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CENTRE FOR SOCIAL AND EARLY EMOTIONAL DEVELOPMENT

PREVENTING AND RESPONDING TO VIOLENCE AND PROMOTING SOCIAL INCLUSION AND COMMUNITY CONNECTION:

A RESEARCH PROJECT FOR THE EASTERN METROPOLITAN SOCIAL ISSUES COUNCIL (EMSIC)

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PREPARED BY:
E Clancy, B Marshall and J Toumbourou,
Deakin University

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CENTRE FOR SOCIAL AND EARLY EMOTIONAL DEVELOPMENT (SEED)
Phone: +61 3 9244 5248
Fax: +61 3 9244 6858

Deakin University
221 Burwood Highway
Burwood VIC 3125
www.deakin.edu.au/seed

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EASTERN METROPOLITAN SOCIAL ISSUES COUNCIL REPORT

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PURPOSE

This report has been prepared for members of the Eastern Metropolitan Social Issues Council (EMSIC) to summarise the work conducted by Deakin University and provide recommendations for consideration in relation to regional approaches to address violence in vulnerable communities and promote social inclusion and community connectedness.

BACKGROUND

In early 2015, EMSIC members determined two priority areas: **Violence in Vulnerable Communities**[1] and **Social Inclusion and Community Connectedness**. In June 2015, Deakin University was appointed as a research partner to review current work in these priority areas, identify partnership approaches and make recommendations for future opportunities. The report was supported by the input of two Advisory Groups, consisting of EMSIC members.

PROCESS

Deakin conducted a range of activities as part of this project. An initial desktop mapping exercise identified relevant current activities in these areas, including local and broader programs of work. This mapping was then circulated for comment and feedback from stakeholders and reviewed. A literature review identified national and international evidence regarding best practice to prevent and respond to the identified priority issues. Consultation with a range of stakeholders, including practitioners and academic partners, was conducted to further develop areas in which the literature was less extensive, and to determine opportunities for further work. Additional work was conducted in relation to identifying potential process and outcome indicators that could be used to monitor progress in the priority areas. A draft evidence report was presented to the EMSIC Council in December 2015, and a workshop conducted in February 2016 with local stakeholders to discuss the research findings and areas for future work and to obtain further feedback on the evidence report.

EVIDENCE REPORT

The evidence report has now been finalised, and includes the results of the literature reviews, activity mapping, indicators and suggested domains of work. The Evidence report is included, commencing on Page 9 of this document.

[1] It is noted that whilst the initial briefing referred to Violence in Vulnerable Communities, engagement with the Advisory Group and consultation identified the key priorities as Family/Domestic Violence and Violence against women, and Community violence, hence this report focuses on those areas.

WORKSHOP FINDINGS

A regional workshop was held in February 2016, with EMSIC members and associate members and other regional organisations invited. Approximately 45 stakeholders attended this workshop, at which the evidence report was tabled and discussed in detail. Attendees were asked to consider three key questions in relation to the materials presented on both Violence and Social Inclusion.

- **What are the implications of the research for their organizations?**
- **What would success look like?**
- **What is needed to achieve this success?**

Key themes arising from the discussion are summarised below.

VIOLENCE

Participants generally responded positively to the material presented in relation to Violence, particularly for those who are less regularly embedded in this work. The emphasis on social determinants and drivers of violence against women/ family violence and community violence was considered helpful and promoted discussion of the importance of embedding a prevention agenda. Groups noted the current state-wide and regional focus on family/domestic violence and violence against women, including regional partnerships and the Royal Commission into Family Violence, and several found it helpful to refresh their current understanding, whilst noting that several reports and project evaluations due for release will further contribute to the evidence base.

Participants identified the need to build on and support, rather than duplicate, existing work in this area, particularly through partnerships such as Together for Equality and Respect (TFER), the Eastern Metropolitan Regional Family Violence Partnership (EMR RFVP), the Indigenous Family Violence Regional Action Group (IFVRAG) and the Outer East Child and Youth Area Partnership (OECYAP). There was a strong emphasis on adopting a collective impact approach to moving forward, with increased collaboration and coordination of effort, and am emphasis on population health outcomes. Broadening the reach of work into CALD communities and engaging in co-design with the community were considered important. There were also opportunities identified to extend and work with other sectors, particularly the private and business sectors, as the majority of engagement to date has been with the public sector and NFP groups. Other opportunities related to engaging and working more effectively, particularly with youth and in schools, and with place-based responses where appropriate.

SOCIAL INCLUSION

Participants noted that the evidence in relation to Social Inclusion is less well developed, and highlighted opportunities for further investigation, particularly in relation to grey literature and pending or current evaluations. An emphasis on sharing information through repositories including The Well was emphasised, to build on the available evidence base. There was strong interest in the discussion around rates and trends of volunteering in the region, with discussion around reasons for changes in volunteering practices over time, and formal versus informal activities. There was also a recommendation for a gendered perspective on social inclusion, noting the strong inter-relationships between the two priority areas, and the potential for work to address both.

There was also discussion around authorising environments, including the current focus and direction of the Regional Management Forum and opportunities to use municipal health and wellbeing plans to explicitly focus on both violence and social inclusion and embed drivers of liveability.

The proposed draft indicators were welcomed, but further work is considered necessary to develop these materials, including discussion with community members.

RECOMMENDED APPROACHES

The Evidence Report notes seven areas or domains of work for consideration for each of Violence and Social Inclusion (refer to Section 8 of the Evidence Report). As indicated, in some of these areas, work is already progressing well, with established partnerships, and the role of EMSIC could be best suited to supporting and promoting this established work. In addition, due to the interactions between the priority areas, there is a cross-over in relation to domains of work. These priority areas are still a focus of emerging research.

As new information becomes available, including evaluations of current programs and the recommendations of the Royal Commission and Government response, this may prompt further consideration of these core themes. However, a review of the domains of work in the Evidence Report identified key opportunities for consideration across the prevention to response continuum, which are summarised below.

1. PROMOTING POSITIVE CHILD AND YOUTH DEVELOPMENT

The most cost effective and highest potential interventions to both prevent violence and promote social cohesion seek to eliminate or mitigate early life course predictors of violence and disengagement within a whole of community preventative approach. This builds on the evidence that where children are exposed to a clustering of developmental risk factors such as socio-economic disadvantage or maternal prenatal alcohol usage, they are neurologically primed towards negative behaviours including violence, along with other negative social and health outcomes. Implementing evidence-based primary prevention approaches across the region has the potential to change behaviour and mitigate these negative pathways, changing the trajectory for an entire generation, and improving regional outcomes.

Such approaches would target the development of social and emotional competence and address place-based disadvantage early in the life course, leveraging common catchment points such as early childhood, primary and secondary school settings to deliver child/youth and parenting programs that develop and reinforce life skills around emotional regulation, emotional intelligence and pro-social behaviours, seeking to alleviate known risk factors and promote protective factors. Much of the current activity in this space is already coordinated through place-based approaches, such as the Communities that Care approach, or within MCH and school settings, where child and parenting programs are delivered. For a more detailed discussion of the evidence, refer to the Evidence Report, Sections 8.A.1, p39, Section 8.A.5, p44 and Section 8.B.2, p47).

2. TARGETING GENDER EQUITY: PRIMARY PREVENTION OF FAMILY VIOLENCE

A regional focus on improving gender equity is a recommended upstream prevention activity in relation to the prevention of violence against women and children, and also has strong implications for increased community inclusion for women. This action recognises that the primary social determinant of violence against women and their children is gender inequality and rigid gender roles. Programs to promote gender equity need to be delivered in a range of settings, including community groups, workplaces, schools, faith communities, and other natural groupings, in order to maximise regional exposure. Such programs develop awareness of existing gender norms, help participants understand and challenge their own assumptions and modify behaviours to promote a more equitable society.

There is already significant regional activity in this space, largely coordinated through the Together for Equality and Respect (TFER) coalition. Endorsement and support of the TFER framework would appear the most appropriate use of resources, as many members are already actively engaged with the TFER strategy. This would then support greater alignment of effort and reduce risks of duplication. This work will need to align with responses to recommendations arising from the Royal Commission, which have state-wide and regional implications. For further information around the evidence base and current activities, refer to Section 8.A.2 of the Evidence report, p40).

3. TARGETING HARMFUL USE OF ALCOHOL AND OTHER DRUGS TO ADDRESS COMMUNITY SAFETY

The harmful use of alcohol and other drugs has been found to have a strong relationship with increased frequency and severity of both community and family violence. Existing regional activities target both alcohol and drug usage, but these could be better aligned. Senior leadership would also support regional action to reduce both supply of and demand for alcohol, and advocate for necessary rehabilitation and treatment facilities. This would be likely to enhance community safety, with a flow-on benefit to increased community connection as people feel safer in their local communities.

Activities could include increased work through DHHS bodies such as the MHAOD planning council, the regional Ice Action planning group and the Action against Alcohol Flagship. Other models for consideration across Melbourne include “hot-spot” programs in the North-West and Southern regions, and engaging researchers in an advisory capacity to monitor and recommend best practice approaches. Engagement from Victoria Police, coordination of existing research projects, broader consideration of the regional approach currently underway in Knox, and the Southern Metropolitan regional activity around licencing and outlets all offer potential opportunities for a whole of community approach, based in the evidence and focused on community needs and community involvement. For further information in relation to this recommendation, refer to Section 8.A.3, p42 of the Evidence report.

4. REPURPOSING VOLUNTEERING: PRIMARY AND SECONDARY PROMOTION OF SOCIAL INCLUSION

The Evidence Report notes the importance of volunteering for both those who volunteer and those to whom they provide services. In particular, it was noted that volunteering can actively remediate the effects of social exclusion, strengthen bridging social capital, support increased networks and promote positive role models. However, current rates of volunteering in the Eastern Region are below the Victorian average, and much of the activity relates to parents and their association with sporting and recreational facilities. Whilst these are important sources of community connection and should be encouraged, the region can strive to achieve a broader and greater range of volunteering engagement, with explicit consideration seeing volunteering as a positive contributor for those who are engaged in volunteering, as well as the actions or services delivered.

A regional plan to increase volunteering within the EMR and broaden its reach and depth, with a focus on the activities of volunteers and how they can work in relevant spaces, would help to enhance regional wellbeing. This could be informed by previous work conducted in 2008 regarding a regional approach to volunteering and civic participation, and build on the existing coordination role played by LGA's and local volunteer coordination agencies such as Eastern Volunteers or the Boroondara Volunteer Resource Centre. Consideration of mechanisms to increase informal volunteering would also be helpful. For further information around the evidence base, refer to Section 8.B.4 of the Evidence Report, p48.

5. SERVICE SYSTEM RESPONSES TO FAMILY VIOLENCE AND SOCIAL INCLUSION

Screening, pathways and responses for Family Violence

The Evidence Report and workshop discussions noted that whilst there are strong responses in place to support victims of family violence, some members raised concerns that current connections, screening and referral pathways from the universal service system are not well established or understood, or are inconsistent across the region. This includes advocacy, refuges, legal assistance, child and family welfare, housing and social welfare. The Royal Commission also noted a need for better integration and support across the universal and mainstream service sector, particularly around hospitals and health care services.

This aligns with the need to promote universal screening systems to identify those who are at risk, remaining consistent with the Common Risk Assessment Framework (CRAF) that has been identified for review through the Royal Commission. It is important to improve referral pathways to ensure that those at risk are able to access the support they require, particularly at high risk times such as pregnancy, leaving relationships. Service systems also need to ensure coverage for those who are more difficult to reach, such as those experiencing multiple forms of disadvantage, CALD communities, individuals who identify as GLBTIQ and those with barriers to communication.

It also needs to ensure coverage and responses for children who are exposed to violence, and consideration of how to best minimise the impact that such exposure may have. For further information in relation to these approaches, refer to Section 8.A.4, p43 and 8.A.7, p46 of the Evidence Report.

Screening, pathways and responses for Social Inclusion

Whilst this area of work is less well developed, there are indicators that specific cohorts are at increased risk of social exclusion, including specific age cohorts such as disengaged youth and isolated older adults, some cultural minority groups, and those experiencing disability or with limited communication. There is a need to develop more effective mechanisms to identify those who are at risk of social exclusion. This would help to determine relevant risk factors, capability for and barriers to engagement, and then develop strategic plans to address needs in a community-driven and culturally relevant way.

Potential approaches build on a strengths-focussed approach to identify and build local community leadership, such as the Opening Doors program currently operating in some parts of the region. There are also opportunities to embed aspects of the liveability focus, currently being trialled in the Boroondara region, with a focus on working with both place-based and socio-cultural cohorts to address their needs and promote community cohesion. For further information in relation to mechanisms to screen and promote social inclusion, including in diverse communities, please refer to Sections 8.B.2, p47, 8.B.5, p49 and 8.B.6, p49 of the Evidence report.

6. OTHER DOMAINS OF WORK

Other recommendations arising from the report require further development, particularly as the evidence base is less well established and there is a need for further research. This includes embedding a focus on liveability in local planning (S8.B.1, p46). This is currently being explored in Boroondara, and findings from the pilot programs will be of benefit in understanding what works and how to embed this practice into regional approaches. Working to develop youth resilience and embracing digital communities is another emerging area, and further developments in this space are anticipated (refer S8.B.7 of the Evidence report, p49).

Capacity building for organisations, particularly in relation to developing the evidence base around both social inclusion and prevention of violence, is also an area for consideration, where partnerships with relevant expertise could add value and contribute to developing evidence-informed practice (refer Section 8.B.3, p48).

FURTHER READING

For further reading, please refer to the complete Evidence Report, which includes literature reviews, proposed indicators, and detailed activity mapping and is provided commencing on Page 9 of this document.

NEXT STEPS

It is recommended that EMSIC members consider the recommended approaches summarised in this report, and the accompanying evidence report. It is important to recognise and build on existing work in these areas, in order to leverage and build on community strengths, and to complement this with resourcing, regional advocacy and new areas of work where required.

ALIGNING EFFORT INTEGRATION AND COORDINATION – PREVENTING AND RESPONDING TO VIOLENCE AND PROMOTING SOCIAL INCLUSION AND COMMUNITY CONNECTION:

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EVIDENCE REPORT

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We acknowledge the Wurundjeri people of the Kulin nation as the traditional owners of the land that we work on and we pay our respects to them, their culture and their elders, past, present and future.

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CONTRIBUTIONS

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CITATION

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CONTENTS EVIDENCE REPORT

EXECUTIVE SUMMARY

The Eastern Metropolitan Social Issues Council (EMSIC) was established to better integrate and align joint regional efforts in prevention and intervention of key social issues in Melbourne's Eastern Metropolitan Region. In planning activities in 2014/15, EMSIC identified social inclusion and addressing interpersonal violence in vulnerable communities as two priority issues for the region. In order to inform EMSIC's approach to these issues, Deakin University was appointed as a research consultant to produce a report which: (i) reviewed the available evidence; (ii) mapped work in progress; (iii) identified potential indicators; and (iv) reviewed potential partnership approaches, in order to make recommendations for future opportunities.

This report presents the results of the analyses of: (i) available literature; (ii) potential indicators; and (iii) mapping of work in progress around the region. Two literature reviews, provided as appendices, synthesise the evidence regarding effective interventions that can be coordinated at the community level to prevent and respond to violence and to promote social inclusion and mitigate social exclusion. These reviews highlight the need for integration across primary, secondary and tertiary prevention levels, working across the life span and ensuring a focus on diverse and hard-to-reach cohorts. Community and regional approaches that seek to promote social inclusion and violence prevention also need to complement state and national level approaches.

The regional mapping activity identified a wide range of current activities across many organisations which are currently focused on these priority areas, and this information is captured in the detailed mapping, also provided as an appendix.

Based on systematic reviews of the available evidence, seven domains of work have been identified in relation to both violence in vulnerable communities and promoting social inclusion. These provide opportunities for regional integration and coordination between EMSIC members and relevant stakeholders that would result in measurable reductions in levels of violence and social exclusion across the region over time. If progressed, they have implications for developing regional partnerships and both process and outcome indicators. The potential domains of work are summarised in the table below.

DOMAINS OF WORK	EVIDENCE-BASED ACTIONS
Preventing and responding to Violence in Vulnerable Communities	
1) Child and youth focused violence prevention	1. Early parent education and support that promotes gender equality in relationships and social and emotional competence in early childhood 2. Parent education and support programs for range of age cohorts from early primary to adolescents 3. Consistent curriculum and organisational supports for childcare/preschool settings 4. Whole-of-community approach to prevention of youth violence 5. School programs: respectful relationships curriculum with whole-school approach.
2) Broad adult-focused community interventions to address gender equality	1. Advocate for and support the work of existing partnerships, including TFER 2. Consider and review program evaluations and determine regional priorities, with support from RMF 3. Continue to emphasise Municipal Health and Wellbeing plans as mechanism to promote and coordinate regional and local action.
3) Target harmful usage of alcohol and other drugs	1. Develop and consider regional action plan to address supply and demand pressures for alcohol 2. Proactively monitor and respond to demand for treatment and service capacity to address substance usage.
4) Screening to detect and interventions to protect women and children who are victims of family violence	1. Screening: a) Review available risk identification approaches consistent with CRAF, particularly for universal service system b) Train diverse agencies in their use and referral pathways. 2. Protection: a) Map existing agencies and services b) Client-centred review c) Trial and evaluate best practice models d) Commitment to information exchange e) Advocacy interventions f) Consistent social and public messaging.

DOMAINS OF WORK	EVIDENCE-BASED ACTIONS
5) Reduce pathways to violence associated with disadvantage	Develop and implement range of programs with focus on intersectionality across: 1. Maternal and child health services 2. School-based programs, complemented by tutoring and mentoring support 3. Community based programs.
6) Rehabilitation for violence offenders	Support information exchange around best practice evidence-based strategies for perpetrator rehabilitation and accountability.
7) Engage and consult with minority groups to identify and address their unique needs	1. Develop agreed set of monitoring tools for diverse communities 2. Train users 3. Collect data and report on cohorts of need 4. Ensure appropriate, culturally sensitive and accessible services for diverse cohorts.
Promoting social inclusion and community connectedness	
1) Liveability	1. Advocate for increased focus on liveability in planning and service delivery 2. Consider recommendations for service design arising from DHHS Boroondara Liveability collaboration study.
2) Reduce pathways to social disadvantage associated with place-based disadvantage	Develop and implement range of programs across: 1. MCH services 2. School-based programs, complemented by tutoring and mentoring support 3. Community based programs.
3) Capacity building for program design, implementation and evaluation	Capacity building workshops on program design and delivery, including evaluation. Support for range of evaluation techniques, including formative and developmental evaluation to support emergent programs.
4) Increase volunteering rates	1. Develop and implement a strategy to increase volunteering rates across the community 2. Provide training for organisations in responding to changes in volunteering practices.
5) Community-based programs and leadership development	Consistent rollout of community-based programs across EMR which support grass-roots needs identification, develop leadership and support implementation of community-led projects to address social inclusion e.g. Opening Doors.
6) Common regional measurement	1. Detailed analysis of data, including AURIN and ABS, to identify drivers of disadvantage and exclusion, especially with reference to diverse and isolated groups 2. Program planning to meet diverse needs.
7) Promoting resilience and working with digital communities	Activities to be determined, pending further review of actions arising from new VicHealth Mental Wellbeing Strategy 2015-2019

A regional workshop was conducted in February 2016 with EMSIC members and broad regional representation to consider these domains of work. Arising from this consultation, a Council report was prepared, and is included as Pages 3–8 of this document. This report brings together broad areas for consideration by the EMSIC Council for targeted action.

1. INTRODUCTION AND BACKGROUND

EMSIC ROLE AND PURPOSE

The Eastern Metropolitan Social Issues Council (EMSIC) was established in 2014 as a senior executive leadership forum in the Eastern Metropolitan region, committed to working to increase integration and alignment of regional efforts to improve community health and wellbeing. Members and associate members include senior executives from state and local government departments, non-governmental organisations, health organisations, academia and industry (for full membership lists, refer to **Appendices A** and **B**). EMSIC aims to promote the best underlying conditions to enhance collective regional effort to maximise safety, wellness and fulfilment, engagement and connection and economic means and prosperity. EMSIC also aims to provide effective, efficient and integrated support for those whose health and wellbeing is not optimal.

Through a collaborative process in early 2015, EMSIC members identified two priority areas for effort: **Violence in Vulnerable Communities** (ViVC) and **Social Inclusion and Community Connectedness** (SI&CC). In order to inform EMSIC's approach to these issues, Deakin University was invited and successfully appointed as a research partner to review current work in these priority areas, identify partnership approaches and make recommendations for future opportunities. The report was supported by the input of two EMSIC Advisory Groups, one for each priority area. These were formed by nomination, with membership detailed in **Appendix C**.

PROJECT AIMS

The research project was initiated in May 2015. Its aims were to:

- analyse available data and existing work and provide expert input on partnership approaches for the two priority issues of violence in vulnerable communities and social inclusion and community connectedness within a population health framework
- provide recommendations to EMSIC on the implementation of evidence-based interventions which provide significant opportunity for regional integration and coordination between EMSIC members and relevant stakeholders to reduce service gaps, duplication and disproportionate servicing in specific localities, and
- map and analyse existing efforts and comment on the individual and collective impacts of this effort including development of agreed impact indicators.

RESEARCH TEAM

A Deakin University research team was established and led by Professor John Toumbourou and Professor Bernie Marshall, with the full research team detailed in **Appendix D**.

SCOPE OF WORK

The priority of addressing violence in vulnerable communities broadly reflects EMSIC member concerns with interpersonal safety. The nature of vulnerable communities was a specific topic for discussion with the Violence Advisory Group, and a decision was made to predominantly focus on the issue of family violence, particularly violence against women and their children. Other areas for consideration were aspects of elder abuse, racial abuse and community violence.

Social inclusion and community connectedness relates to EMSIC member concerns with a range of aspects of community connection and participation, including addressing social exclusion and marginalisation of specific populations, the need for cultural inclusion and social harmony and community education and infrastructure enablers of community connectedness and liveability.

PROCESS

The research team agreed on a series of activities to meet the project aims. This included a brief review of current data, to gain a more thorough understanding of the scope and severity of the relevant issues in the region and their societal implications. A comprehensive review of current programs in place within the region was also conducted with a view to their goals, target populations or areas, intervention strategies, partnership approaches and evaluation frameworks.

Concurrently, literature reviews were conducted to identify national and international best practice approaches, suitable for regional application that could address ViVC and SI&CC, including their determinants, risk factors and information about measurement indicators. Following from review of high quality systematic studies, the research team also conducted further consultation to identify areas of promising activity where the research base suggests positive results might be expected.

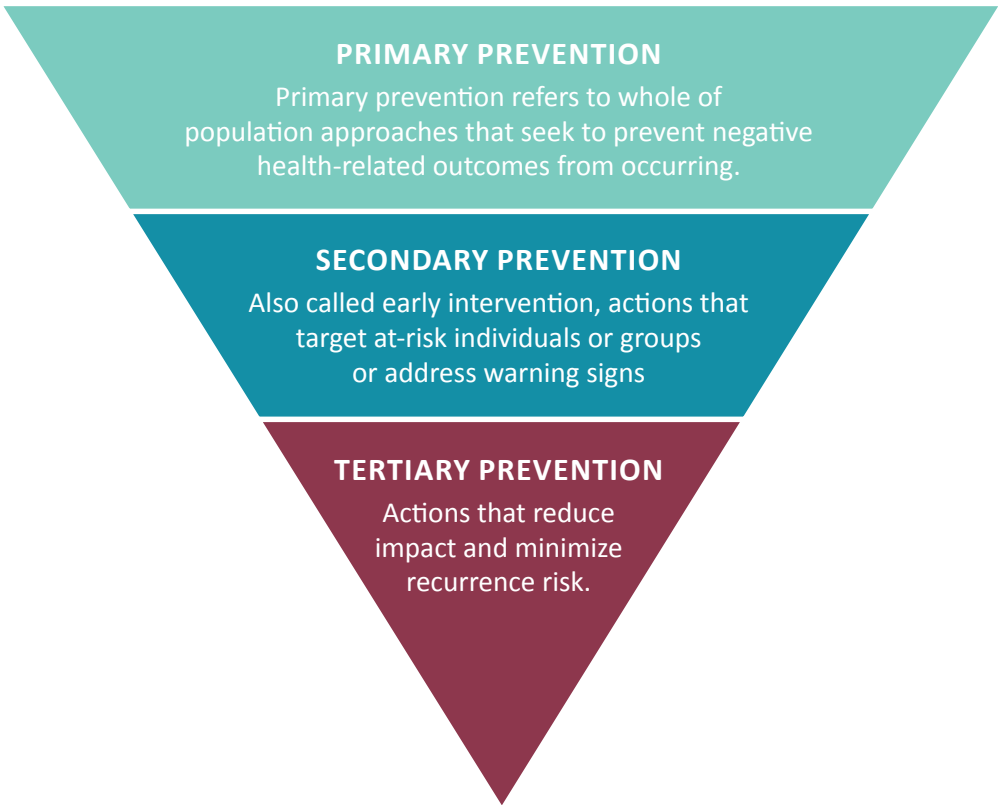
Drawing from these streams of work, an analysis was conducted of existing programs against best practice approaches, the scope and scale of the problem, and the partnership models. From this, recommendations were made identifying potential opportunities for EMSIC members to collaboratively drive successful social change in the Eastern Metropolitan region.

POPULATION HEALTH AND SOCIO-ECOLOGICAL APPROACHES

This report adopts a **population health** approach (Australian Institute of Health and Welfare, 2015) which aims to improve the health and wellbeing of the regional population, through reducing inequities between and within specific groups and addressing the needs of the most disadvantaged. An effective population health approach requires engagement, partnership and collaboration across the range of relevant entities, including government, community and cross-sectoral partners to effectively address the broad range of determinants that shape health and wellbeing ([VHA], 2015), consistent with the aims of EMSIC.

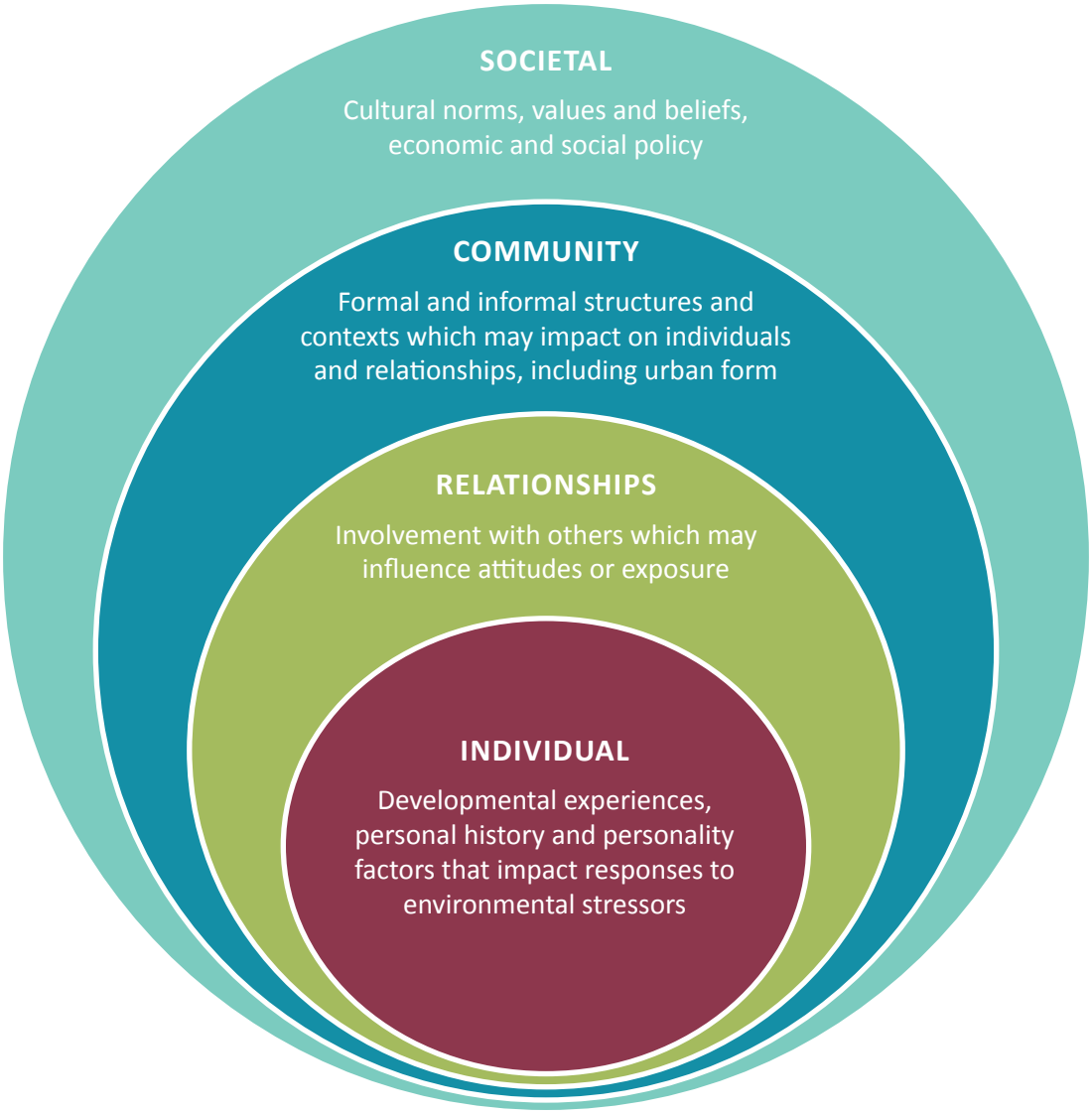
In adopting such an approach, this report examines social determinants of the priority issues in order to address upstream factors, with a focus on primary prevention as the most effective mechanism, as well as supporting early intervention and tertiary treatment and responses. Social determinants of health refers in this context to the conditions in which people live and work that either enhance or detract from their wellbeing, such as gender and access to housing, education, employment, transport and services. These determinants have a significant role in causing inequalities. The focus is therefore on identifying primary social determinants for both violence and social exclusion, and then addressing these across multiple levels, including societal, community and individual, across the spectrum of **primary, secondary and tertiary health interventions** to eliminate or mitigate known risk factors or causes (Figure 1).

FIGURE 1: PRIMARY, SECONDARY AND TERTIARY PREVENTION, ADAPTED FROM WALDEN AND WALL (2014)



The report also assumes a socio-ecological approach (Figure 2), recognising the complex interplay between determinants at four levels: individual, relationship, community and societal. This implies that a range of interventions are likely to be required, with coverage and consideration as to their impact across each of these levels, in order to deliver sustainable improvement.

FIGURE 2: A SOCIO-ECOLOGICAL APPROACH, ADAPTED FROM VHA (2015)



These approaches underline the need for a systemic range of health promotion approaches, including place-based, whole-of-population and targeted sub-population interventions and life course approaches, to tackle health inequalities. (VicHealth, 2008)

2. UNDERSTANDING THE PROBLEM

In order to more fully understand the nature of the priority issues identified by EMSIC, this section provides background on the region, addresses definitions and key terms used in the report, the scope and impact of the identified priority areas, known causes, risk factors and social determinants and relevant frameworks to address these issues. It also summarises key contextual information regarding relevant international, national and local priorities, strategies and activities.

ABOUT THE REGION

The Eastern Metropolitan region covers the seven Local Government Areas of Boroondara, Manningham, Whitehorse, Monash, Maroondah, Knox and Yarra Ranges. At the 2011 ABS census, the total population was 1.029 million, with a projected growth rate of 7%, significantly below the Victorian average of 17.5%. The current regional population at the last census was older than the Victorian average, with above average levels of early adulthood (15-24 year olds) and older adults (45-65, 65-85 and 85+ years), and below average levels of children and 25-44 year olds. This trend is expected to continue with a projected increase in older adults, drawing on regional health status profiles (DHHS, 2014). The population is culturally diverse, with almost a quarter of the population born in non-English speaking countries, most commonly China, India and Malaysia, and over a quarter speaking a language other than English at home, most often Mandarin, Cantonese and Greek, and around 4% report low English proficiency. There is a small indigenous population, focused in the outer Eastern area around Healesville area. Unsurprisingly, given this cultural diversity, the region has higher new-settler arrivals than the Victorian average, but a lower proportion are humanitarian visa holders.

In terms of social engagement indicators, the region scores highly, with the lowest crime rate, including family violence incidences, and lowest levels of substantiated child abuse in the state (DHHS, 2014). Socio-economic status is generally above the Victorian average, with lower unemployment rates and mortgage stress, highest levels of education, lowest percentage of low income families and social housing, but the highest levels of median rentals. One in five report active volunteering, which is slightly above the Victorian average, and over 90% feel there are good facilities and services available regionally. Overall, the region scores highly in relation to health status, with the highest life expectancies for males and females, although high levels of sedentary work are a risk. The region is well served generally by public transport, medical and educational facilities, both public and private.

However, it is important to recognise that this aggregate level data does not identify specific localities or population groups which are disproportionately exposed to disadvantage. Geographically, certain areas of concentrated social or public housing and financial disadvantage are present within the region, which has experienced a decline in housing affordability and increased rental and mortgage stress ([EAHA], 2011). In addition, specific population groups such as the elderly, women, children, culturally diverse groups, indigenous people and those with disabilities may be at increased risk of disadvantage and require particular attention (Australian Institute of Health and Welfare, 2015).

As an example of local population mapping, the City of Boroondara (2015) recently released an analysis of social exclusion, which identified that although their LGA region scored as one of the healthiest in the state, largely due to its high socio-economic status, specific areas of disadvantage and groups at increased risk of social exclusion were identified and mapped, based on census data, to identify particular pockets of need for relevant Council planning.

VIOLENCE IN VULNERABLE COMMUNITIES

Definitions

This report has adopted the following definitions and typologies of violence, drawing on the work of the World Health Organization (WHO) and the international Violence Prevention Alliance (VPA). For the purpose of much of the international research in relation to preventing violence, these organisations define violence as:

> *"the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." (World Health Organization, 2015).*

Within the definition provided, violence may be inflicted in multiple ways, including physical, sexual or psychological attacks, or deprivation. For the purposes of this report, the focus is on interpersonal violence, being violence between individuals, including both *family and intimate partner violence* and *community violence*.

Family violence is considered to include violence against women, intimate partner violence (including current or former partners), child maltreatment and elder abuse. For many organisations, their focus is specifically on violence against women, which the United Nations, in their Declaration on the Elimination of Violence Against Women (1993), considers to encompass, but not be limited to:

- physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation
- physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution

- physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. (United Nations, 1993)

Elder abuse is considered by the World Health Organization (2002) to include:

- single or repeated acts, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.
- It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect (World Health Organization, 2002).

Community violence consists of *acquaintance* and *stranger* violence and includes youth violence, assault by strangers (both physical and sexual assault) and acquaintance rape. Whilst further data will be provided later, it is important to highlight that Australian prevalence data ([ABS] Australian Bureau of Statistics, 2012) reveals that 95% of all violence, whether physical or sexual violence, or threats, and whether experienced by males or females, is perpetrated by males. As such, interpersonal violence is a highly gendered crime, and this needs to be considered in developing appropriate prevention strategies and responses.

Other areas of community violence include violence related to property crimes and violence in workplaces and other institutions. However, due to limited time and resources, and in discussion with the Advisory Groups, a decision was made not to focus on these other areas of community violence report, although there is overlap and proposed strategies may have beneficial outcomes. For example, programs that successfully increase gender equity within the community are likely to have a positive impact on workplace sexual harassment. The current national and state focus on family and intimate partner violence has raised the profile and attention paid to family violence. This includes the advocacy and profile of the 2015 Australian of the Year, Rosie Batty, the release of the new national framework for the prevention of violence against women and children (Our WATCh, 2015a) and more locally the work of the Victorian Royal Commission into Family Violence (2015). The currently high levels of public attention and momentum provide an opportunity for strengthening and continuing action to prevent and minimise the significant and long-term harm due to family violence.

Within Victoria, the *Family Violence Protection Act 2008* has a specific definition of family violence, which specifies a broader list of behaviours, as follows:

a) behaviour by a person towards a family member of that person if that behaviour:
   (i) is physically or sexually abusive; or
   (ii) is emotionally or psychologically abusive; or
   (iii) is economically abusive; or
   (iv) is threatening; or
   (v) is coercive; or
   (vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or

b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a).

This broader definition presents some challenges in relation to the research base, as some forms of violence, particularly economic abuse or coercion, may not be identified by perpetrators or victims as violence. Research into such behaviours is generally less extensive, as are the resources applied to the issues. However, in this report, the authors have tried to take this broader conceptualisation into account in reviewing areas of promising practice, indicators and forming recommendations.

Incidence of violence

The initial focus for this report was violence in vulnerable communities. In order to identify those communities at elevated risk of violence, and hence considered vulnerable, available data and public information was reviewed relating to the incidence of violence and risks of increased violence within the Victorian community. In relation to victims of violence, a recent comprehensive analysis of data obtained from the ABS 2012 Personal Safety Survey (P. Cox, 2015) shows that violence is common in Australia, with four out of ten women and five out of ten men having experienced at least one incident of violence since the age of 15 (P. Cox, 2015). Males are more likely to have experienced violence overall, and physical violence is more common than sexual violence for both women and men. Women are more likely to experience sexual violence than men.

Regardless of the form of violence, 95% of perpetrators of violence are male ([ABS] Australian Bureau of Statistics, 2012), indicating a clearly gendered pattern of violent behaviour. Males are more likely to have experienced violence from a stranger and in places of entertainment or public spaces, whereas women are most likely to experience violence from a known person, most often a former intimate partner and in their own home.

Within this data, the following groups are considered at increased risk of experiencing violence:

- women in relation to domestic violence, with around one in three women experiencing some form of physical or sexual violence from the age of 15, and one in four women having experienced physical violence from a current or previous partner (P. Cox, 2015)
- children, with many women who experience domestic violence caring for children who experience or are exposed to that violence. (P. Cox, 2015)
- males aged 18-24, in relation to community violence ([ABS] Australian Bureau of Statistics, 2012).
- Aboriginal and Indigenous Australians (VicHealth, 2007)
- older people, particularly in relation to non-physical issues such as economic abuse (VicHealth, 2007)
- people experiencing social or economic disadvantage (VicHealth, 2007)
- people from culturally and linguistically diverse backgrounds, particularly where English proficiency is limited (VicHealth, 2007)
- people with a disability (VicHealth, 2007).

Table 1 includes data from the ABS Personal Safety Survey (2012). This found that 7% of the Victorian adult population had experienced either physical or sexual violence in the past 12 months. Whilst were males more likely to experience violence overall, it was twice as likely that the perpetrator was a stranger, it occurred more commonly outside the home, such as at recreational or entertainment venues and it was more likely a single incidence of physical violence (Our Watch, ANROWS, & VicHealth, 2015). For women, whilst violence was less likely overall, it was more than twice as likely that the perpetrator was known to them, whether a current or past partner, a friend or other known person, and most commonly the assault occurred in their home. Associated with this, for women an assault is more often part of a broader pattern, rather than a once-off event, and often harder to escape when it occurs within the domestic home. In addition, when violence occurs in intimate relationships, emotional, physical and sexual abuse may co-occur and overlap. For both males and females, those aged 18-24 were most at risk, with the risk declining with age, but this experience was still highly gender specific. Cox's (2015) extensive analysis of data from the 2012 ABS Personal Safety Survey noted that one in four women have experienced at least one incidence of violence from an intimate partner, with women four times more likely to live in fear following an assault than men, five times more likely to require medical attention and five times more likely to be killed.

TABLE 1: DATA FROM ABS PERSONAL SAFETY SURVEY (2012)

ABS – PERSONAL SAFETY SURVEY 2012 – VICTORIAN DATA

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Experienced violence during the last 12 months	194.1	9.1	114.7	5.2	308.8	7.1
Experienced physical violence during the last 12 months						
Physical assault	125.3	5.8	67.2	3.0	192.5	4.4
Physical threat	104.3	4.9	45.5	2.0	149.8	3.4
Total	191.9	9.0	102.8	4.6	294.7	6.8
Experienced sexual violence during the last 12 months						
Sexual assault	NP	NP	16.0	0.7	NP	NP
Sexual threat	NP	NP	NP	NP	NP	NP
Total	NP	NP	18.0	0.8	NP	NP

OF THOSE WHO EXPERIENCED VIOLENCE IN THE LAST 12 MONTHS*

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Relationship to perpetrator						
Stranger	148.1	6.9	35.4	1.6		
Known person	74.9	3.5	84.5	3.8		
Partner			33.7	1.5		
Current partner			10.6	0.5		
Previous partner			23.1	1.0		
Boyfriend/girlfriend or date			17.5	0.8		
Other known person			38.2	1.7		
TOTAL	2,142.3	100	2,219.7	100	4,362.0	100

FOR THOSE WHO EXPERIENCED VIOLENCE IN THE LAST 12 MONTHS

Age	Males		Females		Persons	
18 to 24 years	64.8	22.8	32.3	11.8	97.2	17.4
25 to 34 years	59.0	14.0	30.8	7.3	89.8	10.6
35 to 44 years	28.8	7.2	15.4	3.8	44.2	5.5
45 to 54 years	25.2	6.8	23.6	6.1	48.7	6.4
55 years or more	16.3	2.4	12.6	1.7	28.9	2.1
Total	NP	NP	18.0	0.8	NP	NP

Table 1: Data from abs personal safety survey (2012)
NP = not published as data too small
* Individuals may experience violence from multiple perpetrators, so totals may exceed 100%

The costs of violence

EMSIC members identified violence as a key regional priority through a collaborative process. The following section details some of the national data demonstrating the severity and cost of various forms of violence. However, it is important to note the potential for under-reporting, with recent NSW studies (Birdsey & Snowball, 2013; Grech & Burgess, 2011) finding that less than half of all those who attended domestic violence centres as victims of family violence had reported the incident to police, and for those who do not attend such centres, it is likely these numbers are significantly higher. Older victims, those who are married and victims of assaults not included weapons or serious injury were less likely to make a report, with the most common reasons being fear of revenge from the perpetrator, shame or a perception that the incident was unimportant.

It is clear that interpersonal violence, particularly violence against women and children, has significant individual and community level impacts, including personal, physical, psychological and economic impacts. Interpersonal violence is a risk factor for lifelong health and social problems which is both predictable and preventable and action can and should be taken at a range of levels.

The obvious immediate negative personal outcomes of violence include its impact on physical and psychological health and wellbeing, and a victim's actual or perceived safety. Treatment of injuries can be costly and require time and resources over an extended period. In the longer term, individuals may have reduced job stability or be unable to maintain employment, with financial impacts and broader social costs. Additional pressures are experienced by agencies responsible for social and/or legal support, and those involved in other forms of advocacy and support for potential victims. There is also considerable effort to quantify the financial costs and impacts of various forms of violence. A 2013 KPMG report (Forsyth, 2013) estimated the costs of violence against women at $14.7B USD, or 1.1% of Australian GDP. A 2009 estimate (The National Council to Reduce Violence against Women and their Children (NCRVAWC), 2009) found that a 10% reduction in incidence occurs by 2021-22 would result in savings of $1.6 billion in economic costs.

When considering the costs of alcohol-related violence, the IF Foundation ((2013) noted that annually, almost 400 people die and 70,000 are victims of alcohol-related assaults, including 24,000 victims of alcohol-related domestic violence. For witnesses, the impact of violence is also significant, both in the immediate aftermath and longer-term. In particular, for young people who witness family violence, girls are more likely to become victims themselves in adult relationships (Our WATCh, ANROWS, & VicHealth, 2015), and males are more likely to become perpetrators of family violence, through patterns of learned behaviour.

Causes of violence

The following discussion details some of the evidence regarding the causes and risk factors for various forms of interpersonal violence. However, it is important to note that these risks may be cumulative. For example, women with a disability are twice as likely as those without a disability to experience violence and abuse ([WDV], 2015), with Indigenous women 34 times more likely to be hospitalised as a result of family violence than non-Indigenous women (Steering Committee for the Review of Government Service Provision, 2014). The impacts of isolation and restricted communication channels are compounded for those with limited English proficiency, or who are culturally or geographically isolated. In addition, an analysis by Seniors Rights Victoria (Joosten, Dow, & Blakey, 2014) noted that as for other forms of family violence, elder abuse is gendered. For all forms of elder abuse (financial, psychological/emotional, physical, social and sexual) men were more likely to be perpetrators, and women more likely to be victims, with older women approximately 2.5 times more likely to report abuse than older men.

Violence against women

Violence against women is the leading contributor to premature death and ill-health for women under 45 years ([COAG], 2015). While violence occurs in a range of settings, ABS data suggests women are most likely to experience violence in their home, and that whilst women from a range of demographics are impacted, young women, those with a disability and Indigenous women experience higher rates in Australia (2012).

Whilst there is no single cause of violence against women, the recently released national framework for the prevention of violence against women and children (Our WATCh, 2015a) identifies four key gendered drivers of violence. These are:

1. condoning of violence against women
2. men's control of decision making and limits to women's independence in public and private life
3. rigid gender roles and stereotypical constructions of masculinity and femininity
4. male peer relations that emphasis aggression and disrespect towards women.

Where the above gendered drivers of violence occur, they can be reinforced by other interacting factors, including community or social norms that condone violence generally, previous experiences of exposure to violence, the harmful use of alcohol and other drugs, financial and social disadvantage and backlash factors (when male dominance, power or status is challenged). In such conditions, the probability, frequency and or severity of violence against women is increased (Our WATCh, 2015a). Hence, it is clear that a focus on gender equality must be core to any effective solution.

Causes of violence: community violence

The ABS data in Table 1 demonstrates that, consistent with research findings, youth are more at risk of violence overall, with young males being particularly at risk in entertainment or recreation venues, such as pubs or nightclubs, where alcohol is often involved. The World Health Organization (WHO, 2006) identifies key drivers of community violence as:

- a societal normalisation of violence;
- prior experiences or witnessing violence;
- rigid gender stereotypes for young men which promote physical confrontation;
- gang or specific cultural norms and expectations; and
- harmful use of alcohol and other drugs.

In addition, when considering community sexual assault or harassment, all the drivers of violence against women should be considered (Our WATCh, 2015a). Community violence also includes racially motivated violence and racial vilification, which is particularly experienced by those who are visibly identified as different by their cultural or religious dress, skin colour or appearance, including indigenous Australians (VHREOC, 2013). In addition to the above community violence factors, racial prejudice and stereotypes are a significant factor in driving racially motivated violence.

Causes of violence: elder abuse and abuse of people with a disability

Whilst the research in relation to elder abuse and abuse of people with a disability is less well developed, similar risk factors have been identified as contributing to violence for both groups ([WDV], 2015; Ellison, Schetzer, Mullins, Perry, & Wong, 2004; Seniors Rights Victoria, 2015). For victims, common factors include:

- physical, psychological and financial dependence;
- family conflict;
- isolation;
- lack of services; and
- illness.

For abusers, contributing factors include:

- prior experiences of family conflict;
- unemployment and financial distress;
- alcohol and drug usage;
- emotional problems; and
- carer stress

Another significant factor includes negative social attitudes in relation to the aged or those with disabilities, where such views of aging contribute to the devaluing of older people or those with disabilities. Targets of violence are often those who are perceived as less powerful, such as those who are unable to communicate what has happened, or are restricted in their physical movements.

CURRENT ACTIVITIES: INTERNATIONAL, NATIONAL AND STATE-LEVEL STRATEGIES

International work

At an international level over the past 15 years, there has been considerable effort focused on the issue of violence prevention, including youth and intimate partner violence and elder abuse by the World Health Organization (WHO). The 2002 *World report on violence and health* detailed a range of recommendations for violence prevention. In 2010, the UN created UN Women, the UN Entity for Gender Equality and the Empowerment of Women (UN Women, 2016). This entity exists to support bodies such as the Commission on the Status of Women, help implement standards internationally and lead and coordinate UN work on gender equality, including regular progress monitoring. WHO's (2014) *Global Status Report on Violence Prevention* provides a comprehensive picture of the global issues of violence and the progress of 133 countries in implementing recommendations from the 2002 report. This provides a report on each country in relation to action plans, legislation, policies, prevention programs and current data trends, particularly in relation to homicide rates.

Whilst Australia's data reflected a significant amount of coordinated activity (refer to snapshot overleaf), there are significant opportunities to continue to improve the safety of our communities, particularly in relation to youth violence prevention.

FIGURE 3: WHO GLOBAL STATUS REPORT ON VIOLENCE PREVENTION (2014): AUSTRALIA SNAPSHOT

AUSTRALIA

Population: 23 050 471 | **Gross national income per capita:** US$ 59 790 | **Income group:** High | **Income inequality:** –

ACTION PLANS, POLICIES AND LAWS RELEVANT TO SEVERAL TYPES OF VIOLENCE

National action plans

Interpersonal violence	YES	Child maltreatment	YES
Youth violence	YES[1]	Intimate partner violence	YES
Sexual violence	YES	Elder abuse	YES[1]

National social and educational policies

Incentives provided for high-risk youth to complete schooling	YES[1]
Housing polices to de-concentrate poverty	YES[1]

Firearms

Laws to regulate civilian access	YES[1]
Mandatory background check	YES[1]
Handguns/long guns/ automatic weapons	YES[1]/YES[1]/YES[1]
Carrying firearms in public	YES[1]
Programmes to reduce civilian firearm possession and use	YES[1]

Alcohol

Adult (15+) per capita consumption (litres of pure alcohol)	12.2
Patterns of drinking score	LEAST RISKY ①❷③④⑤ MOST RISKY
Excise taxes	Beer: YES Wine: NO Spirits: YES

LAWS AND PREVENTION PROGRAMMES BY TYPE OF VIOLENCE

KEY: No response/ don't know – | Limited ❶ | Partial ❷ | Full ❸ | Once/few times ❶ | Larger scale ❷

Child maltreatment laws		Enforcement
Legal age of marriage (male/female)	18 / 18	
Against child marriage	YES	①②❸
Against statutory rape	YES[1]	❶②③
Against female genital mutilation	YES[1]	❶②③
Ban on corporal punishment (all settings)	YES[1] (NO)	❶②③

Child maltreatment prevention programmes		Implementation
Home visiting	YES	①❷
Parenting education	YES	①❷
Training to recognise / avoid sexually abusive situations	YES	①❷

Youth violence laws		
Against weapons on school premises	YES[1]	①②❸
Against gang or criminal group membership	YES[1]	❶②③

Youth violence prevention programmes		
Pre-school enrichment	NO	–
Life skills and social development training	NO	–
Mentoring	YES	❶②
After-school supervision	NO	–
School anti-bullying	YES	①❷

Intimate partner violence laws		
Against rape in marriage	YES[1]	①②❸
Allowing removal of violent spouse from home	YES	①②❸

Intimate partner violence prevention programmes		
Dating violence prevention in schools	YES	①❷
Microfinance and gender equity training	YES	①❷
Social and cultural norms change	YES	①❷

Sexual violence laws		
Against rape	YES[1]	①②❸
Against contact sexual violence without rape	YES[1]	①②❸
Against non-contact sexual violence	YES	①②❸

Sexual violence prevention programmes		
School and college programmes	YES	①❷
Physical environment changes	YES	❶②
Social and cultural norms change	YES	①❷

Elder abuse laws		
Against elder abuse	YES	①②❸
Against elder abuse in institutions	YES	①②❸

Elder abuse prevention programmes		
Professional awareness campaigns	YES	①❷
Public information campaigns	YES	①❷
Caregiver support	YES	①❷
Residential care policies	YES	①❷

VICTIM LAWS

Providing for victim compensation	YES[1]	①❷③
Providing for victim legal representation	YES[1]	①②❸

VICTIM SERVICES

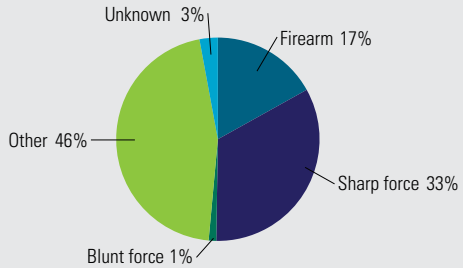
Adult protective services	YES	①❷
Child protection services	YES	①❷
Medico-legal services for sexual violence	YES	①❷
Mental health services	YES	①❷

DATA ON VIOLENCE

National prevalence surveys for non-fatal violence

Child maltreatment YES | Youth violence YES | Intimate partner violence YES | Sexual violence YES | Elder abuse YES

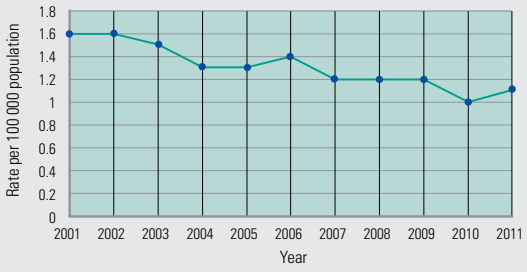
Mechanism of homicide[2]



Reported homicides (2011) N= 244, Rate= 1.1/100 000 (64.3% M, 35.7% F)

Sources. Mechanism: Police/ Reported homicides: Police

Trends in homicides



Source: Police

[1] Subnational.
[2] Homicides classified as commited without a weapon are included in "other".

Data collection by multisectoral consensus meeting and cleared by Department of Health.

National focus

Australia's efforts to tackle community violence, particularly violence against women and their children, have increased dramatically over the last decade, with a greater intensity over the last 12-24 months. The federal government released the National Plan to Reduce Violence against Women and their Children 2010 – 2022 ([COAG], 2010), detailing six overarching National Outcomes which provided a focus for all governments to work towards, ranging from primary prevention to strong support services and effective justice responses to perpetrators. The outcomes were:

1. Communities are safe and free from violence
2. Relationships are respectful
3. Indigenous communities are strengthened
4. Services meet the needs of women and their children experiencing violence
5. Justice responses are effective
6. Perpetrators stop their violence and are held to account.

Australia's National Research Organisation for Women's Safety (ANROWS, (2015) was also established in 2013 as an independent, not-for-profit company under the National Plan.

On 27 June 2015, the Second Action Plan ([COAG], 2015) was released. This plan seeks to build on and continue the momentum of the existing work at the national level, and details work at the federal and state levels.

The five main priority areas for the Second Action Plan are:

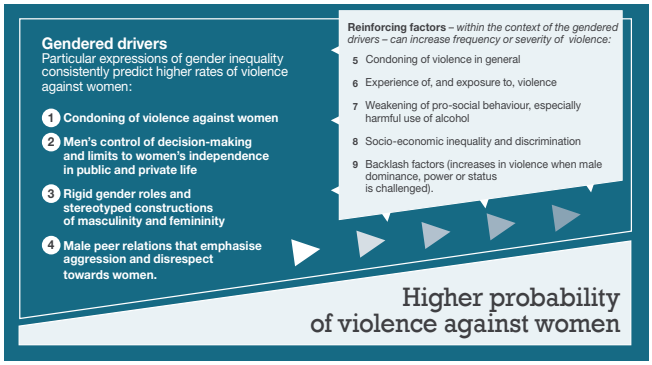
1. Driving whole of community action to prevent violence
2. Understanding diverse experiences of violence
3. Supporting innovative services and integrated systems
4. Improving perpetrator interventions
5. Continuing to build the evidence base.

Relevant national agencies also include Our Watch (2015c), originally established in July 2013 as the Foundation to Prevent Violence against Women and their Children. Our Watch focuses on delivering a primary prevention approach to drive change in the national attitudes, behaviour and cultures that underpin and drive violence against women and children (Our WATCh, 2015d). In particular, the emphasis is on addressing key drivers of violence, particularly in relation to gender equality and addressing rigid gender roles through a range of activities, including targeted campaigns, education and research, partnering with agencies such as ANROWS and VicHealth, as well as government and other bodies, to drive a primary prevention approach to end violence against women and their children.

A shared framework for preventing violence against women

At a primary prevention level, a new national shared framework for preventing violence against women and their children was developed by Our Watch, ANROWS and VicHealth (Our WATCh, 2015a). This framework draws on previous frameworks (VicHealth, 2009) and has been updated in relation to emerging and strengthening evidence around the causes and best approaches to prevent violence against women and their children.

FIGURE 4: GENDERED AND REINFORCING DRIVERS OF VIOLENCE AGAINST WOMEN (OUR WATCH, 2015A)



The framework (Figure 4) proposes four gendered drivers of violence, which have been demonstrated to consistently predict increased risks of violence against women. The framework also notes five reinforcing factors which, when experienced within the context of the above gendered drivers, may increase the frequency or severity of violence.

The framework identifies a range of essential and supporting actions that must be undertaken in order to prevent violence. These will necessarily involve policy and legislative responses and programs implemented in the settings where people live, work, learn and play and tailored to individual contexts and needs.

These actions are detailed in Figure 5 below.

FIGURE 5: ESSENTIAL AND SUPPORTING ACTIONS TO PREVENT VIOLENCE (OUR WATCH, 2015A)

There is also other national work promoting gender equality more broadly, particularly in workplaces. This includes the activity of the Workplace Gender Equality Agency (2015), an Australian Government agency focused on promoting and improving gender equality in Australian workplaces. The Australian Stock Exchange (2015) has also implemented diversity recommendations in its Corporate Governance principles, and the Male Champions of Change movement (2015) is actively promoting the benefits of gender diversity in organisations and communities.

Victorian work

The Victorian sector has been highly active in this area over more than a decade, particularly through the activity of VicHealth, Women's Health Services and as a founding partner with Our Watch. The Victorian Royal Commission into Family Violence commenced in February 2015 and provided a final report to government on 29th March 2016 (State of Victoria, 2016a). This report includes over 200 recommendations which the government has committed to adopting, and which will inform future strategy and planning development at the state level. The Victorian government has also commissioned ANROWS to develop a Victorian Family Violence Index, with work underway in conjunction with the University of Melbourne, and anticipated delivery in June 2016. The Index will help measure the effectiveness of activities to address family violence, as well as informing future policy and resourcing in Victoria.

Various state government organisations, particularly VicHealth, the Departments of Health and Human Services, Education and Training and Justice and Regulation, and Victoria Police already have explicit programs that focus on reducing interpersonal violence, particularly violence against women and children, and alcohol and drug-related community violence. The Victorian Government (2016b) has released a consultation paper in preparation for developing a Gender Equity Strategy, which will promote equal social, civic and economic participation for women, as well as addressing the primary causes of violence against women.

Following commissioned research (Flood, Fergus, & Heenan, 2009), DEECD developed a secondary school curriculum focused on violence prevention and respectful relationships (Department of Education and Early Childhood Development, 2014). Our Watch was funded by the Victorian Government to extend this to a whole-school approach through the Respectful Relationships in Schools projects (Our WATCh, 2015e) in a range of schools, and is evaluating this program and its success, with a government commitment (Department of Premier and Cabinet, 2015) to include respectful relationships education into the Victorian curriculum from Prep to Yr 10, starting in 2016.

Public grants programs have also enabled the development of a range of initiatives. VicHealth funded a range of programs which trialled and implemented a range of programs in various settings including workplaces, education, early childhood and sports clubs. This has provided some very helpful findings in relation to effective practice and engagement. The last stage of this program was a site-based saturation approach (Monash City Council, 2015) which is currently being evaluated with final reports due in early 2016. Whilst there are specific learnings from each program, more general findings relate to considerations of matching programs to individual community needs and capacity, and working with the community to co-create or adapt existing programs to ensure they are relevant and respond to priority community concerns, as well as the general capacity and readiness for implementation. Another finding relates to the complementarity of a range of programs that can provide mutual reinforcement. As an example, the Baby Makes 3 program (Carrington Health, 2015) is a three-week program that provides education to first-time parents around gender stereotypes and equality in relationships. An initial internal evaluation of the pilot program showed that it was well received, effective and cost-efficient (Flynn, 2011). A final evaluation of the EMR project (Community Crime Prevention, 2015) has been developed, including a cost-benefit analysis, and this is expected to provide further information once released.

The Department of Justice, through its Community Crime Prevention Grants, also funded a range of projects which have also contributed to the growing evidence base around effective prevention and response. These included area-based strategy development, led by regional Women's Health Services and implementation work across a diverse range of settings, including early childhood services and workplaces, as well as a male champions program which sought to challenge family violence and sexist attitudes. An interim evaluation of this grants program (Willis, 2014) found some encouraging results, including positive movement in raising participant awareness and motivating behavioural change, as well as building effective partnerships and collaboration. In addition to the grants, Our Watch supported a community of practice for those involved to meet, share information and support each other in implementation. These programs, as well as the VicHealth-funded programs above, will add to the evidence base around what works, once final evaluations are released.

Eastern Metropolitan Region

The activity mapping and consultation conducted as part of this research highlighted a wide range of activities that are focused on preventing violence in the Eastern Metropolitan Region, from prevention to response. Much coordination and integration of this work has been conducted through existing networks, including Together for Equality and Respect [TFER], the EMR Regional Family Violence Partnership ([EMR RFVP], 2015) and the Indigenous Family Violence Regional Action Group [IFVRAG]. The TFER (2013) strategy and partnership, led by Women's Health East (WHE), was launched in 2013 and supports and coordinates primary prevention activities to prevention violence against women. The EMR RFVP, which commenced in 2007, provides leadership to support an integrated and coordinated family violence response, support the safety of women and children and ensure perpetrator accountability. For the Indigenous community, the IFVRAG provides specific, culturally relevant and community-led responses to educate, prevent, respond to and reduce family violence in Aboriginal communities.

The Outer East Children and Youth Area Partnership (OECYAP) is one of 8 cross-government and sectoral partnerships in Victoria aiming to improve outcomes for vulnerable children, young people and their families. The OECYAP emerged from the *Protecting Victoria's Vulnerable Children's Strategy* (Department of Health, 2012) and comprises senior representatives from state and local government and community service organisations and representation from TFER, IFVRAG and EMR RFVP. In 2015, the OECYAP worked with existing partnerships with a focus on addressing family violence in EMR to identify system gaps and opportunities for future work. This process identified the primary prevention of family violence as a key priority for action. In 2016, OECYAP member organisations will explore their role in preventing family violence (both internally as workplaces, and externally as service providers) and work together to prevent family violence through local sporting clubs and local business. This activity will be underpinned by the Our Watch *Change the Story Framework* and linked to the *Together for Equality and Respect: A Strategy to Prevent Violence Against Women in Melbourne's East 2013–2017* (TFER (Women's Health East, 2013)), in line with collective impact principles.

As indicated, there is a significant amount of focus and effort in relation to family violence in particular at multiple levels, with a range of coordinating mechanisms and agencies involved in both prevention and response activities. This presents an opportunity to harness that collective effort and investment through alignment of activity and acknowledgement of individual strengths.

SOCIAL INCLUSION AND COMMUNITY CONNECTEDNESS

Definitions and international research

Whilst there is no universally agreed definition of Social Inclusion, this report adopts the definition of the Australian Social Inclusion Board, which defines **social inclusion** as having the resources, opportunities and capabilities to:

- learn (e.g. participate in education and training);
- work (e.g. participate in employment, unpaid or voluntary work, including family and carer responsibilities);
- engage (e.g. connect with people, use local services and participate in local, cultural, civic and recreational activities); and
- have a voice (influence decisions that affect them).

Community connectedness similarly looks at the extent to which individuals feel able to engage, participate and interact with others in their community and the community overall. As one of the suite of Community Indicators Victoria (CIV), it is considered an indicator of a healthy community as well as individual health and wellbeing. Broadly, then, social inclusion and community connectedness refer to the experience that people are able to participate in key areas of the economic, social and cultural life of their community (Boardman, 2010).

Whilst these concepts are important, any discussion of social inclusion must address the opposite states of social exclusion and community isolation. Social exclusion refers to social experiences and perceptions of isolation and rejection that reduce the quality of life of individuals and community cohesion, through a lack of meaningful and constructive social and economic participation (Australian Institute of Health and Welfare, 2009). One definition is provided as the:

> *restriction of access to opportunities and [a] limitation of the capabilities required to capitalize on these [opportunities] (Hayes, Gray, & Edwards, 2008)*

The processes that lead to social exclusion are multi-dimensional and involve interactions between economic, political, social and cultural domains, across the various ecological levels of individual, household, group, community, country and global influences (Taket, 2014).

As noted by Prof Gillian Triggs, President of the Australian Human Rights Commission (2013), there is also a strong correlation between social exclusion and discrimination, with many situations of exclusion arising from discrimination against individuals or groups on the grounds of their attributes, or social, economic or physical disadvantages. This impacts opportunities for employment, access to healthcare and education and wider community participation. The ability to participate in society is a basic human right, reflected in the Universal Declaration of Human Rights (United Nations, 1948) and a range of other documents in international, federal and state law.

When individuals experience social exclusion, it has negative impacts on a range of wellbeing domains, including physical and psychological health, subjective wellbeing and quality of life, awareness of and access to resources, completing education, finding employment and financial security. Many of these impacts continue to intensify the cycle of disadvantage, particularly for children growing up in such situations, who lack the opportunity to participate in activities which may alleviate this disadvantage. This is often combined with restricted autonomy, and increases the probability that they will continue to experience disadvantage and exclusion as adults. Social disadvantage and exclusion is also in itself associated with increased risks of experiencing violence, particularly family violence, and can be a deliberate perpetrator tactic to isolate victims.

Effective regional social inclusion strategies will likely result from a framework that: (i) addresses the full scope of economic, social and cultural dimensions of social inclusion; (ii) aligns with national and global efforts to increase social inclusion; (iii) involves collaboration between community agencies to effect changes at the community and group level, while also where possible encouraging social capital (meaningful social ties) at an individual and household level; and (iv) encourages a shift in overall culture through addressing social inclusion across all community and organisational policies, procedures, service design and delivery (as opposed to limiting social inclusion efforts to individual interventions) (Crisp, 2014).

Experiences of social exclusion and community isolation

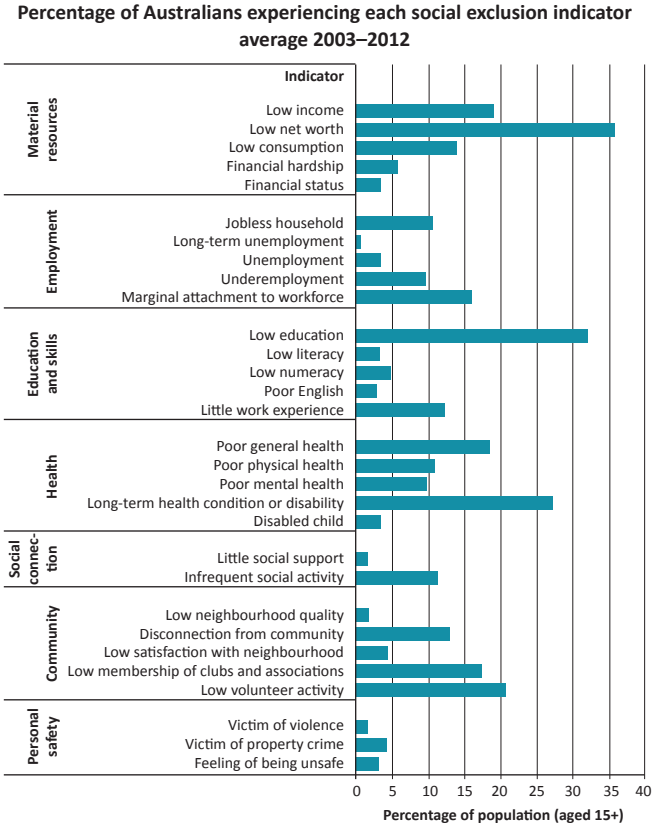
The Brotherhood of St Laurence, working with the Melbourne Institute of Applied Economic and Social Research (2014), developed a Social Exclusion Monitor. This was based on research (Scutella, Wilkins, & Kostenko, 2009) that sought to identify who experiences social exclusion, broadening out from financial disadvantage as the only measure. Using data from the Household, Income and Labour Dynamics in Australia (HILDA) survey, this work focused on seven domains, and 30 measurable components of disadvantage, to develop a composite measure of social exclusion, as indicated in Figure 6. The research identified that each factor contributed to social exclusion, with those experiencing at least 4 indicators across at least 2 domains at risk of deep exclusion.

Using this measure, across Australia, some specific groups are more at risk of exclusion, particularly:

- females
- elderly persons, especially those living alone
- those with limited English proficiency
- Indigenous Australians
- those with long term ill health or disabilities
- single parents
- residents of public or social housing
- hose with limited education (Yr 11 or less).

It is also suggested that carers and disengaged youth are at increased risk of exclusion.

FIGURE 6: PERCENTAGE OF AUSTRALIANS EXPERIENCING SOCIAL EXCLUSION BY INDICATORS, AVERAGES 2003-2012. (BROTHERHOOD OF ST LAURENCE & MELBOURNE INSTITUTE OF APPLIED ECONOMIC AND SOCIAL RESEARCH, 2014)



At an aggregate level, the ABS publishes four Socio-Economic Indexes for Areas (SEIFA), which can be used to analyse local trends to identify specific local areas where relative socio-economic disadvantage is more pronounced. These tools can be useful for planning and service allocation, as demonstrated by recent research conducted by the City of Boroondara (2015). Although generally considered a more affluent LGA, Boroondara is also home to some specific pockets of disadvantage, with 6% of local community neighbourhoods in the bottom quintile of most disadvantaged areas of Victoria. Figure 7 provides an indication of relative social advantage and disadvantage for the seven LGAs which form the Eastern Metropolitan region. Whilst all are within the uppermost quartile in Victoria, there is still considerable variation, with some LGAs having pockets of quite significant disadvantage.

FIGURE 7: EASTERN METROPOLITAN LGA MEASURES OF SOCIO-ECONOMIC INDEXES FOR AREAS ((ABS) AUSTRALIAN BUREAU OF STATISTICS, 2011)

LOCAL GOVERNMENT AREA (LGA) INDEX OF RELATIVE SOCIO-ECONOMIC ADVANTAGE AND DISADVANTAGE, 2011

LOCAL GOVERNMENT AREA NAME (LGA)	USUAL RESIDENT POPULATION	SCORE*	RANKING** WITHIN VICTORIA	MINIMUM SCORE FOR SA1S IN AREA	MAXIMUM SCORE FOR SA1S IN AREA
Boroondara (C)	159134	1114	80	953	1205
Knox (C)	149334	1039	65	754	1188
Manningham (C)	111312	1081	76	970	1189
Maroondah (C)	103880	1034	64	804	1187
Monash (C)	169268	1054	71	867	1187
Whitehorse (C)	151335	1057	72	773	1167
Yarra Ranges (S)	144540	1022	61	826	1161

* Scores: a lower score indicates that an area is relatively disadvantaged compared to an area with a higher score. SA1 index scores are standardised to a mean of 1000 and a standard deviation of 100 across all SA1s in Australia.

** Ranking: all areas are ordered from the lowest to highest score, with the area with the lowest score given a rank of 1 and the area with the highest score is given the highest rank.

Further information about specific drivers of social inclusion or exclusion is available through mapping databases such as AURIN (2015). This would provide an opportunity to review measures such as walkability, access to vehicles, volunteering, involvement in sports, cultural activities, and to overlay this with specific population groups, such as women, CaLD, people with disabilities, the elderly, GLBITQ, youth or indigenous, to develop targeted programs relevant to these groups. Other data from Community Indicators Victoria (2015) is available at an LGA level. This can include a range of indicators, such as a sense of community, access to resources and services, open space, employment and education.

CURRENT ACTIVITIES

National activity

At a national level, there are a range of policy areas and frameworks that relate to the development of a more socially inclusive society. These include employment and social welfare assistance, immigration and multiculturalism strategies, and a range of other elements. Such programs are implemented nationally, but have a significant impact across the region, particularly as they relate to reducing disadvantage and assisting individuals or families. Additionally, the overall tone of discussion around community participation and encouraging diversity is critical to supporting individual communities or groups to become more socially connected and promoting inclusive. Community initiatives such as the National Social Inclusion Week (Social Inclusion Week, 2015) also promote a broader sense of inclusion and opportunities for participation for everyone across cultures, age groups, nationalities and the disadvantaged.

Victorian activity

The Victorian Government's Plan Melbourne (2014) was a metropolitan planning strategy, designed to establish overall land use policy for Melbourne over coming years, given rapid population growth. The focus was on maximising opportunities for jobs, services and transport to be accessible and close to home, in order to sustain and drive liveability. This plan is now being refreshed (Department of Environment, 2015) to ensure that key issues such as housing affordability, the impact of climate change and other relevant areas are also incorporated into the planning framework. The related discussion paper suggests that the updated Plan Melbourne 2016 will reference the UN Sustainable Development Goals of economic prosperity, social inclusion and environmental sustainability, all important to building liveability. This plan also includes a focus on so-called '20-minute neighbourhoods', which aim to increase local accessibility to services, employment and opportunities for participation. This is supported by local activity centres where transport, services and infrastructure are concentrated, such as in Box Hill or Ringwood in the EMR.

Whilst the concept of liveability is broad, liveable communities can be defined as:

> *safe, attractive, socially cohesive and inclusive, and environmentally sustainable, with affordable and diverse housing linked via public transport, walking and cycling to employment, education, public open space, local shops, health and community services, and leisure and cultural opportunities. (Lowe et al., 2013)*

Liveable communities are also a driver of general wellbeing as centres of participation and service hubs. The Victorian Public Health and Wellbeing Plan 2015-2019 (Department of Health and Human Services, 2015) was released on 1 September, 2015. This will drive the government's commitment to improve the health and wellbeing of all Victorians, with a focus on the most disadvantaged, in relation to the priority areas of:

- healthier eating and active living
- tobacco free living
- reducing harmful alcohol and drug use
- improving mental health
- preventing violence and injury
- improving sexual and reproductive health.

Key platforms for change under this Plan include:

- healthy and sustainable environments
- place-based approaches
- people-centred approaches.

Local activities

As reflected in the activity mapping, there are a range of activities that seek to promote social inclusion within the Eastern Metropolitan Region. LGAs drive a range of programs from cultural groups and neighbourhood houses, to men's sheds and HACC services. State and LGA governments have also collaborated to drive neighbourhood renewal or activation programs in targeted areas such as Bayswater and Holmesglen. Community and cultural groups aim to provide relevant activities for specific population cohorts, and there are specific capacity building ventures such as the Opening Doors program, now located at LINKHealth.

Other activities which are seeking to drive community participation include initiatives such as VicHealth's Community Activation Program (VicHealth, 2015c), which aims to create and activate local places to increase opportunities for both physical activity and social connection, with the Manningham Plaza being a successful grant recipient. The OECYAP is also actively working to improve education and employment outcomes of young people leaving out-of-home-care, with a focus on increasing their community connections and giving them greater say in decisions that affect them.

3. PARTNERSHIPS

This research was specifically tasked with identifying ways to increase partnership approaches to the identified priority approaches. As such, models of effective partnership to engender social change were of interest, particularly the Collective Impact approach, which has been adopted across several state and local entities.

COLLECTIVE IMPACT

The Collective Impact model (Hanleybrown, Kania, & Kramer, 2012; Kania, 2011) provides a framework to address complex social issues, facilitating commitment and structured, collaborative participation from organisations across different sectors to a shared agenda and goals. This model has been adopted internationally (e.g. White House Council for Community Solutions) and within Australia, including by the Victorian Department for Health and Human Services, South Australia's Department for Communities and Social Inclusion and groups such as the Centre for Social Impact and the G21 regional alliance (Geelong Regional Alliance, 2015).

The model suggests five key conditions for collective impact, being:

- **A Common Agenda**: all participants (organisations, agencies, community members) share a common understanding of the problem and a joint approach to solutions through agreed actions.
- **Shared Measurement**: there is agreement on what data will be collected and how success will be measured and reported, driving alignment and accountability.
- **Mutually Reinforcing Activities**: a plan is established outlining broad stakeholder consultation and coordination of differentiated but mutually reinforcing actions.
- **Continuous Communication**: there is open and ongoing communication within and between participant organisations, building understanding and trust, promoting shared objectives and informing program refinement.
- **A Backbone Organisation**: ongoing support is provided by an independent staff dedicated to the initiative, providing specific skills to serve the initiative and coordinate participants.

The Collective Impact approach is embedded in many local and state organisations, and explicitly used in existing local partnerships such as the EMR RFVP, TFER and OECYAP. This offers a mechanism for driving effective engagement with other organisations, through alignment and reinforcement. Within this approach, each individual agency is then in a position to identify its particular focus and role within partnerships. Specific roles that might be adopted have been conceptualised by LaBonte (2002) as:

- **Educator/Watchdog**: focus on increasing public awareness of and monitoring social determinants of wellbeing
- **Resource broker**: making internal resources (including finance, personnel or information) more readily available to those who need them
- **Community developer**: supporting community group organisation and action through capacity building and funding
- **Partnership developer**: engaging in joint planning, programing and policy development with others
- **Advocate/catalyst**: development and avocation of relevant policy options to senior government and decision makers.

Within this framework, individual agencies may focus on one or more of these roles, consistent with their capacity and mission, to support collective action to influence the social determinants of core issues, such as violence or social exclusion. Whilst local partnerships are adopting this approach, there is still potentially room for improvement and greater engagement of the broader community and businesses. This will also be challenged as changes are likely to arise from the Royal Commission recommendations.

4. LITERATURE REVIEWS

In order to identify best practice nationally and internationally, literature reviews were commissioned in relation to each of the priority areas. The focus was to identify effective programs to address violence in vulnerable communities and social inclusion. For both priority areas, an initial scoping document was prepared and approved by the relevant EMSIC Advisory Group, and then a rapid systematic review was conducted to identify high quality systematic reviews and meta-analyses of international literature reviewing randomised controlled trials relevant to implementation within a community setting. This information was supplemented with documents sourced from expert advice where there were identified gaps in the literature search.

VIOLENCE IN VULNERABLE COMMUNITIES: THE EVIDENCE FOR INTERVENTIONS

In relation to violence in vulnerable communities, inclusion criteria were evaluations of community-based interventions to address one or more of the following forms of violence:

- violence against women and families
- youth violence
- violence against minority populations
- bullying.

Primary (whole population) prevention reviews were prioritised due to their community-wide approach, which was deemed particularly amenable to community intervention approaches. However, secondary and tertiary prevention approaches targeting specific groups (women who are victims of violence, or interventions targeting perpetrators) were also included. In total, 17 well conducted systematic reviews were included, along with prior reports such as those of the WHO. The full literature review is provided in **Appendix F: Detailed Literature Reviews**, and summarised below. Overall, the reviews provided strong support for primary prevention approaches, and mixed evidence regarding secondary and tertiary prevention approaches, as indicated.

It is important to note that since this review was conducted, a detailed evidence review regarding the prevention of violence against women has been released (Our WATCh et al., 2015), which notes that whilst this is an emerging area of practice, there are some consistent threads for promising further investigation, which will contribute to the evidence base.

Interventions to reduce violence against women and family violence

In general, primary prevention appears to hold the most promise for family violence prevention at a regional level, including strategies that aim to intervene early in children's development implemented universally through local government family and parenting programs and in education settings. In terms of secondary prevention, advocacy interventions designed to support women who are experiencing or have experienced violence demonstrate good effectiveness. There were no randomised controlled trials evaluating community interventions to reduce community rates of aggressive and discriminatory attitudes to women, and no formal proposals under development were identified. This is consistent with Our Watch's findings (Our WATCh et al., 2015) that whilst high quality impact evaluations are rare, there is a strong and growing body of promising practice. Current evaluations of local Victorian programs are likely to add to this evidence base once they are published.

There is promising evidence that primary prevention through secondary school interventions may prevent aggressive attitudes to women and encourage equitable social or gender norms. Selected interventions to address inequitable social or gender norms may be particularly important in those cultures and groups where such issues are assessed to be elevated. Reducing access to alcohol also shows some promise in addressing one of the reinforcing factors for family violence.

Screening programs designed to identify women in the community experiencing violence also demonstrate some promise, as do protection orders and perpetrator rehabilitation programs. However, in order to be effective these programs must be incorporated as a long term, coordinated multi-component approach across a region. To be effective, screening efforts to identify women experiencing violence must transfer into increased referral of women to effective support services, and thereby improved safety.

Interventions to reduce youth violence and school-based bullying

School-based programs demonstrate good effectiveness for prevention and focused interventions for adolescents, particularly programs that focus on relationship and social skills training and include a whole of school approach (Our WATCh et al., 2015). Additionally, the majority of the primary prevention strategies for family violence outlined above are also effective in preventing youth violence (Brown & Putt, 1999, as cited in Fuller, 2015; J.W. Toumbourou et al., 2015). Finally, school-based bullying programs appear to be effective in reducing victimisation and perpetration (Brown & Putt, 1999, as cited in Fuller, 2015), although effects on violent bullying have not been evaluated.

Interventions to reduce violence in at-risk populations

During the evidence review, limited research applicable to the local context was identified regarding evidence-based strategies for specific at-risk populations, including CaLD groups, Indigenous populations, LGBTIQ communities or people with disabilities.

For Indigenous communities, while the effectiveness of violence prevention in these populations has not been well researched, it is recommended that any programs should nurture social capital, be culturally informed, and prioritise the active and central participation and leadership of the Indigenous community. The engagement and leadership of the IFVRAG is critical to this approach.

A Victorian study investigating experiences of violence for women with disabilities (Woodlock et al., 2014) noted their specific needs, including the intersection of disability-based violence and violence against women. This report recommended that responses must be tailored to their unique needs, particularly in relation to service accessibility. Similarly, for LGBTIQ individuals, (Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007) issues have been noted in relation to consider the specific needs of this cohort, appropriate response protocols and increased collaboration. It is likely that other diverse groups including CaLD communities might face similar challenges. Such groups require a cross-sectoral approach with an emphasis on increased collaboration between existing support services for these diverse groups and specific violence prevention and support services, acknowledging and responding to the compounded discrimination which may be faced by people in these communities. Monitoring can ensure that diverse communities are accessing services in rates proportionate to their presence in the population or the estimated population prevalence.

Interventions to reduce elder abuse

For elder abuse, prevention strategies that aim to improve attitudes towards older people, increase social inclusion and provide combined legal and social services to the aging population appear to hold some promise, in addition to programs that improve caregiver mental health.

PROMISING PRACTICE VIOLENCE PREVENTION STRATEGIES

The above evidence review drew on systematic studies and randomised control designs to determine effective interventions. This report also reviewed current programs which have been identified both from the mapping and wider consultation as showing potential to reduce the risks of violence for specific populations who are at risk, particularly when considering family violence and violence against women and children. These are generally founded in strong evidence as to likely causes and effective approaches, such as the VicHealth framework for preventing violence against women (VicHealth, 2009). Whilst there is currently no published evidence at the level of randomised control studies to demonstrate their success, initial evaluations are positive and these suggest promising areas for future resource investment. Where possible, providing sufficient funding to conduct and release comprehensive evaluations of such programs would be a positive contribution to the broader evidence base. In conjunction with its policy and program framework, VicHealth has also developed an evaluation framework (VicHealth, 2015a) which may be used to effectively determine the outcomes of some of these programs of work.

Prevention

Consistent with the evidence base for the gendered drivers of family violence, promising areas for the primary prevention of family violence focus on promoting a more gender-equitable society in a range of settings, including workplace programs which include gender mainstreaming in service planning and delivery, gender equality and audit programs, and respectful relationship education in sporting clubs, community groups and faith-based organisations. Media advocacy programs and initiatives which support champions in the community are also showing some efficacy in changing community attitudes and shifting social norms in relation to gender inequality and violence against women and children.

Local examples include:

- TFER workplace audits and the Speaking Out media advocacy program led by WHE in partnership with EDVOS and ECASA (Women's Health East, 2013, 2015)
- Whole-of-area approaches, including Monash Generating Equality and Respect (GEAR) intensive place-based program (Monash City Council, 2015) and Outer East Preventing Violence in Our Community Program, which worked with 3 local governments to address violence against women and integrate gender equity into council planning across range of services
- Early and first-time parent education on gender equity, through Baby Makes 3 program (Carrington Health, 2015), developed and led in the EMR by Carrington Health (formerly Whitehorse Community Health)

- Respectful Relationships Education in Secondary Schools (RREiSS), with a recent evidence paper released by Our Watch (Gleeson, Kearney, Leung, & Brislane, 2015) noting common national and international elements of successful RRE approaches which include addressing the gendered drivers, having a long-term and whole-school approach, establishing coordination mechanisms including continual improvement and ongoing evaluation, support teachers and use appropriate, interactive and engaging curriculum
- Online and app-based supports.

For specific cohorts and settings, such as faith-based or cultural groups, local community leaders have been engaged as key stakeholders to promote messages within their community, build awareness and become champions for change.

In relation to elder abuse, as indicated above, promising areas include programs that address ageing stereotypes, and the provision of advocacy and combined social and legal assistance (Ramsay et al., 2009).

Early intervention/secondary prevention

Areas of promising practice in relation to early intervention or secondary prevention include the provision of easily accessed information regarding risk factors and available resources, whether through physical documents or cards, apps or websites. Apps include *Daisy*, a national app that connects women to local services and Doncare's *Live Free* app that provides information on risk factors and supports. The *LookOut* website provided by the Domestic Violence Resource Centre Victoria is also a source of information and resources. Such resources help individuals to identify potentially high-risk scenarios, for themselves or others, and access assistance.

Client-centred practices which focus on the individual and their unique needs and concerns are also promising, as they promote a sense of efficacy for the individual. In addition, services need to be tailored and promoted for those groups identified as likely to be at elevated risk. Targeted education or awareness raising work, such as that conducted by the Migrant Information Centre with specific cultural groups, particularly newly arrived migrants or refugees, around cultural and social norms, also shows some promise.

Response/tertiary prevention

Promising areas in relation to family violence services relate to providing individualised services that respect clients, their autonomy and unique needs. Monitoring to ensure that resources meet the demand for support is vital, as is work on service system integration and navigation. Whilst the response sector is highly developed in terms of core competencies and service delivery, opportunities for enhanced system coordination and client transfers, particularly building on the interactions between mainstream and violence specific services, are a potential area for further investment, building on the work of the EMR RFVP. Challenges remain in relation to ensuring that those who need to navigate between a range of service providers, such as refuges, child and family support services, justice and the courts, are provided with effective support, their distress is minimised where possible, information is passed effectively between agencies and care is coordinated.

Competent professional case workers who can assist with navigating the system are an area which shows some promise in helping clients at this time.

Peer support from those who can demonstrate empathy also seems to show some promise. Many women who leave an abusive relationship need to relocate and may be living in some level of reduced circumstances, with financial stress in some cases prompting a return to an abusive situation. Doncare's DAWN program (2012) provides such women with a volunteer mentor over an extended period, in order to provide and promote social support and the ability to create and sustain a new safe life when they are moving through recovery from domestic violence.

In relation to monitoring and minimising negative perpetrator behaviours, male behaviour change programs have shown some promise, but are resource-intensive and expensive, and the evidence is limited, with further evaluation required. Whilst a UK study showed promise (Bloomfield & Dixon, 2015), other results have been more mixed (A Day, Chung, O'Leary, & Carson, 2009), and further local evidence will be required to identify what does work in this space.

Other options include the use of electronic and chemical surveillance techniques such as ankle bracelets and other options to monitor the movement and potentially the drug and alcohol intake of high-risk offenders, to allow for potential threats to be mitigated where conditions such as AVOs have been breached. One comprehensive US evaluation of GPS surveillance techniques (Erez, Ibarra, Bales, & Gur, 2012) appears promising in relation to changing perpetrator behaviours with significant reduction in breaching orders or repeat offenses. However, further and local evaluation of such approaches and their interaction with existing judicial, criminal and family law systems would be important to determine the suitability within the Australian context.

Social Inclusion and Community Connectedness: the evidence for interventions

When reviewing interventions that sought to increase social inclusion or community connection, the focus was also on those that explicitly sought to reduce social exclusion, by contrast. Inclusion criteria were evaluation of community interventions designed to address one or more of the following:

1. reducing place-based disadvantage and social economic exclusion
2. ensuring social inclusion and reducing social isolation for people with a disability and aged populations
3. ensuring social inclusion and valuing diversity for minorities including Culturally and Linguistically Diverse (CaLD), Indigenous and Gay, Lesbian, Bisexual, Transgender, Intersex and Queer (GLBTIQ) populations.
4. ensuring participation in building social capital.

A total of 23 studies were reviewed, with the full literature review provided in **Appendix F: Detailed Literature Reviews**. In general, there were few studies evaluating social inclusion interventions, and those identified were of limited quality. However, best practice strategies identified from the literature are summarised below.

BEST PRACTICE SOCIAL INCLUSION STRATEGIES

There is evidence from randomised community trials that positive youth development programs contribute to healthy child development and may lead to increased civic engagement (volunteering) and lead to benefits in reducing health and social problems at a population level over time. There was some evidence suggesting social inclusion interventions that focus on empowerment may have benefits. Social inclusion interventions in disadvantaged communities addressing community safety may be important for increasing social inclusion. In addition, violence prevention programs that targeted parental risk factors were also associated with improved social outcomes for children and adolescents.

Overall, there was some support from small studies for the potential for community intervention to increase social inclusion in participants. It is unclear, however, whether community interventions aimed at increasing social inclusion may have benefits for the wider community due to a scarcity of research assessing this. There appeared to be a possible trend towards increased effectiveness of interventions that focus on empowerment and there was some evidence to suggest that interventions may have reduced effectiveness if key risk factors such as community safety are not addressed.

Evidence for place-based programs such as neighbourhood redesign or urban renewal was limited and conflicting, which is concerning, especially given their expense. Community mobilisation efforts seemed to be effective in reducing place-based disadvantage for those involved in the mobilisation activities, but not for the broader community. In relation to specific vulnerable groups or diverse populations, there was no intervention strategy or evaluation study that could be said to have superior evidence for reducing social isolation and exclusion. Given this situation, it is important that innovative intervention strategies continue to be developed and carefully evaluated.

Promising practice social inclusion strategies identified

Due to the relatively limited results from the literature review, further consultation was conducted with identified stakeholders in relation to programs that show promise in promoting social inclusion and minimising social exclusion.

One key initiative which showed considerable promise was the Opening Doors program, initially coordinated by IEPCP (2015) and now located at LINKhealth. This community leadership program adopts an asset or strengths-based approach to community development. Existing or emerging community leaders are supported to develop locally relevant grass-roots programs or projects intended to engage community members at risk of social isolation. Modelled on the Leadership Victoria Williamson Program, an initial evaluation (Held, 2011) demonstrated increased leadership confidence and capability for participants, as well as a range of projects established or underway to strengthen community connection and reduce isolation in the local area. Specific programs include English conversation classes, U3A programs, support groups for transgender parents and a men's kitchen program.

An external evaluation has now been commissioned and this would provide a useful and highly relevant contribution to the evidence base for successful programs within the region.

Given the limited evidence regarding the efficacy of community renewal projects, a range of local community or neighbourhood renewal programs were reviewed. Interim evaluations (Department of Human Services, 2005) appeared positive, but no final evaluations were able to be identified which reviewed the sustainability of the outcomes of these investments.

Other social inclusion programs that target specific groups include Neighbourhood or Community Houses, usually coordinated by LGAs, and population specific programs such as Men's Sheds and youth programs. These all seek to provide opportunities for meaningful engagement for those deemed at risk of social exclusion or a lack of participation. Whilst there is limited formal evaluation of many of these programs, Men's Sheds have been more comprehensively reviewed and show strong promise. Several studies both within Australia and internationally have found evidence that Men's Sheds provide an enabling, relevant, supportive and meaningful activity centre, with positive outcomes in relation to mental health, community participation and social inclusion (Cordier & Wilson, 2013) for a range of groups including older men, those with disabilities (Hansji, Wilson, & Cordier, 2015; N. Wilson et al., 2015) and depression (Culph, Wilson, Cordier, & Stancliffe, 2015; N. Wilson et al., 2015). Of interest, many sheds also offer inter-generational mentoring, with a focus on targeting disadvantaged populations (Cordier & Wilson, 2014).

5. MAPPING

In order to identify current activity within the region, a mapping exercise was conducted, focusing on relevant programs, projects or other initiatives which targeted the priority areas.

From public websites and information of EMSIC members, an initial desktop review was conducted from June to July 2015 to identify potential programs, services or projects which targeted outcomes related to violence or social inclusion. Based on this desktop review, an initial mapping document was circulated to Advisory Group members, who were asked to provide feedback and identify gaps or missing information. EMSIC members were then also provided with a developed draft and asked to provide feedback, confirm contents and identify any gaps. It is important to note that whilst care was taken to review as much information as possible, due to time and resource constraints it was not possible, nor considered appropriate, to conduct a more comprehensive consultation exercise, nor to review the veracity of all information from the available materials. As such, the mapping may be incomplete. In addition, as the mapping was conducted at a specific point in time, some programs may no longer be in operation, and others may have since commenced.

However, this mapping does provide some indication of the nature of current activities in the Eastern Metropolitan region of Melbourne, as well as the range of organisations who are involved in work related to these priority areas. The detailed maps are provided as Appendix E: Detailed mapping in this report. For each organisation, the mapping attempted to identify the target population for the activities, and where possible, relevant indicators and evaluation plans or strategies which are supporting the implementation.

6. INDICATORS

The research group also worked to identify indicators which may be of value in determining the scope and scale of the problems, causes and risk factors, program outputs and measures of change for each priority area. The focus was on finding robust data sets, which are publically accessible, as localised as possible, with regular data collection and the ability to identify relevant population groups.

For both violence and social inclusion, the process to locating relevant indicators involved an initial search using the Google search engine. Keywords such as ‘crime’, ‘violence’, ‘community’, ‘LGA’, ‘Victoria’ were used to limit searches. Several large databases hosted by different organisations were resulted in the searches such as the Australian Bureau of Statistics, Victoria Police and Community Indicators Victoria. Data sources were tracked down if the data were not originally collected by these hosts to determine whether these data were publicly available and whether they have been populated utilised in other databases. Not only direct indictors of crime were included; indicators for predictors (risk factors) of crime such as alcohol-related emergency room admissions, alcohol and illicit drug use, and social disadvantages were also included in the search list. Decisions were made to include indicators in the search list if the data were provided at the community level (LGA, regions, postcode or suburbs), and multiple waves of data were collected (for some databases trend data were available). Draft lists of the indicators were circulated to the advisory groups for comment. Two meetings were also held with groups examining indicators for violence against women in the Eastern Region. The identified indicators were categorised on the basis of whether they were relevant to outcomes (violence/ social exclusion), risk factors, systems and processes and, in the case of violence prevention, gender inequality. The indicators were each analysed to identify the relevant geographic areas and time periods to which they applied. This resulted in a matrix of various potential indicators, which could be used to support program development and evaluation of progress, immediate and longer-term outcomes of relevant programs in the region. The proposed indicators are provided as appendices to this report (refer Appendices G and H) for detailed review.

7. GAPS AND STRENGTHS

In reviewing the current levels of activity as documented through the activity mapping, it is clear that there is a significant amount of work currently focused on preventing and responding to family violence in particular, with a range of coordinating partnerships. In addition, the current broader authorising environment has raised the profile of activities and provides momentum.

The Collective Impact approach (Hanleybrown et al., 2012; Kania, 2011) mentioned earlier provides a framework to address complex social issues, facilitating commitment and structured, collaborative participation from organisations across different sectors working towards a shared agenda and goals. As noted, existing partnerships including TFER, EMR RFVP and OECYAP demonstrate some of these conditions, as indicated in Table 2. Whilst there are opportunities for strengthening components and raising the profile of this activity, the fundamental principles provide a sound basis for expansion.

TABLE 2: COLLECTIVE IMPACT APPROACH AS APPLIED TO TFER, EMR RFVP, OECYAP

Collective Impact Element	TFER	EMR RFVP	OECYAP
Common agenda	Reflected in TFER strategy and vision, Shared Commitment document and TFER Action Plan	Reflected in EMR RFVP mission, strategic plan, drivers/priority areas, MoU and operating principles.	Adopting TFER framework and reflected in planning
Shared measurement	The TFER Evaluation Framework includes shared objectives, indicators, evaluation tools and resources	Data working group actively engaged in creating data picture for EMR to understand and inform practice.	Currently working to identify and develop shared indicators and measurement
Mutually reinforcing activities	Shared and complementary initiatives contribute to the six regional objectives	MoU between members explicitly spells out relationships between stakeholders and interrelationships	Agreement to align prevention work with TFER plan
Continuous communication	TFER communication plan, implemented via website, communiques and partner forums	EMR RFVP communicate via newsletter, website and forums.	Ongoing and regular communication between members, regular forums
Backbone support	Leadership from WHE	Leadership from independent Chair, and role of Regional Integration Coordinator to support collaboration.	Support from DET through Area Partnership Coordinator role.

This demonstrates many of the elements of Collective Impact for these partnerships. However, it appears that in some other areas, greater coordination of effort would be valuable, as there appear to be situations in which multiple agencies are replicating similar activities. Given relatively scarce resources, pooling knowledge and collaborating would appear to be of benefit. The recommendations from the Royal Commission also appear to support for greater investment in local coordination and collaboration, including governance and information sharing, through the Safe Hubs concept.

In relation to other aspects of violence, there is significant investment in relation to the harmful use of alcohol and other drugs, but this may require further attention. Elder abuse and the abuse of persons with a disability do not seem to gain the same levels of interest and whilst the Eastern Elder Abuse Network ((2015) has been in place since 2010, it appears to have had less regional focus. Given the relatively older demographics of the region which are projected to increase, it would seem relevant to focus on this area moving forward, particularly as it applies across culturally diverse communities where there may be variation in expectations between the elderly and younger family members in particular who have been raised in Australia and may have less of a collectivistic approach.

In relation to Social Inclusion or Exclusion, there is a range of programs in place across the region, often coordinated and/or funded by the LGAs. However, there is frequently little evidence base or evaluation of the outcomes of these programs. In order to provide effective solutions, investment in capacity building for program explication and evaluation would be a relevant priority across the region, to increase the evidence base about what does work within specific contexts and for specific cohorts. Additionally, given the changing nature of communities, a focus on finding innovative ways to reach those who are not participating in traditional forums is required, and this may involve a significant online component.

8. DOMAINS OF POTENTIAL WORK

The following table summarises potential domains of work identified and evidence-based actions for consideration by EMSIC. These areas were identified as arising from the evidence base around what works, and from consultation with stakeholders around current activity, capacity and identified needs.

DOMAINS OF WORK	EVIDENCE-BASED ACTIONS
Preventing and responding to Violence in Vulnerable Communities	
1) Child- and youth-focused violence prevention	1. Early parent education and support that promotes gender equality in relationships and social and emotional competence in early childhood 2. Parent education and support programs for range of age cohorts from early primary to adolescents 3. Consistent curriculum and organisational supports for childcare/preschool settings 4. Whole of community approach to prevention of youth violence 5. School programs: Respectful Relationships curriculum with whole-school approach.
2) Population-based community interventions to address gender equality	1. Advocate for and support the work of existing partnerships, including TFER 2. Consider and review program evaluations and determine regional priorities, with support from RMF 3. Continue to emphasise Municipal Health and Wellbeing plans as mechanism to promote and coordinate regional and local action.
3) Target harmful usage of alcohol and other drugs	1. Develop and consider regional action plan to address supply and demand pressures for alcohol 2. Proactively monitor and respond to demand for treatment and service capacity to address substance usage.
4) Screening to detect and interventions to protect women and children who are victims of family violence	1. Screening: a) review available risk identification approaches consistent with CRAF, particularly for universal service system b) train diverse agencies in their use and referral pathways 2. Protection: a) map existing agencies and services b) client centred review c) trial and evaluate best practice models d) commitment to information exchange e) advocacy interventions f) consistent social and public messaging
g) Reduce pathways to violence associated with disadvantage	Develop and implement range of programs with focus on intersectionality across: 1. Maternal and Child Health services 2. school-based programs, complemented by tutoring and mentoring support 3. community-based programs.
h) Rehabilitation for Violence Offenders	Support information exchange around best practice evidence-based strategies for perpetrator rehabilitation and accountability.
i) Engage and consult with minority groups to identify and address their unique needs	1. Develop agreed set of monitoring tools for diverse communities 2. Train users 3. Collect data and report on cohorts of need. 4. Ensure appropriate, culturally sensitive and accessible services for diverse cohorts

DOMAINS OF WORK	EVIDENCE-BASED ACTIONS
Promoting social inclusion and community connectedness	
1) Liveability	1. Advocate for increased focus on liveability in planning and service delivery. 2. Consider recommendations for service design arising from DHHS Boroondara Liveability collaboration study.
2) Reduce pathways to social disadvantage associated with place-based disadvantage	Develop and implement range of programs across: 1. MCH services 2. school-based programs, complemented by tutoring and mentoring support 3. community-based programs.
3) Capacity building for program design, implementation and evaluation	Capacity building workshops on program design and delivery, including evaluation. Support for range of evaluation techniques, including formative and developmental evaluation to support emergent programs.
4) Increase volunteering rates	1. Develop and implement a strategy to increase volunteering rates across the community. 2. Provide training for organisations in responding to changes in volunteering practices.
5) Community-based programs and leadership development	Consistent rollout of community-based programs across EMR which support grass-roots needs identification, develop leadership and support implementation of community-led projects to address social inclusion e.g. Opening Doors.
6) Common regional measurement	1. Detailed analysis of data including AURIN and ABS, to identify drivers of disadvantage and exclusion, especially with reference to diverse and isolated groups. 2. Program planning to meet diverse needs.
7) Promoting resilience and working with digital communities	Activities to be determined, pending further review of actions arising from new VicHealth Mental Wellbeing Strategy 2015-2019.

Noting the scale, severity and potential impacts of both violence and social exclusion, and consistent with a population health approach, these areas of work prioritise primary prevention approaches to eliminate or minimise known determinants and risk factors, in order to reduce their occurrence. However, in acknowledging that such efforts take time to deliver community impact, the report also identifies secondary approaches that target those at increased risk, and tertiary responses for those already affected by violence or lack of social inclusion. It is noted that although the two evidence reviews were conducted independently, due to the overlap in some key risk factors, some domains of work are relevant to both the Violence and Social Inclusion priority areas, and as such are addressed in both sections.

Initial domains of work were derived from the evidence review, which identified areas where strong evidence supported efficacy of interventions or approaches. Additional areas were also identified from reviews of promising practice, consultation and consideration of regional capacity and capabilities needed to address these issues. Once a broad work domain was identified, it was developed through a description of specific programs which might be of relevance. Comparison was made against current practice as identified during the mapping process, to determine areas of strength and opportunities for further engagement, particularly in relation to partnership opportunities. Where relevant ongoing state or national level work was implicated, this was highlighted, with opportunities for support or complementary programs identified. Potential indicators for baseline and outcome evaluation were also identified with respect to each domain.

A. VIOLENCE IN VULNERABLE COMMUNITIES: DETAILED DOMAINS OF WORK

Best practice evidence, national and international frameworks all emphasise that as for any public health or community-wide issue, effective community level violence interventions must operate and be reinforced across the spectrum from primary prevention through to tertiary response and in a range of settings. Additionally, community and regional approaches to violence intervention should complement existing state and national level approaches to intervention. The evidence highlights the need for violence intervention approaches to provide integrated services targeting the various levels of violence prevention. This requires operating within a framework that allows a variety of organisations to contribute within their areas of expertise or focus.

As primary prevention approaches have been consistently identified as having the clearest evidence, they should be prioritised as the more cost-effective and humane approaches. However, the importance of effective secondary and tertiary responses is also emphasised.

1) Child and youth-focused violence prevention

The most cost-effective and highest potential interventions to prevent violence (J.W. Toumbourou et al., 2015) look to eliminate or mitigate early life course predictors of later violent behaviour, as part of a whole of community prevention approach. This requires implementing evidence-based primary prevention approaches universally across the region, with the intent to change behaviour in child and adolescent cohorts. Conducting analysis of the presence of specific risk factor analysis will also potentially identify higher risk population groups (e.g. those experiencing social disadvantage, children who have experienced family violence) within specific geographic areas. For such groups, secondary prevention activities can be tailored and then monitored to ensure that targeted risk factors are in fact reducing as planned, with consequent reductions in overall levels of violence across the community.

Typical universal interventions may operating in a range of settings, including:

- early-learning (e.g. pre-school and kindergarten) curriculum and centre design (including equipment/toys and staffing/HR policies) that promote a diverse range of gender roles, model healthy conflict management and address bullying behaviours
- primary school training to develop or improve classroom social and emotional competency
- parent education programs provided through primary and secondary school forums, with emphasis on gender roles and equality, and attitudes to women
- secondary school: relationships education, self-esteem and explicit concept of meaning of consent as a whole-school approach.

Secondary prevention approaches include:

- targeted programs to work with children exposed to family violence, including mentoring and education support to establish alternative models of healthy relationships
- bullying prevention programs in schools where children report high rates of victimisation.

Current programs in the Eastern region that meet these criteria include:

- **MCH parenting support**. Support for parents during early childhood can help with establishing healthy child development and monitoring milestones. Operated by LGAs, MCH centres are the ideal point of contact for early childhood. This includes **Baby Makes 3**, an early parenting program provided by MCH centres to support the establishment of healthy relationships for first-time parents. It is noted that the current project funding for this program (from the Department of Justice and Regulation's Community Crime Prevention Grants program) ceased as of December 2015, with a formal evaluation due for release shortly. However, the program is currently operating in 19 LGAs across Victoria, with potential for broader rollout.
- **Pre-school programs** which focus on equal gender norms and self-esteem, as currently being developed and trialled locally by both WHE and Doncare.
- **School programs:**
  - **Respectful Relationships curriculum**, implemented across P-10 years and coordinated by DET with VicHealth (e.g. Building Respectful Relationships Curriculum. The recent evidence paper (Gleeson et al., 2015) draws on international and local information to provide support for cluster trials around a whole school approach to implementing this curriculum.
  - **Social and emotional competency training**: National school-based programs such as KidsMatter for primary schools (2015) and MindMatters (Secondary schools) (KidsMatter, 2015; MindMatters, 2015) are designed to support mental health and wellbeing, and supported by the federal Department of Health and beyondblue.

Potential indicators to monitor progress towards outcomes include:

- attitudes to women/gender equality survey to identify specific geographic or population cohorts for intervention, potentially modelled on the NCAS (ABS) (VicHealth, 2014)
- gender equality measures to monitor progress in diverse settings, including employment, equitable parenting roles
- eventual reduction in violent offending, particularly in younger cohorts.

Specific actions to support this domain include:

1.1. **Consistent approach to early parent education**, to be delivered through LGAs as managers of MCH centres. This includes:

  1.1.1. Availability and universal access to early parenting education with focus on gender roles and establishing healthy relationships, such as Baby Makes 3

  1.1.2. Broad availability of parent education programs to be delivered through Community Health settings, libraries and other access points

  1.1.3. Tailoring of parenting supports for relevant diverse groups based on population e.g. CaLD, GLBTIQ, people with disabilities and Indigenous communities.

1.2. Review and promote effective and evidence based models of a range of **parent education supports** across age cohorts from early to teen parenting. Examples include the Triple P model (Triple P, 2015) which has demonstrated efficacy in Australia for reducing childhood antisocial behaviour, a pre-cursor of adult violence.

1.3. Develop, implement and review consistent curriculum and organisational supports for both government and non-government providers of **childcare/preschool settings**, to promote diverse gender roles and equity.

1.4. Consider broader rollout of community based integrated approaches to address problem behaviours in youth cohorts, e.g. **Communities That Care** (current pilot in Knox), once evaluation outcomes are released.

1.5. Support universal rollout of whole-of-school approach to mandatory **school-based respectful relationships curriculum**, including any recommendations arising from evaluations once released.

Given the focus here on early and school-based interventions, there is a logical alignment for regional staff from the Department of Education and Training (DET) and LGAs (as custodians of early parenting supports) to take lead roles in coordinating and advocating these approaches, along with community health agencies and other partners. This could be facilitated through the existing OECYAP.

2) Broad adult-focused community interventions to address gender equality

Local, national and international frameworks (Our WATCh, 2015a; VicHealth, 2009; World Health Organization, 2010) all recognise the primary social determinant of violence against women and their children as gender inequality and rigid gender roles. Whilst there is little documented evidence around strategies for social change, inferences can be drawn from other public health approaches to change behaviours and attitudes (Our WATCh et al., 2015). General principles for change in social norms require that such programs provide broad community coverage to reach maximum numbers. As well as broad marketing campaigns, interventions should be delivered through natural gatherings, such as workplaces, sporting clubs, faith communities, cultural groups, community groups, indigenous groups or other groups. To maximise effectiveness, such programs need to be tailored to the group's needs, context and preferred modalities, and championed internally to build credibility.

These programs should build awareness of existing gender norms, help participants understand how their own assumptions may influence behaviour and therefore how to modify them. It is also important to look at embedded change to demonstrate gender equity principles. For example, in organisational settings, this would include reviewing organisational practices, leadership opportunities and operational delivery to identify and address systemic barriers to equality. These interventions can also provide information and support to those at risk of experiencing violence within a culturally relevant manner and emphasis the unacceptability of violence or controlling behaviours. It is important that where such programs are considered, rigorous monitoring and evaluation is incorporated, to increase the evidence base as to what does work in relation to adult attitudinal and behavioural change, systemic organisational change and service provision and utilisation change, given the relative paucity of clear evidence available at this stage.

Typical programs: There is a range of promising practice in this space. VicHealth has funded a range of programs across Victoria which applied a primary prevention approach in diverse settings including workplaces, MCH settings, faith-based groups, youth-focused services and local government (VicHealth, 2012). Evaluation of the programs showed some promise, and also explicitly noted challenges in relation to systemisation and sustainability. A further stage of this project involved an intensive place-based approach, Generating Equality and Respect (Monash City Council, 2015), which is active in a range of settings within the LGA of Monash. Whilst formal evaluation is yet to be released, initial findings were positive in relation to participation and some evidence of cultural change. Other programs include a range of projects funded by the Victorian Department of Justice through the Reducing Violence against Women and their Children grants program, part of the Community Crime Prevention Program, most of which are currently being evaluated. Again, these were implemented across all the Victorian regions, with various programs focusing on regional strategy and action plan development, workplaces, including regional and rural locations and MCH settings. There was also an explicit program targeting male community leaders (City of Cardinia, City of Casey, & City of Greater Dandenong, 2015) to publically campaign against and challenge sexist attitudes.

Relevant broader campaigns at the state and federal levels include public awareness of the Victorian Royal Commission activities, the activity of groups such as Our Watch and statements from public figures such as Rosie Batty and Tom Meagher. These have the potential to strengthen the community appetite for conversations around changing attitudes and behaviours, consistent with the Health Belief Model, which suggests that two levers are required to change negative health behaviours. Firstly, increasing the awareness of the potential seriousness, perceived threat or negative impact and consequences of continuing to engage in certain behaviours is important. Secondly, information needs to be provided about how to effect such a change.

Current examples of programs that would meet these criteria include:

- **Workplace Gender equity training and audits**: As run by WHE, sessions can be tailored to include discussion of gender analysis and planning, an organisational audit and a review of how organisations can build gender equity within their workplace and programs.
- **Gender equity – local government programs:** The Municipal Association of Victoria (2016), currently works with LGAs to embed the prevention of violence against women and gender equity into council policies and programs.
- **Consistent social and public messaging** delivered across the region could communicate agreed messages about taking action to prevent domestic violence and gender inequity. This could be delivered through websites, in specific settings, at community events and by engaging local community leaders, including White Ribbon Ambassadors and Champions for Change. However, care needs to be taken in crafting such messages, to ensure that they are delivering the intended messages to the target audiences. A recent US study (Keller, Wilkinson, & Otjen, 2010) of an public campaign against domestic violence found that following the campaign, whilst women were more likely to see domestic violence as a serious issue, men deemed it less serious following exposure to the campaign.
- **Cohort-specific approaches** for hard-to-reach cohorts, such as:
  - for young males engaged in sports club activities, campaigns that promote gender equality, access and respectful relationships, such as the AFL's Respectful Relationships campaign (2015) and the Yarra Ranges You&I project (2015)
  - youth-focused campaigns, including The Line (Our WATCh, 2015b) which provides information on respectful and equal relationships
  - early/first-time parent education, which focuses on establishing healthy relationships after the birth of a child, such as Baby Makes 3. This also includes home visitations, parenting groups, regular contact and monitoring of child development against social and emotional milestones
  - parenting and relationship programs being delivered to a range of CaLD groups across Melbourne, including the EMR. Specific cultural groups already identified include Vietnamese, Indian, Sudanese and Croatian (InTouch, 2015), Burmese and Iranian groups (Migrant Information Centre, 2015).

Indicators

Similar to the child and youth prevention focus above, potential indicators include:

- changes in results for attitudes to women survey in specific geographic or population cohorts, including attitudes and explanations for violence
- gender equality measures to monitor progress in diverse settings, including employment, equitable parenting roles
- eventual reduction in violent offending.

Recommended lead agency

Given their existing work in this space, including the development and leadership of a regional strategy, the TFER partnership would seem logically positioned to take a lead role in the coordination of this approach, building on their existing focus.

Specific actions

2.1. That EMSIC **advocate for and support the work of existing violence prevention partnerships**, such as TFER, through internal role modelling, advocacy of the importance of prevention work and resource commitment to gender equity.

2.2. EMSIC to **consider and review the range of program evaluations** which are currently underway once released, in order to determine which approaches have particular relevance for the EMR. Considerations would include:

- relevant focal populations for the EMR, based on census data and new arrivals to identify hard-to-reach populations, and the potential for intersectional approaches that address multiple forms of violence or discrimination
- availability and targeting of human and financial resources
- integration of evaluation plans in program design, to increase the available evidence base
- consideration of immediate priority settings to leverage existing momentum (e.g. schools implementing Respectful Relationships education, AFL sporting groups), as well as longer-term opportunities
- potential opportunities to integrate messaging across programs for complementary impact.

2.3. To engage LGAs more holistically in this work, the continued **emphasis on family violence prevention in municipal health and wellbeing planning** would assist with prioritisation of effort. Engagement and coordination via the Regional Management Forum (or its successor forums) would also assist with the best use of resources.

3) Target harmful usage of alcohol and other drugs

The use of alcohol and other drugs has been identified as a contributing or reinforcing factor to most forms of violence. For community violence it is considered a primary cause, whilst for family violence, it is a reinforcing factor where gender inequality is present. Hence, whether considered as primary or secondary prevention, targeting the harmful usage of such substances is anticipated to reduce violence. Given its higher prevalence, alcohol use is implicated in more than ten times the number of injuries and deaths than illicit drug use. Hence, the current report recommends a focus on alcohol usage as a priority. This includes advocating at a state and federal level for initiatives that include pricing-based strategies and reduced licensing hours. Broad public health campaigns that target cultural attitudes to harmful alcohol usage are also important.

There are also promising interventions that can be implemented at a regional level to **reduce both supply and demand of alcohol**, and to **target hotspot locations** where rates of violence are higher, through a combination of regulatory and compliance activities. Reducing the supply and demand for alcohol will, amongst other things, reduce secondary school age alcohol use. Reducing secondary school age alcohol use has been shown to will over time lead to fewer using illicit drugs when they enter early adulthood.

At a regional level, effective **supply reduction strategies** include:

- monitoring to strengthen responsible serving of alcohol
- social marketing to discourage parent and peer supply
- lobbying to increase local powers to restrict alcohol markets across the community.

Effective **demand reduction** includes:

- school-based programs
- brief intervention in primary care services
- social marketing.

Reducing violence in locations identified as 'hot spots' is also be important, including activities such as liquor accords, which are a joint initiative with licensees, police, LGAs and the Victorian Commission for Gambling and Liquor Regulation (VCGLR).

Existing local initiatives

The existing Eastern Metropolitan **Action on Alcohol Flagship** could be harnessed in partnership or supporting roles by EMSIC members as relevant. This group is currently developing its ongoing strategy, which includes a focus on regional prevention and planning. The Communities That Care program, currently being implemented in Knox, has a focus on substance use, amongst other problem behaviours.

Illicit Drugs

This report has also considered the situation in relation to the harmful usage of illicit drugs. There are effective screening and intervention programs that target problematic substance use, particularly ICE which, whilst relatively infrequent, can result in significant violent outbursts. These programs include online and face-to-face interventions and advocacy programs, which are a focus for local alcohol and drug planning groups. However, such programs are not a focus at this stage. This does leave untreated serious triggers for violence, but the first priority must be available treatment resources. Whilst screening and intervention programs are warranted, unless there are adequate referral pathways, it would be irresponsible to recommend further investment in screening.

In relation to treatment facilities, there are a range of recent changes to the adult AOD treatment system which are continuing to be embedded. There have also recently been 8 new treatment beds added to the service system, additional resourcing to respond to ICE and growth funds to strengthen the Youth AOD service system. The EMR Mental Health and Alcohol and Other Drugs (MH&AOD) Planning Council is charged with monitoring service system capacity to manage demand for acute and long-term inpatient and outpatient treatment services, which are coordinated through DHHS.

Indicators

Potential indicators to monitor the effectiveness of supply-side pressures related to the density of alcohol license. Demand indicators would be based on existing surveys (e.g. Community Indicators Victoria, Turning Point and Victorian Child and Adolescent Monitoring System (VCAMS)) which assess community understanding and changes in attitudes to the usage of alcohol and other drugs, and monitor the rates of alcohol and other drug usage in specific cohorts.

Specific actions

3.1. EMR Action Against Alcohol Flagship group develop priorities for consideration by the regional MH and AOD Planning Council with a view to working with EMSIC to develop a regional action plan which addresses both supply and demand levers, to drive a reduction in harmful alcohol usage. This would then allow individual agencies to identify opportunities for involvement.

3.2. EMSIC members use their advocacy powers to increase resourcing for effective drug and alcohol treatment facilities, to address illicit drug use.

4) Screening to detect and interventions to protect women and children who are victims of family violence

This involves a systemic approach to identify those who are experiencing family violence and providing responses that empower and help them to find safety for themselves and their children.

Screening

Initially, this would involve developing a regional screening approach to supports service providers across the universal service system (e.g. health, education) in identifying risk factors associated with violence in their clients or in local communities. A current pilot program which integrates such an approach with mainstream services is the MABEL project (2015), which works within MCH settings and is operated by Eastern Community Legal Centre (ECLC) and Eastern Domestic Violence Service (EDVOS).

This approach may involve the tailoring of supporting tools for contacts or specific cultural groups. However, the overall approach to identifying risk factors for individuals or groups must be consistent with the CRAF (Common Risk Assessment Framework). This will enable effective integration of responses with other relevant services, including police, community legal services, courts, child protection, housing and homelessness services, all of which may be in contact with these women. An associated public marketing campaign could emphasise a key message that violence against women and children is unacceptable, that there are detection systems in place and there will be support available and action taken to address violence.

4.1. Specific screening actions:

4.1.1. **Review of risk identification approaches:** In order to identify the most appropriate regional tools, it is recommended that further work include a thorough review of all potential tools, including identification and testing of tools to work with CaLD communities, elderly, those with disabilities and LGBTIQ communities. Testing the sensitivity and efficacy of a range of measures, this would enable recommendations for key targeted screening instruments which identify the relevant risk factors and could be implemented by primary service providers across the region. As noted, these need to be consistent with the CRAF, and support a broader rollout of that existing risk assessment and management framework.

4.1.2. **Training in risk identification tools:** Once established, EMSIC members could deliver training for primary health providers, including medical practitioners, nurses, MCH staff, allied health practitioners and non-health service providers who are likely to be in contact with these women, in the use of such tools to help identify those at risk of experiencing family violence.

Protection

Once potential victims are identified, a coherent and integrated system response must enable safe and successful referrals to effective resources and support. This needs to include a range of service providers across the government and non-government sector, such as housing, welfare, social security, policing, courts and legal services. It also needs to cater for information exchange across jurisdictions where relevant. Such an integrated response could potentially be supported through the Services Connect model (2016), currently being trialled across 8 Victorian regions, and led in the Outer East by Anglicare. Services Connect seeks to deliver integrated human services, support access and connect people with the right supports to address the range of their needs, and provides a positive way forward.

By adopting a health-based and person-centred approach, the individual and their unique needs can be considered, with a case-management approach adopted to help with system navigation, particularly for those with highly complex needs across a range of services. Such an approach must cater to the needs of the most vulnerable, including those with disabilities, children, the elderly and others who are likely to experience cross-sectoral disadvantage. Services also need to include detailed information regarding legal and systemic responses for protection, including Intervention Violence Orders, and the benefits and risks of legal action, to support informed decision making. It is important that these services must be adequately resourced to cater for those referred and in need of assistance.

A targeted approach is the Gold Coast Domestic Violence Integrated Response (GCDVIR) which appears to be producing positive outcomes (Justo, 2009). This allows for a well-coordinated, appropriate and consistent response, which enhances safety, reduces secondary victimization and decreases the incidence of domestic violence. This model offers a way forward for better coordination between relevant agencies, including domestic violence service providers, child protection agencies, welfare and housing supports, justice and corrections services. However, challenges in relation to different frames of reference, lack of trust, poor communication and power or funding imbalances will need to be addressed, with a focus on active and collaborative leadership to drive true collaboration (Potito, Day, Carson, & O'Leary, 2009).

4.2. Specific protection actions

4.2.1. **Mapping:** The currently available services within the Eastern Region need to be mapped to identify agencies who provide relevant services, and the range and volume of specific services available. This would include crisis support, domestic violence case work, housing, welfare, legal assistance, justice and courts and child and family services. Once this information is available, it could be mapped against population areas and service needs to identify potential gaps in service provision. In particular, this would need to determine the system accessibility for a diverse community, including those with disabilities, CaLD and GLBTIQ individuals, who may not feel that their needs are being met within the current services. Culturally specific programs could be increased and expanded as required.

4.2.2. **Client-centred review:** The service system should be reviewed by a working group including consumers, from the perspective of a client's journey. This would help identify opportunities for greater integration, especially in interactions with the universal service system.

4.2.3. **Trials and evaluations of best practice models:** The working group should also review and evaluate best practice models, such as the Gold Coast integrated response, to identify opportunities for enhanced collaboration. Randomised trials of a range of intervention models that better integrate screening and support systems across municipalities could be established and evaluated, in order to identify the most effective approaches. This work should be integrated with existing work in the region that is seeking to reduce violence against women.

4.2.4. **Information exchange:** Agencies can agree on protocols, including Memoranda of Understanding, for local information sharing and co-management where multiple agencies are engaged with a single family or client, to facilitate better cross-agency collaborations and minimise client stressors through more effective handovers.

4.2.5. **Advocacy interventions** for women to fully understand their options can be developed, with the support of peer-led programs to promote personal autonomy and choice.

4.2.6. **Consistent social and public messaging** delivered across the region could communicate agreed messages about taking action to prevent domestic violence and gender inequity. This could be delivered through websites, in specific settings, at community events and by engaging local community leaders, including White Ribbon Ambassadors and Champions for Change. However, care needs to be taken in crafting such messages, to ensure that they are delivering the intended messages to the target audiences. A recent US study (Keller et al., 2010) of an public campaign against domestic violence found that following the campaign, whilst women were more likely to see domestic violence as a serious issue, men deemed it less serious following exposure to the campaign.

5) Reduce pathways to violence associated with disadvantage

This recommendation acknowledges that exposure to social exclusion and a lack of community engagement, particularly in childhood, has been identified as a significant social determinant of both community and domestic violence. A focus on reducing levels of social disadvantage, with a particular focus on child development, is therefore anticipated to reduce the potential pathways to subsequent violent behaviours. (Note that this recommendation also relates to Social Inclusion, hence is re-emphasised in that section of the report).

Typical interventions

Effective interventions cover a range of developmental stages, as well as community-focused initiatives that promote and enhance social capital. This includes:

- **Visiting mothers** identified as being at risk (e.g. young mothers, CaLD communities, mothers with peri-natal anxiety or depression etc.) during the prenatal, postnatal and early developmental stages of their child's life, to monitor their wellbeing and progress towards developmental milestones. The focus is on helping parents to build secure parental attachment and address their own learned behaviours. Where concerns are identified or milestones not being met, earlier referral pathways to relevant supports for parents and children could minimise negative impacts through parental training and therapeutic interventions. This would continue the existing focus of MCH services.
- **School-based programs** targeted to disadvantaged primary schools can help to address social exclusion for the majority of children, as schools offer a strong catchment point. Through the Communities That Care program, the Knox region is currently commencing a local pilot of the **Strengthening Families** intervention (Strengthening Families, 2015). This program works on skills building with parents and children, and has been shown to reduce pathways to violence, family conflict and school bullying while also strengthening social inclusion. We recommend that this local pilot be supported, with outcomes reviewed for consideration of a wider rollout if effective. Additional screening and referral pathways from local youth services would help to identify those not well engaged with school systems.
- Services that provide **tutoring and mentoring for children** with high-risk factors for violence can offer protective effects, while encouraging social connection and bridging social capital. Whilst various not-for-profit and community groups (e.g. The Smith Family's Learning for Life program, Uniting Care) operate in this space, there is opportunity for broader support, including through LGA facilities such as libraries and community houses, where such tutoring might be facilitated, building relationships providing role modelling and practical support for disadvantaged youth. Homework clubs, tutoring and mentoring can help to reduce disadvantage, with support available from groups such as the Centre for Multicultural Youth (2015). The volunteering workforce for such initiatives will be supported by efforts to promote volunteering in the region (Refer to Social Inclusion recommendations).

- **Community-based programs** such as Communities That Care (2015) provide support for local areas to identify relevant issues and implement a range of evidence-based programs that foster healthy behaviours and social commitment in children and youths, such as Resilient Families (focus on adolescent alcohol usage) and Strengthening Families (see above).

Indicators

- Reduction in measures of disadvantage, including education participation and attainment and employment participation
- Community perceptions of inclusion
- Levels of community involvement including activity and volunteering rates.

Specific recommendations

5.1 Review and develop an action plan to increase regional opportunities for reduction in social disadvantage which identify those who are at risk of disadvantage and provide additional support. This would include a range of universal service system agencies, including:

- 5.1.1 MCH services
- 5.1.2 school-based programs (e.g. Strengthening Families)
- 5.1.3 access to tutoring and mentoring support for those identified as at risk
- 5.1.4 community-based programs.

This approach could also be supported through leveraging Municipal Health and Wellbeing plans as indicated above, and a regional approach strengthened through senior forums such as the Regional Management Forum.

6) Rehabilitation for violence offenders

Whilst prevention is a priority, it is also important to adopt effective approaches for the rehabilitation of violence offenders. Programs designed and funded to rehabilitate violence offenders should reduce recidivism at a regional level, and transparency and accountability regarding reductions in recidivism is important. First offenders should be a major focus of rehabilitation efforts, as early intervention with offenders has been shown to be more effective than later intervention. Interventions at this level must use evidence-based practices and have adequate and coordinated follow-through and support. Despite media pressure, there is dubious evidence for more assertive police responses.

The NSW Towards Safe Families practice guide (NSW Department of Attorney General and Justice, 2012) is a helpful summary of evidence-based practice. Programs should include a focus on power and control, looking at how men have been socialised to choose to use violence, a review of the social and cultural factors that support male privilege and a sense of entitlement. Programs then deliver a range of interventions with individual men to help them make different choices, such as reconsidering personal narratives that justify violence and motivational enhancement to engender the willingness to change. Programs also focus on emotional awareness and regulation strategies to manage distressing emotions without resorting to violence or control. There is also a process of ongoing risk assessment and management, which determines the meaning of non-participation, seeks feedback from partners about risk and changes (or not) in behaviour, with an emphasis on safety planning for the family. Overall, effective programs target emotional regulation, attitudes and beliefs that support the use of violence as a way to achieve goals. One such approach, aggression replacement therapy (Goldstein, Glick, & Gibbs, 1998) shows considerable promise as a specific technique.

Issues with current practice

Current evidence suggests that many current programs are not effective, which is concerning given their expense (A Day et al., 2009). Indeed, recent data suggests that those who commence but do not complete behaviour change programs are at increased risk of reoffending, compared to those who have not attended at all (McMurranam & Theodosi, 2007; Olver, Stockdate, & Wormith, 2011); hence, program completion is a high focus.

In addition, behavioural change programs are not suitable for all offenders. For those with extreme risks, such as high levels of narcissism or psychopathy, other approaches are required (Vlais, 2014), including active engagement with corrections to monitor behaviour. The broader need for system-wide integration is also a key issue for this area, as highlighted by No To Violence (Vlais, 2014). Some positive initiatives have been implemented locally, such as action in the Dandenong region, led by Victoria Police Asst Commissioner Luke Cornelius with the Chief Magistrate in Dandenong Court to expedite family violence court hearings, using maximum timeframes and other initiatives to promote perpetrator accountability. In addition, the use of electronic and chemical monitoring of offenders shows some promise in reducing contact and reoffending, as well as improving victim perceptions of safety (Erez et al., 2012).

Leadership in this domain could be provided through the existing EMR RFVP which seeks to support the sector, and engagement with the Eastern Men's Behaviour Change networks around sharing best practice.

Specific actions

6.1. Consider a workshop for interested participants, focused on the design and delivery of effective perpetrator interventions. This would provide a valuable opportunity for capacity building to learn about current best practice, which is an evolving space, and to identify opportunities for local interventions, including those relevant to specific CaLD and GLBTIQ cohorts. This workshop could also provide helpful support and increased understanding across the universal services system.

7) Engage and consult with minority groups to identify and address their unique needs

It is important that a regional system considers the unique needs of diverse local populations. An effective regional system will drive inclusive engagement and consultation with minority groups in consideration of their safety, security and ability to access relevant services. Consideration regarding the accessibility of housing/shelter, legal assistance and financial assistance for diverse cultural groups, including those on temporary visas is important, particularly as some government resources may not be available to them.

Adopting a common regional monitoring instrument to encourage regularly sampling of the safety and social inclusion of vulnerable sections of the community (including CaLD populations) would be a practical means of strengthening the regional service system and would facilitate engagement through consultation and collaboration with minority groups and the local agencies that represent them. Service evaluations could use this instrument to monitor increases in social integration and safety of minority groups across the region. This recommendation should sit as part of an integrated system that targets many levels and risk factors within a community, and which is monitored with key indicators to track progress at a regional level.

Indicators

Specific indicators of access and service engagement for diverse communities will need to be developed in collaboration with the relevant communities.

Specific actions

7.1. **Develop an agreed set of questions and monitoring tools** to identify needs and safety of diverse communities groups. This will need to include consideration of response integrity (e.g. for CaLD groups, where partners are acting as translators, or for people with disability who have no functional communication, where carers may be involved, these are a high priority for sensitive and trained assessment).

7.2. **Train EMSIC members** and broader service organisations and providers (e.g. GPs, community health services) in the use of these tools.

7.3. **Collect data** to identify cohorts of need. Engagement with relevant agencies and experts will be required e.g. VALID (Victorian Advocacy League for Individuals with Disability), Angela Taft (Judith Lumley Centre, La Trobe University).

7.4. **Ensure provision of services for diverse cohorts** that are appropriate, culturally sensitive and accessible (e.g. older women, males, GLBTIQ individuals, people with disabilities. This needs to be mapped to local needs and informed by an intersectoral approach, including agencies such as Women with Disabilities Victoria (WDV).

B. SOCIAL INCLUSION AND COMMUNITY CONNECTEDNESS: DETAILED DOMAINS OF WORK

As for violence, international and national public health research emphasises the importance responses to social inclusion and community connectedness that operate from primary prevention through early intervention to remediation. Whilst many of the drivers of a lack of social inclusion and community connection may be associated with broader state or federal trends (such as employment and educational disadvantage), a regional approach needs to consider what actions can be implemented at the local level to respond to these issues, minimise exposure to risk factors and promote cohesion for local communities. Indeed, as community connection and inclusion is usually experienced at the local community level, it is vital to operate in this context. As noted earlier, the new Victorian Health and Wellbeing Plan 2015-2019 (Department of Health and Human Services, 2015) seeks to support sustainable improvements in health and wellbeing. This plan notes that the best outcomes are achieved when change is owned locally, adapted to particular needs and local circumstances, and local communities are empowered to make the necessary changes within the communities and settings where they live, learn, work and play.

Consistent with a public health approach, this section emphasises a primary prevention approach as well as supporting the continued activity of many, including EMSIC members, who are actively working with those who experience social exclusion, particularly providing social welfare and service access. By providing a framework which notes the spectrum of activity, this enables organisations to identify opportunities to contribute to their areas of expertise or focus.

1) Liveability

As noted earlier, liveability refers to the degree to which communities are safe, attractive, environmentally stable and socially cohesive and inclusive, including issues of housing, transport, education, employment, open spaces, services, leisure and cultural opportunities (Lowe et al., 2013). This provides a more detailed understanding of key regional drivers of social inclusion and potential local barriers. Armed with this knowledge, organisations are better placed to advocate and activity engage with regional and state planning functions that drive local built environments and transport links. Current state plans emphasise 20-minute neighbourhoods and regional/sub-regional activity centres promoted through Plan Melbourne (Department of Environment, 2015) and the place- and person-centred platforms for change to achieve the priorities of the Victorian Public Health and Wellbeing Plan (Department of Health and Human Services, 2015). This would also support town and infrastructure planning at the LGA level, to ensure service access and availability, address barriers and increase liveability.

Municipal Health and Wellbeing plans are already required to address the priorities of the Victorian Public Health and Wellbeing Plan locally. However, there is an opportunity to better integrate and coordinate this activity through existing forums such as the Regional Management Forum. This would provide opportunities for enhanced coordination of planning, policy alignment and program implementation across council boundaries.

These forums are responsible for establishing shared place-based priorities that focus the efforts of local and state government departments at a regional level, as they bring together senior representatives from local government and regional offices of state government departments. Other relevant health partnerships include the Primary Care Partnerships, which bring together health and community services, LGAs and other agencies in relation to health promotion and primary healthcare, as well as health-service based Primary Care and Population Health Advisory Committees.

Current activities

LGA planning currently includes a significant focus on programs that support physical and emotional wellbeing, particularly service delivery of leisure and fitness centres, walking groups, libraries and community houses. Liveable neighbourhoods foster many positive aspects, including social inclusion, resilience, safety from violence and access to local services and amenities that promote wellbeing. Some municipal strategic plans (e.g. Boroondara) specifically include community inclusion as an identified priority or target specific target.

The current DHHS Boroondara Liveability Demonstration Collaboration Project will provide further evidence around successful regional approaches, once completed and evaluated. In addition, programs such as the Heart Foundation's Healthy by Design provide guidance for planners to build environments that support active living, and thereby connection. As an example, Boroondara has activity pursued this area, with a range of actions in partnership with members of the Boroondara Public Health and Wellbeing Plan Advisory Committee such as advocating for reduced speed limits in identified shopping strips, designing laneway improvements that create accessible and attractive spaces, and cycling and walking group activities that promote community activity. Strengthening this approach and promoting regional actions across municipalities is anticipated to support greater inclusion.

Indicators

Potential indicators for enhanced liveability would relate to perceptions of community inclusion, safety, and engagement, as measured through tools including Community Indicators Victoria and localised assessments. Regional assessment of broader health and wellbeing risk factors would also be relevant.

Specific actions

1.1. **Identify opportunities for increased focus on liveability** through both place and person-centred approaches to planning and service delivery, particular at LGA and regional planning levels.

1.2. Once completed, **consider results of DHHS Boroondara Liveability collaboration study** and implications for regional activity.

2) Reduce pathways to social exclusion associated with place-based disadvantage

NB: This recommendation is also included as Recommendation 5 under Preventing violence.

Social exclusion relates to a lack of opportunity and means to engage in activities such as education and employment, as well as community connection and influence. Place-based disadvantage entrenches such exclusion, and also contributes to it passing on to the next generation unless there are deliberate interventions to ensure successful early participation. Regional strategies to address pathways to social exclusion therefore need to tackle place-based disadvantage through a whole-of-life approach, with a focus on mitigating risks of generational transmission. This includes:

- engaging and supporting vulnerable mothers during prenatal, postnatal and early developmental stages of their child's life
- school-based programs to promote effective social and academic engagement, such as the Strengthening Families intervention
- facilitate mentors and tutors who can support students, promote effective study and provide role models. Given that parents may themselves be under pressure and have limited resources, they may be limited in their capacity to support learning, and external supports can offer protective effects. This also encourages volunteering in meaningful roles, where both participants can increase their social connection and create bridging social capital (supportive relationships between people with and without resource advantages)
- community-based programs which seek to address other determinants of social disadvantage are critically important, given the multifactorial nature of disadvantage and its wide-reaching implications. This includes issues such as housing affordability and access, transport, education and training, employment and access to health services.

Indicators:

Potential indicators relate to:

- reduction in measures of disadvantage, including education participation and attainment, employment participation
- community perceptions of inclusion
- levels of community involvement including activity and volunteering rates.

Specific recommendations

2.1. Review and develop an action plan to **increase regional opportunities for reduction in social disadvantage** which identify those who are at risk of disadvantage and provide additional support. This would include a range of universal service system agencies, including:

- 2.1.1. MCH services
- 2.1.2. school-based programs (e.g. Strengthening Families)
- 2.1.3. access to tutoring and mentoring support for those identified as at risk
- 2.1.4. community based programs.

This approach could also be supported through leveraging Municipal Health and Wellbeing plans as indicated above, and a regional approach strengthened through senior forums such as the Regional Management Forum.

3) Capacity building for program design, implementation and evaluation

During the evidence review and mapping conducted as part of this research, it was noted that, whilst there were a range of programs which explicitly or implicitly sought to promote social capital, program planning and evaluation was difficult to determine, with limited evidence available as to which programs are most effective and for which groups. As such, capacity building programs that deliver increased program design and delivery capacity, including evaluation approaches that build the evidence base, are required.

Indicators

For this recommendation, the relevant indicators of success relate to an increase in documented program logics and outcome evaluations of local programs, which contribute to the evidence base for what works.

Specific recommendations

3.1 EMSIC members to collaborate in hosting capacity building workshops on social inclusion program design, implementation and evaluation, using the support of those skilled in areas such as program logic and evaluation techniques to help community agencies to develop and review their programs. This information could also be provided in online forums such as The Well, where it is accessible to a range of partners.

4) Increase volunteering rates

Volunteering has been shown to contribute to social inclusion and social capital in Australian studies (Leong, 2008; L. Wilson & Mayer, 2006). It can help reduce feelings of personal isolation, offer people skills, social contacts, support a greater sense of self-worth, and challenge stereotypes held in relation to different social groups.

The most recent national data on levels of volunteering ((ABS) Australian Bureau of Statistics, 2010) suggests that overall, 32.6% of Melbournians were engaged in volunteering, with women, parents, those having English proficiency and those aged 35-74 most likely to volunteer, often in sports or physical recreation activities. Those who volunteer were more likely to also be involved in other community activities, and to feel greater overall life satisfaction, supporting the benefits of volunteering for social inclusion. This behaviour is also strongly influenced by early life experiences, with those who see volunteering modelled or who volunteer early more likely to engage in volunteering later in life. For the EMR specifically, DHHS profiles (2014) suggest a lower level of volunteering at around 20.6%.

Despite general increases in rates of volunteering nationally, there is an increasing demand for support, (Volunteering Australia, 2012). Additionally, the nature and formalisation of volunteering roles are changing, which requires evolution from community agencies and a greater understanding of the needs of those who choose to volunteer, what they are hoping to gain from such activities, and how to retain, value and support them, as well as the needs of service beneficiaries. Recruitment, selection and training and induction for volunteers in their roles is critical to delivering effective and sustainable services, in keeping with community expectations and the desires of volunteers for different forms of volunteering.

Through matching interested parties, particularly those who are themselves at risk of exclusion and are not participating in other activities (e.g. disengaged youth), with social-inclusion opportunities such as visiting isolated or at-risk community members, opportunities for cross-age relationship building and the development of bridging social capital would be maximised. Such roles may be coordinated through existing frameworks such as Volunteering Victoria, GoVolunteer, Eastern Volunteers or more local agencies which are often coordinated through the LGA's, such as the Boroondara Volunteer Resource Centre or the Whitehorse Participation and Volunteering coordinator.

Existing programs

Local existing volunteering opportunities include programs such as the CFA and SES, the L2P program (Synergistiq, 2014) which connects mentors and learner drivers, community access assistance through provision of transport and Meals on Wheels, home or aged care visitation, language and study support to promote school participation, and environmental activities including parkland and nature reserve maintenance. One program which combines many elements of successful programs is the Boroondara Casserole Club (Boroondara, 2016). This meal-sharing project connects people who enjoy cooking and are happy to share an extra portion of a home-cooked meal with older neighbours living close by. This program develops bridging social capital, creating new connections between local residents whilst meeting a genuine need for nutrition, and also offers flexibility for volunteers who are able to specify their preferred level of commitment and contribute at a time that meets their needs.

Indicators

Potential indicators include:

- increase in rates of volunteering, especially in younger cohorts
- increase in CIV indicators that 'my community cares'.

Specific recommendation

4.1. Develop and implement a strategy to increase volunteering rates across the community. This strategy could specifically target areas that address EMSIC priorities such as decreasing violence, place-based disadvantage and the experience of social exclusion of minority groups. Beneficial action approaches argue that population-wide improvements can be maximised where volunteers are trained in strategically planned and evidence-based activities. When programs are being designed, they must include formal evaluation, in order to increase the evidence base. Further consideration as to how to engage existing volunteer agencies and networks would be required to develop this approach. Review and consideration of a previous regional review of volunteering and civic participation in the Eastern region (Borderlands Cooperative, 2008), would form a useful starting point for such an approach.

4.2. Provide training for organisations on how to respond to these changes in volunteering practices, such as workshops on micro-volunteering, would also be useful, to support community based agencies to adapt to these changes.

5) Commitment to community-based programs and leadership development

Community based programs which seek to promote community connection and build local leadership provide an important mechanism for grass-roots development. Such programs assist local emerging leaders and are able to be flexible and adapt to meet the needs of their participants, which is particularly relevant in working with CaLD communities, diverse needs or those experiencing discrimination or disadvantage.

Current programs

The Opening Doors program (Inner East Primary Care Partnership, 2015) currently operated by LinkHealth operates in 4 LGA areas of the EMR, and explicitly supports current or emerging community leaders to develop their ability to implement relevant programs to increase social inclusion and community connectedness. An initial evaluation (Held, 2011) showed promising outcomes, and funding to support a broader rollout of this community leadership capacity building approach would increase community capacity for social inclusion programs across the region, pending results of an external evaluation which has been commissioned.

Indicators

Relevant indicators would initially include measures of program participation, but longer term outcomes could be drawn from Community Indicators Victoria, including perceptions of community connection and safe and supportive networks.

Specific actions

5.1 Support and advocate for broad rollout of community programs which promote localised and targeted actions, particularly asset-based community development to promote community connection and empower local leadership, such as the Opening Doors program.

6) Common regional measurement to monitor vulnerable groups

A more detailed understanding of the relevant regional determinants of both social exclusion and a lack of community connection is needed. Such information is available through detailed analysis of mapping databases such as AURIN (2015). This would provide an opportunity to review measures such as walkability, access to vehicles, volunteering, involvement in sports and cultural activities. Other data from Community Indicators Victoria (2015) is available at an LGA level. This can include a range of indicators, such as a sense of community, access to resources and services, open space, employment and education. Such analysis would also support the development of common regional instruments that would monitor social inclusion in sections of the community that may be at risk. This should include a focus on specific population cohorts and their needs, such as young mothers, CaLD groups, particularly if recently migrated, people with disabilities, the elderly, GLBITQ, youth or indigenous.

Once identified, such information would support the development of targeted programs relevant to these groups. Social inclusion could be improved by adopting policies and service delivery approaches aimed at ensuring equitable access to community resources. It is unclear whether interventions for increasing social inclusion within minority groups are effective. However, it appears that social inclusion interventions framed within a participatory and/or empowerment approach may be more effective. Policies and procedures across all community organisations which are built on an awareness of the unique challenges different minority groups may face in accessing community resources should be adopted and monitored to ensure that individuals are able to participate in key areas of the economic, social and cultural life of their community. Responding based on ongoing monitoring of social inclusion in samples from targeted minority groups may be a feasible means of developing a system that can ensure social inclusion in these diverse groups.

It is also important engage with advocacy groups who can present their needs, supporting an empowerment approach across aspects of marketing, program design, accessibility, mentoring and training.

7) Promoting resilience and working with digital communities

Given demographic changes in the nature of community across Australia, which include a reduction in formal religious participation, increased employment rates and decreased volunteering, it is important to look at new ways to build a sense of community, including through online communities, where individuals are able to gather and develop new social links. This is particularly relevant for young people, who are more likely to gain an important sense of their community from virtual networks, which may have a range of impacts on their wellbeing. This emerging area has been identified as a priority, and further work is anticipated arising from the new VicHealth Mental Wellbeing Strategy 2015-2019 (VicHealth, 2015d). Released in December 2015, this strategy includes a priority focus on building resilience and social connection for young people aged 12-25 years. As this strategy is relatively new, further work is required to identify and work with relevant agencies in relation to specific indicators, programs or actions which might be required to harness this opportunity.

However, the companion literature review of evidence-based programs which promote resilience (VicHealth, 2015b) identifies a range of targeted programs which could be considered by partners, depending on their identified needs and cohorts.

9. CONCLUSIONS

This report has identified a range of evidence-based actions which are likely to support the EMR in addressing the two identified priority areas of preventing and responding to violence and increasing social inclusion and community connectedness.

These recommendations provide a broad scope for EMSIC members, which reflects the diversity of organisations across EMSIC. Broad dissemination of this report and ongoing consultation to identify opportunities for collaboration will be critical in making maximum use of the information provided. A summary report has been provided to the EMSIC Council, detailing recommended areas of work for consideration by Council members. This Evidence Report provides further detail regarding those recommendations.

10. APPENDICES

APPENDIX A: EMSIC MEMBER ORGANISATIONS AND REPRESENTATIVES

NAME	POSITION	ORGANISATION
ALAN LILLY	Chief Executive Officer	Eastern Health
ANDI DIAMOND	Chief Executive Officer	Monash Council
BERNIE MARSHALL	Professor & Associate Dean	Faculty of Health, Deakin University
CHRIS POTTER	Director Community Programs	Manningham City Council
DARREN YOUNGS	Regional Director	Anglicare Victoria
EMMA KING	Senior Policy Analyst	Victorian Council of Social Services
GABRIEL LEVINE	Regional Director	Department of Justice
JACK BLAYNEY	Assistant Commissioner	Victoria Police
JACKY CLOSE	Executive Officer	Outer East Health and Community Support Alliance
JOANNE BUTTERWORTH-GREY	Senior Manager	Melbourne East RDA
KAREN LARGE	Director Victorian & Tasmanian Office	Australian Government Department of Health
KEN SMITH	Divisional Social Programme Secretary – Eastern Victoria Division	The Salvation Army
KERRY STUBBINGS	Director Community Services	Knox City Council
KRISTINE OLARIS	Chief Executive Officer	Women's Health East
LES CHESSELLS	General Manager	Mullum Indigenous Gathering Place
MARTIN WISCHER	Victorian General Manager	RDNS
PETER RUZYLA	Chief Executive Officer	EACH
ROD HILL	Professor	Melbourne East Regional Development Australia Committee (Chair)
RONDA JACOBS	Chief Executive Officer	Carrington Health (Whitehorse Community Health Service)
SALLY MISSING	Executive Officer	Inner East Primary Care Partnership
SANDY AUSTIN	Regional Director Southern & Eastern Metropolitan Health	Department of Health and Human Services
SOPHY ATHAN	Consumer representative	Board Member Health Issues Centre

APPENDIX B: EMSIC ASSOCIATE ORGANISATIONS

NAME	POSITION	ORGANISATION
ADAM SCHICKERLING	Area Manager	Annecto
AIDAN MCGANN	Regional Director Metropolitan South East	VicRoads
ANGELA FORBES	Chief Executive Officer	Connections
ANITA FRAYMAN	Committee Member	Australian Association of Gerontology (Vic)
ANNIE CARNELL	General Manager Primary Care	Manningham Community Health
ANTHONY RAITMAN	Deputy Regional Director	Department of Education & Early Childhood Development
BELINDA CROCKETT	Lecturer, Health Sciences	Swinburne University
CAROLYN MCCLEAN	Director Community Development	City of Boroondara: Community Development
CHRISTINE CLIFTON	Consortium Manager	Eastern Metropolitan Region Palliative Care Consortium
DEB SEDDON	Manager Community Development	Whitehorse City Council
DEB TSORBARIS	Chief Executive Officer	Centre for Excellence in Child and Family Welfare
DOREEN STOVES	Chief Executive Officer	Doncare
GEOFF DARLISON	Local Area Commander	Victoria Police – Knox
GERRY MAK	Chief Executive	Uniting Care Lifeassist
GLEN TOBIAS	State Manager	Neami National, Fairfield
GRAEME ARTHUR	Superintendent/Divisional Commander	Victoria Police – Knox
HAKAN AKYOL	Director	Office of Multicultural Affairs & Citizenship Department of Premier & Cabinet
HARRY MAJEWSKI	Chief Executive Officer	Inner East Community Health Service
JANICE TAYLOR	Researcher/Physiotherapist	Australian Association of Gerontology (Vic)
JOHN EYRE	Chief Executive Officer	Arbias
KARYN MCPEAKE	Chief Executive Officer	Inspiro
KATHY PATON		Knox City Council
KERRI GODING	Executive Officer	Healesville Interchurch Community Care Inc.
LORRIANE LIDDLE	Director Client Services South East	Victorian Aboriginal Child Care Agency
MARYCLARE MACHEN	Executive Director	Eastern Domestic Violence Service
MICHAEL SMITH	Chief Executive Officer	Eastern Community Legal Centre Inc.
OLIVE AUMANN	General Manager: Health Department	Carrington Health (Whitehorse CHS)
PAMELA YOUNG	Chief Executive Officer	Uniting Care East Burwood Centre
QUINN PAWSON	Chief Executive Officer	Prahran Mission
RAY CRANWELL	Chief Executive Officer	ALKIRA
RICHARD DAVEY	Business & Relationship Manager	Benetas
SIMON LEWIS	Chief Executive Officer	Onemda
SUE HERBST	Manager	Migrant Information Centre
SUE ROSENHAIN	Health Promotion Manager	Women's Health East
THERESE DESMOND	Chief Executive Officer	Oakleigh Centre
VIRGINIA ALLWOOD	General Manager East Division	SCOPE

APPENDIX C: ADVISORY COMMITTEE MEMBERSHIPS:

EMSIC – Violence in Vulnerable Communities Advisory Committee

Co-Chairs

Graeme Arthur (Vic Police) and Anthony Raitman (DEECD)

Members

Peter Ruzyla (EACH), Bernie Marshall (Deakin), Kristine Kolaris (WHE), Cathy Keenan (DHHS), Doreen Stoves (Doncare)

Secretariat

Jenny Meagher (DHHS) / EMML – Kristin Michaels

EMSIC – Addressing Social Inclusion and Community Connectedness Advisory Committee

Chair

Aidan McGann (VicRoads)

Members

Carolyn McClean (Booroondara), Sue Herbst (MIC), Sophy Athan (HIC), Adam Schickerling (Annecto), Annette Worthing (DHHS), Sally Missing (IEPCP)

Secretariat

Jenny Meagher (DHHS) / EMML – Kristin Michaels

APPENDIX D: DEAKIN TEAM

Deakin Research Team

- Professor Bernie Marshall
- Professor John Toumbourou
- Ms Elizabeth Clancy
- Ms Bethany Devenish
- Dr Catherine Bauld
- Dr Rachel Leung
- Ms Berni Murphy
- Ms Stef Clark

Deakin Academic Reference Group

- Dr Gennady Baksheev
- Dr Susan Balandin
- Professor Andrew Day
- Dr Caderyn Gaskin
- Dr Matin Ghayour-Minaie
- Associate Professor Peter Miller
- Dr Bosco Rowland
- Dr Lata Satyen
- Professor Ann Taket
- The Centre for Health through Action on Social Exclusion (CHASE)
- The Faculty of Health Biostatistics Unit and Deakin Health Economics

APPENDIX E: DETAILED MAPPING

LGAs and state government departments/agencies

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	INDICATORS	EVALUATION PLANS
LGAS	Strong social inclusion focus Some specific FV programs	**Overall**: Community programs, libraries, recreation/sport, childcare/ parenting, immunisation, disability/aged, community buses, Neighbourhood and Community Houses, Men's Sheds, life activity clubs, grant programs/strategy and policy and evidence-based approaches **Specific:** Children and youth, ageing, disability action plans, access & inclusion plans				
Boroondara		**Ten community and neighbourhood houses:** Boroondara's local neighbourhood and community houses provide social events, childcare, training and courses for people of all ages and backgrounds to participate in. http://www.boroondara.vic.gov.au/our-city/community/centres **Five libraries.** Council also provides a Home Library Service. **12 Maternal & Child Health Centres.** Chinese-speaking (Mandarin) Balwyn Maternal & Child Health group meets monthly for people who live, study or work in Boroondara with children from 0 to school age. Council also runs the Mother Goose Program at Ashburton. Questions about family violence asked at 4 wk check-up if appropriate. **Social support programs and community transport** (http://www.boroondara.vic.gov.au/residents/ageing-disability/social-support-programs http://www.boroondara.vic.gov.au/residents/ageing-disability/community-transport) **360 (Youth Services).** Youth Services team runs programs and events for young people in Boroondara. School-focused youth programs include Good Life Farm and promoting respectful relationships. Casserole Club: meal-sharing project that connects people who like to cook and are happy to share an extra portion of a home-cooked meal with older neighbours living close by. Three **men's sheds** in Boroondara run by community organisations with support from Council. **Community Gardens** **Boroondara Access 4 All (BA4A) Network:** to develop real and alternative access, inclusion and social options for people with disabilities **Boroondara Interfaith Network** aims to create awareness and dialogue through building relationships that nurture harmony, deepen understanding and respect in community	Creating an age-friendly Boroondara strategy 2014-19 (http://www.boroondara.vic.gov.au/residents/ageing-disability/positive-ageing) Access and Inclusion Plan 2013-17 (http://www.boroondara.vic.gov.au/your_council/local-laws-policies/community/access-and-inclusion-plan) Cultural Diversity Plan 2014-18 (http://www.boroondara.vic.gov.au/our-city/community/diversity) Draft children and young people's strategy, Boroondara Public Health & Wellbeing Plan (http://www.boroondara.vic.gov.au/your_council/local-laws-policies/community/health-wellbeing-plan) Social exclusion and disadvantage research http://www.boroondara.vic.gov.au/our-city/all-about-boroondara-social-statistics/social-exclusion-and-disadvantage, Boroondara Homelessness Protocol (http://www.boroondara.vic.gov.au/residents/health-wellbeing/housing-homelessness), http://www.boroondara.vic.gov.au/community-directory/community-groups/community-gardens (http://www.boroondara.vic.gov.au/our-city/sport-leisure/accessible-recreation/access-all-abilities), (http://www.boroondara.vic.gov.au/our-city/community/interfaith-network)	Whole-of-population approach with specific programs targeting relevant population groups	KPI related to number of people who live, work or study in Boroondara participating in programs Extensive research conducted on localised (SA1) data around indicators of social isolation.	Quarterly and annual reporting undertaken

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	INDICATORS	EVALUATION PLANS
Knox		Healthy Together programs (VicHealth), Access and Inclusion Plan for people with disabilities			Knox – Community Health & Wellbeing Plan has solid indicators http://www.knox.vic.gov.au/Files/Health/The_Priorities_-_Knox_Community_Health_and_Wellbeing_Plan_2013_-_2017.pdf	
Manningham		• Prevention of Violence Against Women Strategy focusing on Gender Equity and Primary Prevention including Elder Abuse (ongoing) • Community Strengthening Project – Live Well in Bulleen targeting community connection, social inclusion (new) • Access, Equity and Diversity Strategy targeting vulnerable and diverse communities (ongoing) • Plaza Park Project – targeting community connection through site activation at MC2 (new) • Inclusive Employment to support social inclusion (new)	www.manningham.vic.gov.au	Women workforces, seniors Vulnerable/ disadvantaged communities in Bulleen Diverse communities Disadvantaged, disengaged, vulnerable community People from diverse backgrounds including PWD, mental health issues etc.	Health and Wellbeing Indicators as part of the MPHWP PVAW Indicators	Manningham: Evaluation Plan for Live Well in Bulleen and Plaza Park Project
Maroondah		Lead: Melbourne East Regional Sport & Recreation strategy				
Monash		Age Friendly Monash, Generating Equality and Respect (with MonashLink, VicHealth), Various programs – documented in Health & Wellbeing Partnership Plan 2013 – 2017, Community Safety Framework 2015-2020, Access & Equity Framework 2013 – 2017, Council Plan 2013-2017, Multicultural Action Plan 2013-2017, Early Years Action Plan 2013-2017, Monash Youth Plan 2013 – 2016, Disability Action Plan 2013 – 2017.	http://www.monash.vic.gov.au/Home	Whole-of-population approach	All Monash strategies have yearly indicators, actions, measurable outcomes	All strategies and annual actions evaluated yearly via Council Annual Reporting Cycle and program-specific evaluation requirements
Whitehorse		Council Plan 2013-2017, Municipal Public Health and Wellbeing Plan 2013-2017, Accessible Communication Guide, Positive Ageing Strategy 2012-2017, Diversity Policy and Action Plan 2012-2016, Whitehorse Reconciliation Action Plan 2011-2015 Whitehorse Community grant-funded programs including Mitcham Community House Family Violence Program, Family Access Network Life Skills Programs for Young People, EACH Family Support and Counselling & Uniting Care East Burwood Centre Emergency Relief.	http://www.whitehorse.vic.gov.au/	Whole of population	Yearly action plans developed and reported against	

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	INDICATORS	EVALUATION PLANS
Yarra Ranges		A range of relevant strategies/policies including: • Reconciliation Framework for Action; Equity, Access & Inclusion Strategy; Gender Equity Action Plan; Child and Youth Strategy; Essential Engagement • Community Planning Framework takes a community development approach, facilitating communities to address local needs, issues and opportunities, incl. disadvantage, economic development and social need • Grant program actively aligns with Council's evidence-based strategies to seek projects that improve key health and wellbeing indicators: healthy eating, gender equity (for example) • School-focused youth services, youth Safety, mentoring and counselling services work with young people and their families and communities to strengthen resilience and mental health (ongoing status under review) • Partnership approach with emerging and vulnerable communities including CaLD, and long-term commitment to strengthening Indigenous communities • Capacity building through volunteer programs, training and grants • Work with sports club around GLBTIQ, specifically homophobia • Work with sports clubs to address gender inequity at board level • Advocacy effort informed by evidence e.g. retention of community legal services, need for affordable housing, mental health needs • Community safety and resilience through emergency preparedness, remote community planning and family violence (for example) • Advocacy on need for better public transport to outer areas to enable education and employment • A range of initiatives and projects to increase access and wellbeing of people with a disability: autism training and social connection, employment and social enterprises, accessible tourism, engagement and consultation, sector mapping and community support.	Website Council reports Strategy and Policy Adopted community plans	Disadvantaged communities, especially more remote where access to services, education, transport and employment are limited by distance and poor social infrastructure. Young people who have high rates of mental illness. Emerging CaLD communities. Indigenous community members.	Yarra Ranges: Health & Wellbeing Profile has wide range of indicators, as do associated advocacy documents http://www.yarraranges.vic.gov.au/files/assets/public/webdocuments/corporate-services/governance/policies-strategies-governance/hwb_health_profile_2012-13.pdf http://www.yarraranges.vic.gov.au/About-Council/Strategies-policies-and-legislation?dlv_DLV%20Public%20Form=(pageindex=4)	Yearly action plans developed and reported against
DHHS	Family violence and Social inclusion	**Victoria's Action Plan to Address Violence against Women and Children – Everyone has a responsibility to act.** Creating child safe organisations Closing the Gap Projects Community Renewal projects Bayswater North Victoria's Vulnerable Children – Our Shared Responsibility Building more inclusive communities for people with disabilities	http://www.dhs.vic.gov.au/home	Whole of population, with focus on broad health promotion and specific vulnerable communities		

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	INDICATORS	EVALUATION PLANS
DET	Largely Family Violence	Ongoing engagement, esp. re ViVC in schools education and transition points. OECYAP	http://www.education.vic.gov.au/Pages/default.aspx	Whole of population, with focus on broad health promotion and specific vulnerable communities.	Currently under development	
VicHealth programs	Family violence and Social inclusion	Range of programs implemented through grants, and via LGA agencies	www.vichealth.vic.gov.au	Whole of population	Valuable frameworks for program design	Detailed evaluations of programs funded
Victoria Police ED2 FVU	Family Violence	Family Violence Working Group	Yarra Ranges Community Safety Committee and Family Support services	FV Support Organisations	FV trends & reporting of FIR's within PSA	None advised
Knox		Eastern Domestic Violence Outreach Services. EDVOS	Anglicare Services	'At risk' victims of domestic violence	Increase offender charge rate	
		Anglicare Men's Behaviour Change		Male offending in FV situations	Decrease in recidivist behaviour	
		Safe Futures Foundation		'At risk' victims, victims of recidivist behaviour	Decrease/apprehension of ongoing FV behaviour	
VicRoads	Social Inclusion	Victorian Community Road Safety Grants Program (VCRSGP) • VCRSGP aims to increase engagement and breadth of community involvement in addressing road safety issues. There are 8 registered community road safety groups within Metropolitan South East (MSE) Region that are actively involved. The VCRSGP reaches community from early childhood through to older road users, people with low literacy and CALD communities. • Within MSE Region, VCRSGP consists of a variety of programs including: – Driver education on how to stay safe in the road environment and gain a licence for people with low literacy, CALD communities and new arrivals. – Programs to prevent drink driving in CALD communities. – Bicycle safety education for newly arrived children and young cyclists from CALD backgrounds. – Early childhood safety programs to educate CALD parents on pedestrian and passenger safety for their children. – Driver and pedestrian safety programs for older road users and mobility device users, including people from CALD backgrounds. – 'I might not see you, but you can always see me' campaign to educate all road users on how visually impaired people get around in the road environment and impact that other road user behaviour can have on them.	https://www.vicroads.vic.gov.au/ • VCRSGP https://www.vicroads.vic.gov.au/safety-and-road-rules/road-safety-programs/vicroads-community-road-safety-grants-program https://www.visionaustralia.org/living-with-low-vision/learning-to-live-independently/road-and-pedestrian-safety/i-might-not-see-you-but-you-can-always-see-me • L2P https://www.vicroads.vic.gov.au/licences/your-ps/get-your-ps/preparing-for-your-licence-test/l2p-learner-driver-mentor-program	VCRSGP and L2P – Whole of population (road users)	Program specific indicators VCRSGP and L2P – Agreements with each community group/ municipality detail indicators, outputs and outcomes. These vary from program to program. Some examples are: change in road user behaviour, greater understanding of road safety, less crashes and traffic offences, pass rate for obtaining a driver licence, road safety strategies put in place.	Program specific – • VCRSGP – Quarterly progress meetings with community groups and 6 monthly and annual reporting. Funds provided to community groups to evaluate programs annually. • L2P – An extensive evaluation was undertaken in 2014. Quarterly reporting and annual reports.

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	INDICATORS	EVALUATION PLANS
VicRoads	Social Inclusion	Level crossing removal at Mitcham, Blackburn L2P program (mentoring to provide new drivers with opportunity to get access). • L2P is a learner driver/volunteer mentor program that assists learners under 21 years of age who do not have access to a supervising driver or vehicle to gain 120 hrs driving experience required to apply for a probationary licence. L2P not only helps disadvantaged young Victorians get their licence; it also boosts their driving skills for future employment and deters unlicensed driving. Overall focus on increasing physical community access.				

Other community agencies, organisations and service providers

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
AMES Adult Multicultural Education Services	Social inclusion	English classes offered, full-time or part-time, day or evening to newly arrived migrants, registered job seekers and others with language and literacy needs. Inc's vocational focus (e.g. English & Retail, English for Vocational & Further Study, Certificate in Food Handling & Information Technology)	Department of Immigration & Citizenship	Newly arrived migrants, to registered job seekers and to others with language and literacy needs.	Box Hill	None advised	None advised
Anglicare Victoria	Both – with specific FV programs and general social support.	Family and Community Services Eastern aims to promote the best outcomes for vulnerable children, young people, individuals, families and communities in the Eastern Region • Alcohol and other drugs (youth, adult and parent/carer support) • Child FIRST and Family Services • Family Violence (Men's Behaviour Change and Men & Boys) • Financial Counselling • Meridian • Parentzone (parent education) • Services Connect A proposal is currently being implemented to develop a specialist AOD/FV senior practitioner for both individual, and group work with men, women and families.	http://www.anglicarevic.org.au	Vulnerable and in need of support: children, women, men, families, homeless, unemployed, AOD, co-occurring (mental health and AOD), family violence, CALD, indigenous, and socio-economic disadvantage	Eastern Region Offices in: Box Hill Bayswater Lilydale	FARE – (Foundation for Alcohol Research & Education) National framework for action to prevent alcohol-related family violence (FV); • Introduce whole of community to prevent FV • Assist people most at risk of FV through early identification and support • Provide support for people affected by family violence and protect them from future harm • Continue to build evidence base by investing in data collection and evaluation	Evaluation of AOD/FV senior practitioner position at end of funding (proposed June 16)

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
Annecto	Social Inclusion	Community Inclusion organisation – Works with people with disability and older people across region, providing support to help people remain safe at home for as long as possible	www.annecto.org.au	Focus on those experiencing financial disadvantage, social isolation and various emerging/ existing 'minority groups'	South-Eastern Region – based in Ringwood	Delivery KPIs in place – indicators under development, using CIV	
Armenian Planned Activity Group	Social inclusion	Social support service for Armenian ethnic community members who are aged, frail, isolated or have disabilities. Provides respite care for families and carers. Community languages spoken include Armenian	church1@optus.com.au	Community members who are aged, frail, isolated or have disabilities.	Surrey Hills	None advised	None advised
Benetas Home Care, Eastern	Social inclusion	Extended care case-management service for people who are aged, frail or have disabilities, so they may remain in their own housing. Provides home help, maintenance, advocacy, emotional support, social activities, emergency assistance, nursing services and assistance with daily living activities and meal preparation. Eligibility determined by local ACAS. Level 4 supports people with high-level care needs.	www.benetas.com.au	People who are aged, frail or have disabilities	Eastern metropolitan LGAs	None advised	None advised
Box Hill Italian Senior Citizens' Club	Social Inclusion	A program, varying from time to time, provides social, cultural and recreational activities for senior citizens over 55 years old from Italian ethnic community. Community languages spoken include Italian	http://www.serviceseeker.com.au/cgi-bin/wdb.cgi?state=VIC&type=service&action=query&id=87301	Senior citizens over 55 years old from the Italian ethnic community.	Eastern Metropolitan	None advised	None advised
Burwood Community Centre	Social Inclusion	Opportunities for recreation and social interaction for the aged.	tom.thorpe@bigpond.com	Elder	Burwood	None advised	None advised
Cambodian Community Welfare Centre	Social Inclusion	Provides recreational activities, outings for elderly members of Cambodian and Cambodian Chinese ethnic communities. Community languages spoken include Cambodian	bunnarys@optusnet.com.au	Elderly members of Cambodian and Cambodian Chinese ethnic communities	Nunawading	None advised	None advised
Camcare		Community-based NFP focused on supporting people in Boroondara and surrounds through adversity including unemployment, ill health, relationship difficulties, financial stress, hardship, homelessness and food security issues. Chairs Boroondara Family Violence Network and has worker for Cross-Cultural Parenting Education Project	http://camcare.org.au/services-projects/community-services/family-violence/	People who are facing personal hardships or difficult life circumstances	City of Boroondara and neighbouring areas	None advised	None advised

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
Carrington Health (previous Whitehorse Community Health Service)	Largely Community health Baby Makes 3 – FV Prevention program	Primary health, allied health, dental, children's health, chronic disease management, Men's Shed, parenting programs (Baby makes 3) Carer support Community services to enable people to age in place	http://www.carringtonhealth.org.au Refer to strategy plan to 2030 for goals	Diabetes, Children/family, Men, elderly, oral health care and CALD, esp. Chinese community	Box Hill + consortium with Inner East, Manningham and MonashLink Connect4Hlth	TBC	Some evaluation e.g. Baby Makes 3 program
Chinese Community Social Services Centre (CCSSCI) Inc.	Social Inclusion	Ethno-specific organisation providing community support services to aged, children, young people and families within Chinese community in Victoria, through: • funded Community Settlement Services programs; • funded HACC programs • funded Home Care Packages services • specific short-term projects • recruitment and training of volunteers • on-going consultation and review with professionals from external organisation	www.ccssci.com.au	Aged, children, young people and families within Chinese community in Victoria	Victoria	None advised	None advised
COTA Victoria		COTA (Council on the Ageing) is the primary organisation representing interests of older Victorians. Vision: A just, equitable, inclusive and humane society in which older people live well, with dignity and purpose. Mission: To advocate for, resource and mobilise older people to create an age-friendly Victoria.	http://cotavic.org.au/	To advocate for, resource and mobilise older people to create an age-friendly Victoria.	Victoria Wide	None advised	None advised
Crossway		Baptist Church with domestic violence support groups	http://www.crossway.org.au/			None advised	None advised
Doncare	Domestic violence and Social inclusion	Provides a range of community-focused services, including: • Information and crisis support • Social supports for seniors • Family services • Counselling • Domestic violence advocacy and support (includes creative therapy and support groups, mentoring (DAWN) and app-based prevention and programs (IMatter and Live Free), Chair of Manningham Family Violence Action Group • Case management • Volunteering in Manningham • Op Shops	http://doncare.org.au	Whole of community, with some programs focused on Manningham residents, students and/or workers.	Based in Manningham, but many programs have broader focus	Service delivery and funding targets, tracking of referrals,	Program specific. Current external evaluation (UniMelb) being conducted re IMatter Internal Consumer Advisory Board provides feedback
EACH	Social inclusion & specific Family Violence programs	Large range of programs related to social inclusion, and specific family violence programs as outlined below.	www.each.com.au	Broad population approach: specific – children (including early years), CaLD, male blue collar workers	Eastern region: mainly around City of Maroondah but into Yarra Ranges, Knox,		

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
EACH	Social inclusion & specific Family Violence programs	• Ringwood Family Relationship Centre • Family violence identification • Family violence screening • Family Capacity Building program • Counselling, Support, Referral	www.ringwoodfrc.org.au			EACH Prevention of Violence Against Women and their Children Strategy 2014-2015 Assist people most at risk of FV through early identification and support Provide support for people affected by family violence and protect them from future harm	Pre- and post-intervention service effectiveness surveys
		Intervention Order Support Service (joint program with Eastern Victims Assistance Program and Ringwood Magistrates' Court) supports seamless referral pathways and application support for victims of family violence. Eastern Victims Assistance Program has a specific Aboriginal family violence worker at Boorndawan Willam Aboriginal Healing Service to provide information and referral information to the Aboriginal community.	Family Violence Intervention order applicants of Ringwood Magistrates' Court Aboriginal clients who are victims of family violence		EMR		
		Rebound and Bridging the Gap These 2 programs (run for young people aged 13-16) run in conjunction with Victoria Police and although not exclusively family violence, most of the young people participating have a family violence background. Both programs have specific sessions on family relationships, and attitudes/behaviours relating to violence.	EACH Youth and Family 2016 Group Program Plan	Rebound – Young People and 13-16 who have displayed early indications of criminal behaviour and who have experienced instability in multiple contexts (e.g. housing, family, health) Bridging The Gap – Young people that have significant risk factors for offending and who have displayed early drug and alcohol use.	EMR	Reduction in individual risk factors identified in care plans. Ability to articulate and apply knowledge, modify behaviour re communication skills, emotional awareness, family functioning etc.	Rebound evaluation by project officer funded by federal AG's Proceeds of Crime Program. Bridging the Gap: current external evaluation conducted by Adventureworks.
		• Social Inclusion Programs • Project Hope • Health Champions • Mothers Living Well • Bush Tucker program					Bush Tucker Program evaluation

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
EACH	Social inclusion & specific Family Violence programs	Health Promotion – Gender Equity • Together for Equality and Respect (TFER) • Prevention of Violence Against Women and their Children Strategy • Gender Equity Training • Gender Equality Self-Assessment • Gender Equity staff surveys • 16 days of Activism • Communities That Care (CTC)	• Together for Equality and Respect action plan				
		• Supporting Kids in Primary School (SKIPS) across EMR providing teacher training and class programs for Yrs 5&6 in mental health promotion and destigmatisation • Gamblers Help Eastern (GHE), including financial counselling, therapeutic counselling, Community Ed/Development, Venue Support Work and Chinese Peer Connection. • GHE has variety of community based health, wellbeing and social inclusion programs including group work to reduce harm specific to gambling affected, disadvantaged and vulnerable people/families • Financial counselling programs are specific to social inclusion and to reduce financial harm to disadvantaged and vulnerable people/families and community • Maroondah/Yarra Ranges NILS (no interest loan services)	http://skips.each.com.au/ Targets a broad population. Predominantly adults, but some youth projects. CALD and Indigenous communities.	Eastern Region; in 11 locations: • Ringwood • Boronia • Yarra Junction • Healesville • Box Hill • Doncaster • Hawthorn • Clayton X2 • Glen Waverly • Chadstone			
		• Multiple MHCSS group programs across EMR enhancing social inclusion (including Art therapy, Exercise, Peer Support, Wellness, Mindfulness, Music therapy, Outdoor, etc. • MHCSS (EMR) & PHAMS (OEMR) individual support for social inclusion • "Lets Talk About Children" pilot with FAPMI/EH supporting parents with a mental illness • Secure Tenancies (OEMR) support for at risk of homelessness with a focus on victims of FV					
Eastern Community Legal Centre	Social Inclusion – some FV work also	Free legal assistance. ECLC is committed to reform that achieves equality and social justice within the legal system for communities and people experiencing disadvantage. In addition to direct legal services, ECLC also undertakes Community Development activities that empower clients, workers and the general community. Elder Abuse Awareness Worker. ECLC raises awareness of legal issues and provides education through projects and partnerships, workshops, media, events and publications. ECLC has a small staff team and over 100 volunteers. ECLC is located in EMR and serves LGAs Whitehorse, Boroondara, Manningham, Maroondah, Knox and Yarra Ranges.	http://eclc.org.au/	Communities and people experiencing disadvantage	Eastern Region – offices in Box Hill, Boronia and Healesville + outreach locations	None advised	None advised

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
Eastern Health	Involvement in FV and Community care – ageing in place	Maroondah, Box Hill, Angliss, Healesville Hosps: clinical services. Also runs: ECASA, Turning Point, Spectrum, Aboriginal Health program, Family Violence programs, Advanced Care Planning, Community care (moving to more in-home services where possible) and research program.	http://www.easternhealth.org.au/	Whole-of-community	EMR	Refer website –state and local targets	Refer website and DHHS
Eastern Melbourne Regional Family Violence Partnership (EMR RFVP)	FV Focus	Partnership model with independent chair and regional integration coordinator to provide leadership for integrated and coordinated family violence responses that support and promote the safety of women and children and ensure perpetrator accountability.	http://easternfamilyviolencepartnership.org.au/	Women and children	EMR	Data working group looking at a range of indicators	
Eastern Melbourne Regional Palliative Care Consortium	Social Inclusion via family engagement	Nil violence activities (but may input re elder abuse.) SI&CC – Provides coordination, care and palliative nursing to those with life-threatening condition/families incl. in nursing homes, disability accommodation and in home.	http://www.emrpcc.org.au/	Clients with life-threatening conditions	EMR	None advised	None advised
Healesville Indigenous Community Services Association	Social inclusion	Indigenous – services, support, activities	http://www.hicsa.org.au/about-hicsa	Indigenous of Yarra Valley, Healesville	Keeping place in Healesville	None advised	None advised
Health Issues Centre	No specific focus on priority issues	State based support for informing and raising voice of health sector consumers. Some research re health literacy for Indigenous clients and refugee women. No specific local focus.	http://healthissuescentre.org.au		State wide advocacy, not local	None advised	None advised
Indigenous Family Violence Regional Action Group (IFVRAG)	Family Violence	RAGs have leadership role in developing and implementing specific, culturally relevant and community-led responses to educate, prevent, respond to and reduce family violence in Aboriginal communities.	http://www.thelookout.org.au/sites/default/files/IFVRAG-operating-guidelines-june15-2012.doc	Indigenous population of EMR	EMR	TBA	TBA
Inner East Community Health	Social Inclusion	Youth mental health and wellbeing service to young people aged 12 to 25 years.	http://headspace.org.au/headspace-centres/hawthorn/	On-going	Young people aged 12 to 25 years	None advised	None advised
IEMML/ EMML EMPHN	No specific programs in place at present – await post transition	Coordination of services, training and education, facilitate engagement between healthcare agencies, partners and community, investigates local health needs to develop services. Support for GPs, primary health care providers. Current transition to EMPHN.	http://www.emphn.org.au/page/programs/ http://megpn.com.au/ http://emml.com.au/	General	EMR+	None advised	None advised

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
IEPCP	Violence – esp. FV, through TFER and EEAN Social Inclusion – especially through Opening Doors	Participate in TFER. Extensive on-line resource on PVAW for 'The Well'. Toolkits underway: family violence and elder abuse Provide financial and practical support to Eastern Community Legal Centre for advocacy and service coordination on prevention and response to Elder Abuse **Eastern Elder Abuse Network** (EEAN): Convenors (with Eastern Community Legal Centre (ECLC) **Chasing the Luck:** project to reduce harm from problem gambling in Chinese community. Provide support to: **Opening Doors** – community leadership program for social inclusion. Now managed by Link Health and Community **The Well:** Development of an online resource to support integrated planning, action and evaluation around key issues such as family violence, alcohol use and misuse, mental health, (also health literacy, obesity, food security). Refer also to OEHCSA	http://www.iepcp.org.au/ All detailed in IEPCP operational plan. http://www.iepcp.org.au/chasing-luck http://www.iepcp.org.au/opening-doors	Monash, Manningham, Boroondara, Whitehorse Agencies working with older people (all eastern region) Chinese-speaking community Socially isolated people	Inner eastern municipalities	Project work plan includes evaluation measures, evidence base	Seeking evaluation of Opening Doors Process evaluation of Elder Abuse and EEAN Extensive evaluation underway with Deakin Uni and Vic Responsible Gambling Foundation
Life Activities Whitehorse	Social Inclusion	For people retired or approaching retirement and looking for a club to enjoy a range of social and physical activities.	http://life.org.au/the-clubs/whitehorse/	Older Whitehorse residents	Whitehorse	None advised	None advised
Melbourne East RDA – Regional Development Australia	Social Inclusion focus	Regional development: largely funding and system support. Strategic priorities: connecting +55s with younger people by sharing experience, knowledge, skills Integrated transport needs Mapping and delivering transport solutions: Transport: Journey-to-Study (2012) re tertiary students Regional sport and recreation strategy being developed (Maroondah lead)	http://www.rdv.vic.gov.au/regional-development-australia/eastern-melbourne	Community focus	Eastern Melbourne LGAs	None advised	None advised
LINK Community Health (formerly Monashlink)	Social Inclusion and Family Violence	Provides GP, women's health, dental, allied health, HACC, counselling and mental health support, child health. Also runs a range of programs for health promotion, healthy communities and community development, such as partners in recovery (MH program), health promotion (violence, closing the gap, food security, LINKPets), gambling prevention/recovery and Opening Doors	www.linkhc.org.au	Community health – for residents of Monash and surrounding areas	Monash, and neighbouring areas of Kingston, Greater Dandenong and Knox	None advised	None advised

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
Migrant Information Centre (Eastern Melbourne)	Social Inclusion	Support to: 1. refugees and migrant families to promote successful settlement, including: • Individual case work • Group information sessions to raise understanding of life in Australia e.g. role of police, educational pathways, women's and men's health, financial literacy, healthy eating etc. • Homework support and play groups • Specific programs, e.g. parenting, employment, driving programs to assist people to understand/feel connected to their new communities • Individual case work for young people/young people's programs, e.g. recreational programs, programs to assist in finding part-time work, career options etc. • Road safety programs including preventing drug and drink driving, pedestrian safety programs, bike education for children, preparing older drivers to consider mobility as they age • Migration advice 2. Older people with disabilities and carers, who, due to issues of diversity, face barriers to accessing HACC services 3. Refugee community leaders to strengthen capacity to support their communities 4. Family violence counselling/family violence support groups 5. Family support to people from CaLD communities living in Inner East	http://www.miceastmelb.com.au/	Available to people living in LGA areas of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and Yarra Ranges.	EMR	None advised	None advised
Mullum Mullum	Social inclusion	Indigenous – services, support, activities and advocacy Strong role in cultural SI&CC	http://www.mmigp.org.au/	Indigenous of EMR	Keeping place in Croydon	None advised	None advised
OEHCSA	Violence: especially FV	Participate in TFER Alcohol use and misuse issues paper HACC Alliance/EMR Active Service Model **Qualitative Research:** Participatory Action Research documenting the lived experience of family violence. **The Well:** Development of an online resource to support integrated planning, action and evaluation around key issues such as family violence, alcohol use and misuse, mental health, (also health literacy, obesity, food security)	http://www.oehcsa.org.au/ OEHCSA strategic plan	Knox, Maroondah, Yarra Ranges	Outer Eastern municipalities	None advised	None advised

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
ONEMDA	Social inclusion, violence prevention for adults with disability	Disability – day services, support, activities for adults with disabilities	http://www.onemda.com.au/	Adults with disability	East Doncaster, Lower Templestowe	None advised	None advised
RDNS	Other – Community health	Frontline services: focus on ageing in place, dementia, wound care, OPHELIA project to enhance health literacy, 9incl. CaLD focus]esp. Vietnamese], diabetes care and skin health program, visiting pharmacy)				None advised	None advised
Salvation Army	Violence prevention, including FV and AOD Social Inclusion	Frontline service delivery: Domestic violence/accommodation and refuge Human trafficking/slavery Safe from the Start – helping children who have witnessed DV The Bridge – AOD programs	http://www.salvationarmy.org.au/en/Who-We-Are/our-work/	Vulnerable	Southern Territory based in Blackburn	None advised	None advised
Seniors Rights Victoria		Seniors Rights Victoria provides information, support, advice and education to help prevent elder abuse and safeguard the rights, dignity and independence of older people. Services include a Helpline, specialist legal services, short-term support and advocacy for individuals and community and professional education. Seniors Rights Victoria also provides leadership on policy and law reform and works with organisations and groups to raise awareness of elder abuse.	http://seniorsrights.org.au/	Older people and community and professional education	Victoria wide	None advised	None advised
U3A various local programs	Social Inclusion	Retired or semi-retired people who want to become more active, make new friends and expand skills and learning opportunities. U3A is a community of people sharing knowledge and skills.	https://www.u3avictoria.com.au/	Usually older residents	Regionally based, across Eastern and Outer Eastern regions.	None advised	None advised
Together For Equality and Respect Partnerships (partners include WHE, all CHSs, LGAs in EMR, IEPCP, OEPCP, EMPHN, RFVP, OECYAP, Victoria Police	Prevention of violence against women	Led by WHE, this regional strategy and action plan provide a coordinated, evidence based approach to the primary prevention of violence against women across the Eastern Metropolitan Region. TFER takes a collective impact approach to this work. The partnership works to a common vision, objectives, indicators of success and common evaluation tools. Governance structures for the partnership include WHE as the lead organisation, a leadership group providing strategic directions to the implementation of the action plan and to the partnership as a whole, and a highly skilled evaluation working group which has developed the evaluation framework using a development evaluation approach.	http://whe.org.au/tfer/partners/	Whole of population	EMR	Outlined in the action plan http://whe.org.au/tfer/resources-document-sharing/action-plan/ and the evaluation guide book http://whe.org.au/tfer/resources-document-sharing/evaluation-guidebook/	http://whe.org.au/tfer/wp-content/uploads/sites/2/2014/06/Executive-Summary-of-regional-Evaluation-framework-July-2015.pdf

WHO	FOCUS	WHAT	SOURCE	TARGET POPULATION	REGION	INDICATORS	EVALUATION PLANS
Various Senior Citizens Centres and Clubs	Social Inclusion	Box Hill Seniors Citizens Centre, Mitcham Senior Citizens Centre, Nunawading Senior Citizens Centre, Blackburn Senior Citizens Centre		Older Whitehorse residents	Whitehorse	None advised	None advised
VCOSS	Social Inclusion	Advocacy for: • Affordable housing • Better public transport, especially in outer suburbs, Accessible Transport Working Group	http://vcoss.org.au/	Social Services clients	State-wide advocacy	None advised	None advised
WHE	Family Violence: TFER Previous programs also had Social Inclusion focus	Women's Health Promotion Agency: provides leadership on: • Together for Equality and Respect Action (TFER) plan – Regional Action plan for preventing violence against women Priority areas: • Preventing violence against women • Sexual and reproductive health • Gender equity for health outcomes • Previous program: Investing in Women: Building a Socially Connected East – report suggests strong outcomes. Current programs include: • Speaking Out: (EMAP) supporting women who have experienced violence to be media/public speaking advocates – independent evaluation undertaken • Gender equity training Direct organisation support for organisational change especially around gender equity auditing. Development of regional social marketing campaigns for 16 Days of Activism against gender violence each Nov/Dec. See https://listeningtoandlearningfromwomen.wordpress.com/	http://whe.org.au/	Population – changing attitudes to violence against women Addressing determinants of VAW i.e. gender inequality and adherence to rigid gender stereotypes	Eastern region broadly	Range of engagement, participation, attitudinal change indicators – refer to documents. Also organisational systems change towards gender equality e.g. policy changes, changed practices e.g. in relation to gendered data analysis, applying a gender lens	Evaluation plan overview and summary provided

APPENDIX F: DETAILED LITERATURE REVIEWS

Eastern Region (EMSIC) Violence in Vulnerable Communities: a rapid systematic literature review

Bethany Devenish[1,2]

Email addresses:

BD: bethany.devenish@deakin.edu.au

Abstract

Background

Violence causes significant physical, emotional and psychological consequences for victims, and a high economic cost to individuals, communities and the criminal justice system. There is significant community concern regarding violence against women and 33% of children report witnessing levels of family conflict that are sufficient to cause future problems. Additionally, violent behaviour develops in around 10% through childhood and adolescence and can lead to problems later in life such as violence against women, intimate partner and family violence. After adjusting for violence against women and youth violence, vulnerable minorities (such as people from Culturally and Linguistically Diverse (CaLD) backgrounds) often face additional risks of violence that may require specialist interventions. There is community readiness to reduce violence across the Melbourne Eastern Metropolitan Region.

Method

Given the limited time frame, a rapid systematic review was conducted. The review was directed by a scoping document (24 June 2015) approved by an Eastern Metropolitan Social Issues Council (EMSIC) Violence Prevention Advisory Group. We searched for high quality systematic reviews and meta-analyses of international literature reviewing randomised controlled trials relevant to implementation within a community setting. This information was supplemented with documents sourced from expert advice where there were identified gaps in the literature search. Reviews were included, provided they incorporated a focus on women and family violence, youth violence, violence against minority populations or bullying. Primary (whole population) prevention reviews were prioritised due to their community-wide approach (which is therefore particularly amenable to community intervention approaches). However, secondary and tertiary prevention approaches targeting specific groups (women who are victims of violence, or interventions targeting perpetrators) were also included.

Results

We summarised findings from 17 well conducted systematic reviews and also examined prior reports such as those from the World Health Organization (WHO). There was strong evidence supporting the effectiveness of primary preventative approaches, and mixed evidence regarding secondary and tertiary prevention approaches.

Conclusion

Overall, primary prevention appears to hold the most promise for family violence prevention at a regional level, particularly strategies that aim to intervene early in children's development implemented through local government to assist families and in school settings. In terms of secondary prevention, advocacy interventions designed to support women who are experiencing or have experienced violence demonstrate good effectiveness. Reducing access to alcohol shows promise. There were no randomised controlled trials evaluating community interventions to reduce community rates of aggressive and discriminatory attitudes to women, and we identified no proposals under development. However, there is some promising evidence that primary prevention through secondary school interventions may prevent aggressive attitudes to women and encourage equitable social or gender norms. Selected interventions to address inequitable social or gender norms may be particularly important in cultures and groups, where these issues are assessed to be elevated. Screening programs designed to identify women in the community experiencing violence also demonstrates some promise, as do protection orders and perpetrator rehabilitation programs. However, in order to be effective these programs must be incorporated as a multi-component approach across a region. To be effective screening efforts to identify women experiencing violence needs to transfer into increased referral of women to effective support services, and thereby improved safety.

School-based programs demonstrate good effectiveness for prevention and indicated intervention for adolescents, particularly programs that focus on relationship and social skills training. Additionally, the majority of the primary prevention strategies for family violence outlined above are also effective in preventing youth violence. Finally, school-based bullying programs appear to be effective in reducing victimisation and perpetration, although effects on violent bullying have not been evaluated.

In terms of elder abuse, prevention aimed at increasing social inclusion and providing combined legal and social services to the aging population appears to hold some promise, in addition to programs that improve caregiver mental health and attitudes towards older people. While the effectiveness of violence prevention in Indigenous populations has not been well researched, it is recommended that these programs should nurture social capital, be culturally informed, and prioritise the active and central participation of the Indigenous community. Similarly, violence prevention with people with disabilities, Gay, Lesbian, Bisexual, Transgender, Intersex and Queer (GLBTIQ) communities and ethnic minority communities should incorporate an increased awareness of their unique community

[1] School of Psychology, Faculty of Health, Deakin University, Burwood.
[2] Consulting Group, Faculty of Health, Deakin University, Burwood.

needs, particularly in terms of accessibility of services, and increase collaboration between existing support services for these minority groups and violence prevention and support services. Monitoring can ensure that minorities are accessing services in rates proportionate to their presence in the population.

Recommendations

It is clear from the reviewed evidence, that effective violence intervention at a community level needs to be reinforced across the primary, secondary and tertiary levels of prevention. Additionally, community and regional approaches to violence intervention need to complement state and national level approaches to intervention. There is a need for violence intervention approaches to provide integrated services targeting the various levels of violence prevention, and therefore community efforts at preventing violence should be provided within a framework that allows for a variety of organisations to contribute. As primary prevention approaches have been consistently identified as having the clearest evidence, they should be prioritised as the more cost effective and humane approaches.

1. Implement effective prevention approaches across the region within the framework of a life course approach that seeks to change behaviour in child and adolescent cohorts guided by demographic predictions of their trajectory growing up within geographic locations into adults through time. These should be guided by an analysis of the risk factors for violence that are reported to be elevated in surveys of child and adolescent cohorts in specific geographic areas within the region. This information should then guide the selection of interventions. Regional intervention efforts should be monitored over time to ensure that targeted risk factors and violent behaviours are in fact reducing as planned. Effective interventions include school-based and comprehensive approaches to parent education. Parent education programs should be selected for evidence that they can reduce child reports of family conflict. Improved classroom social and emotional competency training should form a component of school approaches, where assessment reveals competencies are low. Particular emphasis may also be given to those approaches that may lead to the development of improved attitudes to women. Bullying prevention may be an important strategy in schools where children report high rates of victimisation.
2. Implement effective interventions that target reductions in the risk factor of harmful alcohol use. There are promising interventions that can be implemented at a regional level to reduce supply and demand and violent hotspots. At a regional level effective supply reduction strategies can include monitoring to strengthen responsible serving of alcohol, social marketing to discourage parent and peer supply and lobbying to increase local powers to restrict alcohol markets across the community. Effective demand reduction can include school programs, brief intervention in primary care services and social marketing. Reducing violence in locations identified as being 'hot spots' for excessive alcohol related violence can also be important. Regional EMSIC strategies and priorities should support the Action on Alcohol Flagship within the Eastern Metropolitan Region efforts in this area and be monitored to ensure they are being effectively implemented.
3. Develop a strategy to implement an effective screening system to detect and protect women who are victims of violence. By conducting a social marketing campaign to publicise the availability of a regional screening system, the key message could be disseminated that violence against women is unacceptable. Health service providers and other primary carers (such as MCH) should be involved in the prevention and identification of possible violence. Screening done poorly is ineffective, and so screening programs need to move beyond identification of women who are victims of violence to successfully and safely referring these women to effective resources and support and include integrated procedures in housing, welfare, social security, policing and the law. Additionally, strategies for women at risk of violence should include increased access to information regarding Intervention Violence Orders. Given more evidence is required in this area, randomised trials evaluating interventions to better integrate screening and support systems across municipalities should be considered. This work should be integrated with existing work in the region that is seeking to reduce violence against women.
4. (See related recommendations 1 related to social inclusion and community connectedness, Devenish, 2015). Reduce the pathways to violence associated with disadvantage. Effective interventions include programs that involve visiting vulnerable mothers during the prenatal, postnatal and early developmental stages of their child's life. The Maternal and Child Health Services are involved in this to some extent; their involvement could be further extended for the purpose of screening/identification and action. The Strengthening Families intervention works with vulnerable families in contexts such as disadvantaged primary schools and has a track record in reducing pathways to violence, whilst also strengthening social inclusion. Tutoring and mentoring for children with high risk factors for violence can offer protective effects, while encouraging social connection and bridging social capital. Prevention programs that include education to inform the community and change their attitudes in relation to violence against women should also be implemented. Randomising places of disadvantage into service system interventions should be considered.
5. Ensure effective approaches are adopted for the rehabilitation of violent offenders. Programs designed and funded to rehabilitate violent offenders should reduce recidivism at a regional level, and transparency and accountability regarding reductions in recidivism is important. First offenders should be a major focus of rehabilitation efforts, as early intervention with offenders has been shown to be more effective than later intervention. Interventions at this level must use evidence-based practices and have adequate and coordinated follow through and support. Interventions relevant to minorities (e.g., CaLD and GLBTIQ) should also be developed and implemented.

6. (See related recommendations 2 related to social inclusion and community connectedness, Devenish, 2015). Finally, with regard to these recommendations, it is also important that a regional system considers the unique needs of neglected or minority groups. An effective regional system will monitor that minorities are safe and secure and accessing the above services. Consideration regarding the accessibility of housing/shelter, legal assistance and financial assistance for minority groups and people on temporary visas is important, particularly as some government resources may not be available to them. Adopting a common regional monitoring instrument to encourage regularly sampling of the safety and social inclusion of vulnerable sections of the community (including CaLD populations) would be a practical means of strengthening the regional service system and would facilitate consultation and collaboration with minority groups and the local agencies that represent them. Service evaluations could use this instrument to monitor increases in social integration and safety of minority groups across the region. The above recommendations should sit as part of an integrated system that targets many levels and risk factors within a community, and which is monitored with key indicators to track progress at a regional level.

EMSIC Project Introduction

The Eastern Metropolitan Social Issues Council (EMSIC) was established to better integrate and align joint regional efforts in prevention and intervention of key social issues in Melbourne's Eastern Metropolitan Region[1]. EMSIC is a voluntary collaboration between senior executives from organisations involved in key aspects of public value to the Eastern Metropolitan Region, which includes the local government areas of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and the Yarra Ranges[1]. Stakeholders include NGOs, Commonwealth, state and local governments, Eastern Health, academia and industry[1]. EMSIC aims to promote the optimal underlying conditions for enhancing collective regional effort to maximise the regional populations' safety, wellness, fulfilment, engagement, connection, and economic means and prosperity[1]. To achieve this, EMSIC works to identify significant regional social issues, and form impact measures, evaluate the existing evidence base, map and analyse existing programs and efforts, and decide on and motivate collective action regarding these regional social issues[1].

In planning activities in 2014/15, EMSIC identified social inclusion and addressing interpersonal violence in vulnerable communities as two priority issues for the region[2]. In order to inform EMSIC's approach to these issues, Deakin University was appointed as a research consultant to produce a detailed report reviewing current work, identifying partnership approaches and making recommendations for future opportunities. The scope of this work included a focus on evidence-based interventions to address the priority areas. The priority of addressing violence in vulnerable communities broadly reflects EMSIC member concerns with community safety but predominately refers to prevention of family violence particularly against women and children, while also encompassing other issues.

This document presents a rapid systematic review that forms a component of the Deakin work outlined above. The review was directed by a scoping document (24 June 2015) approved by an EMSIC Advisory Group. The scoping document aimed to provide an evaluation of high quality evidence regarding interventions that (i) reduce and address women and family violence, youth violence, minority populations and bullying (ii) can be incorporated in a public health framework and (iii) demonstrate feasibility for implementation within a regional context.

Method

As outlined above, Deakin University was asked to provide recommendations to EMSIC on the implementation of evidence-based interventions to address violence in vulnerable communities, particularly family violence, with an emphasis on opportunities for enhanced partnerships. EMSIC Advisory Group members were provided with the following search strategy in 'Project Management Plan for Deakin Tasks for Eastern Region (EMSIC) violence in vulnerable communities rapid literature review' by John Toumbourou, which was approved out of session in late June 2015.

Existing high quality reviews of programs and intervention strategies that can be implemented at the community level and evaluated using a rigorous randomised trial design were synthesised to answer the following questions: (i) What are the major interventions that communities can implement to reduce violence against women and family violence? (ii) What are the major interventions that communities can implement to reduce youth violence? (iii) What are the major interventions that communities can implement to reduce violence in minorities? (iv) What are the major interventions that communities can implement to reduce bullying? The inclusion criteria were programs and intervention strategies that can be implemented at a community level and that have been evaluated using a rigorous randomised trial design. Extraction involved describing models, measures and effects for an informed lay reader, with focus on relevance to the Eastern Region.

Several sources were identified as having relevance and were therefore included in this rapid review:

1. Relevant high quality systematic reviews and meta-analyses
2. Reviews, reports and books that examined the topic of violence within the Australian setting
3. Model programs from Blueprints, a registry of evidence-based youth development programs, and the Washington Institute for Public Policy, which provides cost-effectiveness analysis of evidence-based research.
4. The World Health Organisation (WHO) reports regarding violence prevention and intervention
5. Due to no review or meta-analysis specific to ethnic minority or GLBTIQ populations being identified, papers evaluating an intervention for violence against or within these populations were included.

[1] 2015 Eastern Metropolitan Issues Council: Terms of Reference
[2] 2015 Eastern Metropolitan Issues Council: Priority Issues Identification Advisory Committee Progress Report

Eastern Region (EMSIC) violence in vulnerable communities review

Framework for Violence Prevention

A brief summary is provided below regarding the framework of intervention methods included in this review. This summary is only provided as a general introduction to these frameworks, as this review will be incorporated into a larger report that will provide a more detailed section on the causes of violence.

Gender Basis of Violence Prevention

Australian Bureau of Statistics data for violence in Australia (see Figure 1) consistently identifies two significant trends: (i) interpersonal violence (IPV) that results in an offence or injury is most commonly perpetrated by males, and (ii) IPV perpetration that is at its highest prevalence during adolescence and young adulthood. The role of gender in the perpetration of violence has been widely researched. A vast body of literature has found strong links between violence and beliefs about masculinity, and broad socialisation and cultural processes have been identified as key influences at various stages of adulthood in these definitions of masculinity and femininity, and beliefs about violence. Individuals are continuously engaged in the process of defining masculinity within the context of their personal lives, and this process is strongly influenced and shaped by the meanings assigned by the cultural and social context they reside in.

Early socialisation is thought to be particularly influential in shaping the definitions of masculinity, with some key risk factors for this process being abuse, disrupted attachment and modelling, and biological predisposition. However, while there are key times of risk identified by research, there are also key opportunities for change across the life course, the significant turning points for criminal behaviour including incarceration, marriage, fatherhood and employment. Additionally, it is argued that definitions of masculinity are likely to have a strong effect on violence during adolescence and young adulthood, as this developmental stage is a time of increased focus on establishing a sense of self in the world. These key risk factors and key opportunities for change (early socialisation, key turning points, and adolescence and young adulthood) may provide critical points in time in which prevention efforts may be particularly effective. Additionally, the social and cultural context of a region, specifically in regards to beliefs about masculinity, femininity, and violence, appears to be important in shaping an environment that either encourages, or discourages, violence against women. Community actions to address gender norms that promote violence against women may be particularly important in cultural groups that have high levels of gender inequality.

Ecological Framework for Violence Prevention

Interpersonal violence is viewed to be a result of the interaction between many different risk factors at four levels – individual, personal relationships, community contexts and societal factors. The ecological framework encapsulates these risk factors, incorporating the life course approach to violence prevention, and treating each level with equal importance. Effective regional violence prevention not only prioritises effecting changes in attitudes at the community and social level, but then also facilitates changes at the individual and personal relationship level through secondary and tertiary preventative efforts. The collaboration of community agencies to facilitate changes at each of these levels appears essential for effective and lasting change.

What are the major interventions that communities can implement to reduce violence against women and family violence?

1. Implement effective prevention approaches across the region within the framework of a life course approach that seeks to change behaviour in child and adolescent cohorts guided by demographic predictions of their trajectory growing up within geographic locations into adults through time. These should be guided by an analysis of the risk factors for violence that are reported to be elevated in surveys of child and adolescent cohorts in specific geographic areas within the region. This information should then guide the selection of interventions. Regional intervention efforts should be monitored over time to ensure that targeted risk factors and violent behaviours are in fact reducing as planned.

The World Health Organisation (WHO) (2013, pp.1-2) found strong support for the effectiveness of parenting programs in preventing all forms of violence. Parenting programs for violence intervention aim to prevent child maltreatment by improving parenting skills parent understanding of child development and encourage the use of age-appropriate positive discipline (WHO 2013, pp.1-2). Interventions seek to target key risk factors identified earlier in this review at the individual level (experience of child maltreatment, family conflict), relationship level (family attitudes, attitudes to women) and societal level (social and cultural norms regarding parental dominance over children, discipline, and child maltreatment). Parenting program components that appear to lead to more positive outcomes include: basing them on a solid empirical base; clearly defined target population; implemented at a time when participants are most receptive to change; relevant and acceptable to participants; have sufficient sessions for the target population (i.e. high risk require longer duration); are run by well trained and well supervised staff; incorporates monitoring and evaluation; provides opportunities for parents to practice new skills; teach principles rather than techniques; teach positive parenting strategies and age-appropriate positive discipline; and consider relationship difficulties amongst parents (WHO 2013, p.13-14).

Given the incidence (first episode) of IPV is highest throughout adolescence and young adulthood, it is important that community interventions targeting IPV against women in this age bracket are identified. Educational and skills-based interventions for the prevention of violence against women in adolescent and young adult populations have not demonstrated promising results. Mixed results have been found regarding the efficacy of interventions designed to prevent adolescent IPV (De Koker, Mathews, Zuch, Bastien, & Mason-Jones, 2014). Five of the six interventions incorporated a focus on gender power inequities, however of these, only three demonstrated positive effects on IPV outcomes (De Koker et al., 2014, p.9). Episodes of interpersonal violence (IPV) and attitudes, behaviours and skills related to IPV were not found to significantly improve in adolescents or young adults in a meta-analysis of 38 education and skills-based interventions for relationship and dating violence (Fellmeth, Heffernan, Nurse, Habibula, & Sethi, 2013). These interventions included both primary and secondary interventions held within school or community settings, that aimed to raise awareness about abuse, promote positive relationships, enable help-seeking and peer support, challenge discriminative viewpoints and encourage the development of protective skills (Fellmeth et al., 2013, p.5). The lack of support for this mode of intervention is at first surprising, given these interventions target both relational and societal risk factors at a pivotal age, and suggests it may be insufficient to reduce violence simply by affecting change in attitudes towards IPV.

Given high rates of child neglect and abuse and family conflict the seeds that lead to violence may be sown in early life and childhood for many, a shift in social and cultural norms and child-rearing practices on a broader community level may be necessary. Later sections of the present report review evidence for parent education and school social-emotional competence programs. The evidence reveals that these programs have overall positive effects in reducing child behaviour problems that are important risk factors that lead to youth violence and IPV. Preventing early life-course problems may lead to adolescent interventions being more effective.

2. Implement effective interventions that target reductions in the risk factor of harmful alcohol use. There are promising interventions that can be implemented at a regional level to reduce supply and demand and violent hotspots. Regional EMSIC strategies and priorities should support the Inner Eastern Primary Care Partnership efforts in this area and be monitored to ensure they are being effectively implemented.

Alcohol is a significant risk factor for IPV, and there is evidence that interventions designed to reduce access to and harmful use of alcohol are effective in reducing IPV (WHO 2014). There has been limited evaluation of community level alcohol interventions (Miller, 2015), and so it is at this stage unclear as to how effective they may be in reducing IPV. Voluntary alcohol programs for individual businesses demonstrate minimal, if any, effectiveness in Australia, and community alcohol accords and venue accreditation schemes show mixed effects (Miller, 2015). Targeted police enforcement shows promise, the Australian 'Alcohol Linking Program', that tracked the association between drinking venues and arrests and fed this information back to problem venues, was associated with a 36% drop in alcohol-related criminal incidents and assault rates (Miller, 2015). Additionally, some community action projects that incorporate both enforcement of liquor licensing laws and publicity campaigns, local task force activities, community forums and discussion groups have shown promise for reducing alcohol-related violence (Miller, 2015). 'The Well', an online resource developed to provide a framework behind key issues for the Eastern Region, also identifies enforcement as a means of tackling alcohol use and misuse at a community level (7.1.1, Outer East Health and Community Support Alliance, 2015), suggesting this may be an important strategy to adopt for reducing both alcohol misuse and violence in this region.

Monitoring interventions are being implemented in Australian randomised community trials and use techniques such as coordinated alcohol purchase attempts by youth that look under the age of 18 to assess whether responsible serving of alcohol is occurring. When paired with feedback to alcohol sales managers and licensees, they lead to reductions in unregulated alcohol sales (Bosco Rowland et al., 2013). Social marketing is also being implemented in Australian randomised community trials to discourage parent and peer supply of alcohol to underage youth (Bosco Rowland et al., 2013). Early evidence from these community trials suggests that they reduce youth alcohol use; while their effects on IPV are unknown, it is being investigated in long-term follow-ups. Evidence that the community density of alcohol sales outlets increases early alcohol use (B. Rowland et al., 2014) and both assault and domestic violence (Livingston 2008; 2011; as cited in B. Rowland et al., 2014) has led a number of communities to lobby the state government to increase local powers to restrict alcohol markets within communities.

There is evidence from randomised trials that youth alcohol use can be reduced at a community level through a number of coordinated strategies. Ensuring a coordinated approach to screening and brief intervention programs appears warranted based on current evidence. A recent meta-analysis synthesised findings from 185 randomised trials that have evaluated screening and brief intervention programs in schools and primary care services. Overall, brief alcohol interventions were found to result in significant reductions in alcohol consumption and alcohol-related problems among adolescents (effect size in proportion of a standard deviation = 0.19) and young adults (0.11) (Tanner-Smith & Lipsey, 2015). Although these interventions reduce youth alcohol use and related-problems, their effect on IPV remains to be evaluated. It should be noted that it is more cost-effective to reduce alcohol use at young ages before lifestyles are entrenched. It is difficult to effectively treat adult alcohol use disorders even using costly and time-intensive treatment approaches.

Effective demand reduction strategies also include school alcohol education programs. School-based alcohol education programs have shown some good effects. Australian students attending an internet-based alcohol and cannabis program – CLIMATE schools – were found to consume significantly less alcohol on average per week and have fewer instances of excessive drinking in comparison to students who had instead attended regular health classes, with this effect found to be retained 12 months following the completion of the program (Newton, Teesson, Vogl, & Andrews, 2010). Randomised trials involving 24 Victorian secondary schools found Resilient Families, a universal intervention designed to reduce alcohol use and misuse through school-based family intervention, effective in reducing alcohol use in adolescents (John W. Toumbourou, Douglas Gregg, Shortt, Hutchinson, & Slaviero, 2013). The School Health and Alcohol Harm Reduction Project (SHAHRP study) also identified significant reductions in risky alcohol consumption in response to classroom-based alcohol harm reduction interventions in 2300 Australian secondary students (McBride, Farringdon, Midford, Meuleners, & Phillips, 2004).

3. Develop a strategy to implement an effective screening system to detect and protect women who are victims of violence. Screening done poorly is ineffective, and so screening programs need to move beyond identification of women who are victims of violence, to successfully and safely referring these women to effective resources and support. Given more evidence is required in this area, randomised trials evaluating interventions to better integrate screening and support systems across municipalities should be considered.

There is increasing community recognition that violence against women has been an entrenched tradition in many communities and requires assertive social change. Some of the main approaches to secondary intervention for violence against women include screening, advocacy, counselling and advocacy for safe refuge. A systematic review indicated that screening women in hospitals and community settings increased the identification of women experiencing physical, psychological or sexual interpersonal violence (IPV), although it was unclear how many women experiencing violence were not identified, nor whether some women identified were in fact not experiencing violence (Taft et al., 2013). There was some indication that screening was not associated with adverse effects; however, while more women were identified as experiencing violence through the screening process, the rate of referral to support agencies did not increase, nor was there a significant reduction in violence (Taft et al., 2013). This strongly highlights the need for screening interventions to be incorporated within a framework that provides clear direction and purpose to screening, and leads to increased referrals to effective services.

The women's refuge movement emerged from efforts to support, protect and advocate for women that were in immediate danger. Advocacy interventions are defined as the provision of information and support to facilitate increased access to legal, housing and financial advice, refuges/shelters, emergency housing, psychological interventions, and safe planning advice. Advocacy interventions are not prescriptive, rather, they are empowering women to set goals and find solutions (Ramsay et al., 2009). A meta-analysis of ten advocacy interventions found, that for women in refuges, intensive advocacy interventions (of 12 or more hours) appear to help terminate physical abuse one to two years later, but not before (Ramsay et al., 2009). Additionally, brief advocacy (less than 12 hours) appeared to increase the use of safety behaviours in women (Ramsay et al., 2009). Advocacy interventions included within the meta-analysis incorporated safety planning with women, and facilitating access to community resources including emergency housing, shelters, and psychological care (Ramsay et al., 2009). These results highlight the importance of advocacy interventions at a community and regional level for providing an effective means for assisting women experiencing violence with a way out. Given exposure to violence in childhood is a significant risk factor for later perpetration of violence (Corrales, 2015, p.195), advocacy interventions not only effect changes at a secondary prevention level, but may also be effective as a primary prevention approach.

Evidence that a number of women first experience violence during pregnancy has led to efforts to intervene during this period. There is a limited evidence base evaluating the efficacy of interventions designed to reduce violence against pregnant women. Three randomised trials evaluate the effects of home visitation programs for vulnerable pregnant women; the evidence is promising in that they to lead to a significant decrease in IPV in the first few years, particularly when conducted by a nurse. It is possible that the increased effectiveness of home visitation programs conducted by a nurse may be related to the specific focus on IPV. However, there is no evidence that these decreases are retained over a longer period of time (Van Parys, Verhamme, Temmerman, & Verstraelen, 2014), suggesting the need for these interventions to be coordinated with longer-term follow-up.

A number of studies have evaluated supportive counselling and psychological therapy designed to strengthen social networks and improve women's relationships with their partners; however, these have demonstrated few effects on IPV, other than some temporary reductions during the postpartum period when compared with women who received usual care (Jahanfar, Howard, & Medley, 2014; Van Parys et al., 2014). Most studies showed no significant effects, suggesting counselling and psychological interventions targeting pregnant women may have no efficacy for reducing incidences of IPV (Jahanfar et al., 2014; Van Parys et al., 2014). It is important to note, however, that there are few studies assessing interventions with pregnant women, and the low quality of published studies may have reduced the ability to observe true effects.

4. Reduce the pathways to violence associated with disadvantage. Effective interventions include programs that involve visiting vulnerable mothers during the prenatal, postnatal and early developmental stages of their child's life. Randomising places of disadvantage into service system interventions should be considered.

There is a strong evidence base supporting the implementation of secondary intervention at a community level, with some of the most promising programs being those that target frequent visits to the home to provide advice and support to vulnerable mothers and families. Programs of this type are typically delivered through local government within an extended maternal-child health system. Interventions in this area can include linkage to health and social services, maternal behaviour change to encourage healthy behaviour for the mother and child, prenatal and postnatal care of children, pre-school intellectual enrichment programs, and parent education programs (Brown & Putt, 1999, as cited in Fuller, 2015). Additionally, these programs have been shown to be cost-effective, partly due to the financial savings gained as a result of improved health and wellbeing of participants leading to a decreased need for other support (Fuller, 2015). Finally, effective programs for violence prevention in schools include peer influence strategies, teacher training and anti-bullying programs in schools (Brown & Putt, 1999, as cited in Fuller, 2015).

Community interventions designed to reduce the risk factors of community disadvantage and increase social capital may also be effective for reducing violence against women and children. Unfortunately very little evaluation has taken place; however, the limited evidence available suggests community interventions that focus on empowerment may be most effective for increasing social capital (see review on Social Inclusion).

5. Ensure effective approaches are adopted for the rehabilitation of violent offenders. Programs designed to rehabilitate violent offenders should reduce recidivism, and transparency and accountability regarding reductions in recidivism is important. First offenders should be a major focus of rehabilitation efforts, as early intervention with offenders has been shown to be more effective than later intervention. Interventions at this level must have adequate and coordinated follow through.

Evaluations of perpetrator programs have found mixed support for their effectiveness (Centre for Innovative Justice, 2015). However, ethical considerations and difficulties in the accurate measurement of effectiveness create difficulties in establishing strong empirical support for effectiveness of perpetrator programs, and so it is possible effects may be underestimated (Centre for Innovative Justice, 2015, p.36-38). Promising programs are those which include a swift criminal justice response to non-compliance, ongoing contact with the same judge and early entry into programs (Centre for Innovative Justice, 2015, p.38-39). Early entry into programs can include perpetrators who enter programs within 2-3 weeks of first contact with police, pre-trial involvement in programs, or men who self-refer before police intervention, suggesting that programs which focus on early and intensive (several sessions per week initially) intervention should be prioritised (Centre for Innovative Justice, 2015, p.38-39). Additionally, interventions designed for adolescent perpetrators show promise. Based on a meta-analysis of RCTs, Aggression Replacement Therapy with adolescent perpetrators has strong cost-effectiveness (Washington State Institute for Public Policy, 2015), and has been successfully implemented in an Australian setting.

Overall, there is a strong evidence base supporting the efficacy and cost-effectiveness of primary interventions for IPV that target key risk factors for violence early in the life course, and some evidence suggesting later prevention efforts are still effective. Additionally, interventions designed to reduce the risk factors for violence of disadvantage and alcohol consumption appear to also be key in reducing violence against women and children. Screening interventions show promise for improving the identification of women who are victims of IPV; however, a strong focus on converting this identification into referrals to support is needed. Advocacy interventions appear to be important for secondary prevention at a community level, particularly given even brief exposure (less than 12 hours) resulted in benefits. Interventions for perpetrators of violence that focus on early and intensive intervention are likely to be the most effective in preventing recidivism. It is clear that violence prevention at a community level needs to operate at a primary, secondary and tertiary level, with strong collaboration and integration of resources necessary for the successful targeting of a wide range of risk factors and key opportunities for change.

What are the major interventions that communities can implement to reduce youth violence?

Four main risk factors for youth violence have been identified: community inequality, family conflict and parenting risk factors, school risk factors and alcohol availability and early age alcohol use (J.W. Toumbourou et al., 2015). It is recommended that community intervention for youth violence should therefore target risk factors that have been identified as being elevated in that specific community (Hemphill & Smith, 2010, as cited in Toumbourou, 2015). Several programs designed to address these risk factors have been trialled and demonstrate effectiveness (J.W. Toumbourou et al., 2015).

Programs which address the risk factor of poverty and disadvantage include Pathways to Prevention, Moving to Opportunity, Mentoring, Neighbourhood Renewal and the Northern Territory National Emergency Response/Stronger Futures Policy, although there is limited evidence supporting this last program for reducing violence (J.W. Toumbourou et al., 2015). These programs range from collaborative partnerships, interventions and changes to infrastructure in socially disadvantaged communities, relocation of families from high poverty to low poverty neighbourhoods, and mentoring of high risk youth.

Programs designed to address family conflict and parenting include an Australian pre- and post- natal home visitation programs for at-risk mothers (Kemp et al. 2013, as cited in J.W. Toumbourou et al., 2015), and a program designed to build parent and child skills and health family interactions, which has shown effects on youth substance use and hostile or aggressive behaviour (Spoth & Redmond 2000, as cited in J.W. Toumbourou et al., 2015). Australian programs which incorporate formal parent training had consistent effects on verbal and physical violence (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press). Many of these programs included skill development and practice of skills, in line with WHO recommendations (2013), and were cost-effective (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press).

Programs designed to reduce school level risk factors include Kids Matter and Friendly Schools & Families, and aim to reduce behaviours that lead to school exclusion and disengagement (J.W. Toumbourou et al., 2015). Finally, programs designed to reduce alcohol-related violence include community mobilisation/ alcohol sales monitoring and alcohol entertainment precinct interventions, which aim to reduce violence through community-based monitoring of alcohol-related violence and risk factors (J.W. Toumbourou et al., 2015). Australian alcohol or drug-related interventions for adolescents which incorporated a focus on violence have shown mixed effects on alcohol or drug related harms (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press). It appears program length, teacher competence and interactive processes may increase program effectiveness (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press).

Most well researched preventative interventions for youth violence that have been identified as effective are based in school settings. The exception to this, Communities That Care, engages community stakeholders in creating a strategic community prevention plan to address risk factors for adolescents in the community. The program has been found to lead to decreases in risk factors and delinquency, and some research suggests it leads to decreases in violence behaviour in youth. Communities That Care has been implemented in diverse populations, and has demonstrated effectiveness in an Australian setting (J.W. Toumbourou et al., 2015).

There are many school-based preventative interventions for youth violence. School-based programs for the prevention of youth violence appear to be equally effective amongst both primary and secondary groups, and mixed sex or boys groups, in reducing aggressive behaviour, these reductions being retained 12 months later (Mytton, DiGuiseppi, Gough, Taylor, & Logan, 2006). Programs also appear to have an initial effect on school disciplinary actions for acts of aggression, although these effects are not maintained over time (Mytton et al., 2006). There is some evidence to suggest that interventions which focus on improving relationship and social skills are more effective than interventions which focus on teaching skills of non-response in provocative situations (Mytton et al., 2006).

Two well researched school prevention programs which have a focus on relationships and/or social skills are the Seattle Social Development Project, which has significant effects on violent delinquent acts in participants, and Caring School Community (formerly Child Development Project), which has not reported outcomes for violence or aggression. Three model programs combine both relationship/social skills approaches and self-control skills – Positive Action, Life Skills Training and Fast Track, all of which have demonstrated significant reductions in violence or aggressive behaviour.

The WHO (2014) found strong evidence supporting the effectiveness of school-based programs for the prevention of dating violence. One program that has been identified as a particularly effective program is Safe Dates, a combined school and community prevention intervention designed to reduce dating abuse through educating adolescents and equipping them with skills and resources. Safe Dates has been found to significantly reduce dating victimisation and perpetration in both Caucasian and culturally diverse populations, these effects being retained four years later. Rape awareness and education on self-defence strategies have been found to be ineffective, and confrontational rape prevention programs have been identified as possibly increasing the risk of perpetration, victimisation or negative changes in knowledge (WHO 2014).

Several programs designed to prevent or reduce violence in specific 'at-risk' populations through therapist-run intervention have also been found to be effective. Multi-systemic therapy significantly reduces delinquency and externalising behaviours in participants of different ages, ethnic backgrounds and in both genders. Treatment Foster Care Oregon is designed for places chronic delinquent youths in community foster care homes, and has been found to reduce delinquency and violent offenses in both genders and different ethnic groups. There have been questions raised regarding the cultural adaptability of this program to an Australian setting (Delfabbro, 2005); however, given it has been successfully implemented in the UK, there is preliminary support for the cultural adaptability of the program. Aggression Replacement Training and Functional Family Therapy are designed for delinquent youth, and have been found to significantly reduce further episodes of delinquency.

What are the major interventions that communities can implement to reduce violence in minorities?

An evaluation of interventions specific to particular minority groups is presented below. Unfortunately there is a scarcity of literature evaluating interventions in these minority groups. In terms of violence against women from minority groups, a rape prevention program has been evaluated with a racially diverse sample of college men (in the US), results identifying that culturally relevant treatment may be more effective than traditional treatment (Heppner, Neville, Smith, Kivlighan Jr, & Gershuny, 1999). Further evidence for this can be found in research identifying different pathways to sexual violence between Asian American and European American men (Hall, Sue, Narang, & Lilly, 2000). Research with Caucasian, African American and Latina women found some differences in seeking help from formal or professional support services for domestic violence, but these differences no longer exist when controlling for previous welfare receipt and number of abuse experiences (Postmus, 2015). Finally, a comprehensive review of emerging domestic violence literature with minority groups has identified several areas interventions with minority groups need to focus on (Sokoloff & Dupont, 2005).

Given there are many gaps in the literature for minority groups, evaluation of interventions designed to reduce key risk factors for violence is also likely to be effective. For example, community disadvantage and alcohol consumption are known risk factors for violence (J.W. Toumbourou et al., 2015), and so interventions designed to address these factors which have demonstrated effectiveness in minority groups may also have an effect on violence.

Children

Early childhood home visitation programs delivered by professionals (as opposed to para-professionals) show strong potential for prevention of child maltreatment (abuse or neglect) (Bilukha et al., 2005). Interventions designed to improve professionals awareness of and responses to violence against children show some promise, with some program effects on practitioner knowledge, attitudes and clinical competence, and some improvements in IPV identification and referral rates (Turner et al., 2015). However, effects on frequency of screening were inconsistent (Turner et al., 2015). Universal child abuse media campaigns also show some promise for reducing child abuse and increasing reports of child abuse to helplines, although the evidence for this is only preliminary at this stage (Poole, Seal, & Taylor, 2014). Finally, changes in mandatory reporting for child exposure to family violence has been found to lead to increased reporting of exposure to violence; however, a large proportion (31%) of these were not then referred for further assessment (Cross, Mathews, Tonmyr, Scott, & Ouimet, 2012). The WHO (2010) found that there is some support for programs designed for children and adolescents exposed to IPV or subjected to child maltreatment, and for school-based training to help children recognise and avoid sexually abusive situations.

Indigenous Australians

There is a scarcity in research regarding the effectiveness of interventions designed to reduce violence against and within the Indigenous Australian population. It is suggested that the most effective interventions for family violence within Indigenous populations will use culturally informed models, and with active and central participation of the Indigenous community (Andrew Day, Jones, Nakata, & McDermott, 2011; Memmott, 2015). Additionally, nurturing social capital in Indigenous communities has also been identified as essential for both primary and secondary prevention within these communities (Memmott, 2015).

Aged population

At this point in time, there is not a strong evidence base supporting any particular intervention for elder abuse (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009; World Health Organization [WHO], 2011). Concerns regarding screening for elder abuse have been raised in regards to the possibility of detecting false positives, the high possibility of abusive caregivers being present at professional appointments, and ethical concerns regarding the reporting of suspected abuse (WHO 2011).

A review of interventions aimed at older adults who have been abused, caregivers at risk of abusing older family members, and health professionals who provide care to older adults who have been abused found that recurrence of abuse did not reduce in response to intervention and in fact may increase in response to intervention (Ploeg et al., 2009). There is some evidence that the provision of combined legal and social services to elderly clients leads to a more significantly reduced mistreatment risk than the provision of social services alone; however, as this has not been tested using an experimental design caution needs to be taken as to the weight given these findings (Rizzo, Burnes, & Chalfy, 2015).

The World Health Organisation (WHO, 2011) reviewed evidence for the effectiveness of interventions designed to reduce elder abuse, finding mixed effects for professional awareness and education courses, legal, psychological and education support interventions, and restraint reduction programs. In terms of promising practice, interventions which may be effective include psychological programs for perpetrators, programs designed to effect changes in attitudes towards older people, programs designed to improve caregiver mental health, and, in the long-term, general strategies for preventing violence such as a life course approach (WHO 2011). The WHO (2011) recommend that whenever possible elder abuse interventions should be conducted within an evaluative framework that includes elder maltreatment and cost-effectiveness outcomes, and longer-term follow up. Community connectedness has been identified as a preventative factor for elder abuse (WHO 2011), and so it is possible social inclusion interventions may enhance the effectiveness of violence prevention interventions.

In regards to elder abuse by staff members employed in nursing and residential care facilities, training programs designed to promote positive attitudes towards older people and improve skills in preventing conflict with patients and coping with difficult behaviours, stress management and communication have shown some promise; however, no high quality studies have evaluated these programmes (WHO 2011).

GLBTIQ populations

No studies testing the effectiveness of interventions aiming to prevent the occurrence or reoccurrence of violence against or within GLBTIQ populations were identified. Three community interventions designed to reduce violence against lesbians that have been trialled involved increasing police responsiveness to violence against lesbians, increasing victim service agency awareness of lesbian and gay issues and advocacy for better legislation (Rose, 2003); however, there was no assessment as to effectiveness. It has been suggested that for violence within same-gender couples, interventions should aim to increase training and awareness of gay and lesbian domestic violence issues, development of appropriate response protocols for police and other enforcement agencies, increase collaboration between battered women's community groups and gay/lesbian community agencies, specifically target domestic violence education to the gay and lesbian community, and reduced gender focus of outreach and services for better inclusion of gay men (Kulkin et al., 2007).

Ethnic Minorities

There is a significant scarcity of literature evaluating the effectiveness of interventions designed to reduce violence against and amongst ethnic and racial minorities; however, what research there is suggests that culturally relevant intervention is more effective than more generalised approaches. Services for minority women exposed to violence need to be culturally competent, through provision of bicultural and bilingual services, special accommodations at shelters such as kosher food preparation (Sokoloff & Dupont, 2005). Additionally, addressing different stereotypes of women from minority groups is also important as these stereotypes can prevent women from particular minority groups from receiving equal treatment in the criminal justice system, particularly by police officers (Sokoloff & Dupont, 2005). It has been suggested that two sets of conditions are necessary for successful intervention with minority group victims of domestic violence (Sokoloff & Dupont, 2005). First, material resources need to be available for the most disadvantaged women to improve their opportunities for leaving or changing the immediate family violence situation. Second, organisations should monitor police, prosecutorial and judicial responses to minority victims of violence, and advocate for the particular needs of these marginalised communities.

In terms of interventions designed for perpetrators from minority groups, there is evidence that cultural differences may create different pathways to sexual violence (Hall et al., 2000). Unfortunately to our knowledge, differences specific to particular cultural groups in an Australian setting have not yet been evaluated. Research suggests that culturally relevant interventions for violence perpetration are more effective than more generalised approaches.

As previously outlined, there is some evidence that programs designed to reduce youth violence are also effective with ethnic and racial minority youths. An American program designed to specifically address violence amongst ethnic minority youth created centres in which ethnic minority youth were taken through a curriculum addressing academic development, personal development, family bonding, cultural enrichment, recreational enrichment and career development (Rodney, Johnson, & Srivastava, 2005). Risk of violence significantly reduced in children under the age of 12, but not in adolescents (Rodney et al., 2005). Academic performance and bonding to school were significant protective factors for adolescents in this program, suggesting academic support and increasing social capital in ethnic minority adolescents may be effective in reducing violence (Rodney et al., 2005). Additionally, there has been at least one dating violence program designed specifically for use with ethnic minorities in American that has demonstrated effectiveness (Peskin et al., 2014). The mixed success of these programs suggests some feasibility of interventions designed specifically with ethnic minorities in mind, but much more research is needed.

Disabilities

There is not a strong evidence base supporting current interventions for violence against persons with disabilities (Lund, 2011; Mikton, Maguire, & Shakespeare, 2014). There is some evidence that behavioural and cognitive interventions may be effective in teaching risk-reduction skills to adults with intellectual disabilities; however, whether this translates into reduced mistreatment has not been assessed (Lund, 2011). Of note, a significant gap between community members' and community programs' perceptions of accessibility of programs has been identified (Lund, 2011), suggesting that interventions targeting persons with disabilities may need to have a strong focus on accessibility.

What are the major interventions that communities can implement to reduce bullying?

A growing body of evidence supports the effectiveness of school-based bullying programs for reducing bullying perpetration and victimisation (Evans, Garner, & Honig, 2014; Ttofi & Farrington, 2011). Several program approaches have been identified as being more effective than other approaches, that is, programs which are long-lasting and intensive, include parent meetings or training, improve playground supervision, use firm disciplinary methods, include a whole school anti-bullying policy, use cooperative group work, use videos, and improve classroom management, teacher training and classroom rules (Ttofi & Farrington, 2011). Bullying programs which drew from the work of Dan Olweus, in which adults at school show warmth and interest in their students, set firm limits for unacceptable behaviour, use consistent non-hostile negative consequences for broken rules, and function as authorities and positive role models (Olweus & Limber, 2010) were also found to be more effective than other programs (Ttofi & Farrington, 2011). The inclusion to programs of engagement of peers in tackling bullying appeared to significantly increase rather than decrease the likelihood of victimisation (Ttofi & Farrington, 2011). Programs which operated in ethnically and racially homogenous samples appeared to be more successful than those with more heterogenous groups (Evans et al., 2014), and so adaptation of programs to better meet the needs of ethnically and racially diverse groups appears warranted.

Only four interventions designed to decrease bullying perpetration and victimisation in Australia have been identified in the peer-reviewed literature (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press). Three 'whole school' multicomponent interventions were found to have mixed effects, providing limited evidence of effectiveness for reducing perpetration and victimisation (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press). One indicated intervention consisting of multimodal group intervention targeting risk factors for bullying such as anxiety and self-esteem found some effects on bullying behaviour, although small size and high attrition limit the weight that can be given these results (E. Cox, Leung, R., Baksheev, G., Day, A., Toumbourou, J., Miller, P., Kremer, P, & Walker, A., in press). Notably, this program incorporated meetings with parents and cooperative group work, which have been identified as being more effective than other approaches (Ttofi & Farrington, 2011).

While there is a strong evidence base for school-based bullying programs, the evidence base for the prevention of cyberbullying is still in its infancy. There is limited evidence to suggest cyberbullying programs are effective (Della Cioppa, O'Neil, & Craig, 2015; Nocentini, Zambuto, & Menesini, 2015); however, few cyberbullying programs engage the wider school community, and it has been suggested that targeting the wider school community may lead to more effective cyberbullying programs (Della Cioppa et al., 2015).

TABLE 1

Summary of Included Studies

AUTHOR AND DATE	DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Women and Family Violence				
Ramsay et al. 2009	Meta-Analysis of RCTs	Ten advocacy interventions compared with usual care.	Physical abuse, quality of life, depression, psychological distress, safety behaviours.	Intensive advocacy (12+ hours) may help terminate physical abuse at 12-24 months, but not prior to 12 months. Intensive advocacy may improve quality of life, although confidence intervals include zero, but did not improve depression or psychological distress. Brief advocacy interventions (less than 12 hrs) appear to lead to an increased use of safety behaviours for up to 24 months.
De Koker, Mathews, Zuch, Bastien & Mason-Jones. 2014	Systematic Review of RCTs	5 school-based interventions (including 4 with community components), 1 community-based intervention for adolescent intimate partner violence (IPV).	IPV perpetration, IPV victimisation.	Two trials reported reduced perpetration of physical IPV in comparison to control groups, with one of these trials also reporting reduced perpetration of sexual and psychological IPV. One trial reported reduced IPV perpetration and victimisation. Three interventions found no effects on IPV in comparison to control groups.
Fellmeth, Heffernan, Nurse, Habibula & Sethi. 2013	Meta-Analysis of RCTs, cluster-randomised and quasi-randomised	Education and skill-based interventions for relationship and dating violence in young people. 38 studies in systematic review: 18 cluster-randomised, 2 quasi-randomised.	Episodes of relationship violence, attitudes, behaviour, knowledge and skills related to relationship violence.	No effectiveness on episodes of relationship violence or attitudes, behaviours and skills related to relationship violence. Small increase in knowledge; however, considerable heterogeneity among studies.
Jahanfar, Howard & Medley. 2014	Systematic Review of RCTs, cluster-randomised and quasi-experimental	Ten IPV interventions for pregnant women.	Episodes of IPV, prevention of violence during and up to 1 year after pregnancy, risk for pre-term delivery or low birth weight, depression during pregnancy and postnatal period.	One study found total number of women reporting IPV during pregnancy and after birth reduced in women receiving a psychological therapy intervention. Evidence regarding depression was inconsistent. Program effects on pre-term delivery and low birth weight were not found in the one study that reported on this.
Taft et al. 2013	Systematic Review of randomised or quasi-randomised trials	11 studies examining IPV screening compared with usual care.	Referrals to support agencies, identification of victims/survivors of IPV, occurrence of violence after screening, adverse effects of screening.	Rates of identification increased, particularly in antenatal settings, however rates of referrals were low. Only one study assessed adverse effects, finding no harm associated with screening.

AUTHOR AND DATE	DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Women and Family Violence				
Van Parys, Verhamme, Temmerman & Verstraelen. 2014	Systematic Review of RCTs	Nine IPV interventions for pregnant women.	Occurrence of IPV, mental health, postnatal depression, quality of life, miscarriage, low birthweight or early birth, adverse effects of intervention.	Some reduction in IPV in first few years for home visitation programs and some multifaceted counselling interventions; however, there was limited evidence for improvements in mental health, postnatal depression, quality of life, miscarriage, low birth weight or early birth. No studies reported adverse effects.
Youth Violence				
Mytton, DiGiuseppi, Gough, Taylor & Logan. 2009	Meta-Analysis of RCTs	34 school-based violence prevention programs.	Aggressive behaviour, school and agency responses to acts of aggression, violent injuries.	Aggressive behaviour reduced more significantly in intervention than no intervention controls at post-intervention, and 12 months follow up. Possible reduction in school disciplinary actions for acts of aggression, but not maintained. No information on violent injuries.
Violence against Children				
Cross, Mathews, Tonmyr, Scott & Ouimet. 2012	Review of research, policy and programming in Australia, Canada and US on child welfare response to exposure to IPV	Mandatory reporting, differential response.	Number of cases reported, response to cases reported.	At time of report, only 3 of 8 jurisdictions in Australia include exposure to domestic violence (EDV) as maltreatment type which must be reported. Increased number of EDV reported, 31% of reports of EDV in NSW were not referred for further assessment, no statistics regarding Victoria.
Bilukha et al. 2005	Systematic review of early childhood home visitations for preventing violence	Four early childhood home visitation.	Violence by the child, violence by the parent, IPV, child maltreatment.	Insufficient evidence to support the efficacy of early childhood home visitation for violence by child, parent (excluding child maltreatment) or IPV. Strong evidence suggesting early childhood home visitation programs are effective in preventing/reducing child maltreatment.
Poole, Seal & Taylor. 2014	Systematic review of universal child physical abuse campaigns	15 universal child physical abuse campaigns.	Child abuse outcomes, child behaviour problems, dysfunctional/ coercive parenting behaviours, reports to helplines, parents/ community members implementing campaign strategies, attitudes, knowledge.	Reduction in child abuse outcomes, decreased child behaviour problems and dysfunctional/coercive parenting, increased reports of child abuse to helplines, campaign strategies implemented by community/parents, only one study reported significant improvement in attitudes regarding child abuse prevention, significant increases in knowledge.
Turner et al. 2015	Systematic review of interventions to improve response of professionals to children exposed to domestic violence	21 interventions designed to improve knowledge and responses of professionals.	Knowledge, attitudes towards domestic violence and abuse, clinical competence, screening practice, IPV identification rates, referral rates.	Some effects on knowledge, attitudes and clinical competence. Inconsistent effects on screening. Some effects on IPV identification and referral rates.

AUTHOR AND DATE	DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Violence against the Ageing Population				
Rizzo, Burnes & Chalfy. 2015	Systematic evaluation	Multi-disciplinary social work-lawyer elder mistreatment intervention.	Retention, mistreatment risk.	Clients pursuing combined legal and social services more likely to have reduced mistreatment risk than those pursuing social services only.
Ploeg, Fear, Hutchison, MacMillan & Bolan. 2009	Systematic Review of interventions	8 interventions for elder abuse.	Recurrence of abuse, case resolution, knowledge of elder abuse, awareness of services, perpetrator risk factors, professional knowledge and attitude.	Insufficient evidence to support any intervention for elder abuse.
Violence against people with disabilities				
Mikton, Maguire & Shakespeare. 2014	Systematic review of studies	10 interventions to prevent and respond to violence against persons with disabilities.	Risk or protective factors for violence.	Some effects found; however, when risk of bias accounted for, no interventions were found to be effective.
Lund. 2011	Systematic review of studies	10 community based services and interventions for adults with disabilities who had experienced IPV.	Program accessibility.	Some evidence behavioural and cognitive interventions may be effective in teaching risk-reduction skills to people with ID. Notable gap between service programs' perceptions of accessibility and community members' perceptions.
Violence against ethnic minorities				
Rodney, Johnson & Srivastava. 2005	Pre-post intervention	The Family and Community Violence Prevention Program.	School achievement, school bonding and violence risk assessment.	Violence risk significantly decreased in children under the age of 12.
Peskin et al. 2014	Group randomised trial	It's Your Game… Keep it Real Program.	Emotional and physical dating violence victimisation and perpetration.	Control significantly more likely to experience physical or emotional victimisation, and significantly more likely to be perpetrators of emotional dating violence. No significant differences in violent victimisation.
Bullying				
Nocentini, Zambuto & Menesini. 2015	Systematic review of interventions	13 prevention and interventions studies conducted in a virtual environment.	Bullying and cyberbullying behaviour.	Only 4 programs showed effects on reduction of bullying and cyberbullying.
Ttofi & Farrington. 2010	Meta-analysis of studies	44 school-based bullying programs.	Bullying, victimisation.	Bullying and victimisation significantly decreased.
Cioppa, O'Neil & Craig. 2015	Systematic review of programs	12 cyberbullying intervention programs.	Rates of bullying and victimisation, ease of implementation.	Five of 12 studies reported decrease in victimisation, half of the studies reported decreased cyberbullying perpetration. Most programs included facilitator training and appropriate assessment measures; however, many programs were not manualised and only 3 provided ongoing maintenance and support.
Evans, Fraser & Cotter. 2014	Systematic review of bullying interventions	24 controlled trials of school-based bullying interventions.	Bullying and victimisation.	Half the included studies found the intervention had a significant effect on bullying perpetration and over half had a significant effect on victimisation.

TABLE 2

Summary of Model Programs from Blueprints and Washington Institute for Public Policy.

PROGRAM	SETTING	UNIVERSAL	AGE RANGE	DELIVERY	EVALUATION EVIDENCE	AUSTRALIAN BASED PROGRAMS	PROBABILITY BENEFITS WILL EXCEED COSTS
Multisystemic Therapy	Family and community-based	No: indicated prevention (early symptoms of problem)	12–18	Therapist	Strong evidence for effectiveness. Program leads to lower delinquency and externalising behaviours. Effective for both genders, equally effective with different ages and ethnic backgrounds.	Yes	88%
Treatment Foster Care Oregon	Community families	No: indicated prevention	12–18	Therapist	Strong evidence for effectiveness. Program leads to lower delinquency and violent offenses. Effective for both genders, and for all ethnic groups.	No, and some questions have been raised as to its suitability to Aus. context	65%
Communities That Care	Community	Yes	0–22	CTC trainers and community stakeholders	Program led to decreases in delinquency and risk factors, violent behaviour decreased in year 10 students. Has been implemented in diverse populations.	Yes	59%
Safe Dates	Community, school	Yes, and selective and indicated prevention	12–14	Teachers, health educators, community resource people	Reduced victimisation and perpetration, retained 4 years later. Equally effective for Caucasians and culturally diverse populations.	Yes	Not assessed
Positive Action	School	Yes	5–14	Principal, teachers	Reduced violence in 5th & 8th graders. More effective in 5th grade boys than girls	No	87%
Lifeskills Training	School	Yes	12–14	Teachers	Significant reductions in delinquency, high-frequency fighting and high frequency delinquency at 3 months follow up. Effective with white, middle class, suburban and rural youth, and economically disadvantaged urban minorities.	No	62%
Seattle Social Development Program	School	Yes	Grades 1–6	Teachers	Program participants significantly less likely to have committed violent delinquent acts than control group participants at 18 years of age (6 years post program).	No	65%
Caring School Community	School	Yes	Primary schools	Schools	Reduces substance abuse, but no reports of reduced violence	Yes	60%
Fast Track Prevention Program	School and family	No	Grades 1–10	School	Significantly reduced crime and aggressive behaviour.	No	0%
Functional Family Therapy	Family	No	11–18	Therapist	Significantly reduced delinquency	No	99%
Aggression Replacement Training	Group	No	Adolescents	Therapist	Significantly reduced delinquency	Yes	94%
Functional Family Parole	Family	No	11–18	Therapist	Significantly reduced delinquency	No	75%

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APPENDIX F: DETAILED LITERATURE REVIEWS

Eastern Region (EMSIC) Social Inclusion and Community Connectedness: a rapid systematic literature review

Bethany Devenish[3,4]

Email addresses:

BD: bethany.devenish@deakin.edu.au

Abstract

Background

'Social inclusion' and community connectedness refer to the experience that people are able to participate in key areas of the economic, social and cultural life of their community. The inverse of this, 'social exclusion', is a multi-dimensional process, resulting from unequal power relationships at individual, household, group, community, country and global levels, that reduces the quality of life of individuals and community cohesion. Community connection and social capital refers to people having meaningful social ties. The experience of social inclusion and exclusion can vary significantly for individuals, groups and communities across time and in different contexts, leading to the possibility that collective efforts may deliberately modify these community characteristics over time. People who experience multiple disadvantages are most at risk of experiencing increased social exclusion. Multiple disadvantages that may lead to social exclusion include school failure, child and adolescent behaviour problems, unemployment, old age, single parenthood, being a member of a minority group (particularly if recently migrated or in a linguistically/culturally isolated group), long-term sickness and disability, mental health problems and learning difficulties. Social inclusion and community connection may increase feelings of belonging and wellbeing, and may also lead to improved physical health and decreased risk for medical and community health intervention. The report that follows was completed as part of a Deakin University consultancy to the Eastern Metropolitan Social Issues Council (EMSIC) with the objective of reviewing literature evaluating community efforts to improve social inclusion and community connectedness and reduce social exclusion.

Method

Given the limited time frame, a rapid systematic review was conducted. The review was directed by a scoping document (23 June 2015) approved by EMSIC Social Inclusion Advisory Group. To identify relevant papers, four electronic databases were searched for interventions evaluating social inclusion. A lateral search was also undertaken of references found in several key papers and reviews. The review focused on evaluations of community interventions.

Results

We summarised results from 23 studies. There were few studies evaluating social inclusion interventions, and those identified were of limited quality. There is evidence from randomised community trials that positive youth development programs may lead to increased civic engagement (volunteering) and lead to benefits in reducing health and social problems at a population level over time. There was some evidence suggesting social inclusion interventions that focus on empowerment may have benefits. Social inclusion interventions in disadvantaged communities addressing community safety may be important for increasing social inclusion.

Conclusion

Overall, there is some support from small studies for the potential for community intervention to increase social inclusion in participants. It is unclear, however, whether community interventions aimed at increasing social inclusion may have benefits for the wider community due to a scarcity of research assessing this. There appeared to be a possible trend towards increased effectiveness of interventions that focus on empowerment and there was some evidence to suggest that interventions may have reduced effectiveness if key risk factors such as community safety are not addressed.

The following recommendations are made based on evidence from the present review and also from the related review examining violence in vulnerable communities (Devenish, 2015).

[3] School of Psychology, Faculty of Health, Deakin University, Burwood.
[4] Consulting Group, Faculty of Health, Deakin University, Burwood.

Recommendations

1) (See related recommendation 4 related to Violence in Vulnerable Communities, Devenish, 2015).
Develop a regional strategy to reduce the pathways to social exclusion associated with place-based disadvantage. Effective interventions include programs that involve visiting vulnerable mothers during the prenatal, postnatal and early developmental stages of their child's life. The Strengthening Families intervention works with vulnerable families in contexts such as disadvantaged primary schools and has a track record in reducing pathways to violence, while also strengthening social inclusion. Tutoring and mentoring for children can offer protective effects, while encouraging volunteering opportunities that can increase social connection and bridging social capital (supportive relationships between people with and without resource advantages). Randomising places of disadvantage into service system interventions should be considered to contribute to enhanced evaluation.

2) (See related recommendation 6 related to Violence in Vulnerable Communities, Devenish, 2015).
Adopt a common regional instrument to monitor social inclusion in vulnerable sections of the community that may be at risk due to issues that include old age, being a member of a minority group (particularly if recently migrated or in a linguistically/culturally isolated group) and disability. Social inclusion can be improved by adopting policies and service delivery approaches aimed at ensuring equitable access to community resources. It is unclear whether interventions for increasing social inclusion within these minority groups are effective; however, there did appear to be some evidence that social inclusion interventions that were framed within a participatory and/or empowerment approach may be more effective. Policies and procedures across all community organisations that are built on an awareness of the unique challenges different minority groups may face in accessing community resources should be adopted and monitored to ensure that individuals are able to participate in key areas of the economic, social and cultural life of their community. Responding based on ongoing monitoring of social inclusion in samples from targeted minority groups may be a feasible means of developing a system that can ensure social inclusion in these diverse groups.

3) Implement a regional strategy to increase volunteering rates across the community in areas that address EMSIC priorities such as decreasing violence, place-based disadvantage and the experience of social exclusion of minority groups. Volunteering has been shown in randomised trials to hold a range of health and social benefits. Beneficial action approaches argue that population-wide improvements can be maximised where volunteers are trained in strategically planned and evidence-based activities. Given more evidence is required in this area, randomised trials evaluating volunteering program effects on social inclusion in the Eastern Region should be designed. This should be evaluated using a randomised trial comparing different geographic areas. The target measures should include increasing volunteering, sense of community and reducing experiences of social isolation in monitoring surveys of target minority samples.

EMSIC project introduction

The Eastern Metropolitan Social Issues Council (EMSIC) was established to better integrate and align joint regional efforts in prevention and intervention of key social issues in Melbourne's Eastern Metropolitan Region[5]. EMSIC is a voluntary collaboration between senior executives from organisations involved in key aspects of public value to the Eastern Metropolitan Region, which includes the local government areas of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and the Yarra Ranges. Stakeholders include non-government organisations (NGOs), Commonwealth, state and local governments, Eastern Health, academia and industry. EMSIC aims to promote the optimal underlying conditions for enhancing collective regional efforts to maximise the regional populations' safety, wellness, fulfilment, engagement, connection, and economic means and prosperity. To achieve this, EMSIC works to identify significant regional social issues, and form impact measures, evaluate the existing evidence base, map and analyse existing programs and efforts, and decide on and motivate collective action regarding these regional social issues.

In planning activities in 2014/15, EMSIC identified two priority areas for the region, being **Social Inclusion and Violence in Vulnerable Communities**[6]. In order to inform EMSIC's approach to these issues, Deakin University were appointed as research consultants to produce a detailed report reviewing current work, identifying partnership approaches and making recommendations for future opportunities, including the implementation of evidence based interventions that provide significant opportunity for regional integration and coordination to reduce service gaps, duplication and disproportionate servicing in specific localities.

[5] 2015 Eastern Metropolitan Issues Council: Terms of Reference
[6] 2015 Eastern Metropolitan Issues Council: Priority Issues Identification Advisory Committee Progress Report

This report presents a component of a larger body of work, being a rapid systematic review of research programs that focused on the priority area of addressing social inclusion and community connectedness. This priority broadly reflects EMSIC member concerns with social exclusion and marginalisation of specific populations, and the need for cultural inclusion and social harmony4. The review was directed by a scoping document (23 June 2015) approved by the EMSIC Social Inclusion and Community Connectedness Advisory Group. The review aimed to provide an evaluation of existing high-quality evidence regarding interventions that

(i) reduce the negative social impacts of place-based disadvantage and increase the social inclusion of minority groups

(ii) can be incorporated in a public health framework and

(iii) demonstrate feasibility for implementation within a regional context.

Method

An initial search strategy and scoping document was prepared by Prof. John Toumbourou and circulated to members of the EMSIC Social Inclusion Advisory Group on 18 June 2015. This included four main focal areas:

1. Investigation of indicators and interventions to reduce place-based disadvantage and social economic exclusion.

   What are the major interventions that communities can implement to reduce place-based disadvantage and its negative social impacts?

   To what extent do effective interventions encourage and address bridging social capital (social connections between diverse SES groups)?

2. Investigation of indicators and interventions to ensure social inclusion and reduce social isolation in disabled and aged populations.

   What are the major interventions that communities can implement to increase social inclusion and reduce social isolation for disabled and aged populations?

3. Investigation of indicator and interventions to ensure social inclusion and valuing diversity for minorities including Culturally and Linguistically Diverse (CaLD), Indigenous and Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (GLBTIQ) populations.

   What are the major interventions that communities can implement to increase social inclusion and reduce social isolation for minority populations?

4. Investigation of indicator and interventions to ensure participation in building social capital.

   What are the major interventions that communities can implement to increase social capital?

To identify relevant papers, four electronic databases were searched: PsycInfo, Academic Search Complete, Social Work Abstracts and SocINDEX. A lateral search was also undertaken of references found in several key papers and reviews.

Five searches were conducted in June 2015 in order to address the above key questions. Search strings were created by combining related terms using OR and connecting key concepts using AND (see Appendix A). All searches were limited to 1990 onwards and to peer-reviewed journals. To be included in the review, studies needed to contain an evaluation of a community intervention. A total of 47 articles were screened by full text, with a total of 23 articles meeting inclusion criteria. A summary of included studies can be found in Table 1.

An introduction to Social Inclusion and Community Connectedness

A great deal of literature has explored the concepts of social inclusion and community connectedness. In what follows a brief summary is provided relevant to how these constructs have been incorporated into frameworks for community interventions (the focus of the present review).

Ecological framework for social inclusion

'Social inclusion' and community connectedness refer to the experience that people are able to participate in key areas of the economic, social and cultural life of their community (Boardman, 2010, p10). 'Social exclusion' refers to social experiences and perceptions of isolation and rejection that reduce the quality of life of individuals and community cohesion. The processes that lead to social exclusion are multi-dimensional and involve interactions between economic, political, social and cultural domains, across the various ecological levels of individual, household, group, community, country and global influences (Taket, 2014, p.3). Effective regional social inclusion strategies will likely result from a framework that: (i) addresses the full scope of economic, social and cultural dimensions of social inclusion; (ii) aligns with national and global efforts to increase social inclusion; (iii) involves collaboration between community agencies to effect changes at the community and group level, while also where possible encouraging social capital (meaningful social ties) at an individual and household level; and (iv) encourages a shift in overall culture through addressing social inclusion across all community and organisational policies, procedures, service design and delivery (as opposed to limiting social inclusion efforts to individual interventions) (Crisp, 2014, p.250).

Results and discussion

Place-based disadvantage

Positive youth development, healthy child development: Given very few interventions designed specifically to reduce place-based disadvantage have been conducted, research evaluating the pathways between place-based disadvantage and poorer outcomes provide some indication of where prevention efforts may be most effective. There was sound evidence from two randomised trials that positive youth development programs can reduce risk factors (such as school failure and substance abuse) in places of disadvantage that would otherwise lead to the inter-generational continuation of poverty (LoSciuto, Freeman, Harrington, Altman, & Lanphear, 1997; LoSciuto, Hilbert, Fox, Porcellini, & Lanphear, 1999; LoSciuto, Rajala, Townsend, & Taylor, 1996). A randomised controlled trial of the Across Ages project, a school- and community-based program that aimed to assist disadvantaged middle school students by increasing social relationship skills, service learning in aged care and mentorship involving the pairing of older (age 55 plus) adult mentors with young adolescents, led to decreases in drug use and increases in future optimism (LoSciuto et al., 1996). A randomised community trial involving a 2-year longitudinal follow-up of school-age youth involved in the Woodrock Youth Development Project, a multicomponent community- and school-based program designed to assist youth in disadvantaged schools to develop social, emotional and academic skills and access community opportunities, demonstrated reduced substance use, improved social capital and community cohesion (better race relations, increased social trust and tolerance), and increased school attendance (LoSciuto et al., 1997; LoSciuto et al., 1999).

There is a strong evidence base suggesting much of the negative effects of both family and community socio-economic status on children and adolescents can be explained through the effects of economic stress on parenting, parent depression and parent conflict (Devenish, 2015). Violence prevention interventions that target parent risk factors associated with place-based disadvantage have demonstrated improved outcomes. Some of the most promising programs are those that target frequent visits to the home to provide advice and support to vulnerable mothers and families. Programs of this type are typically delivered through local government within an extended maternal-child health system.

Interventions in this area can include linkage to health and social services, maternal behaviour change to encourage healthy behaviour for the mother and child, prenatal and postnatal care of children, pre-school intellectual enrichment programs, and parent education programs (Brown & Putt, 1999, as cited in Fuller, 2015). Additionally, these programs have been shown to be cost-effective, partly due to the financial savings gained as a result of improved health and wellbeing of participants leading to a decreased need for other support (Fuller, 2015).

The Strengthening Families intervention works with vulnerable families in contexts such as disadvantaged primary schools, has been successfully implemented in an Australian setting, and has a track record in reducing pathways to violence, while also strengthening social inclusion (see the violence review: Devenish, 2015). Tutoring and mentoring for children can offer protective effects, while encouraging social connection and bridging social capital (see the positive youth development strategies described above).

Finally, qualitative data suggests some feasibility of sports-based social inclusion programs for increasing social mobility and social inclusion in disadvantaged youths by integrating sports with education and development of life skills (Spaaij, 2009).

Neighbourhood redesign: There was limited and conflicting evidence regarding other interventions designed to reduce place-based disadvantage using neighbourhood redesign. Three interventions were identified that aimed to reduce place-based disadvantage using neighbourhood redesign strategies (Blackman, Harvey, Lawrence, & Simon, 2001; Jalaludin et al., 2012; Petticrew, Kearns, Mason, & Hoy, 2009). One neighbourhood renewal intervention was Australian-based, and so are highly relevant to the Eastern Region (Jalaludin et al., 2012). The other neighbourhood renewal interventions were based in the UK, and so are likely to have relevance for the Eastern Region (Blackman et al., 2001; Petticrew et al., 2009). Given the limited research specific to social inclusion, the findings of interventions designed to address place-based disadvantage were reviewed for possible relevance.

In general, the interventions that were implemented at a regional level to address place-based disadvantage through urban renewal programs (Blackman et al., 2001; Jalaludin et al., 2012) had limited evidence supporting their effectiveness. Given the high expense associated with these interventions, these should not be implemented in the future without a sound evaluation. A focus on social interventions did not lead to improvements (Jalaludin et al., 2012), while a focus on physical structures led to limited benefits (Blackman et al., 2001). It is important to note that while perceived safety increased as a result of structural changes in the community, perceived cohesion did not, and so it is unclear whether an intervention designed to improve both safety and social inclusion simultaneously would have led to more significant improvements.

Pre-post evaluation of an urban renewal program in the UK, involving environmental improvement, renovation grants, and improvements in security and road safety, found significant reductions in smoking, and a significant improvement in the mental health of both adults and children in the community but no improvements in respiratory health or use of health services (Blackman et al., 2001). Perceptions of safety and burglary rates improved significantly in response to the program, however more respondents reported 'poor community spirit' after the intervention than before (Blackman et al., 2001).

In contrast, pre-post evaluation of an urban renewal program in a public housing community in Sydney was found to have no significant effects on household perceptions of safety and aesthetics or other health outcomes including BMI, physical activity, hazardous alcohol consumption and psychological distress eight months after the program had been conducted (Jalaludin et al., 2012). The urban renewal program included internal and external upgrades to properties, in addition to social interventions such as community engagement activities (family fun days, street picnics), learning and employment programs, and community meetings (Jalaludin et al., 2012). This difference is notable, given the specific focus on social interventions did not lead to a significant changes in one community (Jalaludin et al., 2012), while a focus on physical structures in the other did lead to improvements (Blackman et al., 2001).

There are several possible explanations for the limited benefits of urban renewal. First, unlike the positive youth development interventions, the neighbourhood renewal interventions failed to target the inter-generational causes of disadvantage in areas such as child neglect and abuse, school failure and youth substance abuse.

Second, the effects of the urban renewal interventions may have been enhanced, depending on what components were included. These interventions had the potential to improve community safety and public health, where evidence-based interventions to address these were included. Improvements in mental health are associated with significant increases in perceptions of safety and may need to be targeted in intervention plans (Blackman et al., 2001). Targeting issues such as community violence would fit with research suggesting neighbourhood characteristics such as violence and perceived safety mediate the association between community socio-economic status and negative health and psychological outcomes (Meyer, Castro-Schilo, & Aguilar-Gaxiola, 2014; Timperio, Veitch, & Carver, 2015). It is therefore possible that in order to improve sense of safety and community connection it may be necessary to target community violence and improved mental health outcomes in disadvantaged communities.

Third, disadvantage is unlikely to be solely the product of community influences, and so other determinants of wellbeing, such as inadequate national and state policies that reduce income, education and mental health may also reduce the effectiveness of community interventions if not addressed simultaneously. In order to evaluate what community interventions add above and beyond national and state policies, evaluations need to include community control groups. Notably, both urban renewal interventions lacked a control group, and so it is unclear whether some effects were due to factors outside of the community intervention context.

Between-groups evaluation of the effects of new public housing found tenants who moved into new public housing had more significant improvements in psychosocial outcomes such as status, identity and sense of progress compared with other public housing residents who did not move; however, no significant differences were found between these two groups in terms of changes in health, loneliness or mental health outcomes (Petticrew et al., 2009). Access to a garden was associated with improvements in mental health and social functioning, and it appeared that older people may experience reduced mental health and wellbeing in response to moving house (Petticrew et al., 2009). In-depth interviews with a sample of the residents who moved suggested that relocating did not have a negative effect on social relationships, and in fact may have led to a slight increase in connecting with neighbours (Kearns, 2008). Additionally, sense of belonging, cohesion, empowerment, perceptions of safety and collective efficacy increased significantly over time, particularly for those who had moved from a flat to a house, amongst both those who had moved and the control group (Kearns, 2008). Neighbourhood improvements had a trend towards association with sense of cohesion, safety and collective efficacy (Kearns, 2008).

Community mobilisation: There was some evidence that community mobilisation for neighbourhood renewal may be effective in reducing place-based disadvantage for those involved in the mobilisation, but not for the wider community (Kelaher, Warr, & Tacticos, 2010). Neighbourhood renewal is designed to establish partnerships between local agencies and residents and encourage the sharing of resources to reduce place-based disadvantage (Kelaher et al., 2010). Each area designs an action plan designed to increase community pride and participation, and tackle housing, environment, employment, education, local economy, crime and safety, health and wellbeing, and access to services (Kelaher et al., 2010). A between-groups evaluation of a community-based participatory neighbourhood renewal has not demonstrated area benefits for health status and life satisfaction, but has had significant benefits in health status and life satisfaction of community members who participate in the intervention (Kelaher et al., 2010). Unfortunately it was unclear what the key focus of interventions included in the analyses were. It is possible that design elements of the action plans in the included communities reduced the potential for wider area benefits but, given the lack of information provided, this cannot be further explored. It is important to note that designed interventions were not as effective for immigrants from non-English speaking countries, adults with an education below year 10 level and unemployed community members (Kelaher et al., 2010). Community interventions may need to be adapted to better target these groups.

The information outlined above leads to the following recommendations:

Reduce the pathways to social exclusion associated with place-based disadvantage. Develop a regional strategy to reduce the pathways to social exclusion associated with place-based disadvantage. Effective interventions include programs that involve visiting vulnerable mothers during the prenatal, postnatal and early developmental stages of their child's life. The Strengthening Families intervention works with vulnerable families in contexts such as disadvantaged primary schools and has a track record in reducing pathways to violence, while also strengthening social inclusion. Tutoring and mentoring for children can offer protective effects, while encouraging volunteering opportunities that can increase social connection and bridging social capital (supportive relationships between people with and without resource advantages). Randomising places of disadvantage into service system interventions should be considered to contribute to enhanced evaluation.

Targeted interventions for vulnerable populations

Seven studies examined interventions designed to reduce social isolation of the aging population (Bartlett, Warburton, Lui, Peach, & Carroll, 2013; Clarke, Clarke, & Jagger, 1992; C. C. Collins, 2006; Crane-Okada et al., 2012; Routasalo, Tilvis, Kautiainen, & Pitkala, 2009; Stevens, Martina, & Westerhof, 2006; Stewart, Craig, MacPherson, & Alexander, 2001). All studies were conducted in diverse groups within western nations, and so results are generalisable to the Eastern Region. These involved individualised support and group strategies as described below.

Individualised support: Randomised controlled trials found that individualised support did not lead to significant increases in social support or perceived loneliness of elderly people living in England (Clarke et al., 1992) or social support in older women after breast cancer surgery (Crane-Okada et al., 2012).

Group interventions: Group interventions with the elderly led to mixed results. A number of community based group interventions have been evaluated, including an educational intervention (C. C. Collins, 2006) and friendship/community support groups (Bartlett et al., 2013; Martina & Stevens, 2006; Routasalo et al., 2009; Stevens et al., 2006; Stewart et al., 2001). Pre-post evaluations of a community based educational intervention found significant reductions in loneliness, particularly in elderly participants from ethnic minorities (C. C. Collins, 2006), however friendship and community support group interventions did not significantly reduce loneliness, including results from a randomised controlled trial (Bartlett et al., 2013; Martina & Stevens, 2006; Routasalo et al., 2009; Stevens et al., 2006; Stewart et al., 2001). The study in which a reduction in loneliness was observed did not include a control group (C. C. Collins, 2006) and so results need to be treated with caution. Significant changes in perceived social support were observed in a pre-post evaluation of a support group for widows (Stewart et al., 2001), but other studies did not find significant increases in social support (Bartlett et al., 2013; Routasalo et al., 2009), despite an increase in the number of reported friends observed in a randomised controlled trial (Routasalo et al., 2009).

Research utilising semi-structured interviews found a friendship enrichment program for women led to significant increases in quantity and quality of friendships, improved attitudes towards playing an active role in relationships, and improvements in subjective wellbeing (Martina & Stevens, 2006).

Overall, it would appear that there is limited support for interventions designed to reduce social isolation of the elderly; however, the low quality of studies found mean effects may have been missed. Notably, no intervention attempted to increase community participation or connections of the elderly with younger age groups.

Mentoring: Only two studies were identified that tested whether interventions could increase social inclusion for disabled populations, both of which aimed to provide mentoring or increase skills of people with disabilities (Chng, 2013; Raghavendra, 2013). Results from both studies are relevant to the Eastern Region; however, there was limited community impact, and so, given both interventions require a significant outlay of time due to the need for one-on-one training, these should not be implemented without a solid evidence base. Training of mentors based in mainstream retirement groups in Australia was found to significantly increase activity and total engagement of three older women with intellectual disabilities, but not increase social engagement (Chng, 2013). However, given the limited verbal ability of the women, it is possible that the method with that social engagement was scored did not accurately reflect social inclusion (Chng, 2013). All three women displayed higher levels of activity engagement in a social context, and were attending the groups 24 months later (long after data collected ceased), suggesting social inclusion was achieved (Chng, 2013). Training of Canadian youth with cerebral palsy, physical disability or acquired brain injury to assist in using the internet to build social networks has also been trialled, pre-post evaluation identifying significant improvements in performance and satisfaction with internet use (Raghavendra, 2013). Interviews with the youth found that internet accessibility led to strengthening of current relationships, and for some, the development of new friendships (Raghavendra, 2013).

Participatory intervention: There is limited evidence for community interventions from racial or cultural minority groups. Some support was found for participatory interventions with racial/cultural minority groups; however, this was on the basis of one low quality study, and so this approach should not be implemented without a stronger evidence base. Community Health Workers met with community members on a regular basis to collaborate with the community regarding which health issues to prioritise, and to design interventions (Michael, Farquhar, Wiggins, & Green, 2008). A pre-post evaluation found significant increases in perceived social support in Latino and African American communities in the United States (Michael et al., 2008). Given there was only one study identified, and the study was not based in Australia, results must be interpreted with caution. However, given an Australian study mentioned previously found community-based participatory interventions led to improved outcomes in community members who participated in the intervention (Kelaher et al., 2010), there is some preliminary support for this design.

Of particular note, the community-based participatory design of the Australian study had reduced effectiveness in minority populations (Kelaher et al., 2010), yet when utilised with a specific focus on minority groups in America it was found to increase perceived social support (Michael et al., 2008). It is therefore possible that adapting the design to specifically target minority populations in Australian communities may lead to increased effectiveness in these populations.

In overview the evidence summarised above revealed there is no intervention strategy or evaluation study that can be said to have superior evidence for reducing social isolation and exclusion in vulnerable groups. Given this situation, it is important that innovative intervention strategies continue to be developed and carefully evaluated. The included evaluation studies do provide some valuable directions as to how social isolation and exclusion might be assessed and monitored with measures including sense of community (O'Connor, 2013), social support (Michael, Farquhar, Wiggins, & Green, 2007) and loneliness (Stewart, Craig, MacPherson, & Alexander, 2001). If EMSIC were to agree on a common regional instrument (indicator measure) to monitor social inclusion and exclusion in vulnerable sections of the community that would provide a valuable foundation for evaluation efforts across a variety of organisations and sub-populations including older aged populations, recently migrated or CaLD groups, and people with a disability.

The information outlined above leads to the following recommendations:

(See related recommendation 6 related to Violence in Vulnerable Communities, Devenish, 2015). Adopt a common regional instrument to monitor social inclusion in vulnerable sections of the community that may be at risk due to issues that include old age, being a member of a minority group (particularly if recently migrated or in a linguistically/culturally isolated group) and disability. Social inclusion can be improved by adopting policies and service delivery approaches aimed at ensuring equitable access to community resources. It is unclear whether interventions for increasing social inclusion within these minority groups are effective; however, there did appear to be some evidence that social inclusion interventions that were framed within a participatory and/or empowerment approach may be more effective. Policies and procedures across all community organisations that are built on an awareness of the unique challenges different minority groups may face in accessing community resources should be adopted and monitored to ensure that individuals are able to participate in key areas of the economic, social and cultural life of their community. Responding based on ongoing monitoring of social inclusion in samples from targeted minority groups may be a feasible means of developing a system that can ensure social inclusion in these diverse groups.

Civic engagement

There is evidence that communities can use positive youth development frameworks to increase community rates of civic engagement and volunteering. There is less evidence that whole of community social capital interventions are effective.

Increasing youth civic engagement: In the systematic review by Catalano, Toumbourou, and Hawkins (2014), evidence was synthesised across a range of randomised trials suggesting that communities can use coordinated strategies to increase positive youth characteristics such as civic engagement and volunteering. For example, the Across Ages project, a school- and community-based program that aimed to assist disadvantaged middle school students by increasing social relationship skills, service learning in aged care and mentorship involving the pairing of older (age 55 plus) adult mentors with young adolescents (LoSciuto et al., 1996). The intervention was evaluated in a randomised community trial. Benefits were most notable in those receiving mentoring and included improvements in school attendance and attitudes to older people. Drug use was reduced and future optimism improved (LoSciuto, Rajala, Townsend, & Taylor, 1996). In their review (Catalano et al., 2014, p.433) also described a range of other community trials of positive youth development programs that showed benefits including increased youth volunteering rates. These interventions also had effects on indicators of healthy youth development including: reduced violence, alcohol and drug use; teen pregnancy; and improved school completion rates (Catalano et al., 2014, p.433).

There is evidence that these strategies may also enhance social inclusion in areas such as race relations. The Woodrock Youth Development Project (LoSciuto et al., 1997; LoSciuto et al., 1999) was a multicomponent community- and school-based program designed to build 'bridging social capital' (supportive voluntary relationships between youth with and without resource advantages) and to assist youth in disadvantaged schools to develop social, emotional and academic skills and access community opportunities. A randomised community trial evaluation with a 2-year longitudinal follow-up of school-age youth demonstrated reduced substance use, that improved social capital and community cohesion (better race relations, increased social trust and tolerance) and increased school attendance (Catalano et al., 2014, p.433). There is promising potential for the Eastern Region to encourage and support volunteers to deliver effective prevention and positive development interventions to increase bridging social capital and reduce the causes of inter-generational disadvantage (J.W. Toumbourou, 2015).

Community social capital interventions: There is limited evidence to evaluate the impact of whole of community social capital interventions. Three studies of varying quality evaluated the effects of interventions designed to increase social capital (Brune & Bossert, 2009; O'Connor, 2013; Pronyk et al., 2008); however, the generalisability to the Eastern Region may be limited, with a pre-post between-groups intervention based in Nicaragua (Brune & Bossert, 2009), a clustered randomised trial based in rural South Africa (Pronyk et al., 2008), and pre-post study based in the US (O'Connor, 2013). Management and leadership training programs were found to increase civic participation and cognitive social capital (i.e. trust, social harmony) but not structural social capital (i.e. attendance in meetings, increased contribution in meetings) in communities identified as being low in social capital in Nicaragua (Brune & Bossert, 2009). In the only randomised controlled trial of an intervention designed to increase community social capital, both cognitive and structural social capital were found to increase more significantly in women in rural South Africa involved in group-based microfinance and participatory gender and HIV training (that incorporated leadership training) when compared to women from other communities where no intervention had been introduced (Pronyk et al., 2008). These results suggest that social capital can be generated through empowerment and leadership training; however, given these interventions were conducted in areas of significant poverty, results may have very limited generalisability to the Eastern Region.

A facilitated neighbourhood social intervention, in which a host invited 7-10 neighbours who they didn't know well to their home for three meetings, was found to significantly increase sense of community, self-efficacy and neighbouring, but not participation. The meetings involved trained members facilitating conversations and activities to improve relationships and sense of community and encourage engagement in civic action (O'Connor, 2013). Interviews with participants highlighted several processes that may be important for increasing social capital: a feeling of membership, shared emotional connection, influence in the group and needs fulfilment (O'Connor, 2013). There were significant limitations with the study design, due to the absence of a control group and issues with reliability of measures used, and so caution must be taken as to the weight given results. It is also of note that none of the interventions identified assessed whether social capital increased in members of the community who did not participate in the intervention. Given the limited literature available, the combined results from all studies provide preliminary support for increasing social capital through interventions that focus on empowerment of participants.

Qualitative analysis of a community-based early childhood intervention program that aims to enhance existing services, fill service gaps, and support staff working with high-risk families suggests that in order to build social capital, community health promotion programs should recognise the dual needs for basic services and social inclusion, and for minorities engage the community in tackling inequalities in access to information, resources, services and community membership (Shan, Muhajarine, Loptson, & Jeffery, 2014). Additionally, it appeared that hiring local staff and encouraging existing staff to develop relationships in the community may be instrumental for longer-term success, but precautionary measures to prevent burnout due to blurred private and work lives is important (Shan et al., 2014). Finally, mixed results have been found regarding the feasibility of sports programs for increasing social capital. Qualitative research with inactive women suggested sports may increase social capital, particularly team sports (Ottesen, Jeppesen, & Krustrup, 2010), however research with disadvantaged youths identified only modest improvements in social capital (Spaaij, 2009).

In overview the above summary demonstrates that there have been a range of interventions evaluated that encourage community engagement, voluntary civic participation and social connection. Amongst the best evaluated community interventions have been those that use older and same-aged mentors to encourage and support positive youth development in disadvantaged youth. These interventions did not measure benefits for the volunteering mentees. However, randomised trials have shown that volunteering has a range of benefits including improved physical health (Schreier, Schonert-Reichl, & Chen, 2013). Adolescent volunteering also predicts longitudinal increases in adult social inclusion indicated by school completion and adult civic engagement (Moorfoot, Leung, Toumbourou, & Catalano, 2015). Beneficial action theory argues that population-wide health and social improvements can be maximised where volunteers are trained in strategically planned and evidence-based activities (Toumbourou, 2015).

The information outlined above leads to the following recommendations:

Implement a regional strategy to increase volunteering rates across the community in areas that address EMSIC priorities such as decreasing violence, place-based disadvantage and the experience of social exclusion of minority groups. Volunteering has been shown in randomised trials to hold a range of health and social benefits. Beneficial action approaches argue that population-wide improvements can be maximised where volunteers are trained in strategically planned and evidence-based activities. Given more evidence is required in this area, randomised trials evaluating volunteering program effects on social inclusion in the Eastern Region should be designed. This should be evaluated using a randomised trial comparing different geographic areas. The target measures should include increasing volunteering, sense of community and reducing experiences of social isolation in monitoring surveys of target minority samples.

What measures of social capital may have relevance to the Eastern Region?

There is very limited research evaluating the reliability and validity of measures of social capital (see Table 2). Evaluation of measures used at a state and country level in the US identified a number of measures that appear to have adequate validity, particularly Putnam's Index, and Lee & Kim's scales (Lee & Kim, 2013). Other social capital measures have demonstrated validity, but may have limited validity in the Eastern Region of Melbourne (Chen et al., 2015; Paiva et al., 2014). The Australian Institute of Family Studies (2001) suggests empirical investigations of social capital should include a clear operationalisation of social capital that reflects understanding of the concept, clarity regarding whether social capital or outcomes of social capital are being measured, and a measure that creates clear understanding of the relationship between the individual dimensions of social capital (i.e. a measure of a given social network should relate to the measure of trust and reciprocity within that network). Additionally, the Australian Bureau of Statistics provides a detailed framework and indicators for the measurement of social capital in Australia (Australian Bureau of Statistics, 2004). The Australian Bureau of Statistics identify a large number of measures of social capital suitable for use within an Australian setting depending on the focus of intervention, including social participation, social networks and social support, voluntary work and civic participation, inclusiveness and sense of belonging, acceptance and tolerance of diversity and trust/trustworthiness (See Table 3).

TABLE 1

Summary of Included Studies

AUTHOR AND DATE	STUDY DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Community Interventions				
Jalaludin et al., 2012	Pre-post intervention design N=28	Urban renewal program: internal and external upgrades, and social interventions such as community engagement, learning and employment initiatives & community meeting place.	Perceptions of safety and aesthetics; BMI; physical activity; hazardous alcohol consumption; psychological distress.	No significant differences.
Blackman, Harvey, Lawrence & Simon, 2001	Pre-post intervention design N=749 adults & 249 children	Urban renewal program: environmental improvement, renovation grants, and improvements in security and road safety.	Respiratory index, psychological distress index, GP visits, out-patient visits and inpatients stays.	Significant changes in smoking and psychological health, but not respiratory health or visits to health services.
Petticrew, Kearns, Mason & Hoy, 2009; Gibson, Thompson, Kearns & Petticrew, 2011	Longitudinal between groups design Intervention N=339 Control N=392	Moving into newly build social housing compared to living in older social housing.	General health, mastery, psychosocial outcomes, mental health.	No significant differences between intervention and control in changes in self-reported general health, loneliness or mental health outcomes (including social functioning). Significant improvement in mastery, but not between groups. Significant improvements in psychosocial outcomes (status, identity and sense of progress) relative to control group.
Kelaher, Warr & Tacticos, 2010	Between groups design Intervention N=1510 Surrounding area N=750	Neighbourhood renewal: community-based participatory initiative compared with no renewal.	Health status and life satisfaction.	No changes in health status and life satisfaction over time between communities; however, significant improvement in those in community who participated in the intervention.
Spaaij, 2009	Mixed methods N=77	Sports Steward Program: sports-based social inclusion program that aims to also educate and develop life skills in disadvantaged youths.	Semi-structured interviews: social capital, social mobility.	Modest gains in social capital, some objective and subjective gains in social mobility.

AUTHOR AND DATE	STUDY DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Reducing pathways to disadvantage while building social capital				
LoSciuto et al., 1996.	Randomised trial of students. N = 562 randomised to control and 2-intervention levels.	Across ages. Disadvantaged middle school students received social relationship training and volunteering in aged-care opportunities. One intervention group also received mentoring from older adults (55 and older).	Quantitative assessment of school attendance, attitudes to older people, substance use.	Benefits were most notable in those receiving mentoring and included improvements in school attendance and attitudes to older people. Drug use reduced and future optimism improved.
LoSciuto et al., 1997; LoSciuto et al., 1999.	Randomised trial of school students. Intervention N=244, control 474.	Woodrock Youth Development Project. Disadvantaged youth received peer mentoring, and support for involvement in community opportunities.	Quantitative assessment of race relations and ethnocentrism and inclusion (school attendance).	Improvements in race relations and perceptions of others from different cultural or ethnic groups, school attendance and reduced substance use.
Disability Interventions				
Chng, Stancliffe, Wilson & Anderson, 2013	Non-concurrent multiple baseline design N=3	Support training program for older adults with intellectual disabilities.	Participant activity engagement; social engagement; total engagement.	Significant improvements in activity engagement and total engagement but not social engagement.
Raghavendra, Newman, Grace & Wood, 2013	Pre-post intervention design N=18	One-on-one support strategies to facilitate social networking via the internet of youth with disabilities.	Performance and satisfaction with internet use, with a focus on social networks and participation; achievement of goals set to overcome problems.	Significant improvement in performance and satisfaction with internet use; average achieved goals was above expected achievement.
Aged interventions				
Bartlett, et al., 2013	Three pre-post pilot studies Site 1 N=42, site 2 N=15, site 3 N=16	Community-based interventions for older adults	Loneliness; social support.	No significant differences in loneliness or social support for first two sites, significant differences in third site however there were very significant validity concerns.
Clarke, Clarke & Jagger, 1992	Randomised controlled trial. Intervention N=523, control=261	Individualised support or control.	Physical health, social support, independence, perceived loneliness, morale, perceived health status, mortality.	Only significant difference was that perceived health status was higher in experimental group than control post-intervention.

AUTHOR AND DATE	STUDY DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Aged interventions				
C. Collins and Benedict (2006)	Pre-experimental, one-group, pre-post design N=339	Community-based educational program for older adults.	Mastery, loneliness and stress.	Significant improvements in all measures. Greatest reduction occurred in ethnic minority groups.
Crane-Okada et al., 2012	Experimental, randomised block, longitudinal. Immediate contact N=50, usual contact N=46, delayed contact N=46.	Senior peer telephone counselling for older women after breast cancer surgery; immediate contact, delayed contact or usual contact.	Anxious mood, social support, and coping.	No intervention effects were found post-intervention, or six months and 12 months post-intervention for anxious mood or social support. A significant interaction between age and intervention was found for coping six months after intervention in that participants in the usual contact group were least likely to seek support. When controlling for effects of age, seeking support decreased significantly for those who received counselling.
Routasalo, Tilvis, Kautiainen & Pitkala, 2008	Randomised controlled trial Intervention N=117, control N=118	3 month psychosocial rehabilitation group intervention or usual community control.	Friendships, loneliness, social network; wellbeing.	Intervention had significantly more friends and improved wellbeing than control one year after the intervention, but no significant differences in loneliness or social network at 3 or 6 months post-intervention.
Steven and Tilburg (2000)	Pilot study N=32	Friendship program for women vs control.	Loneliness.	States that loneliness reduced more significantly than in control, but this was not at 0.5 significance level.
Stewart, Craig, MacPherson & Alexander, 2001	Pre, post and delayed post within subjects N=28	Support groups for widows.	Social support, positive and negative affect, loneliness.	Significant changes in social support and positive affect, but not negative affect or loneliness.
Martina & Stevens, 2006	Pre-, post- and 3-month controlled qualitative trial Intervention N=60, control N=55	Friendship program for women vs control.	Semi-structured interviews: quantity and quality of friendships, improvements in friendships, subjective wellbeing, active stance in social relations, loneliness.	Significantly more women from interventions had improvements in quantity and quality of friendships 6 months after intervention. No significant differences between groups in improvements or deteriorations in friendships. Moderate improvements in subjective wellbeing and active stance in social relations in intervention compared to control. Loneliness decreased in both intervention and control with no significant differences between the groups, and both groups continued to experience loneliness.

AUTHOR AND DATE	STUDY DESIGN	INDEPENDENT VARIABLE	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Minority Interventions				
Michael, Farquhar, Wiggins, & Green, 2007	Pre-post intervention N=170	Community-based participatory research study for African American and Latino communities.	Social support, self-report physical health, depressive symptoms.	Significant improvements in social support, health and depression.
Social Capital Interventions				
Brune & Brossert, 2009	Pre-post between groups design Intervention N=118, control N=92	2 management and leadership training programs and 1 control in Nicaragua.	Community level indicators of social capital: structural (participation and frequency of attendance), cognitive (feelings of trust and solidarity, social harmony and sociability).	More significant increase in cognitive social capital in intervention group than control, but not other measures of social capital.
O'Connor, 2013	Pre-post pilot N=28	Facilitated neighbourhood social intervention.	Sense of community; self-efficacy; neighbouring; participation.	Significant improvements in sense of community, self-efficacy and neighbouring but not participation.
Pronyk et al., 2008	Cluster randomised trial. Intervention N=426, control N=419	Group based microfinance and participatory gender and HIV training for women in rural South Africa.	Social capital: structural, cognitive.	Women in intervention more likely to report both types of social capital than women at 2-year follow-up.
Ottesen, Jeppesen, & Krustrup, 2010	Pre-post intervention Football N=25, running N=25	16-week running or football intervention for inactive women.	Focus group interviews and online questionnaire: social capital	Appears to be positive development of social capital in both groups, with team sports appearing to have an advantage over individual sports.
Shan, Muhajarine, Loptson, & Jeffery, 2014	Mixed methods N=87	KidsFirst: multi-site community-based early childhood intervention program.	Focus groups and semi-structured interviews: social capital.	Social capital appeared to be essential for success of programs, and was highly valued by participants.

TABLE 2

Summary of Social Capital Measures

AUTHOR & DATE	MEASURE	COUNTRIES MEASURE HAS BEEN VALIDATED FOR USE	SUMMARY OF PSYCHOMETRIC PROPERTIES
Lee & Kim, (2013)	Putnam's Index – measures of civic involvement and volunteering, informal sociability and trust.	US	Limited face validity; some content validity; demonstrates nomological and convergent validity.
	Kim et al. Scale 1 – measures of civic involvement and volunteering, informal sociability and trust.	US	Limited face validity; some content validity; demonstrates nomological and convergent validity.
	Kim et al. Scale 2 – measures of civic involvement and volunteering, informal sociability and trust.	US	Limited face validity; some content validity; demonstrates nomological and convergent validity.
	ANHCS social capital index – measures of participation in wide range of organisations or groups.	US	Limited face and content validity; demonstrates nomological and convergent validity
	Petris social capital index – number of employees hired at voluntary organisations.	US	Limited face, content, nomological and convergent validity
	BRFSS measure – social/emotional support.	US	Limited face and content validity; demonstrates nomological and convergent validity
	Rupasingha, Goetz, & Freshwater index – social/emotional support.	US	Limited face, content and convergent validity; demonstrates nomological validity.
Chen et al., 2015	Social Capital Investment Inventory – measures of bonding capital (personal networks, trust, and reciprocity) & bridging capital (capital associated with social organisations).	China	Single factor structure and strong internal consistency.
Paiva et al., 2014	Social Capital Questionnaire for Adolescent Students – measures of school social cohesion, friendships, neighbourhood social cohesion and trust.	Brazil	Good internal consistency, reproducibility and construct validity.

TABLE 3

Summary of Social Capital Measures in Australia identified in ABS Measuring Social Capital 2004

SURVEY	SOCIAL PARTICIPATION	SOCIAL NETWORKS AND SUPPORT	VOLUNTARY WORK & CIVIC PARTICIPATION	INCLUSIVENESS AND SENSE OF BELONGING	TOLERATION & ACCEPTANCE OF DIVERSITY	TRUST AND TRUST-WORTHINESS
General Social Survey, Australia, 2002	*	*				
Survey of Disability, Aging & Carers, 1998	*	*				
New South Wales Child Health Survey	*		*	*		*
Community Participation Survey, Surf Coast Shire, 2001	*		*	*		*
Social Capital Questionnaire, 1998	*	*	*	*	*	*
The Australian Longitudinal Study of Women's Health[1]	*	*				*
Health and Participation Survey, 1997	*	*	*	*		*
Victorian Population Health Survey, 2001	*	*	*		*	*
Voluntary Work Survey, 2000		*	*			
Time Use Survey, 1997	*		*			
Families, Social Capital and Citizenship Survey, 2001		*	*			*
The Queensland Household Survey	*		*		*	
Community Capacity Questionnaire, Tasmania, 2001				*	*	*

[1] Includes measure of violence

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APPENDIX G: VIOLENCE INDICATORS

VIOLENCE Problem indicators

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	WHAT LEVEL? (state, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)
Victoria Police	Family violence	# of family violence incidents (L17 reports) i) where children present ii) charges laid iii) where IVO applied for (and breaches of AVOs) iv) where family violence safety notice were issued v) homicides by intimate partners vi) first time vs repeat offenders	Family	LGA, PSA	2009/10–2013/14	Annual	N/A
Victoria Police	Crime	# of violent offences, property offences, all offences, drug offences, family violence callouts	Community	State, municipalities	2011	1991, 1996, 2001, 2006	Comparison between municipalities/between municipalities and Victoria
Turning Point	Alcohol-related family violence, assaults, serious road injuries	# of incidents or events and rates on: • alcohol related serious road injuries • high, medium and low alcohol hour assaults • alcohol-related family violence	Community	LGA	2013 (depending on the survey/ dataset used)	Data presented over a 10-year period where available	Sort by gender, age-group
Ambulance Victoria	# callouts to family violence incidents	# of family violence incidents where ambulance attended, witnesses, response, repeat attendances	Family	Postcode, suburb of residence	2014–15	Annual	LGA
DHHS – Victorian Emergency Minimum Dataset (VEMD)	Emergency department presentations	# of emergency department presentations as a result of family violence incidents (Demographics: age, sex, postcode and suburb of residence, country of birth, preferred language spoken at home)		Postcode, suburb of residence	2014 / 15	Annual	Sort by demographics
		Injury surveillance item: human intent (e.g. assault, self harm), cause of injury					
DHHS – Victorian Admitted Episodes Dataset (VAED)	Hospital admissions	# of hospital admissions as a results of family violence incidents (Demographics: Age, sex, postcode, suburb and local government area of residence, country of birth)		Suburb and LGA	2014 / 15	Annual	Sort by demographics
		Injury surveillance item: human intent (e.g. assault, self harm), cause of injury, involvement of alcohol					

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	WHAT LEVEL? (state, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)
Crime statistic agency	Crime – victim reports; also report trends over 5 years	• Crime against person including homicide, assault, sexual offences, abduction, robbery, blackmail and extortion, stalking, harassment and threatening behaviour, dangerous and negligent acts endangering people • Property and deception offences – arson, property damage, burglary/ break and enter, theft, deception	Community	State, LGA, suburb	2009/10-2014/15	Annual	• Sort by age, sex • Reported relationship of victim to offender (i.e. current partner, ex-partner, family member, non-family member, unknown to victim) • Reported whether offences was family event related
DJR	Crime – AVOs	# intervention order applications and outcomes of intervention order applications	Crime	LGA	Ongoing	Annual	
DJR	AVO	% of AVOs breached	Effectiveness of intervention orders				
DJR	Crime	Family Violence Database	Crime	LGA	2010	Ongoing analysis	
DHHS	Child Protection Notices	# of child protection notices issued					

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethic group etc?)	LOCATION/ SPECIFIC ISSUE	WEBSITE	REMARKS
The Victorian Child and Adolescent Monitoring System (VCAMS)	Crime in community	• Proportion of children who feel safe • Proportion of young people who feel safe • Rate of recorded crime in the community	Community	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • The Victorian Child Health and Wellbeing Survey • Law Enforcement Assistance Program
	Bullying	# of family violence incidents (L17 reports) i) where children present ii) charges laid iii) where IVO applied for (and breaches of AVOs) iv) where family violence safety notice were issued v) homicides by intimate partners vi) first time vs repeat offenders	Individual	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for bullying indicators include: • Victorian Student Health and Wellbeing Survey • Attitude to School Survey
	Law-abiding behaviour	• Most common offences for young people in custodial detention • Crime where the offender was a child or young person (rate) • Young people 10–17 years under community-based supervision (rate) • Young people 10–17 years in youth justice facilities (rate) • Number of cautions issued to young people • Crime where the victim was a child or young person (rate)	Community	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • Client Relationship Information System • Law Enforcement Assistance Program

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethic group etc?)	LOCATION/ SPECIFIC ISSUE	WEBSITE	REMARKS
The Victorian Child and Adolescent Monitoring System (VCAMS)	Alcohol-related family violence, assaults, serious road injuries	# of incidents or events and rates on: • alcohol related serious road injuries • high, medium and low alcohol hour assaults • alcohol-related family violence	Community	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • Client Relationship Information System
	Family functioning	• Proportion of children with high levels of family stress • Proportion of children and young people who have a parent involved in the criminal justice system	Family	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • School Entry Health Questionnaire • Corrections Intake Files
		# of emergency department presentations as a result of family violence incidents (Demographics: age, sex, postcode and suburb of residence, country of birth, preferred language spoken at home)								
Community indicators Victoria	Access to alcohol	Injury surveillance item: human intent (e.g. assault, self harm), cause of injury	Community	Eastern Metro areas: Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse, Yarra Ranges	2013	N/A	N/A		http://www.communityindicators.net.au/metadata_items/risky_alcohol_consumption	

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethic group etc?)	LOCATION/ SPECIFIC ISSUE	WEBSITE	REMARKS
Community indicators Victoria	Gambling	• Number of electronic gaming machines within 2.5kms, per 1000 adult population aged 18+), and per 1000 residents; • Net electronic gaming machines expenditure ($ per adult aged 18+ and $ per residents); • Average distance to nearest electronic gaming machine (EGM) (kilometers)	Community	LGA	2013	Annual	N/A		http://www.vcglr.vic.gov.au/home/resources/data+and+research/data/ https://www.data.vic.gov.au/data/dataset/2011-local-government-area-profile	Data.vic populate data from the ABS
Turning point	Alcohol and drug use	Injury surveillance item: human intent (e.g. assault, self harm), cause of injury, involvement of alcohol	Community	LGA	2013 (depending on the survey/ dataset used)	Data presented over a 10-year period where available	Sort by gender, age-group		http://aodstats.org.au/VicLGA/ Details of methodology and datasets see: http://aodstats.org.au/Documents/AODstats%20Methods_final%202014.10.02.pdf	Turning point pull data from the following surveys/datasets: • Victorian emergency department presentations data from the Victorian Emergency Minimum Dataset (VEMD); • Victorian hospital admissions data from the Victorian Hospital Admitted Episodes Data (VAED); • Alcohol- and drug-related ambulance attendances from the Turning Point Ambo project; • Alcohol and drug treatment services data (ADIS); • Victorian mortality data from the Australian Coordinating Registry (ACR) • Serious road injuries from the VicRoads Road Network Database (RNDB); • Aggregated assault and family incident data derived from the Victoria Police Law Enforcement Assistance Program data (LEAP); • Directline counselling, information and referral service data.

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethic group etc?)	LOCATION/ SPECIFIC ISSUE	WEBSITE	REMARKS
The Victorian Child and Adolescent Monitoring System (VCAMS)	Adolescent alcohol and drug use	• Proportion of young people who drink alcohol, smoke cigarettes, sniff glue or chrome, or use marijuana or other illegal drugs	Individual	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • The Victorian Child Health and Wellbeing Survey
Data.vic	Alcohol and drug use	% of AVOs breached	Community	Municipalities, metropolitan regions	2011	N/A			https://www.data.vic.gov.au/data/dataset/2011-local-government-area-profile	Data.vic populate data from the ABS
Data.vic	Education characteristics	• % year 9 students who attain national minimum standards in reading, writing, numeracy • % of population who did not complete year 12 • % of population with higher education qualification • % students attending a government school	Community	Municipalities, metropolitan regions	2011	N/A			https://www.data.vic.gov.au/data/dataset/2011-local-government-area-profile	Data.vic populate data from the ABS
City of Greater Dandenong website	Education	• Person attending tertiary education excluding TAFE • Residents with bachelor or post-graduate qualifications	Community	State, municipalities	2011	1991, 1996, 2001, 2006	Comparison between municipalities or comparison between municipalities and Victoria		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities	The City of Greater Dandenong and the Victorian Local Government Association populate data from the ABS
City of Greater Dandenong website	Employment	• Unemployment rate • Residents not in labour force • Labour force participation rate • Percent of persons as professionals and labourers • Percent of persons age 15 to 19 in full time employment	Community	State, municipalities	2011	1991, 1996, 2001, 2006	Comparison between municipalities or comparison between municipalities and Victoria		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities	The City of Greater Dandenong and the Victorian Local Government Association populate data from the ABS

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethic group etc?)	LOCATION/ SPECIFIC ISSUE	WEBSITE	REMARKS
Data.vic	Economic characteristics – disadvantage	• % of persons with individual income <$400 per week • % female and male low income • % families headed by one parent • % female and male one-parent families • % of households with income <$650 per week • % low income families with children • % population with food insecurity	Community	Municipalities, metropolitan regions	2006, 2008	N/A			https://www.data.vic.gov.au/data/dataset/2011-local-government-area-profile	Data.vic populate data from the ABS (2006), Centrelink (2008), and Victorian Population Health Survey 2008
VCAMS		• Proportion of children from families that ran out of food and couldn't afford to buy more • Proportion of young people from families that ran out of food and couldn't afford to buy more • Specialist Homelessness Services assistance rate for children and young people	Family	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type	Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx	VCAMS brings together data from across government to track the progress of children and young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include: • The Victorian Child Health and Wellbeing Survey • Specialist Homelessness Services Collection, AIHW
The City of Greater Dandenong website	Social disadvantage	• One-parent household	Community	Municipalities, postcode, suburb	2011	2001, 2006	N/A		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities	The City of Greater Dandenong and the Victorian Local Government Association populate data from the ABS
The City of Greater Dandenong website	SEIF measure of disadvantage	This index weighs conditions such as incomes, educational attainment, occupations, housing ownership, English fluency and unemployment, as recorded by the 2011 Census, to produce a single overall measure of relative social and economic disadvantage.	Community	Municipalities, postcode, suburb	2011	1996, 2001, 2006	N/A		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities	The City of Greater Dandenong and the Victorian Local Government Association populate data from the ABS

VIOLENCE System and Process Indicators

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	WHAT DOMAIN?	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)
Agencies	Service delivery	# of family violence incidents (L17 reports) i) where children present ii) charges laid iii) where IVO applied for (and breaches of AVOs) iv) where family violence safety notice were issued v) homicides by intimate partners vi) first time vs repeat offenders	Service delivery	Variable	Annual	Annual proposed	Sort by region, age-group etc
Various – LGA	Service delivery	% of FV Support referrals met/turned away (unmet need)	Service delivery	Variable	Annual	Annual proposed	Sort by region, age-group etc
DJR	Alcohol-related family violence, assaults, serious road injuries	# of incidents or events and rates on: • alcohol related serious road injuries • high, medium and low alcohol hour assaults • alcohol-related family violence	Response sector				
DHHS	System	% primary care/other staff trained in CRAF					
LGA	Early intervention	# of emergency department presentations as a result of family violence incidents (Demographics: age, sex, postcode and suburb of residence, country of birth, preferred language spoken at home)	Early intervention	LGA			
VicPol	System	Injury surveillance item: human intent (e.g. assault, self harm), cause of injury	Response sector				
	System	Confidence in reporting to VicPol	Response sector				
DJR/Others	Early intervention	Injury surveillance item: human intent (e.g. assault, self harm), cause of injury, involvement of alcohol	Early intervention				
		% of AVOs breached					

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	WHAT LEVEL? (State, region, LGA etc)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)
City of Dandenong	Gender equity	# of family violence incidents (L17 reports) i) where children present ii) charges laid iii) where IVO applied for (and breaches of AVOs) iv) where family violence safety notice were issued v) homicides by intimate partners vi) first time vs repeat offenders	Gender	LGA	2011 – ABS	5 years	Gender, age group, LGA
WHE	Gender equity	TFER – Gender audit summaries if available	Gender	LGA	Annual	Annual	
VicHealth	Alcohol-related family violence, assaults, serious road injuries	# of incidents or events and rates on: • alcohol-related serious road injuries • high, medium and low alcohol hour assaults • alcohol-related family violence	Gender	State based/ Metro vs regional	2013	1995, 2009, 2013	Some ethnic groups specifically captured
Various – LGA	Community engagement	% of workplaces contacted and training provided (eg White Ribbon accreditation)	Gender	LGA			
		# of emergency department presentations as a result of family violence incidents (Demographics: age, sex, postcode and suburb of residence, country of birth, preferred language spoken at home)					
		Injury surveillance item: human intent (e.g. assault, self harm), cause of injury					
		% of faith-based communities contacted and training provided					
		Injury surveillance item: human intent (e.g. assault, self harm), cause of injury, involvement of alcohol					
Victorian Department of Education and Training	Early years / school / youth engagement and education	% of early years facilities – training in gender roles, stereotypes					
		Primary schools – self esteem					
		% of AVOs breached					
		TAFE/tertiary sector – healthy relationships and consent					
White Ribbon	Community engagement	# of White Ribbon ambassadors (including repledged) or similar (e.g. Challenge Family Violence in Casey)	Gender	LGA			
ABS	Gender equity	Rates of workplace participation and remuneration			2012	5 years	Gender, region, ethnicity, age
		General Social Survey – Distribution of caring, volunteering and social activities			2014	4 years	State only, gender, age group, CaLD, income
		Unpaid work vs paid work			2012		
Media Monitors	Gender equity	Media representation – % of editors, articles by women					
Vic Government	Gender equity	Proportion of female senior managers, CEO's					

APPENDIX H: SOCIAL INCLUSION INDICATORS

SOCIAL INCLUSION Inclusion Exclusion Indicators

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
City of Boroondara report	Social exclusion	ABS SEIFA measures of social disadvantage, mapped to SA1 census data units to specifically localise areas of social disadvantage.	Social exclusion, disadvantage	LGA, PSA	2011 – ABS	5 years	Gender, age group, LGA			http://www.boroondara.vic.gov.au/our-city/all-about-boroondara-social-statistics/social-exclusion-and-disadvantage
ABS Census	Social isolation	Single person household	Social isolation	LGA, PSA	2011 – ABS	5 years	Gender, age group, LGA			
The Victorian Child and Adolescent Monitoring System (VCAMS)	Safety	• Proportion of children who feel safe • Proportion of young people who feel safe	Community	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type, offence type		Click on the indicator of interest to access an interactive map of trend data and LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx
Indicators of Community Strength	Safe and inclusive community	Includes: i) subjective wellbeing; ii) feeling part of the community; iii) social support; iv) perceptions of safety.	Community	LGA – Eastern Metro	2008	Every 3 years	Not specific – one general finding	Community Indicators Victoria		http://www.communityindicators.net.au/lga_profiles
More comprehensive breakdown…..										
	Wellbeing and community	Community connectedness		Whitehorse	2011	2007	Gender, age,	VicHealth Indicators Survey	Scroll to each section and click on “show more”	http://www.communityindicators.net.au/live_reports/whitehorse_wellbeing_and_community_connectedness
	Connectedness	Support from friends/neighbours			2008	Every 2 years	General	Dept. of Planning and Community Development		
		Opportunities to participate in arts and cultural activities			2007	2007	Gender, age	CIV Survey		
		Participation in arts and cultural activities			2011	2007	Gender, age	VicHealth Indicators Survey		
		Participation in citizen engagement			2011	2007	Gender, age	VicHealth Indicators Survey		

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
	Connectedness	Cultural diversity: acceptance of cultures			2007	2007	General	CIV Survey		http://www.communityindicators.net.au/live_reports/whitehorse
		Public transport to work on census day			2011	Every 5 years	General	ABS		
		Have a say on important issues			2008	Every 2 years	General	Dept. of Planning and Community Development		
		Employment rate			2011	Every 5 years	General, gender, age	ABS		http://www.communityindicators.net.au/live_reports/whitehorse_0
		Housing affordability: household costs 30% or more of gross income			2011	Every 5 years	General	ABS		
		Housing affordability: rental costs 30% or more of gross income			2011	Every 5 years	General	ABS		
		Housing affordability: mortgage costs 30% or more of gross income			2011	Every 5 years	General	ABS		
	Community	Adequate physical exercise		Maroondah/ Knox	2011	Annual	Gender	Victorian Population Health Survey		http://www.communityindicators.net.au/live_reports/knox_maroondah_and_yarra_valley
		Risky alcohol use		Yarra Valley	2011	Annual	General	Vic. Population Health Survey		
		Psychological distress			2011	Annual	General	Vic. Population Health Survey		
		Community connectedness			2011	2007	Gender, age	VicHealth Indicators Survey		
		Support from friends/neighbours			2008	Every 2 years	General	Dept. of Planning and Community Development		
		Volunteering			2011	Every 5 years	Gender, age	ABS		
		Parents involved in school activities			2008		General	Dept. of Planning and Community Development		

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
	Community	Feel safe home alone during day			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe home alone during night			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe walking alone during day			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe walking alone during night			2011	2007	Gender, age	VicHealth Indicators Survey		
		Work/life balance			2011	2007	Gender, age	VicHealth Indicators Survey		
		Housing affordability: household costs 30% or more of gross income			2011	Every 5 years	General	ABS		
		Housing affordability: rental costs 30% or more of gross income			2011	Every 5 years	General	ABS		
		Housing affordability: mortgage costs 30% or more of gross income			2011	Every 5 years	General	ABS		
		Public transport to work on census day			2011	Every 5 years	General	ABS		
		400-800 metres to public transport			2012		General	Department of Transport		
		Opportunity to participate in arts and cultural activities			2007	2007	Gender, age	CIV Survey		
		Participation in arts and cultural activities			2011	2007	Gender, age	VicHealth Indicators Survey		
		Cultural diversity: acceptance of cultures			2007	2007	General	CIV Survey		
		Have a say on important issues			2008	Every 2 years	General	Dept. of Planning and Community Development		
		Employment rate			2011	Every 5 years	Gender, age	ABS		
		Local employment (living-working in LGA)			2011	Every 5 years	General, gender, age	ABS		

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
	Community	Unemployment			2013-2014		General	Department of Education Employment and Workplace Relations		
		Participation in citizen engagement			2011	2007	Gender, age	VicHealth Indicators Survey		
	Social Capital	Adequate physical exercise		Boroondara/ Monash/	2011	Annual	General	Vic. Population Health Survey		http://www.communityindicators.net.au/live_reports/boroondara_social_capital
		Psychological distress		Manningham	2011	Annual	General	Vic. Population Health Survey		
		Community connectedness			2011	2007	Gender, age	VicHealth Indicators Survey		
		Support from friends/neighbours			2008	Every 2 years	General	Dept. of Planning and Community Development		
		Unemployment			2013-2014		General	Department of Education Employment and Workplace Relations		
		Local employment (living-working in LGA)			2011	Every 5 years	General, gender, age	ABS		
		Volunteering			2011	Every 5 years	Age	ABS		
		Volunteering			2006	Every 5 years	Gender, age	ABS		
		Parents involved in school activities			2008		General	Dept. of Planning and Community Development		
		Feel safe home alone during day			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe home alone during night			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe walking alone during day			2011	2007	Gender, age	VicHealth Indicators Survey		
		Feel safe walking alone during night			2011	2007	Gender, age	VicHealth Indicators Survey		

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
	Social Capital	Work/life balance			2011	2007	Gender, age	VicHealth Indicators Survey		
		400-800 metres to public transport			2012		General	Department of Transport		
		Opportunity to participate in arts and cultural activities			2007	2007	Gender, age	CIV Survey		
		Participation in arts and cultural activities			2011	2007	Gender, age	VicHealth Indicators Survey		
		Cultural diversity: acceptance of cultures			2007	2007	General	CIV Survey		
		Have a say on important issues			2008	Every 2nd year	General	Dept. of Planning and Community Development		
		Participation in citizen engagement			2011	2007	Gender, age	VicHealth Indicators Survey		
Statistical data for Victorian Communities	Health & wellbeing – Young People	Youth disengagement rate		LGA	2011–2012		General	ABS	*Click on the link to 'Indicators of health and wellbeing' *Click on Community in the blue section at the top. *Select locality for comparison. *Click on Young People	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		Adolescents who do not have trusted adult		LGA	2009		General	Department of Education and Early Childhood Development (2012)		
	Community Strengthening	Volunteering in last 12 months		LGA	2011		Age, gender, total	Census	*Click on 'Volunteering by age and sex'	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Statistical data for Victorian Communities	Community Strengthening – Wider Community	Adult members of organised groups (sports, church, community)		LGA	2008		General	DPCD Measures of Community Strength and Connection		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		Live in an active community – get involved		LGA	2008		General	DPCD Measures of Community Strength and Connection		
		Adults who feel valued by society		LGA	2008		General	DPCD Measures of Community Strength and Connection		
		Adults who feel themselves to be part of the community		LGA	2007		General	CIV Survey		

VCAMS brings together cross-Government data to track progress of children & young people against key health, wellbeing and development outcomes. Data sources for law-abiding behaviours include:

- Victorian Child Health & Wellbeing Survey
- Law Enforcement Assistance Program

SOCIAL INCLUSION Risk Factors

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
The Victorian Child and Adolescent Monitoring System (VCAMS)	Social exclusion	• Proportion of children who are bullied • Proportion of young people who are experiencing cyber-bullying • Proportion of young people who are bullied most days	Peer bullying	Regions, LGA	2015 for some indicators	Longitudinal data where available	Sort by a range of demographics (where available) such as age, gender, family type		Click on indicator of interest to access interactive map of trend data, LGA profile	http://www.education.vic.gov.au/about/research/Pages/vcamstableau.aspx
Australian Early Development Index	Child development problems	Early education and care; physical independence/motor skills; social competence; Emotional maturity; language and cognitive schools; communication skills and general knowledge	School readiness	LGA, SLA, school, student	2012 and prior	Every 3 years	Highly specific	AEDI (Australian Early Development Index)	Under 'Search Community Profiles' type	https://www.aedc.gov.au/resources/community-profiles
ABS Census	Unemployment	Unemployment	Economic exclusion	LGA, PSA	2011 – ABS	5 years	Gender, age group, LGA			
Vichealth Population Health Survey	Mental Health	Lifetime prevalence of anxiety and depression		EMR	2011–2012	2007	Gender	VicHealth Indicators Survey	p6 Table 9.3	https://www2.health.vic.gov.au/getfile//?sc_itemid=%7b861FD695-520C-47B8-A206-BFCB90693EBE%7d
		Lifetime prevalence of anxiety and depression		LGA	2011–2012	2007	Gender	As above	p8, Table 9.4	Open PDF
		Sought professional help for mental health problem		EMR	2011–2012	2007	Gender	As above	p16, Table 9.7	
		Sought professional help for mental health problem		LGA	2011–2012	2007	Gender	As above	p17, Table 9.8	
	Modifiable health risk	Smoking status		EMR	2011–2012		Gender	As above	p11, Table 2.5	https://www2.health.vic.gov.au/getfile//?sc_itemid=%7bA42EE2EF-9C2C-4C22-8A6E-F9F4D1ECFFC3%7d
	Behaviours	Frequency of smoking		EMR	2011–2012		Gender	As above	p12, Table 2.6	Open PDF
		Smoking status		LGA	2011–2012		Status	As above	p14, Table 2.7	
		Frequency of smoking		LGA	2011–2012		Status	As above	p20, Table 2.8	
	Modifiable health risk	Short-term risk of alcohol-related harm		EMR	2011–2012		Gender	As above	p34, Table 2.15	

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Vichealth Population Health Survey	Behaviours	Short-term risk of alcohol-related harm		LGA	2011–2012		Males	As above	p36, Table 2.16	
		Short-term risk of alcohol-related harm		LGA	2011–2012		Females	As above	p38, Table 2.17	
		Short-term risk of alcohol-related harm		LGA	2011–2012		General	As above	p40, Table 2.18	
		Long-term risk of alcohol-related harm		EMR	2011–2012		Gender	As above	p52, Table 2.22	
		Long-term risk of alcohol-related harm		LGA	2011–2012		General	As above	p54, Table 2.23	
	Modifiable health risk	Daily vegetable consumption		EMR	2011–2012		Gender	As above	p66, Table 2.28	
	Behaviours	Daily vegetable consumption		LGA	2011–2012		General	As above	p68, Table 2.29	
		Daily fruit consumption		EMR	2011–2012		Gender	As above	p73, Table 2.31	
		Daily fruit consumption		LGA	2011–2012		General	As above	p76, Table 2.32	
		Daily water intake		EMR	2011–2012		Gender	As above	p111, Table 2.48	
		Daily water intake		LGA	2011–2012		General	As above	p112, Table 2.49	
	Modifiable health risk	Physical activity		EMR	2011–2012		Gender	As above	p117, Table 2.52	
	Behaviours	Physical activity		LGA	2011–2012		General	As above	p120, Table 2.53	
		Body weight status		EMR	2011–2012		Gender	As above	p150, Table 2.64	
		Overweight/obesity		LGA	2011–2012		Males	As above	p154, Table 2.65a	
		Overweight/obesity		LGA	2011–2012		Females	As above	p156, Table 2.65b	
		Psychological distress		EMR	2011–2012		Gender	As above	p174, Table 2.70	
		Psychological distress		LGA	2011–2012		General	As above	p176, Table 2.71	
		Distress – unable to manage daily activities		EMR	2011–2012		Gender	As above	p186, Table 2.74	
		Distress – days unable to manage activities		LGA	2011–2012		General	As above	p188, Table 2.75	
		Distress – visits to health professional		EMR	2011–2012		Gender	As above	p198, Table 2.82	
		Distress – visits to health professional		LGA	2011–2012		General	As above	p200, Table 2.83	
		Physical health as main reason for distress		EMR	2011–2012		Gender	As above	p204, Table 2.86	
		Physical health as main reason for distress		LGA	2011–2012		General	As above	p206, Table 2.87	

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Vichealth Population Health Survey	Social inequalities in health	Ran out of food in the last 12 months		EMR	2011–2012		Gender	As above	p8, Table 10.4	https://www2.health.vic.gov.au/getfile//?sc_itemid=%7b78A5E9D6-3BD8-48EE-BE6C-1C956DE7E84E%7d
		Ran out of food in the last 12 months		LGA	2011–2012		General	As above	p10, Table 10.5	Open PDF
		Reasons for not having food		EMR	2011–2012		Gender	As above	p15, Table 10.7	
		Reasons for not having food in the last 12 months		LGA	2011–2012		General	As above	p20, Table 10.8	
Statistical data for Victorian Communities	Health and wellbeing – young people	Adolescents who do not have someone to turn to for advice		LGA	2009		General	Department of Education and Early Childhood Development (2012)		
		Adolescents not satisfied with quality of life		LGA	2009		General	Department of Education and Early Childhood Development (2012)		
	Health and wellbeing – LGA comparison	Click on particular indicator to see comparison data		LGA					*Click on LGA comparison in blue section at the top	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
	Asylum seekers and Refugees	Municipality		LGA	2014	Unknown	General	Statistical data for Victorian Communities		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Statistical data for Victorian Communities	Community Strengthening – family and Social life	Adults who agree that they lack time for friends/family		LGA	2012		General	VicHealth Indicators Survey	*Click on "Measures of community connection and other local survey results"	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		Adults experiencing 'time pressure'		LGA	2012		General	As above		
	Community Strengthening – family and Social life	Adults-help from friends family when needed		LGA	2008		General	DPCD Measures of Community Strength and Connection		
		Accessed family and community support services, 2012/13		LGA	2012-2013		General	Victorian Child and Adolescent Monitoring System (DEECD)		
	Community Strengthening – mental health	Adolescents with highest level of psychological distress		LGA	2009		General	Department of Education and Early Childhood Development Adolescent Profiles,	*Click on 'Measures of community connection and other local survey results'	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		% Adults reporting a high/very high degree of psychological distress		LGA	2011–2012		General	Victorian Population Health Survey 2011/12		
		Adults with inadequate sleep (<7 hours per weekday)		LGA	2012		General	VicHealth Indicators Survey		
		Adolescents without positive psychological development		LGA	2009		General	Department of Education and Early Childhood Development Adolescent Profiles, 2009		
		Adolescents with eating disorders		LGA	2009		General	As above		

DATA SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data)	DATA COLLECTION INTERVAL (if repeated)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Statistical data for Victorian Communities	Community Strengthening – sexual health	Sexually-active adolescents who do not practise safe sex by using a condom		LGA	2009		General	As above		http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		Rate of sexually transmissible infections in 12-17 year olds (per 100,000 young people)		LGA	2012		General	Victorian Child and Adolescent Monitoring System (DEECD), 2012		
	Disability and carers	Disability		LGA	2011		Age, gender, total	Census	*Under 'Disability and Carers'	http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities
		Lone persons by disability status		LGA	2011		Age, gender, total	Census		
		Carers		LGA	2011		Age, gender, total	Census		

VCAMS data sources for bullying indicators include:

- Victorian Student Health and Wellbeing Survey
- Attitude to School Survey

SOCIAL EXCLUSION System and Process Indicators

SOURCE	BROAD INDICATOR	SPECIFIC INDICATOR	DOMAIN	LEVEL (state, regional, LGA)	YEAR (most recent data collection)	DATA COLLECTION INTERVAL (if repeat data collection)	HOW SPECIFIC? (e.g. sort by gender, age-group, ethnic group etc?)	REPORT	LOCATION/ SPECIFIC ISSUE	WEBSITE
Agencies	Service delivery	# Volunteering services	Volunteering	Variable	Annual	Annual proposed	Sort by region, age-group etc.			
Various – LGA	Service delivery	# Social inclusion programs	Social inclusion	Variable	Annual	Annual proposed	Sort by region, age-group etc.			
Schools	Service delivery and policy	Bullying prevention and intervention	Social exclusion	Variable	Annual	Annual proposed	Sort by region, age-group etc.			
Schools	Service delivery and policy	School suspension and exclusion		Variable	Annual	Annual proposed	Sort by region, age-group etc.			

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DEAKIN
UNIVERSITY

CENTRE FOR SOCIAL AND EARLY EMOTIONAL DEVELOPMENT (SEED)
Phone: +61 3 9244 5248
Fax: +61 3 9244 6858

Deakin University
221 Burwood Highway
Burwood VIC 3125
www.deakin.edu.au/seed