Mothers also generally showed a good understanding of child development (RAB) and were open to trying new strategies (TOPSE, Learning dimension). The five interviewees could identify ways in which MIM had had a positive impact on their relationship with their children. After completing MIM, mothers had developed increased confidence in their ability to parent effectively and to put boundaries in place for their children.

All participants in the 2017 group felt that MIM gave them insights about the impact of DFV on their children, and those interviewed could describe how DFV had impacted their children or their parenting. It is not clear at this stage whether this is due to effective program facilitation or to the general high insight levels of the 2017 group participants. This information is not available for the 2016 groups.

. . . a mum who appeared to be disconnected from her child in the beginning, but then was freely choosing to play with her child towards the end – that was really lovely. [facilitator]

Peer support in the group, as well as support from facilitators and having a space to talk about their feelings, were factors in this increased confidence. Interviewees suggested a link between general self-confidence and their confidence in parenting. The emphasis on self-care in each session helped mothers re-learn the importance of small acts of grooming and spending a little effort on themselves.

Six months post-program, mothers continued to report that they had a better understanding of their children's behaviour since completing MIM, and felt more confident in their ability to respond appropriately and positively to their child.

1.15 How were Mothers dealing with their stress?

Levels of anxiety and depression, and capacity for self-compassion were measured for the 2017 group only (PHQ-4, Self-compassion scales). While these mothers started the group with a good ability to be kind to themselves when things went wrong, their levels of self-compassion improved considerably over the course of the program.

Information from the interviews suggest that the opportunity to talk with other mothers with similar experiences helped some mothers normalise their own feelings. The self-care component of the group and the self-care quotations were also seen as important in helping mothers show greater compassion towards themselves.

> *Every day I have new struggles but now it's less, not like before. I try to have a deep breath and listen to my calm side, not like respond straightaway to the stressful thing and shout and whatever, just take a moment and have a deep breath and remember all the positive things.*

However, levels of anxiety and depression for the 2017 mothers increased considerably over the course of the MIM program, based on a scale that measured mood during the preceding two weeks. It is likely that the difficult life circumstances for all families involved with MIM were responsible for this increase in stress, rather than the program itself, and this is borne out by interview comments. Responses from mothers during the six-month follow-up interviews also support the notion that stress levels measured by the PHQ-4 pre- and post-MIM were related to external factors affecting mothers, such as having to participate in court processes, the financial pressures associated with separation and single parenting, and trying to negotiate shared parenting or contact arrangements with ex-partners. The impact of these negative external factors could be alleviated by a casework support component being built into the role of the program facilitators.

Despite these external factors, all mothers interviewed at the six-month point stated that they continued to make time for self-care on a daily basis, which indicates that MIM has been effective in teaching or reawakening in mothers strategies which may be used to deal with stress.

1.16 Is MIM effective in reducing social isolation?

All mothers felt socially isolated, both before and after the group, although this feeling was reduced for the duration of the program. Interviewed mothers valued the connections they made within the group but in most cases these did not appear to continue once each program had finished. Participant comments suggest that ten weeks is often not long enough to build enduring connections. While most interviewed mothers had support from

> *I remember being nervous the first time I came in. I was pretty much an emotional wreck and I was very silent, I think, for the first three times. [Before the group] I hadn't been around more than two people at once for a long, long time.*

family and friends or services, one mother, whose family lived overseas, had no connections she found supportive.

The MIM program has provided opportunities for mothers to connect with other mothers with similar experiences and this was an important element in some participants' experience of the program. A sense of isolation is a common experience for mothers of young children, particularly when parenting on their own, and it is beyond the scope of a ten-session program to significantly change this. However, facilitators need to be conscious of linking participants into supportive networks where necessary. Careful attention should be paid to the needs of women from culturally and linguistically diverse backgrounds, particularly where language may be a problem.

I guess the sad thing is that you go through that program and you kind of build up this relationship, this trust with them [the facilitators]… it's a shame that then, those two, can't personally provide ongoing support.

A major factor in reducing mother's sense of social isolation during the program was also the support received from facilitators, particularly the weekly phone calls. Mothers spoke of the difficulty of losing that support from facilitators at the end of the program. However, the three mothers at the six-month follow-up interview felt that they had had enough support, suggesting that while the small casework component of MIM had been appreciated, these mothers did not have high support needs. Other mothers with fewer internal and external resources may be in a very different position.

1.17 Program Delivery and Client Satisfaction

Participants were generally happy with the program which adhered closely to MIM structure and content as set out in the session guide.

While there is no data for the 2016 programs, the 2017 program adhered to the MIM session structure and included the trauma-informed practice content. Participants felt that their agency and autonomy was respected, that the program was culturally responsive and inclusive, and that participation in MIM helped to strengthen their relationships with their children. All participants felt extremely or somewhat satisfied with the program and all said they could recommend it other mothers.

Facilitators believed that mothers responded positively to the group and this is supported by all the participant feedback. The warm and relaxed group atmosphere fostered by the facilitators and the connections made between participants and facilitators appear to have been critical to mothers' experiences. The one-to-one engagement between facilitators and mothers appears to have been

It was nice to have a chat to some of the other women and just hear what they've been through and what they're still going through and realise that there are other people that share the same feelings and have shared the same road or a similar road to you.

particularly important, both during and between sessions. Phone calls and messages were appreciated even if the mother was not able to answer or respond.

Both participants and facilitators noted that it was difficult to discuss some issues with the children so close, and some separation could be useful, through using a larger space or an extra facilitator. In addition, several participants would have liked more assistance for their children in dealing with trauma issues. Given the age of the children, both participants and facilitators advocated for a morning session so as not to disrupt nap time.

At the six-month follow-up, mothers continued to speak highly about their experience of the program. However, mothers also identified the need for more DFV content and for facilitators to have specialist skills in working with children and DFV, to make the program engaging and relevant to each family's circumstances.

> *The only other thing I'd say is maybe just a bit more about family violence. What it actually is as well, not just only about the physical stuff, but the underlying emotional.*

1.18 Recruitment, Referrals and Assessment

For all groups, most referrals were received during the week preceding the first group session. This did not allow adequate time for the assessment process. As a result, the Term 4 2017 group was cancelled due to a lack of referrals a week before the group's commencement. Recruitment difficulties for the Term 4 2017 program were exacerbated by the provision of the better-resourced Children and Mothers in Mind program. Staff feedback suggests that improvements could be made in communicating the target population and the need for an assessment to potential referrers.

A significant proportion of the referrals came from two sources – the North East Metro Child and Family Services Alliance, and maternal and child health services. This suggests that professional relationships and networking contribute to successful recruitment, and that services with a focus on young children were more conscious of the need for a program working with both mothers and children. Surprisingly few referrals came from Child Protection, given the large proportion of participants who had current or previous Child Protection involvement.

Facilitators found the assessment process useful as a means of assessment and engagement. There was some concern that the focus on past trauma history was too great, leading to false expectations of what would be addressed during the program. Information about participants' trauma history is required to build a participant profile to compare with the target population. Beyond this, professional skills are essential to obtain enough information about participants' trauma backgrounds to support them effectively in relation to its impact on parenting, without unduly intruding.

Conclusions

Within the limitations of the small sample size, the MIM program appears to have a positive impact.

The MIM 2016-17 cycles of the MIM program boosted participants' confidence in themselves and their parenting skills, while assisting with trauma-informed parenting strategies. The opportunity to connect with other mothers with similar trauma backgrounds and to talk about these experiences and feelings was an important component, as was the self-care content of the program. These positive effects of the MIM program continued to be present six months following the completion of the program.

By its design, MIM is limited in the extent to which it can have an impact on issues such as social isolation, the impact of environmental stressors, and directly intervening with children themselves. It is hoped that the casework component added in the "Children and Mothers in Mind" adaptation of MIM will overcome these limitations.

The MIM program plays a role in supporting young families in the aftermath of FDV and may act as a catalyst for mothers in moving on and re-building their lives and the lives of their children.

> *We had a little girl . . . this sassy little girl, nearly three years old, and . . . she was jumping on her mum and her mum was laughing and it was just really beautiful. The little one had picked up on the idea that connection and affection were really important in this space.*

Recommendations

The data collected from this small sample of mothers and program facilitators, and in particular their comments about their experiences of MIM, lead to the following recommendations.

1. That a component is added to the program to allow mothers time (separate from their children) to learn more about DFV and its impacts and to engage with their own trauma issues.

2. That session content is delivered with flexibility to ensure that the content remains relevant and resonant for women at different stages in their journey away from violence.

3. That casework capacity is built in to the facilitator roles so that mothers and children are supported in dealing with:
    - external stressors such as housing, court processes, contact arrangements between father and children, or social isolation; or
    - child-specific issues.

4. That program planning makes MIM relevant and engaging for mothers from culturally and linguistically diverse backgrounds. This could include:
    - discussions during the assessment process of parenting with the participant's culture;
    - provision of extra support as appropriate to help with language or reading difficulties.

5. That facilitators continue to be highly skilled in DFV issues and child and family casework, and become very familiar with the program. Ideally, facilitators should gain experience of running the program repeatedly over time to build these skills.

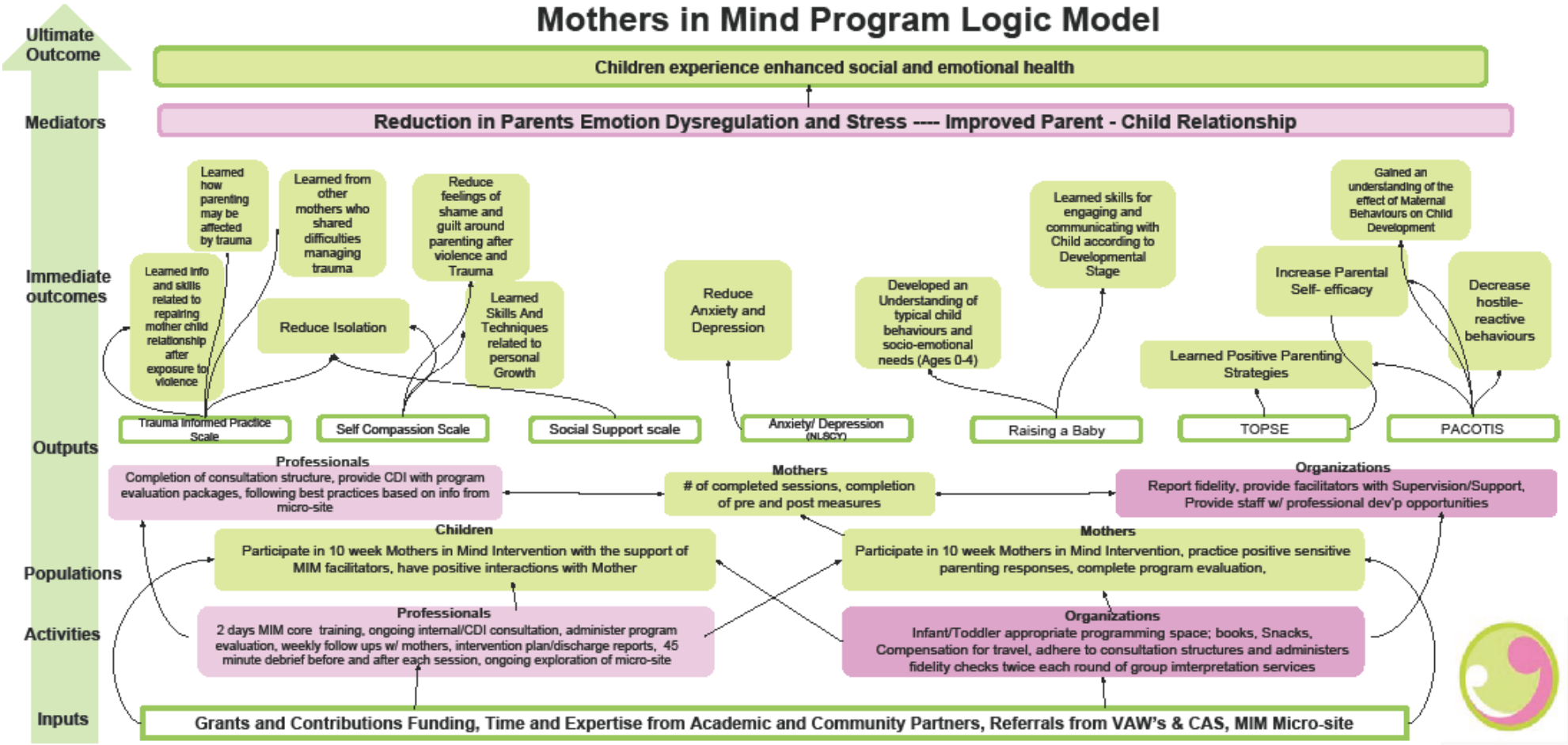
6. That one facilitator is present for every two mothers, as recommended in the MIM session guide.

7. That the program is run in a larger space, with room for children to play separately from their mothers, and with the possibility for active play.

8. That program sessions are held in the morning so as not to clash with afternoon naptimes for young children.

Appendices

Appendix 1: MIM Program Logic



Appendix 2: Description of Data Collection tools

Parent Assessment Tools - pre-MIM only

The Initial phone screening tool was created by the Child Development Institute and was used to collect information about referral source and reason for referral into MIM. This referral information was used to assess where referrals were coming from and to further understand why referrals were being made, that is, how the community views MIM and its objectives.

Demographics form: Participants from all groups completed the demographics form during their first MIM session. Participants provided information about their age, gender, cultural background, relationship status, employment status and level of education. Participants also provided information about previous history of hurtful experiences, such as neglect, physical, emotional and sexual abuse.

Parent Assessment Tools - pre- and post-MIM

Parenting Survey (PS): The 25-item Parenting Survey was developed by the Child Development Institute and utilised three subscales from Abidin's (1986) 120-item Parenting Stress Index: Parental Competency, Emotional Closeness and Isolation.

- The Parental Competency subscale measured participants' understanding of child development and child management skills (e.g. 'I feel capable and on top of things when I am caring for my child'). High scores on this subscale can be associated with participants feeling uncertain about their role as a parent. A score of 35 or higher on this subscale (out of a total of 55) is considered clinically concerning.
- The Attachment subscale measured participants' feelings of emotional closeness to their child, as well as their ability to observe and understand their child's feelings or needs (e.g. 'When I was young, I never felt comfortable holding or taking care of children'). High scores on this subscale can indicate that either the parent does not feel emotionally close to their child, or that parents feel unable to understand their child's feelings or needs. A score of 16 or higher on this subscale (out of a total of 35) is considered clinically concerning.
- The Isolation subscale measured participants' feelings of social isolation (e.g. 'I feel alone and without friends'). A score of 11 or higher on this subscale (out of a total of 30) is considered clinically concerning.

The items on these subscales were rated on a 5-point scale, where 1 represented 'Strongly agree' and 5 represented 'Strongly disagree'. The Parenting Survey was completed twice, pre- and post-MIM. After reversing negatively formulated questions, total scores on each subscale were calculated and compared using paired-samples t-tests. The Parenting Survey was completed by the Term 3, 2016 and Term 4, 2016 group participants only. It was removed from the Child Development Institute Evaluation Package at the beginning of 2017.

The Tool to Measure Parenting Self-Efficacy (TOPSE) was used to measure a change in perceived parenting self-efficacy across seven subscales measuring:

- emotion and affection (e.g. 'I have a good relationship with my child') ,
- play and enjoyment (e.g. 'I am able to have fun with my child'),
- empathy and understanding (e.g. 'I am able to listen to my child'),
- control (e.g. 'As a parent I feel I am in control'),
- discipline (e.g. 'I am able to reason with my child') and
- learning (e.g. 'I am able to learn and use new ways of dealing with my child').

A 14-item version of the TOPSE was used for this evaluation. This condensed version was created by the Child Development Institute from Kendall and Bloomfield's (2005) original 48-item TOPSE. The items were rated on an 11-point scale, where 0 represented 'completely disagree' and 10 represented 'completely agree'. The TOPSE was completed twice, pre- and post-MIM. Total scores on each subscale were created out of a total of 20, with a lower score indicating a lower level of perceived parenting self-efficacy for that subscale. These total scores were compared using paired-samples t-tests. The TOPSE was completed by participants from all three groups.

The Social Support Scale (SS): The eight-item SS measured participants' perceived levels of social support. The Child Development Institute created this instrument based on the 24-item Social Provisions Scale (Cutrona & Russell, 1987). Items such as 'If something went wrong, no-one would help me' and 'I lack a feeling of closeness with another person' were rated on a four-point scale, where 1 represented 'Strongly disagree' and 4 represented 'Strongly agree'. The responses were summed to create a total score out of 32, with a higher score indicating that participants felt a higher level of social isolation. Total scores were compared using paired-samples t-tests. The SS was completed twice, pre- and post-MIM, by the 2017 participants only.

The Patient Health Questionnaire for Depression and Anxiety (PHQ-4): The four-item PHQ-4 was used to measure the experiences of anxiety and depression experienced by participants within the previous two weeks (Kroenke, Spitzer, Williams & Lowe, 2009). The PHQ-4 is divided into two subscales: 2-item PHQ-2, consisting of core criteria for depression (e.g. 'Feeling down, depressed or hopeless'), and the GAD-2, a two-item measure of anxiety (e.g. 'Feeling nervous, anxious, or on edge'). The items were rated on a four-point scale where 0 represented 'Not at all' and 3 represented 'Nearly every day'. The responses are summed to create a total score out of 12, with a higher score indicating higher levels of depression and anxiety. Total scores were compared using paired-samples t-tests. The SS was completed twice, pre- and post-MIM, by the 2017 participants only.

The Self-Compassion Scale (SC) was used to assess how individuals typically acted towards themselves when faced with difficult situations. The 12-item SC is a shortened version of the 24-item Self Compassion Scale (Raes, Pommier, Neff & Van Gucht, 2011). The SC is divided into six subscales:

- 2-item Self-Kindness (e.g. 'I try to be understanding and patient towards those aspects of my personality that I don't like');

- 2-item Self-Judgment (e.g. 'I am disapproving and judgmental about my own flaws and inadequacies');
- 2-item Common Humanity (e.g. 'I try to see my failing as part of the human condition');
- 2-item Isolation (e.g. 'When I fail at something that's important to me, I tend to feel alone in my failure');
- 2-item Mindfulness (e.g. 'When something upsets me, I try to keep my emotions in balance'); and
- 2-item Over-Identification (e.g. 'When I fail at something important to me, I become consumed by feelings of inadequacy').

The items were rated on a five-point scale, where 1 represented 'Almost never' and 5 represented 'Almost always'. After reversing negatively formulated items, a total score was calculated out of 60, with higher scores indicating greater self-compassion. Total scores were compared using paired-samples t-tests. The SC was completed twice, pre- and post-MIM, by the 2017 participants only.

Raising a Baby (RAB): This 16-item scale assessed participants' knowledge of the social and emotional needs of infants and toddlers and developmentally appropriate expectations (Kelly, Korfmacher & Buehlmann, 2008). Items such as 'Strong-willed toddlers need to be spanked to get them to behave', and 'Toddlers learn more when they play on their own', were rated on a 4-point scale, where 1 represented 'Strongly disagree' and 4 represented 'Strongly agree'. A total score was calculated out of 64 both pre- and post-MIM and these scores were compared using paired-samples t-tests. RAB was completed by the 2017 participants only.

The Parental Cognitions and Conduct Toward the Infant Scale (PACOTIS) assessed parental cognitions and conduct towards their children. This 10-item instrument is divided into two subscales: Perceived Parental Impact, which measures parents' perceptions of how their behaviour affects their children and includes items such as 'Regardless of what I do, my child will develop on his/her own'; and Parental Hostile-Reactive Behaviours, which measures parents' self-reports of their hostile-reactive behavioural tendencies towards their children, including items such as 'I have lost my temper when my child was particularly fussy/difficult'. The 10-item PACOTIS was created by the Child Development Institute and condensed from the original 28-item scale (Boivin et al., 2005). Items were rated on an 11-point scale, ranging from 0 = 'Not at all what you do, how you think, how you feel' to 10 = 'Exactly what you do, what you think, how you feel'. Total scores on both subscales were calculated out of 50 and compared using paired-samples t-tests. PACOTIS was completed by the 2017 participants only.

<u>Program Assessment Tools</u>

The Trauma Informed Practice Scales (TIPS) were created by experts on trauma-informed practice in the DFV context, survivors of DFV and front line-advocacy workers (Sullivan & Goodman, 2015). This evaluation used three subscales from the TIPS package, which was completed post-MIM only:

- An 8-item Cultural Responsiveness and Inclusivity scale, measuring the degree to which participants felt the program and staff were culturally responsive and inclusive. Participants rated items such as 'Peoples' cultural backgrounds are respected in this program'. Total scores were calculated out of a total of 24.
- A 15-item Agency scale, measuring the degree to which participants felt the program and staff respected their agency and autonomy. Participants rated items such as 'I decide what I want to work on in this program'. Total scores were calculated out of a total of 45.
- A 5-item Parenting scale, measuring the degree to which participants felt the program helped them to strengthen their relationships with their children. Participants rated items such as 'Staff support me to strengthen my relationships with my children'. Total scores were calculated out of a total of 15.

All scales were rated on a 4-point scale, where 0 represented 'Not at all true' and 3 represented 'Very true'. TIPS was completed by the 2017 participants only.

The Client Satisfaction Questionnaire form was created by the Child Development Institute to collect information from participants regarding their overall satisfaction with the Mothers in Mind program. This form included questions about participant satisfaction with their experiences throughout the program and opportunities to provide feedback for facilitators. The Client Satisfaction Questionnaire was completed by participants from all groups.

The Group Fidelity and Integrity Checklist mirrors the core elements of the MIM program, and evaluates facilitators' adherence to the MIM program as set out in the MIM session guide. It is designed as an internal check by agency staff familiar with the MIM program twice within each 10-week intervention. The checklist was completed by the evaluator twice during the Term 2, 2017 group.

Interviews were conducted with both participants and staff.

- Participants: Semi-structured interviews with mothers took place in July 2017, occurring either within one month of completing the program for mothers from Term 2, 2017, or at least six months after completing the program for mothers from Terms 3 and 4, 2016. These interviews further explored participants' experiences of MIM, with a particular focus on how they thought MIM impacted their relationship with their children. The interview questions are provided at Appendix 4.
- CPS staff: Facilitators from all groups were interviewed in August 2017. These interviews further explored facilitators' experiences of MIM, including their perceptions of how well MIM achieved its aims. The interview questions are provided at Appendix 4.

Appendix 3: Data collection tools

Demographic Information Form

Psychometric measures

- Parenting Survey
- Tool to Measure Parenting Self Efficacy (TOPSE)
- Social Support Scale (SS)
- The Patient Health Questionnaire for Depression and Anxiety (PHQ-4)
- Self Compassion Scale (SC)
- Raising A Baby Scale (RAB)
- The Parental Cognitions and Conduct Toward the Infant Scale (PACOTIS)

Program Assessment Tools

- Trauma Informed Practice Scale (TIPS)
- Client Satisfaction Questionnaire

Demographic Information Form

Please answer the following questions.

1. Referral Source (who referred you to this program?):

O Self referral O Child Protection O Kinder/ Child Care

O Maternal Child Health Nurse O Community Agency

O Other _____

2. Your Age: _____

3. Your Child's Age:

O Infant (0-1 year) O One (13-24 months) O Two (25-36 months) O Three (27-48 months)

O Over four (> 49 months)

4. What is your country of birth? _____ 5. How many years have you lived in Australia? _____

6. If you were not born in Australia, are you a:

O Australian Citizen O Permanent Resident O Refugee

O Conditional Permanent Resident (Sponsorship) O Temporary Resident (visitor)

O Other (please specify): _____

7. How would you describe yourself?

O Aboriginal O African O Torres Strait Islander

O New Zealander O Anglo Australian O East Asian (China, Japan)

O European O Filipino O South American

O North American O Mixed O Middle Eastern O UK

O Pacific Islander (Polynesia, Melanesia, Micronesia) O South Asian (India, Sri Lanka etc.)

O South Asian (Thailand, Vietnam etc) O Other (please specify): _____

8. Is English your first language? O Yes O No

9. What is your main source of income?

O Workcover O Wages/Salaries O Child Support

O Government Assistance O Disability O Other: _____

10. What is your <u>current</u> annual household income? (Please include child support and financial aid)?

O $0-9,999 O $10-19,999 O $20-29,999 O $30-39,999 O $40-49,999

O $50-59,999 O $60,000+

11. Please indicate the highest level of education you have completed.

O No schooling O Some high school O Completed TAFE

O Some Primary O Completed high school O Some university

O Completed Primary O Some TAFE O Completed university

12. What is your <u>current</u> relationship status:

O Single, never married O Divorced O Separated, living apart

O Widowed O Married/defacto/partnered, living together

O Other _____

<u>Information about your child</u>

13. Where is your child <u>currently</u> living?

O With you O With his/her other parent O With another family member/friend

O Out of Home Care (i.e. foster care, kinship care) O Other_____

14. Has your child ever lived away from you?

O Yes O No

a) **If yes, please indicate:**
Child's age at the time he/she lived away from you? _____

15. Has your child ever been exposed to (i.e. seen, heard or heard about) the abuse of a parent/caregiver?

O Yes **O** No **O** Not Sure

16. Have you ever had any involvement with DHHS Child Protection (Select ALL that apply)

O Yes, when I was a child and/or teenager

O Yes, previous involvement with this child or another child

O Yes, I am currently involved with Child Protection

O No, I have never had any involvement with Child Protection

Experiences

The next section of questions is checking in about the different types of hurtful experiences you have had in your life. There are five areas that are asked about: experiences of neglect, physical abuse, sexual abuse, emotional or psychological abuse and exposure to family violence.

Most questions are broken up into two parts:

1) Have you experienced this in the last year? If yes, what was your relationship to the person who was abusive?

2) Have you experience this in the past, meaning when you were a child, youth or as an adult prior to the last year. If yes, in what age range did it happen and what was your relationship to the person who was abusive.

We understand that these questions may be difficult to answer. Please take your time and check in with a facilitator whenever you need to. Thank you for taking the time to fill in this information.

Neglect

(e.g.not providing YOU with enough clothing, food, attention, shelter, education, medicine, medical care or supervision)

17. Growing up, did you ever experience any form of neglect? O Yes O No

a) If yes, when did it occur?

Age Range	Yes/No
Birth to 6 years old	**O** Yes
7 to 11 years old	**O** Yes
12 to 17 years old	**O** Yes

Physical Abuse *(e.g.: pushing, hitting, punching, throwing of objects, destruction of property)*

18. Have you experienced physical abuse within the last year? **O Yes** **O No**

a) If yes, what was your relationship to the abuser?

O Parent/Caregiver

O Partner (i.e. husband/wife; boyfriend/girlfriend; defacto)

O Other Adult (i.e. family member/relative/family friend)

O Other: _____

Have you ever experienced physical abuse in the past (child, youth or adult)? **O Yes** **O No**

If yes, what age(s) did it happen and what was your relationship to the abuser?

Age Range	Yes/No	Relationship to the abuser
Birth to 6 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
7 to 11 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
12 to 17 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Boyfriend/girlfriend **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
Over 18	**O** Yes **O** No	**O** Parent/Caregiver **O** Partner (husband/wife; boyfriend/girlfriend; defacto) **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____

Sexual Abuse (e.g. unwanted touch, sexual assault, pressuring for intimacy, forcing of degrading sexual acts, withholding intimacy)

19. Have you experienced sexual abuse within the last year? **O Yes** **O No**

a) If yes, what was your relationship to the abuser?

O Parent/Caregiver

O Partner (i.e. husband/wife; boyfriend/girlfriend; defacto)

O Other Adult (i.e. family member/relative/family friend)

O Other: _____

Have you ever experienced sexual abuse in the past (child, youth or adult)? **O Yes** **O No**

If yes, what age(s) did it happen and what was your relationship to the abuser?

Age Range	Yes/No	Relationship to the abuser
Birth to 6 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
7 to 11 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
12 to 17 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Boyfriend/Girlfriend **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
Over 18	**O** Yes **O** No	**O** Parent/Caregiver **O** Partner (i.e. husband/wife; boyfriend/girlfriend; defacto) **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____

Emotional or Psychological Abuse *(e.g. threats, name calling, possessiveness, isolation from friends/family, controlling what you wear or access to medical care)*

20. Have you experienced emotional or psychological abuse within the last year? **O Yes** **O No**

a) If yes, what was your relationship to the abuser?

- **O** Parent/Caregiver
- **O** Partner (i.e. husband/wife; boyfriend/girlfriend; defacto)
- **O** Other Adult (i.e. family member/relative/family friend)
- **O** Other: _____

Have you ever experienced emotional or psychological abuse in the past (child, youth or adult)? **O Yes** **O No**

If yes, what age(s) did it happen and what was your relationship to the abuser?

Age Range	Yes/No	Relationship to the abuser
Birth to 6 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
7 to 11 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
12 to 17 years old	**O** Yes **O** No	**O** Parent/Caregiver **O** Boyfriend/Girlfriend **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____
Over 18	**O** Yes **O** No	**O** Parent/Caregiver **O** Partner (i.e. husband/wife; boyfriend/girlfriend; defacto) **O** Other Adult (i.e. family member/relative/family friend) **O** Other: _____

Exposure to Family Violence (e.g. see, hear, observe the aftermath or feel the tension due to verbal, physical,

sexual or psychological violence between OTHER ADULTS in your family)

***This does not include any abuse that happened directly to you, but rather abuse that you may have witnessed between other adults.**

21. Have you been exposed to family violence within the past year? **O Yes O No**

a) If yes, who was the violence between?

- **O** Parents/Caregivers (or parent and their partner)
- **O** Family members
- **O** Other: _____

Have you ever been exposed to family violence in the past (child, youth or adult)? **O Yes O No**

If yes, what age(s) did it happen and who was the violence between?

Age Range	Yes/No	Relationship to the abuser
Birth to 6 years old	**O** Yes **O** No	**O** Parents/Caregivers (or parent and their partner) **O** Family members **O** Other: _____
7 to 11 years old	**O** Yes **O** No	**O** Parents/Caregivers (or parent and their partner) **O** Family members **O** Other: _____
12 to 17 years old	**O** Yes **O** No	**O** Parents/Caregivers (or parent and their partner) **O** Family members **O** Other: _____
Over 18	**O** Yes **O** No	**O** Parents/Caregivers (or parent and their partner) **O** Family members **O** Other: _____

Parenting Supports

22. All parents need a break from parenting at some point in time. How often do you feel like you need a break from parenting?

o Most of the time o Sometimes o Rarely

23. What support(s) do you use when you feel like you need a break from parenting? (Select ALL that apply)

o Family members o Overnight Respite o Friends/neighbours

o Self care (i.e. taking time for yourself) o Occasional Child Care

o Voluntary Respite Program o Regular Child Care (i.e. child attends everyday)

o I don't have any options to get a break from parenting o Other: _____

24. Goals: What do you feel you got out of attending Mothers in Mind? (Check ALL that apply)

o A chance to talk about parenting with other mothers who have had similar experiences

o More confidence in my parenting

o Helpful ways to cope with anger, worry and stress

o Time to play with my child

o Some more ideas on how to respond to my child in a sensitive and caring manner

o Better understanding of what helps children feel safe and secure

o Better understanding of how hurtful experiences can impact parenting and relationships

o Other: _____

Thank you for taking the time to answer the questions.

Pre-Group Parenting Survey

Mothers in Mind

Please circle one response for each of the following statements. If you have more than one child attending the MIM program with you, please focus on the child that you are most concerned about. While you may not find a response that exactly describes your feelings, please circle the response that comes closest to how you feel.

1 = Strongly Agree 2 = Agree 3 = Not Sure 4 = Disagree 5 = Strongly Disagree

1. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.	1 2 3 4 5
2. Being a parent is harder than I thought it would be.	1 2 3 4 5
3. I feel capable and on top of things when I am caring for my child.	1 2 3 4 5
4. I can't make decisions without help.	1 2 3 4 5
5. I have had many more problems raising children than I expected.	1 2 3 4 5
6. I enjoy being a parent.	1 2 3 4 5
7. I feel that I am successful most of the time when I try to get my child to do or not do something.	1 2 3 4 5
8. Since I brought my last child home from the hospital, I find that I am not able to take care of this child as well as I thought I could. I need help.	1 2 3 4 5
9. I often have the feeling that I cannot handle things very well.	1 2 3 4 5
10. It takes a long time for parents to develop close, warm feelings for their children.	1 2 3 4 5
11. I expected to have closer and warmer feelings for my child than I do and this bothers me.	1 2 3 4 5
12. Sometimes my child does things that bother me just to be mean.	1 2 3 4 5
13. When I was young, I never felt comfortable holding or taking care of children.	1 2 3 4 5
14. My child knows I am his or her parent and wants me more than other people.	1 2 3 4 5
15. The number of children I have now is too many.	1 2 3 4 5
16. I feel alone and without friends.	1 2 3 4 5
17. When I go to a party, I usually expect not to enjoy myself.	1 2 3 4 5
18. I am not as interested in people as I used to be.	1 2 3 4 5
19. I often have the feeling that other people my own age don't particularly like my company.	1 2 3 4 5
20. When I run into a problem taking care of my children, I have a lot of people to whom I can talk to, get help, or advice.	1 2 3 4 5
21. Since having children, I have a lot fewer chances to see my friends and to make new friends.	1 2 3 4 5

For the following statements please circle your choice from 1 to 5.

22. When I think about myself as a parent I believe:
    1. I can handle anything that happens
    2. I can handle most things pretty well
    3. Sometimes I have doubts, but find that I can handle most things without any problems
    4. I have some doubts about being able to handle things
    5. I don't think I handle things very well at all

23. I feel that I am:
    1. A very good parent
    2. A better than average parent
    3. An average parent
    4. A person who has some trouble being a parent
    5. Not very good at being a parent

24. What were the highest levels in school or college you and the child's father have completed? (Please circle one response for each)

Mother

1. 1^{st} to 8^{th} grade
2. 9^{th} to 12^{th} grade
3. Some college/university
4. College/university graduate
5. Graduate or professional school

Father

1. 1^{st} to 8^{th} grade
2. 9^{th} to 12^{th} grade
3. Some college/university
4. College/university graduate
5. Graduate or professional school

25. How easy is it for you to understand what your child(ren) wants or needs?
    1. Very easy
    2. Easy
    3. Somewhat difficult
    4. It is very hard
    5. I usually can't figure out what the problem is

(TOPSE) This section asks about some of your experiences as a parent											
Using the scale below, please circle how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10.											
0 Completely disagree	1	2	3	4	5	6	7	8	9	10 Completely Agree	
1. I am able to help my child reach their full potential	0	1	2	3	4	5	6	7	8	9	10
2. I am able to have fun with my child	0	1	2	3	4	5	6	7	8	9	10
3. As a parent I feel I am in control	0	1	2	3	4	5	6	7	8	9	10
4. I am able to stay calm when my child is behaving badly	0	1	2	3	4	5	6	7	8	9	10
5. I understand my child's needs	0	1	2	3	4	5	6	7	8	9	10
6. I am able to listen to my child	0	1	2	3	4	5	6	7	8	9	10
7. I am confident my child can come to me if they're unhappy	0	1	2	3	4	5	6	7	8	9	10
8. I have a good relationship with my child	0	1	2	3	4	5	6	7	8	9	10
9. I am able to reason with my child	0	1	2	3	4	5	6	7	8	9	10
10. I can find ways to avoid conflict	0	1	2	3	4	5	6	7	8	9	10
11. I know I am a good enough parent	0	1	2	3	4	5	6	7	8	9	10
12. I manage the pressures of parenting as well as other parents do	0	1	2	3	4	5	6	7	8	9	10
13. I am able to make the changes needed to improve my child's behavior	0	1	2	3	4	5	6	7	8	9	10
14. I am able to learn and use new ways of dealing with my child	0	1	2	3	4	5	6	7	8	9	10

(SS) This section asks about some of the supports in your life								
The following statements are about relationships and supports that you get from others. For each of the following, please use the scale and circle whether you strongly agree, agree, disagree or strongly disagree. You may circle any number between 1 (Strongly disagree) and 4 (Strongly Agree).								
1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree					
1. If something went wrong, no-one would help me				1	2	3	4	
S/C) This section asks about your experiences as an ind				1	2	3	4	
3. There is someone I trust whom I would turn to for advice if I was having problems				1	2	3	4	
4. There is no one I feel comfortable talking about problems with				1	2	3	4	
5. I lack a feeling of closeness with another person				1	2	3	4	
6. There are people that I can count on in an emergency				1	2	3	4	
7. I feel part of a group of people who share my attitudes and beliefs				1	2	3	4	
8. There is no one who shares my interests and concerns				1	2	3	4	

(PHQ-4) This section asks about ways you might have been feeling recently							
Over the **past two weeks** have you been bothered by these problems? Please answering by circling a number on the scale from 0 (Not at all) to 3 (Nearly everyday)							
0 Not at all	1 Several Days	2 More days than not	3 Nearly every day				
1. Feeling nervous, anxious, or on edge				0	1	2	3
2. Not being able to stop or control worrying				0	1	2	3
3. Feeling down, depressed or hopeless				0	1	2	3
4. Little interest or pleasure in doing things				0	1	2	3

(S/C) This section asks about your experiences as an individual

The scale ranges from 1 (almost never) to 5 (Almost Always) To the left of each item, indicate how often you behave in the stated manner, using the scale below :	
1 2 3 4 5 Almost never	Almost Always
1. When I fail at something important to me, I become consumed by feelings of inadequacy	1 2 3 4 5
2. I try to be understanding and patient towards aspects of my personality that I don't like	1 2 3 4 5
3. When something painful happens, I try to take a balanced view of the situation.	1 2 3 4 5
4. When I am feeling down, I tend to feel like most other people are probably happier than I am	1 2 3 4 5
5. I try to see my failing as part of the human condition	1 2 3 4 5
6. When I am going through a very hard time, I give myself the caring and tenderness I need	1 2 3 4 5
7. When something upsets me, I try to keep my emotions in balance	1 2 3 4 5
8. When I fail at something that's important to me, I tend to feel alone in my failure	1 2 3 4 5
9. When I am feeling down I tend to obsess and fixate on everything that is wrong.	1 2 3 4 5
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most	1 2 3 4 5
11. I'm disapproving and judgmental about my own flaws and inadequacies	1 2 3 4 5
12. I'm intolerant and impatient towards those aspects of my personality I don't like	1 2 3 4 5

(RAB) The following questions are about how you think most babies and toddlers act, how they grow, and how to care for them. Please choose the answer that best fits what you think about babies and toddlers in general using the following scale:				
1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree	
1. Children who learn to recognize feelings in others are more successful in life				1 2 3 4
2. Strong-willed toddlers need to be spanked to get them to behave.				1 2 3 4
3. A 6-month-old baby will respond to someone differently depending on whether the person is happy, sad or upset.				1 2 3 4
4. Parents spoil babies by picking them up when they cry.				1 2 3 4
5. Talking to babies only really becomes important when they are old enough to start using some of their own words.				1 2 3 4
6. Children have the right to their own point of view and should be allowed to express it.				1 2 3 4
7. When babies or toddlers get upset, they need to depend on themselves to feel better.				1 2 3 4
8. Giving toddlers a lot of choices leads to power struggles				1 2 3 4
9. The best way to help a toddler through a tantrum is to ignore them				1 2 3 4
10. It is important for parents to understand their own feelings when dealing with their upset children				1 2 3 4
11. Toddlers learn more when they play on their own				1 2 3 4
12. Children under three are too young to understand or care how other people feel				1 2 3 4
13. A toddler's misbehaviour is a sign they need help from his/her parent				1 2 3 4
14. Parents should expect that toddlers are going to protest and tantrum				1 2 3 4
15. Parents should praise a child's efforts even in the results are not right				1 2 3 4
16. Children who learn to handle feelings have better relationships with others				1 2 3 4

(PACOTIS) This section asks about some of your experiences as a parent

Please indicate to what extent each statement accurately describes your actions, your thoughts, or your feelings towards your child *over the past two months*

0 Not at all what you do, what you think, how you feel	1 2 3 4 5 6 7 8 9	10 Exactly what you do, what you think, how you feel
1. My behaviour has little effect on how much my child will interact with others in the future	0 1 2 3 4 5 6 7 8 9 10	
2. I have lost my temper when my child was particularly fussy/difficult	0 1 2 3 4 5 6 7 8 9 10	
3. My behaviour has little effect on the personal development of my child	0 1 2 3 4 5 6 7 8 9 10	
4. I've been angry with my child when he/she was a particularly fussy/difficult	0 1 2 3 4 5 6 7 8 9 10	
5. Regardless of what I do, my child will develop on his/her own	0 1 2 3 4 5 6 7 8 9 10	
6. When my child cries, he/she gets on my nerves	0 1 2 3 4 5 6 7 8 9 10	
7. My behaviour has little effect on the intellectual development of my child	0 1 2 3 4 5 6 7 8 9 10	
8. I have raised my voice with or shouted at my child when he/she is particularly fussy/difficult	0 1 2 3 4 5 6 7 8 9 10	
9. My behaviour has little effect on the development of emotions (eg. happiness, fear, anger) in my child	0 1 2 3 4 5 6 7 8 9 10	
10. I have left my child alone in his/her bedroom when he/she is particularly fussy/difficult	0 1 2 3 4 5 6 7 8 9 10	

(TIPS) Please let us know how true the following statements are as you think about your interactions with staff in this program on a scale from 0 to 3 or circle "?" if you don't know. You may feel different ways about different staff members. Please respond with your overall impression of the staff.

0 Not at all true	**1** A little true	**2** Somewhat true	**3** Very True	**?** I don't know
1. I am learning more about how children react emotionally when they have witnessed or experienced abuse, and other hardships				0 1 2 3 ?
2. Staff help me explore how children's relationships can be affected by witnessing or experiencing abuse, and other like difficulties				0 1 2 3 ?
3. I am learning more about how my own experience of abuse can influence my relationships with my children.				0 1 2 3 ?
4. The program provides opportunities for children to get help dealing with the abuse and other hardships they may have experienced or been affected by				0 1 2 3 ?
5. Staff support me to strengthen my relationships with my children				0 1 2 3 ?

(TIPS) Please let us know how true the following statements are **as you think about your interactions with staff in this program** on a scale from 0 to 3. You may feel different ways about different staff members. Please respond with your overall impression of the staff using the following scale:

0 Not at all true	**1** A little True	**2** Somewhat True	**3** Very True	
1. Staff respect my privacy.				0 1 2 3
2. Staff are supportive when I'm feeling stressed out or overwhelmed				0 1 2 3
3. I decide what I want to work on in this program				0 1 2 3
4. Staff treat me with dignity				0 1 2 3
5. Staff respect the strengths I have gained through my life experiences.				0 1 2 3
6. Staff respect the strengths I get from my culture or family ties.				0 1 2 3
7. Staff understand that I know what's best for me.				0 1 2 3
8. In this program, I have opportunity to connect with others.				0 1 2 3
9. I have opportunities to help other survivors of abuse in this program				0 1 2 3
10. The strengths I bring in my relationships with my children, my family or others are recognized in this program				0 1 2 3
11. Staff respect the choices that I make				0 1 2 3
12. In this program, I can share things about my life on my own terms and at my own pace				0 1 2 3
13. I have the option to get support from peers or others who have had experiences similar to my own				0 1 2 3
14. Staff can handle difficult situations				0 1 2 3
15. I can trust staff				0 1 2 3

(TIPS) Please let us know how true the following statements are **as you think about your interactions with staff in this program** on a scale from 0 to 3. You may feel different ways about different staff members. Please respond with your overall impression of the staff using the following scale:

0 Not at all true	**1** A little True	**2** Somewhat True	**3** Very True	
1. Peoples' cultural backgrounds are respected in this program.				0 1 2 3 ?
2. Peoples' religious or spiritual beliefs are respected in this program.				0 1 2 3 ?
3. Staff respect peoples' sexual orientation or gender expression				0 1 2 3 ?
4. Staff understand what it means to be in my financial situation.				0 1 2 3 ?
5. Staff understand the challenges faced by people who are immigrants.				0 1 2 3 ?
6. Staff understand how discrimination impacts peoples' everyday experience.				0 1 2 3 ?
7. Staff recognize that some people or cultures have endured generations of violence, abuse, and other hardships				0 1 2 3 ?
8. This program treats people who face physical or mental health challenges with compassion.				0 1 2 3 ?

Client Satisfaction Questionnaire

1. Overall, how satisfied were you with your experiences in Mothers in Mind®?

	Extremely satisfied
	Somewhat satisfied
	Neither satisfied or unsatisfied
	Somewhat unsatisfied
	Not satisfied at all

2. What did you like about participating in the group?

_____

_____

3. What did you not like about participating in the group?

_____

_____

4. Would you recommend this group to others? Yes No

5. Have you noticed any positive changes in your relationship with your child/infant as a result of your participation in the group? Yes No

   Please explain:

_____

_____

6. Do you feel that attending this group has made you a better parent? Yes No

   Please explain:

_____

_____

7. Did you complete the goals that you set out for yourself at the beginning of the group?

	I completed all of my goals
	I completed some of my goals
	I did not complete any of my goals

Please explain:

_____

Do you feel that attending this group helped you to begin to develop connections with others attending the group or with people and/or agencies in your community Yes ☐ No ☐

Please explain: ?

_____

_____

8. The Mothers in Mind® group included both mothers and children/infants, How did you feel about this structure for group? Would you prefer:

   ☐ The group structure stay the same (mothers and children/infants together for the entire session)

   ☐ There is some time during the session when the children/infants are cared for in another room and the mothers participate in a discussion with facilitators

   ☐ The children/infants are cared for in another room for the entire session while the mothers participate in the group

9. What do you feel you got out of attending Mothers in Mind®?" **(Check ALL that apply)**

   ☐ A chance to talk about parenting with other mothers who have had similar experiences

   ☐ More confidence in my parenting

   ☐ Helpful ways to cope with anger, worry and stress

   ☐ Time to play with my child

   ☐ Some more ideas on how to respond to my child in a sensitive and caring manner

   ☐ Better understanding of what helps children feel safe and secure

   ☐ Better understanding of how hurtful experiences can impact parenting and relationships

   ☐ Other: _____

10. What did you find most helpful from the group?

_____

11. What would you suggest be done differently in future groups?

_____

12. Any other suggestions, comments, ideas, feedback...?

_____

Thank you for your feedback!

Appendix 4: Semi-Structured Interviews

Participant Interview Questions

1. To begin, tell me tell me a little about yourself?
    - Current situation / Family / Children (is mother still separated from perpetrator?)

2. Tell me about the Mothers in Mind program you have attended
    - How did you become involved/find out about it?
    - Just completed or 6 months on?
    - What did you think about it (facilitators, other participants, venue, activities)?

3. How many sessions were you able to attend?
   What kept you coming to the group? / What got in the way of you coming to the group?
   (facilitators, other participants, venue, activities)

4. What were some of the things that were discussed within the program?
   (eg. taking care of oneself, impact of violence on the child, responding to the child's needs - safety, development, temperament)

5. Please give me an example/s of how the program has had an impact on you?
    - What are the main things you have taken away from the program?
    - Have these had an impact on you in any way?

6. Did you notice any changes in your stress levels as a result of coming to the group? [Please explain]
   For follow-up interviewees: If yes, do you still notice these changes?

7. Did you notice any changes in your relationship with your child as a result of coming to the group? [Please explain] *For follow-up interviewees:* If yes, do you still notice these changes?

8. How do you think the experience of violence has affected your relationship with your child? [Please explain]

9. Do you and your family get support from other services?
    - Can you tell me about other people or agencies or members of your cultural community who have been helpful to you and why?
      (Draw ecomap of informal and formal support)

10. Is there anything that you would like to see change or improved within the Mothers in Mind program that could be of help to you or other mothers?

11. Is there anything else about the Mothers in Mind program or your experiences of the program that might be useful to talk about?

Staff Interview questions

1. Role of interviewee: Facilitator / Manager

2. For Facilitators: Dates of program you facilitated _____

3. To start us off, could you tell me about your experience of facilitating the Mothers in Mind program?

4. Please take me through the referral process for MIM (step by step).
    - What worked well?
    - What problems did you encounter?
    - How could these be avoided in the future?

5. Please discuss the process of undertaking assessments with the mothers in the group
    - Were there any issues you encountered?
    - What worked well in this process?
    - How do you think the assessment tools could be improved?

6. In your opinion, what did mothers hope to get out of the group?

7. How well do you think mothers engaged with the program content?
    - Topics that worked well
    - Activities that worked well (free play, welcome circle, talk play connect, goodbye circle)
    - Areas mothers had difficulties

8. Please provide an example of how you think the Mothers in Mind program has made an impact on participants? (*Prompt: do these relate to mothers' hopes – question 6*?)
    - What worked well?

9. How do you believe the children experienced the time during the group?
    - Were there any difficulties for the children?
    - Were there any challenges for the facilitators in managing the children and their interactions with their mothers or others in the group?

10. What were some of the other difficulties you encountered in the delivery of the program? (eg. Size of group, location of group, room environment, CALD issues, etc.)
    - How did you overcome these?
    - What can future group facilitators do to avoid these difficulties?

11. How did you perceive the dynamic between;
    - You and the other facilitator?
    - Facilitators and the mothers? (including group and individual conversations)
    - Facilitators and the children?

12. What has your contact been with other services in relation to the Mothers in Mind program you facilitated? (eg. Linking mothers to supports following the program)
    Does the program fit well into the current service system?

13. How do you think the Mothers in Mind program could be enhanced?

14. As a facilitator / manager, tell me about the training and guidance you received before and during the group?
    - Initial training (through Angelique?)
    - Session guide and its content?
    - Other support from Canada or CPS?

15. Is there anything else about the Mothers in Mind program or your experiences as a facilitator / manager of the program that might be useful to discuss?

References

Abidin, R. R. (1986). *Parenting stress index.* Charlottesville, V. A.: Pediatric Psychology Press.

Australian Bureau of Statistics. (2013). Personal Safety Survey, Australia, 2012 (Cat. No. 4906.0). Canberra: ABS.

Boivin, M., Perusse, D., Dionne, G., Saysset, V., Zoccolillo, M., Tarabulsy, G. M., & Tremblay, R. E. (2005). The genetic-environmental etiology of parents' perceptions and self-assessed behaviours towards their 5 month old infants in a large twin and singleton sample. *Journal of Child Psychology and Psychiatry 46*(6), pp. 612-630.

Buchanan, F. (2008). Mother and infant attachment theory and domestic violence: Crossing the divide (Stakeholder Paper 5). Sydney: ADFVC.

Child Development Institute. (n.d.) Mothers in Mind Final Report 2012-15. Prepared for the Alva Foundation.

Cox, P. (2015). Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. *Horizons Research Report, Issue 1.* Australia's National Research Organisation for Women's Safety: Sydney.

Cutrona, C. E. & Russell, D. W. (1987). The provisions of social relationships and adaptation to stress. *Advances in personal relationships 1*(1), pp. 37-67.

Department of Health and Human Services [DHHS] (2013) Assessing children and young people experiencing family violence: A practice guide for family violence practitioners. Melbourne: Victoria.

Department of Health and Human Services [DHHS] (2016). *Roadmap to Reform: Strong families, safe children – the first steps.* Melbourne: Victoria.

Diemer K. (2012) Measuring Family Violence in Victoria: The Victorian Family Violence Database. Melbourne: Vic Dept of Justice, Melbourne.

Flannery, K., Irwin, J., & Lopes, A. (2000). Connections and cultural difference: Women, groupwork and surviving domestic violence. *Women Against Violence, 9,* pp. 14-21.

Graham-Bermann, S. A. , Lynch, S., Banyard, V., DeVoe, E. R., & Halabu, H. (2007). Community-based intervention for children exposed to intimate partner violence: An efficacy trial. *Journal of Consulting and Clinical Psychology, 75*(2), pp. 199-209.

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect, 32*(8), pp. 797-810.

Hooker, L., Kaspiew, R., & Taft, A. (2016). Domestic and family violence and parenting: Mixed method insights into the impact and support needs (ANROWS Landscapes 01/2016). Sydney: ANROWS.

Humphreys, C. (2007). Talking to my mum: Strengthening relationships between mothers and children in the aftermath of family violence. *Developing Practice 19*, pp. 12-15.

Humphreys, C. (2011). Rebuilding together: Strengthening the mother-child bond in the aftermath of violence. *DVRCV Quarterly, 3*(Spring/Summer), pp. 6-10.

Humphreys, C., Thiara, R. K., Sharp, C., & Jones, J. (2015). Supporting the relationship between mothers and children in the aftermath of domestic violence. In Humphreys, C., & Stanley, N. (Eds.) *Domestic violence and protecting children: New thinking and approaches*.

Humphreys, C., Thiara, R. K., & Skamballis, A. (2011). Readiness to change: Mother-child relationship and domestic violence intervention. *British Journal of Social Work, 41*(1), pp. 166-184.

Kelley, J., Korfmacher, J., & Buelhman, K. (2008). *Ways of being with children.* University of Washington, Seattle, WA: Unpublished manuscript.

Kendall, S. & Bloomfield, L. (2005). Developing and validating a tool to measure parenting self-efficacy. *Journal of Advanced Nursing 51*(2), pp. 174-181.

Kroenke, K., Spitzer, R. L., Williams, J. B., & Lowe, B. (2009). An ultra-brief screening scale for anxiety and depression: The PHQ-4. *Psychosomatics 50*(6), pp. 613-621.

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of American Academy of Child and Adolescent Psychiatry, 45(8), pp. 913-918.*

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical Psychology & Psychotherapy 18*(3), pp. 250-255.

State of Victoria (2016). *Royal Commission into Family Violence: Summary and Recommendations* (Parl Paper No 132, 2014-2016). Melbourne: State of Victoria.

Sullivan, C., M., & Goodman, L. (2015). A guide for using the Trauma Informed Practices (TIP) Scales. Available at: dvevidenceproject.org/evaluation-tools

Thiara, R. K., & Humphreys, C. (2017). Absent presence: The ongoing impact of men's violence on the mother-child relationship. *Child & Family Social Work 22*, pp. 137-145.

Women's Health in the North. (2016). *Violence against women: Information and facts 2015-2016.* Retrieved from http://www.whin.org.au/images/PDFs/FViolence/FVFactsheets2016/FVFactsheet_NMR_final_Dec_2016_Final.pdf