



# Children and Mothers in Mind Independent Evaluation 2018 – 2019 Participant and Facilitator Feedback

## Final Report - July 2019



## Acknowledgements

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Cover image from Kids First Powerpoint template.

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# Executive Summary

## Background

Kids First, formerly the Children's Protection Society, provides support services to vulnerable families and children living in the North East Melbourne metropolitan area, and experiencing complex issues such as sexual abuse, child neglect, family violence, homelessness, poverty, mental health, drug and alcohol issues and the consequent trauma experienced.

From mid-2017 to mid-2019, Kids First piloted *Children and Mothers in Mind (CMIM)*, in collaboration with Merri Outreach Support Service, the Sexual Assault & Family Violence Centre in Barwon, Anglicare Victoria and Quantum Support Services in Gippsland and FamilyCare in Shepparton.

*Children and Mothers in Mind* is an Australian first program designed specifically for mothers and children under four years, who have had hurtful experiences such as family violence, childhood abuse or sexual assault. It incorporates:

- the *Connections* psycho-educational program for mothers and children experiencing violence in relationships, developed by Mothercraft in Canada;
- the *Mothers in Mind (MIM)* playgroup-based program, developed by Dr Angelique Jenney (University of Calgary, Canada) and the Child Development Institute; and
- one-to-one support, through counselling, case support and referral, and brokerage.

## Evaluation aims

The *CMIM* evaluation aimed to:

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

## Methodology

The evaluation was designed to provide deep and detailed information about the program to supplement data collected by:

- the DHHS evaluation of the Family Violence demonstration projects;
- the evaluation activities led by Dr Angelique Jenney (psychometric measures, demographic data).

The evaluation focussed on post-program interviews with 46 mothers who had completed the program and who volunteered to be interviewed. Thirteen of these women were interviewed a second time 6 months after the first interview. Facilitators from all *CMIM* locations and Kids First managers were also interviewed (13 facilitators and 4 child workers). In addition, participation and referral data were collected.

## Participation

Across all program sites, 35 cycles of the *CMIM* program were implemented between August 2017 and June 2019, and 490 women and children received a service. While the average number of participants in the groups were six women and eight children, group numbers ranged from four to nine women and four to fourteen children in any one group.

Consideration should be given to a staff-participant ratio which enables therapeutic work to be carried out – the *MIM* session manual recommends 1 staff member for 2 mothers – both for adults and for staff managing the children’s group.

Across all programs, there was an average drop-out rate of 25% over the course of each program cycle. Unavoidable commitments, such as court appearances or illnesses kept families away, but for those families who completed the program, many made great efforts to attend group session, despite major adversity and crises in their life circumstances.

## The service system context

Recruitment has been most successful from within the organisations offering the *CMIM* program and from the family violence, family services and maternal and child health sectors, where workers were aware of the importance of mother-child work in DFV contexts. *CMIM* was thus well situated within organisational contexts offering family support and family violence services. Referrals were low from child protection, although the source of support for women referring themselves is unknown.

Some problems were experienced with a number of unsuitable referrals in some areas, a predictable issue in the early stages of a new program, as professionals familiarise themselves with the details of the program. Similarly, some early guidance gaps in relation to the assessment process and paperwork for evaluation purposes was addressed during the pilot.

Apart from challenges in relation to information sharing with DFV services which will hopefully improve with time, there were no unmanageable issues raised about collaborating with other services on behalf of *CMIM* clients, while facilitators were clear on their role and its limits.

## Impact of the program on participants

Individual experience of the program varied between mothers, but the following elements were seen as highlights by participants:

- Help to better understand how the experience of DFV can affect children, and how hurtful experiences can impact parenting and relationships. This understanding allowed mothers to better understand and respond to their children’s behaviours.  

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*To look after yourself as a mum and to look after yourself as an individual. To know that you’re doing a good enough job. [participant]*

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- Peer engagement with women who had similar experiences made mothers feel better understood and validated their experiences.
- The facilitator participant relationship was a critical agent of change. The development for almost all women of a trusting relationship, emotional support and positive reinforcement, was an important factor for women to build their confidence and to feel safe enough to engage with sometimes difficult program content.

- The self-care component of each session and the take-home quotations were valued highly by mothers. Women reported re-learning the importance of small self-care actions in boosting their self-confidence, which in turn improved parenting confidence.

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*Confidence, my confidence has grown. This group helped me a lot – emotionally, physically, financially. It brought a little bit of my essence back which linked in with confidence which helped me a lot. Instead of being so hurt or fragile it gave me a little bit of a lesser term, a little bit more fire in your belly that no this is not okay, this is not a right, no this is not my fault [participant]*

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- *CMIM* was seen by some mothers as a catalyst for further change in their lives, a step in the right direction.
- Mothers interviewed six months after completing the program reported that the positive impacts of participating in *CMIM* continued to be felt.

Facilitators provided the following examples of the impact of the *CMIM* program on participating families.

- Seeing mums begin to put their children’s needs before their own;
- Seeing a child returning to Mum as the secure base;
- Mothers’ increasing availability to their children over the duration of the program, in terms of being present and responsive to the children’s cues;
- A mother who moved from bearing an overwhelming burden guilt and shock at the beginning of the program, to a state of greatly reduced anxiety and fear. Her child’s behaviour reflected the mother’s improving mental state.
- Seeing the moments of delight and connection between mothers and their children.

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*They see their child differently, that their child isn't naughty, or that their child is wonderful and beautiful and has so many strengths, and has just had some challenges. [facilitator]*

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The highly positive feedback from participants and staff alike reinforces, and adds depth to, the significant changes reported by Wall and Lawrence (2019) on a range of measures. It is clear that participants have gained value from all the areas discussed above – an understanding of DFV and its impacts, improved mother-child relationships, parenting confidence, and self-care. Interviewees were able to cite examples of their change in understanding and how they interact differently with their children as a result of the program.

The client group was diverse, including families from culturally diverse backgrounds, whose English was imperfect, and women with low literacy levels. Staff needed to adapt program materials and activities to suit individual needs.

The *MIM* component of *CMIM* was valued by mothers for what they learned about DFV and its impact on themselves, their children and the mother-child relationship. Women valued the chance to have time away from their children, a benefit in itself, as well as providing the opportunity to talk about difficult issues without young children being present.

While children took longer to settle, and some struggled with the separation from their mothers, most got to a stage where they enjoyed the child only space and developed in confidence. The child worker role was significant in creating a safe place for traumatised children to play and representing the children’s voice and needs in the professional team.

The *MIM* playgroup boosted mothers' confidence in their parenting and ability to put boundaries in place for children's behaviour. They noted a positive change in their relationship with their children after participation in *MIM*, and attributed this to being better able to understand their children's behaviour and respond appropriately. With the increased understanding of their children gained during *MIM*, mothers were able to consolidate learning and enjoy engaging with the children.

The one-to-one work aided the development of an individual trusting relationship with a *CMIM* professional and this enabled greater emotional support. Including counselling, case support, and

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*When I met with one of the case workers on my own, I remember getting very emotional, because I was able to talk to her openly and not worry about triggering anybody else, even though it triggered myself, it didn't trigger anybody else. [participant]*

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referral and brokerage, one-to-one work also made a significant positive contribution to women's engagement, their understanding of the content and their ability to apply this learning to their own situations and to their parenting. Facilitators employed creativity in customising *CMIM* to suit the circumstances of individual mothers and their children.

*CMIM* staff reported that the strength of the program lies in the flexible delivery of all the elements listed above. The length of the program, in allowing time for trusting relationships to be built, was seen as crucial. Facilitators pointed to the predictability and routine of group sessions, and the sense of safety which was nurtured in the group space as central to program effectiveness.

**The trauma-informed, therapeutic focus of *CMIM*, which creates a space where mothers are seen as good parents and good people, is a highly effective feature of *CMIM* which distinguishes it from many other services. The program has the potential to provide further assistance for families who require some support but are not able to commit to a group program for the full 22 weeks, through the development of a range of alternative service pathways. These could include supported referrals, brief intervention, interim support until a *CMIM* program is available and suitable, or the separate provision of *Connections* and *MIM* programs.**

### Peer Support and Social Connectedness

Discussions with mothers about their support networks at the end of the program showed a picture that varied considerably between individuals. Unfortunately, pre-program data was not available to evaluate change. Outside *CMIM*, some families were extremely isolated, while some were receiving support from numerous services. Some mothers received a lot of positive support from their families and multiple friends, whilst others have had to move away from their support networks and were no longer in contact with them. Three case studies have been included in section 5 of the report to illustrate these differences.

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*They talked openly and supported each other – where a mum couldn't see strength in their own ability, the other mums could give examples, support each other . . . [facilitator]*

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The *CMIM* program promoted healthy social connectedness within the group environment. It also assisted women to connect with the formal services they needed, and to community activities and organisations. However, as the case studies show, a number of factors are in play here. The program does not have the scope to assist women to heal fractured relationships with family and friends, and DFV survivors become ready to trust and develop new relationships at their own individual pace. This is an area, however, where many families are vulnerable, and it is important that trauma-informed services improve their approach to this problem.

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*I felt very supported after the group. Personally, I felt that I was okay. I felt that I'd reached a stage where at the time I felt like I was getting back on track. [participant]*

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## Organisational issues – operations, communication and collaboration

One of the strengths of *CMIM* is its widespread program delivery, across organisations and geographic locations. Interagency collaboration is always a challenge, and especially so in the early implementation stages of a new program. The challenges faced by Kids First and the collaborating organisations, and by their staff were typical of those affecting pilot projects in the early stages of implementation. These challenges included difficulties in recruiting suitably qualified and experienced staff, some destabilising staff turnover, some lack of understanding and support of *CMIM* on the part of organisational hierarchies, practical issues stemming from staff based in different agencies and therefore different buildings co-facilitating the program, and some gaps in communication and arrangements to maintain good communication and collaboration between collaborating agencies.

*CMIM* management was aware of the issues raised and endeavouring to resolve them through filling key management roles. In any collaboration, regular interagency meetings at management level are crucial to iron out collaboration and communication issues, and need to be prioritised. It is anticipated that future implementations of this model will take the structural and administrative issues raised into account.

Under the leadership of Kids First, the *CMIM* organisations provided a range of opportunities for reflective practice, supervision and professional development. These developed over time as the implementation of the pilot progressed. The presence of a skilled team leader or senior practitioner experienced in collaboration in therapeutic group work situations is important to assist facilitator partnerships to function smoothly, manage tensions and provide support and containment.

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*You're constantly feeling scared. It can feel very lonely, and it just seems like this is your life forever, and then when you join the group you realize that no, I don't have to feel scared every day. I'm not the only person going through this, and there is light at the end of the tunnel. It definitely helped put those things into perspective for me. [participant]*

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## Concluding Comments

**The strong evidence base of the *Connections* and *MIM* components of the *CMIM* program have led to an intervention that is valued highly by participants (mothers and children) and staff alike. The creation of a safe space for both mothers and children, and the nurturing of a trusting and therapeutic relationship with facilitators in addition to peer support are significant. In interviews immediately after the program, and 3-6 months later, mothers reported an increased understanding of the impact of violence on their children and gave examples of how they were more responsive to their children, and enjoyed spending time with them.**

**What makes the group program work especially well, are the wrap-around components, including the one-to-one support, casework and referral, the brokerage to get families to group and connect them to community, and the flexibility and creativity with which facilitators have used these components to provide a service suited to each family's individual situation.**

**The issues raised in this report relating to operations, communication and collaboration were developmental issues normal to a program operating in a pilot implementation phase. It is**

anticipated that future implementations of this model will take the structural and administrative issues raised into account.

## Issues for consideration in future implementations of *Children and Mothers in Mind*

The issues for consideration listed here have emerged from interviews with *CMIM* participants and staff as important principles for successful implementation of a program such as *CMIM*. Senior staff were aware of most of these issues when consulted and were planning strategies to address them.

- *While funding targets restrict flexibility on staff-client ratios, advocacy should be ongoing regarding the danger of losing the therapeutic value of the program when client targets (both adults and children) are too high.*
- *Clear publicity and communication with other services about the program will reduce the number of inappropriate referrals.*
- *Clear communication regarding assessment and evaluation processes and training in these areas will ensure they run smoothly.*
- *Facilitator skills in engagement and therapeutic trauma-informed practice are critical to the success of the program.*
- *Further adaptation of program materials and activities may be necessary to meet individual needs.*
- *With suitable funding, the child worker role has the potential to enhance the therapeutic nature of *CMIM* for children.*
- *Programmatic approaches which promote healthy, supportive family and social relationships for families who have experienced *DFV* will complement programs such as *CMIM*.*
- *Where possible, premises with outside play spaces should be used to allow older children more freedom of movement, easing the pressure for the child during the two-hour group time.*
- *The establishment of a pool of workers with ongoing employment in the organisation, who are trained to deliver *CMIM*, will provide back-up for *CMIM* facilitators and may assist in retention of staff.*
- *In future implementations of *CMIM*, organisations can build on the excellent framework of supervision, support and training that was developed during the pilot, including high quality clinical leadership.*
- *It is recommended that regular inter-agency meetings at management level are prioritised, particularly in the early stages of any collaboration, to ensure a common understanding of the program philosophy and logic, as well as the prompt and smooth resolution to administrative issues*

# 1 Background to the Research

## 1.1 Children and Mothers in Mind

*Children and Mothers in Mind (CMIM)* is an Australian first program designed specifically for mothers and children under four years, who have had hurtful experiences such as family violence, childhood abuse or sexual assault.

Such traumatic experiences can undermine a mother's ability to provide care, thus severely impacting the nature of the fundamental relationship between her and her children (Thiara & Humphreys, 2017). Research has indicated that abused women experience significantly greater stress levels and are more likely to act in an aggressive manner towards their children (Nixon et al, 2017).

A strong mother-child relationship is a powerful predictor of positive outcomes for the child (McGee, 2000). However, the stressful influences of living with violence can result in entrenched, unhealthy parenting patterns and in mother and child serving as constant reminders to each other of earlier traumatic experiences (Hilton, 1992; Lieberman, Van Horn & Ippen, 2005). Infants and young children are at an especially high risk due to both their physical and developmental vulnerability and their close proximity to caregivers during incidences of violence. This can result in irregular brain development, emotional dysregulation, developmental delays, and sensitivity to conflict, PTSD symptomology and decreased levels of social interaction (Kimball, 2016).

*CMIM* was developed to provide mothers with the opportunity to access trauma-informed parenting information, whilst connecting with other mothers who have had hurtful experiences in their lives. The program aimed to strengthen mothers' self-care, self-compassion and stress management skills in relation to parenting. Finally, the program aimed to support the mother-child relationship through enhancing mothers' sensitivity and responsiveness to her child and strengthening feelings of parenting self-efficacy.

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*You can recover from all the physical, mentally, all that stuff, from a domestically violent relationship. It does get better.*  
[participant]

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The program incorporates the *Connections* psycho-educational program for mothers and children experiencing violence in relationships, developed by Mothercraft in Canada; and the *Mothers in Mind (MIM)* playgroup-based program, developed by Dr Angelique Jenney (University of Calgary, Canada) and the Child Development Institute, Toronto.

Following a trial of *Mothers in Mind* in 2016-17, Kids First acted on feedback that participants wanted some space away from the children to develop their understanding of the impacts of domestic and family violence (DFV) on their parenting, by expanding the program to create *Children and Mothers in Mind*. Each *CMIM* program was delivered over a 22 week period and had three main components:

- *Connections* – 8 week group for mothers and children separately, so that mothers can address trauma issues
- *MIM* – 10 week playgroup for mothers and children together to support the mother-child relationship

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*[CMIM] just gave me a greater understanding of why things have happened and things aren't like that forever. There's always a way out and we've experienced these traumas but there is ways of coping and healing. It's not this way forever. Tomorrow's not going to be the same as today. The sun's going to come up tomorrow. You're going to wake up tomorrow.*  
[participant]

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- One-to-one support - the combination of therapeutic group work and casework running throughout the program distinguishes this program from counselling or casework models of intervention.

## 1.2 The University of Melbourne evaluation

The University of Melbourne has been contracted by Kids First Australia through a Learning System Grant to undertake an independent evaluation of the *CMIM* program, focusing on interviews with program participants and facilitators. This follows on from an earlier University of Melbourne evaluation of the original *Mothers in Mind* program, and supplements the data collected by:

- the DHHS evaluation of the Family Violence demonstration projects;
- the evaluation activities led by Dr Angelique Jenney (psychometric measures, demographic data).

The *CMIM* evaluation aimed to:

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

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*I just understood sort of his behaviour a little bit more, and that you know when he's having a difficult moment that that passes, rather than getting caught up in that moment and being sort of anxious or sort of stressed over it – you sort of just wait for it to pass. [participant]*

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The evaluation research involved collection of referral and participation data, and interviews with program participants and staff. Data collection commenced in June 2018 and concluded in July 2019. As shown in Table 1, the evaluation focused on selected program locations at different times. Programs considered by the evaluation included all those offering the *CMIM* program. They were located in the Northern metropolitan area (Kids First and Merri Outreach Support Service), the Western metropolitan area (Kids First), Barwon (Sexual Assault & Family Violence Centre – SAFVC), Gippsland (Anglicare Victoria and Quantum Support Services) and Shepparton (FamilyCare). For groups 1-4 and 7-8, a sample of adult participants in the North Metropolitan and Barwon programs were interviewed. For groups 5 and 6, the focus was on programs in Shepparton, Gippsland and the West Metropolitan area. Some participants (those who were contactable and consented) were interviewed a second time 6 months after their post-program interview. Staff from all locations were interviewed once during the evaluation. For a full list of program locations and data collection activity, see Appendix A.

**Table 1: CMIM regions and participants in the evaluation research**

Program Dates	Group No.	Regions included	No. of Program Participants Adult (children) who completed program	No. of Post program interviews	No. of Follow up (6 month) interviews
Aug - Dec 2017	1&2	North Metro Barwon	21 (25)		8
Feb - June 2018	3&4	North Metro Barwon	15 (17)	9	3
Aug - Dec 2018	5&6	Shepparton Morwell Werribee	28 (38)	16	2
Feb - June 2019	7&8	North Metro Barwon	17 (23)	8	n/a

Post program interviews were conducted with a total of 46 participants, 13 facilitators and 4 child workers, across all sites, as well as program managers. Follow up interviews (3-6 months post program) have been conducted with 13 participants.

*Knowing that we've been through this and that's okay because we've got each other. We're going to do everything we can to be okay, so making the future look positive [participant]*

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

## 2 CMIM participation, referrals and the service system context

### 2.1 CMIM Participation

Across all program sites, 490 women and children participated in one of the 35 cycles of the *CMIM* program offered between August 2017 and June 2019 (Table 2). While the average number of participants in the groups were six women and eight children, group numbers ranged from four to nine women and four to fourteen children in any one group.

Across all programs, there was an average drop-out rate of 25% over the course of each program cycle. Rates varied between locations (19% - 32%).

*Discussion: Where groups hosted large numbers of children, facilitators faced challenges in providing a therapeutic, trauma-informed environment, especially when staff members were caring for children ranging from small babies to active four-year-olds. This applied especially in the child-only group during the Connections component, but also created a very busy environment in the MIM playgroup*

which was not conducive to participants engaging with program content and activities. During the Intake process, staff in some programs were able to balance numbers, needs and ages of participants (adult and child) to ensure they were able to attend to all participants adequately.

Issues for Consideration:

- While funding targets restrict flexibility on staff-client ratios, advocacy should be ongoing regarding the danger of losing the therapeutic value of the program when client targets (both adults and children) are too high.

**Table 2: CMIM Participation Numbers**

Total number of adult participants (mothers): Aug 2017- June 2019	214
Total number of child participants: Aug 2017- June 2019	276
Proportion of adult participants who did not complete the program	25%
Average number of adult participants (mothers) per program	6.1
Average number of child participants per program	7.9
Number of programs delivered: Aug 2017- June 2019	35

**2.2 Barriers to participation**

As would be expected, many of the families attending CMIM were still grappling with major challenges in their lives related to the DFV they had experienced or were trying to separate themselves from.

For example, many women named contact with their ex-partner as the principal cause of stress for both themselves and their children, specifically citing the stress associated with receiving drunk or disruptive phone calls or emails and ongoing court matters relating to separation, contact with children or intervention orders. These women stated that the court-related issues caused them stress and anxiety and took up a lot of their time. A few women stated that this directly affected their parenting.

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*After being in court with [my ex-partner] ... I've got to be able to take care of my kids and I was knocked down for like four or five days after those affidavits where I didn't want to move and my body felt like lead. [participant]*

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Some women mentioned also mentioned that their partner’s inconsistent involvement in their children’s lives caused their children stress. A few women stated that their children often did not want to visit their fathers and when they did see their fathers, they were emotionally deregulated or stressed. Further, some women mentioned feeling anxious about their children interacting with their ex-partner unsupervised.

A second example is housing and financial issues, which prevented a few women mentioned from attending some CMIM sessions. Several women stated that they had moved in with family members and were consequently not living comfortably. Further, one woman mentioned that her ex-partner was still financially abusive and was living in their house. While facilitators provided one-to-one support for these issues, they did not believe that they had been, in fact, a major barrier to attendance.

With these life circumstances, it is to be expected that some women stated that poor mental health - feeling stressed, anxious or depressed - affected their parenting and prevented them from attending CMIM sessions. Facilitator interviews suggest that the impact of mental health on mothers' participation varied between programs, depending on how thorough initial assessments had been in diverting women from the program whose mental health status was likely to prevent them from participating fully.

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*Some sessions, when she sleeps at her dad's, she will come home Sunday night and... she won't [have slept]. She is just not in a good place. So, the next morning... I haven't been able to take her to group. That is very stressful, knowing that she is not coping with sleeping at her dad's. [participant]*

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A few women mentioned that they could not attend or participate in some of the Connections sessions, as their children would not separate from them. These women stated that they

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*I know one mum in particular, she went through a huge crisis during the group . . . she had to leave the house with nothing and she still came every Friday. . . . Some weeks she was present, and she wasn't always 100 per cent available to the girls but some of the stuff, you know, the horrendous weeks she'd have, that's why I would say to her, "Come in. I've got this. The girls and I are doing Play-Doh. It's good" . . . She never missed one group. [facilitator]*

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appreciated being able to catch up with the facilitators over the phone to discuss any missed content or further support. Facilitators reported that the major factors preventing women from attending CMIM were mainly the things that physically kept them away, such as illness, work commitments, child protection or court matters. These matters did affect how well women were able to be present in the group, and facilitators supported them according to individual needs.

*Discussion:* With care taken at assessments about whether families were "ready" for the group, the challenges women faced in their lives outside group did not always prevent them from attending. In fact, there is evidence that women made efforts to attend as group sessions provided some relief from external stressors. The therapeutic "holding" nature of the group fulfilled an important function.

*The degree to which mothers' engagement with group discussions and activities was impaired by these external stressors is not measurable on the available evidence. However, reports from facilitators and participants indicate that facilitators were creative in finding alternative ways for women to engage with program content.*

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*It's a big bond that hasn't been broken, we still connect with one another, it's lifelong. Those relationships are there for life. [participant]*

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## 2.3 Referral Sources

Data about referral sources in Table 3 relates to Northern metropolitan and Barwon programs for groups 1&2 and 3&4, and for all program locations for groups 5&6 and 7&8.

Nearly half (44%) of the participants were referred from within the organisations providing the CMIM program. Internal referrals made up just over half of all referrals from Family Services and DFV services respectively. In this field women are encouraged to make contact with programs themselves, and this accounts for the relatively large number of self-referrals, Data about how these self-referring women came to know about the program is not available.

**Table 3: Referral Sources**

Referral Source	No. of referrals
Family Violence (incl. 1 Refuge)	60
Family Services/Support	55
Maternal & Child Health	20
Self-Referral	16
Child Protection	4
Children's service	3
Aboriginal Service	2
Mental health/parenting	1
Other	1

*[I was] given this opportunity to meet a wonderful bunch of mums who have been in the same situation where we've continued our relationship outside of the group. We've actually formed friendships from it, which is so nice for us and so good for the children because we've all been in similar situations and, yeah, we can all relate to one another, yeah, and help to continue to support each other. It doesn't just end. [participant]*

**Discussion:** The large proportion of internal referrals to CMIM indicates that the program was well situated within organisations offering family support and family violence services. Efforts to publicise the program to Maternal and Child Health services have also been successful. Referrals from child protection were lower than might be expected for a program of this nature, and while this may be partly due to the challenges for child protection workers in working with cases involving family violence, ongoing conversations with child protection are important.

Comments from some staff about the workload involved in receiving large numbers of unsuitable referrals, indicates the importance of clear publicity and communication with other services about the program. This understanding of a program does develop with time as the program becomes better known across the local service system.

**Issues for Consideration:**

- Clear publicity and communication with other services about the program will reduce the number of inappropriate referrals

## 2.4 Working with other services

Facilitators believed that mothers got more out of CMIM when they also had supports outside CMIM. Participants reported being linked into services such as psychologist or counselling, material aid, DFV services, disability supports, Child First and family support services, legal services, playgroups, parenting supports and housing services.

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*We tend to find that mums do better when they've got... You know, whether it's mental health counselling, family violence counselling, family support case management. There's something that they need, running alongside the group, that's not just our group. [facilitator]*

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As would be expected, collaboration with these services was reported to be easiest when they were delivered by the same organisation as CMIM. It was harder to connect with and share information with staff from outside organisations, though facilitators from a number of locations, including outside Melbourne, commented on the value of working for a well-known and respected organisation in influencing how overtures to other organisations were received.

In some cases, facilitators were concerned that case managers from other sectors, such as housing, were not sufficiently attuned to children's needs. On the whole, however, working with other services has been effective for clients, whether it be material aid charities, counselling or case management.

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*It's a collaboration, and so you're actually all taking on different responsibilities, but providing that kind of cohesive response... service response to a client. I think that's the success. And building those relationships means that you also get referrals, like an outside success of that. The challenges are other services wanting to handball certain... or wanting to pass on clients to us and then close, or not wanting to take responsibility for certain tasks, and trying to push that back on us when it's not our responsibility. [facilitator]*

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Staff from programs outside Melbourne reported strong working partnerships with other services in their community, with few problems in working with other professionals involved. However, the choice of services is not as great as in the metropolitan area, and long waiting times can result in the lack of timely support.

Some specific issues were reported, such as a difficult relationship with child protection and difficulties in obtaining the CRAF risk assessment form from DFV services. Staff in Shepparton were unhappy with the rate of referrals from DFV specific services and from child protection.

*Discussion: Apart from challenges in relation to information sharing with DFV services which will hopefully improve with time, there were no unmanageable issues raised about collaborating with other services on behalf of CMIM clients, while facilitators were clear on their role and its limits.*

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*We've noticed that the mums that don't have anything else other than us are the ones where often a crisis happens and then all of a sudden we're in there, trying to do everything. [facilitator]*

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### 3 CMIM Program Components

As a whole, participants were generally positive about the *CMIM* program. While they spoke most about what they learned and how they valued the program as a whole (see section 4), there were also comments specific to each main component of the program.

#### 3.1 Assessment

Mothers met with facilitators prior to the program to learn about what to expect from the program and the program requirements. The process helped many mothers feel prepared to start the program, helped reduce nervousness and made mothers more comfortable during group sessions.

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*The first half of the group was mainly working on our feelings, and where we were. And the second half of the group was working on the kids' feelings, and how they were. [participant]*

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While facilitators generally felt their assessments were thorough, it was noted that children required longer to settle in and feel comfortable in the group setting, often 3-4 weeks.

However, a few women noted that at first the program seemed too long and daunting and that parts of the paper work were difficult to understand. Assessment is an important and skilled component and some facilitators expressed the

need for training in this area, in terms of familiarity with and understanding of the assessment tools, and clarity around which families were not suitable or not ready for the program.

#### 3.2 Connections

*Connections* was an 8-week group for mothers and children separately that allowed mothers to spend time away from their child, connect with other mothers and gain an increased understanding of healthy relationships and their importance to healthy child development. Most women commented favourably about the psycho-educational content of the *Connections* component that allowed them to better understand DFV. Further, they appreciated gaining a better understanding of the impact of trauma on children, and strategies to respond to them appropriately, leading to greater confidence in parenting.

Many of these women specifically requested that the *Connections* component should either be lengthened by a few weeks or have longer sessions, stating that they wanted more time to discuss each topic as there was a lot of material to cover and it was difficult to have in-depth discussion during the playgroup with the children around.

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*It gave me time to just take two hours out for myself and acknowledge what I've been through and identify where I needed help. [participant]*

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Facilitators noted that women varied in their ability to engage with the material as it was presented, and that it would be useful to be able to simplify the material for some mothers. In particular, facilitators noted self-esteem (in some groups), the Family Violence Act, and the impact of DFV on a child's brain development as difficult topics for the women.

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*They would help you solve problems that weren't even really relevant to the Children and Mothers in Mind group. You know, they'd help really guide the way to help you with your situation. Really supportive. [participant]*

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The children's group was staffed by two child workers / educators, with the aim of providing a safe space for traumatised children to play independently of their mothers. The child worker role was organised and funded independently at each program location, and interpretation of the role varied - some took an exclusive child-focus in running the children's group during *Connections*, others were more involved with mothers, and in some locations assisted in the first sessions of *MIM* to ease the transition for children.

Interviews with facilitators highlighted their view that this role is highly skilled and an important component of the *CMIM* professional team - responsibilities including support of children in the transitions between mother-and-child activities and children-only time, and advocacy for the child's perspective, to help mothers see their children's needs, and in staff discussions about meeting the needs of each family.

### **3.3 Mothers in Mind**

The *Mothers in Mind* component was a 10-week playgroup that supported mothers to connect and play with their children and to find joy in this, with the aim of strengthening the bond between mother and child. Mothers noted that the playgroup allowed them to spend time with their children as prior to the group, they had little time to spend with their child or had trouble playing together. Many women appreciated being able to watch their children socialize with the other kids and grow in confidence. Further, many mothers found the stories and songs they learned during the playgroup were a useful tool for positively reinforcing their mother-child bond.

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*It was good because I got to witness things that I don't see at home.... She was amazing. Like, it's a side of my child that I never saw, and now that I've experienced it I know different things to do with her, so I think that was great. [participant]*

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The transition from *Connections* to *MIM* had challenges for everyone. Some mothers were reluctant to lose the women-only time. Similarly, children had to move from their own group to the more complicated space of playing with their mothers. With experience, facilitators developed strategies to manage this issue, including a lot of verbal preparation for both mothers and children, and the use of the child worker as extra support in the transition.

### **3.4 One-to-one support**

Mothers were provided with individual counselling or casework which consisted of weekly phone calls and the opportunity for further support, such as brokerage or material support, emotional support, further discussion of content. The precise nature of this support varied between programs, from the offer of therapeutic counselling sessions, to phone calls or home visits, or even just individual conversations taking place before, during or after the group sessions. This depended on the facilitator skills as well as the degree of contact women were comfortable with. General emotional support regarding women's self-care and what was happening in their lives was an important element of this one-to-one work.

One-to-one support was also used to go over content which Mums had missed, or which needed reinforcing, "to unpack the material specifically for them". Facilitators also rang mothers to prepare them about the content to be addressed in the next session and check if it would trigger traumatic flashbacks. While some women did not engage outside group sessions, facilitators believed that those women who participated in follow-up conversations got more out of the group sessions.

Women commented favourably on the one-to-one discussions with a facilitator about program content and the opportunity to catch up on any missed content as well as the emotional support they received. Many mothers also mentioned that they appreciated the practical support and brokerage which alleviated difficult circumstances and helped families engaged with community activities.

Some mothers described how one-to-one conversations facilitated the development of an individual trusting relationship with a CMIM professional, providing them with a deeper level of emotional support.

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*I think one of the really positive things was the phone call each week... That was just a really good opportunity to have one-on-one chat about what the group had done, if anything had come up for us, and how they could support us further...I think that was really important because you did not always get that chance in the group and it meant you didn't feel forgotten, because someone was following you up one-on-one. [participant]*

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*Discussion:* Clarity about the program's inclusion and exclusion criteria is of utmost importance for facilitators during the assessment phase. Training and support are important for facilitators in managing complex and lengthy paperwork needed for both assessment and evaluation purposes. Review and adjustment of the intake and assessment process took place across all programs in June 2018 and again in January 2019, to clarify eligibility issues so that candidates in unsuitable circumstances were not admitted, ensure potential participants had realistic expectations of what the program offered and increase staff skills in assessment.

All components of the CMIM program were generally valued by participants. While generally positive, women's views varied on the Connections and MIM components, and how they fitted together, suggesting that no one way of structuring the program and presenting the content will suit the wishes of every individual. As has been the case, these decisions will be based on professional judgements, and support should be given to facilitators who need to adapt program materials for participants with lower language, literacy or understanding levels. With suitable funding levels, the children's group has the potential to be an additional therapeutic component to the program, increasing the focus on child participants and their needs.

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*I think [one-to-one contact with a facilitator] was really important because you did not always get that chance in the group and it meant you didn't feel forgotten. [participant]*

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One-to-one work also made a significant positive contribution to women's engagement, their understanding of the content and their ability to apply this learning to their own situations and to their parenting. Facilitators employed creativity in customising CMIM to suit the circumstances of individual mothers and their children.

CMIM staff reported that the strength of the program lies in the flexible delivery of all the elements listed above. The length of the program, in allowing time for trusting relationships to be built, was seen as crucial. Facilitators pointed to the predictability and routine of group sessions, and the sense of safety which was nurtured in the group space as central to program effectiveness. The trauma-informed, therapeutic focus of CMIM, which creates a space where mothers are seen as good parents and good people, is a highly effective feature of CMIM which distinguishes it from many other services.

*The program has the potential to provide further assistance for families who require some support but are not able to commit to a group program for the full 22 weeks, through the development of a range of alternative service pathways. These could include supported referrals, brief intervention, interim support until a CMIM program is available and suitable, or the separate provision of Connections and MIM programs.*

**Issues for Consideration:**

- *Further adaptation of program materials and activities may be necessary to meet individual needs.*
- *Clear communication regarding assessment and evaluation processes and training in these areas will ensure they run smoothly.*
- *With suitable funding, the child worker role has the potential to enhance the therapeutic nature of CMIM for children.*

## 4 Program content and effectiveness

In interviews with participants, a number of questions relating to program outcomes were asked, to ascertain mothers' views of their own learning. Almost all participants believed that the program had contributed to their understanding and skills in key areas (see Table 4). These key areas are discussed in more detail in the following pages.

**Table 4: Participant views on program effectiveness**

Question	Number of valid answers	Number (%) of affirmative responses
Did the program give you a chance to talk about parenting with other mothers who have had similar experiences?	44	43 (97.8%)
Did the program give you more confidence in your parenting?	44	43 (97.8%)
Did the program give you helpful ways to cope with anger, worry and stress?	44	44 (100%)
Did the program give you time to play with your child?	44	44 (100%)
Did the program give you some more ideas on how to respond to your child in a sensitive and caring manner?	44	44 (100%)
Did the program give you a better understanding of what helps children feel safe and secure?	44	44 (100%)
Did the program give you a better understanding of how hurtful experiences can impact parenting and relationships?	44	44 (100%)
Did the program help you to understand your child better?	45	45 (100%)
Did you notice any changes in your relationship with your child as a result of coming to the program?	44	43 (97.8%)

## 4.1 Increased understanding of DFV and its impact on children

Interviewed women valued the education about DFV and the signs to look for in potential partners provided during the *Connections* component. Some women aimed to use this information to educate their children on DFV and signs of an unhealthy relationship.

All the interviewed mothers reported gaining a better understanding of how the experience of DFV can affect children, and of how hurtful experiences can impact parenting and relationships. This understanding allowed these mothers to better understand and respond to their children's behaviours. Further, most mothers noted that the parenting tips they learned were useful in allowing them to respond sensitively to their children's trauma related behaviours and anxieties.

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*I didn't realise that they'd actually suffered trauma to the extent that they had from seeing it all and just being there... and being there and learning about that, it really helped me understand why they were acting the way they were. [participant]*

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Many of the mothers also noted that the program gave them insight into how their own behaviour can affect their children and allowed them to work through any resentment or blame they felt towards their child and change their behaviour accordingly.

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*I suppose it made me stop and process what's actually happened or happening, in terms of the treatment from my ex. Processing that in a healthy way helped me... deal with it and ultimately move through it. [participant]*

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In follow-up interviews six months after the program finished, most of the interviewed women continued to note the importance of understanding DFV in allowing them to gain self-confidence and move forward. They continued to show insight into how their children were affected by DFV and this understanding continued to influence their parenting. Many mothers reported employing the parenting tactics learned at *CMIM* when faced with difficult behaviours.

Further, during the follow-up interviews, some of the mothers showed insight into understanding how being exposed to DFV during childhood may have affected them themselves.

## 4.2 Improved mother-child relationship

Most of the interviewed mothers mentioned that the program allowed them to rebuild and strengthen the bond between them and their child. All but one mother (97.8%, see Table 4) noticed a positive change in their relationship with their child.

All of the interviewed mothers agreed that the program helped them understand their own children better. Many felt better equipped to comfort their children and help them deal with any anxiety or stress they were feeling. All of the mothers agreed that they had gained a better understanding of what helps children feel safe and secure. This is supported by analyses of participant scores on the "Raising a Baby" scale, which indicate a significant increase in knowledge of their children's social emotional needs and developmentally appropriate expectations both at the post-*Connections* and post-*CMIM* evaluation periods. However, no significant improvement in scores was found in mothers' self-reported parental hostile and reactive behaviours towards their children on the "Parenting Behaviours and Perceptions Towards the Child" scale (Wall & Lawrence, 2019).

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*It really has amplified kind of our bond. Like, I'm getting a lot more 'I love you Mummy', a lot more cuddles, a lot more kisses, whereas she used to say 'love you Mum' and then run away, she'll sit next to me and she'll be like, do you want to read a book Mummy. Let's read a book. [participant]*

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MIM sessions were seen as instrumental in teaching mothers the importance of spending time and playing with their children and being present when they are engaging with their child. Interviewees were able to describe how they used the communications strategies taught during the program, such as getting down to their children's level, to more easily connect with, and respond more sensitively to, their children. Of the interviewed mothers, 97.8% (see Table 4) agreed that they had learned more ideas on how to respond to your child in a sensitive and caring manner.

Mothers were enthusiastic about the books they received from the program, and many found them useful in both explaining their emotions to their children and helping their children understand their own emotions.

Six months after finishing the program, most women agreed that they felt their bond with their children was stronger than before completing the program. Many mothers continued to use the take-home materials to facilitate communication between them and their child, and most again stated that the program made them understand the importance of spending time engaging with their children. Exercises such as the bucket analogy and circles of security were given as concrete examples of how they acted on their continued awareness of their child's needs and responsiveness to those needs.

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*Sometimes I'd go to group and be like, "This week [my child] was just really struggling with this." We'd discuss it, and then I'd go home and I'd try out whatever they said, and come back and go, "Oh, my God it worked." Or "Oh, my God, [my child's] anxiety is not as bad as it was". [participant]*

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### 4.3 Increased confidence in parenting

The interviews indicated that one of the main benefits of the program was that it increased mothers' confidence in their parenting. Most interviewed mothers mentioned that the program

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*I learnt that I'm not a bad person for what's happened. I'm a great mother regardless of what's happened. I support my daughter solely by myself every day, so we're doing something right. [participant]*

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made them feel a lot more secure in their own parenting with 97.8% (see Table 4) stating that the program had given them more confidence in their parenting. Further, analyses of mothers' scores on the "Tool of Parenting Self Efficacy" scale revealed a significant increase in parenting self-efficacy at both time points from pre-Connections to post-Connections and post-Connections to post-MIM. Analyses of mothers' scores on the scales for "Parenting Behaviours and Perceptions Towards the Child" also indicated a significant increase in mothers' self-reported parental impact from the pre-Connections to post-program measurements (Wall &

Lawrence, 2019).

Mothers attributed this change in confidence to both positive feedback and suggestions from the facilitators, specifically mentioning the comments they received on their interactions with their children during the MIM sessions, and a deeper understanding of domestic and family violence gained during Connections sessions.

Many women mentioned that gaining this self-confidence assuaged some of the self-blame they were experiencing and helped them reclaim their identities. Facilitators also noted this – that women who grew their parenting self-confidence, or found it again, also showed greater confidence and ability to manage other areas of their lives.

Six months after completing the program, the interviewed mothers continued to note the effects the program had on their confidence and felt that this gain in self-confidence had allowed them to

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*Doing these exercises and talking about things has made me realize that this connection is special and that it is unique. I am important to him and that was something that I felt my ex-partner had pretty much diminished in me. [participant]*

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move forward in their lives. Additionally, the women noted that they had gained a better understanding of the importance they had in the children's lives.

#### 4.4 Self-care and Stress Management Skills

The interviewed mothers noted understanding the importance of self-care and stress management as a crucial learning of the program. A central theme that arose from the interviews was the mothers' desire to be a 'good mum'. Prior to the program, this desire resulted in the mothers investing most of their time in managing external stressors such as their ex-partner, court or financial issues and spending any remaining time focusing on their child. This meant that they devoted very little time and effort to looking after themselves.

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*It's like looking after yourself as well so that you can help your child. Because if you're feeling anxious and you're feeling stressed and tense and you're in a different zone you can't help your child the best way you can so you've got to look after yourself. [participant]*

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Participating in the self-care component of each session allowed mothers to become aware that looking after and taking time for themselves was crucial to giving their children the best care. The interviewed women noted that this component taught them to be kinder to themselves and to practice self-compassion. Many of the interviewed mothers further mentioned that the program increased their hopes of recovery and their optimism about the future. Mothers also mentioned the benefits of the take-home materials such as feeling reassured about their futures after viewing the self-care quotes they received from the program.

The stress management strategies covered in the group enabled most mothers to more effectively manage stress. Of the interviewed women, 100% agreed that they had learned helpful ways to cope with anger, worry and stress (see Table 4). The women specifically mentioned the exercises aiding them when managing external stressors, such as court or issues with their partner, and internal stressors, such as their own mental health.

Further, with the support of the facilitators, and session content focused on stress management, many mothers gained a better understanding of both their own negative emotions and feelings, and their children's frustrations, and learned methods to handle them. The women indicated that this allowed them to be more patient, present and receptive towards their children. Analyses of mother's scores on the Patient Health Questionnaire for Depression and Anxiety found a significant reduction in their combined scores for anxiety and depression as well as for their

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*I've learned my coping mechanisms. If I have a letter from the lawyer now and they've had correspondence, I'm not floored by it. I'm just taking it as it is. I'm just glad that my daughter and I are happy and healthy, emotionally, mentally and just not letting it get to me as much. [participant]*

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individual anxiety and depression scores between the pre- *Connections* and post-*CMIM* evaluation periods (Wall & Lawrence, 2019).

Six months on, responses from the follow-up interviews indicated many mothers had retained the strategies for self-care and stress management they had learned during the program. The women noted the importance of self-care in allowing them to be good parents. Most mothers also continued to show optimism about moving forward and recovering.

Most mothers also continued to use the stress management skills from *CMIM* when parenting. They specifically mentioned employing breathing and calming techniques, meditation and different methods of communicating with their children.

*Discussion: The highly positive feedback from participants reinforces, and adds depth to, the significant changes reported by Wall and Lawrence (2019) on a range of measures. It is clear that participants have gained value from all the areas discussed above – an understanding of DFV and its impacts, improved mother-child relationships, parenting confidence, and self-care, the delivery of program content has been effective. Mothers reported a greater understanding and were able to cite examples of this in action.*

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*There was always those quotes that helped you get through. Breathe deeply. It sounds silly, but just those sorts of things sometimes really give you perspective to go okay, you're just going to have to get through it. Yes, it's going to be tough, and yes, you might not feel it, but you will feel better at some point soon. [participant]*

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*Tactful prompting and modelling by facilitators assisted mothers to respond to the children's cues and the focus on effectively engaging and communicating with children during MIM sessions. The therapeutic nature of the mother-facilitator relationship and the support from participants group is likely to have reinforced the self-care messages and to have played an important role in the decrease in anxiety and depression scores. It is notable that the skills and strategies learned had not been forgotten by women interviewed six months later.*

## 5 Peer Support and Social Connectedness

### 5.1 Peer Support

For many of the interviewed women, the peer support they experienced was a hugely important contributor to the value of the program for them, and for some, this translated into ongoing supportive friendships. Over the course of the program, mothers were able to interact and build relationships with other mothers who had similar experiences to their own. All but one interviewee (97.8%, see Table 4) stated that they felt the program gave them a chance to talk about parenting with other mothers who had similar experiences. Some of these friendships were still active six months after the conclusion of the program.

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*We still do catch up, yeah. Definitely. Sometimes the girls will be like "Oh my God, I just need to see you girls, I'm having a horrible week this week." Or "I have to go to court again." We'll just catch up, or pop around for a coffee. [participant]*

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Most of the interviewed women stated that learning about DFV was instrumental to them recognizing that they were not alone and that many other women have experienced DFV, and described how recognising this helped them to move forward. Many mothers also stated that they

appreciated meeting other mothers who had had similar experiences and that having peer support either within or outside the group was comforting. Further, engaging with women who had similar experiences made them feel better understood and validated their experiences. It also gave them

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*It's nice to know that there's other women who have been in your situation. You can hear their stories, relate to them, and it makes you feel better about yourself because you think "oh, I'm not alone." There's other women who have been through this. This is what they went through. This is what I went through. This is what they're doing now and how they're moving forward. [participant]*

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the opportunity to share useful tips for coping with DFV, parenting and dealing with ex-partners.

While there were some women who sought out long-term friendships with others in the group, others stated they wanted to move past their DFV experience after the program and thus did not want remain friends with the women from the group.

Whilst some mothers appreciated group rules around not discussing their personal experiences in great depth, others found this prevented them from forming strong connections with the other women. However, some mothers found that other participants discussed their personal experiences in too much detail, leading mothers to feel like they were expected to provide support to other women when they did not yet feel in a place to provide this support.

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*I think sometimes when 'the facilitator' left the room there was a bit of sharing of stories . . . and for me, I got a bit triggered by that. It was just unfortunate. [participant]*

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## 5.2 Social Connectedness

Women's scores for the Social Support Scale (Wall & Lawrence, 2019) showed no significant change pre-program to post-program. This scale measures ongoing connections and whether there is someone a woman can rely on, feel comfortable talking about problems with or feel close to. While CMIM staff promoted the healthy friendships developed in the group, and linked women to other

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*I felt like the program was too short, and I felt like it could have been extended, or even if we had another program that we could go back to, to help support us...It just helped me so much with my feeling, so I felt like it just came to a stop. And then it was like I was left alone again. I was on my own again. [participant]*

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*I wanted [my daughter], and I, and [my son] to feel a part of something. [participant]*

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services or community activities where appropriate, these ongoing connections do not, of themselves, create social support. Indeed, when interviewed, many mothers wished for CMIM to continue beyond the 22 weeks as they missed the support and social interaction and felt isolated once the program had ended.

Many mothers also described gaining further support for themselves and their children as one of their primary reasons for participating in CMIM.

To better understand the social support networks of families who have experienced DFV, interviewers discussed with women their support networks at the end of the program, in the domains of both family and friends, and formal service provision. Unfortunately, without similar information being collected at the commencement of *CMIM*, it is not possible to comment on any changes in these social support networks, or what effect participation in a program like *CMIM* has on social connectedness. However, these discussions demonstrated the variation in social support networks for families who have experienced DFV - some families being extremely isolated, while others received support from numerous services. Some mothers received a lot of positive support from their families and multiple friends, whilst others have had to move away from their support networks and are no longer in contact with them.

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*I tried to reach out to different services. There wasn't anything specific that could really help me or support me. I guess I just wanted support. [participant]*

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The following case studies have been compiled based on these discussions with participants, to provide some insight into how levels of support and connectedness can greatly differ for victim/survivors of family violence. Names and identifying details have been changed.

### **Case Study 1: Olivia and Jessie**

Olivia is the mother of daughter Jessie, aged 13 months. Since ending her relationship with Paul, Jessie's father, Olivia and Jessie have moved in with Olivia's parents. Paul continues to live in a house owned by Olivia but refuses to contribute to the mortgage or move out of the property. Olivia has engaged a lawyer for assistance in getting her house back. Although she has only met her lawyer three or four times, they email regularly, and Olivia finds her very helpful.

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*I don't know how I would have done it without my mother and father. I can see how people can't get out of these situations. I don't know how I would have done it without them.*

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Olivia has minimal contact with Paul outside of legal proceedings. Occasionally, Paul will contact Olivia and ask to see Jessie. When this happens, Olivia will ask Paul to complete a drug test, as she is concerned about his substance use. Olivia says that Paul never responds to this request.

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*When she [the lawyer] took on my case, I just felt pure relief because she was really good at what she was doing. That was absolutely invaluable.*

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Olivia describes having numerous people she can turn to for support. As well as having a close relationship with her parents, who help taking care of Jessie, Olivia also receives emotional support and advice from a close friend whom she sees once a week. Olivia's cousin also helps out with Jessie, and she and Olivia

catch up for a chat every three weeks.

Olivia has also found several services very helpful. Soon after Jessie was born, a Maternal and Child Health Nurse helped Olivia recognize Paul's tactics of coercive control and referred her to the *CMIM* program for further support. The MCH Nurse visited Olivia and Jessie every couple of weeks for three months after Olivia separated from Paul. When Olivia began *CMIM*, both she and the MCH nurse agreed that Olivia and Jessie no longer needed these visits.

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*She [the counsellor] said you're good to go. I don't think there was anything else I was connected to. But there was nothing else I felt like I needed to be connected to. I was amazed at what was out there and what I was receiving.*

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The MCH Nurse also referred Olivia to a family violence counsellor. Olivia saw this counsellor for

several months whilst simultaneously participating in *CMIM*. Olivia had previously seen a couples counsellor with Paul, whom she found really unsupportive. The couples counsellor had failed to recognize Paul's behavior as DFV, instead describing Paul's violence as 'cultural differences'. Olivia had a good relationship with her new counsellor and felt she received lots of practical advice, particularly around going to court. Olivia stopped seeing her counsellor just before *CMIM* ended, because they both felt she no longer needed the counsellor's support.

Olivia really enjoyed participating in *CMIM*, particularly mentioning the one-on-one conversations she had with the *CMIM* facilitators. Although she's sad that the program has finished, Olivia feels she can contact the *CMIM* facilitators for advice at any time.

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*To be honest, I think apart from my parents, the counsellor, my friend and my cousin, there wasn't much else. I wasn't reaching out to anyone else. That was it. That was all I needed.*

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Since finishing *CMIM*, Olivia and Jessie regularly attend swimming lessons, music classes and story time activities at the local library. Olivia continues to feel supported by her lawyer and isn't currently engaged with any other services. She feels well supported by her family and friends and plans to reconnect with her counsellor in the future if she feels she needs extra support.

## Case Study 2: Melanie and Kara

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*I don't really get much support, like, I have to work it out by myself really.*

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Melanie is mother to her three-year-old daughter, Kara, and separated from Kara's father, Tim. They see Melanie's father, Bill, most days. Bill and Kara have a very strong and loving relationship, and Bill cares for Kara when Melanie attends appointments. Melanie describes her relationship with her father as positive, but feels Bill provides more practical support than emotional support. Melanie has a couple of friends that she feels she can talk to, however, they all live far away from her so she doesn't see them very often.

Kara sees Tim every second week, although Melanie says Kara doesn't like visiting him. Melanie and Tim are only in contact when Kara is sick. Kara has been experiencing some health problems over the last few months which have resulted in a couple of hospital stays. These hospital stays, as well as ongoing financial issues and court attendance, have meant that Melanie and Kara have missed quite a few *CMIM* sessions. However, despite missing sessions, Melanie found the *CMIM* facilitators very supportive and she also enjoyed talking to the other mums in the group.

Melanie has been seeing a family violence counsellor fortnightly for over a year. Her counsellor referred her to the *CMIM* program. Over the last two months, Melanie has had so many other appointments with her lawyer and Kara's doctor that she's had to keep rescheduling her appointment with her counsellor. Her counsellor warned her that if Melanie reschedules again, she will have to close her case. Melanie is worried because she already knows that she has to reschedule their next appointment. Melanie said, "I think that I'm not going to have a family violence counsellor anymore...She's my only support at the moment."

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*They [the financial counsellor] didn't help. They just told me things I already knew.*

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Recognising Melanie's limited supports, *CMIM* facilitators linked Melanie with a financial counsellor and a children's counsellor. Melanie met with the financial counsellor for one session but didn't get

much out of their meeting. Melanie contacted the children’s counsellor to set up an appointment, however, they never called her back.

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*I don't want to be alone. After this group, I have got nobody.*

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Kara doesn’t yet go to kindergarten but will be starting next year. Melanie has tried to get Kara involved in activities however, she says that Tim has prevented Kara from attending.

Melanie is not sure where she is going to get support after *CMIM* ends. She has tried contacting a specialist family violence service for case management, but she is waiting to be assessed. She wishes that the *CMIM* facilitators could provide longer-term support beyond the *CMIM* program.

### Case Study 3: Hasini and Yesa

Hasini and her two-year-old daughter, Yesa, have been living in a refuge for a few months. Hasini’s family live overseas, and she has very limited supports in Australia. Neither Hasini nor Yesa have any contact with Dev, Yesa’s father, and are both protected by an intervention order.

Hasini is currently going through the Family Law Court and is receiving support from Legal Aid but doesn’t find her lawyer helpful. Hasini says that her lawyer doesn’t provide her with enough information, which makes her feel very stressed.

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*I'm with Legal Aid, and whenever I try to talk to her [the lawyer], I can't really reach her.*

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*My case manager is literally the one person that I have here that I can count on because my family's not here.*

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Hasini feels extremely supported by her refuge case manager. Her refuge case manager has assisted Hasini with setting up Centrelink payments, goes with her to court and helps care for Yesa. Hasini’s refuge case manager also referred her to *CMIM*. Hasini also receives emotional support from the other women living at the refuge.

Hasini and Yesa enjoyed taking part in *CMIM* and got on well with the other mothers and children in the group. Throughout the program, Hasini met with one of the *CMIM* facilitators several times just to talk. The *CMIM* facilitators also provided Hasini with vouchers which she found greatly helpful as, at the time, she was not receiving any income.

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*There were lots of things happening at the time, still are happening. But I think that if I didn't have CMIM, it would have been worse.*

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Since *CMIM* finished, Hasini and Yesa remain supported by their refuge case manager and the other women living in refuge. She is not sure who will support her when she inevitably moves out of refuge.

*Discussion: The importance of peer support in helping women realise they are not alone in their situation cannot be over-estimated, and supportive conversations and social activities were mentioned by many women. Based on “Opportunities for connection with others with similar experiences” scores in The Trauma-Informed Practice Scales (Wall & Lawrence, 2019), the value of peer support appears to have been felt more strongly at the beginning of the program than at the end. It is possible that women were more aware of the complications of making new friendships by the end of the program, although facilitators maintained the delicate balance of promoting connections between women and encouraging women to set healthy boundaries when a relationship became too one-sided and not mutually supportive.*

Women's support networks - of family, friends and professional support - are frequently sabotaged by DFV perpetrators, and the experience of social isolation is a very common one. The CMIM program promoted healthy social connectedness within the group environment by assisting women to connect with the formal services they needed and to community activities and organisations. However, as the case studies show, a number of factors affect each family's

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*Because it's putting you in touch with all these people who are going through this crisis, and... you're a helper, you want to help other people. So, I think it can be a bit of an issue... It was really good that I had [the facilitators] to point out to me, "Hey... these problems aren't your problems; you direct them to us" ... I think that's important advice to have. [participant]*

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*You can't be there for someone else when you're trying to fix yourself. And so, I actually distanced myself from one [friendship]... because I felt like, "No, I can't take on board more than I've got". [participant]*

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situation. The program does not have the scope to assist women to heal fractured relationships with family and friends, and DFV survivors become ready to trust and develop new relationships at their own individual pace. What looks like a similar level of social connections may be experienced as supportive by one woman while another woman may feel that she is on her own.

This is an area, however, where many families are vulnerable, and it is important that trauma-informed services improve their approach to this problem.

#### Issues for Consideration:

- Programmatic approaches which promote healthy, supportive family and social relationships for families who have experienced DFV will complement programs such as CMIM.

## 6 Women's experience of the program

Many women saw CMIM as an opportunity to heal and move forward. Mothers wanted to meet other women with similar experiences, or saw the program as an opportunity to break their routine and try out a new experience that would allow them to be less socially isolated.

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*To kind of get out of my comfort zone, get to mix with other mums and maybe have a bit of a social interaction and just sort of break from my normal routine. [participant]*

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Women aimed to learn more about DFV, strategies for coping with stress and parenting after DFV. They wanted help understanding both their own experience and their children's, and were looking for advice on how to minimize the impacts of DFV on their family

While not all women had a clear idea of what they would gain from the program, they did want

something to change in their relationship with their children. The goals set by many mothers were centred on gaining support for both themselves and their children after DFV - specifically, to attain assistance in rebuilding their relationship with their child and becoming better mothers. Some mothers also mentioned wanting support in dealing with external stressors such as their ex-partner or court. Mothers who could remember the goals they set with facilitators reported in post-program interviews that they had met these goals.

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*I wanted to understand more about how family violence affects the children, and how you can help them and change it, and try and fix it. [participant]*

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Women reported that their experience was hugely determined by the quality of their facilitator. Most interviewees described the facilitators as empathetic and understanding and expressed how instrumental this was in creating an environment in which the participants felt comfortable sharing and discussing sensitive topics. Of the interviewed mothers, 100% (see Table 4) agreed immediately post-program that the facilitators understood them and the challenges they were facing. This relationship with the facilitator appears to have been important in creating an environment where women and children felt comfortable – changes in facilitator were criticised and deprecated by several interviewees.

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*They didn't treat us like we were people with issues who were less or something... they treated us as equals and just women trying to get through life and thrive and I think that's really positive. [participant]*

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Further, most of the mothers stated that they believed the facilitators to be knowledgeable and skilled. Facilitators tactfully recommended solutions and strategies to mothers to aid both their own recovery and their difficulties with their children. While one mother noted that she felt her facilitators were too forceful in making suggestions however, most they were grateful the facilitators did not force them to make changes but instead, recommended strategies they could employ.

Many women also appreciated the support they received from facilitators in dealing with challenges occurring in their lives outside the group. Specifically, some women stated that they received support and advice on how to manage contact with their ex-partners and court-related issues. Further, some mothers appreciated receiving material support such as vouchers for taxi fares, practical items such as a pram or activities they could do with their children.

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*[The facilitator] was very calm and very welcoming and really, she just had that nurturing, caring aura about her, she made it a really nice experience. I didn't feel embarrassed, I didn't feel ashamed, I felt comfortable and able to speak to her comfortably. [participant]*

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Six months on, whilst one mother stated that she did not feel comfortable with one of her facilitators who she felt judged by, most of the interviewees continued to express how empathetic and comforting they found the facilitators to be. Many of the mothers still felt comfortable reaching out to their facilitators to ask for help or for a referral well after the program had finished.

*Discussion: The interviews speak to the importance of the facilitator-participant relationship in creating a therapeutic environment. The development for almost all women of a trusting relationship, emotional support and positive reinforcement, was an important factor for women to build their confidence and to feel safe enough to engage with sometimes difficult program content. Facilitator skills in engagement and positive support were critical to the success of the program. High scores in the Trauma-Informed Practice Scales support what women said in the interviews (Wall & Lawrence, 2019).*

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*I think who is the leader of the group is probably very key. So, I think [my facilitators] were very well-equipped to do this job well but I think you could have people who maybe weren't as experienced or confident and that might mean it doesn't work as well. [participant]*

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*Recommendation:*

- *Facilitator skills in engagement and therapeutic trauma-informed practice are critical to the success of the program.*

## 7 Children's experience of the program

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*Her confidence has grown. She loves singing there. She loves playing . . . She's made little friendships with a couple of children her age. So, it's been good for her. It's been really good for her. [participant]*

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Most of the interviewed mothers stated that they felt their children had a positive experience and were well looked after during the program. They noticed positive behavioural changes in their children, and that their child's confidence had increased, often attributing this to the praise they received from facilitators and the opportunity to play with and successfully befriend children of the same age. Many mothers noted that their children became more comfortable around other people and more outgoing.

Facilitators spoke of how they strived to create stability, routine, and safety in the group environment, with freedom within clear boundaries, and told many stories of children who blossomed in confidence during the program. Some mothers noted that having a positive routine gave the children a sense of stability and something to look forward to each week. Many mothers noted that at the conclusion for the program, the children would continue to look forward to the group and were disappointed when they did not attend.

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*Seeing those relationships rebuild, to know that a child now trusts that mum is actually going to be emotionally available, and they're seeking them out again... The other thing that you see is the child return to mum, so the child being able to go and explore and play, and then come back to mum... and mum responding to that. It's nice to see that change and that play out. [facilitator]*

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The separation of mothers and children during the *Connections* component was a challenge for many children, who took a while to settle in the child only group. However, facilitators reported that their management of the separation became more skilled with experience, and that most children enjoyed the child-only group. Many mothers found that, after being separated during the *Connections* sessions, their children were more confident that their mothers would come back for them and thus were less anxious when separated and able to be more independent. Some mothers also noted an increased capacity in their children to understand and self-regulate their emotions, such as anger and anxiety.

The group spaces observed by researchers were cheerful engaging spaces, where great care had gone into thinking about how things were set out to provide a range of play opportunities for children and their mothers. However, some facilitators reported that they had been unable to obtain premises with adequate space for older children to move around, particularly advocating for the availability of an outside play area.

Six months after the program, mothers continued to note the changes in confidence, independence and sociability that occurred in their children over the course of the program. In some cases, these behavioural changes carried over to other contexts such as at kindergarten.

*Discussion:* The stability and routine of the group sessions, in both the children's group and MIM, appears to have created a safe and enjoyable environment for the children who attended the program. Facilitators were conscious that their engagement with the children should support the primary mother-child relationship, and created warm welcoming environments for the children to play in.

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*She is just more aware of her emotions now. Before, she never used to say, "I am happy today. I am this today. I am sad." Now she knows all the emotions and is very open and expressive about that. [participant]*

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Issues for Consideration:

- Where possible, premises with outside play spaces should be used to allow older children more freedom of movement, easing the pressure for the child during the two-hour group time.

## 8 Staffing Issues

### 8.1 Recruitment and retention of staff

Over the two years of the program's life as a demonstration project, there were a number of challenges in recruiting suitably qualified and experienced staff, as well as some destabilising turnover of staff. As discussed in the interim report, the causes of these difficulties are unclear, but are likely to include:

- the part-time and time-limited nature of the facilitator positions;
- the intensity of running two groups each week over a long period of time, with little break between one program and the next;
- small staff numbers, with few backup staff to support leave arrangements.

*Discussion:* Recruitment of a larger pool of trained staff within CMIM organisations would allow for the development of a more integrated staff team, facilitating back up and support, and lessening the intensity of service provision. Strategies such as these were already occurring or under consideration in CMIM organisations towards the end of the pilot, but are dependent on ongoing funding arrangements.

Issues for Consideration:

- The establishment of a pool of workers with ongoing employment in the organisation, who are trained to deliver CMIM, will provide back-up for CMIM facilitators and may assist in retention of staff.

### 8.2 Staff training and support

One of the key strengths of CMIM is the passion and commitment of its staff at all locations where it is delivered. Staff interviews provided evidence of the responsiveness of facilitators to issues arising and the many creative ways in which the group environment, group activities and other aspects of program delivery were continually adjusted to suit the individual and group needs of participants.

The importance of highly developed skills in the areas of trauma-informed therapeutic work, and a knowledge of family violence, child development and attachment was also highlighted.

Almost all facilitators interviewed had completed *Connections*, *MIM* and *CRAF* training, though not always prior to the start of their group role. Those staff who did not complete this training were those who came into the program at a later stage to replace another staff member,

and they were mentored by more experienced colleagues. The training and the manuals for the two group programs were positively viewed as good introductions to these programs, though the *Connections* manual needed considerable adaption to fit the Australian DFV context at the outset.

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*. . . to walk with them a little way towards teaching them that the world has good things for them, and that they are good people, I find it really rewarding, and quite profound.*  
[facilitator]

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*So much of the work is around mum understanding the child's needs and why they are doing certain behaviours and mum understanding how to regulate self, or how to manage those behaviours and mum understanding how that then--she can do that as well with her child and help regulate him, or whatever it is. It's like education of mum and education of child and modelling that kind of brings it together.* [facilitator]

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While there was some variability among facilitators in the amount of experience and knowledge they reported having in relation to trauma, DFV and working with survivors in a therapeutic way, there is evidence of considerable development of skills and understanding throughout the life of the program. Facilitators had found their own training through organisational support, their own research, or relied on past qualifications and experience. Levels of confidence among facilitators varied, with some wanting more training in these areas. However, *CMIM* management reported good levels of skills, as observed in regular consultations.

A number of opportunities for reflective practice, supervision and professional development were available to *CMIM* facilitators:

Supervision varied from site to site, ranging from a very basic accountability level, to reflective discussion about individual clients. The quality of supervision improved with the establishment of the team leader position.

Communities of Practice were valued, both for the rich discussion between professionals from a variety of backgrounds, and for the discussion about specific issues arising in groups – Angelique Jenney's expert input was acknowledged. Facilitators appeared to most value specific topics informing *CMIM* practice, which for those outside Melbourne, make these meetings worth the travel.

Support from the *CMIM* clinical coordinator was highly valued, both in terms of the value of consultations and of her provision of literature and other resources for use with clients and to supplement the program manuals.

The team discussions before and after each group session (referred to by facilitators as pre-brief and de-brief) were not only essential to share information, coordinate support for clients and plan the group sessions themselves, but also provided opportunities for reflective practice and peer support.

The levels of frank and open discussion required for joint group facilitation were initially challenging for many facilitators, particularly those coming from a case management rather than a therapeutic practice background. In some locations, the presence of a skilled team leader or senior practitioner familiar with this style of working assisted facilitator partnerships to function smoothly, manage tensions and provide support and containment.

De-briefing for facilitators, in relation to the support they provide clients and the traumatic experiences they hear about, is essential for supporting practitioner well-being, particularly in light of the length of the program. Some facilitators have received de-briefing through supervision, and others have set up arrangements for themselves, but there has been no systematic attention paid to this aspect of worker support to date.

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*So they see their child like the problem child, the naughty child, he's this, he's that. And so for us to be able to say, "He's so funny. Look at how funny he is. We've had such great laughs with him." Or to just help the mums... little things. "He was kind to another child. Look at how strong he is." Just to write a different narrative around their child. [facilitator]*

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An ongoing focus on facilitators having highly developed skills in the areas of trauma-informed therapeutic work, and a knowledge of family violence, child development and attachment is essential, through prior education and experience, specialist training (beyond MIM training) and ongoing supervision specific to CMIM. Due to changes in management over the last twelve months, and the demands of early implementation of a new program, there has been no coordinated focus on these issues to date, although adjustments such as the provision of local support through team leaders have been effective.

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*I'm just so pleased that it's there for mothers who need it. I'm so glad I was able to be there for it and go through the 18 weeks. As I say, I wish all mothers could do this course, to understand your child better and yourself better. It was just absolutely brilliant for that. I'm very happy that I got to do the program. I'm honoured that I got to do it. [participant]*

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Discussion: Under the leadership of Kids First, the CMIM organisations provided a range of opportunities for reflective practice, supervision and professional development. These developed over time as the implementation of the pilot progressed. The presence of a skilled team leader or senior practitioner experienced in collaboration in therapeutic group work situations is important to assist facilitator partnerships to function smoothly, manage tensions and provide support and containment.

Issues for Consideration:

- *In future implementations of CMIM, organisations can build on the excellent framework of supervision, support and training that was developed during the pilot, including high quality clinical leadership.*

## 9 Interagency collaboration and communication

One of the strengths of CMIM is its widespread program delivery, across organisations and geographic locations. Interagency collaboration is always a challenge, and especially so in the early implementation stages of a new program. No major issues were reported through staff interviews. However, concerns that were raised include:

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*I think it's probably one of the best things I could have done. I'm so glad I found out about it and got to take part in it. Without it I think I'd still be grappling with lots of the hurt and not knowing how to deal with it and not having anyone else who I knew had gone through it with young children. Yes, I think it's definitely a very positive course and anyone who has been through a similar thing should have the chance to do it. I really hope it gets offered for a long time. [participant]*

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- local variations in program delivery compromised fidelity to delivery models in the early days of the program, though this was later resolved;
- some lack of understanding and support of CMIM on the part of organisational hierarchies;
- practical issues stemming from staff based in different agencies and therefore different buildings co-facilitating the program (eg. different policies, lack of access to room bookings);
- a desire for better communication between CMIM programs, expressed most strongly by regional program staff. Issues raised included the difficulties experienced by facilitators in obtaining information about how to collect, record and submit the measures, and poor organisation of the Community of Practice meetings.

*Discussion: An important factor affecting these issues was the developmental nature of a pilot project in the early stages of implementation, the turnover of staff in key management positions, and the sporadic occurrence of interagency meetings (with the exception of the quarterly governance meeting) which would have been organised by the coordinator.*

*CMIM management was aware of the issues raised and endeavouring to resolve them through filling key management roles. In any collaboration, regular interagency meetings at management level are crucial to iron out collaboration and communication issues, and need to be prioritised.*

*Issues for Consideration:*

- *It is recommended that regular inter-agency meetings at management level are prioritised, particularly in the early stages of any collaboration, to ensure a common understanding of the program philosophy and logic, as well as the prompt and smooth resolution to administrative issues.*

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*It changed my mindset, I thought, rather than getting up in the morning, having my coffee and doing what I need to do, I'm actually going to have my coffee and then hang out with kids for a bit. When they're settled and ready to do their own thing, then I'll shift over here and do what I need to do. So making sure that the kids were settled, rather than just thinking about, Oh my God, I've got all this stuff that I need to do, just reminding myself that they still needed my attention and if I actually just give them five minutes of my attention, and make sure they're settled, then they'll leave me alone for half an hour. So, it was just working out my own emotions as well . . . So it definitely did help, they found ways for me to work around obviously discussing things with the kids and dealing with my own emotions. . . I often felt guilty, or I felt like I was being a bad mum, but then the other women would say, "no the other day, my son was really bothering me and I snapped and then later on, I felt bad as well." And I was like, oh okay, it's not just me doing it, it's okay. So, just that reassurance really helps. [participant]*

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## Appendix A

### CMIM programs and evaluation activities covered by this report

*Table 5: Appendix A. CMIM programs and evaluation activities covered by this report*

		N metro	W metro	Barwon	Gippsland	Shepparton
Aug - Dec 2017	Group 1	Referrals Part. Int Staff Int		Referrals Part. Int		<i>no group</i>
	Group 2	Referrals Part. Int Staff Int		Referrals Part. Int		<i>no group</i>
Feb - June 2018	Group 3	Referrals Part. Int Staff Int		Referrals Part. Int		<i>no group</i>
	Group 4	Ref Part. Int Staff Int		Referrals Part. Int		<i>no group</i>
Aug - Dec 2018	Group 5	Referrals	Referrals Part. Int Staff Int	Referrals	Referrals Part. Int Staff Int	Referrals Part. Int Staff Int
	Group 6	Referrals	Referrals Part. Int Staff Int	Referrals	Referrals Part. Int Staff Int	Referrals Part. Int Staff Int
Feb - June 2019	Group 7	Referrals Part. Int Staff Int	Referrals	Referrals Part. Int Staff Int	Referrals	Referrals
	Group 8	Referrals Part. Int Staff Int	Referrals	Referrals Part. Int Staff Int	Referrals	Referrals

Referrals – Referral data was collected for these programs

Part. Int – participant interviews were conducted in relation to these programs

Staff Int – staff interviews were conducted in relation to these programs