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"Waiting for Someone to Ask": Successful Implementation of an IPV Response by Bicultural Settlement Staff with Refugee Women in Australia

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ABSTRACT

Refugee women are less likely to seek support for intimate partner violence (IPV). This study examined an IPV intervention by bicultural settlement staff in Australia, aiming to enhance the capacity of settlement services to address IPV. The Safety and Health After Arrival (SAHAR) study was conducted in five settlement services in New South Wales. Bicultural caseworkers were trained to use the ACTS IPV screening tool and follow-up protocol, translated into several languages. Data were collected through focus groups (24 caseworkers, 4 IPV specialists) and interviews (5 managers). Seven themes emerged: *(1) Confidence grew rapidly; (2) Clear and simple tools matter; (3) Language matching facilitates connection; (4) Settlement services can do this; (5) Disclosing is more complex for refugee women; (6) Care and inclusivity enable disclosure and help-seeking; (7) Women choose different pathways*. Culturally tailored interventions and bicultural workers are crucial for supporting IPV disclosure and response. Implementing IPV screening in settlement services is feasible, increasing IPV awareness and providing disclosure opportunities. Ongoing training, support, and further research on long-term sustainability are needed.

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Countries providing resettlement for refugees have developed government-led policies and programs to improve settlement outcomes for migrants and refugees (Fratzke et al., 2021). Over the past two decades, Australia has been one of the top three countries of resettlement for refugees after the United States and Canada and has built a network of specialist services for migrants

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and humanitarian entrants which operate alongside mainstream services (Department of Home Affairs, 2021; Shergold et al., 2019).

Australia's settlement programs assist refugees in the first 5 years after arrival with English language acquisition, employment and education, housing, healthcare, family and social support, transport, legal services and civic participation (Department of Home Affairs, 2022). In Australia, many programs are provided by non-government, community-based, multi-cultural service organizations which serve as primary access points for refugees (Shields et al., 2016; Smyth et al., 2017; Vaughan et al., 2020). However, "successful" resettlement includes many challenges (Curry et al., 2018). Staff in settlement services provide information and support and regularly encounter a range of psychosocial issues experienced by refugees including violence from an intimate partner (IPV) (Vaughan et al., 2020). One-third of refugee and migrant women in Australia are estimated to experience IPV (Segrave et al., 2021). Pre- and post-migration factors, including forced migration, insecure immigration status, visa conditions (noting women who have permanent residency can still feel insecure), lack of knowledge regarding Australian laws contribute to heightened risk of IPV (Njie-Carr et al., 2021; Vaughan et al., 2020). However, most refugee services are not set up to identify and respond to IPV, and staff often lack the necessary confidence and capacity to respond (Holtmann & Rickards, 2018; Njie-Carr et al., 2021; Vaughan et al., 2020).

IPV screening and response interventions, including staff confidence and capacity development, have been widely introduced and evaluated in healthcare settings (Creedy et al., 2021; Hegarty et al., 2020; Heron & Eisma, 2021; O'Doherty et al., 2014) but few studies have been conducted in community agencies for refugee and migrant women.

In one study of settlement services and mainstream IPV services, settlement service staff reported being unprepared to respond to women experiencing IPV, while mainstream IPV services reported being not set up to respond to immigrant-specific issues (Wachter, Heffron, et al., 2021).

Evidence of the barriers and enablers have been reported mostly in health care settings. Barriers include: high patient volume; lack of integration with existing processes; unavailability of specialist back-up services; lack of privacy; insufficient training; and a lack of knowledge about the IPV policy and protocol belief that IPV response is the responsibility of other professionals (Creedy et al., 2021; Heron & Eisma, 2021; Hudspeth et al., 2022; Sargeant et al., 2023; Spangaro et al., 2021). Cultural safety has also been found to be a key factor for Indigenous women when responding to IPV screening and response (Fiolet et al., 2020; Spangaro et al., 2019). Enablers include: management commitment; employment and retention of a bicultural workforce; adequate funding; staff training in identification and response; connectedness

with communities and the development of relationships and referral processes with local IPV service providers (Holtmann & Rickards, 2018; Hudspeth et al., 2022; Messing et al., 2022; Vaughan et al., 2015, 2020; Wachter, Heffron, et al., 2021).

Research into the experience of healthcare professionals implementing IPV screening and response finds that implementation is improved by: having sufficient time with women; safe physical spaces to meet; availability of specialist back up services and referral options: IPV screening questions that are clear and straightforward; training; and executive support (Hegarty et al., 2020; Heron & Eisma, 2021; Hudspeth et al., 2022; Spangaro et al., 2021; Tarzia et al., 2021).

Research into the experience of women experiencing IPV largely comes from the experience in healthcare settings (Creedy et al., 2021; Heron & Eisma, 2021; Korab-Chandler et al., 2022; Robinson et al., 2021). Direct asking by a trusted worker in a safe environment is associated with high rates of IPV disclosure (Heron & Eisma, 2021; Korab-Chandler et al., 2022; Spangaro et al., 2021) whereas, fear of the consequences of disclosure, reluctance to break up the family, concern for the perpetrator, lack of knowledge of law and services, lack of material resources, limited personal support, and presence of the partner or children are identified as barriers to IPV disclosure and help-seeking (Robinson et al., 2021).

For migrant and refugee women, IPV disclosure and help-seeking have the added complexities of language barriers, time and complexity created by using interpreters (including unavailability of female interpreters and women's concerns about the interpreters being members of their community), acculturation stress, perceived visa insecurity, community influence, and culture-based differences in understanding what constitutes abuse in the country of settlement (Creedy et al., 2021; Femi-Ajao et al., 2020; Fiolet et al., 2020; Guillery et al., 2012; Peters et al., 2022; Satyen et al., 2019). Furthermore, migrant and refugee women are found to be "thinking transnationally" about the implications of taking action on IPV, weighing up the impacts on family and networks in both the host country and their country of origin (Muruthi et al., 2022). Escalation of the abuse and a heightened threat to the safety of children are identified as triggers for migrant and refugee women to seek help (Femi-Ajao et al., 2020). However, some commentators warn that the focus on refugee and migrant women's "culture" in IPV policy and programs is often racialized, conflated with difference and fails to consider an intersectional analysis of structural inequalities (Abji et al., 2019; Maturi & Munro, 2023).

Despite regularly encountering women with experience of IPV, implementing IPV interventions in multi-cultural community-based agencies is largely untested (Clarke et al., 2024) and views of settlement staff are not well known, although these workers often have similar cultural and/or language backgrounds and resettlement experiences. In response to this knowledge gap,

the SAHAR study introduced and evaluated a culturally tailored IPV identification and response strategy with refugee women accessing settlement services in NSW, Australia (Spence et al., 2024). This paper reports the experience of caseworkers, designated IPV workers and managers at five settlement service sites who implemented SAHAR intervention, and addressed the following two research questions:

(1) What do settlement workers and managers consider were the enablers and barriers to implementation of the SAHAR IPV screening and response intervention?
(2) What do settlement workers and managers perceive to be the factors that support or inhibit disclosure and help-seeking by refugee women experiencing IPV?

Method

A summary of the study sites and intervention is provided below, a more detailed description of the acceptability of the intervention is provided elsewhere including its acceptability (Spence et al., 2024), the experience and results of IPV screening (Spangaro et al., 2025) and findings regarding coercive control (Spence et al., 2025).

Study sites

The SAHAR project was implemented in four government-funded settlement services in NSW, Australia, with one site delivering the Humanitarian Settlement Program (HSP) for refugees' during their initial 18 months, with a focus on integration, accommodation, employment, education, and English learning, while four sites offered the Settlement Engagement and Transition Support Program (SETS) available to refugees from 18 months to 5-year post-settlement, providing support in English language skills, healthcare, employment, housing, legal systems, family issues, civic participation, and citizenship. Both programs were delivered by community-based NGOs with bicultural case workers, and all sites had specialist IPV workers.

Study intervention

SETS and HSP caseworkers received 2 days of training on IPV and response including implementing the ACTS IPV screening tool (Hegarty et al., 2021). The ACTS tool, translated into Arabic, Farsi, Chinese, Vietnamese, and Urdu, included questions about fear, threats, controlling behavior, and physical violence over the past year. Specialist IPV workers received an additional half-day training on the SAHAR response. Bilingual caseworkers conducted

screenings at the HSP site. All women were offered IPV information cards, and positive screens led to referrals to IPV workers, who provided risk assessments, safety planning, and external service referrals. For women who accepted the referral, IPV workers discussed options and impacts, conducted risk assessment using the Danger-Assessment for Immigrant women (DA-I) (Messing et al., 2013), undertook safety planning, and made referrals to external services as necessary. The study was implemented for 4 months at each site. At SETS services, which are used opportunistically, the questions were asked at their first meeting with a caseworker during the study period. At the HSP site, the protocol directed women to be asked at their 6-month case review meeting, a point in time when the crisis of arrival has abated, greater rapport with the caseworker is likely to have occurred and the HSP protocol directs that each family member is to be seen alone.

Study participants

Caseworkers and specialist IPV workers at the SETS and HSP sites were invited to participate in focus group discussions to share their experience of implementing the SAHAR IPV screening and response tools, and the factors that staff thought supported and hindered disclosure and help-seeking by women experiencing IPV. Additionally, the managers at the five sites were invited to participate in one-to-one interviews. The focus group questions explored participants' experience of implementing the IPV screening and response tools, their views about what supported and hindered IPV disclosure and help-seeking, and what they thought contributed to the achievement of positive outcomes for women. The manager interview guide explored managers' perceptions of staff experience implementing the intervention, views about what supported and hindered IPV disclosure and help-seeking, as well as broader organizational factors that affected implementation. Focus group discussions and manager interviews were undertaken by members of the research team JS, NS, CTA, and JC and were audio recorded.

Data analysis

The four research team members, who had all facilitated at least one focus group or manager interview, familiarized themselves with the transcripts and individually undertook initial thematic coding on four of the transcripts using Saldana's first and second cycle coding framework (Saldana, 2021). First cycle coding included attribute coding of the data as well as holistic coding and In Vivo coding. First cycle coding involved initial coding to summarized segments of the data (Saldana, 2021). Second cycle coding is more analytical which allows for more detailed categorical and thematic organization of the data (Saldana, 2021). The first cycle coding

was discussed by the team resulting in a preliminary coding tree based on the holistic and "InVivo" coding, which is a process of assigning codes based on short phrases and words which are then expanded to themes and data managed using NVIVO Version 14 (Lumivero, 2023) qualitative data software. The process was repeated for the remaining transcripts and the themes were progressively developed, amended, and refined during second cycle coding (Saldana, 2021). A final team review amended some themes and added a small number of new themes which were subsequently refined using the NVIVO Version 14 (Lumivero, 2023). Throughout the process, an inductive approach was used to generate themes from the data while also linking data to factors identified in the research aims and protocol.

Ethical considerations

The study was approved by the University of Wollongong Human Research Ethics Committee (2021/388) and conducted in line with the WHO ethical and safety guidance on research with women who have experienced IPV (WHO, 2001).

Results

Four members of the research team worked in pairs to conduct focus group at five services with 24 of the 35 staff who implemented the intervention. Focus groups ranged from 72 to 93 min, with an average time of 81 min. Manager interviews were undertaken one-to-one with five managers by two members of the research team with interviews ranging from 29 to 51 min and an average time of 45 min. The focus groups and manager interviews were professionally transcribed. Table 1 provides a summary of characteristics of the caseworkers, specialist IPV workers and managers from the five study sites.

Seven themes were developed that describe the enablers and barriers for settlement staff who implemented the SAHAR screening and response tools: *(1) Confidence grew rapidly; (2) Clear and simple tools matter; (3) Language matching facilitates connection; (4) Settlement services can do this; (5) Disclosing is more complex for refugee women; (6) Care and inclusivity enable disclosure and help seeking and (7) Women choose different pathways*. Each of these themes is described below, with supporting quotations provided. The identification tag includes site number (see Table 1) followed by designation: Manager (M), Caseworker (C) and IPV specialist (I).

Table 1. Participants characteristics.

	SETS 1	SETS 2	SETS 3	SETS 4	HSP1	Total
Staff who implemented the intervention						
Case workers, female	4	4	2	4	7	21
Case workers male	–	2	2	1	1	6
IPV specialists (all female)	1	2	2	1	2	8
Languages spoken (in addition to English)	Arabic, Chinese, Dari, Farsi, Hazaragi	Arabic, Assyrian, Dari, Farsi, Hindi, Tamil, Punjabi, Urdu	Arabic, Assyrian, Chaldean, Dari, Farsi, Swahili, Vietnamese	Arabic, Hindi, Kinyamalengi, Pashto, Swahili, Urdu,	Arabic, Bhutanese, Dari, Farsi, Hazaragi, Hindi, Malayalam, Nepalese, Pashto, Tamil, Urdu.	16
Total staff who implemented the intervention	5	8	6	6	10	35
Participants in focus groups and manager interviews						
Caseworkers focus groups	5	3	6	5	6	24*
IPV specialist focus group (multi-site)	1	–	1	2	–	4*
Manager interviews	1	1	1	1	1	5
Total participants in focus groups and manager interviews (excl. duplicates)	6	4	7	6	7	29

*Four IPV specialists also participated in caseworker focus groups.

Confidence grew rapidly

Prior to commencing the study, participating staff, while supportive of the study, were apprehensive about conducting IPV screening and anxious about responding to disclosures. Some worried that direct asking about IPV would be too intrusive or even offensive to women visiting the service. One participant said, ". . . it's a very sensitive topic to discuss or raise. And in certain cultures, it may also be seen as being offensive or a bit too personal." (5-C5)

> Caseworkers had different levels of prior knowledge and experience in regard to IPV with many indicating it was a new area of practice for them: " . . . it was new to us, and it's not a favorite topic to talk about it, even for us, among us. So, I guess we needed some time to process how we're going to understand it." (2-C2)

Confidence grew rapidly during training and after a short period of implementation such that caseworkers overwhelmingly spoke positively about the experience of implementing the screening tool, reporting that it was easier than expected and a practice that should be continued.

> . . . when I did the first screening, I was, to be honest, very scared because I wasn't exposed to that stuff . . . but doing it and then I'd just go to the questions again and again so that I feel be more confident of asking. (4-C2)

Another participant said: "I was thinking it would be difficult, but it wasn't. I was scared go to this area . . . But when I started, I see the crisis relaxed [the women] were comfortable, and I was comfortable." (5-C)

Concerns about the IPV questions causing offense did not eventuate, with caseworkers reporting their perception of a high level of acceptability by women. This gave encouragement to the caseworkers, with some reporting that their skills developed while implementing the tool.

> It did get easier . . . Because every time I see a woman, I'm screening the woman, her reaction, her questions was letting me to improve my skills of how to communicate . . . how to allow me to ask these four questions. (3-C3)

Some caseworkers found the screening procedure empowered and equipped them in undertaking what was a sensitive new area of practice, for example:

> It's actually - this screening gave me a bit more power . . . Having this paperwork is kind of giving me more courage that this is necessary to complete with all the women, and I'm not asking you random questions. (5-C5)

Clear and simple tools matter

Managers and caseworkers believed the provision of SAHAR's clear and simple tools translated into community languages, together with the pre-

intervention training from the research team were key to successful implementation.

> The questions were very clear and very easy for the people to understand, especially when it comes with the direct translation script. (1-C2)

> . . . for me, it was quite easy because the wording was simple, easy to understand. (1-I1)

The simplicity of the ACTS tool with its short preamble and only four questions were reassuring for staff who found it could be readily incorporated into their practices and procedures. As one caseworker said: " . . . it's very simple . . . four questions which covers all the aspect[s]. It's the way designed the questions, it's very user-friendly, I would say."(5-C6)

Regarding the training, caseworkers highlighted that the rationale for the intervention, the opportunity to practice the procedures, about IPV were particularly valuable.

> For me, it was the training that we had. The training we had helped me, yeah, how to screen women. Not only that, and be prepared if woman ask me, "Why are you screening me?" (3-C3)

Additionally, the value of regular support from the research team was noted by all the managers.

> I think one of the things that made it not easier but understood was the regular catch-up with your team . . . because you provided a space for front-liners to ask questions and clarify certain misconceptions. (3-M)

Language matching facilitates connection

Another strong theme to emerge from the data was the value of language matching between the settlement workers and women. At the four sites delivering the SETS program nearly all SAHAR interventions were delivered by a worker speaking the woman's language, predominantly Arabic, also Dari, Farsi, Chinese and Vietnamese. At the HSP site, which supported refugees with a greater diversity of client languages, most women were seen by workers speaking their language with a small number requiring an in-person or telephone interpreter. A total of sixteen languages were spoken by the staff, English was rarely used (see Table 1). Caseworkers, specialist IPV workers, and managers said this high level of language matching made screening much easier as it enabled rapid, strong connections between workers and women, and helped establish a basis of trust for discussion of IPV to occur. As one participant said: "I think because there wasn't any language barrier, it was much easier." (5-C3); while another participant stated: "I know six or seven languages, which really helped me with the screening except for one family . . . I got help from one of the case managers, working with us."

Even though settlement staff were experienced in working with interpreters, they reported that using interpreters for the SAHAR intervention inhibited discussion of IPV due to its highly personal nature and women's concerns about confidentiality.

> It will be definitely a challenging thing when we're using the interpreter . . . because the reason is it is a sensitive matter. It's really a sensitive personal issue, . . . sharing that kind of sensitive issues in front of someone, it will be definitely a big barrier. (5-C6)

Use of telephone interpreters was seen as especially problematic: " . . . if we are using an interpreter phone, I think often those interpreters are not exactly relaying the subject matter exactly the way we want to relay to them." (5-C4)

The language matching offered by settlement services was central to a broader understanding by staff that their services could offer a culturally welcoming setting for refugee women who were socially isolated and sometimes reluctant to use mainstream services.

> . . . the reason I think the client came to us, because they didn't have anywhere else to go. Yes, the trust obviously was there, but because when they arrive in Australia, their source of connection they have is very limited . . . They're so scared of the police because it's a stigma. . . So, they come and say, "This is actually happening. My husband . . . " (2-C1)

However, it was also pointed out that language matching and cultural connection brought complexities and could be barriers for women, particularly if they thought that disclosing to a worker from their community meant that this information could become known to others in that community. As one participant observed: "Workers from the same culture may inhibit women from disclosing they may not disclose because they might feel that if I disclose them, it may spread in the community." (5-C4)

Several workers said they shared the discomfort of their female clients in talking about this sensitive issue, particularly in the early stages of implementation, as explained by one worker.

> For me personally, at the beginning, it was a bit uncomfortable because no matter what, I'm from the same culture, and talking openly regarding these things and asking questions, especially with the clients that we haven't established a relationship for a long time, it's a bit hard. (2-C1)

Workers identified strongly with women from their own cultural background. Workers and managers thought this contributed to a depth of understanding about their clients' cultural perspectives, challenges, and strengths such that being from the same country of origin or language group was mainly seen as an asset that could be consciously utilized.

> So, our cultural perspective is like it's a patriarchal family, right? We are brought up that way . . . regardless of different cultural perspectives, we have some similarities. I'm

> talking in general, right? My community, Afghan community, and some of the Irani community that I'm working in, so I feel like we have quite a lot of similarities, actually. (2-C3)

Another caseworker said: "So, coming from a country like having really tough backgrounds, I feel it really helps. For myself, I am from Pakistan." (4-C2)

Settlement services can do this

Participants reported that the SAHAR intervention was successfully implemented and were in favor of continuing IPV screening and response within their services. This was despite each service coming from a different starting point which impacted their ability to implement SAHAR. For example, sites 4C and 5 M had specialist IPV worker in place for some time before the study commenced and as a result had some capacity already in place to support internal referrals, while for three of the services, IPV workers had only just started at the services prior to implementation and internal referral protocols were not well established. One of the participant managers said in regard to the SAHAR intervention: "I think it was reasonably smooth, the implementation of it . . . yeah, it was pretty smooth, I think. It's not a big deal . . . I don't think it was very difficult. It's only . . . four extra questions." (4-M)

Another manager stated:

> If we are to dive deep into the domestic and family violence space, we've got to embed this particular screening tool. We've got to be asking questions that are relevant. Not only are relevant to the project, but questions that will enable us to continue beyond the project. (3-M)

Other reasons given for continuing IPV identification and response and embedding the intervention in settlement services were:

(i) Workers and managers were aware that a proportion of women attending the service would be experiencing IPV and not spontaneously speaking about it. Notwithstanding the sensitivities and complexities, workers and managers saw value in directly asking women about IPV to create an opportunity for women to speak up: " . . . no one asked them. They have been waiting for someone just to ask them." (3-C3)

(ii) Asking standardized questions about IPV raised awareness about the issue among settlement service clients. Participating staff described how women arriving in Australia were unfamiliar with the laws and norms around IPV, and the intervention helped to raise awareness: " . . . there were some clients who did not really have an idea about what DV is, so it actually also helped to give the awareness."

> So, this [is] awareness actually and when I was telling her about domestic violence and things and, "This is what is included in domestic . . . " she's like, "Oh, yes. Yes. Oh, okay. Okay" and she was understanding it. (4-I1)

Workers said the increased awareness meant that some women may reflect on their situation and come back later to the worker and disclose.

> . . . when I talked to her about it, she was crying, and she was silent. She wanted to share. Now she has this awareness, and she wanted to tell me more about it, but . . . there was something stopping her. She said, "When I come next time, probably I'll make my mind and then share about it." (4-I1)

Disclosing is more complex for refugee women

Settlement workers and managers described barriers to IPV disclosure for their clients commonly reported by women in all communities including apprehension of the consequences of disclosure. These included women not wanting to end their relationship, fear of retribution, fear of losing their children and lack of financial resources, as commented on by these two participants: " . . . most of them are scared moving forward. They don't want to separate because they have children." (4-I1) "It's . . . financial. They are scared they can't handle to pay rent, to cover the school expenses." (3-I1)

Workers and managers identified additional complexities to disclosure for refugee women including language barriers; community pressures; risk of stigmatization and exclusion; pressure not to speak to outsiders about family matters; perceptions of visa insecurity; and fears about losing their children in cultures where patriarchal norms dictate that the father has child custody. This participant emphasized the issue of potential stigma: "It could be shame. Community shame . . . stigma in the community." (2-C2) While another pointed to insecurity about immigration status: "They don't have a permanent visa, so they scared if they say something, the husband will send them back to country." (1-C2)

Workers often spoke about women attending the service having a *"lack of knowledge about how things work in Australia"*, this combined with a lack of understanding of Australian law, as well as social isolation experienced by women created significant barriers.

> They haven't anybody. And lack of knowledge of the country. They don't know where they have to go . . . they haven't enough confidence to make a decision. . . they're really relying to the husband. (1-I1)

Another barrier to disclosing abuse, frequently raised by workers and managers from the was that refugee women, particularly those newly arrived in Australia, did not recognize some behaviors as abusive or excessively controlling as they are normalized in their countries of origin. Women did not know that these behaviors were defined as forms of IPV in Australia and, consequently, did not speak of them even when asked directly by workers.

> . . . because they are new to the country and some of them may not have – in the countries that clients come from unless it's a physical violence, they don't think that it's a domestic violence. (5-M)

> They are newly migrant, and they have been in country less than a year, and it's a completely different environment . . .The culture they come from, even hitting, verbal abuse, and financial control, it's a part of their life. (5-C6)

> Caseworkers also expressed the view that, for some women, speaking up about IPV or other personal family matters with an outside person was a cultural taboo: " . . . in our culture, that is not accepted to ask about very, very personal things." (3-C1)

> . . . they have the rumour that Australia destroyed the family. Australia have the tools to separate the family, the husband and wife . . . So, some of them like, "No, no, we will not touch this area, and we will keep together regardless." (5-C2)

Care and inclusivity enable disclosure and help seeking

Most workers reported that their demonstration of care with women visiting the service, building of trust and development of rapport provided an enabling environment for disclosure. Language matching (see above) and a direct understanding of women's backgrounds by the workers were also seen as contributing to enabling worker–client relationships.

> I knew this client. She came a few times, and she saw few cases in her own community, and it was for her an eye-opener, "I don't want the same thing to happen to me." And she asked me. I said, "There is always help." And the minute it [IPV] happened; she called me. (2-C2)

Participants reported that providing an inclusive and welcoming environment at the settlement services, contributed to cultural safety for service users. The wide range of activities and groups conducted by the services such as citizenship courses, English language classes and cultural festivals, as well as individual advice and referral, were seen by the workers as helping to create a sense of belonging for clients and an inclusive environment where conversations about personal issues could take place.

> . . . they all say, "We don't have anybody else to go to. We are new in Australia, and you are the only community or organisation that we feel like we can come and get connected with." (2-C1)

Confidentiality was highlighted by workers as essential to ensure women were able to speak about IPV. Particularly for this group, it was imperative to feel confident the information would not leak back to their community.

> . . . when we are discussing our issues, we don't want to our community being aware. I was telling them about the confidentiality and the process, but it's obvious if they can't trust it, they don't feel comfortable. They can't open up. (5-C3)

Knowing that the settlement service deals with IPV was observed by one manager as an incentive for women to self-refer and get help: "I've definitely heard from a number of clients' feedback saying that 'I didn't

know that you provided domestic and family violence. Now I know.'" (3-M)

Women choose different pathways

A low proportion of women who screened positive for IPV took up the offer of referral, to an IPV specialist. Participants identified possible reasons including: women not wanting to take further action at that time; fear of retribution; fear of breaking up the family; reluctance to retell their story to a different worker; and concerns about the information getting back to their community. One of the participant managers said: "Sometimes they (the caseworkers) would say that the woman didn't want to see somebody else, didn't want to pursue it, they did not want to go there." (4-M) While a caseworker participant stated:

> Sometimes they get a threat from the family members . . . clients are like, if I disclose the fact to the DV worker and if this has come to the notice of my husband actually so I have other children actually and he will be treating the children in the same way. (2-C3)

Caseworkers also pointed out that acting can take time, and women may need multiple opportunities before seeking help.

> ...when we talk with the clients first time, it was shocking them . . . And slowly, slowly, when we talk about these topics more . . . people get more familiar with the system, and then we encourage them. And also, they understand to speak out. (1-C2)

Caseworkers and managers identified that some women reach a tipping point or crisis that precipitates action.

> This are usually the time they don't mind other people to take part in it. Yeah. Because they know, "I'm in a very critical time. There is either my safety or my children's safety involved." (1-M)

> She was not agreeing firstly, like, "No, I cannot go to police. I'm not reporting this. It's fine. He will change and everything will be fine." But after some time . . . she did go to police. She said, "You encouraged me to do this, and I think this was the right decision. And no matter what my people think or my community leader thinks, I'm not living anymore with him." (4-I1)

In considering the range of pathways taken by women, workers and managers also observed that many women chose never to disclose, and some who did disclose chose to remain in abusive relationships.

Discussion

The SAHAR project introduced and evaluated a culturally tailored IPV screening and response intervention for refugee women accessing settlement support services. The study sought to understand settlement staff experiences in

implementing the SAHAR intervention, and to learn from their views about the barriers and enablers for disclosure and help-seeking by refugee women experiencing IPV.

Initial apprehension by settlement staff, due to cultural constraints to discussing sensitive family matters, was quickly dispelled with pre-intervention training. Clear and simple tools translated into community languages, and organizational and research team support, all contributed to successful implementation.

Factors seen as particular to migrant and refugee women were language barriers and complex relationships with diaspora communities, while language matching, shared backgrounds, and culturally safe service environments were viewed as conducive to disclosing and seeking help for IPV. The similar backgrounds shared by settlement staff and the women they support has enabling and inhibiting effects of supporting implementation of the intervention. Most staff working in settlement services are migrants or former refugees with lived experience of pre- and post-arrival challenges which, combined with their work-based interaction with women experiencing IPV, positions them as expert informants about the barriers and enablers to disclosure and help-seeking for women experiencing IPV.

Previous research on IPV response has identified that settlement staff felt unprepared and unsupported to undertake IPV response, in having to figure out how to make it work (Block et al., 2022; Wachter, Heffron, et al., 2021). The SAHAR pre-intervention training, ongoing support during implementation seemed to overcome this type of problem. Similarly, the availability of onsite specialist IPV workers to whom caseworkers could refer, ameliorated the time pressures on settlement staff and lack of referral options that were identified as key constraints in Wachter et al.'s study (2021) of IPV response in settlement service were present in SAHAR.

In relation to the expert informant status of the caseworkers in this study, most settlement workers believe their lived experience gives them a greater understanding of the challenges faced by their clients, the settlement experience and the impacts for women and families (Settlement Council of Australia, 2024). Another Australian study by Block et al. (2022) found that services providers identified a need for a holistic and integrated approach when responding to survivors of IPV.

Maturi and Munro (2023) argue that dominant responses to IPV among refugees and migrants often rely on simplistic and culturally biased assumptions. These responses typically blame the culture of these populations for IPV, influenced by racist stereotypes (Ghafournia, 2017). This "culture talk" diverts attention from broader racialized inequalities that contribute to IPV, as noted by other literature (Maturi & Munro, 2023).

While migrant women face similar stressors following IPV as other women there are compounding factors such as immigration status, socio-structural elements like gender roles, and the context of their situation (Njie-Carr et al., 2021). These intersecting factors create a complex web of

continuous oppression, increasing the risk of domestic violence victimization for immigrant women. Similar to Williams et al. (2024) we found that connections are vital for women to feel part of the community. Thus, there is an intersection of gender, culture and migration vulnerability/acculturation stress that needs addressing, our study confirmed that this is indeed possible by introducing a culturally tailored IPV screening and intervention response (Njie-Carr et al., 2021). Our findings are consistent with research that emphasizes the complex interaction of gender roles, culture, and migration vulnerability for refugee women experiencing IPV (Muruthi et al., 2022; Perales et al., 2023; Waller et al., 2022). Our study participants highlighted that women arriving in Australia were unfamiliar with the laws and norms around IPV, which is consistent with other findings (Vaughan et al., 2020; Wachter, Dalpe, et al., 2021) and the intervention helped to raise awareness. However, there is also inconsistency in reporting to, and seeking help from law enforcement agencies (Satyen et al., 2019) suggesting this is an area that should be explored further.

Regardless, these dynamics occur while families are grappling with acculturation stress in countries of settlement where mainstream services and institutions are largely insensitive to the complexities being experienced (Maturi & Munro, 2023).

Strengths & limitations

This study is notable for being the first to evaluate the implementation of a culturally tailored IPV screening and response intervention specifically designed for refugee women accessing settlement support services. It showed positive engagement from service providers and used high-quality, evidence-based tools. However, the 4-month implementation period was too short to assess long-term effectiveness, and high staff turnover affected sustainability.

Implications for policy, practice & research

Policy integration: Integrate IPV interventions such as SAHAR into broader settlement policies and programs.

Feasibility: IPV screening and response in settlement services increased IPV awareness and disclosure opportunities. Settlement services are an additional touchpoint for IPV prevention and early intervention thus continued funding of specialist IPV workers in settlement services is warranted.

Broader applicability: Assess the applicability of the SAHAR in different contexts and with other refugee populations.

Varied responses: Women responded differently to IPV disclosure, with some accepting referrals and others not. We need to explore acceptability for women in future evaluations of this population.

Referral uptake: Investigate strategies to increase the uptake of referrals to specialist IPV workers.

Long-term sustainability: Future studies should focus on the long-term sustainability of IPV interventions in settlement services including ongoing training and support for staff. SAHAR processes could be implemented as part of onboarding for new staff and service managers with regular in-service training and debriefing opportunities, to address high-staff turnover.

Future research: Evaluate SAHAR with different methods such as realist evaluation, participatory research methods or community-based participatory research.

Conclusion

The SAHAR project successfully implemented a culturally tailored IPV screening and response intervention for refugee women in Australian settlement services. The study demonstrated positive engagement from settlement services and effective use of evidence-based tools which were apparently well received by refugee women. Key enablers included language matching, clear screening tools, and a culturally safe environment. Overall, settlement services are well-positioned to support refugee women experiencing IPV, provided they receive adequate resources and support.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author, (JC). The data are not publicly available due to information that could compromise the privacy of research participants.

Ethical standards and informed consent

The study was approved by the University of Wollongong Human Research Ethics Committee (2021/388). All procedures used in the study were in accordance with the Declaration of Helsinki of 1975, as revised in 2000. Informed consent was obtained from all participants for being included in the study.

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