The forgotten victims

Prisoner experience of victimisation and engagement with the criminal justice system

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

RESEARCH REPORT

ISSUE 01 | AUGUST 2018

ANROWS acknowledgement

This material was produced with funding from the Australian Government and the Australian state and territory governments. Australia's National Research Organisation for Women's Safety (ANROWS) gratefully acknowledges the financial and other support it has received from these governments, without which this work would not have been possible. The findings and views reported in this paper are those of the authors and cannot be attributed to the Australian Government, or any Australian state or territory government.

Acknowledgement of Country

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present, and future, and we value Aboriginal and Torres Strait Islander history, culture, and knowledge.

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Published by

Australia's National Research Organisation for Women's Safety Limited (ANROWS)
PO Box Q389, Queen Victoria Building, NSW, 1230 | www.anrows.org.au | Phone +61 2 8374 4000
ABN 67 162 349 171

The forgotten victims: Prisoner experience of victimisation and engagement with the criminal justice system
(Research report) / Andrew Day, Sharon Casey, Adam Gerace, Candice Oster, Deb O'Kane.
Sydney : ANROWS, c2018.
Pages ; 30 cm. (Research report, Issue 01/2018)

I. Women prisoners – Australia. II. Domestic violence – Help seeking behaviour. III. Intimate partner violence – Help seeking behaviour – Research. IV. Victim services. V. Victims of crimes surveys – Australia.

I. Day, Andrew. II. Casey, Sharon. III. Gerace, Adam. IV. Candice Oster. V. O'Kane, Deb.

ISBN: 978-1-925372-85-4 (print) | 978-1-925372-87-8 (online)

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This report addresses work covered in the ANROWS research project 14.21 *The forgotten victims: Prisoner experience of victimisation and engagement with the criminal justice system*. Please consult the ANROWS website for more information on this project.

ANROWS research contributes to the six *National Outcomes of the National Plan to Reduce Violence against Women and their Children 2010-2022*. This research addresses National Plan Outcome 4 – Services meet the needs of women and their children experiencing violence.

Suggested citation:
Day, A., Casey, S., Gerace, A., Oster, C., & O'Kane, D. (2018). *The forgotten victims: Prisoner experience of victimisation and engagement with the criminal justice system* (Research report, 01/2018). Sydney, NSW: ANROWS.

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Author acknowledgement
We would like to sincerely thank our industry partner (Ms Bernie McGinnes, Department for Correctional Services, SA) and all of our interviewees who freely gave their time to support this research. We are indebted to the following members of our project reference group for supporting this research: Ms Katherine McLachlan (University of South Australia, the Adult Parole Board, SA, and previously Victim Support Services), Dr Robyn Martin (Curtin University), Ms Joanne Leonello (Aboriginal Services Unit and member of the Domestic and Family Violence Committee, Department for Correctional Services, SA), Ms Tahnya Wood (manager of the Specialist Services Unit in the Department of Correctional Services, WA, and Ms Helen Cheetham (manager of the Specialist Unit, Adult Justice Services). The views expressed in this report do not necessarily reflect those of either the reference group members or the agencies that they represent.

The authors would like to acknowledge the philanthropic support of Sparke Helmore Lawyers for this research, without which it would not have been possible.

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Executive summary

Many women in prison have experienced intimate partner violence (IPV). As this form of violence is often intergenerational and entrenched, women in prison are widely considered to be at particular risk of ongoing victimisation following release from custody. And yet, their support needs often go unrecognised, and it is likely that a range of barriers exists that prevent ex-prisoners from accessing services.

This research documents a series of interviews with both incarcerated women and service providers in one Australian jurisdiction to arrive at an understanding of help-seeking behaviour and how this might inform service responses. It is not concerned with advancing current understandings of why women come into contact with the justice system, although it is clear that services and programs that prevent IPV will contribute to reduced criminal justice involvement. The analysis is positioned within a review of current theories of how people seek help from both formal and informal sources and how these theories might apply to women in prison.

These theories suggest that any individual who experiences IPV must: 1) recognise and define the abusive situation as intolerable; 2) decide to disclose the abuse and seek help; and 3) select a target for the disclosure and where to subsequently seek help from. At the same time, the ability to seek help is influenced by a broad range of individual, interpersonal and socio-cultural factors. Socio-culturally, for example, IPV is often viewed through the lens of particular social, religious and cultural institutions where male–female power inequalities are reinforced. Figure 1 provides a summary of those factors that influence help-seeking at each stage of the process.

The interviews with women in prison clearly illustrated the need for service providers to offer support at each of these three stages; they also illustrated how the process of re-entering the community leaves many women who have been released from prison feeling insufficiently empowered to access help independently. The interviews with service providers highlight that although services are available to victims of IPV, they rarely provide the type of support required to engage ex-prisoners.

The research suggests there is much that can be done to prepare women for their eventual release back into the community and to support them in the period following release. Specialist safety services are needed to provide education and information about IPV, to assess the particular risks faced by women in prison, to broker service access with community agencies and to provide general support and advocacy. In short, a dedicated integrated response to community reintegration is indicated that can help to break the cycle of victimisation and incarceration that is characteristic of the lives of many women in Australian prisons.

Figure 1 Model of help-seeking and change for women in prison

Introduction

Women represent the fastest-growing section of the prison population, not only in Australia but across the Western world. And yet despite notable differences between the genders in the types of offences that result in imprisonment, service responses have, to date, been largely informed by knowledge about male prisoners. What are sometimes referred to as gender-responsive theories of crime, however, propose that female offenders experience unique life events that create offence pathways that are dissimilar to those of male offenders (Bloom, Owen, & Covington, 2005; Salisbury & Van Voorhis, 2009), drawing attention to how adverse life events (such as the experience of abuse) often act as key antecedents to a range of personal problems that, in turn, lead to offending. It has been well established, for example, that women in prison self-report higher levels of need than males for mental health and substance abuse services, as well as for parenting and family counselling programs (Fedock, Fries, & Kubiak, 2013; Spjeldnes, Jung, & Yamatani, 2014). Needs in these areas are likely to exist prior to, during and subsequent to incarceration and thus the provision of support for women leaving prison becomes a key area of service delivery.

This study is not concerned with the causes of crime or the way in which sentences are handed down. Rather, the focus is on understanding how support can be provided to women who are leaving prison to help reduce the risk of intimate partner violence (IPV). It is clear that some women return to situations in which there is a genuine concern for their safety, and yet significant barriers may exist that prevent them from engaging with community services.

The aim of this report is to highlight those factors that potentially influence help-seeking, from both the perspective of women who are in prison and those government and non-government agencies that provide support after release. From the outset, however, it is important to note that any decision to seek (or not to seek) help will be inevitably bounded by the context in which the problem arises and the choices that are available to women at the time. With this in mind, it is important to first understand current thinking and theorising about help-seeking in general, before seeking to apply this knowledge to the experiences of women in prison.

Literature review

Intimate partner violence (IPV) is not only the most prevalent form of violence against women,[1] but a major contributing risk factor to mental illness (e.g. depression; post-traumatic stress disorder; substance abuse), physical ill-health (e.g. hypertension), and homelessness (Cerulli, Poleshuck, Raimondi, Veale, & Chin, 2012; Golding, 1999; Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Morgan & Chadwick, 2009; On, Ayre, Webster, & Moon, 2016). IPV is most often classified by type – including: physical (i.e. threat or use of force against a partner to cause harm or death); sexual (i.e. threat of or use of force to engage a partner in sexual activity without consent; attempted or completed sexual act without consent; or abusive sexual contact); emotional/psychological (i.e. using threats, actions, or coercive tactics that cause trauma or emotional harm to a partner); and financial (i.e. being unable to make even small financial decisions; being denied control of one's own income)[2] (see Breiding, Basile, Smith, Black, & Mahendra, 2015; Cortis & Bullen, 2016; On et al., 2016) – cumulative victimisation (as compared to single incidents) is known to often result in serious problems across the life-course, particularly when it commences prior to 18 years of age (Carlson, McNutt, & Choi, 2003; Classen, Palesh, & Aggarwal, 2005; Seedat, Stein, & Forde, 2005; World Health Organization, 2013).

In fact, research by Whitfield and colleagues (2003), which involved more than 8000 participants, found that childhood physical abuse, childhood sexual abuse and the witnessing of maternal IPV approximately doubled a woman's own risk of victimisation, with this figure increasing when multiple types of childhood victimisation had occurred. The most severe form of IPV, intimate partner homicide (IPH), is now recognised as a global public health problem (Murphy, Liddell, & Bugeja, 2016). More commonly perpetrated by men against women (and in some cases, their children), this type of violence is considered preventable as it tends to follow an identifiable history of physical, sexual and/or psychological abuse (Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Virueda & Payne, 2010).

Over the past decade, a range of strategies for addressing IPV and IPH have been implemented at local, state and national levels. In Australia, the most recent of these has been *The National Plan to Reduce Violence against Women and their Children 2010-2022* (Council of Australian Governments [COAG], 2011) and the Victorian *Royal Commission into Family Violence* (Victoria. Royal Commission into Family Violence, 2016). Despite attempts to raise awareness, and what appears to be greater availability of resources and services aimed at reducing the incidence and prevalence of IPV, it has been reported that many formal services are under-utilised (Fleming & Resick, 2016; Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Kaukinen, Meyer, & Akers, 2013; Morgan & Chadwick, 2009). Studies have also concluded that a lower percentage of women who have experienced abuse actively access specialist services (Barrett & St Pierre, 2011; Mouzos & Makkai, 2004) compared to the number who seek help from informal supports such as friends, family members and co-workers (Barrett & St. Pierre, 2011; Flicker et al., 2011; Moe, 2007).

Disclosure of IPV has shown to be dependent on a number of factors, even when help-seeking involves informal supports. As Sylaska and Edwards' (2014) review noted, willingness and motivation can be influenced by victims' demographic characteristics (e.g. gender; age; socio-economic status), intrapersonal attributes (e.g. the meaning attached to violence; feelings of fear preventing disclosure) and situational variables (e.g. type of violence; severity and/or frequency of violence; witnesses to the violence). Importantly, when the experience with informal supports is positive, more formal help-seeking decisions are made, including the utilisation of law enforcement, crisis accommodation and financial support (Goodkind, Gillum, Bybee, & Sullivan, 2003; Moe, 2007).

Given that some individuals do not disclose their IPV experiences and that a substantial proportion of victims rely solely on informal supports (Barrett & St. Pierre, 2011; Du Mont, Forte, Cohen, Hyman, & Romans, 2005; Fanslow & Robinson, 2010; Flicker et al., 2011) rather than accessing formal services, it is important to understand those barriers that discourage disclosure; in particular, why women may choose not to access services that have the potential to ensure safety and decrease the physical and psychological symptoms that result from victimisation (Kennedy et al., 2012; McCart, Smith, & Sawyer, 2010). From the outset, however, we note that some studies will classify certain behaviours as help-seeking while others will not. For example, survivors may make disclosures that go unrecognised by others as requests for help. The aim of this review of the published literature is to identify what is currently known about barriers and enablers to the disclosure of IPV and

1 While women and men can be both perpetrators and victims of interpersonal violence, for the purpose of the present review, the focus is on female victims. Consequently, if used, the male pronoun will refer to perpetrators and the feminine pronoun to victims. It should also be noted that the terms "IPV victim" and "IPV survivor" are used in the literature. As noted by Liang, Goodman, Tummala-Narra, & Weintraub (2005), these terms represent women as both victims and survivors who actively resist the violence in their lives in order to ensure their safety.

2 Social and spiritual abuse also constitute IPV (Harpur & Douglas, 2014; Morgan & Chadwick, 2009).

subsequent help-seeking behaviours. This research is specifically interested in understanding help-seeking in women who are involved with the criminal justice system, but it is necessary, in our view, to first understand help-seeking for IPV more broadly, before considering the impact of the confluence of victimisation and incarceration.

In order to contextualise this information, the literature review will begin with a consideration of *how* and *why* these decisions are made, before briefly reviewing the scope of help-seeking behaviours and the main theoretical perspectives that seek to explain help-seeking in the IPV domain. This is followed by a review of what is known about barriers to help-seeking and the specific experiences of women who are involved in the criminal justice system.

Defining intimate partner violence

Although IPV was initially generally associated with physical violence perpetrated by an *intimate partner*, its definition has subsequently broadened to include sexual, psychological, social, economic and spiritual abuse (Harpur & Douglas, 2014; Morgan & Chadwick, 2009). An intimate partner has been defined as a current or former spouse, boyfriend/girlfriend or individuals involved in any other type of intimate or dating relationship, which may be cohabiting or non-cohabiting (Lum et al., 2016; Sawyer, Coles, Williams, & Williams, 2015). IPV applies to both heterosexual and same-sex relationships. In terms of the definition of the various types of abuse, physical violence includes various forms of physical harm and assault, such as being pushed, choked, hit, the use of a weapon or object to cause harm, as well as threats to harm, while sexual violence is any non-consensual and/or coercive intercourse, sexual act or sexually assaultive behaviour (i.e. unwanted touching) (Mouzos & Makkai, 2004; On et al., 2016; Webster et al., 2014). It is important to note that non-consensual sex between married spouses was only recognised as the criminal act of rape and legislated in all Australian jurisdictions in 1992 (Harpur & Douglas, 2014). Psychological abuse, also described as emotional abuse, can include: degrading and offensive language and conduct; stalking; and threats that control, intimidate and isolate a person and that incite fear and distress within the victim (O'Leary & Maiuro, 2001; On et al., 2016). Also falling under the umbrella of psychological abuse are social, economic and spiritual abuse, which are specific forms of IPV that involve coercive, intimidating, controlling and isolating behaviours through means such as denying a partner access to finances or denying a partner the ability to see family and friends independently (Cortis & Bullen, 2016; Mouzos & Makkai, 2004; Webster et al., 2014). While non-physical psychological forms of IPV may not lead to physical injury, they can cause equal or greater harm to a victim and are frequently reported as coinciding with physical and sexual violence (On et al., 2016; Webster et al., 2014).

Describing the victims of intimate partner violence

IPV can affect people irrespective of gender, relationship type, socio-economic status, religion, ethnic or cultural background, age or geographic location (Beaulaurier, Seff, & Newman, 2008; Calton, Cattaneo, & Gebhard, 2016; Howard, Trevillion, & Agnew-Davies, 2010; Meyer, 2016). There are, however, certain factors that can render a person to be more vulnerable and susceptible to its occurrence, either as victim or perpetrator. Although some early research suggested that bi-directional abuse (i.e. where both partners are perpetrators and victims) was the most common form of IPV (Headey, Scott, & De Vaus, 1999), this notion has now been consistently rebutted in the literature. There is, for example, evidence to support the claim that male-to-female perpetrated violence is the more predominant form and leads to more sexual violence and more severe harm (both physically and mentally) as well as more significant injuries (Hegarty et al., 2010; Robertson & Murachver, 2007). There is also an increased likelihood that male-to-female IPV will escalate to IPH (Cussen & Bryant, 2015; Murphy et al., 2016; Virueda & Payne, 2010). The Australian Bureau of Statistics' (ABS) 2016 *Personal Safety Survey* reported that two in five adult Australians had experienced an incident of physical or sexual violence since the age of 15, 42 percent of whom were men (3.8 million) and 37 percent women (3.4 million). Females were, however, almost three times more likely to experience violence by a current and/or previous partner they lived with than males (17%; 1.6 million compared to 6.1%; 547,600).

Studies (e.g. Gass, Stein, Williams, & Seedat, 2011) that have found no statistically significant difference between male- and female-perpetrated IPV have generally used the Conflict Tactics Scale (CTS; Strauss, 1979). This measure has been widely criticised for not taking into account coercive tactics, the context, the intensity or the consequence of a behaviour; nor does the CTS include incidents that occur post-separation; and it excludes sexually abusive behaviours, stalking and choking (Hegarty & Roberts, 1998; Taft, Hegarty, & Flood, 2001). Taft and colleagues (2001) have argued that examining perpetration

and victimisation data from multiple sources in Australia, such as police, courts and hospitals, continuously paints a different picture than that depicted in studies using the CTS, and reflects that, although there are undoubtedly male victims of IPV, the vast majority of IPV victims are female. In fact, researchers have stated that when context and motive are accounted for, female-to-male violence is often reactive, a retaliation to IPV or occurs in self-defence (Taft et al., 2001; Wolf, Ly, Hobart & Kernic, 2003). For example, Murphy et al. (2016) found in Victoria's 120 recorded incidents of IPH between 2000 and 2008, just over half the female perpetrators (n = 16/30) had recorded histories of IPV victimisation perpetrated by their partner. Similarly, in a national overview of domestic/family homicides in Australia from 1 July 2002 to 30 June 2012, IPV accounted for 56 percent (n = 654) of victims of domestic/family homicides, with 75 percent (n = 488) of female victims having a known prior history of IPV (Cussen & Bryant, 2015).

Factors associated with low socio-economic status, such as poverty or low income, poor housing, unemployment, living in rural or remote areas and low education levels are known to place women at an increased risk of victimisation (Campbell & Mannell, 2016; Dillon, Hussain, Loxton, & Khan, 2016; Morgan & Chadwick, 2009; Ragusa, 2012). There is also evidence that certain minority groups are over-represented in IPV victimisation statistics. These include Aboriginal and Torres Strait Islander women, women with disability, women with mental health issues and incarcerated women (Campbell & Mannell, 2016; Eliason, Taylor, & Arndt, 2005; Harpur & Douglas, 2014; McCarthy, Hunt, & Milne-Skillman, 2017; Morgan et al., 2016; Royal Commission, 2016; Zust, 2009; Zweig, Schlichter, & Burt, 2002).

There is minimal research, particularly in Australia, on the prevalence of and risk for victims of IPV with pre-existing mental health conditions (i.e. the focus is typically on the impact of IPV on mental health given the strong association between IPV and adverse mental health outcomes for victims), although Pill, Day and Mildred (2017) have recently discussed the impact of complex trauma on safety behaviours. IPV victims have been shown to experience high rates of depression; anxiety; low self-esteem; self-harm and suicidal ideation; post-traumatic stress disorder (PTSD); and an increased risk of co-morbid mental illness (Bacchus, Mezey, & Bewley, 2003; Ferrari et al., 2016; Hegarty et al., 2010; Howard et al., 2010; Kessler, Molnar, Feurer, & Appelbaum, 2001; Mertin, Moyle, & Veremeenko, 2015). There is also evidence that victims of IPV have an increased risk for co-occurring drug and alcohol abuse, with drugs and alcohol often used as avoidance coping mechanisms (Bacchus et al., 2003; Howard et al., 2010). A number of studies have also found some evidence of a link between mental health problems and IPV victimisation (e.g. Devries et al., 2013; Hahn, McCormick, Silverman, Robinson, & Koenan, 2014; Riggs, Caulfield, & Street, 2000; Stith, Smith, Penn, Ward, & Tritt, 2004; Trevillion, Oram, Feder, & Howard, 2012), although this body of work – in the absence of longitudinal research designs – has been unable to determine the direction of causality (Trevillion et al., 2012).

Scope of help-seeking behaviours

Help-seeking is often the first step taken by individuals in their efforts to escape IPV (Amar, Bess, & Stockbridge, 2010; Sylaska & Edwards, 2014). It incorporates a range of behaviours, including: seeking advice, encouragement, support (emotional and financial) or a place to stay from peers and family members; support from religious or spiritual leaders; attending counselling, general practitioners (GPs), medical centres or hospitals; the involvement of police, lawyers or the legal system; moving to a domestic violence shelter; or engaging with victim services organisations. In essence, help-seeking involves a process of seeking-out information, support and protection (Liang et al., 2005).

As noted above, the majority of victims have been reported to prefer informal (e.g. friends, family members, co-workers) over formal (e.g. police, medical staff, social workers, counsellors/mental health professionals) support providers; this preference is consistently shown to be independent of victim characteristics such as race/ethnicity and age (e.g. Barrett & St. Pierre, 2011; O'Campo, Shelley, & Jaycox, 2007), although typically the constraints that may limit these choices are not described. A large Canadian study by Barrett and St. Pierre (2011) reported that just over 80 percent of female survivors of physical and sexual abuse (n = 922) used at least one informal support source, compared to the 66 percent who utilised at least one formal source and/or support. The most frequently used informal help-seeking strategies were disclosure to a friend or neighbour (67.5%), family member (66.5%) or co-worker (27.8%). Formal help-seeking most frequently involved contacting a counsellor (39.1%), talking with a doctor or nurse (31.9%) or contacting a crisis line or centre (17.3%); less frequently, it involved contacting police or court-based services (6%), an emergency shelter or transitional housing program (11%) or contacting a women's centre (11.2%). The authors (Barrett & St. Pierre, 2011) concluded that despite the "widely perpetuated image of women in

violent relationships as passive recipients of violence" (p. 59), their findings demonstrate an attempt by women in abusive relationships to actively use available resources – both formal and informal – to ensure their survival and/or assist them in exiting these relationships. Given the long-term consequences of IPV, it is concerning, however, that just over one-third of the women surveyed (34%) reported using no formal supports or services. The most recent Australian data on help-seeking, the *Personal Safety Survey* (ABS, 2016) shows, for example, that two-thirds of men and women who experienced physical assault by a male did not report the most recent incident to police (69% or 908,100 for men and 69% or 734,500 for women).

In an earlier Canadian study, Du Mont et al. (2005) examined whether public awareness campaigns and service enhancement programs led to changes in the utilisation of support services over time. A comparison of national data from 1993 (n = 2019) and 1999 (n = 922) relating to reports of physical and/or sexual violence revealed an upward trend, although once again the preference was for informal, rather than formal, support. Comparisons of the data sets with respect to informal supports revealed that abuse victims in the later period were significantly more likely to disclose a violent incident(s) to a family member (66.4% vs 43.9%) or friend/neighbour (67.4% vs 45.4%). While this trend was also found for formal support services, the percentage of women accessing these services was lower: disclosing to a doctor or nurse (31.9% vs 23%); counsellor or psychologist (39.1% vs 14.7%); presenting to a shelter or transition house (11% vs 7.8%); a crisis centre (17.3% vs 4.2%); a women's centre (11.2% vs 3.4%); and/or a community or family centre (15.4% vs 4.7%). Of those women who did not seek help, fewer women surveyed in the later study reported they did not know about any services (6.4% vs 17%) or that services were not available (0.8% vs 14.5%). Despite these changes, the authors noted that the overall rates of service utilisation remained low even when women were aware of the services that were available.

A New Zealand study, undertaken by Fanslow and Robinson (2010), revealed a slightly different trend to that described above. Participants in their sample (n = 956), comprising almost equal numbers from rural and urban areas, had experienced one or more acts of IPV in their lifetime. Those who had experienced moderate or severe abuse (n = 362) reported having been victims of both sexual and physical violence. While the majority of women (76.7%) had disclosed their experience of IPV to at least one other person, not all sources of support proved to be helpful. The largest proportion (43.5%; n = 416) used informal help-seeking strategies, seeking help from parents (37.4%) or siblings (29%). Just over one-quarter (27%; n = 258) used both informal and formal sources and/or support, with 4.2 percent (n = 40) accessing formal supports and no informal supports. Almost one-quarter (23.3%) indicated that they had not told anyone about their experience of IPV nor had they engaged in any help-seeking behaviour. It is worth noting that women in this study who had experienced severe physical violence were significantly more likely to disclose the abuse than those whose experience was exclusively sexual violence. In terms of whether the help-seeking had been successful (i.e. regarded as "helpful"), less than half of the women who disclosed their partner's violence to his family reported that these individuals tried to help. Similarly, one-third of women who had experienced abuse who disclosed experiencing violence to their own family members reported that the person they told had not tried to help. Satisfaction with formal supports was no higher, ranging from 15.9 percent who were satisfied with the help offered by GPs and other healthcare providers (24.4% sought help); 21.9 percent who were satisfied with mental healthcare providers (13% sought help); and 31.3 percent who were satisfied with police (25.4% sought help). The important point to take from this study is that while disclosure rates may exceed those that have been reported previously, 40 percent of the women in the study who had experienced IPV stated that no one had tried to help them.

Research undertaken by Flicker et al. (2011) examined the differential impact of concomitant forms of violence (i.e. physical, sexual, psychological, and stalking) on informal help-seeking behaviours in a large sample (n = 1756) of "White" (75.3%), African American (11.3%) and Latina (7.6%) women. In addition to experiencing physical abuse by a male intimate partner, 247 (14.1 %) reported they had experienced sexual abuse; 420 (24.5%) experienced psychological abuse; and 204 (11.6%) had experienced stalking by that same partner. Consistent with previous research, women (irrespective of cultural background) reported that that they preferred informal help-seeking strategies, turning to family (31.9% overall) and friends (30.8% overall). However, while Latina women were equally likely to seek help from family, they were less likely than "White" women to seek help from friends. The police (26.5% overall) and mental healthcare services (25.6% overall) were the most frequently used formal support services, with the women less likely to take out protection orders (16% overall) or seek medical care (12.2% overall). As in other studies (e.g. Hutchinson & Hirschel, 1998; Pearlman, Zierler, Gjelsvik, & Verhoek-Oftedahl, 2003), African American and Latina women in this study were more likely to seek help from the police. African American

women were also more likely to seek protection orders than their "White" counterparts, while "White" women showed an increased propensity to engage with mental health services. In terms of concomitant violence and help-seeking strategies, the study found that women who experienced stalking sought help from a greater number of sources than those who experienced physical abuse without stalking. Women who had experienced sexual abuse used fewer sources of support than women who had experienced other forms of violence. Neither ethnicity nor the experience of psychological abuse was associated with the number of help-seeking strategies used. Based on their findings, the authors concluded that the overall amount of abuse experienced is unrelated to help-seeking behaviours but, rather, it is the specific types of concomitant abuses experienced that lead the victim to seek help.

Australian research, reported by Taylor and Putt (2007), focused specifically on the experience of sexual violence by women from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds. Despite the prevalence of abuse within each cohort, available and satisfactory support – either informal or formal – was limited. While there are some common factors that potentially limit access to support across all cohorts (e.g. shame, guilt, family attitudes), cultural context was also found to play a critical role in decisions to not seek help. In terms of help-seeking, informal supports were less accessible, with barriers including familial denial of sexual violence and the fear of being ostracised (by family and the wider community) should they report a perpetrator to the police. Another barrier identified by participants in this study was fear of retaliatory violence against children and/or family members by a perpetrator and his supporters. At the formal level, women voiced concerns about inadequate and culturally inappropriate responses by police (e.g. not being believed; being further traumatised by the police response); failure by the police and criminal justice system to adequately punish perpetrators; and, importantly, fear of social welfare officers removing their children. Additional barriers to help-seeking for women from culturally and linguistically diverse backgrounds included not knowing or understanding that the sexual violence is a criminal act and the loss of family support. At the formal level, the barrier to involving police appeared to be exacerbated for some culturally and linguistically diverse victims/survivors, due to previous adverse experiences with the police in their former homeland. Many also reported a fear of deportation should the offence be reported to authorities and concerns about discrimination that would influence how police dealt with the matter.

In summary, this body of research indicates that women are more likely to disclose their experience of IPV to family, friends or peers and seek help from these same sources. When the outcome of this disclosure is positive, there is a greater likelihood that victims will be encouraged to engage with formal services (Liang et al., 2005). Conversely, a negative response from informal sources, particularly early in the help-seeking process, would appear to leave many women feeling isolated and to decrease the likelihood of further help-seeking behaviours (Goodkind et al., 2003). Furthermore, some groups in the community are likely to face additional barriers to help-seeking. In the following section, we briefly review some of the major theoretical explanations of how and why those who have been victimised might engage in help-seeking behaviours.

Help-seeking behaviours: Theoretical perspectives

More generally, for example in the medical and psychological literature, help-seeking has been understood as part of a process that begins with the identification of a problem, after which there is voluntary and conscious action on the individual's part that leads to interpersonal interaction with potential helpers (Cornally & McCarthy, 2011). While theory is less well developed in relation to victims of IPV, Burgess-Proctor (2012b) notes two broad points of theoretical consensus regarding women's decision-making: First, it is a process that develops and evolves *over time* (e.g. some women may resist formalised help-seeking until specific events occur that prompt them to seek help; e.g. Fugate et al., 2005); and second, help-seeking is the result of a *complex combination of influences* at the individual, cultural and structural levels (e.g. economic dependence on a partner, fear, abuse severity, presence of children, marital status) (e.g. Hutchinson & Hirschel, 1998; Krishnan, Hilbert, & VanLeeuwen, 2001). In addition, Burgess-Proctor points to a further point of consensus emerging from the psychological literature on coping – considered closely related to help-seeking – namely, that women's prior trauma histories also have the capacity to influence their help-seeking behaviours (Taft, Resick, Panuzio, Vogt, & Mechanic, 2007).

Although comparatively few researchers have investigated help-seeking from a theoretical perspective (rather than examining factors at an individual level approach), it is particularly important to consider the larger socio-cultural context in which IPV occurs (Liang et al., 2005). Several theoretical frameworks have now emerged that seek to explain help-seeking, the obstacles

confronted by those who attempt to escape partner violence (Grauwiler, 2008; Moe, 2007) and decision-making for help-seeking (Kennedy et al., 2012; Liang et al., 2005). Perhaps the most significant recent change has been a shift from the binary notion of "leave" or "stay", to more complex conceptualisations of what is often a difficult process (Alaggia, Regehr, & Jenney, 2012). The following review summarises the most prominent theoretical approaches and follows the three general typologies cited by Gover, Romisich and Richards (2015), namely, psychological response, process and socio-cultural models.

Psychological response models

Learned helplessness model

The first major psychological response theory to address IPV and help-seeking was Walker's (1991; 2001; 2009) *battered women's syndrome*. While some have argued that this is not a theory of help-seeking per se, Walker nonetheless postulated that help-seeking efforts decrease as the severity of violence escalates, resulting in a psychological "paralysis" that becomes more pronounced over time (Burgess-Proctor, 2012b). According to Walker, rather than it being a choice made by women to remain in violent relationships – and thereby be complicit in, and accepting of, the violence by remaining silent – the lack of any proactive help-seeking is a learnt behaviour. While those who silently endure violence may appear passive to the outside observer (Doerner & Lab, 2005; Walker, 1991; 2001; 2009), Walker describes a pattern of agency, whereby victims in the company of their abusive partners attempt to avoid potentially abusive situations by altering their behaviours in various ways (e.g. trying harder to please their partner; becoming more compliant or submissive if abuse is a response to their perceived lack of "perfection" or "obedience"; see also Towns & Adams, 2000; Walker, 1991).

When recurrent behavioural adjustments fail to either stop or reduce their victimisation, women are taught that their efforts are ineffective (Kearney, 2001; Walker, 1991). The consequence – *learned helplessness* – is a belief that any attempt to regain control will be futile. Rather than engaging in unpredictable behaviours (i.e. disclosing to external sources), women in these circumstances continue to engage in highly predictable behaviours (Walker, 1991; 2001; 2009). In addition, learned helplessness is conceptualised as cyclical, involving three types of "deficits": motivational, cognitive and affective. The woman who has experienced violence is affected by a "motivational deficit" when she believes her responses have no effect on her outcomes and there is no incentive to emit new responses – in effect the belief that nothing can be done to change the situation leads the woman to stop trying. This "motivational deficit" produces a "cognitive deficit", which consists of an inability to learn that outcomes can be contingent on responses in a new situation (e.g. if the situation were to change or an opportunity arose to leave the relationship it would not be taken up given the belief that nothing can change and that change is not within her control). Finally, these "cognitive deficits" result in an "affective deficit" or depressive state that further feeds the motivational deficit and thus the cycle is said to continue. In this sense, learned helplessness has a dual effect: initially the victim is incapacitated, unable to make any proactive help-seeking decisions and then, over time, becomes isolated. The longer the abusive relationship, the more self-blame and shame the victim feels for not taking action. As a consequence, immobilisation occurs and the likelihood of disclosure is decreased (Kearney, 2001; Walker, 1991; 2001; 2009).

Survivor model

Some researchers have been critical of Walker's learned helplessness model (1991; 2001; 2009), arguing that it pathologises victims and contributes to the stereotype of women as irrational and submissive (Gondolf & Fisher, 1988; Grigsby & Hartman, 1997). For example, Gondolf and Fisher's (1988) *survivor theory* directly contradicts the notion of learned helplessness. Based on research investigating the responses of more than 6000 women housed in US shelters, this theory suggests that the tendency to rely on emotion-focused coping strategies (i.e. responding to threat, trauma or stress by altering one's emotions; see Lazarus, 1991) as posited by the learned helplessness model decreases with prolonged exposure to increasing abuse severity. Women in their study who found themselves subject to escalating violence were able to actively resist IPV with increased help-seeking. Gondolf and Fisher hypothesised that in the face of increasing violence, these victims were pushed out of their private and "invisible" environment into a "visible" field of help-seeking (Gondolf & Fisher, 1988; Gondolf, Fisher, & McFerron, 1988). Their subsequent proactive response is seen, however, as an evolved coping process rather than a predetermined coping style based on personality traits. Where a victim remained in a violent relationship, this was found to be the result of available resources being inadequate or a "system failure", rather than passivity or helplessness.

Support for this proposition was found in the research undertaken by Websdale and Johnson (1997). Their evaluation of the

Kentucky Job Readiness Program revealed that the availability of appropriate services and support (e.g. provision of independent housing, employment, assistance with transportation etc.) helped women to end abusive relationships, live productive lives and avoid IPV re-victimisation. However, while the survivor model advanced help-seeking theorising, the variables said to influence behaviour are still limited to the individual and interpersonal levels (Burgess-Proctor, 2012b). Consequently, no attention is paid to the manner in which broader social systems impact on decision-making.

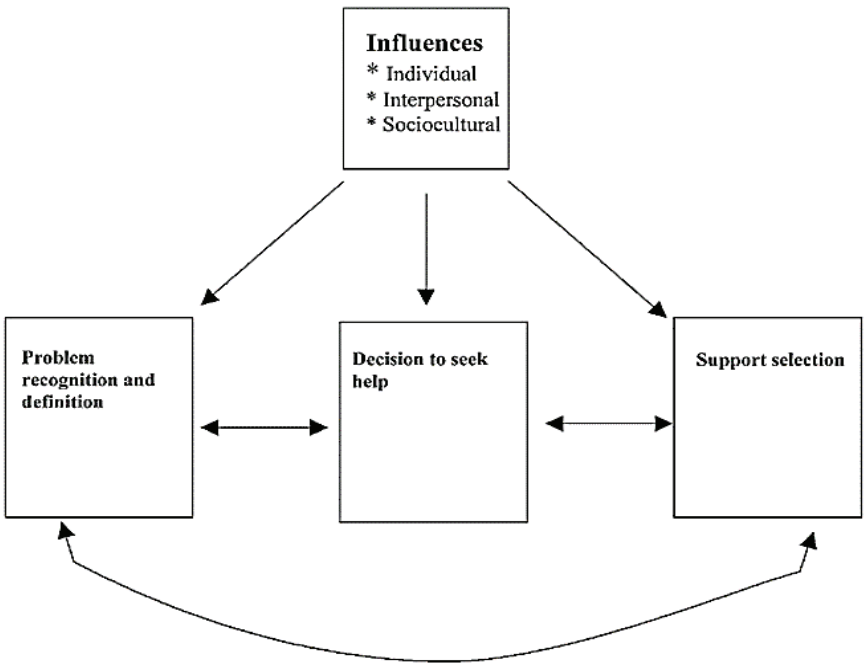
Process models

As the name suggests, process models consider help-seeking to be a *process* rather than a discrete incident, with a focus on the non-linear sequence of internal and external reactions to victimisation. These models suggest that internal reactions (e.g. self-blame; shame; fears of retaliation; homelessness) have the capacity to influence external behavioural reactions to victimisation (Lutenbacher, Cohen, & Mitzel, 2003; Peckover, 2003), which include attempts to manage partner violence, help-seeking behaviours and the multiple ending and re-initiating of an abusive relationship (Liang et al., 2005).

Cognitive process model

Liang and colleagues' (2005) model of IPV help-seeking, based in cognitive theory and ecological systems, is perhaps one of the most widely recognised. Their model specifies three stages whereby the individual who experiences IPV must: 1) recognise and define the abusive situation as intolerable; 2) decide to disclose the abuse and seek help; and 3) select a target for the disclosure and subsequent help-seeking. Non-linear in nature, these stages form a dialectical process whereby each informs the other in an ongoing feedback loop (Figure 2). And while the model describes help-seeking in primarily cognitive terms, the authors also acknowledge the manner in which emotions are linked to, and mediate between, cognitions and intentional acts (Brandstadter, 1998).

Figure 2 Liang et al.'s (2005) model of help-seeking and change



The ecological element of the model is the influence of individual, interpersonal and socio-cultural factors on the feedback loop. Definitions of abuse may shift over time as a function of an individual's readiness to change their life (and vice versa); abusive behaviour may be minimised as "aberrant" by the pre-contemplative individual whereas the same level of abuse may lead the contemplative woman to consider the pros and cons of taking action (Prochaska, DiClemente, & Norcross, 1992).

Interpersonal and socio-cultural factors also significantly affect women's definitions of IPV. In terms of the former, the very nature of intimate relationships (which may constantly alternate between violence and loving contrition) can make clarifying an abusive relationship both difficult and confusing. Cognitive distortions and dissonance may be caused by both the abuser and the victim's support network (e.g. when physical and verbal abuse is re-framed or re-defined). Socio-culturally, IPV is often viewed through the lens of particular social, religious and cultural institutions where male/female power inequalities are reinforced.

Individual, interpersonal and socio-cultural influences also impact on help-seeking decisions. From an individual perspective, two internal conditions have been identified as fundamental: 1) recognition that a problem is undesirable; and 2) seeing that a problem is unlikely to go away without help from others (Cauce et al., 2002). In relation to the first condition, a stage model has been applied whereby access to help is in direct response to the severity of the abuse (i.e. IPV victims move from private attempts of placating/resisting their abusers, to informal help-seeking, to formal help-seeking as the violence increases in severity). With respect to the second condition, research suggests that victims seek out help when they believe their own resources and alternatives are depleted (Lempert, 1997). Finally, interpersonal and socio-cultural influences such as gender, class and cultural context play a powerful role in terms of beliefs around such issues as family privacy, divorce and gender roles.

Concern has also been raised by IPV victims about cultural sensitivity in how mainstream service providers work with minority group victims (Latta & Goodman, 2005). Other factors include: negative police responses (e.g. failure to arrest the abuser; victim not listened to; situation trivialised); racism; socio-economic status; and homophobic stereotyping. Poor access to existing services (e.g. due to class or systemic barriers) also means that women who have experienced violence often need to consider the potential costs of seeking help (e.g. loss of privacy, stigmatisation, threats by abusive partners).

The important theoretical contribution of the Liang et al. (2005) model is its focus on: problem definition and appraisal; help-seeking decisions; selection of a help provider; the critical role of socio-cultural factors; and the feedback loops characterising the process. Its simplicity also allows some of the key ideas to be translated into practice. However, Kennedy et al. (2012) have noted shortcomings of the model, including a failure to conceptualise the receipt of help or the degree to which women's needs are met, and how positive outcomes are facilitated, as part of the help-seeking process.

Rational choice model

Other process models investigate the decision-making and cognitive processes underlying help-seeking in greater depth. For example, process models that are based on rational choice theory describe victims in terms of "rational" and "thoughtful" decision-makers who weigh up the costs and benefits of disclosing their victimisation (e.g. whether perpetrators are consistently penalised versus the likelihood of victim-blaming or protection) and then make a decision. Although many rational choice models focus on offending behaviours and subsequent sanctions (formal and informal) at the expense of cost-benefit analysis (Kingsnorth & MacIntosh, 2004), this is a key feature of Choice and Lamke's (1997) conceptual model. This model is based on an integration of four theoretical approaches: learned helplessness (Seligman, 1975); psychological entrapment[3] (Brockner & Rubin, 1985), the investment model (Rusbult, 1980; 1983; Rusbult & Buunk, 1993); and reasoned action/planned behaviour theories[4] (Ajzen, 1985; Ajzen & Fishbein, 1980; Fishbein & Azjen, 1975).

3 Defined as a "decision process whereby individuals escalate their commitment to a previously chosen, though failing, course of action in order to justify or 'make good' on prior investments" (Brockner & Rubin, 1985, p. 5). In the IPV context, the victim must first demonstrate investment towards a goal (e.g. time, energy in a congenial and non-violent relationship); receive negative feedback about attaining her goal (i.e. continued abuse); experience uncertainty in the face of negative feedback (i.e. decide to "try harder"); if a decision is made that the goal is attainable, question whether it is worth the investment. Self-questioning produces conflict and a sense that "too much is invested to quit".

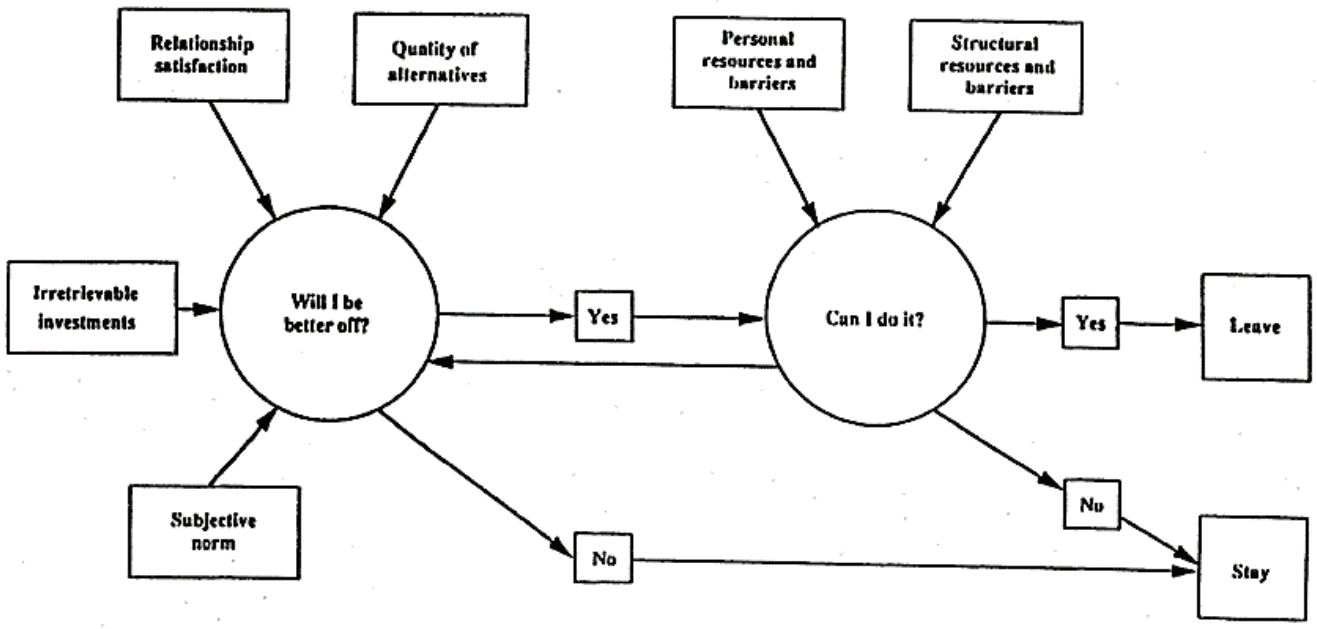
4 Both the investment and reasoned action/planned behaviour approaches assume the woman will: a) be subjectively satisified with her current relationship; b) determine her attitude towards further maintaining it; and c) decide whether she is better off leaving. The investment model is based on making a relative cost-benefit analysis with the concepts of satisfaction, quality of alternatives and irretrievable investments identified as central components. Reasonable action/planned behaviour is based on the assumption that human beings are rational and make systematic use of information available to them (i.e. people consider the implications of their actions before they decide to engage in them.

According to Choice and Lamke (1997), stay/leave decisions made by women in abusive relationships revolve around two central questions that are influenced by several factors (Figure 3), namely, "Will I be better off (outside the relationship)?" and "Can I do it (exit successfully)?" These questions have been used to organise concepts from the four approaches into a single framework, which are then used to understand stay/leave decisions. Seen as temporal in nature, answering the first question is said to determine the relevance of the second, although the two steps may operate in a cyclical manner, with responses to the second influencing the decision outcomes of the first (e.g. an abused woman may decide she is dissatisfied with her relationship and wants to leave but perceives she lacks the resources to do so).

The theories of reasoned action/planned behaviour, investment and entrapment are directly involved in the first step of the model. Here the decision will be one involving an assessment of quality of life ("Will I be better off?"), influenced by: feelings of relationship satisfaction (e.g. whether rewards are greater than costs); perceptions of irretrievable investments (e.g. a decision to stay despite being dissatisfied due to high investments); the quality of any alternatives (e.g. where a decision to stay is based on a perceived lack of alternatives and a sense of being trapped); and subjective norms (i.e. the influence of the perceptions of significant others regarding a woman's partner and the quality of her relationship). If a decision is made that the quality of life is better outside the relationship, the second step – "Can I do it?" – follows. This question is influenced by the theories of: reasoned action/planned behaviour (e.g. being in possession of the requisite resources to perform a particular behaviour provides a strong sense of control regarding the performance of that behaviour); psychological entrapment (i.e. the decision to invest further in the relationship or to leave); and learned helplessness (e.g. a lack of perceived control/self-efficacy will inhibit leaving while high self-efficacy can motivate effective problem-solving strategies).

Choice and Lamke (1997) have further argued that the combination of personal and structural resources and barriers contribute to an IPV victim's evaluation of whether she can successfully leave an abusive relationship. Consequently, a woman with a variety of personal and structural resources at her disposal will experience a greater sense of control over her

Figure 3 Choice and Lamke's (1997) conceptual model of abused women's stay/leave decision-making processes



circumstances, and thus will be more successful in terms of leaving than the woman who must face a vast array of personal and structural barriers. An important element of the overall model is the implication that factors which may contribute towards a commitment to remain in an abusive relationship may be irrelevant to a woman's decision to leave that relationship. What Choice and Lamke (1997) are suggesting is an identity shift from one invested in the couple (i.e. "I have to be in this relationship") to one of survival (i.e. "I have to get out of this relationship").

One of the major benefits ascribed to rational choice models of help-seeking behaviours is the manner in which cost-benefit analyses may differ at each locus of decision-making as a function of victim characteristics (e.g. ethnicity) and/or situational variables (e.g. cohabitation, prior victimisation). This was illustrated in a large US study (n = 5272) conducted by Kingsnorth and MacIntosh (2004). While no difference was found between "White" and African American victims of IPV in terms of reporting abusive behaviour and supporting an abuser's arrest, African American victims were significantly less likely to support prosecution, irrespective of the perpetrator's race. Explanations for this included a lack of confidence in that system to meet the victim's needs, prior negative experiences with criminal justice officials or simply the lack of necessary resources (e.g. transportation, child care, income etc.) that might be required to cooperate with a prosecution. The likelihood of supporting a prosecution was found to decrease where the victim was still cohabiting with the abuser (potentially due to fear of retaliation or economic risk), but increased when children were present (perhaps reflecting the risks of child endangerment posed by the abuser) or when there was evidence of prior victimisation or a protective order in place.

Socio-cultural models

The major criticism of psychological response and process models of explaining help-seeking behaviours is the failure to fully articulate the role of cultural and structural variables (Burgess-Proctor, 2012b). Several models have been proposed that seek to redress this shortcoming, although not all have been subject to extensive empirical analysis.

Social entrapment model

Moe (2007) adopted Ptacek's (1999) social entrapment theory to describe the structural impediments to successful help-seeking by IPV victims. Despite continued attempts to resist, as noted in Gondolf and Fisher's (1988) survivor hypothesis, many victims of IPV are thought to be frustrated by inadequate institutional responses (e.g. insufficient resources, lack of support). Social entrapment thus occurs when coercive control tactics on the part of the abuser are combined with social and institutional failures (e.g. criminal justice, social service and healthcare systems) to adequately respond to IPV. The sense of being socially entrapped and that nothing can be done to stop the victimisation is further exacerbated when support from community networks (e.g. family, friends, workplaces, schools) is not forthcoming.

Moe (2007) garnered support for this approach based on an analysis of qualitative interviews (n = 19) conducted with domestic violence shelter residents undertaken from the position of epistemic privilege.[5] The women in the study were highly active help-seekers who reported feeling trapped in relationships mainly due to the failure of various agencies to adequately assist them. In fact, Moe suggested that they exuded a sense of "learned hopelessness" rather than helplessness. The majority reported being abandoned by friends and family or that when support was provided it came with an ultimatum (i.e. not to return to the abuser or risk being alienated from the family). While most had contacted the police – with some achieving immediate relief – few abusers were arrested and rehabilitation programs generally were not viewed as addressing the abuser's violent behaviour. Women faced other obstacles, including: limited access to shelters (e.g. lack of beds; time limitations on stays; age limits on children); the risk of losing children (i.e. prosecution for a failure to protect them from abuse); and the lack of health insurance or money to pay medical expenses. While those women in the study whose help-seeking efforts met with unconditional and empathic institutional and/or social support did report a sense of empowerment and a belief in their ability to continue efforts to resist partners who engaged in coercive control tactics, those who believed that they were ignored or that their situation was downplayed had feelings of being deserted, silenced and blamed for their victimisation.

Socio-structural barriers appeared to be particularly problematic, especially for women with a criminal record who were excluded from many of the services from which others could benefit (e.g. higher paying jobs, transitional housing). For these women,

5 Epistemic privilege holds that members of marginalised groups are better positioned than members of socially dominant groups to describe the ways in which the world is organised according to the oppressions they experience (Collins, 1989; Hartsock, 1987).

even calling the police for protection became a risk if there was an outstanding warrant for them. Moe (2007) concluded that despite the study being small, the findings do speak to the notion that "every little bit matters…[that] one helpful response may spur further help-seeking efforts [and] may…legitimize a woman's claims to other agencies. Just as failed help-seeking may be cumulative in effect, so too might successful help-seeking" (p. 694).

Stigmatisation model

Another model that considers how factors at the individual, interpersonal and socio-cultural levels impact on help-seeking behaviours is Overstreet and Quinn's (2013) intimate partner violence stigmatisation model. In general, stigmatisation is proposed to occur in response to the exertion of power to identify, stereotype and label the differences in those who are socially devalued, which, in turn, leads to them being disapproved of, rejected, excluded and discriminated against (Link & Phelan, 2001). Labelling, a powerful mechanism through which stigmatisation operates, serves to structure beliefs about and behaviours towards those with stigmatised identities. For example, whereas the term "victim" may absolve blame from the woman who experiences IPV, it can also construct an image of someone who is trapped, passive, weak and responsible for that victimisation (Dunn, 2005). A social construction such as this not only devalues the experience of IPV but, according to Overstreet and Quinn, equates victimisation with a lack of agency. The victim-blaming component of IPV highlights a key dimension of stigma and what is seen as the origin or cause of the stigmatised identity.

Critical to understanding how stigmatisation impacts on help-seeking behaviour are the model's three "stigma": stigma internalisation; anticipated stigma; and cultural stigma (Overstreet & Quinn, 2013). Two of these are identified as self-stigma: *stigma internalisation* and *anticipated stigma*. The former speaks to the extent to which the IPV victim comes to believe (or even consider) that negative stereotypes regarding their stigmatised identity is true for them (i.e. they have internalised the stereotype as part of their own personal identity). This is related to constructions of IPV victims as "weak" and "helpless" or devaluations of IPV as "shameful". Victims report feelings of self-blame, shame and embarrassment about abuse, which then contributes to the internalisation of these stigmatising beliefs as being true, and then reinforces barriers to help-seeking from both informal and formal support networks (e.g. Petersen, Moracco, Goldstein, & Clark, 2004; Wilson, Silberberg, Brown, & Yaggy, 2007).

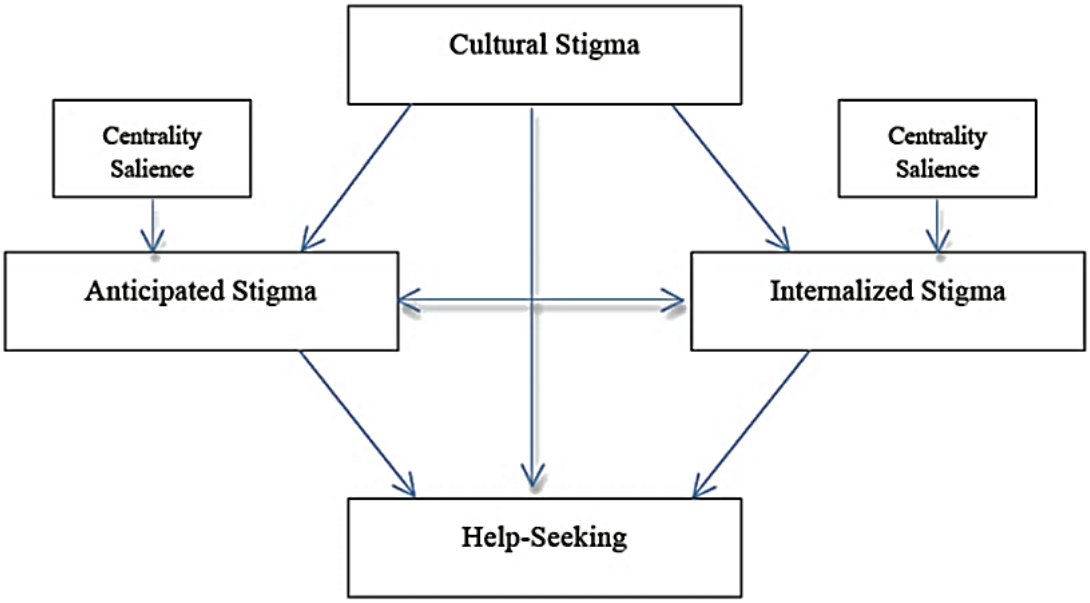
Anticipated stigma refers to the extent to which a woman fears or expects stigmatisation (i.e. prejudice or discrimination) should others find out about her IPV experiences. It is a particular barrier to help-seeking from informal support networks, due to the fear that family or friends will judge or criticise victims should they disclose the abuse or seek to deal with an abusive relationship (e.g. Fugate et al., 2005; Lutenbacher et al., 2003). Anticipated stigma stems from previous negative experience following disclosure to family and friends that has served to reinforce the stigmatising beliefs about IPV victims as "weak" or "stupid" for staying in an abusive relationship. It can also be a barrier to formal help-seeking, for example, when women feel that they are devalued by healthcare providers. Anticipated stigma is made more complex when an individual does not fit societal expectations of an IPV victim (e.g. women in same-sex relationships, or older women).

Finally, *cultural stigma* highlights the way in which negative beliefs and stereotypes about IPV at the societal level can influence the experience of IPV stigmatisation at the individual and interpersonal levels. For example, where society fails to recognise IPV as a problem, women can feel the only option is to hide the abuse from others and deal with it as a personal matter (e.g. Beaulaurier et al., 2008). This may have the effect of intensifying feelings of responsibility for the abuser's behaviour and thereby reduce help-seeking behaviour. Another example of cultural stigma is when partner abuse is perceived by community members as a normal occurrence that should be endured or solved in a personal way (Morrison, Luchok, Richter, & Parra-Medina, 2006).

The model shown in Figure 4 is said to illustrate how the socio-cultural context in which IPV occurs can negatively impact on those who experience abuse. While increased cultural stigma around IPV has a direct effect on internalised and anticipated stigma, which then impacts on help-seeking, cultural stigma can also directly impact on help-seeking behaviours. Moreover, the interplay between internalised stigma and anticipated stigma can be bi-directional – where the internalised stigma is greater for people who experience IPV, there is an increased likelihood of anticipated stigma from others; however, anticipating or even experiencing stigma from others can also lead to increased internalisation of IPV stigma.

Also impacting on anticipated and internalised stigma is centrality and salience. Centrality refers to the extent to which women see IPV as a central aspect of their identities (e.g. they

Figure 4 Overstreet and Quinn's (2012) IPV stigmatisation model



may not fit the stereotypical profiles of victims or do not perceive themselves to be in an abusive relationship). Situations that reduce the centrality of partner abuse, while minimising the stigma around IPV, also have the potential for those experiencing abuse to lessen their help-seeking behaviours. Salience can also shape help-seeking behaviours. The identity of IPV has both concealable and visible components, which means there may be times when IPV becomes more accessible to the victim. For example, where an individual experiences an abusive incident, IPV may become more accessible, its salience increases, and so does the potential for internalised stigma. Identity salience can also heighten anticipated stigma. For example, a specific moment in time when consequences of the abuse (e.g. visible bruising) make the event salient and require a behaviour with potentially negative outcomes (e.g. devaluation by others; job loss if work is missed). Conversely, the salience of IPV may also lead to the recognition that the abuse is intolerable and facilitate the help-seeking process.

Feminist pathways model

In her recently developed model, Burgess-Proctor (2012b) adopted a feminist pathways[6] framework to explore women's help-seeking behaviours. Burgess-Proctor argued that this approach is suitable given its developmental nature that "attends to intersecting influences at the individual, cultural, and structural levels" (p. 311). It has particular utility in the current context given the framework was initially developed to examine the trajectories of female offending behaviours. For example, Daly's (1994) research identified the specific avenues, including abuse experiences, addiction and economic marginalisation, by which women may become involved in crime. Patton (2003) has also highlighted the significant conceptual overlap between theories of IPV victim help-seeking and the feminist pathways model, defining pathways as "enablers"; that is, the support services "that women perceived enabled them to overcome or remove identified barriers to leaving and starting a new life" (p. 4).

Burgess-Proctor (2012b) based her model on in-depth life-history interviews (n = 22) conducted with women living in the community (n = 15) and women's shelters (n = 7), and included information about help-seeking in *any* abusive relationship (rather than focusing on their most recent experience). All of the women in the study had experienced some form of victimisation during childhood (in many cases multiple types), including physical

6 The feminist pathways model is an extension of the life-course criminological framework that examines women's and girls' offending behaviours in the context of their past victimisation experiences (Belknap, 2007).

and sexual abuse, neglect, substance abuse and exposure to parental IPV. Based on her findings, she claimed that rather than conceptualising pathways as enablers, it was more appropriate to consider help-seeking as a trajectory of behaviour in the same manner as offending is conceptualised. Supporting her claim, Burgess-Proctor pointed out the tendency of adult victims to use or avoid certain help-seeking strategies on the basis of childhood victimisation experiences (i.e. childhood experiences launch long-term help-seeking trajectories for those who grow up to experience adult IPV). In other words, once a pattern is established, adults follow the pathway until such time as an event (or series of events) forces them to adopt an alternative help-seeking trajectory. Childhood victimisation was found to inhibit help-seeking in several ways: by creating an expectation of abuse; lowering one's sense of self-worth; prompting withdrawal; engendering learned silence; and promoting attachment to an abusive partner. For some women in the Burgess-Proctor (2012b) study, childhood victimisation had the opposite effect and they reported drawing on the experience to facilitate help-seeking (i.e. it served as a promoter rather than inhibitor). The three main promoter mechanisms are encouraging boundary drawing, fostering a "fighter" mentality and inspiring a determination to end the cycle of violence.

The unanswered question in this model is what determines whether childhood victimisation inhibits or promotes help-seeking in adulthood. One possibility is the severity of childhood victimisation, although there is evidence that participants in the Burgess-Proctor (2012b) study with multiple and severe victimisation had *both* help-seeking inhibitors and promoters. However, the small sample size in this study is an important consideration here, before firmer conclusions can be drawn. Another possibility is that childhood victimisation is more likely to promote help-seeking in the early stages of IPV or before the abuse has become particularly severe. Alternatively, help-seeking decisions may not be driven by childhood victimisation at all but, rather, exposure to help-seeking resources as noted by research described above (e.g. Barrett & St. Pierre, 2011), which then serves to distinguish between inhibitors and promoters. A final issue to consider is the impact of social structural forces that may lead different groups of women (e.g. based on cultural context or socio-economic status) to favour formal versus informal help-seeking strategies.

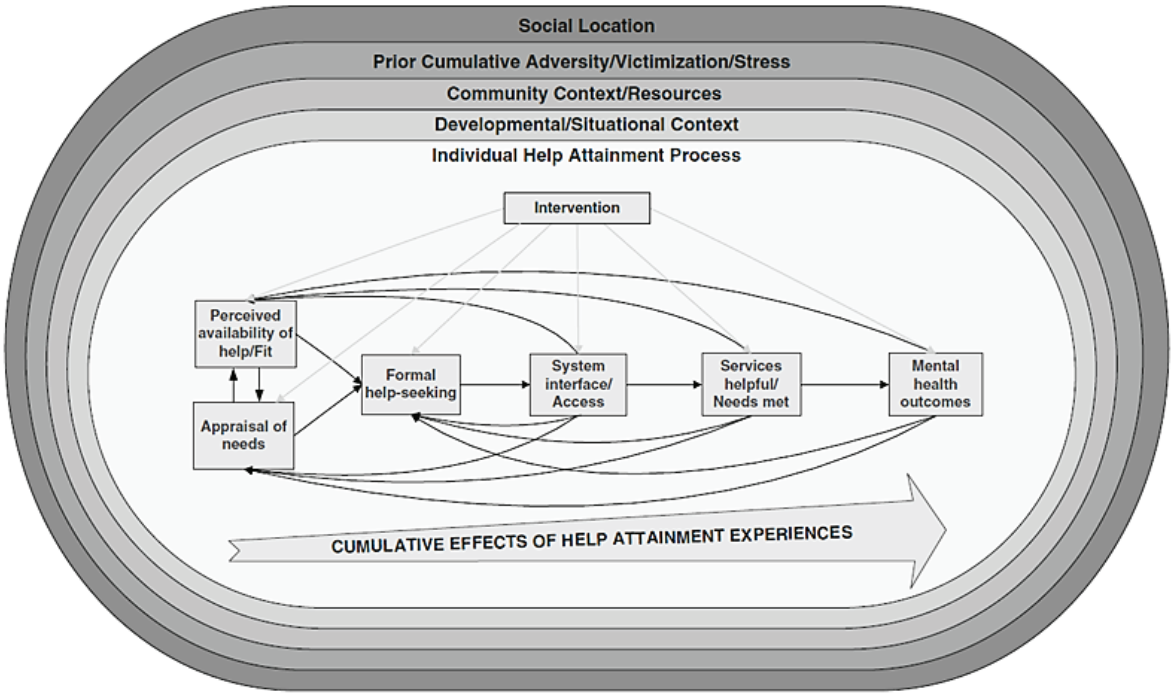
Help attainment model

This model, developed by Kennedy et al. (2012), incorporates elements from Liang et al.'s (2005) cognitive process model in addition to the concepts of social location (i.e. one's position within intersecting systems of stratification such as socio-economic status, race/ethnicity and gender), multiple contextual factors (e.g. appraisal of needs, availability and accessibility of help, relationship to the perpetrator, presence of children) and cumulative victimisation. The model is based on a life-course approach that includes the dynamic, contextualised nature of development whereby important transitions demarcating the life-course (e.g. marriage, parenthood, leaving an abusive partner) are highlighted. It also rests upon the assumption that a differential accumulation of adversity occurs in various forms (e.g. victimisation, chronic stressors, negative life events, discrimination) over time, the basis of which is primarily social location, with the outcome being divergent trajectories and increasing disparities between individuals (e.g. mental health). In this model, transitional periods are identified as times of increased vulnerability. Consequently, a woman's particular developmental stage will be influential in terms of the experience of stress and cumulative adversity; it will also serve to shape both her needs and her options for accessing help.

The help attainment model is said to: 1) put the influence of social location, cumulative victimisation and adversity, community setting and the developmental/situational context in the foreground; 2) emphasise the importance of examining the attainment of effective formal help that meets women's needs and thereby facilitates positive mental health outcomes; and 3) highlight how interventions can facilitate the attainment of help within a variety of domains and promote positive mental health outcomes among women who have experienced sexual and/or physical victimisation (Kennedy et al., 2012). Thus, what differentiates it from other theories and models described in this review is an emphasis on the attainment of assistance and support when it is needed, rather than a focus on barriers to, and the processes of, help-seeking. In addition to the Liang et al. (2005) elements, there is an emphasis on the role of interventions as enabling factors that facilitate access to multiple forms of effective help and promote positive mental health outcomes for the survivors of sexual and/or physical violence.

The help attainment process is depicted in Figure 5. This illustrates its conceptual, heuristic nature wherein the individual level help attainment process is embedded within and fundamentally influenced by: the contextual factors of social location; prior cumulative adversity and victimisation; the community context and availability of resources; and the developmental/situational context. In other words, these contextual factors shape each step of the process whereby abuse survivors attain help. The first two

Figure 5 Conceptual model of Kennedy et al.'s (2012) model of help attainment



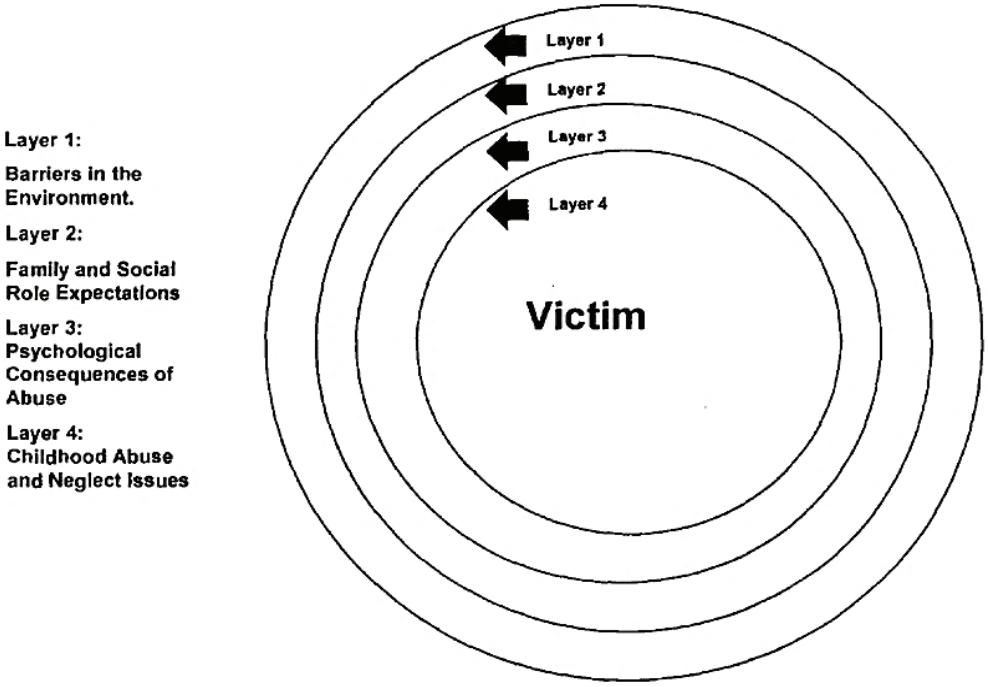
components of the process, perceived availability of help/fit and appraisal of needs, are said to co-occur and be reciprocally influential. The help attainment steps progress from left to right with feedback arrows used to highlight ways in which experiences at any stage of the process can in turn influence future attempts to secure formal help.[7] The large arrow across the bottom of the process depicts how negative experiences are conceptualised as accumulating or "snowballing" over time, thus creating further barriers to the attainment of effective help for survivors of physical or sexual violence. As shown in the figure, an intervention that facilitates help attainment and positive mental health outcomes can take place at any stage of the process. Perhaps the major limitation of the model is its focus on formal help-seeking. Given research that indicates that women are most likely to seek informal help (e.g. Barrett & St. Pierre, 2011; Flicker et al., 2011; Moe, 2007), and that success of informal help-seeking is frequently the driver for accessing formal services/resources, there is perhaps a need to reconfigure the model to show how this process occurs.

Barriers to help-seeking, disclosure and services for victims

As the various theoretical approaches and models of help-seeking illustrate, the decision to leave an abusive environment is rarely a simple, straightforward one, and multiple factors have been identified as potential barriers to the provision of effective responses to violence. Consequently, criticisms of individual level approaches are well founded; there is now sufficient evidence to support the claim that victimisation is not the result of some "problem" that resides within women (Salazar & Cook, 2002; Yick & Oomen-Early, 2008). Despite the complexity and inter-relatedness of help-seeking theories, it is nonetheless important to consider the various barriers to help-seeking that women who have experienced IPV have identified – without losing sight

7 By way of example: If a woman accesses formal help but finds the services unhelpful and her needs are unmet, when appraising her current needs in the future and assessing the availability of help from her point of view, it is more likely that she will decide not to seek help because of what happened during that prior interface with formal services.

Figure 6 Grigsby and Hartman's (1997) model of barriers:
Effects of external environment and life expectancies on victims of IPV



of the importance of intersectionality (i.e. the interconnected nature of the social categories such as gender, race, class and so forth and, therefore, how different layers of oppression impact on the individual).

An early attempt to integrate the various barriers faced by women can be found in Grigsby and Hartman's (1997) barriers model. As shown in Figure 6, this model places the victim at the centre of four concentric circles, each of which represents a barrier with the potential to impede her safety. At the outer level is the environment, which includes factors such as the abuser, financial issues, police assistance, the criminal justice system and the mental health system. Next is family, socialisation and role expectations, and covers issues such as values and/or beliefs about relationships, religious values or beliefs and family of origin. At the third layer is the psychological consequences of violence, which addresses factors such as the physical or somatic results and psychological consequences (e.g. depression, PTSD). Finally, the innermost layer includes barriers from childhood abuse and/or neglect (i.e. early messages about abuse and safety; psychological consequences of that abuse/neglect). As can be seen, the primary locus of analysis is not the individual but society and context. The list of barriers discussed below includes issues discussed by Grigsby and Hartman, as well as more recent research in the help-seeking realm. Given the theoretical approach used above, the various factors have been grouped at the individual, socio-cultural and structural level.

Individual level

Relationship status

Research investigating relationship or marital status has primarily focused on whether it acts as a barrier or promotes decisions to report IPV to the criminal justice system (Akers & Kaukinen, 2009; Felson, Messner, Hoskin, & Deane, 2002; Kaukinen, 2004a). A study conducted by Ruiz-Peréz, Mata-Pariente and Plazaola-Castano (2006) involving a random sample of Spanish healthcare users (n = 91) reported that fewer IPV victims in relationships made proactive help-seeking decisions than their single or separated counterparts. A similar finding was noted in a study by Akers and Kaukinen (2009). Using data drawn from the Canadian General Social Survey (n = 894), marital status was shown to be a barrier to police reporting for married female IPV victims, but less so for single women in the study. According to Akers and Kaukinen, their findings can be explained in terms of: 1) the greater social and financial entrapment experienced by victims married to an abusive perpetrator; and 2) the likelihood that married victims may have stronger emotional ties to their partner and thus wish to protect them from the legal repercussions of police intervention.

Victim age

Limited research has been undertaken that identifies and addresses specific barriers to help-seeking in older women (i.e. those aged over 45 years) who experience IPV (see Akers

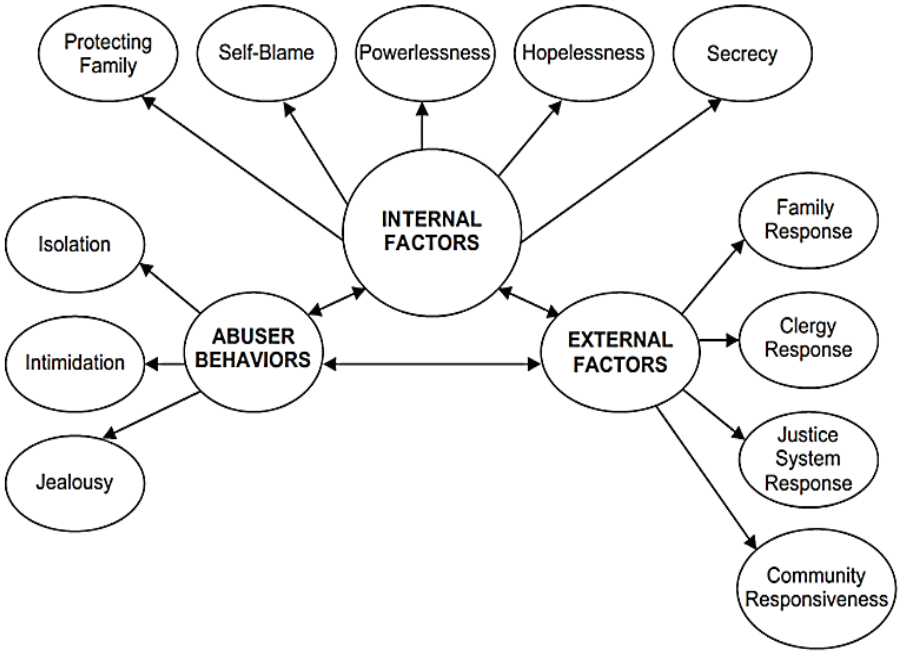
& Kaukinen, 2009; Beaulaurier et al., 2008; Beaulaurier, Seff, Newman, & Dunlop, 2005; 2007). Based on the existing evidence-base, it would appear that women in this age group report similar barriers to their younger counterparts (e.g. family reactions, criminal justice responses), although some age-specific barriers have been noted. A study by Zink, Regan, Jacobson and Pabst (2003), which did not focus specifically on help-seeking, is relevant here. Of particular interest is that study participants (n = 46), who were all aged over 55 years, were predominantly women from the middle and upper income bracket, a population group not typically studied. Three types of reasons for not leaving abusive relationships were given. The first, *cohort effects*, were identified as reflecting membership of a group of individuals who were born at a certain period of time and who raised families during the 1960s and 1970s. Although some of the reasons documented for remaining in abusive relationships were similar to those given by younger women, marked differences were apparent in terms of intensity or degree, including lack of job skills and money, lack of educational qualifications and the needs of younger children. Feelings of shame and the loss of social status were strongly entrenched, as was the loss of "investment" in family and community following years of marriage. Next, *period effects* described unsuccessful early efforts to seek help. While some participants were surprised that their experiences of abuse were abnormal or even worthy of special attention, others reported how societal ignorance and denial of family violence (child, domestic and elder abuse) resulted in them receiving little or no assistance. Finally, *ageing effects* reflected the physical, emotional and functional challenges associated with ageing and the limited options available for making changes to existing relationships. Notably, health-related issues related both to the victim and to the abuser played central roles in decisions to remain, as did the fear of loneliness.

The most extensive research in this area appears to have been undertaken by Beaulaurier and colleagues (Beaulaurier et al., 2008; Beaulaurier et al., 2005; 2007). Based on findings from 21 focus groups (n = 134) with women aged 45 to 85 years, these researchers developed a descriptive model that outlines various internal and external factors that are related to each other and the abuser's behaviour, both of which serve to create help-seeking barriers (Figure 7).

Internal barriers include the following:

- protecting family (an inability to support family members if spouse/ partner does not contribute to family income;

Figure 7 Beaulaurier et al.'s (2008) barriers to help-seeking (BHS) model



fear that revealing IPV or abuse might disrupt the victim's relationship with younger or adult children; belief that their children/other family members would not believe them or would be extremely angry for revealing violence perpetrated by the abuser; the victim's need to keep the family intact superseding concerns regarding safety, negative exposure of children to violence in the home and other fears related to remaining in a violent situation);

- self-blame (a victim's belief they are responsible for the abuse; in the context of long marriages this can take on increased power, with abusers exploiting the victim's sense of self-blame and shame to maintain control);
- powerlessness (acceptance of the abuser's total control over the victim's life; abuser's control over economic and social resources and opportunities are a strong contributor, particularly when abuse begins in early stages of the relationship);
- hopelessness (the sense that "nothing can be done"; beliefs that services are targeted towards younger rather than older women; immigrant women believing they are ineligible for services); and secrecy (reluctance to discuss private family matters with "outsiders" given strong generational prohibitions) (see Beaulaurier et al., 2005).

External barriers identified in this study included:

- family response (fear that family members would not be supportive of them talking about their IPV experiences; relatives frequently denied the abuse, blamed the victim, or were hostile to the idea of "breaking up the family");
- clergy response (religious beliefs about the sanctity of marriage or rights/roles of women and men made it difficult to consider leaving a marriage; when consulted about abuse, clergy reinforced these beliefs, encouraged staying with the abuser, and offered little or no practical assistance);
- justice system response (a significant systemic help-seeking barrier, this was generally seen as something that worsened the situation for the victim because it increased the abuser's rage or because the victim did not want the abuser to be arrested by the police); and
- responsiveness of community resources (not knowing where to get help or, alternatively, not knowing how to access services) (Beaulaurier et al., 2007).

Finally, *abuser behaviours* take the form of:

- isolation (forcing victims away from sources of support such as family and friends, thereby making the connection to the abuser the only significant relationship in the victim's life);
- intimidation (the sense that a spouse or partner's abusive behaviour poses a danger to the victim or her family; this sense of terror can occur in relationships when there is no physical violence), and jealousy (serves as an initiation or escalation of violence; linked with an abuser's need for control).

Interestingly, women in the study were not supportive of an approach to separate them from their abusers. The level of dependence of older women on family and community, their sense of commitment to multigenerational systems that they believe to be reliant on them and poor employment prospects mean that solutions for many older women require methods to minimise and cope with the abusive behaviour rather than a major shift in living arrangements.

Disability

Despite the attention paid to IPV, few have investigated the intersection between the fields of disability and IPV (see Mikton & Shakespeare, 2014). Although societal myths unhelpfully suggest women with disability or life-limiting illnesses are single and asexual (Barnett, Miller-Perrin, & Perrin, 2005), statistics indicate they are more susceptible to various forms of violence across a range of environments where the perpetrators are most commonly their domestic partner (although abusers can also be family members and carers) (Brownridge, 2006; McCarthy et al., 2017; Salwen, Gray, & Mona, 2016; Shah, Tsitsou, & Woodin, 2016). Women report the same type and severity of IPV (i.e. physical, sexual, financial, emotional etc.), but can also be subject to specific types of abuse including: the refusal to administer medication; refusal to assist with toileting, bathing, dressing or eating; preventing the use of a wheelchair, cane, respirator, or other assistive device; sabotaging of hearing aids or guide dogs; making threats to leave the relationship that will result in institutionalisation for the woman; or using unnecessary touching, force or roughness when bathing, dressing or transferring the victim (see Hassouneh-Phillips & Curry, 2002; McFarlane et al., 2001; Plummer & Findley, 2012; Saxton et al., 2001).

Thiara and colleagues (2012) point out that in addition to the barriers caused by perpetrators, there are other obstacles that many women with disability face when seeking support that might be more easily achieved by women without disability, including: physically inaccessible services; inaccessibility of

publicity materials; lack of accessible alternative accommodation (e.g. refuges); social stereotypes (e.g. women with disability are asexual, tragic or burdens to society); and poor understanding of disability and impairment-specific abuse on the part of professionals, which leaves women with disability without protection from general sources of support (e.g. criminal justice system).

In their examination of risk factors faced by women with disability based on the *Canadian General Social Survey*, Brownridge (2006) found that women with disability not only had a 40 percent greater risk of violence in the five years preceding the interview, but were also at a greater risk of severe violence. An examination of perpetrator- and victim-related characteristics revealed that a partner's patriarchal dominance, sexual possessiveness and sexual jealousy significantly increased the odds of violence for women with disability (as compared to women without disability), while victim-related variables were either unrelated (e.g. education, socio-economic status) or had a negative influence on the risk (e.g. a decrease of 4% each year as women aged).

A qualitative study conducted in the UK by Shah et al. (2016) investigated how 15 women with either a cognitive, sensory or physical disability experienced various forms of violence, including physical and sexual violence, emotional abuse or economic coercion. Participants recounted experiences of violence over the life-course, which began in childhood within their families and in some cases through contact with medical professionals and continued through adolescence and into adulthood with partners who engaged in various forms of abuse (e.g. physical, sexual, emotional, economic). Some women also reported being victims of impairment-specific abuse (e.g. isolation, control and manipulation). The women were also critical of a lack of access to support, in particular formal support systems. It was reported, for example, that the negative attitudes of support services (e.g. social services, women's support services), the court system, police and the medical system served to further alienate and isolate victims. Participants also highlighted that the failure of some support services to provide accessible shelters made it impossible to escape their abusive partners, particularly when they lacked informal supports (e.g. their families were involved in the life-course abuse). Based on their findings, the authors pointed to the manner in which violence specific to an individual's impairment is often not recognised as violence either by professionals or, in some cases, by the victim. Instead, it is seen as part of the everyday life of a person with disability who is dependent on the perpetrator for personal care. In addition to the barriers faced by women without disability, they also face the additional problems of physical inaccessibility of specialist victim support systems and disbelief when reporting their experiences to professionals.

While limited attention has been paid to understanding the impact of IPV for women with physical and sensory impairments, even less attention has been paid to the intersection of intellectual disability and violence. This was addressed in a recent UK study by McCarthy et al. (2017), who interviewed 15 women with learning disabilities regarding: their understanding and experience of IPV; its impact on them and, if they had any, their children; their coping strategies; whether and how help was sought to leave the relationship; and their life after leaving the abusive relationship. Six main themes were found:

- *Severity of the abuse* included incidents of extreme physical assault (e.g. stabbings, attempted strangulations) and potentially life-threatening injuries. Sexual abuse was common and, in some cases, occurred in the presence of the victims' children. The women were also subject to financial abuse (most often with perpetrators using the victims' money for drugs and alcohol), and psychological and emotional abuse (e.g. goading women about their disability or mental health problems). Ending the relationship was of little help, often serving to escalate the abuse.
- *Psychological impact* describes the impact of the abuse on the women and their children. This included feelings of humiliation and experiencing low self-esteem.
- *Women's resistance strategies* included verbally resisting or standing up to the perpetrator, in some instances hitting back or rejecting the perpetrators' apology. All women in the sample eventually left the violent relationship.
- *Perpetrator issues*, as the theme suggests, refers to factors experienced by the perpetrator as indicated by the victim (and corroborated by key workers associated with the women). While the men did not have learning disabilities, they did have mental health problems and, for some, drug and alcohol dependency (with a minority experiencing serious physical health problems). Perpetrator behaviour tended to be jealous and manipulative, with many making threats of self-harm, suicide and/or murder (including the murdering of children). There were strong histories of previous partner abuse and animal cruelty (a link between this and IPV is well established in the literature; see Febres et al., 2014).
- The *Seeking help* theme revealed that although professionals were often aware of the abuse, little was done because the information came by way of indirect sources rather than the women with learning disabilities specifically seeking help to leave the relationship. However, most women reported

that once help was sought from formal sources they felt unsupported and few had any knowledge or understanding of services (i.e. information was not presented in a way that was accessible or easily understandable).

- The *Life after the abuse* theme indicated that many women experienced ongoing harassment, intimidation and serious assaults for a period following the end of their relationship. Once free from the abusive relationship, however, most reported improvements in their lives. McCarthy et al. (2017) point out the relevance of capacity to exert and express choice. When controlling behaviour, intimidation and violence begin very early in a relationship, the ability of a woman with learning disabilities to make choices can be compromised by the trauma experienced.

Fear and intimidation

Perhaps the most dominant and obvious barrier for women seeking help is the severity of abuse being perpetrated by the abuser and the associated fear. The nature of IPV can instil a fear of retaliation from the abuser, causing the woman to be concerned for both her own safety and for that of her children (Fugate et al., 2005; Leone, Lape, & Xu, 2014; Meyer, 2011a; Ragusa, 2012; Rose et al., 2011; Wolf et al., 2003). Fear of disclosure to formal support services (in particular police) has also been shown to be a key barrier to help-seeking in the recent meta-synthesis of research conducted by Morgan et al., (2016) on data from the UK Programme of Research on Violence in Diverse Domestic Environments (PROVIDE).[8] In all three studies reviewed, women reported fear that the abuse would escalate if the police became involved. This was a major concern, with participants claiming that there would be negative implications for the victims of IPV for certain outcomes (e.g. the imposition of protection orders). Research undertaken by Leone et al. (2014), however, suggests that the fear of retaliation or escalating violence depends on the type or severity of abuse being experienced. Their findings nonetheless revealed fear to be a significant barrier for women (n = 124) who had experienced what they described as *intimate terrorism* (i.e. IPV involving a general pattern of physical violence and coercive control), but not for women (n = 239) experiencing *situational violence* (i.e. IPV occurring as a reaction to some specific situation or conflict). One in three victims of intimate terrorism cited fear as the primary reason for not calling the police, and one in nine for not contacting a counsellor or other service provider.

A fear of not being believed or supported by both formal and informal support networks has also been shown to impede help-seeking, as has the fear: of being stigmatised and discriminated against, victim-blamed and criticised; of being incarcerated; that the perpetrator will not be arrested or receive only minimal consequences; or that child protection services will become involved, leading to the possibility that children will be removed (Fugate et al., 2005; Leone et al., 2014; Meyer, 2011b; Morgan et al., 2016; Overstreet & Quinn, 2013; Owen & Carrington, 2015; Pritchard, Jordan, & Jones, 2014; Rose et al., 2011; Wolf et al., 2003). Some women also fear the end result of their abuser being arrested and sent to jail and the negative implications that this may have for her family (Fugate et al., 2005). Women in the PROVIDE studies (Morgan et al., 2016) also reported they did not want to be seen as "weak" by family and friends, and that they needed to "stand up for themselves" against their abuser.

Victim's sexual orientation

While difficult to determine, it would seem that rates of IPV among women in same-sex relationships[9] are similar to, or marginally higher than, those reported among heterosexual women (Edwards, Sylaska, & Neal, 2015; Walters, Chen, & Breiding, 2013). Research conducted by Edwards et al. (2015) has also revealed that while similarities exist in terms of risk factors

8 The meta-synthesis included data from five studies in the PROVIDE research program: IRIS (Identification and Referral to Improve Safety of women experiencing domestic violence), with participants recruited via GP settings; LARA (Linking Abuse and Recovery through Advocacy), with recruitment via Community Mental Health Teams; PATH (Psychological Advocacy towards Healing), with recruitment via Specialist Domestic Violence and Abuse (DVA) services; WS1 (Workstream 1), with males recruited through GPs (sexuality unknown); and WS3 (Workstream 3), with gay men recruited through sexual health (GUM) clinics.

9 While the term "lesbian" has often been assigned to women who engage in same-sex relationships, several terms common in the LGBTQ community have recently begun to appear in the broader literature and apply to individuals who are biologically female. For example, those whose gender identity and assigned-at-birth gender is consistent are described as "cisgender" and the term "queer" is used to refer to a rejection of fixed identity categories (Halberstam, 2011). For example, individuals who identify as "genderqueer" reject the idea that one belongs to a fixed category of male or female. Until recently, the term same-sex IPV has been used to describe any physical, psychological or sexual abuse between two intimate partners of the same gender or sex (e.g. Murray, Mobley, Buford, & Seaman-DeJohn, 2007). However, this excludes any individual who: a) does not identify within the gender binary; b) identifies as transgender; and/or c) identifies as genderqueer in addition to, or instead of, identifying as lesbian, gay or bisexual. While broad in scope, the term same-sex relationship is commonly adopted when referring to relationships between two women and, as some research also considers transgender women who are victims of IPV (from both male and female partners), these women may be referred to as trans*. Finally, the term sexual minority refers to individuals whose sexual orientation differs from the heterosexual majority of the population.

for IPV victimisation and perpetration, there are additional risk factors (e.g. the combination of minority status and majority values that leads to conflict) that may help explain increased rates of IPV among sexual minorities. In terms of help-seeking, Turell and Herrmann (2008) found that despite an increased likelihood that women in their study primarily sought help from friends (perceived as "family" within the LGBTQ community), this was the least successful way to deal with IPV experiences. Women in the study reported that disclosure was a significant barrier to help-seeking due to the negative reactions from others or because they lacked a safe person to tell. Formal sources of help were also seen as a barrier, with most participants relating a belief that service providers would not take violence between women seriously and feared that they would have to educate providers on sexual orientation.

More recently, Calton, Cattaneo and Gebhard (2016) conducted a comprehensive literature review investigating barriers to help-seeking in same-sex relationships and trans* relationships,[10] identifying three barriers that they saw as key. The first was a *limited understanding of problem*, which the authors attributed to a lack of research in the field (i.e. while some barriers are similar to those with heterosexual couples, they argue aspects of same-sex [and LGBTQ] are unique and thus warrant special scrutiny). Power and control tactics specific to minority sexual orientation or gender identity include factors such as threats of disclosure (i.e. "outing" a partner to a co-custodial parent, employer, family or friends, resulting in fear of loss of children, employment, relationships with family and friends; threats to out a trans* partner's identity and/or history) and use of bi/transphobia to suggest others will not believe the relationship or the IPV is real, or if help is sought that service providers will discriminate against the victim once they know she is in a same-sex or trans* relationship (Fountain & Skolnik, 2007; Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007).

Stigma, the second barrier, refers to the discrimination and prejudice experienced by those who are not heterosexual or cisgender (see Hendricks & Testa, 2012; Norton & Herek, 2013). It was seen as a two-way barrier in that it both impeded help-seeking attempts and prevented helpers from offering support. Victims of IPV may not seek help because previous experiences with stigma lead them to believe service providers will treat them with the same level of discrimination, which appears to be the case for bisexual and trans* individuals (Budge, Tebbe, & Howard, 2010; Mohr, Jackson, & Sheets, 2016). Given many individuals manage their sexual orientation and/or gender identity because of the fear of stigma, help-seeking may lead to family and friends becoming aware and thereby reduce potential support (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). Although research has not specifically targeted interpersonal discrimination in the context of IPV support services, Renzetti (1996) reported participants felt they received a poor response (e.g. providers were unhelpful; responded in a homophobic manner; treated victims as though invisible). A more recent review of the literature by Turell and Cornell-Swanson (2005) revealed little change, with IPV victims revealing they were broadly dissatisfied with formal support services, including DV agencies, shelters, crisis lines, police, lawyers and clergy. The review does not make clear why victims across the various studies were dissatisfied but Calton et al. (2016) suggest it may be that when seeking help from the various agencies, the victims were treated with the discrimination and invalidation described in Renzetti's study.

The final barrier, *systemic inequities*, reflects the legal and policy structures that favour same-sex couples. While some jurisdictions (e.g. Canada, New Zealand, some US states and very recently Australia) recognise same-sex marriage, it was found that laws relating to domestic violence had not been modified to reflect such changes (e.g. those relating to protection orders). Police may also discriminate, particularly in cases of trans* women. This was evident in findings from a nationwide survey conducted by Grant et al. (2011) that revealed nearly half of those who responded felt uncomfortable seeking police assistance, most likely in response to their experience of harassment or discrimination by police (29%) and police brutality. The review also revealed the difficulties experienced by women in same-sex relationships and trans* women with respect to accessing assistance at shelters (Helfrich et al., 2008). For example, women in the Renzetti (1996) study reported they did not seek refuge in shelters for fear of rejection (based on their sexual orientation) or because their abusive (female) partner would be able to locate them and access the same shelter. Similarly, trans* individuals may fear rejection or being misunderstood by shelter residents or staff.

Perceived effectiveness/ Helpfulness of support

A considerable number of women do not seek help in the belief that it cannot change their situation, while others who engage with formal and informal supports indicate that they will not do so again (Fanslow & Robinson, 2010; Fugate et al., 2005; Goodkind et al., 2003; Turell & Cornell-Swanson, 2005;

10 The review covered LGBTQ and IPV; the focus here will be on the findings relevant to women in same-sex relationships.

Walker, 1991, 2001, 2009). For those who decide not to return, explanations generally relate to negative experiences, including perceived poor services and indifferent attitudes towards IPV victims. Others choose not to engage with formal services because they lack confidence in the ability of agencies (such as the police or the criminal justice system) to assist them, primarily due to a perceived power inequity between themselves and legal professionals and a history of experiencing discrimination and marginalisation (e.g. Ragusa, 2012). This is particularly the case with respect to discrimination against sexual orientation (as described under Victim's sexual orientation) and on racial/cultural grounds. As Cripps and McGlade (2008) have noted, the responses available to Indigenous Australian women who are victims of IPV have typically been viewed as culturally inappropriate and thus ineffective. For other women, the sense of being unsupported is closely tied to the failure of services to recognise their need for assistance. Women in the PROVIDE (Morgan et al., 2016) studies described feeling disappointed that their GPs did not initiate discussions about IPV despite their presentation with signs of physical abuse or their attempts to raise the issue by directing attention to harm caused by their partner. This failure on the part of medical staff left the women feeling confused and that the abuse was of little consequence. Women in the study were least likely to discuss their concerns with mental health staff out of all health professionals.

An examination of the negative experiences of three criminal justice help-seeking strategies (i.e. calling the police, prosecuting abusers and obtaining protection orders) was conducted in the US by Burgess-Proctor (2012a) through interviews with women (n = 22) – who had experienced at least one incident of emotional, verbal, physical or sexual abuse by an intimate partner. Calling the police was the only strategy that provided some level of satisfaction, although this was for only five of the 22 women. The remaining women reported a range of difficulties, including: failure of police to arrest partners on outstanding warrants for domestic abuse; slow response by police to calls for help; feeling manipulated by police into taking out a warrant against their abuser and then sanctioned when attempting to drop the charges; condescending and dismissive attitude of police towards victims; and the victim being arrested rather than the abuser. The court system was a source of intense dissatisfaction, with the women being dissatisfied both with the judicial process (which was found to be frustrating and confusing) and with unhelpful judges and non-judicial court staff. Feeling overwhelmed by the court process often led to the women not being believed by those within the system. Finally, the obtaining of protection orders was typically met with procedural challenges and poor attitude of court staff.

These findings are consistent with those of Meyer (2011b), who examined the experiences of female IPV victims (n = 29) who had contact with police and judges or magistrates within an Australian criminal justice system for the purposes of IPV-related support and protection. While all women had engaged in informal help-seeking behaviours on numerous occasions, they had also approached one or more formal sources of support prior to the current specialised service provider. Almost half the women had contacted police, which occurred in response to an increase in frequency and severity of the violence. Around the same number had engaged with the court either by making a Domestic Violence Order (DVO) application as part of criminal proceedings against an abusive partner (initiated during an abusive relationship) or making a DVO application after separating from a partner.

Despite being proactive and engaging in diverse help-seeking patterns, women in the study stated they frequently delayed reporting abuse to the police due to the fear of gendered discrimination and a lack of police support combined with a fear of retaliation by the intimate partner. Dissatisfaction with police outcomes was predominantly associated with the police displaying a lack of interest and understanding, which prevented them from meeting the victims' need for support and protection. Despite these negative experiences, some victims went on to seek help from a judge or magistrate, although this generally resulted in further negative responses. The women who applied for DVOs (for themselves and their children) described the court experience as traumatising and often disrespectful. This negative experience was further exacerbated when breaches of the DVO were not dealt with appropriately by the court. The authors concluded that stereotypical and victim-blaming attitudes fail to promote victim protection and offender accountability

Socio-cultural level

A number of factors potentially impact at this level, including socialisation, cultural beliefs and gender roles ascribed to women. For example, it has been suggested that lower rates of IPV have been demonstrated in cultures that value gender equality and individualism over those where collectivism is the norm (Archer, 2006). The higher IPV rates in other cultures is typically predicted by women's lack of rights, lack of access to education and employment and societal acceptance of men's dominance over women (Heise & Kotsadam, 2015). Also problematic within cultures where IPV is prevalent are changes in what were once clearly defined power structures in marital relationships (Kaukinen et al., 2013). The so-called "status

incompatibilities" said to arise have been held responsible for increases in male-perpetrated violence and coercive control (Kaukinen, 2004b; Vieraitis, Kovandzic, & Britto, 2008). Here again, the conception of intersectionality is key. In other words, the issues that fall within the socio-cultural level cannot be considered in isolation but, instead, need to be examined in the context of the interlocking patterns of sexism, racism, socio-economic disadvantage, disability and homophobia (see Nixon & Humphreys, 2010).

Family, socialisation and role expectations

For women, socialisation occurs in environments where gender roles are rigidly defined; the concept of masculinity is linked to toughness, male honour or dominance and authority; where family violence is tolerated; and males are perceived as having ownership of women. Belief systems such as these can become a barrier to women's help-seeking. Just as important is the pressure placed on women to keep problems within the family (Dasgupta, 2007; Lempert 1997). Previous research has also taken into account women's gender role expectations as reasons for staying with abusers (Anderson & Saunders, 2003; Lichtenstein & Johnson, 2009); men and women are both subjected to socialisation practices that teach culturally and/or religiously appropriate gender-specific behaviours and attitudes, which can include ideals such as women being obedient homemakers to their dominant male partners. Spiritual women who seek advice from religious leaders may be encouraged to stay in the relationship.

Marrs Fuchsel, Murphy and Dufresne's (2012) consideration of role expectations among immigrant Mexican women in the US provides an example of the possible impact of role expectations around marriage. Most women stated their fathers, rather than their mothers, spoke to them about their role as wife and what this entailed. Subsequent to the marriage, there was an increased likelihood of IPV, which the researchers attributed to the women feeling obliged to succumb to their husband's power. A few women were told by their mothers to take care of themselves as women, of a need to be respected by men and the importance of not engaging in pre-marital sex. There was no discussion of participants having ever learnt vicariously from their mothers what it meant to be a wife or to be married or that their comments should be interpreted in the context of living in a marginalised minority culture.

Culture-specific gender norms can influence the way in which victims of IPV both define abuse and how they engage in help-seeking behaviours (Agoff, Herrera, & Castro, 2007; Amanor-Boadu et al., 2012; Lee, 2013; Ting & Panchanadeswaran, 2009). For example, social ties that encourage a culture's traditional gender norms may not provide victims with avenues of support. Moreover, patriarchal views can impose gender norms on women *and* men, which influences gender-based roles. Cultural scripts of masculinity or *machismo* emphasise the importance of attributes such as physical strength, courage, honour, independence, manliness, aggression and male dominance (O'Neal & Beckman, 2016). Cultural expectations such as these frequently result in displays of physical aggression, sexual promiscuity, alcohol use, insecurity and female oppression and, according to some theorists, goes some way to explaining IPV in particular communities. According to Perilla, Bakeman and Norris (1994), this occurs because these cultural scripts maintain differences in gendered power whereby women are always morally and physically inferior to men.

Racism and discrimination

O'Neal and Beckman (2016) have pointed to the centrality that the experience of "White" women has had in discourses relating to female oppression, the consequence of which is that the resulting theories frequently offer little for women of colour. Just as important is the need to consider how discrimination based on ethnicity, gender, age, ability, sexual orientation and class interact on several levels and thereby provide a more complete examination of the contextual factors that shape women's experiences. Therefore, while the issues of ethnicity and culture are considered independently here, they nonetheless interact with other factors in serving as barriers to help-seeking and, like other barriers discussed here, should not be considered as unitary factors.

Early research by Rasche (1988) into the experiences of African American women seeking help from formal sources (e.g. police) for domestic violence provides culturally based explanations for the tensions that exist between law enforcement agencies and women of colour. Loyalty to their race was an example of why African American IPV victims refused to report their abusers; Robinson and Chandek (2000) describe this as family and community solidarity against a backdrop of racial oppression in the US. While such decision-making may support African American men, who have been systematically subjected to severe prejudice and discrimination at the hands of the criminal justice system, it has also meant that IPV has been tolerated. More recent research by Lichtenstein and Johnson (2009) with an older cohort of African American women would suggest this refusal

remains entrenched across the life-course. Not unexpectedly, the research found the primary barriers to reporting IPV were gender roles (i.e. women as obedient to husband, Church and family), age dependency (i.e. lack of housing, personal income, driver's licence, working vehicle and good health) and a mistrust of law enforcement. In essence, women who reported their husbands for abuse were seen as violating the gender norm of being a good wife and risked being stigmatised by Church, family and community.

Although immigrant women have a heightened vulnerability to IPV due to immigration-related stressors, it has been suggested that there is a decreased likelihood they will access appropriate services, largely due to a lack of cultural safety in the service system (Ting & Panchanadeswaran, 2009). While it is important not to stereotype experiences, Yoshioka, DiNoia and Ullah (2001) argue that specific personal and cultural barriers to help-seeking among South Asian and Southeast Asian immigrants may include a particular sense of shame and fear and a lack of access to information about personal rights (see also Raj & Silverman, 2002). South Asian and Southeast Asian immigrant women have also been noted to experience situational barriers such as economic dependence, immigration regimes that contribute to their insecurity and a lack of support for communicating their needs in languages other than English (Lee, 2013; Raj & Silverman, 2002). Other factors that have been identified as having a potential impact on help-seeking and decision-making include: ensuring marriages remain intact and the stigma of divorce, which has been suggested is sometimes experienced by immigrant Chinese women (Midlarsky, Venkataramani-Kothari, & Plante, 2006); and fear of being ostracised by their communities should they engage in formal help-seeking, which may affect Asian (Abraham, 2000; Ting & Panchanadeswaran, 2009) and American Muslim women (Abu-Ras, 2007; Hassouneh-Phillips, 2001). In fact, Arab immigrant women who hold more traditional beliefs and attitudes about women have been reported to be much less likely to engage with formal services to address partner abuse (Abu-Ras, 2007).

The relevance of this work to Australian communities needs to be carefully evaluated. For example, the Healing Foundation and White Ribbon Australia (2017) have argued that any effective strategy to prevent and reduce Aboriginal and Torres Strait Islander family violence must be "based in truth" (p. 6), recognising the impacts of: founding violence, structural violence and cultural breakdown; intergenerational trauma; disempowerment; and alcohol and other drugs. The Healing Foundation further argues that current strategies to reduce violence in Aboriginal and Torres Strait Islander communities have relied on the culturalisation of Western violence prevention programs in ways that overlook the need to understand violence in "a historical context, recognising the effects of foundational and structural violence, and the wide ranging continued impacts on the lives of Aboriginal and Torres Strait Islander men and boys" (p. 4). The report (p. 15) identifies some key points of difference that need to be considered when developing policies to support Aboriginal and Torres Strait Islander violence prevention.

While there appears to have been limited research investigating barriers to help-seeking for Aboriginal and Torres Strait Islander women, the work reported by Taylor and Putt (2007) does offer some insights in terms of their experience regarding sexual violence. Not unsurprisingly, some barriers are similar to those of non-Indigenous women with respect to shame and lack of familial support, which appears to be associated with the normalisation of abuse in some communities. A more significant barrier is the direct experience of unsatisfactory responses from police who fail to take reports of abuse seriously or to respond in culturally safe ways. This can lead to distrust, not just of the police but the criminal justice system more generally, when perpetrators are not dealt with adequately.

Structural level

At a structural level, factors such as social norms and cultural beliefs that reinforce gender inequality, gender role expectations and acceptance of violence to resolve conflict (Liang et al., 2005; Ting & Panchanadeswaran, 2009) serve to create conditions that make it very difficult for women to access informal and formal sources of help. These damaging norms and beliefs can become entrenched in the social, political and legal structures of society, and are often widespread in the very institutions that exist to support those affected by abuse. Consequently, women experience difficulties reporting abuse to formal sources (e.g. police) and accessing medical care.

Social isolation

Social networks (i.e. familial and community) provide emotional, social and economic support, particularly as the first step in help-seeking for IPV victims. As noted by Grigsby and Hartman (1997), a strong link has been found between the absence of social networks (i.e. social isolation) and violence against women (see Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Heise, 1998; Menjívar & Salcido, 2002). This isolation, which

can be an attempt by the abuser to keep the victim secluded and dependent (Beaulaurier et al., 2007; Dobash & Dobash, 1979 Wilson & Daly, 1996), is exacerbated for women whose immigration status is not finalised or if they belong to a cultural/ethnic minority. Isolation removes victims from sources of support (e.g. family, friends, work colleagues), resulting in the abuser becoming the only significant relationship in the victim's life. If the abuser forces the victim out of the workforce, she also becomes financially dependent. The net result can be: an IPV victim with little access to information about the dynamics of abuse; diminished options for her personal safety (e.g. access to shelters) and access to community resources; and limited access to legal information (e.g. protection orders, separation, child custody).

Rose, Campbell and Kub's (2000) research found that isolation not only constrained women from seeking support but for some was self-perpetuating. Although the women they interviewed were of the belief that their sense of isolation was the result of their partner's abusive and controlling behaviours, the aftermath (e.g. jealousy, suicide threats on the part of the abuser, or a sense of shame and fear on the part of the victim) created a more complex and prevalent pattern of the self as isolative. In other words, these women defined themselves as "hard to get to know" or as being uncomfortable around other people. Rose and colleagues saw this as an altered sense of identity, a sense of disempowerment in response to the negative messages received from their abusers (see Smith, Tessaro, & Earp, 1995). The long-term effect is said to be behavioural change whereby women become more distanced from potential supporters and further entrapped in an abusive relationship.

Consistent with the notion of intersectionality, marginalisation can intensify social isolation. Denham and colleagues (2007), found that one fifth of non-IPV victims in their North Carolina (US) study reported having no social supports, whereas half of the Latina IPV victims in the study stated they had no social supports. These women were not only geographically removed from friends and family, but they also had little access to any formal support services. It seems that even when Latina migrants in the US are in close proximity to their supports, they are less likely to seek help as compared to other migrant women (notably European and/or African American). However, as Agoff et al. (2007) showed, social networks do not necessarily equate to positive outcomes. In their investigation of the social relations of Mexican immigrant women they found family could serve to perpetuate IPV by maintaining dangerous environments for the victim. This has been shown to occur when families tolerate the abusive situation or even promote the actual abuse (Agoff et al., 2007; Marrs Fuchsel et al., 2012).

Reporting to law enforcement

Another barrier to help-seeking from formal criminal justice supports, particularly police, is IPV victims' prior experiences and expectations of criminal justice system responses (Beaulaurier et al., 2007; Overstreet & Quinn, 2013; Ragusa, 2012; Wolf et al., 2003). Wolf et al.'s (2003) study into barriers for IPV victims' help-seeking identified a theme regarding victims' negative prior experiences with police. The experiences identified within the theme included: the abuser not being arrested; the victim incorrectly being identified as the primary aggressor and being arrested for defending herself; the victim feeling they were not listened to or their situation being trivialised; abuser manipulation of and bonding with the police; stereotyping of race, socio-economic status and sexuality by police; and language barriers. Ragusa (2012) reported that in her sample (n = 36) more than half the time police were contacted (56%), the abuser was not arrested, while Meyer (2016) reported an incident where police refused to assist a victim on the basis that she had failed to press charges when they had previously attended at the victim's home.

Older women in Beaulaurier et al.'s (2007) study also voiced concerns about police responses to IPV, stating they felt the police would not understand their situation, would ridicule them and even feared they would be harmed by police. In fact, this research found that responses by the criminal justice system was one of the predominant help-seeking barriers. This is consistent with what Ragusa (2012) found in her Australian research. Several participants in her study reported that ex-partners had breached intervention orders on numerous occasions with either no or only minor consequences. In a report by the Victorian Law Reform Commission (2006) it was determined that police do not regard breaches of Family Intervention Orders, specifically those involving non-physical forms of IPV, as serious.

Many women have concerns about Child Protective Services (CPS) becoming involved and removing children from the mother's care. This can be a reality for some mothers who stay with an abusive partner, whether by choice or due to the barriers discussed herein. As noted by Meyer (2011a), IPV victims in her study who had taken the initial step to seek help from CPS or health professionals (both of whom are legally required to report when a child requires protection due to family violence), were given an ultimatum to leave their abusive partner or risk

removal of their children. While the women stated that they understood why these measures were in place and accepted that their child(ren) were in a dangerous situation, the issue this raises is that *the women* were viewed by CPS as endangering their child(ren), rather than the abusive partner. While the women had sought help to leave, no one provided them with that assistance (Meyer, 2011a). This may be a particular concern for those who identify as from Aboriginal and/or Torres Strait Islander cultural groups, given the history of child protection responses (included forced removals) that has impacted heavily on many communities.

Some victims have also experienced issues regarding court responses to intervention order applications while trying to protect and include their children (Meyer, 2011a; Ragusa, 2012). Under the *Domestic and Family Violence Protection Act 1989* (Qld), children can be included and protected by court orders with their mothers if a child is exposed to IPV. However, Meyer (2011a) found that respondents who wanted to leave their abusive partners had difficulty in having their child(ren) included on their court orders as they had not been physically harmed, and also due to the belief by the courts that in some cases, particularly where the child(ren) has not been harmed, it is important for both parents to remain in contact. Issues related to intervention orders, lack of support to understand or navigate complex criminal justice system processes, the perception of IPV being treated as non-serious and even victims being unaware or uninformed of the criminal nature of IPV by the criminal justice system, have been identified as barriers to formal help-seeking (Ragusa, 2012).

Other criminal justice system barriers identified by IPV victims include: it being male dominated; that women feel uncomfortable with or find it inappropriate to seek and receive help from male police officers; a belief that the criminal justice system will be biased against female victims (Beaulaurier et al., 2008; Meyer, 2011a; Ragusa, 2012); and for those living in rural areas, the likelihood that people within the system will be relatives or close acquaintances (Fugate et al., 2005; Lichtenstein & Johnson, 2009).

Seeking medical services

Due to the physical and psychological implications of IPV for its victims, healthcare professionals and settings such as GPs, ambulance services, hospitals and mental health service providers are seen as important formal help-seeking services. However, research would suggest that IPV is largely undetected and undisclosed in healthcare settings (Hegarty, O'Doherty, Astbury, & Gunn, 2012; Mertin et al., 2015). Barriers to disclosure generally relate to the perceived inappropriateness of: the setting; time constraints; lack of a specific line of questioning when treating patients; and the attitudes and training needs of professionals. In Bacchus et al.'s (2016) investigation of an IPV screening intervention by in-home perinatal-care providers in the US, the major potential barrier to IPV disclosure was the home visitor's communication skills and visible discomfort in discussing IPV. Despite this, many women in this study, regardless of whether they had or were experiencing IPV, felt that screening and providing women with safety plans and relevant resources was beneficial. This echoes earlier research by Plichta (1992), who determined that IPV enquiry by GPs served to increase disclosure. And yet Hegarty et al. (2010), and later Bacchus et al. (2003), who looked at disclosures to health professionals (e.g. GPs, home-care visitors and accident and emergency staff) found only a small number of women are asked by health professionals about IPV. These and more recent studies (e.g. Fugate et al., 2005; Mertin et al., 2015; Rose et al., 2011) have found that one of the major barriers in these situations is the shame and embarrassment women experience that prevents them from raising the topic themselves.

The importance of health professionals' attitudes and responses as a barrier to women's disclosure was recently demonstrated in the Bacchus et al. (2016) perinatal-care study. Participants who had discussed their IPV issues with either their GP or accident and emergency staff reported dissatisfaction with the responses they received (e.g. being advised to rest or take a holiday), with only one out of eight women who disclosed abuse being provided with information regarding IPV resources. Mertin et al.'s (2015) recent study revealed Australian GPs also failed to provide victims with the necessary information to assist with accessing IPV-related resources. Of the women (n = 87) who sought medical assistance and disclosed IPV, 61 percent (n = 53) continued to be treated by GPs for depression, anxiety or PTSD with prescription medication alone, while only 25 percent (n =22) were referred to counselling in addition to treatment with medication. This points to a lack of knowledge on the part of health providers regarding IPV, its ramifications and available resources. This claim is supported by Rose et al. (2011), with mental health professionals in their study stating they were not appropriately trained in, and lacked knowledge of, IPV and IPV-relevant issues (e.g. legal and housing rights). Interestingly, mental health services providers indicated that they did not see IPV enquiry as part of their role in terms of addressing their client's mental health issues. Finally, many women accessing health services reported that, just as with the criminal justice system, they feel uncomfortable broaching

the topic of IPV with a male health professional (Bacchus et al., 2003; Rose et al., 2011).

The specific needs of women in prison

The theoretical section above illustrates there are a multitude of individual, socio-cultural and structural factors that complicate help-seeking. While some of the proposed models lack strong empirical support, it is nonetheless clear that victims display a wide range of formal and informal help-seeking behaviours. This body of research also shows that many victims do seek out some form of assistance, frequently from multiple sources, although the general consensus is that irrespective of culture or age, the majority who do are more likely to seek informal rather than formal support (Barrett & St. Pierre, 2011; Du Mont et al., 2005; O'Campo et al., 2007). Additional barriers to help-seeking may vary cross-culturally but, in general, these relate to: a lack of resource awareness or lack of resource availability; factors relating to economic resources such as income, age, education and employment; racialised factors such as isolation, degree of acculturation, immigration status and experiences of justice; discomfort with unresponsive healthcare providers; unfamiliarity with or questioned effectiveness of protection orders; and the breaking of familial and cultural norms. Common barriers to help-seeking also involve fear on the part of the victim: fear of shame, embarrassment and loss of privacy; fear of retaliation from the perpetrator; fear of skepticism and arrest from law enforcement; and fear of losing custody of children.

The socio-structural barriers faced by women also draw attention to the specific difficulties faced by those who experience the confluence of victimisation and incarceration. The experience of the criminal justice system is clearly a relevant consideration, as well as the specific needs of incarcerated women that lead to their engagement with the justice system. A recent review of the needs of women in prison by Casey, Day and Gerace (2015) summarises many of these and provides a useful foundation for understanding help-seeking among women in prison (see also Kilroy, n.d.). While most of these have already been considered in this review, what is important here is the impact of having multiple needs and how this not only increases vulnerability but also has the potential to make barriers more entrenched and help-seeking more difficult. Thus the focus of this section of the report is not to attempt to explain why women may be criminalised (or indeed the role that victimisation plays in this), but to draw attention to the complexity of needs that women in prison often present with.

Mental health

The mental health needs of women in prison are significant (Derkzen, Booth, Taylor, & McConnell, 2013; Fazel, Sjöstedt, Grann, & Långström, 2010; Scott, Lewis, & McDermott, 2006; Tye & Mullen, 2006). These relate to mental health problems that were present prior to imprisonment (e.g. existing mental illness and/or substance abuse), exacerbation of mental health problems as a result of imprisonment (e.g. increased depression and anxiety), as well as those social needs (e.g. intimate partner sexual and physical violence, lack of social support) and gender-specific circumstances (e.g. dependent children, primary caregiver role) that impact adversely on mental health (Martin & Hesselbrock, 2001). It has also been suggested that processes such as psychiatric de-institutionalisation have resulted in an increasing number of persons with severe mental illness in prison (Hatton & Fisher, 2008; Wolff, Blitz, & Shi, 2007). In what remains the largest synthesis of data relevant to the mental health needs of prisoners, Fazel and Danesh (2002) investigated the prevalence of serious mental disorder (psychosis, major depression, antisocial personality disorder) in Western general prison populations. Of the 62 relevant studies included in this review, females made up approximately 19 percent (n = 4260) of participants. A small minority (4%) were diagnosed with a psychotic illness, 12 percent with major depression and 21 percent with antisocial personality disorder. Prevalence rates for any personality disorder (including antisocial personality disorder) were 42 percent and 25 percent for borderline personality disorder.

Studies comparing the mental health needs of female and male prisoners have suggested that there are differences in both prevalence and symptomology of mental disorder. In Drapalski, Youman, Stuewig and Tangney's (2009) study, for example, higher proportions of female inmates reported clinically significant symptoms of anxiety, somatisation and traumatic stress, whereas higher proportions of males reported clinically significant symptoms of mania, antisocial features and alcohol problems. A study by Zlotnick et al. (2008) of prisoners enrolled in substance abuse treatment reported that compared to males, females were 3.5 times more likely to have experienced a lifetime mental disorder and 2.7 times more likely to have experienced a lifetime severe disorder (major depression, psychotic disorder, bipolar disorder). The largest difference between females and males was for eating disorders, with females 18 times more likely to have experienced any eating disorder than males. Females also had higher odds of other individual mental health problems, including PTSD, borderline personality disorder, affective disorders, anxiety disorders and

psychotic disorders, but lower odds of antisocial personality disorder. A higher proportion of females had also experienced a previous psychiatric hospitalisation.

In an Australian study involving 58 male and 29 female prisoners in minimum-maximum security prisons who were within one month of release, Shinkfield, Graffam and Meneilly (2009) noted that 20.7 percent reported a physical health condition and substance use history, 14.9 percent a mental health condition and substance use history and 13.8 percent exhibited all three types of condition. Ogloff et al.'s (2013) survey of Victorian prisoners concluded that for both males and females, the most prevalent illnesses included major depressive episodes and PTSD. They reported that almost half (46%) of women, compared to 14.7 percent of men, were found to have met the criteria for PTSD at the time of the interview.

Particular concerns have been raised regarding the detection of mental illness in female prisoners. Moloney and Moller (2009) discussed the World Health Organization's *Kyiv Declaration on Women's Health in Prison*, which focused on mental health, victimisation and substance use needs of incarcerated females. They suggested that "there remains a need to bridge the gap between this international instrument, and research and practice in the treatment of mental illness among women involved in the criminal justice system" (p. 431). A New Zealand study (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001) of 1287 remand and sentenced prisoners (males = 1117, females = 170) found that 80.8 percent of inmates with a lifetime diagnosis of bipolar disorder had received psychiatric treatment in prison, but only 46.4 percent with major depression and 37 percent with schizophrenia and related disorders had received treatment. Specific to females, five of 22 inmates with a current major depression diagnosis needed admission to a hospital.

Parsons, Walker and Grubin (2001) compared the efficacy of a standard prison questionnaire to detect mental disorder in a sample of 382 female remand prisoners from two UK prisons. While community psychiatric nurses using a semi-structured interview incorporating multiple measures identified 227 (59.4%) of the women as having a current mental disorder, less than 20 percent (n = 73, 19.1%) of these women were identified by the prison screening instrument. The researchers suggested that this was "a missed opportunity" (p. 201) for treatment. In an examination by Warren and South (2009) of the properties of the Structured Clinical Interview for DSM-IV Personality Disorders-Personality Questionnaire (SCID-II) with 261 women at a maximum security prison, the measure was found to have good sensitivity (i.e. correctly identifying presence of a disorder), but lesser specificity (i.e. correctly identifying absence of disorder) for detecting personality disorders identified in clinical interviews, and low positive predictive power but high negative predictive power. The researchers advocated that the measure not be used in isolation from other measures. Kubiak, Beeble and Bybee (2012) found support for the suitability of the K6, a six-item screener of past-year DSM-IV diagnosis, for use with incarcerated females. However, they suggested that the usual threshold of a cut score of 13 to indicate presence of disorder be lowered for use with incarcerated persons.

A small number of other papers have considered screening developmental disorders. In particular, challenges in screening for autism spectrum disorders (ASDs) (Robinson et al., 2012), foetal alcohol syndrome (FAS), neurodevelopmental disorder (ARND) (Burd, Selfridge, Klug, & Bakko, 2004), and intellectual disabilities (Hayes, 2007) were highlighted. It is worth noting that Baldry, McCausland, Dowse and McEntyre (2015) have considered the specific role that disability plays in the pathways to imprisonment among Aboriginal women. Finally, Borschmann et al. (2017) have drawn attention to the risks of self-harm and suicide for those who have been released from prison.

Sexual and physical abuse

In Martin and Hesselbrock's (2001) study of 49 female inmates: 49 percent reported "a traumatic sexual incident as a child"; 41.9 percent reported having had sexual relations with an adult when they were less than 14 years of age; and 19 percent reported having had sexual relations with a parent. In their current relationships: more than 90 percent reported emotional abuse by a partner (91.4%); 65.7 percent reported physical abuse; and 64.6 percent reported sexual assault. Of those who met a current diagnosis of PTSD, 22 had experienced an event involving extreme fear and helplessness (16 in childhood or adolescence). In another study of 100 women awaiting trial or serving their sentence, Green, Miranda, Daroowalla and Siddique (2005) found that 48 percent of respondents had been sexually molested in childhood, 26 percent physically abused and 25 percent neglected. These figures are startling. Beyond documenting the prevalence of abuse histories in women prisoners, some studies have attempted to examine the relationships between abuse and subsequent outcomes. In the Australian Drug Use Careers of Offernders study (Johnson, 2006a), for example, past sexual and emotional abuse as a child or adult predicted subsequent mental health problems, but not substance use. Another study

by Milligan and Andrews (2005) found that childhood sexual abuse was related to self-harm, with bodily shame partially explaining this relationship (being Caucasian was also shown to be significantly related to self-harm).

Kimonis et al. (2010) investigated whether externalising and internalising disorders could explain the relationship between childhood abuse and subsequent suicidal behaviour, as well as lifetime criminality and recidivism. Participants were 266 adult females, 129 of whom were in prison and 137 residents in a substance abuse treatment facility. The findings revealed that a significant relationship between childhood abuse and suicide-related behaviour was fully mediated by externalising behaviours (antisocial features, alcohol and drug problems); and that internalising behaviours were related to a childhood abuse history, but not suicide-related behaviours. Externalising behaviours (but not internalising behaviours) were partly explained by the relationship between childhood abuse and criminality, but recidivism was not explained by externalising disorders. The researchers concluded that treatment focusing on victimisation, mental health and externalising behaviours "may be well-placed" (p. 601).

Sexual and physical assault is not confined to relationships that occur prior to entry into the prison environment. A US study of sexual victimisation in prison undertaken by Wolff, Blitz and Shi (2007) found that 27.2 percent of female inmates with a mental disorder and 20.9 percent without a mental disorder reported victimisation by another inmate or staff. The proportion appears to be lower in Australia, where a study by Schneider et al. (2011) investigated the associations between sexual coercion (both prior to and during incarceration), physical assault in prison and psychological distress. An initial sample of 4574 prisoners in NSW and QLD were recruited, but with exclusion criteria (e.g. inability to consent, lack of English-language proficiency) and missing correctional service data the final sample consisted of 2018 men and 333 women. For the female sample, 18.9 percent met the criteria for extreme distress. More women had experienced sexual coercion outside of prison (59.5% vs 13.4% males), with similar proportions of women and men having been threatened with sexual coercion/assault in prison (6.6% vs 6.9%) and having experienced sexual coercion in prison (3.9% vs 2.6%); fewer females had experienced physical assault in prison (24.3% vs 33.8%). Multivariate analysis revealed that significant predictors of distress were: being threatened with sexual coercion/assault in prison (but not actual sexual coercion in prison); sexual coercion outside of prison; physical assault in prison; being female; not being visited while in prison; being Aboriginal; and having poorer general health.

Substance misuse

The use and abuse of licit and illicit substances has been identified as a major factor in the initial arrest of women (Eliason, 2006) and a key contributor to the increasing incarceration of female offenders (Adams, Luekefeld, & Peden, 2008; Staton, Leukfeld, & Logan, 2001; Tindall, Oser, Duvall, Leukefeld, & Webster, 2007). For many women, crimes are committed either under the influence of drugs or as a means to support their drug use (Adams et al., 2008; Chesney-Lind & Pasko, 2013; Johnson, 2004; 2006b; Roll, Prendergast, Richardson, Burdon, & Ramirez, 2005). In the US, for example, results from the Arrestee Drug Abuse Monitoring (ADAM) program have revealed that at the time of arrest, between 33 percent and 82 percent of females tested positive for at least one drug (see Roll et al., 2005). Once incarcerated, treatment needs are high, with the greater proportion of female prisoners meeting the criteria for current substance use problems, including dependency, in addition to presenting with physical and mental health problems (Adams et al., 2008; Belenko & Peugh, 2005; Mahmood, Vaughn, Mancini, & Fu, 2013).

In a study assessing the substance use treatment needs of a large sample of women (n = 1404) at admission to one of eight residential prison treatment facilities in the US state of California, Grella and Greenwell (2007) found the most commonly used substances prior to admission were cocaine/crack (50%) and amphetamines (41%). A similar pattern was revealed in terms of self-reported treatment needs, with 38 percent cocaine/crack users and 34 percent amphetamines users indicating a "considerable" or "immediate" need for counselling or treatment. In another US study, Tindall et al., (2007) compared substance use preference and patterns of use in a group of women (n = 160) under community supervision (probationers) with a group appearing before a drug court (n = 173). It was hypothesised that probationers would be more heavily involved in criminal activity whereas the drug court clients would have more extensive drug use histories. The findings, while seemingly contradictory, do in fact support the strong link between drug use and crime. Compared to drug court clients, a significantly higher percentage of probationers reported lifetime use, with the most frequently reported drugs being opiates (75% of probationers vs 33% of drug court clients) and amphetamines (63% vs 28%) although the reverse was true for cocaine/crack (87% vs 76%). Probationers were also significantly more likely than drug court clients to be poly-substance users, with a higher proportion indicating they had used five drugs or more. Although the study revealed that drug court clients used for more days than probationers over the 30-day period prior to data collection, except for cocaine

(8.69 vs 0.58 days), there was a combination of licit and illicit substances favoured by drug court clients, which included alcohol (6.49 vs. 1.58 days), sedatives (3.2 vs. 1.59 days) and marijuana (6.15 vs. 2.69 days).

The most recent profile of the drug use and offending histories of Australian women prisoners is that to emerge from the Drug Use Careers of Offenders (DUCO) data (Johnson, 2006a), which is based on a sample of 470 incarcerated women from six jurisdictions (Indigenous = 128; non-Indigenous = 340). When compared to the general population, female prisoners who used drugs were younger (42% vs 17% aged under 30 years; mean age of 33.1 years); had lower levels of education (7% vs 38% completed Year 12); were disproportionately single (90% vs 50%); and relatively impoverished prior to entering prison (30% vs 4% living in public housing; 5% living on the streets). Indigenous women in prison, like their male counterparts, were over-represented in the sample (27% vs 2% of the population); they were also younger, had lower education levels and a greater proportion had lived in public housing (69%) or on the streets (22%) prior to incarceration than non-Indigenous women in prison. Some 59 percent of Indigenous and 63 percent of non-Indigenous women had been using illicit drugs in the 6 months prior to their arrest, and 68 percent of Indigenous compared to 37 percent of non-Indigenous women in prison were found to be regular consumers of alcohol.

Based on the DUCO data, Johnson (2006b) reported slightly different profiles for drug dependency, alcohol dependency and co-occurring drug and alcohol dependency in incarcerated women. The profile for women who were drug dependent was as follows:

- young women aged 35 and under;
- women with an education level of Year 10 or less, an apprenticeship or technical and further education (TAFE) training;
- non-Indigenous women;
- single women or those living in cohabiting relationships;
- women without children;
- women not receiving at least half their income from welfare benefits; and
- women for whom at least half their income came from crime or sex work.

This is distinct from the profile for incarcerated women who were alcohol dependent, which was as follows:

- Indigenous status;
- victim of physical abuse;
- unlikely to be earning an income from crime or sex work; and
- unlikely to be engaging in prescription drug use.

Finally, the profile for concurrent drug and alcohol dependence for women in prison was as follows:

- living in poor housing at the time of arrest;
- growing up with family members who have drug and alcohol problems; and
- unlikely to be earning an income from crime or sex work.

Johnson's (2006b) exploration of the DUCO data provides a breakdown of the substance use patterns of incarcerated Australian women. While there are similarities to what has been found in the US, as described above, the major differences may relate to drug preferences or availability, most notably crack cocaine. Nevertheless, a substantial proportion of women in the DUCO study regularly used "destructive" drugs. For example, 46 percent reported using heroin at some point in their lives while 27 percent had used it in the months prior to participation in the study. A similar differential between any use and current use was noted for other drugs surveyed, including amphetamines (61% vs 37%) and benzodiazepines (31% vs 15%). A composite category, which included ecstasy, hallucinogens, street methadone and morphine, was heavily weighted towards lifetime use (54% vs 6%), while cannabis was the most frequently reported drug used by participants in the sample (78% lifetime use vs 40% in the previous 6 months). Of those women who indicated heroin use, for 80 percent it was at least daily. By comparison, daily use was reported by 63 percent of cannabis users, 56 percent of amphetamine users and 21 percent of women with a preference for cocaine. Evidence of multi-substance abuse was less entrenched in this sample than that found in the US studies: 26 percent reported they used two types of drug in the six months prior to arrest and 36 percent averaged three types. Approximately half of the women surveyed self-identified as regular users of drugs other than cannabis in the 6 months prior to arrest.

The DUCO (Johnson 2006b) study also provides a comparison of Indigenous and non-Indigenous women in prison across the six Australian jurisdictions. While the sample size is not large, the findings are nonetheless informative given the differences. For example, non-Indigenous women were not only more likely than their Indigenous counterparts to be regular users of drugs

(other than cannabis) but also more likely to be poly-substance users. On the other hand, Indigenous women in prison reported higher levels of alcohol and cannabis use, the former contributing to higher levels of alcohol dependency in this population (e.g. 54% of Indigenous women surveyed were alcohol dependent – or dependent on a combination of alcohol and drugs – compared to 17% of non-Indigenous women).

Physical health

A smaller number of studies have addressed the physical healthcare needs of female prisoners, either through a primary focus on the area or within larger studies examining psychological, physical and social needs. These studies focus on cardiovascular health, sexually-transmitted diseases (STDs), reproductive health and pregnancy and the healthcare of older prisoners. Physical health needs were identified as an important area of potential unmet need as, "regardless of the exact age used for definitional purposes, women in prison are roughly 7 to 10 years "older" in a health sense than their chronological cohort in the community" (Reviere & Young, 2004, p. 57). Factors contributing to this include pre-existing health and living conditions, and access to healthcare both prior to and while incarcerated. In one study by Staton et al. (2001), perceived lack of empathy from treatment staff and doctors together with difficulties in obtaining appointments or more specialised medical treatment were discussed by participants as barriers to seeking medical care in prison. Prior to incarceration, fears of substance misuse being identified by medical staff and difficulties in paying for services were also identified by participants as barriers to seeking care.

Risk factors for cardiovascular disease were investigated by Plugge, Foster, Yudkin and Douglas (2009) in a sample of 505 women in two UK women's prisons. Results revealed that 13.1 percent engaged in 30 minutes or more of moderate physical activity, 12.7 percent ate at least five pieces of fruit or vegetables daily and 44 percent met criteria for healthy body mass index (BMI). In the sample, 85.3 percent of participants smoked and 7.4 percent were hypertensive. There were few changes between when the women entered prison and at a 1-month follow-up, with the amount of tobacco smoked (but not the proportion of women smoking) decreasing significantly and significant weight gain noted particularly for those underweight at prison entry. Predictors of these risk factors were: for smoking, being less than 30 years, "White", leaving school at 16 years or under and being unemployed prior to imprisonment; for being underweight, being "White" and unemployed prior to incarceration; for blood pressure, being 30 years or over; no significant predictors were found for physical activity.

It has been noted that incarcerated females around the world are not likely to have had routine STD screening and treatment, either prior or subsequent to imprisonment (Katz et al., 2004; Messina & Grella, 2006). Within prison, barriers to accessing screening and treatment for STDs include lack of routine screening in prison and detention facilities, reluctance to access services and the short length of stay of some detainees (Katz et al., 2004). However, the literature would suggest that this is an area of need, with one study of 344 incarcerated women finding that 1.6 percent were HIV positive and 25.4 percent tested positive for hepatitis C (HCV; Leukefeld et al., 2012). In a US study by Katz et al. (2004), a screening, diagnostic and treatment clinic was set up at a juvenile detention facility. Almost half (49.5%) of the facility's female detainees agreed to be screened for chlamydial and gonorrhoeal infection, which revealed positivity rates of 13.9 percent for chlamydial infection and 5.9 percent for gonorrhoeal infection (three females tested positive for both infections). The researchers advocated regular STD screening at admission and during incarceration, and the use of less-invasive procedures (e.g. urine tests) to address reluctance for treatment.

In a descriptive study by Kane and DiBartolo (2002) involving a convenience sample of 30 women in a rural US detention centre, two participants were HIV positive. It was noted that "almost half" of the participants previously had an STD and more than half reported never using condoms, with 30 percent of the participants having had two or more partners in the preceding 6 months. One-third of a subgroup of the sample who previously had gynaecological examinations (n = 22) reported having an abnormal Pap smear or STD. Two of the participants were pregnant at the time of assessment. Chronic illnesses were also investigated, with 10 participants reporting asthma and other conditions including diabetes (n = 2), hepatitis (n = 2), seizure disorder (n = 1) and two inmates were classified as having a permanent disability. In Messina and Grella's (2006) study into the relationship between childhood (less than 16 years) traumatic events and subsequent mental and physical outcomes, an increased number of traumatic events was predictive of higher odds of hepatitis or an STD, gynaecological medical problems and overall reports of fair/poor self-reported health. Race/ethnicity and (to a lesser extent) marital status and age were significant in some of these models.

One study by Reviere and Young (2004) has examined the healthcare needs of older women in prison. This investigation was conducted within the context of the increasing number of women in prison in the 45-54 and 55-plus age groups, and the greater healthcare needs of older women (and, in particular, minority women) in comparison to males. Data were drawn from a previous service provision study by Young and Reviere (2001). Dividing institutions into those reporting greater than or equal to 10 percent (n = 12) and less than 10 percent (n = 30) of people over 50 years of age, only one statistically significant difference emerged, with a higher proportion of prisons with less than 10 percent of older women testing for cervical cancer. It was reported that "just over one-half" had hospice services available, with a greater proportion of prisons with older people/women providing hospice services (67% vs 43%).

Parenting

It has been estimated that 55 percent to 80 percent of women in prison are mothers of children. US Bureau of Justice statistics show 84 percent of women in prison were living with their children prior to their arrest (cited by White, 2012). This is reflected in Watterson's (1996) earlier study of US incarcerated women that found some 80 percent of women in prison were mothers, of whom 70 percent were single parents, and 85 percent had custody of their children prior to arrest. It is worth noting that while men can usually count on their female partner to care for their children while they are in prison, women seldom have this option (Horn & Towl, 1997). In a UK study by Caddle and Crisp (1997), 61 percent of women in prison were mothers to children aged under 18 and/or were pregnant. The women tended to become pregnant at a much earlier age than their non-incarcerated peers (55% as teenagers compared with 20% in the community sample). They were also more likely to be single mothers (27% compared to 8%). The children themselves were young (30% under 5 years, 68% between 5 and 16 years) and most (71%) had been living with their mother prior to her being incarcerated. For 85 percent of those children who had lived with their mother, the current incarceration of their mother was the first time they had been separated for a prolonged period.

Casey-Acevedo and Bakken (2002) found that while 79 percent of female prisoners received at least one visit from a friend or family member, the most frequent visitors were friends rather than family members. More than half (61%) of those who were mothers did not receive any visits from their children. The authors observed that one of the most devastating aspects of imprisonment for women was separation from family and friends, especially their children, and that the separation that follows the end of visits can be a harrowing experience for many prisoners. Loper and Tuerk (2006) noted that there were no differences in institutional infractions between women with children and women without. However, mothers were more likely than women without children to be incarcerated for property or drug offences, whereas women without children were more likely to be incarcerated for violent offences. Both groups showed the same range of adjustment problems once in prison. Loper and Gildea (2004) have suggested that female prisoners seek relief from the stress of separation from loved ones by forming bonds with other women in prison or participating in surrogate families. They argued that this results in a large proportion of incarcerated women forming family-like relationships within the prison. Collica (2010) has further argued that prison programs have the unique ability to contribute to the creation of "pseudo families" and positive social relationships among prisoners.

Cultural needs

There has been much written about possible reasons for the over-representation of Aboriginal and Torres Strait Islander peoples in Australian prisons, which provides context for any discussion about the levels of need that currently exist. For example, Baldry and Cunneen (2014) have argued that it is only within a broader context of the strategies and techniques of colonial patriarchy that the reasons why particular social groups become the targets of penal excess can be understood. It is beyond the scope of this report to critique this literature, except to note that a range of specific needs may be present in Aboriginal and Torres Strait Islander men and women in prison. Jones (2001), for example, has made the distinction between culturally universal needs and treatment targets and culture-specific needs and treatment targets. Among the culturally universal needs, she lists substance abuse treatment, domestic and family violence programs, sexual offender treatment, support for personal and emotional problems (trauma and loss), physical health services, mental health services, parenting programs, employment and job readiness programs, community reintegration, follow-up and support. Culturally specific needs identified by Jones involve needs related to acculturation/deculturation (loss of connection to one's culture); separation, displacement and abandonment; coping with discrimination; identity issues and being bicultural; and reconnecting with spirituality. Jones argued that all of these culture-specific needs, in turn, will affect the manner in which those more universal needs will be met, including the need for violence to be addressed by programs in a meaningful way.

An important point to remember here, however, is that made by Bonta, LaPrairie and Wallace-Capretta (1997) who observed that while Indigenous offenders in Canada are culturally diverse, they are often treated as being a homogenous group. Hazelhurst (1987), for example, has maintained that the effects and implications of imprisonment for Aboriginal and Torres Strait Islander peoples from rural and remote communities may be very different from those experienced by Aboriginal and Torres Strait Islander prisoners who come from urban settings. The majority of prison facilities in Australia are located in urban areas and, as a result, Aboriginal and Torres Strait Islander people from remote and very remote areas are geographically isolated from their extended families and their communities when they are incarcerated. This will invariably impact upon their experiences (e.g. their roles as parents will be disrupted; they may be prevented from being initiated into lore/law; they may fear for their relationships with partners). It is, however, now well established that women in prison have poorer status than men on all key indicators of disadvantage and this pattern is particularly pronounced for Aboriginal and Torres Strait Islander women. Consequently, Aboriginal and Torres Strait Islander women typically need more intensive and multi-faceted services than other sections of the prison population, if resources are to be allocated in an equitable way.

Findings from Nancarrow's (2016) doctoral thesis further serve to highlight differences between how Indigenous and non-Indigenous women view the criminal justice system in relation to the specific issue of family violence. Non-Indigenous women by-and-large viewed the criminal justice system as a viable option for intervening to stop the violence and to hold perpetrators accountable for their actions, although most did not believe the system was sufficiently effective in delivering these outcomes. Indigenous women, on the other hand, were found to view the criminal justice system as a direct source of harm to themselves and their families, by enforcing separation (e.g. through incarceration) and failing to understand women's obligations to family and community.

The needs of non-English speaking women in prison are highlighted by an unpublished survey by Kilroy (2013). She reported that more than three-quarters of this group had been sexually assaulted, usually more than once, throughout their lives. Nearly all (85%) said that because they lacked the resources to ensure their own and their children's safety, they would return to violent homes, and language and cultural barriers were identified as a particular problem for many.

Implications for help-seeking for women in prison

The preceding summary of current knowledge about the needs of women in prison illustrates the particular vulnerability of incarcerated women. A majority of these women appear to have extensive victimisation histories that includes childhood sexual abuse, IPV and violence by both non-intimates and carers (Eliason et al., 2005; Johnson, 2004; Salisbury & Van Voorhis, 2009). The rates of sexual abuse experienced by women prior to prison entry are also thought to be much larger than those for women in the general community (Stathopoulos, Quadara, Fileborn, & Clark 2012). What is evident is the confluence of risk factors for IPV and incarceration: factors such as childhood physical and/or sexual abuse; drug and alcohol abuse; homelessness; social disadvantage; and mental health issues (DeHart, 2008; Lynch & Logan, 2015; Stathopoulos et al., 2012). Consequently, a large proportion of incarcerated women hold the dual status of "survivor" and "offender" (Pritchard et al., 2014). This can place many in the precarious position where doubt is raised about their status as a victim, which may further inhibit their ability to access the services that would typically be available to a woman who has experienced violence in the community.

The trajectories by which women end up within the criminal justice system are not the same as those that apply to their male counterparts. The development of gender responsive theories of crime has articulated the unique life events that differentiate women's pathways into the criminal justice system (e.g. Bloom et al., 2005; Chesney-Lind, 1989; 1997; Kruttschnitt & Gartner, 2003; Salisbury & Van Voorhis, 2009). These adverse life events become antecedents to a range of personal problems, which, in turn, lead to incarceration. Attention has also been paid to the specific pathway between IPV victimisation and incarceration for certain cohorts of women in prison (e.g. Brennan, Breitenbach, Dieterich, Salisbury, & Van Voorhis, 2012; Daly, 1992; 1994; Salisbury & Van Voorhis, 2009).

What this body of research has revealed is that a woman's experiences of violence and abuse can be a pathway into lower-level criminal behaviour (e.g. substance abuse – see Benda, 2005; Daly, 1992; Lynch & Logan, 2015 – and prostitution when criminalised – see DeHart, 2008) and crimes of higher severity (e.g. violent offences – see Lake, 1993; Pritchard et al., 2014; Richie, 1996). Daly's (1992) early work identified five prototypical pathways into crime, three of which specifically involved intimate partners: a) *street women – escape and survival* were women or girls fleeing abuse and violence, entering

street life and often engaging in drugs, prostitution or theft to survive; b) *drug-connected women* involved a pattern of using and trafficking drugs, often collaborating with intimate partners or family members; and c) *battered women* centrally reflected extreme victimisation from violent partners, leading to criminal behaviour seen tied to the relationship. DeHart's (2008) qualitative study illustrates not just how abuse can directly lead to prostitution, property offences or violent acts, but also the cumulative impact of victimisation over the life span. The narrative accounts of the women interviewed (n = 60 women in maximum security prison) described various pathways, for example, from being prostituted as children by caregivers into adolescent or adult prostitution or being introduced to drugs by adults and having lifelong addictions. However, other pathways were derived from adult relationship violence. For example, women who were coerced by partners into shoplifting or prostitution or women who retaliated against the perpetrator. As Zust (2008) has noted, women may make a bounded choice to engage in illegal activity. Some women, for example, are forced by abusive partners who threaten harm (e.g. with rape, physical injury, murder or sexual violence against them, their children or other family members) to get them to perform the illegal activity.

Brennan et al.'s (2012) quantitative assessment of prison intake measures identified eight pathways into offending, two of which specifically relate to IPV victimisation. The first pathway comprised younger single mothers who had experienced lifelong abuse, anxiety and depression, substance misuse and IPV, with most on their first imprisonment for offences that were family violence-related or involved drug and property offences. Women had experienced violence, including experiences of child sexual abuse, child physical abuse and adult sexual abuse. Social support from families was poor and parenting was found to be stressful. The average age of this group was 33 years. Women in the second pathway had experienced lifelong abuse (including IPV), chronic drug misuse and lived in unsafe housing. These women were, on average, aged 40 years, with children generally aged over 18 years and were predominantly single or divorced. Here again, women had experienced child abuse, including child sexual abuse and sexual abuse as adults. The older women had higher rates of criminal offending, particularly drug offences (i.e. drug possession or use and trafficking), histories of non-compliance (e.g. probation and parole revocations) and multiple detentions.

In a recent extension of ecological/life-course theories of pathways between victimisation and incarceration, Pritchard et al. (2014) compared women's experiences (n = 94) with victimisation, help-seeking and perceptions of incarceration across four different US site types (i.e. jails, prisons,[11] shelters and post-release support groups). The study revealed site-specific needs as well as three ways perceived by women with experience of IPV that incarceration might operate in terms of their service needs. In terms of site-specific needs, women in the shelter group were primarily concerned with protection and practical services but concerns about possible incarceration (e.g. due to outstanding warrants) limited their access to police and early preventive counselling. For those in jail, it was access to drug treatment, counselling and other services perceived to be unavailable prior to arrest. Incarcerated women had significant mental health needs, relating to experiences of intimate partner abuse, substance misuse, and coping with the traumas of criminal activity, incarceration, and apprehension about post-release troubles.

Post-release women had ongoing mental health needs in addition to severe disadvantage due to a lack of access to practical necessities and felony records that contributed to their continuing vulnerability to IPV. The first of the three barriers, *incarceration as a symbolic barrier,* was perceived differently as a function of the site and most prominent for those not currently incarcerated. For those in the shelter, it was a real possibility if their involvement in drugs, alcohol or domestic conflict continued; in fact, it was seen as more immediately threatening than the abuse they were experiencing. Women in the post-release group expressed extreme fears about possible parole violations and felt their felon status was a barrier that isolated them from potential sources of assistance.

Similar feelings of likely stigmatisation were expressed by the group in jail, although none had experienced it, while for the group in prison incarceration represented an additional trauma with which to deal, particularly for those women who had violently retaliated against the perpetrator of abuse. *Incarceration as opportunity* emerged as the major narrative in the jail focus groups. For this group, it was reported that there was a sense that jail could interrupt the trajectory of their abusive circumstances and thereby enable them to access services previously unavailable (e.g. due to a lack of finances, lack of referral or impractical due to life circumstances). While the primary service need for

11 In simplistic terms, jails are most often run by sheriffs and/or local governments and are designed to hold individuals awaiting trial or serving short sentences (e.g. typically less than 1-year sentences but up to 2 years in some jurisdictions) for misdemeanors (i.e. lower-level offences). Prisons are operated by state governments and the Federal Bureau of Prisons (BOP) and are designed to hold individuals convicted of felony offences (more serious crimes).

incarcerated women was drug treatment (frequently the reason for their arrest) they were less hopeful that their concurrent needs (victim and felon) would be addressed.

Finally, *incarceration as a structural barrier* to receiving help was a common thread identified by women from all four sites. A criminal record was seen to obstruct access to specific services (e.g. housing, police assistance or financial assistance for medical care). Women in jail and prison also reported counselling services were only available upon release rather than before or during incarceration.

Issues raised in the pathways research highlight concerns regarding reintegration and recidivism, and whether these also differ for women who have experienced IPV who have been incarcerated. As Eliason et al. (2005) have pointed out, there is a high recidivism risk for women who have experienced IPV and the ramifications of their relationship with the perpetrator/s (e.g. drug use and/or mental health issues) may not be addressed in prison. Eliason et al. also argue that post-release risk is likely to increase when services are limited (e.g. in rural communities) or when cultural norms dictate that personal problems are kept within the family and if a stigma is attached to help-seeking. Lynch and Logan's (2015) comparison of recidivism risk factors for women who have experienced IPV in urban and rural communities in the US state of Kentucky is also informative. The findings revealed that risk of re-arrest at 12 months following release increased significantly if the woman was in a rural area, had lower social support, experienced a higher sense of loneliness, reported problems with substance misuse/dependency, was younger and engaged in various illegal activities during the follow-up period.[12] Of note is that significantly fewer women in the rural sample used available resources to help them cope than did their urban counterparts. While there is the issue of fewer resources being available in rural areas, also problematic is the stigma attached to access due to the reduced levels of anonymity that may exist in small communities. The fact that substance misuse/dependency was associated with arrest at follow-up is consistent with concerns outlined in the Pritchard et al. (2014) study described above and highlights the importance of both in-prison treatment programs and throughcare. The authors highlighted the important role of peer mentoring re-entry programs in providing social support and access to community services, which have been shown to reduce recidivism rates by up to 35 percent (see Fletcher, Sherk, & Jucovy, 2013; Miller, 2009). Programs such as this aim to reduce the number of women who have experienced violence from a pathway of criminal activity by providing resources to help women cope with their ongoing struggles.

Perhaps one of the most challenging issues faced by women in prison may be the impact of incarceration on pre-existing symptoms of trauma. It has been argued (e.g. Covington & Bloom, 2006; Stathopoulos et al., 2012; Zust, 2008) that the coercive nature of prisons serve to re-traumatise women who enter prison with significant trauma needs. The experience has been described as a continuation of repeated physical abuse and chronic emotional stress previously experienced in their interpersonal relationships. This dynamic can often be continued by prison guards and has the effect of further reducing self-esteem and increasing feelings of hopelessness and depression (Fickenscher, Lapidus, Silk-Walker, & Becker, 2001; Zlotnick, Johnson, & Kohn, 2006). Prisons are built on an ethos of power, surveillance and control, which serve the dual purposes of security and punishment. These are the very same tactics used by perpetrators of IPV and serve to highlight the difficulties women face in an environment where the procedures and protocols might be considered to be sexually abusive (Covington & Bloom, 2006). It has been argued that in order for healing to take place, the person with trauma needs safety, dignity and respect (Quadara & Hunter, 2016). Instead there are potentially sexually abusive procedures that include strip searches, pat searches, surveillance by male staff and surveillance by staff controlling sexual access to intimate inmate partners (e.g. Blackburn, Mullings, & Marquart, 2008; Drake, 2007; Moloney, van den Bergh, & Moller, 2009; Pollock & Brezina, 2006). The utility of strip searches is questionable with the detection of contraband exceedingly low (Penfold, Turnbull, & Webster, 2005). Studies in two Australian jurisdictions support this claim. Wybron and Dicker (2009), citing Cerveri et al.'s (2005) report that of the 41,728 strip searches conducted at the Brisbane Women's Correctional Centre between 1999 and 2002, only two searches uncovered contraband of any significance. The statistics are similar in Victoria where 18,889 strip searches were conducted in the women's prison (Dame Phyllis Frost Centre) in 2001-02, with only one item of contraband detected

12 These included: a) passing bad cheques, forging/altering a prescription, or taking money from an employer; b) stealing from a shop; c) stealing from something/someone other than a store; d) knowingly buying or receiving stolen goods; e) breaking into a place to steal something; f) selling, distributing, or helping to make illegal drugs; g) threatening to hurt someone if he or she did not give the participant something she wanted (e.g. clothing, jewellery, money); h) threatening to hurt someone if he or she did not do something the participant wanted him or her to do; i) beating someone up; j) using a knife, gun, or any other weapon to get something from someone; k) exchanging sex for money or drugs; and l) anything else that would have got the participant into trouble.

(Cerveri et al., 2005). This represents a detection rate of 0.005 percent for each jurisdiction. Thus, women are involved in an act that Cerveri et al. (2005) have described as "sexual assault by the state" and report feeling "demoralised, humiliated and traumatised, which appears to fulfil no security imperative" (p. 15).

Summary

In reviewing this body of work it appears that IPV can take a number of different forms and include, but is not limited to, physical violence (i.e. threat of or use of force to cause harm or death), sexual violence (i.e. threat or use of harm to engage in sexual activity without consent, attempted or completed sexual act without consent, or abusive sexual contact) and psychological violence (i.e. using threats, actions or coercive tactics that cause trauma or emotional harm to a partner). Occurring at any point across the life span, its long-term consequences are exacerbated if the abuse (sexual and/or physical) commences in childhood. The various theoretical approaches to help-seeking outlined in this review illustrate that the decision to leave an abusive environment is rarely simple or straightforward. What is evident is that for the majority of women, initial help-seeking behaviours involve informal sources (e.g. friends and family) and, if their response is positive and the need arises, help-seeking moves on to more formal sources. Unfortunately, what the research also shows is that a substantial proportion of women do not engage in help-seeking, formal or informal. There are barriers to help-seeking at the individual (e.g. fear, intimidation, sexual orientation), socio-cultural (e.g. family, socialisation, role expectations, race, ethnicity, culture) and structural levels (e.g. social isolation, perceived effectiveness of law enforcement and medical services).

The wide-reaching physical, psychological, social and economic impact of IPV (e.g. anxiety, depression, lowered self-esteem, PTSD, self-medication with alcohol and other drugs, increased risk of self-harm and suicidal ideation, housing instability, homelessness, isolation from family and friends, loss of income, work difficulties and high absenteeism) bear a striking resemblance to factors identified in gender responsive theories of crime. Research also shows that the same factors associated with criminal activity (e.g. childhood physical and/or sexual abuse, drug and alcohol abuse, homelessness and mental health issues) are linked to abuse in adulthood. As Victoria's Royal Commission into Family Violence (Royal Commission, 2016) noted, "family violence is experienced in the childhood and early years of many women in prison and can disproportionately affect them in their adult life" (p. 37). Family violence, particularly if first experienced in childhood, can normalise abuse. This may go some way to explaining the findings of Robertson and Murachver (2007), whose study of New Zealand prisoners with a history of IPV identified three implicit beliefs condoning violence that were correlated with IPV victimisation: 1) that male violence is acceptable; 2) that women are worth less than men; and 3) that women should never leave their partner, even if they are violent. In short, there is a strong rationale to expect that incarcerated women will experience significant and specific barriers to accessing services that can assist in maintaining their safety post-release. In addition, it may be that service providers experience other barriers to providing services to women in prison. This is the focus of this research.

Methodology

Aim

The aim of this research is to develop an understanding of what both constrains and enables help-seeking in women in prison who have had exposure to IPV in the past, and/or have concerns about their personal safety post-release. This will inform the development of a model of help-seeking behaviour specific to the needs of women prisoners that can inform service delivery in this area.

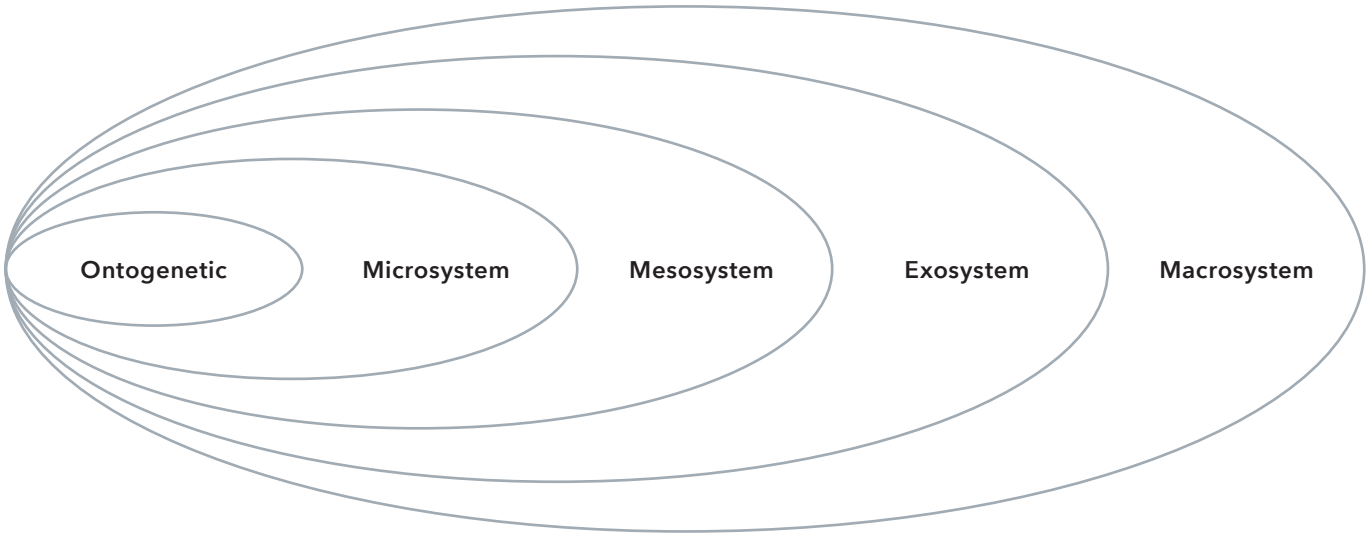
Theoretical framework: An ecological approach

The review of the literature identified a wide range of ways to understand help-seeking in women experiencing IPV, as well as how the specific needs of incarcerated women might create additional barriers to accessing services. Given that previous researchers have identified potential barriers to help-seeking at the individual, socio-cultural and structural levels, an ecological approach (Bliss, Cook, & Kaslow, 2007; Bronfenbrenner, 1977; Grauerholz, 2000) was identified as a useful way of incorporating these various theoretical positions into a single model that could explain help-seeking. The ecological model has been previously used to explore the experience of IPV from the perspective of both victim (Heise, 1998; Horn, 2010 Stith et al., 2004) and perpetrator (Bair-Merritt et al., 2010; Saunders, 2004; Stith et al., 2004) and is used, in this study, as the theoretical framework that informed data collection and analysis. There are five overlapping systems in the ecological model (Bliss, Cook, & Kaslow, 2007) into which women prisoner help-seeking is proposed to be nested:

- The woman's own history and the meaning she makes of it, such as witnessing IPV as a child, embarrassment/shame, knowledge of available resources, mental health, etc. (ontogenetic).
- The personal networks in which she interacts, the history of these networks, and their meaning, such as family relationships, previous experiences/relationships with service providers, etc. (microsystem).
- Linkages between networks or systems at the microsystem level (mesosystem).
- Formal and informal social structures that influence the woman indirectly, such as availability of support services, employment/socio-economic status, social isolation, etc. (exosystem).
- Overarching institutional systems at the cultural or subcultural level, such as gender norms/roles, cultural attitudes/beliefs about IPV and help-seeking, etc. (macrosystem).

The model can be visualised as concentric circles demonstrating the way in which the levels are nested within each other (see Figure 8, adapted from Heise, 1998, p. 265), but is applied in

Figure 8 The ecological model



this research to understand help-seeking in relation to Liang et al.'s (2005) cognitive process model of help-seeking and change (see Figure 2). As described previously, this model specifies three stages whereby the individual who experiences IPV must: 1) recognise and define the abusive situation as intolerable; 2) decide to disclose the abuse and seek help; and 3) select a target for the disclosure and subsequent help-seeking. The ecological element of the model is the influence of individual, interpersonal and socio-cultural factors on the feedback loop, and the model can take into account how IPV is often viewed through the lens of particular social, religious and cultural institutions where male–female power inequalities are reinforced. The Liang et al. model was chosen as the basis for the development of interview questions for women prisoners as it directly considers the level of recognition that IPV is undesirable and the extent to which the women see this as a problem that is unlikely to go away without help from others. It also has the capacity to incorporate systemic factors relevant to criminal justice system involvement, such as negative police responses to IPV or services that are not accepting of those with criminal histories.

The important theoretical contribution of the Liang et al. (2005) model is its focus on problem definition and appraisal, help-seeking decisions, selection of a help provider, the critical role of socio-cultural factors and the feedback loops characterising the process. Its simplicity also allows some of the key ideas to be translated into practice. However, Kennedy et al. (2012) have noted shortcomings of the model. Given criticisms of the model, which include the failure to conceptualise the degree to which women's needs are met, additional questions were included that asked about satisfaction with those services that had been accessed. This methodology is broadly consistent with Sabri et al.'s (2015) use of the ecological model to explore knowledge, access, utilisation and barriers to the use of resources among "Black" women who had been exposed to multiple types of IPV, in which barriers to resource use were identified at the individual, relationship and community levels.

Methods

A mixed-methods approach was used to incorporate data from three different sources: interviews with incarcerated women; a survey completed by incarcerated women; and interviews with key agencies and service providers. All of the data sources were used to:

- explore the perceptions and experiences of incarcerated women in accessing and utilising IPV and criminal justice-based support services both prior to and post-incarceration;
- explore the perceptions of incarcerated women regarding their post-release needs for service access; and
- examine the views and experiences of key service providers and stakeholders about providing services to women in prison.

Interviews with incarcerated women

These explored the nature of the women's contact with criminal justice and support services. The following prompts were developed in light of the ecological framework. It is important to note that the questions were not necessarily intended to relate to the personal experience of IPV help-seeking, with participants given the option of talking more generally about services and the help that they saw was required.

Interview questions

We are interested in your views about when and how, women seek help for issues relating to domestic or family violence. You can talk about your personal experience if you want to, or how you think you would act if you needed help, talk more generally about people that you know or simply share your views.

- Have you ever sought help for IPV or domestic violence (if yes – please can you tell me about it; if no – can you tell me about why you didn't seek help or what you would do if ever you need support)?
- Tell me what would have to happen for you to recognise that there is a problem with domestic violence?
- When would you ask somebody for help? What factors would influence your decision?
- How would you choose who to ask for support? Where would you go?
- What other things would influence when and how you seek help?
- Do you know of any services that could help?
    - Do you have any views about these services?
    - Have you had any experience in the past of trying to access these services?
    - What about other people you know who have tried to access them?
- Are there other factors that would determine how you asked for help? I'm thinking here of cultural factors perhaps, or financial ones or geographical?
- Finally, when we think about women in prison, how much support do they get for dealing with issues related to domestic and family violence?

  - Do you think that domestic violence experiences are acknowledged when someone comes into prison?
  - What are the key things after they are released that someone might need to keep them safe?
  - What would help to improve access to these things and how likely is it that they would be available?
  - How else can services be improved in your view?
- Is there anything else that you would like to add before we finish?

Thank you very much for your time today. Would you like to receive some information about what we find?

Survey

Questions in a brief quantitative survey (see Appendix) were developed from previously devised measures of help-seeking for intimate partner and family violence, including those of Macy, Nurius, Kernic and Holt (2005) and other researchers (Djikanović et al., 2012; Flicker et al., 2011; Krishnan et al., 2001; Sabri et al., 2015). The survey was verbally administered following the interview, with each participant asked about which services she had used, tried to use (but had problems) and not tried to use, including domestic violence services, mental health services, legal services, emergency support and children's protection services. The list of services presented was based on literature review and feedback from the project reference group. For each service, the participant was asked if she was aware of the service; whether she had used the service (had used; had attempted to use but experienced problems; had not used; not applicable to concerns); and if she did use a service, how satisfied she was with the help received. Participants were also asked two open-ended questions about what helped them to access services (e.g. family/friend; speaking to a professional) and what, if anything, made it hard for them to access services (e.g. lack of knowledge of service, difficulty in making appointments, stigma). The women were also asked about release concerns, in particular the areas they thought that they would need the most help with to maintain their safety.

Ethical considerations

The project was carried out according to the National Health and Medical Research Council (NHMRC) (2007) *national statement on ethical conduct in human research*. This statement has been developed to protect the interests of people who agree to participate in human research studies. Key ethical considerations in this study, as in all research with humans, are managing potential risks, maintaining privacy and confidentiality, ensuring participation is voluntary and offering the right to withdraw.

For the incarcerated women, all potential participants were informed (verbally and in writing) of the following:

- *Potential risk*: The potential for participants to experience some level of discomfort or distress during the interview. If they experienced any distress or discomfort, they were informed that the prison psychologist or prison visitor would be informed, who would then take steps to deal with the distress or discomfort. It was also made clear that any reported threats to personal safety would be passed on to the prison management, with the consent of the participant.
- *Privacy, confidentiality and disclosure of information*: All information obtained in the research would be retained by the researchers. Data would be combined in a written report or publication such that no individual responses could be identified. Participants were also informed that a report summarising the findings, but not containing any identifying information, would be provided to ANROWS for possible publication and that all information collected would be stored at James Cook University in a locked cabinet and on a password-protected computer and retained for at least 5 years, after which the data would be destroyed.
- *Voluntary participation*: Participation in any research project is voluntary and individuals are not obliged to take part. Whether or not they decide to participate in the study would not affect the services they receive in the prison.
- *Right to withdraw*: Women had the right to withdraw from the study at any stage with no negative implications (current or future) arising from either correctional services or the researchers.

All of the participants signed a consent form prior to participation.

Interviews with key stakeholders and service providers

These interviews were designed to be consistent with those conducted with the prisoner participants, although given the diversity of service providers who were interviewed, the questions were used as prompts to elicit their broader perspectives on how well the needs of women in prison are met.

Recruitment

Incarcerated women

All women incarcerated in Adelaide Women's Prison were invited to participate in the study (both quantitative and qualitative aspects). Purposive sampling was used to recruit 22 women to ensure that a range of views, backgrounds and experiences were considered.

Initially, the prison manager informed potential participants of the nature of the research and advised that members of the research team would be attending the prison on days specified by management with a view to conducting the interviews. At that time, a member of the research team explained the purpose of the study as outlined in the information sheet and provided interested prisoners with a written copy of the information sheet together with the consent form. It is worth noting here that participants were not selected on the basis of their cultural status. Nonetheless, it was considered likely that Aboriginal (and possibly Torres Strait Islander) participants would be recruited and liaison with the prison cultural advisor ensured that protocols to guide engagement with Aboriginal communities were followed.

All potential participants were advised both verbally and in writing that taking part was voluntary, that they would not be personally identifiable, that there would be no adverse consequences for their participation and that they were free to withdraw from the study at any time. Participants then registered their interest.

Service providers

Purposive sampling was used to recruit key service providers and stakeholders from agencies providing services to women in prison. In addition, the reference group was also asked to identify key service providers who work in this area, who were then, in turn, invited to nominate other key agencies or individuals. Potential participants were then contacted by phone or email and asked if they would consider participating in an in-depth interview.

Interview questions

We are interested in your views about when and how women seek help for issues relating to domestic or family violence. Have you ever worked with a female prisoner or ex-prisoner who has sought help for IPV or domestic violence (if yes – please can you tell me about it)?

- How might they choose who to ask for support? Where would they go?
- What other things would influence when and how they sought help?
- Do you know of any services that can help?
    - Do you have any views about these services?
    - Have you had any experience in the past of women trying to access these services?
    - What about other people you know who have tried to access them?
- Are there other factors that would determine how women ex-prisoners ask for help? I'm thinking here of cultural factors perhaps, or financial ones or geographical?
- Finally, when we think about women in prison, how much support do they get for dealing with issues related to domestic and family violence?
    - Do you think that domestic violence experiences are acknowledged when someone comes into prison?
    - What are the key things that someone might need to keep them safe after release?
    - What would help to improve access to these things and how likely is it that they would be available?
    - How else can services be improved in your view?
- Is there anything else that you would like to add before we finish?

Where possible, each interview was recorded and audio-transcribed for analysis. The interviews with the incarcerated women were analysed using theoretical thematic analysis (Braun & Clarke, 2006), where the identification of themes was driven by a theoretical interest in the ecological model of IPV and help-seeking (Bliss, Cook, & Kaslow, 2007; Bronfenbrenner, 1977; Grauerholz, 2000) and Liang et al.'s (2005) help-seeking model.

Theoretical thematic analysis is understood as a "contextualist" method situated between the "two poles of essentialism and constructionism" (Braun & Clarke, 2006, p. 81). It involves focusing on both the ways in which individuals make meaning of their experiences of help-seeking, as well as the ways in which the broader social context, in this case the various systems (individual, microsystem, exosystem and macrosystem) that make up the ecological model, delimits those meanings. In

addition, we explored linkages between networks or systems at the mesosystem level.

Following the approach outlined by Braun and Clarke (2006), the analysis process proceeded as follows. Familiarisation with the data involved each of the interviews being read through twice, and codes identified that reflect the content of the interviews. The codes were then collated into potential themes, in which a theme "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 82). The online qualitative data analysis software Dedoose (Version 4.3.86, 2012) was used to manage the data and coding process and to collate data relevant to each code.

An experienced qualitative researcher undertook the initial analysis of the interviews. In the initial phase of coding, a subset of transcripts was read by all members of the research team, who made preliminary notes and interpretations on the transcripts. Doing so enabled any re-occurrence of codes to be grouped together into categories and for initial themes to be identified. The research team then met to discuss identified codes and categories, examine similarities and differences in coding between team members and to identify themes.

The next stage involved interpretive analysis, in which a number of questions were asked of the themes in relation to the ecological model: "What does this theme mean?"; "What assumptions underpin it?"; "What are the implications of this theme?"; "What conditions may have given rise to it?"; and "Why do people talk about this thing [help-seeking] in this particular way (as opposed to other ways)?" (Braun & Clarke, 2006, p. 94). Through this questioning process and reading of the literature on the ecological model, and through a consultative process involving discussion among the researchers and members of the reference group, a thematic map of the analysis was generated and the themes defined and named. In this final stage, the "overall story the different themes reveal about the topic" (Braun & Clarke, 2006, p. 94) was identified; this informed the development of an ecological model of help-seeking behaviour in women in prison.

Participants

Incarcerated women

A total of 22 women volunteered to be interviewed. Their mean age *(M)* was 33.05 years (*SD* = 8.17, *Range* = 21-24 years). All of the interviewees identified as Australian, with nine (40.9%) identifying as Aboriginal and one as Australian-European. Fifty percent of the women described their marital status as single (n = 11), with the remainder separated or divorced (n = 4), married or de facto (n = 4) or in a current relationship (n = 2). Fifteen (68.2%) of the 22 reported that they had children (ranging from one child to seven children; *M* = 3.14, *SD* = 2.18), ranging in age from newborn to 30 years of age (*Median* = 7.50 years). Thirteen (n = 13) of the 40 children were under 5 years. For the highest level of education, most of the women had completed some high school (Table 1).

Table 1 Participant highest level of education

Highest level of education	n
Completed some high school (up to Year 9 or 10)	8
Some TAFE	4
Completed some high school (up to Year 9 or 10) and TAFE	2
Completed Year 11	2
Completed Year 12	1
Completed some university	2
Completed Year 12 and TAFE	1
Completed primary school and some TAFE	1
Completed primary school	1

At the time of the interviews, 15 of the women were on remand and seven had been convicted. For those who were sentenced, the reported terms of imprisonment ranged from 3 weeks to 4 years and 5 months. Participants reported that they had spent between 3 weeks and 20 years incarcerated, and were housed in different parts of the prison, including high security.

Service providers

A number of service providers from the same jurisdiction as the prisoner participants were contacted and invited to participate in the research. Some opted to be interviewed informally, rather than to present an official agency view about current service delivery – but were still able to talk generally about help-seeking. A total of 12 service providers were consulted.

Invited service provider groups included representatives from correctional services, women's safety services, the non-government sector, prisoner advocacy, healthcare services, victim support agencies and research organisations. As this is a broad and diverse group of stakeholders, with competing perspectives, no attempt is made to report a consistent position held by all interviewees. Rather, their views are reported as comments that supplement those of the women prisoners. In this way, the intention is to privilege the voices of the women, rather than the services that may play a role in assisting them to find appropriate help and support.

Analysis

The aim of the analysis was to explore the women's perceptions and experiences of accessing support for IPV, drawing on the nested ecological model and Liang et al.'s (2005) model of help-seeking and change. Help-seeking is explored in relation to women's views of both their prior help-seeking and their anticipated help-seeking post-incarceration. A number of individual (ontogenic), relational (microsystem), interacting microsystem relationship (mesosystem), social structure (exosystem) and cultural/ subcultural (macrosystem) factors were identified in the analysis that influenced women's help-seeking for domestic and family violence. As outlined in the previous section, ontogenic factors relate to the women's developmental experiences and personality; microsystem factors relate to women's interactions with others, and the subjective meanings assigned to these interactions; mesosystem factors relate to interactions between relationships at the micro-level; exosystem factors are social structures (both formal and informal) that have an indirect influence on women's IPV help-seeking; and macrosystem factors are overarching institutional systems at the cultural or subcultural level.

In what follows, we discuss how these factors influence the three stages of help-seeking, defined by Liang et al. (2005) as: 1) problem recognition and development; 2) the decision to seek help; and 3) support selection. The perspectives of the women are followed, where appropriate, by comments from service providers (identified only by interview number to maintain confidentiality). This process is represented in Figure 9. As Liang et al. predicted, help-seeking for these women was a non-linear process where each stage informed the other in an ongoing feedback loop. The process was at times chaotic, instinctive and often determined by the actions of others. Help-seeking was furthermore influenced by factors specific to the women's interactions with the criminal justice system, in particular a fear of police/experiences of injustice, the attitudes of services towards female offenders, perceived lack of acknowledgement of IPV in prison, relationships with other women in prison and, for some women at least, prison as a place of relative safety from IPV.

Figure 9 Model of help-seeking and change for women in prison

Stage 1: Problem recognition and definition

In the problem recognition and definition stage, the way in which a person responds to experienced violence is determined by how the problem is defined and the severity with which it is evaluated. For the women in this study, the problem of IPV was defined and recognised predominantly in relation to individual (ontogenic) and relational (microsystem) factors, with some reference to the interaction between the women's partner/abuser and family (mesosystem factor). This is not to imply that exosystem and macrosystem factors are unimportant; rather that they were not at the forefront of consciousness when the women spoke about recognising IPV as a problem that required help.

Ontogenic factors

Several ontogenic factors appeared to affect the women's ability to both recognise a relationship as abusive and define the problem as one that warranted help. These included childhood abuse/neglect, witnessing IPV as a child, women's own previous experiences of IPV and self-confidence/self-belief. Each are outlined in turn, with quotes from the interviews used to illustrate key themes.

Childhood abuse and/or neglect

Childhood abuse and/or neglect was described as influencing the women's ability to recognise IPV in their relationships in two ways. On one hand, by establishing abuse or violence as a normal experience, childhood abuse/neglect impeded women's ability to recognise IPV as a problem:

> When you grow up in an environment where things like this are happening daily, then you think – you start to think that, oh, this is normal. (Interview 1)

On the other hand, women's experiences of abuse/neglect in childhood could also facilitate the recognition of IPV as a problem because of the familiarity of the situation:

> I know [IPV] from the get-go…I grew up having my grandma screw with my head from a very, very young age, so they were the signs of emotional abuse and stuff like that. (Interview 15)

Witnessing IPV as a child and previous IPV

Similarly, both witnessing IPV as a child and women's own previous experiences of IPV was described as facilitating recognition:

> …seeing my mum being hit and then being with my partner and being hit. (Interview 10)

> Interviewer: You feel like you've got a clear idea, because you've experienced it before?
>
> Interviewee: I do, yes; I'd be able to see the signs. (Interview 3)

Self-confidence/Self-belief

Women's self-confidence/self-belief was another factor that affected the ability to recognise IPV as a problem and define it as something that could or should be addressed. Women often appeared to subscribe to the belief that they deserved the abuse; this sense of self, was for some, influenced by their experiences of abuse/neglect as children:

> A lot of the time I thought I deserved it, so I just left it. (Interview 9)

> Interviewer: Would anything else have to happen for you to recognise domestic violence had become an issue, it had become a problem for you?
>
> Interviewee: At the time not much would, because I hated myself. (Interview 18)

It was only with changes in their sense of self, often following intervention from counsellors (a microsystem factor), that interviewees came to recognise IPV as an abnormal situation and not something that was deserved:

> But it was really getting that counselling around building my self-confidence up and realising all the stuff that I was – when I was younger, why I allowed for these things to continue to happen and that it wasn't normal…Before I just thought I deserved it and everything was my fault and – but that was because of the stuff from when I was a child. (Interview 1)

Microsystem factors

At the microsystem level, women's interactions with others affected the ways in which they recognised and defined IPV as a problem. At this stage, women were influenced by their relationship with the abuser, their social/familial connections and their criminal justice-related connections.

Stage 1: Ontogenetic. Service provider perspectives:

Service providers also showed an awareness of how a personal history of victimisation can shape problem recognition, as illustrated in the following quotes.

> These women don't identify as victims (#4)

> Especially if you're somebody that's been brought up in a life of – if your mother and father have been abusive and it's been normalised to you all your life, your brothers and sisters they're all in abusive relationships, everybody's in an abusive relationship so to them it's normal. What are you going to report? (#2)

> I guess it's always asking women, even when you don't think there's no reason to question, but I always still ask do you feel cared for, and putting it in a way that it's not asking are you hit or anything, but do you feel like this person cares for you. That tends to try and break down that oh, yeah, they do look out for me, or oh, not really. (#7)

> I think the big thing is actually having a space where they just can talk about the totality of what's going on in their relationship, without them necessarily needing to say, "I need DV support". (#8)

Relationship with the abuser

One of the main triggers for women to realise that there was a problem in their relationship was when their partner's abuse escalated to the point of physical violence. Up until that point, while women often recognised that there were issues in their relationships, they did not necessarily identify the abuse as a problem needing action on their part (often because of ontogenic factors such as childhood experiences and women's sense of self):

> Interviewer: Tell me what would have to happen for you to recognise that the violence has become a problem?
>
> Interviewee: When I started having to go to the hospital a lot more to get stitches or broken bones, yeah. (Interview 6)

> No, I hadn't, I hadn't got any help for that. It got to the point where I needed an ambulance and that's – and I really thought I was going to die and that's where I realised that things weren't going to change. (Interview 8)

Social/Familial connections

Social and familial connections provided a trigger for some women to recognise and accept that something was not right in their relationship. One woman described this as follows:

> My parents and my mum turned round and said to me one day "you've turned really bitter and I don't like that". That was a hit in the face to me. (Interview 2)

Criminal justice-related connections

Women's connection with the criminal justice system, including being in prison, their connection with services and their relationships with other women in prison also affected their help-seeking for IPV. For example, one woman described how the support of her corrections officer helped her to understand her situation:

> Then going in to see my corrections officer one day and she said to me then, she said "something's going on, you need to tell me what's going on"…That's when I just blurted everything out to her. Yeah, that was pretty much what happened. (Interview 2)

Incarceration itself was a factor in some women's ability to recognise the problem, both in terms of the support they received and the fact of being in prison itself. For example, one woman described interactions with supports in the prison as helping her to realise that the situation with her partner was "not normal" (participation in a "healthy relationships" course provided by a non-government agency, and then talking to a social worker). This woman further noted that it was not until she came into the prison that she was ready to open up to someone about her situation:

> Doing courses like [the healthy relationships course] that is maybe something that can help you open up – like, put a light on your head and say, okay, this is not normal; this is normal. That could be that step that you don't realise yourself. (Interview 1)

> My social worker has been really good, because I opened up to her and said, this is everything I've been through and then she's, like, that's not normal. So she's helped me a lot…I've realised that it's not right. It's not normal. (Interview 1)

Similarly, another woman described being in prison as being "a service in itself" in terms of providing her with the time and space to reflect on and reinterpret her experiences:

> I know people who come to jail and they realise their relationship is bad. Jail is probably a service in itself. That sounds weird, but you get time to think in here and you get time to realise what was the good – the good, the bad, and the ugly. (Interview 9)

Stage 1: Microsystem. Service provider perspectives:

At this level, service providers consistently noted the importance of peer and professional relationships in problem recognition, but also that this depended on the particular professional involved. For correctional services, the final quote illustrates the complexities that arise when, as an agency, they are managing both the perpetrator and the victim.

> Very keen [to be heard] but they're very voiceless. They're not listened to at the prison at all. That's why they really – when I go in I find they're really keen to speak because they're always saying they don't even let us talk, they never give us a voice, they never listen to what we're saying. (#1)

> **Interviewee:** That's right and that's why the peer group here is so crucially important.
>
> **Interviewer:** People here will say, "That's not right" or…
>
> **Interviewee:** Yeah, "He shouldn't be treating you like that". "You're worth more than that". The first time they hear that they won't believe it. Maybe the second time, third time. We model different things to what they're used to. It's just a matter of you keep banging away at it. We ask the question and we care about a woman in a holistic way. (#1)

> **Interviewer:** What about Community Corrections – would people disclose to them?
>
> **Interviewee:** It depends on the officer. It depends on who you've got. (#1)

> When people attended a [prison NGO-delivered] course I was really surprised how many failed to recognise emotional abuse despite their previous contact with the system. (#6)

> In a time of crisis like that when you're having to share some of the most difficult and often shameful aspects of your lives, to have someone who's much more interested in doing a risk assessment from their organisational point of view, that you're trying to get help and they're trying to avoid, effectively, risks. (#9)

> We go oh, come back when you're ready to change. My argument is that's just absolutely not a good enough response, because there's so much that can be done in the meantime. (#11)

> It's a heightened responsibility when the abuser and the woman are both in our system together, which is not uncommon. (#5)

Mesosystem factors

There was only one reference to mesosystem factors (the interaction between factors at the microsystem level) in relation to this first stage of the help-seeking process, namely the interaction between the abuser and the woman's family/friends.

Interaction between abuser and family/friends

One woman discussed the interaction between her partner who used violence, and her family as a factor in her ability to recognise the problem. In the previous section, we discussed the effect of her family's response to what they perceived as changes to her behaviour towards them as being "the biggest trigger" for her to recognise her relationship as being abusive. Linked to this was her partner isolating her from her family:

> I think the biggest trigger for me is when I was in Adelaide living with my partner, it wasn't a big thing because we were in our own house doing our own thing. I was very close to my family and that dwindled away with him. When we moved my family was completely cut off, I was getting yelled at for contacting them so much. It was then that I realised that he was completely controlling everything that I was doing…I came to realise that every single day he was using me as an emotional punching bag and everything was happening to make himself feel better. It just got to the stage it's like I can't do this anymore. (Interview 2)

This discussion further demonstrates the ways in which factors at the various levels are nested within each other and work together to enable women to recognise IPV as a problem.

Stage 1: Mesosystem. Service provider perspectives:

Service providers did not talk about this level or, for example, consider how professional services might engage with family members and/or peer networks, beyond the provision of education programs in the prison.

> **Interviewer:** What would help to make women who are leaving prison safer?
>
> **Interviewee:** I think education. Going into the prisons and running sessions with them about domestic violence and actually highlighting to them. One of the things that we find – one of the first sessions we run with the women every term – so we run an 8- to 10-week program every term with the women that are part of our service – is what is domestic violence. It never ceases to amaze me about women who lived in the violence actually recognising what happened to them as domestic violence. (#2)
>
> We start with the healthy relationships, what even is a healthy relationship, explore what it looks like when it's not so healthy, and then towards the end of it is more we start going okay, so, what happens next, what is the next thing for you [once they leave prison]…[and] connect them into everything else. (#8)

Stage 2: The decision to seek help

The second stage in the help-seeking process is the decision to seek help. The decision to seek help "stems from problem definition and continuously shifts as women's cognitive appraisal of their situation and external circumstances shift" (Liang et al., 2005, p. 66). After recognising that there was a problem in their relationship, whether or not women made the decision to seek help was dependent on a number of interacting factors at the various levels of the ecological model. Women discussed factors at all five levels as affecting their decision to seek help, both in terms of facilitating the decision and as impeding them in their decision-making.

Ontogenic factors

A number of factors at the individual level both impeded and facilitated women in their decision to seek help. These factors included women's self-confidence/belief, their previous experience of IPV, drug/alcohol use and mental health problems.

Self-confidence/Belief

Deciding to seek help for IPV required confidence and self-belief to take action, or to "just speak up" (Interview 9). Lack of confidence could therefore prevent women from making this decision:

> …I think for many women in here [prison], they don't believe in themselves and they worry more about the – like, the barriers and what can't we do rather than what we can do to improve our lives. (Interview 1)

Similarly, another woman stated: "A lot of it comes from self-confidence. A lot of it comes from not being able to do and have a voice and things like that". (Interview 2)

Drug/Alcohol use

Related to this is substance use. Drug and alcohol use outside of the prison was discussed as a pervasive issue for incarcerated women, often used as a means of escaping IPV (and the self-medication of negative emotion) rather than seeking help:

> I use drugs on the outside [of prison] and when you're straight you have to deal with it and all the emotions and stuff…Yeah, that's why on the outside I haven't sought help. (Interview 5)

The use of drugs or alcohol was described as being related to feeling helpless and hopeless, which in turn related to factors at other levels, such as the women's relationships with the perpetrator of violence (microsystem) and partners isolating women from supports (mesosystem):

> I didn't really have time to breathe or – I didn't even have – let alone room to move, to even probably seek out resourceful help. (Interview 9)

Mental health problems

A further ontogenic factor relating to women's decision-making is that of mental health. Having a diagnosis of schizophrenia, and her partner's use of her mental health to persuade others not to believe her, was a significant factor for one woman in her decision not to seek help:

> I've been in domestic violence but I haven't gotten help like that…I was scared…Because he's the father of my kids and because I've got schizophrenia he uses that against me a lot…So if I was like, the people I did talk to about it, they wouldn't believe me because then when they would go speak to him about it he'd be like no, she's just had another episode or – so that's, it was always then put back onto me and my fault. So then I just felt like, well, no one really cared and even when I do tell them the truth it's not like they believed me anyway, so I just, yeah. (Interview 10)

This example demonstrates the various ways in which factors at the ontogenic level are nested with the microsystem and mesosystem levels, and serve to hinder women's decision-making around help-seeking.

Previous IPV

Finally, women's previous experiences of IPV also affected their decision-making. For example, two women discussed how their previous experiences of IPV would facilitate their decision to seek help in the future; having "been down that road" they "don't want to go down that road anymore" (Interview 4):

> Now I would ask for something, for help, straight away. I'm not going to put up with it anymore. I've been in too many relationships like that to not do anything about it now. The moment that I see that he's becoming controlling I'll leave; however, it's not always easier said than done. (Interview 7)

The last part of the above quote demonstrates women's shifting decision-making with changes in their cognitive appraisal of the situation and external circumstances.

Microsystem factors

Relationship factors appeared to have the greatest effect on women at the decision-making stage of the help-seeking process. Women's interactions with others, and the subjective meanings assigned to these interactions, either supported the decision to seek help or prevented women for making this decision. The main interactions affecting women at this stage was their relationship with the abuser, relationships with their children (and, for some women, pets), social/familial connections, connections with support services and criminal justice-related connections.

Relationship with the abuser

Women's relationships with a perpetrator of violence significantly affected their decisions about whether or not to seek help. As with the problem recognition stage, one of the main factors facilitating the decision to seek help was fear. While women often recognised that they were experiencing IPV and that it was a problem, it was not until they feared that they would be significantly injured or killed that they decided to seek help:

> Interviewee: He just – obviously I was scared that he was going to kill me but he beat me that badly that I had to go to the hospital. I'd had enough. Before I lost my life I needed to do something about it…
>
> Interviewer: Did you not know before then it was a problem?
>
> Interviewee: I did know before then. I just didn't do anything about it. (Interview 7)

> Interviewer: …at what point did it get to a point where you said, right, I need help now?
>
> Interviewee: Yeah, when I thought he was going to kill me. (Interview 3)

In contrast, for one woman who described her experience of IPV as involving emotional rather than physical abuse, her concerns about whether her relationship with her partner was "bad enough" affected her decision-making:

> "I didn't actually speak to anyone about it because I didn't think – because mine wasn't physical, it was all emotional. I didn't think that it was bad enough for me to seek [help] – because there were no outward signs" (Interview 2).

While fears for personal safety within the relationship often triggered the decision to seek help, for many this was negated by their fear that seeking help would lead to an escalation in violence and that, should they leave, they would be found by their partner:

> Interviewer: Are there any other reasons why you didn't seek help that you can think of?
>
> Interviewee: Fearful of him. Yeah. I was quite scared to… For me it was fear of leaving him and how he would react to that. (Interview 2)

> I couldn't [seek help]. That's what I mean, if he was to come and get me, they [police] wouldn't be quick enough, they wouldn't be quick enough. (Interview 4)

While these quotes demonstrate the effect of fear on decisions about whether or not to seek help, for some women decision-making was also affected by their fear of losing the relationship with someone they loved:

> No, I didn't [seek help]. I stayed in the relationship, because I was too scared to lose the person, so I guess I was too wrapped up in the love or – yep. Or I didn't want to be alone, so – yep. (Interview 1)

These examples again demonstrate shifts in decision-making as women's cognitive appraisal of the situation changes. Finally, two interviewees discussed how they did not need to make the decision to seek help because the abuser left the relationship; in one case to live in another town while she stayed behind to care for her grandmother (Interview 14), and in another case the woman's husband filed for divorce when he was in prison (Interview 4).

Impact on children (and pets)

Another microsystem factor that had a significant effect on women's decision to seek help was their relationship with their children. For some women, the negative effect of IPV on their children was the main reason they decided to seek help:

> Like the thing that made me actually leave was when he did it in front of my son. Because he was doing it for a long time and when it was just affecting me and I've always been

> taught to not go to the police and deal with things, ra-ra-ra, you know. But as soon as he did it in front of my son, and he was three at the time, it was like no, I'm never letting that happen to him again. That's what actually made me leave and go to the police. (Interview 5)

> Then yeah, just because my son had seen it that's when I thought it was beyond a joke so I thought I needed to talk to somebody. (Interview 17)

The shifts in decision-making because of changes in how the situation is appraised is further demonstrated in one woman's comments about not only being fearful for her child, but also of escalating violence should she decide to seek help:

> I would have never seeked help if my husband didn't go to jail. That was the only time – because I was terrified of him, absolutely terrified of him. Because I had had such horrific injuries from him I just knew that one slip up and – I had my son and then, when I had my son it was even worse. My anxiety was going through the roof when I had my son because I just didn't want anything to happen to him. (Interview 11)

Fears of escalating violence and the effect of this on children led some women to prioritise getting their children to a safe place before they could leave:

> I ended up giving full custody of my son to my grandma so she felt secure, so she didn't have to worry about him doing anything. The reason why he went with my grandma in the first place is because I knew my ex would keep messing with me, which he did, just so my son was safe. (Interview 5)

For another interviewee, it was not until her children were taken into out-of-home care as a result of the IPV that she realised she had to make a decision: "Well pretty much what thing triggered me [to make a decision] is, like, losing my kids" (Interview 13).

For others, children played a role in the decision not to leave. This was because they did not know where to go that could accommodate their children, because of the relationship the children had with their father or because of fears they would lose their children:

> I had five children. It's like where are you going to go with five kids? …It's a bit hard just to pack up and move five kids at that age. They've got school; they've got things like that, their friends. Then they're upset by it all. Not that they were happy to see violence with it, most of the time they didn't, but on occasions they did…Then they would say, "Well, you married him Mum so what [do you want]"; or they go, "You married him it's your fault". (Interview 4)

> Now the father of my kids. I never grew up without having a father. With me having to keep my kids' father around, come a toxic relationship. With that was accepting his drug use and his stealing and all that sort of stuff. Eventually it became a rut of a rollercoaster that I just couldn't find a way out. (Interview 12)

Another microsystem factor identified by one woman was her relationship with her dog, who she described as "like my son" (Interview 3). In her case she felt unable to make the decision to seek help "because he always threatened to kill my dog, and my main concern was my animals" (Interview 3).

Social/Familial connections

Women's social and familial relationships also played a role in their decision-making around seeking support for IPV. Factors that facilitated the decision to seek support included having friends or family who were connected enough to recognise what was happening in the woman's relationship, give voice to the IPV and encourage women to seek help:

> Interviewer: Had you told your family about what was happening?
>
> Interviewee: No, I didn't until I was living there. Because then, yeah, they started noticing. (Interview 16)

While relationships with friends and family could facilitate help-seeking, feelings of embarrassment and shame at the prospect of what friends or family would think of them also hindered women's decision to seek support: "I was too ashamed to [seek help], embarrassed" (Interview 19); "…you really don't want to admit that stuff's happening to you" (Interview 15).

Connection with support services

Women's connection with support services was another important factor affecting their decision about whether or not to seek support. Central to this was women's knowledge that supports are available. Not knowing about services that support women in their situation meant women could not progress from Stage

1 (recognising the IPV as a problem) to Stage 2 (deciding to seek support):

> I was in a domestic violence relationship for 4 years and to be honest with you at the very start when it all started to happen I didn't actually know there was any help out there. I thought that I had to deal with it on my own. (Interview 2)

For women who knew that services were available, the next issue affecting their decisions was being believed by these services. Women expressed concern that should they decide to seek support for IPV they would not be believed:

> Interviewer: What do you think stopped them [friends] going and asking for help?
>
> Interviewee: They're scared too, whether or not people are going to believe them or not. (Interview 17)

The issue of "being believed" related to the extent to which the IPV was visible: "…sometimes it's hard to get help out there unless you're a lot busted up" (Interview 22). Fear of not being believed was particularly the case for women who had a connection with mental health services:

> Interviewer: So what stopped you going further with it [seeking help]…
>
> Interviewee: Because I don't want to lose my kids, like, altogether. But, like I said, he plays on my schizophrenia so it's like, well, are they going to believe me if they've believed him this whole time? Like, yeah, I just, yeah, I don't want to lose my kids altogether. (Interview 17)

> Interviewer: When was it that you actually asked for help?
>
> Interviewee: Starting back 4 years ago and I wasn't afforded any. There was nothing – nothing really there – what they wanted for me was for me to go into mental health and go in through the mental health system and it was me that was deemed as being crazy, not the other way around. (Interview 10)

As the extract above indicates, women had connected with a range of services relating both to their IPV and in relation to other issues in their lives. They had varying experiences, both positive and negative, of these services. As discussed previously, the process of help-seeking is non-linear, with feedback loops between the stages. Thus, previous experiences with seeking support (Stage 3) could influence the way they perceive the problem (Stage 1), their future decision-making (Stage 2) and also their future support selection (Stage 3).

One of the main issues identified as relevant to the women's previous experiences with services was the need to go through complex procedures to access these services. Some interviewees identified the potential for women to return to their IPV situation as a result of difficulties in accessing services and rules relating to not telling others where you are when placed in a women's shelter:

> …they feel like this is one step and another big step again after this. They get to that place, and that point and it's like, well there's no help here so bugger it, I might just go back here and deal with this violence and it just continues and continues. (Interview 20)

> I've tried but really, crisis care puts you up in a hotel room for a night or two. You've got no money, they give you like $20 to last you a week to buy food. You've got no money, no clothes. You can't tell anyone where you are so you've got no support so you're more isolated than when you're in the abuse situation, so you go back. (Interview 15)

Another woman's experience of having to "jump through a lot of hoops" (Interview 7) to access support led to her decision never to ask for support again: "I would never ask them for a single thing again. I would sooner rather cop a beating every day of my life from my partner than go back to one of them" (Interview 7). Another woman described how she did not seek help for IPV because her previous attempts at seeking help were met with a poor institutional response: "The police were not helpful at all and that just turned me off any sort of help. Yeah, because they were useless. They were really useless" (Interview 5).

Criminal justice-related connections

In addition to women's experiences with services outside the prison system, their experiences within the prison also affected their decision-making around seeking support. For example, positive interactions with a social worker when in prison helped two of the women to feel comfortable asking for help. Another identified that relationships with other women in prison who had sought help for IPV helped her to realise what was possible: "Well, she can get help and stuff and make life easier for herself, so why can't I?" (Interview 5).

As discussed previously, being in prison itself could help some women to make the decision to seek help for IPV, particularly in terms of no longer being able to self-medicate negative emotion with drugs or alcohol:

> Being in here [prison], because I use drugs on the outside and when you're straight you have to deal with it and all the emotions and stuff. A lot of stuff from back then, because I've just blocked it out, comes up now and it's like oh, I need to deal with it. (Interview 5)

Stage 2: Ontogenic. Service provider perspectives:

Service providers were generally aware of the barriers to help-seeking that exist for women seeking help, talking about the importance of trusting the service provider, of respectful relationships that facilitate help-seeking, and of providing information about available services.

> Our women don't have trust in many agencies at all really. I find it difficult to refer women to any agency if they don't want to go. (#1)

> **Interviewer:** How is family violence reflected by the way people are spoken to [in prison]?
>
> **Interviewee:** It keeps the cycle going. A woman who's been abused in the community by a partner and then ends up in prison is then abused by the system and then is abused by the male prison officers and strip searched by the prison officers. It goes on and on and on so how do you expect that woman to get released, get out and expect anything different from herself when she gets out? How's that going to happen? Psychologically, how's it going to happen? (#1)

> That's an issue with our women. A lot of our women are invisible to the rest of the community and the rest of the services because they're not going to jump up and down if they don't get something because they don't have the confidence, number one. They don't have the self-esteem, number two. They don't have the resources, number three, to go and get a lawyer and sue anybody. Number four, a lot of them don't feel that they're worth any – they deserve any better. (#2)

> **Interviewee:** Look I would have said having clear information prior to release and some education about how to protect themselves prior to release. Either in a little course or program, or in some format of information.
>
> **Interviewer:** Do you think that happens?
>
> **Interviewee:** No.
>
> **Interviewer:** Is anyone doing that work that you're aware of?
>
> **Interviewee:** Not that I'm aware of, no, not that I'm aware of. Then secondly a transition out into a good quality service, generally for them. That's cognisant of the fact that they are at risk of further domestic violence, if they don't get the support and education they need to help them prevent themselves getting into those circumstances again. That would be the second one. (#3)

> I think pre-work around a sense of identity and worth. I think enabling them to form supportive and meaningful relationships that transition with them and creating a context that has practical support post-release, while sounding really simplistic, is actually I don't think that far off the range. (#5)

> Women often will share that they feel there's a sign on their head that they are prisoners. (#8)

> Now, a lot of people in prison are – I wouldn't say authority-averse, but their experiences with authority haven't been great, so to reach out and to then have surveillance, perhaps, of your children through failure to protect, they're all big obstacles. (#9)

> I think the thing is that I'm not sure that they know – I mean, obviously, they don't like it, but I'm not sure that they can feel they can change things. Certainly, drugs come into play, so there's a cycle of dependence in the situation. (#7)

Mesosystem level

Factors affecting women's decision-making at the mesosystem level included the relationship between the abuser and women's social networks, between the abuser and services, between women's social networks and services and between the services themselves. Overall, these factors were described as hindering any decision to seek help.

Interaction between perpetrator and family/friends

The relationship between the perpetrator and women's social networks was one where many women were isolated from their social network, making it difficult for them to move from problem recognition and definition to the decision to seek support:

> Interviewer: Yeah, so what was stopping you from just leaving?
>
> Interviewee: I had nowhere to go. He kind of stopped me from talking to all my family and that, so he cut off all my support so, yeah. (Interview 18)

Interaction between perpetrator and services

In addition to isolating women from their social networks, the perpetrator might also prevent women from accessing services:

> I think at the hospital – when I'd go into hospital – especially when I had a broken pelvis and a broken back they knew that something wasn't right and then the police came in to speak to me but my husband was still there. I just said it was an accident and what not. (Interview 11)

For this interviewee, the only opportunity she had to seek help was when her husband went to prison: "Well, the only chance I had to ask for help was when my husband went to jail. I just thought, that was a time I thought I had to run for my life" (Interview 11).

Interaction between social networks and services

Given the difficulties women experienced in making the decision to seek help, many of them did not in fact make this decision. Instead, their family, friends or members of the larger community in which they lived made the decision and intervened on their behalf:

> Interviewee: …one of my friends did ring the police one time, and this is how I finally got away from him at the end, because he rang the police and said he was concerned about me, and the police came to the door.
>
> Interviewer: It wasn't you who called the police, it was somebody else who'd called the police?
>
> Interviewee: Somebody else who called the police, because they hadn't seen me for a while. (Interview 3)

Interaction between services

The final mesosystem relationship affecting women's decision-making is the relationship between services. In particular, two women expressed fear that if they sought help, the services would then contact police or welfare services. This connection between services had resulted in both women having their children taken into out-of-home care in the past:

> If you have to report it and stuff there will be police involved; my children have been removed because of the DV. (Interview 21)

> …their reports were a mitigating factor in me losing custody of my son when I gave birth. (Interview 15)

This again demonstrates the way in which negative experiences of accessing services (Stage 3) hinder women in their future decision-making around IPV (Stage 2).

A number of interviewees commented that very few services and programs were available in the prison. It is unclear whether this is the case or based on the perception that little is offered. From the perspective of correctional services, most criminogenic programs (although not considered specialist standalone domestic violence programs) delivered by the department touch on IPV as part of their content. In addition, a number of relevant programs have been delivered by specialist IPV community-based agencies in the prison over the past 2 years, some quarterly. Programs include a number specifically funded by the department.[13] It is

13 B. McGinnes, personal communication 2016
- RASA/NDVS Healthy Relationships Program includes an evaluation and research component – DCS Community Grant
- Quarterly Keeping Safe Program – with NDVS
- Centacare Parenting Program includes a component on the impact of exposure to violence on children – DCS Community Grant
- Annual White Ribbon event
- Making Changes includes a component on relationships
- Relationships Australia 1-1 DV counselling with Aboriginal women

Stage 2: Mesosystem. Service provider perspectives:

A key focus for service providers was the relationships, or lack of relationships, that exist between different services, as well as uncertainty about the role that different agencies have to play in responding to IPV. Many spoke about the possibilities of improving the level of information provided to women while in prison about available service options, with some suggesting that correctional services did not see this work as within their role. However, a department representative suggested that this has changed recently.

> But no, I really don't think there's anything done. Certainly for those leaving prison they'd get nothing in prison. So I don't think Corrections would deliver anything to them about protecting themselves when they get released. (#3)

> **Interviewer:** What information do they get in prison about keeping themselves safe?
>
> **Interviewee:** Fuck all. Excuse my language. Nothing. (#2)

> **Interviewee:** Yeah. I think people who – we still hear – it's very common for us to hear if I'd known you were here 10 years ago I would have left 10 years ago, or if I'd known I was going to get this kind of support I would have left earlier. (#1)

> **Interviewee:** Once a woman gets an intervention order, what we're finding is that then when that intervention order's breached that woman's being arrested. Next time – the next woman's never going to apply for an intervention order. We're creating this criminalisation of victims, which is senseless. A woman who's a victim, how can she stop that man coming into her home if he's more powerful than her and dominating her? She rings the police and calls for help. They come and they arrest them both. I don't understand that.
>
> **Interviewer:** It just entrenches people in the system?
>
> **Interviewee:** It just entrenches them and then it just becomes hopeless.
>
> **Interviewer:** And people learn…
>
> **Interviewee:** In the end they don't ring. (#2)

> **Interviewer:** Why do the prison or community corrections not refer very often?
>
> **Interviewee:** I don't know whether they recognise the need to link women into services like ours. They may not know that we exist. (#1)

> **Interviewer:** What do you think these women need most when they come out [of prison]?
>
> **Interviewee:** My instinct is to say a safe, central connection point…It should be a connection made prior to release. (#8)

> More recently what the agency has done is identify the women within the domestic violence framework, which the agency has developed of the need to recognise women in the criminal justice system as a victim as well as being offenders within the system. I think that that's actually an inherent challenge for all correctional services…in terms of programs again there's not been a great deal offered by the agency itself around the victim. Most of the service that gets delivered has been from external agencies coming in. Some of that is as a result of the growing relationship between us and the domestic violence sector. (#5)

2017

- Aboriginal Women's Group/Healing Circle Project with NDVS
- RASA/NDVS Healthy Relationships Program
- Quarterly Keeping Safe Program with NDVS
- Anglicare Parenting includes component on the impact of exposure to violence on children
- Relationships Australia 1-1 DV counselling with Aboriginal women
- Making Changes includes a component on relationships
- Sessions and consultation on Spirit of Women DV Memorial Project

nonetheless possible to observe that external agencies appear largely unaware of this work. It is also worth noting here that there are considerable practical challenges with program delivery in a context in which the rate of remand is now more than 50 percent of the daily population (with an average release after 45 days). In South Australia, most sentenced women are also released within 2 years.

Exosystem level

The exosystem level of the nested ecological model includes the social structures (both formal and informal) that have an influence on women's help-seeking. A number of factors were identified at this level, including women's financial situation, housing, their geographic location and social isolation. None of these factors were identified as affecting women's problem recognition and definition (Stage 1); however, they did affect women's decisions about whether or not to seek help for IPV (Stage 2). These factors predominantly impeded women in making the decision.

Finances and housing

Women discussed how being financially dependent on the person who used violence made it difficult to make the decision to seek help. Women found it difficult to leave when they had no stable housing to move to. Similarly, lack of finances and housing can mean that women might return to a violent partner. This is particularly the case when leaving prison:

> …housing is probably the biggest issue for women, because women [leave prison] and they don't have any accommodation…and then they go back out to those violent partners... (Interview 1)

Geography

Being geographically isolated also made it difficult for some women to make the decision to seek help when supports (both formal and informal) are far away, and they lack the finances to get there. A further issue in rural areas is that "everybody knows everybody" (Interview 19), meaning women were reluctant to make the decision to seek support due to feelings of shame and embarrassment:

> Well, the shame and embarrassment in [country town]; it's only a small place and everybody knows everybody, if you know what I mean. To actually admit there's a problem opens up a whole sea of questions and you having to answer those questions, or even opening it up to yourself, admitting there is a problem to yourself. (Interview 19)

Social isolation

Social isolation was also a factor, with women identifying that it is difficult to seek support when they have nowhere to go and no one to turn to: "It all comes back to isolation and support networks" (Interview 15). The interconnection of these factors can be seen in the following quote:

> I had to quit my job; I couldn't work anymore and I didn't have my family so I had nowhere to go. (Interview 18)

Social isolation could also be exacerbated when women sought support from shelters and were not allowed to contact friends or family, noting the negative effect of "the isolation that the services impose on you" (Interview 15). As discussed previously, this could lead to women returning to the abuser.

Macrosystem level

At the macrosystem level, factors associated with the decision to seek help included cultural attitudes/beliefs relating to marriage and women's roles and experiences of prejudice (both against people with mental health problems and against those in the justice system). It is important to note from the outset that there is a great deal of diversity of beliefs within cultural groups and the women here are providing illustrative examples from their own experience.

Cultural attitudes/beliefs

Cultural values relating to how marriages should function prevented women from seeking help for IPV. For example, one woman described being brought up in a family where you "don't talk about what happened behind closed doors" (Interview 19). Similarly, a woman stated that "being Aboriginal…people tend to say don't speak about it" (Interview 12). Another woman described being impeded in making the decision to seek help because of her Italian culture, which made her feel embarrassed about divulging her situation: "It made me more embarrassed" (Interview 11).

Stage 2: Exosystem. Service provider perspectives:

Service providers seemed generally aware of these barriers to help-seeking, especially in relation to the availability of safe alternative accommodation post-release.

> They would fall into being homeless as well when they're exiting prison – it's a difficult one. It's a difficult area especially for single women because their income, their Centrelink income, is so low compared to what the rents are out there that they're actually forced to live with someone else or board somewhere, which again makes them vulnerable. (#1)

> We also connect with women in particular…Basically an accommodation and wraparound support service for women exiting prison. For whom we find a significant number have experienced domestic and family violence. So these are women with very high and complex needs. So we work with those in that service. We collaborate strongly with all of the agencies, the women's agencies around that particular cohort. (#3)

> Some of the choices about discharge and accommodation are very limited. We do find that the courts might release them because they can't hold them anymore, but the options for accommodation are really not there, so they have to return to the place that's perhaps not ideal. (#7)

> I think that dependence – so whether it's financially, accommodation. If you haven't got a job or opportunity and a purpose, that's what's going to probably hold you back, especially if your kids are being removed, because your reason to be good can then diminish too. (#7)

> It's just different levels of complexity to access services depending on what demographic you're in, whether you're rural, whether you're male, whether you're same-sex or whether you're not, or if you're disabled. (#9)

Prejudice

Women also discussed the range of prejudices they face that prevented them from making the decision to seek help. Prejudice against people with mental health problems, as discussed previously, meant some women feared they would not be believed if they sought help. For these women, seeking help was particularly difficult given their feelings that no one wants to help them because they are perceived as criminals and therefore unworthy of help:

> No one cares because they think, oh they're drugs addicts… they're criminals. (Interview 11)

> I don't even want to ask [for help] because it's jail, they don't care. (Interview 4)

Stage 2: Macrosystem. Service provider perspectives:

Service providers generally did not talk about how prejudicial attitudes in their organisation inhibited help-seeking. Rather their comments reflected a concern about how the women themselves would engage with their service:

> Well, what happens is you go to a non-specialist NGO, one of the big care bears, as I call them. You'll get placed into, potentially, a queue to get some support in any multiple different dimensions. But what our clients tell us is if they go there, they get put at the bottom of the heap, because they're all too hard. (#3)

> When someone's forced to access the service the end results aren't always as successful as you would hope them to be, because they feel like they're obliged to come [to counselling] because having their children in their care was dependent on that. With mandated services, a lot of times, it makes it really difficult for women to tell us what's happening, because they feel that everything they say would be reported on. (#1)

> There is such a focus on compliance after release – it's like they're on the run. (#7)

Stage 3: Support selection

The third stage of the help-seeking process involves identifying a source of support. The women discussed a range of supports for IPV, both formal (such as domestic violence services, counselling services and the police) and informal (from friends and family). As with the previous stage of the help-seeking process, women's support selection was influenced by a number of factors at all levels of the nested ecological model.

Ontogenic level

In addition to influencing women in the first two stages of help-seeking, women's previous experiences of childhood abuse/neglect and of witnessing IPV also affected their views on support selection, and in particular led to the decision not to seek support from formal sources.

Childhood abuse/neglect

Women whose childhood experiences with support services were negative, and in particular where they felt let down by these services, expressed distrust of these services:

> I've got no faith in police anymore. (Interview 15)

> …because certain services you ask for help actually don't help. When I was younger I was in an environment where I needed to leave. When I left I was put into foster care and almost raped. (Interview 8)

Witnessing IPV

Women who, as children, had witnessed IPV against their mothers and the lack of support from formal services similarly expressed distrust of these services:

> I know that my mum sought help for domestic violence; when we were little we were put in foster care and taken away from the family home. (Interview 10)

Stage 3: Ontogenic. Service provider perspectives:

Service providers tended to talk about this stage in relation to the Stage 1 factors such as a lack of confidence to access help:

> **Interviewee:** I think the women are more vulnerable because they have limited choices. They may not know what actually exists depending on how long they've been in prison. They might be embarrassed about accessing services and telling people about what they've experienced, and I think that limits them and prevents them from accessing services.
>
> **Interviewer:** They have less power over how to manage the service system.
>
> **Interviewee:** I think so.
>
> **Interviewer:** That might just be because they've been out of it for a while and they don't have those – current knowledge or connections.
>
> **Interviewee:** Or they might have such a low self-esteem that they believe that no one is out there that would be willing to help them as well. (#1)

> I think the hardest are often the least serviced and we find all sorts of reasons to argue why we don't have to service them. They came to the appointment late or they're difficult or they're scary or they're messy or they're smelly or they're whatever, and we find other language to say that, but I reckon that's – I think if you're more of your average sort of garden-variety working-class or middle-class woman, White woman, hetero, who hasn't had previous involvement with child protection, I think they're the demographic that are much easier to service. (#9)

Microsystem factors

Interpersonal relationships also commonly affected support selection. The following relationships were involved in the support selection stage of women's help-seeking: relationships with children, having pets, social/familial connections, connections with support services and criminal justice-related connections.

Relationships with children (and pets)

Women's relationships with their children, and their fears about having their children taken away from them, was a significant barrier to women seeking formal support for IPV. This meant that for one woman, no longer having her children in her care meant that she would "go to the police first" (Interview 17) should she be in an IPV situation in the future. One woman also discussed the difficulties of seeking support from a women's shelter unless they also accommodate pets.

Social/Familial relationships

Another interpersonal relationship, namely women's positive relationships with their family and friends, meant that they would choose these informal supports to help them deal with the IPV they were experiencing: "I will always turn back to my mum" (Interview 7); "Support for me is very much a lot to do with my friends" (Interview 2). One woman discussed how she "needed someone big and strong, and so I picked my biggest mate that I could" (Interview 3). With the support of this friend, she was able to leave her partner. Women's informal support networks also helped them in their decision-making by providing advice about which formal services to connect with, or in situations where friends had negative experiences of services, advising them where not to seek support.

Conversely, where women perceived their friends or family members as unsupportive or unavailable, this avenue for support was no longer available to them: "All of my family, all my sisters they've got children now and I don't rely on them for help anymore" (Interview 14). One woman discussed the issue of her friends not understanding the difficulties she had with leaving her partner, and the need for people to be "more understanding of it instead of [saying] 'just leave'" (Interview 18). A further barrier relating to women's relationships with their family was feelings of embarrassment or shame, which made it difficult for some women to seek informal support: "…it's very difficult telling your father about that sort of stuff. Yeah, it makes you feel awkward" (Interview 5).

Connection with support services

In addition to women's relationships with friends and family, their relationship with formal support services also affected their support selection. Having knowledge of what formal supports are available, and what these supports can offer, determined whether or not women would consider this type of support. While many women felt the onus is on them to engage with services ("If you don't go to it, they cannot support you or things like that", Interview 21), others felt that for those women without the self-confidence or belief in themselves to be proactive in seeking help, services should reach out to women, particularly through the provision of information:

> Just if they had more information on them, there is nothing here [in prison], there's no pamphlets, or there's…nothing to give out to people so that they…know where to go. (Interview 3)

In terms of supports for women when leaving the prison, the suggestion was that services connect with women "at the [prison] gate" (Interview 2) to determine what their needs might be in relation to IPV.

For some women, despite knowing about formal supports, they chose not to seek these supports because of a range of beliefs about these services, including that the services could not help them, that services could not understand unless they had experienced IPV themselves, that women would not be believed (e.g. because of mental health issues) or that they would not be taken seriously unless they had suffered significant physical harm:

> I could go to a psychologist and speak to them, but they don't know what I've been going through. Unless they've experienced it they would have no idea. (Interview 2)

> …Like if you haven't been hospitalised or if you haven't reported it then it's nothing, I guess, to some of them. (Interview 18)

In situations where women had sought formal support, the response of these services influenced women's help-seeking. This relates in particular to future help-seeking behaviour in terms of whether or not they would seek support (Stage 2; as discussed previously) and their future support selection (Stage

3). As such, women's positive experiences meant they would continue to seek support from formal services, while their negative experiences (particularly having to jump through a lot of hoops to get access) meant they would not choose these services in the future:

> Interviewee: No, I didn't go to the police, because they didn't help.
>
> Interviewer: In what way?
>
> Interviewee: In the way of I had about five or six reports made to the police and then they all disappeared. (Interview 16)

> I stayed one night at [supported accommodation service; I'll never go back there again. That was absolutely disgusting. (Interview 15)

> I just think, as a female victim there isn't anything really open to you. The department shut… (Interview 10)

Experiences of the criminal justice system

Women were also influenced in their help-seeking for experiences of IPV by their previous experiences with the criminal justice system. A particular concern for these women was a fear of police, meaning that accessing support from this agency was often not considered to be an option:

> …when you are in trouble with the law you do have that fear of the police and stuff like that. (Interview 2)

> …there was no way in hell I was going to the cops, I was on parole. At the end of the day, I was the one with the criminal record, not him. (Interview 15)

While fear of police or experiences of injustice in the criminal justice system was a barrier for many women, women also identified the prison as a place of relative safety ("Safest place for me right now, is here", Interview 4), with some stating that going to prison was a way for them to escape IPV: "just in the end it was easier to go to jail" (Interview 15); "…a lot of girls come to jail to get away from domestic violence" (Interview 11).

Another connection related to being incarcerated was women's relationships with other women in the prison. In relation to the support selection stage of help-seeking, as with women's social/familial connections, other justice-involved women's positive or negative experiences of accessing support influenced the women in their own support selection:

> I talk to a lot of the girls in here [prison]. A lot of them say that – they all say there's no help because if they go to the police the police have restrictions on what they can and can't do. That's why a lot of the time they won't go to the police because they think that they will do nothing for them. (Interview 2)

There were also many opportunities for women to find out about formal services while incarcerated due to the high numbers of women having previous experiences of IPV: "In regard to accessing support services on the outside we're not given that information at all. You get it from the other women" (Interview 2).

Stage 3: Microsystem. Service provider perspectives:

These themes were reflected in the service provider comments about both Stage 1 and Stage 3 of help-seeking, with trust consistently identified as a key issue:

> Yeah well, risk of adverse impact in getting their children. That if they've had experiences, in relationships where there's no trust, and they don't trust government. Then not trusting service providers is a lesser degree of mistrust, but is still there. So the notion that their trust's been abused by government all the time, still it reduces their capacity to go and get services from NGOs. (#3)

Mesosystem factors

In addition to their own interpersonal relationships, relationships between these networks also affected women's decisions about where to go to for support. This included the interaction between the abuser and the women's family/friends, between women's social networks and services, and between services themselves.

Interaction between perpetrator and family/friends

The relationship between the perpetrator and women's friends and family made it difficult for women to choose informal supports. One reason for this was because women feared for the safety of friends and family:

> I didn't want to bring any of my friends or family involved because I was scared of what he would do. If he could do this to me, can you just imagine what he could do to others? (Interview 12)

In addition, women's friends or family might themselves be fearful of the abuser, meaning women could not access their support:

> Everywhere I went people didn't want to take me at their house because they just didn't want that problem to be escalated at their property. (Interview 20)

Being isolated from informal supports was a further barrier to seeking support from this source, as was the perpetrator being involved in the same social networks and therefore knowing where women would go, risking them being found:

> Then I went to another friend's, and he came looking for me, was going everywhere looking for me. I didn't really have anywhere to go that was separate from all the people that he knew. (Interview 3)

Perpetrators might also prevent women from seeking help from support services by monitoring their phone calls and activities:

> A lot of that was I had to seek – go to the police and say look – I couldn't just say – pick up the phone say look, I really need – I need an exit. I need help this weekend. Can you help me today? Can you help me? I had to provide police statements and a lot of that I had to hide around and sneak around which was so hard because [partner was saying] "who are you on the phone to? What are doing? Why are you going to the cops or why is cops here?" (Interview 12)

Connections between social networks and services

A further connection between women's interpersonal networks was between informal supports and formal supports. In particular, as discussed previously, friends and family were often the ones who contacted formal supports, such as domestic violence services or the police, either with or without the woman's knowledge:

> Interviewer: So your mother was the person you went to first?
>
> Interviewee: Yep.
>
> Interviewer: What happened then?
>
> Interviewee: She therefore went to the police, tried to see what she could do from there on and tried to seek a restraining order and help me move out of the house and stuff. (Interview 6)

Interaction between services

Finally, the level of integration of formal services influenced women's support selection, predominantly by referring women to other services: "I was in a domestic violence relationship, and I was referred to them [domestic violence service] from the police. Then that's how I got into that" (Interview 16). Service coordination could also prevent women from seeking formal support through fear that the services would call the police. As discussed previously, fear of police is a significant issue for many women:

> To go to a service previously when I knew that you'd done something wrong and you already had a record, to even have the police involved is very – because you don't know if something's going to happen. If you were going to go to a service and then they said, "Oh, we need to refer this to the police", that would make people back off. (Interview 2)

Exosystem factors

A number of exosystem factors affected women's support selection. These included the availability of support, both within the correctional system and outside of it, in addition to women's finances, their geographic location and social isolation.

Availability of support

The availability of supports for women to access necessarily affected their support selection. Most of the women were aware

Stage 3: Mesosystem. Service provider perspectives:

A central theme for service providers was the level of interaction between services that currently exists. Once again, this related to the provision of coordinated information about what services are available, as well as the problems with maintaining service continuity (which also relates to issues of trust with providers).

> The coordination between the agencies involved in the woman's life is really, really critical. Models often for these women that are…well it's up to her to make the move actually…are not necessarily the most effective because when women leave prison and go back into the community it's a really overwhelming experience.(#1)

> **Interviewer:** So there's no close relationship that would, I guess, encourage or at least allow people to think about whether this is a service that…
>
> **Interviewee:** No, and I think what happens is there's huge turnovers and so any links that may have happened leave with the person that had created them, but I don't think we've had links with the prison in a very long time. (#1)

> And there's no continuity in the professional services. A lot of our women say as well they get tired of going somewhere and they tell someone their story and some of our women's stories are massive, decades and decades of abuse and neglect and violence and trauma and loss and grief. They go back the next week and the worker's changed. They just… (#2)

> We had a meeting the other day just to try and – because our units do work independently…we tend to go on our merry little way. (#7)

> **Interviewer:** So there's danger that everyone does a little bit of it, but no one takes responsibility for that safety.
>
> **Interviewee:** That's a really interesting point. So exactly, it's a big danger. (#3)

> It's a widespread problem about – especially with the whole neo-liberalisation of the welfare sector that we've got, compulsory tendering and so forth, that creates all sorts of competitive barriers to collaborating, and in some ways if one agency is not being resourced to take the lead, why should they take the lead, because it's all financially driven. That's not to say that all the workers fall in – all the managers all operate like that, but they're the pressures that they're under to operate like that. (#9)

> **Interviewer:** But is there a directory then of services that is available for service users to access?
>
> **Interviewee:** One exists but who has access to that I'm not actually sure. (#1).

> No, I think the family violence services need to be more well known and more easily accessible. I think they need to come out of their offices. (#2)

of a number of formal support services that women could access, predominantly women's shelters, domestic violence services, counselling services and the police. In terms of services available within the correctional system, while some women were able to list IPV services they could access, for the most part women did not feel that IPV was either recognised or supported within the prison system:

> A lot of the mental health things in here don't get addressed. A lot – counselling, I don't know how – I know I've been trying to get counselling in here, it's not been offered. I know we have a couple of programs, like [X] which I've done and [Y] which helps with perspective and mindfulness and things like that, but I think counselling and the help with domestic violence things is non-existent, from what I've seen. (Interview 8)

Finances, geography and social isolation

As with the previous stage of making the decision to seek support, the exosystem factors of women's financial situation, geographic location and social isolation affected their support selection. In particular, women worried about the cost of formal services, and discussed difficulties accessing services

that are far away, in addition to not being able to access services that are close to where the perpetrator lives:

> Then because I couldn't get there and check into the hotel that night I was kicked off their service and told they couldn't help me anymore. (Interview 7)

> Interviewer: Did you attempt to go into them [domestic violence service]?
>
> Interviewee: No, because my ex lived down the road. (Interview 16)

Geographic location was a particular issue in small towns with limited services being available: "In a country town [services are] limited" (Interview 2). Social isolation was also a barrier to accessing informal supports due to women's physical isolation from their families and friends.

Macrosystem factors

Finally, at the macrosystem level, the main factors affecting women's support selection were racism and prejudice. These issues were identified as barriers to women accessing formal supports.

Prejudice against Aboriginal and/or Torres Strait Islander peoples

As one woman explained, racist attitudes towards Aboriginal and Torres Strait Islander peoples prevented some women from accessing formal support services:

> A lot of it is because some organisations don't tend to – they just look at an Aboriginal like that person is an alcoholic. That person is very violent…We've been very labelled as indigenised people. A lot of us tend to go we've already been labelled as alcoholic, violent people, stuff like that. A lot of us tend to not seek it [support] anyways, because we've been labelled, which makes it hard. (Interview 12)

This comment resonates with concerns that mainstream services are insufficiently aware of the context in which help-seeking arises and are often unresponsive to the circumstances that face Aboriginal and/or Torres Strait Islander families. At the same time there have been suggestions that a minority of Aboriginal men in prison prefer dominant-culture service providers when concerns about confidentiality arise (Mals, Howells, Day, & Hall, 2008).

Prejudice against women in prison

Similarly, women identified prejudice against justice-affected women, meaning formal services were not made available to them within the correctional system:

> …they don't have any sort of programs for domestic violence. I think they pretty much don't worry about that. They worry about you doing your time and you're in prison. Deal with it. (Interview 13)

Prejudice relating to socio-economic status

In addition, one woman described prejudice against women living in the northern suburbs of Adelaide, an area that is associated with low socio-economic status. She believed this led to slow response times from police, making them an unreliable source of support:

> If I'd been in the eastern suburbs going through this, oh my god, I would have had police attendance there within a couple of minutes. They probably – they would have been all over it to help me. But because it was the northern suburbs I probably could have sat back and ordered a pizza, yeah, and that would have got there first. It's really bad. I don't know what it's like in the southern suburbs, because I don't like that side of town. North is bad, but yeah, there's that whole north–south thing. Yeah, if you're in the northern suburbs you may as well not even bother with anything. (Interview 15)

Stage 3: Exosystem. Service provider perspectives:

Some of the external and exosystem barriers to service access identified by service providers included thresholds for service access, legal obligations related to the conditions of community orders and accommodation problems. These were seen as entrenching criminal justice involvement:

Interviewee: The Family Safety Framework which was the system set up to support high-risk women or women at risk of death or serious injury…It's a multi-agency approach. So every fortnight we get a list of – so there's a risk assessment and once women hit over 45 they're considered to be at risk…it's rare that we get referrals from Corrections in saying that.

Interviewer: So is there a reason why the women in prison won't score over 45?

Interviewee: Generally because they're not having the direct contact with their partners at the time. So the difficulty is – so what we actually do is safety plan around her risk factors at the time, and because she's in prison and not having contact with him supposedly then she wouldn't be considered. But once she left as she still had – and she was part of the corrections system and had to report and disclose that there was abuse happening, then she technically could be referred…So they would get a low score in prison but once they left prison it'd be a higher score because it's based on incidents within the last 14 days. (#1)

Interviewee: She's breaching so we're having difficulty with that. I've been trying to negotiate some domestic violence housing for her. We've been trying to do that for three weeks and we're still not getting…

Interviewer: Why is that difficult? What's the barrier?

Interviewee: Well, everybody tells me the barrier at the moment is if she's not in a relationship with him they can't do anything. They're not. He's just living there and not actually in a relationship and I'm just getting all this block.

Interviewer: There's violence but it doesn't meet their definition of family violence or whatever…

Interviewee: Doesn't meet their definition. (#2)

Then there's financial things about trying to get yourself and/or your children to an agency, navigate things, navigate processes on the phone, be patient, all of that sort of stuff, when it's hard to be patient when you finally get to the point where you want help, and it's hard to be reasonable and sensible, because your life doesn't feel that. (#9)

Interviewee: I think in terms of accommodation when women are exiting the prisons it would be really difficult for them to come directly into a service like ours because of the wait lists. So what happens here is that a lot of the women who want to come into services like ours – because of the larger volume of women needing a service and the amount of beds that we have and the houses that we have, they don't match up. So women are actually banked up in motels and so the women – it would be difficult for the women to access the accommodation side of our service because they're exiting prison. They may not be – they may not have been in an intimate relationship for a long period of time, and so they wouldn't be deemed at risk. (#1)

Interviewer: What's been your experience of domestic family violence issues in people that you've met and worked with?

Interviewee: They're very difficult. I find the support systems really, really difficult to access. Housing's terrible. I have one woman at the moment who's living with her abusive partner, who's living in her own house that her mother bought her that he's trashed while she's been in prison and now she's on a parole order to live in that house. He won't go. (#2)

People need an address in order to be eligible for parole and then the address might not be a safe address for them. They're going to go there, yeah. They're going to go there rather than stay in prison, aren't they? (#3)

I can think of one woman who had been in a really violent relationship, had started pre-release work experience and training and had a transition to employment. That made a difference in her decision-making. (#5)

Stage 3: Macrosystem. Service provider perspectives:

Service providers did talk about some of the attitudinal and cultural barriers that exist in services, although usually services other than their own:

> Organisations like that are very men driven – men-focused organisations and they really don't fit for women and they really do not have the capacity to engage our women. Our women are complex-needs women and don't engage terribly well with mainstream services. (#2)

> There are still many agencies out there who judge women who are domestic violence victims, harshly. But particularly if they've got a criminal, a justice context around them as well. I can just imagine how they'd be treated in agencies that are generic. Because they would be judged. (#3)

> I guess for us – that we wouldn't consider ethnicity a barrier; however, we are aware that women – Aboriginal women are over-represented in all systems, whether it's experience of DV in prisons. So I think there needs to be a little bit more work done in that area and understanding the cultural limits for them in terms of where they exit to, because it might not be one person perpetrating violence towards them. It could be a whole family. So that makes it even more difficult for them. I guess the stereotype of them being in prison makes it difficult for them. (#1)

> I don't think the wider community think about these women at all and I do not think that the wider community understands when we talk about the women as victim/perpetrator. They don't understand why we would place value on their victimhood. Once a woman enters the correctional system – and I only have to read social media and listen to various conversations to have it reinforced to me – they stop being people. (#5)

> I think there's a lot of discussions that go on in domestic violence that all pre-suppose middle-class White women, and we haven't even got to the point of gay women, women in lesbian relationships, men in same-sex relationships, trans… (#9)

> I still think that a lot of the services can feel really alien and they can feel scary colonial, even though the services may not be trying to be that. (#9)

Survey responses

Use of services

Participants reported having used between three and 14 of the 15 services listed in the survey (*Mean* = 7.32, *SD* = 3.26). The most commonly used services were the police (n = 16 of 22 women), crisis lines (n = 14) and shelter or transitional and homelessness services (n = 14). Sixteen of the 22 women had sought help from a family member, friend or neighbour. The least commonly reported services (approached for help with IPV) were community health centres (n = 6) mental health services (n = 6), chaplains (n = 6) and child protection services (n = 5). Specific crisis lines that were named included Lifeline (n = 2), Homelessness Gateway (n = 2), Homelessness Crisis line (n = 2), 13800 (n = 1) and the Domestic Violence Helpline/Hotline (n = 2). Table 2 presents the number of women who had utilised these different services.

Table 2 Use of services/resources for domestic and family violence

Service	n (% of sample)
1. Family/friends/neighbour	16 (72.7%)
2. General Practitioner	10 (45.5%)
3. Counsellor/psychologist	13 (59.1%)
4. Mental health service	6 (27.3%)
5. Crisis line	14 (63.6%)
6. Police	16 (72.3%)
7. Shelter/transitional housing/homelessness services	14 (63.6%)
8. Community health centre (e.g. women's centre, family centre)	6 (27.3%)
9. Emergency service (e.g. ED)	13 (59.1%)
10. Domestic violence service	11 (50.0%)
11. Child protection services	5 (22.7%)
12. Community corrections officer	11 (50.0%)
13. Chaplain or members of religious/spiritual organisations	6 (27.3%)
14. Legal services (e.g. support for divorce/separation, custody order, protection order)	11 (50.0%)
15. Aboriginal health or social service	8 (36.4%)

Satisfaction with services

For those women who had used services, mean satisfaction ratings were similar for each type of service and towards the midpoint of the 1-5 response scale. Table 3 presents these ratings. The service with the lowest mean *(M)* satisfaction was child protection (M = 1.60, SD = 0.55), with which five women had contact. The highest satisfaction ratings were with GPs (M = 3.80, SD = 1.03), and the lesser-utilised mental health services (M = 3.67, SD = 1.75) and Aboriginal health or social services (M = 3.63, SD = 1.69). Comments from the women included: "very satisfied because I was safe" (mental health services); "very dissatisfied – just got given pamphlets and referrals" (shelter/transitional housing/homelessness services); "dissatisfied – didn't get a choice" (child protection services); "very dissatisfied – booked signing dates with violent partner on same day despite restraining order" (community corrections officer).

Table 3 Satisfaction with services

	1 Very dissatisfied	2 Dissatisfied	3 Neither dissatisfied nor satisfied	4 Satisfied	5 Very satisfied	M (SD)
1. Family/friends/neighbour (n = 16)	2	2	4	5	3	3.31 (1.30)
2. GP (n = 10)	0	1	3	3	3	3.80 (1.03)
3. Counsellor/psychologist (n = 13)	1	2	4	5	1	3.23 (1.09)
4. Mental health service (n = 6)	1	1	0	1	3	3.67 (1.75)
5. Crisis line (n = 14)	3	2	3	4	2	3.00 (1.41)
6. Police (n = 16)	6	2	2	6	0	2.50 (1.37)
7. Shelter/transitional housing/ homelessness services (n = 14)	2	2	1	7	2	3.36 (1.33)
8. Community health centre (e.g. women's centre, family centre) (n = 6)	0	0	0	4	2	4.33 (0.52)
9. Emergency service (e.g. ED) (n = 13)	0	2	4	6	1	3.46 (0.88)
10. Domestic violence service (n = 11)	2	1	1	6	1	3.27 (1.35)
11. Child protection services (n = 5)	2	3	0	0	0	1.60 (0.55)
12. Community corrections officer (n = 11)	3	2	0	4	2	3.00 (1.61)
13. Chaplain or members of religious/ spiritual organisations (n = 6)	1	0	1	3	1	3.50 (1.38)
14. Legal services (e.g. support for divorce/separation, custody order, protection order) (n = 11)	2	0	2	7	0	3.27 (1.19)
15. Aboriginal health or social service (n = 8)	2	0	0	3	3	3.63 (1.69)

Reasons for not using services

Across services, the main reasons given by women for not using specific services involved a lack of awareness regarding the resource; or the women having made a choice not to utilise/approach the service. For statutory services (e.g. child protection, community corrections), often the service was not seen as applicable to their concerns (i.e. because they did not have children or because they had not previously been imprisoned).

Comments from women regarding reasons for not using services included "fear", "figure they won't believe me due to previous history" and "too scared" (for police); "thought about it, but had animals" (shelter/transitional housing); "scared kids would be removed from both parents" and "fear of kids being taken" (child protection services); and "never even thought about it" (chaplain and religious/spiritual organisations). Table 4 presents the women's identified reasons for non-utilisation of services.

Table 4 Reasons for not using services

	Wasn't aware of resource or service	Attempted to use, but was unable or experienced problems	Chose not to use the resource or service	Not applicable or suitable to concerns
1. Family/friends/neighbour (n = 6)	1	0	4	1
2. GP (n = 12)	7	1	2	2
3. Counsellor/psychologist (n = 9)	6	1	2	0
4. Mental health service (n = 16)	6	0	2	8
5. Crisis line (n = 8)	3	0	5	0
6. Police (n = 6)	0	0	6	0
7. Shelter/transitional housing/homelessness services (n = 8)	2	1	2	3
8. Community health centre (e.g. women's centre, family centre) (n = 16)	11	0	3	2
9. Emergency service (e.g. ED) (n = 9)	1	0	5	3
10. Domestic violence service (n = 11)	8	0	3	0
11. Child protection services (n = 17)	3	0	2	12
12. Community corrections officer (n = 11)	1	0	2	8
13. Chaplain or members of religious/spiritual organisations (n = 16)	4	0	8	4
14. Legal services (e.g. support for divorce/separation, custody order, protection order) (n = 11)	0	1	3	7
15. Aboriginal health or social service (n = 14)	4	2	4	4

Use of services in the future

For almost all services, except child protection services and chaplains or religious/spiritual organisations, the women believed that they would utilise services in the future for domestic and family violence (Table 5).

Table 5 Would service be used in future for IPV/family violence issues?

	Yes	No	Maybe/ Unsure
1. Family/friends/neighbour	17	3	0
2. GP	19	2	0
3. Counsellor/psychologist	17	4	0
4. Mental health service	18	4	0
5. Crisis line	16	5	1
6. Police	13	8	1
7. Shelter/transitional housing/homelessness services	17	4	1
8. Community health centre (e.g. women's centre, family centre)	17	4	0
9. Emergency service (e.g. ED)	21	1	0
10. Domestic violence service	18	3	1
11. Child protection services	8	10	0
12. Community corrections officer	13	3	0
13. Chaplain or members of religious/spiritual organisations	13	9	0
14. Legal services (e.g. support for divorce/separation, custody order, protection order)	17	4	1
15. Aboriginal health or social service	19	3	0

Note: Numbers for all services do not always equal 22 due to missing data; in the survey, yes or no were the only response options; but some women indicated during their interview that they were unsure or may use the service in the future.

The women were then asked three open-ended questions at the end of the survey regarding enablers and barriers to their accessing services, and perceptions of need for services once exiting prison. Tables 6, 7 and 8 present their responses. Enablers to accessing services (Table 6) were largely focused on encouragement from professionals (e.g. social workers) or family and friends. In other cases, help-seeking was driven by an urgent need (e.g. "urgency of needing accommodation", "fear of children getting hurt").

Table 6 What was it that helped you to access any services?

Participant response and participant number	
Support from a professional or family member/friend:	
Social worker while in prison.	(1)
Family. Social worker at [the] prison after I asked for help.	(5)
Encouragement from mum. Lifeline, saw advertised on TV.	(6)
Encouragement from police who gave [me] the contact details.	(7)
Speaking to the crisis line, who advised about housing and who to contact.	(8)
Hid a lot. Corrections officer, knew something [was] wrong and questioned directly, and therefore commenced access to help.	(2)
Case workers, family members, GP (doctor).	(14)
Crisis line.	(15)
Speaking to a professional.	(16)
Encouragement from [a] friend.	(11)
Friends.	(18)
Self-determination:	
Felt [I] had no other option. Life or death situation.	(3)
Self, got out of hand. Needed to get out for safety.	(22)
Self-talk.	(9)
Self-orientated, trying to find a way out.	(10)
Dry-out centre.	(13)
External triggers:	
Because [my] son witnessed an incident.	(17)
Fear of children getting hurt.	(20)
Other:	
Not applicable.	(4)
Easily accessible.	(19)

Barriers to accessing services (Table 7) mainly involved knowledge of services, as well as issues of stigma, fear and embarrassment.

Table 7 What made it hard for you to access services?

Participant response and participant number	
Knowledge about support options:	
Lack of knowledge, fear.	(6)
Lack of knowledge of what's available. [It's] easy to make contact, but to get help is more difficult.	(7)
Lack of knowledge.	(8)
Lack of knowledge, fear, thinking DV wasn't "bad" enough.	(2)
Lack of knowledge and fear.	(11)
Lack of knowledge of services, repealing self over and over [for] becoming a victim again.	(12)
Stigma, lack of knowledge of services.	(16)
Lack of confidence in support services:	
Scared the resources/services wouldn't be able to keep [me] safe.	(3)
Getting shut down because of [my] history.	(10)
No phone and didn't want [the] police involved.	(21)
No kinship program, no support for big family.	(20)
Stigma, lack of services.	(15)
Fear (for self and of consequences of disclosure):	
Fear for personal safety.	(4)
Money, fear.	(9)
Kids removed, crisis happened.	(13)
Worried [I was] going to lose my kids.	(17)
Partner, due to fear, lack of knowledge.	(18)
Perception of limited personal resources:	
Low self-esteem, feeling unsafe, lack of knowledge.	(1)
Stigma/shame.	(19)
Embarrassment.	(5)
Other:	
Transport.	(14)
Intervention order, for assault in DV. Lack of family support, parents deceased.	(22)

In terms of help with domestic and family violence post-release, participants focused on housing and accommodation, counselling and support. In some cases, participants were "unsure" or believed they would need significant (e.g. "A whole new life", "Everything") help and service provision.

Table 8 When you are released, what do you think you'll need the most help with if you experience any family or domestic violence?

Participant response and participant number	
Housing:	
Housing, counselling.	(3)
Unsure.	(4)
Being housed somewhere safe.	(5)
Housing, support (personal).	(10)
Accommodation.	(11)
Accommodation, counselling.	(20)
A whole new life. Housing.	(21)
Housing, to stay off drugs, positive outcomes, to stop getting in crime.	(22)
Personal support:	
Options, support, counselling.	(1)
Having ease of access to service[s] or a named person.	(2)
Support network.	(8)
Support, housing.	(9)
Counselling for PTSD, moral support, financial support, legal avenues. [My] partner got away with it.	(7)
Counselling.	(15)
Other:	
Accessing services.	(6)
Everything.	(12)
Problems with referrals.	(13)
Finance, housing, assistance with drinking alcohol.	(14)
Self.	(16)
Custody agreement.	(17)
Keeping self safe by knowing self-worth.	(18)
Attend NA, not let family down, [and] continue with couple counselling.	(19)

Discussion

Women who are in prison, or who are justice-involved, are a group that typically has multiple and complex service needs that increase vulnerability to ongoing IPV. The review of theories of help-seeking illustrates how a wide range of individual, socio-cultural and structural factors can complicate any decision to seek help when a woman is concerned for her personal safety. The circumstances and personal histories of women in prison clearly serve to increase the barriers that already exist to effective help-seeking. These include: a lack of resource awareness or lack of resource availability; factors relating to independence and self-sufficiency; fear, shame, embarrassment and loss of privacy; fear of losing custody of children; and the breaking of familial and cultural norms. Compounding these is the high level of stigma and discrimination experienced by many ex-prisoners and the specific challenges facing those who experience the confluence of victimisation and incarceration. As a result, it would appear that many women leaving prison do not receive the type of support that could potentially keep them safe. It is nonetheless also the case that women leaving prison are likely to employ a wide range of formal and informal help-seeking behaviours, despite the difficulties that they experience in any efforts to access support from formal service providers.

In this research, the process of help-seeking was conceptualised in relation to Liang et al.'s (2005) simple three stage model (problem recognition and development, the decision to seek help and support selection). This provided a structure from which to identify the types of support that may prove most effective for those women in prison who face violence following release. It is useful in so far as it draws attention to the need for each stage to be successfully navigated before help-seeking occurs, identifying the need for services that promote problem identification as well as advocacy.

The model was used to structure the accounts that the women prisoners who participated in this study provided about their efforts to keep themselves safe. The messages from these women were clear and related to: a lack of awareness about the threshold when external support is required; a lack of knowledge about the types of services that might be available (the most common reason given for not accessing a support service was a lack of awareness about what might be available; see Table 2); and a pervasive sense of mistrust and under-confidence in existing services – particularly in a context in which there are other demands on their time in the period immediately following release from custody. There was a strong sense that formal services, primarily government but to a lesser extent non-government, are largely unresponsive to their needs and that better approaches can be developed, including those that draw on the strengths of women, their peers and family members.

Importantly, the analysis shows how the three levels of help-seeking are clearly inter-related – that is, the ways in which women define IPV and seek help mutually influence each other. For example, both negative and positive experiences with formal and informal support-seeking often determine how women subsequently define IPV and decide when there is a need to change. It was also clear that help-seeking occurs in a social context and so is influenced by systemic, interpersonal and socio-cultural factors. Thus, the nested ecological model comprising ontogenic, microsystem, mesosystem, exosystem, and macrosystem factors offers a useful overarching theoretical framework from which to develop service delivery at a more systemic level. We believe that service development activities that attend to each level of the ecological model will prove to be more successful.

The purpose of this work was not to evaluate the quality of services that currently exist in the jurisdiction in which the interviews were conducted. It was clear that in this jurisdiction at least, different service providers hold a range of views about what is currently, and should in the future, be made available to women leaving prison. For example, correctional service representatives expressed an awareness of these issues and a commitment to improving service delivery, as well as being able to describe some recent improvements. And yet, those outside of government were often either critical of the lack of current programs or unaware of the efforts that have been made. Their views were, on the whole, shared by the women we interviewed, and may be reflected by those in other parts of the country. However, our observation is that any attempt to develop an integrated or interagency response should not rely on the efforts of only one agency, nor necessarily be led by correctional services. The conclusions of this research, therefore, relate not to the quality of current services, but to the need for all jurisdictions to clearly identify women in prison as a particularly vulnerable group who are likely to be at elevated risk of ongoing victimisation, and for whom significant barriers exist that prevent them from accessing the types of service that may help them to keep safe. In short, a specialised approach is needed for a group that faces a particular set of social and individual circumstances that increase their vulnerability to perpetrators of IPV.

It is also important to note that a significant limitation of this work is the inability to make specific statements about

the help-seeking of different cohorts of women in prison. An important consideration here is understanding the needs of women who identify as from Aboriginal and/or Torres Strait Islander cultural backgrounds, as this is a group that is grossly over-represented in the correctional population. While our survey responses do indicate that these women utilise, and are generally satisfied with, Aboriginal health or social services (and choose not to use mainstream services), it is not possible to draw firm conclusions based on such a small and selective sample. Nonetheless, in our view, this does provide support for further consideration of the need to develop culturally specific support services for women in prison.

One way to think about ways to improve the safety of women who have been incarcerated is in relation to the broader aim of community reintegration. Sotiri (2015) has argued that reintegration services should involve the following components: pre-release engagement; long-term, holistic relational case-management; community outreach models; and housing-first approaches. For Sotiri, the adoption of long-term case-management models should underpin any attempts to support reintegration. Attending to concerns about access to housing, employment, education and social connection is likely to be important here on the basis that it will be much more difficult for women to seek help for concerns about IPV if they have not achieved a level of stability in their lives.

Successful models of reintegration do exist, although these tend to be isolated examples of practice and are not typically focused on domestic violence. Nonetheless, they do offer a framework from which more specialised service responses can be developed. An illustrative example of this is a healthcare initiative in Michigan, USA.[14] In this program, medical navigators help newly released or paroled prisoners obtain their medical records, find a medical home and access needed primary care and speciality services A key element of the model is the identification of soon-to-be-released prisoners (the corrections department sends a listing and case review of each individual to be released within 6 months to the program). Prison "in-reach" sessions are then offered twice-weekly in which education is offered to groups of those nearing release about the services they can expect to receive in the community. This is supported by an individual health screening meeting to determine ongoing health needs and possible eligibility for community programs. The goal is to facilitate access to community-based health services.

It was clear from our interviews with service providers that there are services available, and from our interviews with women in prison that these are not always visible or accessible to them. There was no sense that any integrated pathway for identifying and managing risk currently exists. Once again, this is an observation that we suspect is not unique to the jurisdiction in which this research was conducted, but one that applies across Australia. Although correctional services are in place that support women, both pre- and post-release (including prison social workers, pre-release programs, cultural support workers, community correctional officers), it seems that a specialised service response around IPV that contains the elements of an integrated reintegration approach is required. This should, ideally, be independent and incorporate all relevant bodies in the women's safety sector, including government, non-government and voluntary agencies.

We also agree with Sotiri (2015) that there is a need for people with lived experience of incarceration to be part of the service framework in the community sector at all levels of program governance, design and delivery. Finally, based on our experience interviewing the women in prison, we also recommend that this service considers all aspects of programming and service delivery through what Guarino, Soares, Konnath, Clervil and Bassuk (2009) describe as a "trauma lens". The focus with this approach is to ensure that programs and services reflect a basic understanding of the role of violence in the lives of people who seek help. The principles of trauma-informed care include supporting control, choice and autonomy; sharing power and governance; and integrating care (see Quadara, 2015; Quadara & Hunter, 2016). Quixley's (2010) model of inclusive support for women in prison offers some suggestions for how such approaches have, and can be, implemented in Australian prisons.

The conclusion of this report is that particular attention is warranted to further develop service pathways for women leaving prison. It is clear that the local service arrangements to support women who are concerned about IPV will need to vary between jurisdictions, necessitating local solutions and service configurations. However, we would encourage those agencies that provide support to develop integrated service collaborations that work specifically to promote the safety of women leaving prison. As Sotiri (2015) has argued, "there is frequently an assumption that people receive assistance in preparing for release while they are inside. For the vast majority of people in prisons in Australia, this is simply not the case" (p. 28).

14 See https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline.

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Appendix: Survey

I am going to read a list of potential resources or services that you or someone you know could seek help from for issues related to *domestic or family violence*. I'll ask you if you've used the service before or know anybody who has; how satisfied you were, and if you'd want to use the service in the future. You may have used these services for other reasons, but we are particularly interested in this project in their responses to domestic or family violence.

(1) Family/friends/neighbour

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource or service on a scale of 1 to 5, with 5 indicating that you were very satisfied?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(2) GP

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(3) Counsellor/psychologist/mental health professional

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(4) Emergency service (e.g. ED)

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(5) Crisis line

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

Which line did you call? _____

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(6) Police

(a) Was this resource or service used?

- ○ No
- ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

- ○ 1 Very dissatisfied
- ○ 2 Dissatisfied
- ○ 3 Neither dissatisfied nor satisfied
- ○ 4 Satisfied
- ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(7) Shelter/transitional housing/homelessness services

(a) Was this resource or service used?

- ○ No
- ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

- ○ 1 Very dissatisfied
- ○ 2 Dissatisfied
- ○ 3 Neither dissatisfied nor satisfied
- ○ 4 Satisfied
- ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(8) Community health centre (e.g. women's centre, family centre)

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(9) Mental health service

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(10) Domestic violence service (e.g. Women's Safety Services, Central Domestic Violence Service)

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(11) Child protection services

(a) Was this resource or service used?

- ○ No
- ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

- ○ 1 Very dissatisfied
- ○ 2 Dissatisfied
- ○ 3 Neither dissatisfied nor satisfied
- ○ 4 Satisfied
- ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(12) Community corrections officer

(a) Was this resource or service used?

- ○ No
- ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

- ○ 1 Very dissatisfied
- ○ 2 Dissatisfied
- ○ 3 Neither dissatisfied nor satisfied
- ○ 4 Satisfied
- ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(13) Chaplain or members of religions/spiritual organisations

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(14) Legal services (e.g. support for divorce/separation, custody order, protection order)

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

○ Wasn't aware of the resource or service ○ Attempted to use, but were unable/ experienced problems ○ Chose not to use the resource or service ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

○ No ○ Yes

(15) An Aboriginal health or social service

(a) Was this resource or service used?

○ No ○ Yes

▶ *If yes*

(b1) How satisfied were you with this resource/service?

○ 1 Very dissatisfied ○ 2 Dissatisfied ○ 3 Neither dissatisfied nor satisfied ○ 4 Satisfied ○ 5 Very satisfied

▶ *If no*

(b2) Why didn't you use this service?

- ○ Wasn't aware of the resource or service
- ○ Attempted to use, but were unable/ experienced problems
- ○ Chose not to use the resource or service
- ○ Not applicable/suitable to my concerns

(c) Do you think that you would use this service or resource in the future for DV/family violence issues?

- ○ No
- ○ Yes

(17) Other services (e.g. substance use programs)

General questions

What was it that helped you to access any services? (e.g. encouragement from family, speaking with a crisis line/centre, speaking to a professional like a GP)

What made it hard for you to access services (e.g. lack of knowledge, problems with referral, stigma, lack of services)?

When you are released, what do you think you'll need the most help with if you experience any family or domestic violence?

Age: _____ years

Are you?

- ○ Convicted
- ○ On remand

How much time in total have you spent incarcerated in your life? _____ years

How long is the sentence you are currently serving? _____ years

What is your unit location?

- ○ Living Skills Unit
- ○ Mainstream
- ○ Other _____

What is your cultural background?

- O Australian
- O Aboriginal
- O Torres Strait Islander
- O Maori
- O Asian
- O Other _____

What is your marital status?

- O Single
- O Married/Defacto
- O Divorced
- O Separated
- O Widowed
- O Other _____

Do you have any children?

O Yes O No

How many? _____

Ages? _____

What is your highest level of education?

- O completed primary school (up to and including Year 7)
- O completed some high school (up to Year 9 or 10)
- O completed Year 11
- O completed Year 12
- O some TAFE
- O completed TAFE
- O some university
- O completed university
- O other _____

Thank you. Please remember that your responses are confidential and you will not be personally identified in any report.

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children