Royal Commission
into Family Violence

WITNESS STATEMENT OF JEREMY LUKE HEARNE

I, Jeremy Luke Hearne, social worker, of 3-15 Matthews Ave, Niddrie, in the State of Victoria, say as follows:

1. I am authorised by cohealth to make this statement on its behalf.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3. cohealth made a Submission to the Royal Commission into Family Violence in May 2015. **Attached** to this statement and marked '**[JH-1]**' is a copy of 'Submission to the Royal Commission into Family Violence' dated May 2015. I refer to and adopt that Submission (**Submission**).

4. I have been asked to comment on several matters, some of which have also been canvassed in the Statement.

Current role

5. I am currently employed as the Manager for Prevention North and Inner North at cohealth. This includes co-responsibility for cohealth's state funded Integrated Health Promotion program which prioritises Mental Health, Prevention of Violence Against Women and Sexual and Reproductive Health.

Background and qualifications

6. Between November 2012 and July 2015, I worked at the Western Region Health Centre (which ultimately became cohealth) which provides integrated medical, dental, allied health, mental health and community support services, delivers programs to promote population health and wellbeing, and undertakes research and advocacy. During this time I have acted as the Health Champions Project Leader and Manager Prevention North and Inner North.

7. Between May 2008 and November 2012 I worked at Plenty Valley Community Health which provided services to residents of the City of Whittlesea in dental, disability, physiotherapy, podiatry, diabetes care, psychology, mother-baby services, general practice, women's health, and health promotion. During this

time I acted as the Manager Prevention and Population Health and Team Leader Health Promotion.

8. Between November 2004 and May 2008, I worked at Crisis Support Services which provided a variety of telephone counselling support services including Mensline Australia, which is a national family and relationship support line for men. During this time I acted as the Manager of Programs and Community Liaison Coordinator.

9. I have the following qualifications:

   9.1. In 2003 I obtained Bachelor of Social Work (Hons);

cohealth

10. cohealth is a not-for-profit registered community health service which provides integrated medical, dental, allied health, mental health and community support services. cohealth delivers programs to promote population health and wellbeing, and undertakes research and advocacy.

11. cohealth formed in 2014 as result of a merger between Doutta Galla Community Health, North Yarra Community Health and Western Region Health Centre. Its mission is to improve community health and wellbeing, as well as tackling inequality, in partnership with people and the communities they live in.

12. cohealth has over 850 staff, operating from 44 sites across 14 local government areas in the north and west of Melbourne.

13. Over 110,000 people use our services annually. cohealth provides quality services across family violence, mental health, oral health, alcohol and other drugs, aged care and medical and integrated health services.

14. Our services prioritise those who are disadvantaged or marginalised because we know that these groups experience the poorest health. Our locations service areas with extensive public housing, a high incidence of homelessness and large numbers of new migrants, with 50% of our clients born overseas. In many of our communities, access to employment and education is inadequate, social participation compromised and consequently health status of populations poor. We provide services for:

   14.1. Local communities;

   14.2. Refugees and asylum seekers;

   14.3. Aboriginal and Torres Strait Islander peoples;

   14.4. People at risk of harm associated with alcohol and drug use;

14.5. Families and young people at risk;

14.6. Disadvantaged and disenfranchised people;

14.7. People with or at risk of chronic disease;

14.8. People with or at risk of mental illness or poor mental health;

14.9. Older people with complex needs; and

14.10. People who are, or at risk of being, homeless.

15. cohealth specialises in working together with the people who use our services to design and provide innovative and responsive care, in partnership with communities, consumers and all of our stakeholders.

The role of cohealth in addressing family violence

16. cohealth has both broad and deep experience in the field of family violence prevention and response. We provide specialist response programs such as family violence counselling (over 200 clients a year) and the Victims Assistance Program (over 500 clients a year). We have undertaken extensive family violence primary prevention activities with culturally and linguistically diverse communities and place based initiatives, with a particular focus on the development of community members as peer facilitators.

17. cohealth is an active partner in a range of other family violence primary prevention programs and strategies, including the following:

17.1. Preventing Violence Together, which is the western region action plan to prevent violence against women;

17.2. The UNITED project;

17.3. Respectful relationship programs;

17.4. White Ribbon Day;

17.5. 16 Days of Activism; and

17.6. The Western Region Crime Prevention Advisory Committee (amongst others).

18. cohealth recognises that family violence is a health issue, as it has detrimental impacts on physical and mental health. As such, family violence can be understood as part of a web of the social determinants of health. cohealth's service delivery, prevention work and advocacy are based on the social model of health. This approach also highlights the interaction between family violence and a range of political, social and cultural factors.

Place Based settings and Culturally Based settings

19. cohealth design models for specific initiatives in either a 'Place Based' manner, or a 'Cultural Based' manner, as follows:

20. *Place Based settings*

20.1. A Place Based approach is designed around creating strategies for a community who all live, work or attend a shared place. For example, the geographical nature of the place based approach would mean that the community is defined as one which uses a specific early childhood centre or kindergarten, and are informed by their shared experiences and use of services in that space. Another example of a place based approach is a community within a specific suburb, housing estate or local government municipality. Place based approaches can target the specific determinants of health in a location such as housing, income, or violence.

21. *Culturally Based settings*

21.1. A culturally based approach targets defined cultural groups (for instance, the Indian community, or the Vietnamese community) who share common experiences and needs but may not be living within a finite area. This approach takes account of cultural norms specific to the community, and tailors its approach to their shared cultural or linguistic identity. For example, the 'Living in Harmony' project run through cohealth was contained to three specific targeted communities, which are the Vietnamese, Chinese and Horn of Africa communities, and raises issues specific to those individual communities. Each of these three communities have different issues and different lived expectations associated with family violence and gender equality. No two communities or cultures are precisely alike, so targeted and tailored approaches are the most appropriate way to ensure effective primary prevention and intervention family violence initiatives.

22. In terms of the practical application for these two community based models, at first instance, the model or program must identify the place or cultural community with whom it intends to work. Once the community is identified and defined, there then must be engagement with the community before any work begins to ensure the establishment of trust and respect between the community and funded agency. As each community has its own diverse needs, experiences and characteristics, therefore there is not a uniform method of engagement. However consistent

principles of engagement are utilised which include building trust through listening; honouring community as experts in their lived experience; identifying and naming existing strengths within the community; and identifying and respecting the existence of cultural practices that may assist (or hinder) the change process.

23. cohealth does not enter into work with a community with a pre-determined project in mind, as a program which may be useful to a Western African community, for instance, may not be appropriate for a Indian community. The program must arise from the communities' own requirements and identified needs and it must be built on existing relationships. It is critical that workers meet the community where they are based, to listen to their stories and co-design a tailored response.

Changing cultural attitudes

24. There must be an holistic approach to changing cultural attitudes. The first step in the process is assessing community readiness, as if there is not a willingness or readiness to engage, potential programs or services may not be taken up. This first step starts with conversations with individuals or groups within the community. Assessing community readiness will also assist in determining the starting point for a given initiative. For example Flemington 360 commenced with the simple aim of 'commencing a community conversation about violence against women with people from East African background.' Additional broad questions might include: how do they define health? What does a safe community look like to them? What are current issues faced within the community?

25. If there are issues having a conversation with community leaders, our experience is that strengths within communities often lie elsewhere within the group. We have found that connecting with women, young people or men who take a different view to the community leaders may mean that we can begin a dialogue on issues specific to the community. We can resource those community members who are ready to begin the discussion. It is essential to have community engagement, as programs which are not designed in consultation with the community may be perceived as an imposition.

26. If there is community readiness and engagement, we can create a model which is best suited to the specificities of the group. The model should address both short and long term outcomes. The short term outcomes could simply be the provision of information about support services which are available in the area, and what those support services provide. We then seek to address long term, systemic, and attitudinal change to reduce family violence. This process may begin by discussing what violence means to the community, and whether the definition of

violence is simply physical, or whether it includes verbal, financial and emotional violence.

27. It is also essential to speak with the community with a careful use of language. We have found that some newly arrived communities simply do not have a definition or word for family violence in their culture or language. We seek to have an understanding of the existing expectations of men's and women's roles within the community. We have experienced that initially, it may not be appropriate to speak about 'family violence' using that specific language, but rather start with concepts of gender inequality, and build on the language from there. Alternative conversation starting points have included talking about 'healthy family relationships.'

28. We hold conversations with women within the community in relation to what the Australian legal system has the power to do, and speak about the rights that women have to obtain legal assistance. These kinds of conversations can happen within culturally specific settings, such as doll making celebrations or coffee ceremonies which are a gender specific safe space within the broader communities. Holding the conversations in safe, gendered and appropriate spaces can assist in the a shift in attitudes and understandings of family violence. This kind of gender based engagement is about sharing lived experiences and safely communicating family violence related social norms.

29. We also prepare elements to the community based primary prevention model which can work across different generations, as the beliefs of older people within a community can significantly differ from those of younger members. Different communities, including those defined by language, culture, and identity require different approaches. All communities require long-term engagement to build relationships and trust, and to ensure that approaches work with existing community strengths and structures.

30. The use of community engagement workers sourced from the local community can assist in ensuring the ongoing involvement and engagement in community trust. If there is the support of peer leadership within the community, this will assist in building strategies for sustainability. Long after the project team have left, the teaching and guidance regarding issues associated with family violence can continue by the community engagement workers and peer educators. This also emphasises that the people within the community itself are empowered to solve community-based issues together.

Primary prevention within communities to prevent family violence

31. Community based primary prevention takes time, and community engagement and involvement is the key to successful outcomes. In some communities, there is an immense mistrust of any statutory body or of the police. If cultural change information comes through formal channels, it may seem as though the information is being forced on the community, and the community will often close its doors to further information, advice and support.

32. Some parts of the community require additional focus within prevention activities, such as programs that address the specific needs of women and children from culturally and linguistically diverse backgrounds. The programs should be designed to target the broader determinants of health, such as gender equity, that make these communities more vulnerable to family violence and less able to access support services.

33. Ideally, initiatives should actively engage and encourage men and boys in the primary prevention of violence against women whilst addressing cultural norms. This includes a continuum from early education with boys and young men through to adult institutions such as workplaces and sporting clubs where cultural norms are embedded and perpetuated.

34. While there is currently significant activity in the field of primary prevention, it is fragmented, and severely under-resourced. This prevention work is also undertaken in the absence of a deep evidence-base that can support learning and inform better targeted approaches. There needs to be a sustained investment in the evaluation of primary prevention endeavour. Targeted approaches work at the community level to prevent violence before it starts, or to reduce its impact through earlier recognition.

35. The good prevention work done to date needs further enhancement and expansion. Effective primary prevention requires sustained, secure funding which enables long-term engagement and capacity building with communities.

cohealth primary prevention projects – methodology and evaluation outcomes

36. cohealth has a long history of community based primary prevention work undertaken in partnership with culturally and linguistically diverse communities, and place based initiatives that engage deeply with local communities. These include the following:

    36.1. **STAMP** (Supporting Traditional African Mediators Program) with African communities across the West of Melbourne;

    36.2. **UPSCALE** (UP Skilling Community and Legal Education) with ethnic-Burmese communities in Wyndham and Brimbank;

36.3. **SHIFT** (Supporting Harmonious Indian Families Together) with the Jagriti Forum and Indian communities in Wyndham and Brimbank;

36.4. **Living in Harmony Project** with culturally and linguistically diverse communities living in the Collingwood high rise estates; and

36.5. **360 Degree Turnaround Project** in partnership with Flemington Neighbourhood Renewal.

37. Developing quality relationships within a community setting takes time, and the time spent on a project will have a significant influence on the project's success. These projects are only possible because of prior long term investment in building relationships within the community.

38. The above projects are discussed at length within cohealth's Submission, and the 360 Degree Turnaround Project is outlined briefly below, alongside another case study which is not reflected in detail within the Submission.

360 Degree Turnaround Project

39. cohealth currently works as a partner of the 360 Turn Around Project in the Flemington Community Estate. In 2014 as part of this initiative, we led a project to change gender attitudes in that community. Nine young people (males and females) from East African heritage were recruited to take part in a leadership course. This developed their community engagement skills and increased their knowledge of preventing violence against women as well as promoting gender equity.

40. The community engagement focused on promoting two events, a 'You the Man' (**YTM**) theatre performance and after show discussion, addressing bystander intervention to violence against women, and an accompanying warm up event, with the theme of discrimination, both of which were held at Flemington Community Centre. The Youth Leaders were successful in encouraging their peers to participate, with a total of 156 young people attending the two events.

41. Comparing pre and post survey results, there were increases in the number of people who felt able to take bystander action if they witnessed gender discrimination, and 87.5% of the attendees felt that witnessing the YTM performance increased their confidence to take action on behalf of someone else. Exit interviews and an evaluation session with the Youth Leaders indicated that seven of the group wish to be involved with future Cohealth work in this area, and that all nine members were "satisfied or "very satisfied with the results achieved by the project. The key to the success of the project was the involvement by the Youth Leaders from within the community.

Further Case Study – The 'Be Nice to your Mum' example.

42. Also within the Flemington Community Housing estate, there is an emerging soccer team called 'Phoenix'. Within Phoenix, all coaches and players are young men from East African communities. The male coaches have instigated a compulsory 'Be Nice to your Mum' hour if the players wish to play on the team. The 'Be Nice to your Mum' hour is designed so that the boys or young men help their mothers with household chores and spend time with their mothers for one hour per week. The young men and boys are very keen to play soccer on the Phoenix team, which leads to a strong incentive to complete the task. The focus of the approach is to indoctrinate respectful relationships with women, and to educate the boys and young men about the inequality of the division of labour within the homes of the participants. cohealth hopes that there is a flow on effect to the younger siblings of the young men and boys who partake in the program as the younger siblings observe the respectful way their mothers are treated. Ideally, this program will lead to the status quo of a safe and respectful gender environment.

43. It may be difficult to obtain an insight into the long term effect within the community, as the progress of the program is generational, therefore naturally slow. It is almost impossible to gauge how much the behaviour of the older siblings affects the long term attitudes of the younger siblings.

44. There are also associated cultural impediments, for example, the young women within the community are still not allowed to play soccer which excludes them from the program and its benefits. Yet slow progress of change is still progress. There are now mothers who would not ordinarily have an hour per week to spend with their sons able do so. In this kind of primary prevention program, we are looking for little shards of light that indicate incremental but long term positive change.

Recommendations

45. The root cause of family violence is gender inequity. Actions that remedy gender inequity are required at all levels of government and community. Strategic initiatives which address gender inequities and gender stereotypes are foundation components of a long term approach to eradicating family violence. Women and others have the right to personal safety, and not to be subjected to harassment, abuse, control or violence.

46. Additionally, there is a misunderstanding about the positive role men can play in community change, and the catalyst men can be as a positive voice in effecting

that change. There should be a whole-of-community approach to primary prevention against family violence, which is inclusive of the voices of men and boys who are actively demonstrating positive role modelling behaviours .

47. The response system to incidents of family violence is complex and difficult to navigate. Interactions with services in the legal system, the social service sector and the health system should not compound the difficulties faced by women affected by family violence. Women and others who enter into a system which cannot support them can be placed at additional risk by seeking such assistance. Additionally, response systems are chronically under-resourced. Increased attention to family violence issues is likely to place further pressure on already-stretched response services. Significant additional investment is required.

48. Our service delivery is based upon government data. cohealth's experience is that some of the data is inaccurate as it captures the data using a wide brush. For example, if you examine the data for the whole suburb of Ascot Vale, the data says the people within the community are doing well. However, the data doesn't reflect the reality of pockets within the community that require critical assistance, such as the inhabitants of public housing. The data does not provide granular, street by street detail which is required to make informed decisions about how to best provide health and support services.

49. When you work with a community on a community development project, you need to be sensitive to the effort individuals and groups are putting in and to recognise that appropriately. it is a mistake to assume that you do not have to compensate the community for their time, for instance. There needs to be appropriate recognition that the community are essentially doing what you want them to do, rather than the other way around. This includes consideration for investment in and budgeting for honourarium.

50. The good prevention work done to date needs further enhancement and expansion. Effective primary prevention requires sustained, secure funding which enables long-term engagement and capacity building with communities. This work needs rigorous evaluation of effectiveness.

51. Primary prevention work needs to be tailored and targeted. Population-wide awareness campaigns may be visible and relatively fast, but changes in attitudes and behaviours are unlikely to follow in the absence of targeted, tailored approaches. Different communities, including those defined by language, culture, and identity require different approaches. All communities require long-term engagement to build relationships and trust, and to ensure that approaches work with existing community strengths and structures.

52. A partnership approach is essential in community based primary prevention work. Partnerships provide an opportunity to invest at scale and draw in broader knowledge, skills, expertise and resources to support communities across the prevention continuum. A consequence of successful community based primary prevention is increased community knowledge, understanding and skills. This can result in increased utilisation of local service providers by diverse community members. Inclusion of direct service providers in place based planning and partnerships will equip them with the capacity to respond to the individual needs of diverse communities and improve the experience of those service users.

Jeremy Luke Hearne

Dated: 5 August 2015