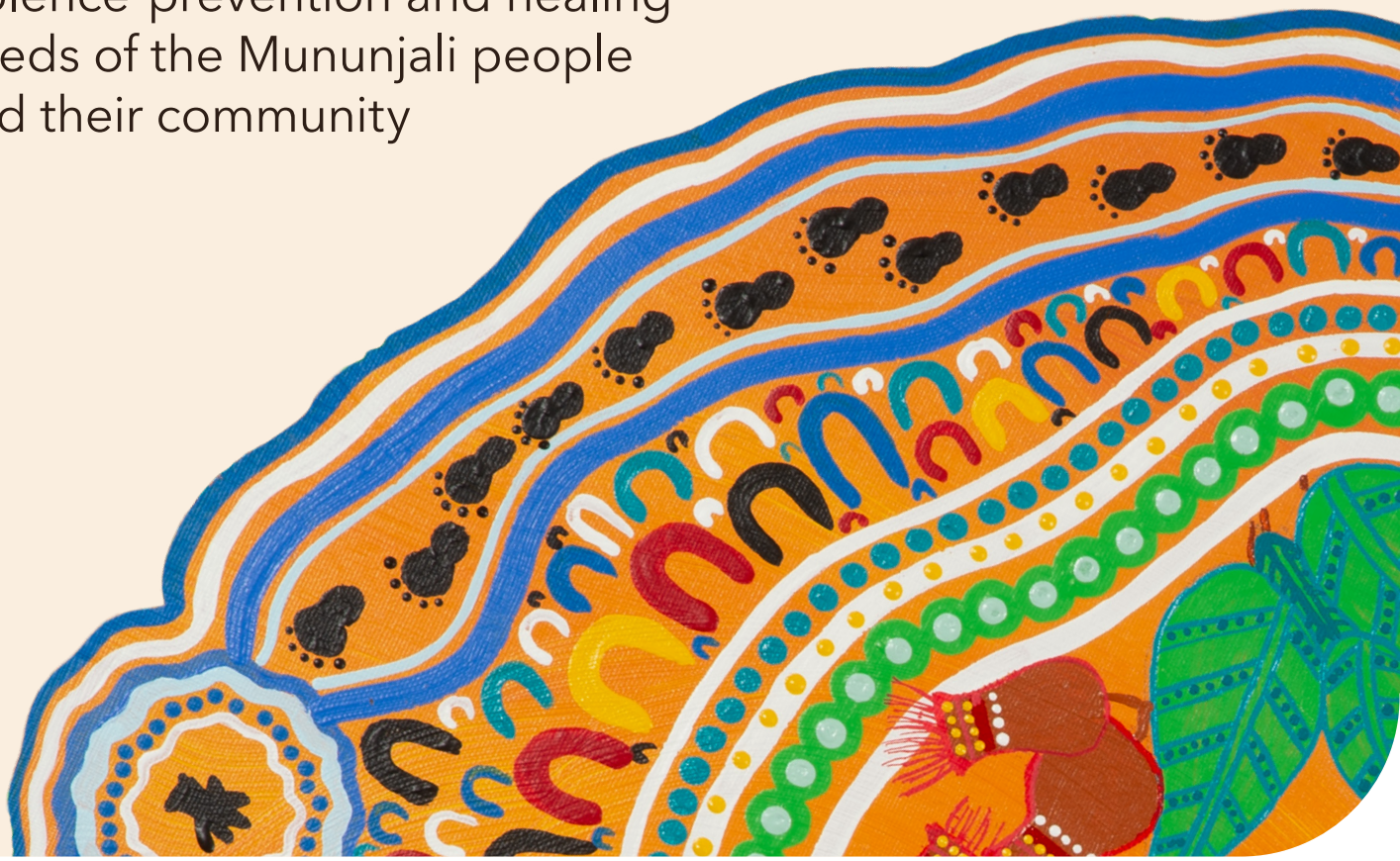
RESEARCH REPORT | ISSUE 02 | SEPTEMBER 2026

Healthy minds, healthy bodies, healthy relationships

A health service to address the violence-prevention and healing needs of the Mununjali people and their community



ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

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Acknowledgement of Country
ANROWS acknowledges the Traditional Custodians of the lands across Australia on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present, and we value Aboriginal and Torres Strait Islander histories, cultures and knowledge.

ANROWS recognises that domestic, family and sexual violence is not a part of First Nations cultures. There is a complex range of interrelated factors associated with the incidence and severity of domestic, family and sexual violence in Aboriginal and Torres Strait Islander communities across Australia. We must first develop a deeper understanding of the ways in which colonial oppression and violence are reproduced through modern structures and institutions. ANROWS strives to understand and play our part in addressing these injustices, including seeking to ensure that our research practices are guided by the Warawarni-gu Guma Statement.

Acknowledgement of lived experiences of violence
ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We would also like to thank the men who shared their stories as part of the community yarning for this report.

We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include 1800RESPECT (1800 737 732), Lifeline (13 11 14), Men's Referral Service (1300 766 491), MensLine Australia (1300 78 99 78) and, for Aboriginal and Torres Strait Islander people, 13YARN (13 92 76).

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Healthy minds, healthy bodies, healthy relationships

A health service to address the violence-prevention and healing needs of the Mununjali people and their community

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This report addresses work covered in the ANROWS research project *Healthy minds, healthy bodies, healthy relationships: A health service to address the violence-prevention and healing needs of the Mununjali people and their community*.

Please consult the ANROWS website for more information on this project.

ANROWS research contributes to the six National Outcomes of the National Plan to End Violence against Women and Children 2022–2032. This research addresses National Outcome 4 – People who choose to use violence are accountable for their actions and stop their violent, coercive and abusive behaviours.

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We pay respect to Elders past and present, and all of those who have provided wisdom, knowledge and guidance on this project. The Social Research Centre is committed to honouring First Nations people's ongoing and unique cultural and spiritual connections to the land, water and seas, and their rich contribution to society.

Special thanks to our community co-researchers:

- Kim Williams for her insight, wisdom, community ties and connections
- Aunty Fay Ward for her support, community ties and commitment to the project
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- Uncle Ian Skeen for his knowledge and community connections
- Uncle Colin Currie for his commitment and support.

The project would not have been completed without your knowledge and support.

The following powerful words were provided to us by a Mununjali community member at the knowledge-sharing workshop in February 2025. The project team feels that the words encapsulate many of the issues and insights the project sought to address:

> I want to acknowledge the Traditional Custodians of the land we gather on today, the Mununjali people, and pay my respects to Elders past and present. I extend that respect to all Aboriginal people here today.
>
> I stand before you as a proud Mununjali woman, deeply committed to the healing and wellbeing of our people. Today I want to talk about something that is not just necessary but urgent, the establishment of an Aboriginal medical centre in Beaudesert.
>
> Health care is not just about treating illnesses: it is about holistic wellbeing, physically, mentally, emotionally and spiritually. Our people often face barriers when accessing mainstream health care. Many of us do not feel culturally safe in those spaces. **We need medical services that understand our history, our generational traumas and our way of healing.** An Aboriginal health service in Beaudesert would ensure that our community has access to health care that respects our culture, our voices and our needs.
>
> The statistics do not lie: Aboriginal people continue to experience significantly poorer health outcomes than non-Indigenous Australians. Chronic disease such as diabetes, heart disease and mental health struggles are far too common. But behind these statistics there are real people: our Elders, our children and our families.
>
> Having a dedicated medical service will provide early intervention, preventative care and community-led health programs to "close the gap" and support long-term wellbeing.
>
> Health is more than just medicine. It is about our connection to community, country and culture. Aboriginal medical centres wouldn't just provide doctors and nurses, it might just encourage young jarjums [children] to become doctors and nurses. It would bring together traditional healing practices, mental health support and social services. It would be a safe space where our people can speak openly, be heard and receive care that acknowledges our identity and lived experiences. The centre would not only benefit our health, but it would also create opportunities for Aboriginal health workers, doctors and nurses, and community leaders.
>
> We need to also empower our people to lead and care for our own community and people. By establishing an Aboriginal medical centre in Beaudesert, we are taking control of our health and wellbeing. This is about self-determination, having a say in how our health services are run. We know what is best for our people, and we must be the ones shaping the future of our health care. Our health is our right, our culture is our strength, and our future depends on action. Together we can make this happen.

Artist	Kim Williams, contemporary and traditional Indigenous art, Beaudesert, Queensland
Footprints	as a community we are walking together on this new journey to help get a community hub/medical centre
Handprints	community putting their hand up to be part of the Mununjali Health Service's "Healthy minds, healthy bodies, healthy relationships" project
Half circles	our mob, First Nation peoples coming together
Small dots in a circle	community on the journey
Water and connection	bringing community together, growth and positive change, achieve goals and inspire positive change
Eagle/water hen	totem of Mununjali mob
Blue represents	trustworthy, peaceful, calmness, inspiration and creativity
Green represents	freshness, nature and life, growth and the cycle of life – hope
Green circles	symbolise a fresh start and new beginnings. Linked to healing and a sense of physical and emotional wellbeing.

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Acronyms

Acronym	Definition
ACCHO	Aboriginal community-controlled health organisation
AHLO	Aboriginal Health Liaison Officer
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
ANROWS	Australia's National Research Organisation for Women's Safety
CP	community participant
DFSV	domestic, family and sexual violence
GP	general practitioner
NACCHO	National Aboriginal Community Controlled Health Organisation
MHS	Mununjali Health Service
NEP	National Empowerment Project
NGO	non-government organisation
SRC	Social Research Centre

Executive summary

Background

The "Healthy minds, healthy bodies, healthy relationships" research project was initiated in response to significant gaps in the availability of culturally safe health services for Mununjali people and their community. The Mununjali people are the traditional owners living on Country in Beaudesert, South East Queensland. The Mununjali Health Service (MHS), in partnership with the Social Research Centre (SRC), led this community-driven research to address domestic, family and sexual violence (DFSV) for Mununjali people, and other First Nations people in the Beaudesert community, using a needs-based intervention developed through a culturally appropriate response.

Aim and objectives

The project aimed to understand the health profile of members of the Mununjali First Nations community who use violence, in order to develop a needs-based intervention for DFSV in Beaudesert. The findings may also be relevant to other First Nations communities outside major urban centres in Australia.

The objectives were to:

- develop a case study of the methods and tools used for designing a health response to DFSV, using best-practice, place-based participatory research approaches with a First Nations community
- produce an evidence-based, co-designed service model (including implementation guide and evaluation framework) for holistic, culturally appropriate health services in Beaudesert, Logan and surrounding regions
- build the capability of the MHS and demonstrate the need for further ongoing funding.

Methods

Key methods used for the project included:

- establishing a governance structure with Elders, community members and stakeholders
- recruiting and training community co-researchers
- 30 qualitative discussions, four workshops and in-depth yarns (interviews) with Elders, community members, men's groups and service providers
- a culturally adapted health-based survey of 105 community members aged 18 and over
- ongoing community engagement, feedback loops and knowledge translation activities.

The research used a community-led participatory action approach in all stages, including survey development, interpretation of findings, and development of the service model and evaluation framework. The research team co-designed a service model with the Mununjali community that centred on the three pillars of healthy minds, healthy bodies and healthy relationships.

Key findings

Community members argued that DFSV could not be adequately addressed without addressing intersecting social determinants of ill health. Accordingly, the findings are organised around these pillars, with consideration also given to other barriers and systemic issues faced by the community.

1. **The Mununjali community experiences a profound and multilayered mental health burden shaped by trauma, loss and historical injustices.**

   Mununjali community members who completed the survey reported high rates of diagnosed mental ill-health, including depression (44%) and anxiety (47%), alongside widespread lifetime trauma. This included physical abuse (57%), emotional abuse (66%), sexual abuse (31%) and significant recent bereavement (70%). These challenges are compounded by systemic and intergenerational harms, including negative interactions with authorities (42%), experiences

of forced removal (24%) and a Stolen Generations history (18%), all contributing to diminished social and emotional wellbeing.

2. **Comorbidities and physical health challenges are widespread and compounded by the shortcomings of local mainstream health services.**

   Two-thirds of survey participants reported at least one chronic health condition, while lifestyle-related risks were widespread. The survey demonstrated common comorbidity, such as alcohol and drug use, intergenerational trauma, mental illness and cognitive disabilities (which are both consequences and drivers of the social determinants of violence), and a service infrastructure that is failing to address these broad and pervasive needs of communities. The annual 715 health check – an important early-intervention tool for a range of social and health determinants – remains underutilised, with 64 per cent of community members not receiving a 715 health check in the past year, and appointments that were attended falling short of the recommended length.[1]

3. **Experiences of violence affect many community members, but there is readiness for change.**

   More than two thirds of survey participants reported experiencing, witnessing or using violence. Half reported being physically hurt by a partner who was angry and one quarter reported using physical violence against a current or former partner when angry. Participants in the interviews and workshops said there is reluctance to use the limited DFSV services that exist due to privacy concerns in a tight-knit community. Despite this, the community demonstrated a normative readiness for change, with widespread agreement among survey participants that violence is not justifiable and that more action needs to be taken to holistically deal with DFSV.

4. **Systemic barriers severely limit access to culturally safe, coordinated and reliable health care in Beaudesert.**

   Despite 65 per cent of survey participants preferring community-led services, only 26 per cent currently accessed Aboriginal medical services due to availability and transport limitations. Interview and workshop participants said there is widespread distrust of mainstream care due to disrespect, racism and poor listening. Access to specialists, counselling, allied health and culturally grounded pathways is inconsistent or absent.

5. **Despite significant adversity, the community demonstrates strong resilience, self-reliance and cultural strength.**

   Community members who were interviewed consistently described drawing on culture, their connection to Country and to family, and collective identity as sources of healing and stability. Most survey participants expressed high self-efficacy, with 89 per cent agreeing that "What happens to me in the future mostly depends on me" and 86 per cent agreeing "I can do just about anything I really set my mind to do" – signalling a powerful foundation for recovery, empowerment and community-led change.

The research demonstrates that despite a culturally safe health service being seen as a critical strategy for both preventing DFSV and healing from past trauma, the Mununjali people of Beaudesert have significant unmet health and support needs. This particularly relates to culturally safe health and mental health services. Additionally, there is a significant lack of health and DFSV services within Beaudesert. These factors compound the community's ability to adequately deal with ongoing intergenerational trauma and social determinants – leading to further mental ill health, chronic physical health conditions, and increased use and experiences of violence. Sense-making and co-design processes with community members underscored the urgent need for a health service based on a hub-and-spoke model, developed as a local, Aboriginal community-controlled health hub in Beaudesert, led by Mununjali Elders and grounded in holistic, trauma-informed care.

The project provides a model for best practice in participatory research and highlights the importance of self-determination, cultural safety and First Nations community leadership in service design and delivery.

[1] The "715 health check" refers to the Medicare bulk-billed item number used for an Aboriginal and Torres Strait Islander Health Assessment provided by a general practitioner.

Implications for policy and practice

Policymakers should:

- seek to fund and establish local Aboriginal community-controlled health hubs, with stepped implementation, and governed by Elders, to meet the specific needs of First Nations communities (such as Beaudesert) that do not already have access to an Aboriginal community-controlled health organisation
- ensure the health hub provides DFSV counselling and early intervention programs for community members who experience and/or use DFSV
- ensure the health hub provides wraparound support for healthy minds, bodies and relationships, including outreach, transport and integration with existing services
- embed trauma-informed, culturally safe and holistic care as core principles
- improve awareness and accessibility of services, including the annual government-funded health checks as part of the Closing the Gap strategy and mental health supports
- foster partnerships with existing mainstream health service providers, government agencies and other local Aboriginal community-controlled services in Beaudesert to ensure sustainable funding and integrated care
- adopt a "no wrong door" approach, enabling warm referrals and access to a range of health, legal and social supports.

Significance

This research provides a robust, community-driven evidence base for policy and practice, supporting the case for a local, culturally safe, and trauma-informed health hub in Beaudesert and other communities outside major urban centres with significant First Nations communities. It highlights the importance of self-determination, community leadership and holistic approaches to address the complex determinants of health and DFSV in First Nations communities.

Directions for future research

Future research should build on the strong foundations of this study by deepening understanding of the complex health, social, cultural and structural determinants that shape DFSV for Mununjali people and the Beaudesert community, and in First Nations communities elsewhere. There is a need for further investigation into how holistic, culturally grounded health responses, and the use of the 715 health check, can be strengthened as effective pathways for early intervention and prevention of DFSV, and support ongoing care. Additional research should also examine the capacity, implementation and long-term impact of a community-controlled health hub, including how culturally safe models of care improve access, trust, continuity of support and DFSV outcomes over time. Given the significant burden of trauma, chronic illness, substance use and service gaps identified, future work should explore interventions that address intergenerational trauma; strengthen cultural healing practices; and support men's, women's and young people's groups as key mechanisms for change.

Longitudinal, community-led evaluation will be essential to track progress, embed ongoing community governance, and ensure services remain responsive to local priorities and aspirations.

Chapter 1: Introduction

1.1 Study background

Under the 2023–2027 research grants round run by Australia's National Research Organisation for Women's Safety (ANROWS), the Mununjali Health Service (MHS) and the Social Research Centre (SRC) received funding to conduct a research project examining the health profile of people who use violence, to inform the development of a needs-based intervention to address domestic, family and sexual violence (DFSV) in the Beaudesert region of South East Queensland.

1.2 Research rationale

Ending DFSV in Australia is a national priority, with perpetrator accountability and intervention now a key policy and research focus. Existing efforts to understand, reduce and prevent DFSV centre on victim-survivors and are supported by a large body of research that focuses on the impacts of violence and the risk factors of victimisation (Flood et al., 2022). Nevertheless, as recognised by both the *National Plan to End Violence against Women and Children 2022–2032* and *The Australian National Research Agenda to End Violence against Women and Children (ANRA) 2023–2028*, there are fundamental evidence gaps pertaining to people who use violence and in Aboriginal and Torres Strait Islander communities (Department of Social Services [DSS], 2022a; Lloyd et al., 2023). Even within the small body of research on people who use DFSV, there is a greater focus on risk factors for perpetration than on understanding the protective factors to inform early interventions and diversions. It has long been recognised that a broader range of perpetration interventions are needed, with flexibility to address co-occurring issues such as mental health and alcohol and drug use (Chung et al., 2020).

The starting point for this piece of work is the *Aboriginal and Torres Strait Islander Action Plan 2023–2025*, which calls for solutions to DFSV that are "strength-based, trauma-informed, community-led, and inclusive of Aboriginal and Torres Strait Islander forms of language, healing, support, and education" (DSS, 2022b). The plan further notes that solutions need to be expanded to include those who use violence, with culturally appropriate responses to support healing as a form of prevention. Further, the growing literature around DFSV within First Nations communities renders it an issue not solely of gender inequity and harmful masculinity but, rather, a confluence of social, historical, political and cultural determinants (Gee et al., 2014). These are determinants that stem from colonisation, systemic disadvantage and cultural disruption, such as alcohol and drug use, intergenerational trauma, mental illness and cognitive disabilities. This has implications for future research and responses to DFSV, including a greater focus on a health response in prevention and intervention.

To address the underlying complexities contributing to the perpetration of violence, and to cultivate internal perpetrator accountability, research to date has recommended a health response to DFSV in First Nations communities, among other measures (Australian Institute of Criminology, 2003; Langton et al., 2020).

The *Closing the Gap: Commonwealth Annual Report 2025 and Commonwealth Implementation Plan 2026* (Commonwealth of Australia, 2026) also continues to prioritise improved health outcomes for First Nations peoples. The Closing the Gap strategy promotes decision-making with First Nations people through partnerships, co-design and culturally appropriate approaches; First Nations-led research; and transferring service delivery to Aboriginal community-controlled organisations. Further information about the alignment of research recommendations with existing government commitments can be found in Chapter 4: Discussion, implementation and recommendations.

The research team conducted an extensive literature review (see Appendix A) which further outlines the evidence base for this work. The review indicated that there is clear scope for human services agencies with a focus on mental, social and physical health and wellbeing to become critical intervention points

for people who use DFSV, as well as for affected communities more broadly.

Additional key insights from the literature review which informed the research design and scope include the following:

- **Unique challenges to addressing DFSV in First Nations communities:** Smaller communities involve distinct risk factors and barriers to help-seeking (e.g. fear of being identified within their community, systemic discrimination when accessing mainstream services, fear of legal repercussions and/or child removal). These challenges required a more culturally sensitive approach when engaging with community and speaking about DFSV (Gallant et al., 2017).
- **The link between poor health outcomes and DFSV:** Poor physical and mental health, including neurological conditions and substance use, are associated with increased likelihood and severity of DFSV perpetration. Both the Aboriginal and Torres Strait Islander Action Plan and the literature reviewed recommend an integrated, multi-faceted solution to DFSV which addresses health outcomes as well as other factors related to perpetration (Langdon et al., 2020).
- **Complex contributing factors:** DFSV in First Nations communities is influenced by complex determinants including social, historical, political and cultural factors related to colonisation, systemic disadvantage and intergenerational trauma. These factors need to be considered when working with First Nations communities (Australian Institute of Criminology, 2003).
- **A culturally appropriate health response:** Effective public health responses to DFSV are required to address the social determinants of DFSV. Regarding First Nations communities, the health response must also be community-led, healing-focused and culturally safe for it to be effective (Tayton et al., 2014).
- **A rights-based approach is essential:** A health response to DFSV within First Nations communities must be underpinned by a human rights approach and aligned with First Nations principles of self-determination, the right to participate, equality and accountability. Recognising Indigenous culture and intellectual property is also required to ensure First Nations people maintain control over their culture and protect all aspects of it (Bustreo & Doebbler, 2021).

1.3 Research aim and objectives

The overarching aim of this project was to understand the health profile of people who use violence to develop a needs-based intervention to addressing DFSV in the Beaudesert region of South East Queensland. Activities were designed to:

- develop a case study of the methods and tools used for designing a health response to DFSV, utilising best practice, place-based and participatory research approaches with a First Nations community
- produce an evidence-based, co-designed service model (including implementation guide and evaluation framework) for holistic, culturally appropriate health services in Beaudesert, Logan and surrounding regions
- build the capacity of the MHS and demonstrate the need for further ongoing funding.

1.4 Contextual background

Mununjali people

Beaudesert and parts of the Logan region are part of the traditional lands of the Mununjali people. The Yugambeh word "Mununjali" is derived from "Munun" (black or burnt earth), referring to the rich, fertile, volcanic black soil of the mid–Logan River valley region, and "Jali" (people), meaning "burnt earth people". Tribal boundaries are said to have extended east to the Birnam Range, north to Jimboomba, south to Tamrookum and west to the Teviot Brook. Mununjali is one of nine clans in the Yugambeh language group. The Mununjali people spoke a special form of the Yugambeh language and still use hundreds of its words today (Australian Institute of Aboriginal and Torres Strait Islander Studies, n.d.).

In 1968, Margaret Sharpe, an academic, wrote down many words and grammar rules from Joe Culham, the son of Coolum, who was known as the "King of the Mununjali" (Sharpe, 1997). Later, in 1978, a Swedish language expert named Nils Holmer created a dictionary and grammar from Mununjali people.

These records help us understand their language and show that the Mununjali spoke a similar language to their neighbours, like the Wanggeriburra clan (Wikipedia, 2025).

Mununjali people are passionate about rugby league and proud of their sporting heroes such as Ashley Taylor, Germaine Paulson and Jamal Fogarty. They have made significant contributions to the arts with Ellen van Neerven, award-winning writer and poet; Chelsea Watego, academic and writer; and Wayne Blair, actor, writer and director. Stephen Page of Nunukul and Mununjali decent was the highly acclaimed creative director of the Bangarra Dance Theatre.

Beaudesert

Beaudesert is a rural town in the Scenic Rim Region of Queensland, located approximately 70 km south of Brisbane and 60 km west of the Gold Coast. It is in the Brisbane South Public Health Network (PHN), the state electorate of Scenic Rim and the federal electorate of Wright (Scenic Rim Regional Council [SRRC], 2025). As of May 2025, the town and surrounding area have a population of around 16,475, up from 14,646 in the 2021 Census – a growth of 12 per cent that has been driven in part by residential development in and around the central township (Area Search, n.d.; SRRC, 2025).

Employment in Beaudesert is concentrated in health care and social assistance, construction, and education and training (Australian Bureau of Statistics, n.d.). Population growth in the area has been ongoing in more recent years, with several residential developments being built close to and just outside the central township (SRRC, 2025).

Approximately 3.7 per cent of residents identify as Aboriginal or Torres Strait Islander. The area has a higher proportion of First Nations residents aged under 14 years or over 65 years (42.7%) compared with the rest of the state (35.6%), indicating a greater need for tailored social and emotional wellbeing supports in the community (Queensland Government Statistician's Office [QGSO], 2025).

Anecdotal feedback from the local community indicates that Beaudesert's service landscape is not keeping up with population growth, underscoring the need for planning and investment to meet the community's evolving needs.

A "service desert"

While rich in culture and community connection, Beaudesert is perceived by locals and service providers as a "service desert". This is partly due to a lack of adequately funded local services and programs; a shortage of service providers with an ongoing presence in Beaudesert; and barriers to service access, such as limited transport to travel to referrals and more specialised medical and health services in the surrounding regions. These barriers manifest across the community and result in a breakdown of individual physical, mental, spiritual and emotional health.

Mainstream health care services

Beaudesert operates a rural hospital, employing around 150 staff. It offers services to adults and children including emergency, maternity, Indigenous health, dental, drug and alcohol, mental health, minor surgery and palliative care services. For major health concerns and management of long-term chronic health conditions, community members are transferred or referred to the larger Logan and Brisbane hospitals and specialist services (SRRC, 2025). Beaudesert residents can access a range of medical transport services depending on eligibility (Scenic Rim Transport, 2025); however, several of these services require travel to outer Logan or Brisbane, 40 to 60 km away. First Nations community members are eligible to access the Mob Link First Nations medical transport service; however, they must first travel to Jimboomba, a 20- to 30-minute drive from Beaudesert.

First Nations health care services

While there are general health services offered across Beaudesert (see Appendix B), there is a dearth of First Nations culturally specific or specialised services. The nearest Aboriginal community-controlled health organisation (ACCHO) and Aboriginal medical service are located 40 minutes away by car, for those with access to personal transport (PHN Brisbane South, 2024). Public transport greatly extends the time taken to reach these services; medical appointments at ACCHOs or at an Aboriginal medical service in the local region require travel by personal vehicle or public transport, with travel times varying from 1 to 3 hours depending on the location. For Elders and community members who are unwell, extended public transport journeys are not a viable option.

Public transport

Public transport connectivity is restricted to several weekday services to Brisbane, Logan and surrounding areas; intermittent weekend bus services commenced in the past 12 months (SRRC, 2025). There are limited internal public transport options available in Beaudesert. The only hire car service (the Green Frog) offers a flat fee of $10 per trip regardless of the time or distance (kilometres) travelled. This service is in high demand and during peak periods consumers may face long wait times. Other transport options include the Mununjali Housing and Development Company, a local service provider which offers limited local and regional transport for Elders and community members. Access to this service is restricted to individuals with a national Home Care Package (funded through the Australian Government Department of Health, Disability and Ageing). These packages have travel costs and reimbursements built into individual plans.

Systemic neglect

Following the publicised violence that occurred in Logan in 2013, significant government funding was directed toward community and child-focused projects, including Logan Together, to address underlying issues of disadvantage and to improve social wellbeing (Logan Together, n.d.). The funding aimed to break cycles of disadvantage by supporting young children and their families through a range of services and programs. While funding may have had scope for broader geographical coverage, services mostly concentrated their efforts in Logan, leaving the Beaudesert community feeling under-serviced and neglected.

There is no direct evidence that funding the Logan Together Initiative deprived other communities; however, debates around "place-based initiatives" involve questions about whether resources directed to one area could be used elsewhere. Proponents of the Logan Initiative argue that it provided targeted support to a specific, disadvantaged community and led to positive outcomes like lower unemployment, better integration of child and family services, and improved literacy rates (Logan Together, n.d.).

Despite Beaudesert falling within several regionally funded service areas, services are primarily delivered in neighbouring urban centres such as Logan, the Gold Coast, Brisbane, Inala and Browns Plains. Despite external organisations receiving funding to provide services and programs for the Beaudesert region, many of these services remain disconnected and invisible to the local community.

Mununjali Health Service

The establishment of the MHS in 2021 was inspired by community feedback and supported by data gathered from surveys conducted in 2019 by the Queensland Department of Justice and Attorney-General with the Beaudesert, Mununjali and First Nations communities. MHS focuses on Aboriginal and Torres Strait Islander advocacy, research and training within the health field.

The MHS Board wanted to further investigate health issues across the community and to develop a health response to addressing DFSV. As an independent Indigenous organisation, it is important for MHS to have a strong evidence base to support the design of its future health services. MHS saw the ANROWS 2023–2027 research grants round and this research project as an opportunity to undertake robust research to inform activities that would make a vital difference in the community.

More importantly, MHS saw an opportunity to embed First Nations–led research through cultural perspectives and community participation and to maintain data sovereignty by conducting the research in and with the Mununjali community.

Chapter 2: Methods

2.1 Study design and methodology

The study design and methodology for this research were developed through a community-led participatory approach grounded in cultural safety and First Nations self-determination. Guided by partnership with the MHS Board and local Elders, the research combined qualitative and quantitative methods to explore the health determinants linked to DFSV and co-design an appropriate health-based response. The methodology emphasised co-production, collaborative sense-making and iterative refinement, ensuring that the research tools, processes and outcomes reflected community priorities, cultural knowledge and lived experience.

The scope of this project was governed by the following key research questions:

1. To what extent are risk factors for poor health present in the profile of people who use DFSV and the communities where it is more prevalent?
2. What is the feasibility of developing a health-based response as a form of primary prevention of DFSV?
3. To assist in understanding the efficacy of a community-owned health response to DFSV:
    a. What are the protective and risk factors that could inform such a response, within the context of a First Nations community?
    b. What type of ongoing evaluation is required to measure this response?
    c. How would such a response be effectively evaluated?

2.2 Research stages

The study used mixed methods, including key informant interviews (and yarning), survey and community consultation, knowledge-sharing and validation workshops. The project comprised six iterative stages, which are unpacked further in Table 1:

- **Phase 1:** Establishment and community consent process
- **Phase 2:** Discovery, literature review and ethics application
- **Phase 3:** Recruitment of community co-researchers, knowledge-sharing and development, community briefings, survey development and refinement, and interview question development
- **Phase 4:** Ethics amendment, survey deployment and qualitative interviews (in-depth yarns)
- **Phase 5:** Sense-making/checking of quantitative and qualitative data and collaborative co-design of a needs-based health response with community representatives
- **Phase 6:** Draft evaluation framework development, reporting and knowledge translation activities.

Security practices used in the study

Information security practices employed by the SRC during all of our projects include:

- physical security (storage of confidential information in locked cabinets/in locked rooms)
- use of strong password protection for all information technology and information assets
- limited access to information (i.e. access limited to the project team and other agreed persons on a "need to know" basis)
- de-identification of the data at the agreed completion of the project
- system cleansing at the conclusion of the project
- cross-cut shredders to destroy in-confidence material
- storing all sensitive information (e.g. the names and contact details of selections) on segregated and encrypted server drives where backups are overwritten every 30 days.

The SRC de-identifies any personal information as soon as is reasonably practicable and as soon as that information is no longer relevant or required in identifiable format for the primary purpose of conducting the research according to the research brief provided by clients. Any files related to projects are deleted pursuant to obligations under the Australian Privacy Principles.

Table 1 Overview of research activities

Phase	Activity	Method/mode	Participants	Research question relevance
Phase 1: Establishment and community consent process (June 2024)	Community consent process	Inception meeting – in person (3 hours)	Elders and members of the Beaudesert and Logan communities	N/A
Phase 2: Discovery, literature review and ethics application (August – October 2024)	Literature review	Desktop	N/A	Questions 1, 2 and 3 (a, b, c)
	Development and submission of research protocol and ethical consideration to AIATSIS	Desktop	N/A	N/A
Phase 3: Recruitment of community co-researchers, knowledge-sharing and development, community briefings, survey development and refinement, and interview question development (February – May 2025)	Recruitment and training of community co-researchers	Online/in person	Beaudesert and Logan community members (*n = 4*)	N/A
	Key informant yarning	In person (45–60 minutes)	Beaudesert and Logan community members, Elders, NGO representatives (*n = 6*)	Questions 1, 3 (a, b)
	Knowledge-sharing community workshop	In person (3–4 hours)	Elders, community members, NGO representatives (*n = 20*)	N/A
	Sense-making community workshop/ review of survey draft and survey development	In person (2 hours)	Elders, community members (*n = 5*)	N/A
	Survey development and refinement	Email	Community co-researchers (*n = 2*)	N/A
Phase 4: Ethics amendment, survey deployment, and qualitative interviews (in-depth yarns) (May – August 2025)	Survey deployment	In person and by email link, QR code and personal mobile (30–45 minutes)	Beaudesert and Logan community members (*n = 105*)	Question 1
	Community interviews (yarning)	In-depth yarning (40–60 minutes)	Elders, women, men, young people, victim-survivors and community members who work in local NGO services (*n = 30*)	Questions 1, 3 (a, b)
Phase 5: Community consultation and co-design of health response (August – October 2025)	Sense-making, data analysis and early insights workshop	Face to face (4 hours)	Community members, Elders and NGO representatives (*n = 10*)	Questions 1, 2, 3 (a, b, c)
Phase 6: Develop evaluation framework, reporting and knowledge translation activities (October 2025)	Proposed service model workshop and evaluation framework development	Face to face (4 hours)	Elders, community members, NGO representatives (*n = 8*)	Questions 2, 3 (a, b, c)

Phase 1: Establishment and community consent process

Phase 1 focused on building the foundations of the project through early engagement with Elders and community members to establish trust, secure community consent and clarify expectations. This stage centred on relationship-building and ensuring that the research approach aligned with local cultural protocols and priorities. These initial conversations created the groundwork for a collaborative, community-driven process that guided all subsequent phases.

Community Elders and key community representatives were invited to an informal gathering at a local community member's home in mid-June 2024. MHS Board members were responsible for inviting Elders and community members through phone calls, texts and face-to-face invites. Due to Beaudesert being a small rural community, it was easy for Board members to identify the community Elders and those they needed to invite to obtain consent for the project. Lunch and refreshments were provided. Researchers who attended this gathering provided spoken and written information about the research project, in addition to having more extensive conversations with Elders.

Core decisions and outcomes included:

- awareness that understanding the health profile of people who use violence required a holistic and integrated research focus on a range of determinants that may lead or contribute to violence
- agreement that a project purely focused on DFSV would risk alienating the community, given harmful stereotyping experienced by the community, concerns about intersecting physical and mental health, social issues seen as inseparable from DFSV, and an awareness of low engagement with DFSV-specific services
- the inception, validation and socialisation of the broad "healthy minds, healthy bodies, healthy relationships" framework underpinning the project (tying to the Social and Emotional Wellbeing Framework[2]).

Phase 2: Discovery, literature review and ethics application

Phase 2 involved deepening the evidence base through a comprehensive literature review of 39 documents sourced through Google Scholar, academic databases, government agencies, journals and papers. The review reinforced the rationale for a community-led, needs-based health response to DFSV – namely, one that was "strength-based, trauma-informed, community-led and inclusive of Aboriginal and Torres Strait Islander forms of language, healing, support and education" and that included "those who use violence, with culturally appropriate responses utilised to support healing as a form of prevention" (DSS, 2022b).

Phase 2 also marked the beginning of the ethics approval process. The SRC requested approval from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) to ensure that the methodology and research tools were grounded in First Nations research principles and a commitment to cultural safety (AIATSIS, 2020). Given that research tools were to be iteratively designed with community participants, the initial ethics application involved developing a research protocol, community consent and approval, while flagging future amendments would be made once the project reached the stage of tool design.

Phase 3: Recruitment of community co-researchers, knowledge-sharing and development, community briefings, and survey development and refinement

Recruitment of community co-researchers

Upon receipt of ethics approval (AIATSIS REC reference number: REC-0393) the project engaged two First Nations co-researchers plus two Mununjali community co-researchers to lead and support project activities. In recognition of their contributions, cultural knowledge and networks, community co-researchers were remunerated through grant funds.

First Nations co-researchers were recruited through an expression of interest process (see Appendix C), which requested contact details, connection to

[2] The Social and Emotional Wellbeing (SEWB) framework was developed out of the National Aboriginal Health Strategy Working Party (1989) and *Ways Forward* (Swan & Raphael, 1995) reports.

community, interest in the project and previous experience in research or community work. Both co-researchers had extensive experience in community engagement and liaison. They were employed on casual contracts and received induction, training and ongoing support from the SRC project manager.

Mununjali community co-researchers were engaged to support the survey deployment and participation phases. They were also casually employed and received SRC induction and training from the project manager to conduct surveys with community members. Co-researchers were not engaged in in-depth interviews or yarns to maintain participant privacy and confidentiality. No prior research experience was necessary; their main role was to use their established community ties to support and promote the project across the two communities. The community working group assisted with their selection.

Knowledge-sharing and development

Following the recruitment of community co-researchers, the project team undertook six key-informant yarns with Beaudesert and Logan community members, Elders and NGO representatives. While researchers took comprehensive notes, these conversations were informal and not audio-recorded. Their primary purpose was to build a stronger understanding of the service landscape and the problems faced in the community to guide preliminary research tool development. No verbatim data from these interviews is presented in this report.

The SRC then facilitated a participatory knowledge-sharing workshop engaging 20 Elders, community members and NGO representatives. This workshop further unpacked critical issues faced by the Mununjali community and was used to develop the health domains in the survey questions and themes in the discussion guide. SRC staff conducted further work on the survey to align the key issues identified by the community with the SEWB framework domains (discussed above). Researchers also reviewed First Nations health survey data (e.g. from the National Aboriginal and Torres Strait Islander Health Survey) to align culturally appropriate questions with each of the healthy mind, body and relationship domains.

Community briefings and survey development and refinement

After this session, the project team developed first drafts of both the survey questionnaire and the discussion guide. These were validated and refined through a face-to-face sense-making community workshop (*n = 20*) and finalised in collaboration with the community co-researchers. This workshop was also used to determine survey recruitment strategies and ideal modes of deployment across the community.

SRC researchers and community co-researchers tested the surveys both internally and externally before finalisation. Due to project timeframes, this was the only testing conducted prior to deployment. Once finalised, these tools and all other key participant-facing documents (such as participant information and consent forms) were submitted to AIATSIS for final review and approval.

Phase 4: Ethics amendment, survey deployment and qualitative community interviews (in-depth yarns)

Ethics amendment

In Phase 4, following feedback from AIATSIS, the project team finalised the research instrumentation ahead of the primary research activities.

Mununjali Elders, community members, NGO representatives, young people (aged over 18 years) and other First Nations people of the Beaudesert community were the target population for research activities. The inclusion and exclusion criteria for both quantitative and qualitative activities are depicted in Table 2.

Table 2 Inclusion and exclusion criteria for quantitative and qualitative activities

Inclusion criteria	Exclusion criteria
• Elders • First Nations members of the Beaudesert and Logan regions • Mununjali community members • NGO service providers and community support groups – including men's group members • Community members aged over 18 years	• Children and young people aged under 18 years • Community members not connected to the Beaudesert, Logan or Mununjali communities

Adopting a place-based approach to data collection allowed the research to be inclusive and flexible, and to effectively engage stakeholders. The design phase included a range of data collection activities and processes to enable community members to participate in consultations in ways that suited their interests and capacity. These activities included participatory workshops, in-depth interviews and yarning groups.

Survey deployment

Established MHS networks were used throughout all engagement and consultation phases, as well as other communications (text, phone call, pamphlet drops), community briefings and meetings with stakeholders to garner interest and participation in fieldwork. Many of the survey participants were informed about the research and encouraged to participate by Elders, family or community members using a snowball sampling technique.

The survey was conducted from Friday 27 June to Friday 8 August 2025. It was administered electronically via a Qualtrics web-based survey platform and took participants 30 to 45 minutes to complete. Researchers and community co-researchers conducted "survey day" events at the local Mununjali community hall in Beaudesert, attended the Beaudesert and Logan NAIDOC week celebrations, and visited Elders and community members in their homes to conduct the surveys. In total, 105 surveys were completed, with survey days and key community events resulting in the most completed surveys.

MHS project staff and community co-researchers supported participants where needed, including assistance for literacy or numeracy concerns. All participants who completed the survey received a $25 GiftPay card, funded via the project.

Quantitative methods

The culturally derived health-based survey first assessed a range of general health measures, followed by sections designed to provide a greater understanding of the current health of the community and the health determinants of DFSV perpetration. A range of questions were included to more deeply understand the current mental, physical, emotional and spiritual landscape of the community. The survey sections and the overarching topic in each section are detailed in Table 3.

Table 3 Survey sections

Survey section	Topics covered
Demographics and general health	Connections to Country and land
Healthy minds	Psychosocial conditions
	Traditional healing
	Grief, loss, resilience and trauma events
	Use of mental health care services
Healthy bodies	Self-assessed health
	Chronic conditions
	Health risk factors
	Healthy behaviour (drugs, alcohol, smoking)
	Maternal health
Healthy relationships	Use and experiences of violence
	Perpetration of violence
	Community attitudes towards violence
	Connection to community

Table 3 [cont.]

Survey section	Topics covered
Experience of health care services	Use of and access to health services
	Experiences of discrimination and racism when accessing health services
	Closing the Gap – annual 715 health check
	Access, availability and affordability of transport to health care services
	Discrimination and racism within the health service system
	Cultural capability of service system

This phase generated the quantitative dataset that would underpin the key findings about health determinants related to the perpetration of DFSV across the community.

Qualitative methods (in-depth yarns)

Qualitative interviews or in-depth yarns occurred simultaneously with the survey period. A yarn is a culturally grounded conversational approach led by First Nations peoples' ways of sharing. It differs from an interview by prioritising relationship-building, trust and open storytelling rather than a structured question-and-answer format.

The project team conducted 30 in-depth yarns with community members. Community members were informed via community networking and flyers that they could take part in both the survey and in-depth yarning components of the research. On completion of a survey (in most cases participants received support from either a researcher or a community co-researcher to complete the survey), the participant was informed of and invited to participate in an in-depth yarn. All the in-depth yarns occurred immediately after completion of a project survey.

If a participant agreed to an in-depth yarn, they received a participant information sheet and signed a consent form. The in-depth yarns were conducted in private spaces with only the researcher and participant present. These yarns were recorded, transcribed and thematically analysed. No in-depth yarns occurred during the public events. Participants who completed surveys at the public events did not wish to participate in an in-depth yarn and researchers believe this was due to the noise and lack of a private space in which to conduct the interview.

The discussion guide and questions to facilitate the in-depth yarns are included in Appendix D. The questions included those relating to:

- personal health stories
- experiences of trauma and violence in personal (previous and current) relationships
- perpetration of violence
- challenges and barriers to accessing DFSV support and cultural health services
- understanding community perceptions about the use and experience of DFSV within a First Nations community
- improving access to culturally safe health care services.

Phase 5: Community consultation and co-design of health response

Community consultation

Phase 5 focused on collaboratively analysing and validating preliminary findings from the quantitative and qualitative research activities through a sense-making workshop which engaged Elders, community members and service providers. This process involved translating the topline quantitative results into pie charts and easy-to-read graphs. These were printed on A3 sheets and shared with each participant at the sense-making workshop. Researchers worked through each of the key results, charts and figures to ensure community members were able to understand the results. Researchers then verbally checked with attendees/community members to see if they felt that the results echoed what they knew about their community. De-identified qualitative statements and quotes were also shared at the sense-making workshop to help bring to life the quantitative results. This process ensured that emerging insights remained culturally grounded in community experience. See Table 4 for a summary of the sense-making workshop.

Table 4 Summary of phase 5 community sense-making workshop

27 August 2025	
Purpose	To provide community members with early insights into the quantitative and qualitative data gathered
Attendees	Elders, community representatives and service providers
Key discussion outputs	The Mununjali community's current health: high levels of trauma, loss, grief, DFSV, substance use, food insecurity, homelessness (revealed through survey)
	Low-level participation in the annual 715 health checks (especially for men)
	The need for a culturally safe, needs-based response to address the social determinants present in the community (DFSV lens)

Co-design of health response

This session was also used to unpack, discuss and co-design a culturally sensitive, needs-based intervention or response to DFSV within the Mununjali and Beaudesert community. Workshop participants discussed the need for a model of care which could best address the issues that had emerged from the qualitative and quantitative data. Different options were discussed at the workshop (discussed in Chapter 3: Detailed findings).

Table 5 Summary of phase 5 community co-design workshop

24 September 2025	
Purpose	Community discussion and co-design of a needs-based response to DFSV
Attendees	Mununjali Elders, community representatives and NGO service providers
Key discussion outputs	DFSV and its links to health
	Men's mental health and the link to DFSV
	The lack of culturally appropriate DFSV services in Beaudesert and the need for them given the high rates of violence indicated in survey responses
	Healthy minds, healthy bodies, healthy relationships – which domains should be the initial focus of the response
	Community agreement that to address the social determinants of DFSV, a holistic understanding of the individual is required; community discussion and agreement that the 715 health check could provide a holistic, culturally safe approach to address current social determinants, and as a vehicle for intervention and prevention of DFSV

Phase 6: Develop evaluation framework, reporting and knowledge translation activities

The final phase of the project comprised the finalisation of the proposed service model and the design of a preliminary evaluation framework, which was then validated through a final community workshop (engaging eight community representatives).

Community workshops and participant feedback guided the refinement of the evaluation framework, indicators, implementation steps and proposed strategies for the development of a sustainable service model. This phase ensured that the emerging model of care was both actionable and aligned with community aspirations and needs, while building capacity for ongoing evaluation and long-term service development.

2.3 Ethical considerations

Community engagement principles and responsibilities

Based on knowledge-sharing with the Mununjali community and the literature review conducted as part of phase 2, the project team developed an engagement and recruitment strategy with a culturally safe approach to community and individual consultation.

All individual and community engagement components of this work were designed to:

- prioritise cultural safety and First Nations self-determination
- be trauma-informed, aligned with the six principles of the Substance Abuse and Mental Health Services Administration (SAMHSA; Center for Disease Control and Prevention, n.d.)
- involve co-production and participatory methods
- align with a place-based approach
- involve community members as community co-researchers.

This project was informed by the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2018) and prioritised the adoption of the highest degree of cultural safety. Team members reflected on personal cultural positioning while acknowledging the impacts of colonial history and dispossession. The project team's engagement approach also strongly aligned with the 10 principles of culturally safe evaluation in the Australian Evaluation Society's First Nations Cultural Safety Framework (Gollan & Stacey, 2021).

Sustainability and accountability

Indigenous lands and waters

The MHS upheld the sustainability of Country and culture and supported social and economic outcomes. The project was undertaken within community using a place-based approach, with minimal impact on the local and surrounding areas. Our aim was to listen and engage in a culturally sensitive way to understand and describe the current situation with the intent of informing future needs.

Indigenous sponsorship

The MHS Board supported this research as funded by ANROWS. Elders and other key Mununjali community groups encouraged MHS to undertake community research to guide the development of a needs-based response to DFSV. The MHS is well placed to contribute to the prevention of DFSV and the promotion of healing within their community.

Cultural training for non–First Nations project team members

To ensure cultural respect and safety of all participants, all non–First Nations researchers acknowledged the need to engage in cultural awareness and critical self-reflection. Strategies to support this included:

- immersion in the Mununjali community and engagement with the MHS Board to support local ownership of the research and grounding in the local community and environment
- using natural community networks to socialise the research, considering community reciprocity and how the research insights would be shared with communities

- partnering with Mununjali community members in coordinating different phases of the project to ensure adherence to cultural protocols and needs (e.g. organisation of consultation sites)
- deployment of feedback loops so community members could see how their contribution is meaningful and to provide participants with the opportunity to engage outside the consultation setting
- providing gratitude payments to communicate respect and compensate for time and insights, which is standard practice in social research and recommended by The Research Society (Gregory, 2023).

Data storage and information management

It is the policy of the SRC to ensure:

- information is protected against unauthorised access
- confidentiality of information is maintained
- information is not disclosed to unauthorised persons through deliberate or careless action
- integrity of information is maintained through protection from unauthorised modification
- information is available to authorised users when needed
- all project staff complete information security awareness training
- all suspected breaches of information security are reported and investigated.

All individuals dealing with information at the SRC, no matter what their status (e.g. employee, contractor or consultant), must comply with the organisation's information security requirements, policies and related information security documents.

Since April 2020, the SRC has hosted all web applications and data collection platforms on Amazon Web Services (AWS) in Sydney, a cloud server which is certified by the Australian Signals Directorate on the Certified Cloud Services List. Information technology infrastructure and systems are hosted within secure server rooms at our office location in Queen Street, Melbourne.

The SRC's data storage and management procedures were approved as part of the AIATSIS ethics approval process (AIATSIS REC reference number: REC-0393).

Chapter 3: Detailed findings

This section presents the findings derived from initial community consultations, key informant interviews, the participant survey and in-depth yarns.

Our analysis indicates a pressing need to incorporate DFSV prevention and intervention initiatives within a comprehensive service and response framework that addresses the physical and mental health and cultural needs of the Beaudesert community.

The current social service infrastructure in Beaudesert has significant limitations. These are compounded by historic systemic violence and ongoing neglect, limiting the social service infrastructure's ability to address the community's holistic health and wellbeing needs. These shortcomings contribute to the increased likelihood of DFSV and complicate the establishment of prevention and intervention strategies.

Considering the influence of social, historical, political and cultural determinants – arising from colonisation, systemic disadvantage and cultural disruption – the data presented in this chapter highlights the importance of adopting a more inclusive, culturally responsive and community-driven approach to DFSV prevention and intervention, embedded in a broader service infrastructure.

In alignment with the holistic healthy minds, healthy bodies, healthy relationships approach developed with the community at the start of this project, the findings are organised into the following subsections:

- **healthy minds** (experiences of mental health, spiritual and cultural health, traumatic life experiences, accessing mental health services)
- **healthy bodies** (physical health, substance use, access to health services and health-seeking behaviours)
- **healthy relationships** (experiences of and attitudes towards violence, types of violence)
- **engagement with services and service infrastructure** (715 health check, perceptions and experiences with services, transport, community service landscape).

3.1 Healthy minds

This section presents findings from survey and qualitative data on the Mununjali people's experiences and needs related to healthy minds. These include mental (ill) health, spiritual and cultural wellbeing, traumatic life experiences and willingness to access mental health services. Understanding this mental health landscape is critical in examining the nature and dynamics of DFSV and identifying potential solutions. If we do not understand people's mindsets, demotivators and individual traumas, we are unable to design appropriate services or understand how/if they will function and support the needs of the community.

Key takeaways

Mununjali people in the Beaudesert community suffer from a serious and complex mental health burden

Mununjali community members reported widespread diagnoses of depression, anxiety, mood disorders and other mental health conditions, with nearly half of surveyed individuals reporting a formal depression diagnosis (44%) and/or anxiety diagnosis (47%).

High rates of exposure to various personal traumas and grief exist across the lifespan, which contribute to and compound poor mental health outcomes

More than half of survey respondents reported experiencing physical abuse (57%) and emotional abuse (66%) across their lifetime, while 31 per cent reported experiencing sexual abuse. Meanwhile, 70 per cent reported experiencing deaths of family and/or friends in the past year, and 36 per cent reported witnessing suicide or an unexpected death in their lifetime.

The collective trauma of historic and ongoing systemic violence, oppression and discrimination contributes to pervasive feelings of hopelessness and diminished social and emotional wellbeing

42 per cent of survey respondents reported having had at least one negative experience with police or government officials, 24 per cent reported a history of being adopted or fostered out, 18 per cent are part of the Stolen Generations, and community members reported grievances around the destruction and oppression of language and culture.

There is a reluctant reliance on "available" rather than preferred services, underscoring gaps in access to culturally safe, community-led mental health care

Despite clear need, only a small proportion of surveyed community members accessed mental health supports in the past year, reflecting barriers related to cost, availability, trust and cultural safety. There is a clear demand for community-led, culturally appropriate mental health services.

Diagnosed mental (ill) health conditions

Data pertaining to diagnosed mental health conditions within the community also underscores the importance of developing DFSV responses that factor in a healthy minds approach. Nearly half of survey participants reported a personal diagnosis of depression or anxiety, with roughly 1 in 5 reporting similar diagnoses in family members under the age of 18 (Table 6). Over a quarter of survey participants also reported a family member over the age of 18 having a schizoid disorder, while more than one third reported a family member over the age of 18 having a mood disorder.

Considering the widespread experiences of trauma documented in the community, high rates of depression and anxiety are unsurprising. It is clear that any health-based response to address DFSV will need to factor in these complex mental health presentations to ensure a holistic approach to adequately tackle issues of DFSV in this community.

Table 6 Self-reported mental health conditions among survey respondents and/or family members (per cent of survey respondents)

Condition	Personal diagnosis	Family member(s) under 18	Family member(s) 18 or older
Depression	44	21	50
Anxiety disorders	47	18	36
Schizoid disorders (schizophrenia and schizoaffective disorder)	7	8	26
Attention deficit disorder or attention deficit hyperactivity disorder	15	24	19
Mood disorders (major and dysthymic depression and bipolar)	18	10	36
Alcohol or other drug use conditions	7	*	13
Other mental health	20	9	25

Note: Question: Do you have, or has anyone in your family been diagnosed with any of the following conditions? (Select all that apply)
Base: All respondents *n = 105*.
* Cell sizes less than 5 are suppressed to protect privacy.

Traumatic life experiences

The survey asked about participants' experiences of a range of traumatic life experiences, including death and grief, abuse, family conflict, mental health issues, poverty, encounters with police, displacement and loss of language. Participants demonstrated a concerning level of exposure to a wide range of traumatic incidences across the lifespan, which indicates a complex set of determinants. Culturally appropriate, holistic DFSV responses will need to take these into account given the links between historic personal experiences of trauma across the lifespan and the reproduction of violence.

70 per cent of respondents experienced a "lot of death" and loss in the 12 months before the survey (Table 7). Interactions with police, welfare or the housing commission had been strained for respondents, with 42 per cent reporting "bad things happen[ing]" and almost half of respondents reporting being "made to live a long way from [their] family" (48%).

Table 7 Percentage of participants who reported experiencing traumatic events

Experience*	Net % with experience	… in childhood	… in adolescence	… in adulthood
Death and grief				
A lot of deaths of family or friends in 1 year	70	22	29	61
Witnessing suicide or an unexpected death	36	10	12	28
History of abuse and family conflict				
Experience of physical abuse	57	29	24	32
Experience of sexual abuse	31	25	10	9
Experience of emotional abuse	66	31	39	44
Family violence/fighting	70	46	43	45
Family breakdown	67	30	39	43
Systemic oppression, violence and displacement				
Negative experience with police, welfare or housing commission	42	13	25	35
Being adopted or fostered out	24	17	10	7
Stolen Generation	18	10	12	11
Made to live a long way from your family	48	14	22	36
Being forced to accept "whitefella ways" and speak English	37	25	22	28
Losing some or all of your traditional language and ceremony	36	27	30	29

Note: Question: Have you ever experienced any of the following events?
*Differences across survey mode mean the following events cannot be included: Witnessing the murder of stranger(s), Shamed for being Aboriginal and people being racist towards you, Not belonging to anything and feeling lost.
Base: All respondents *n = 105*.

Table 8 Reported experiences of loss among survey respondents and their close family within last 12 months

Experienced in the past 12 months	Percentage
Loss of a loved one	73
Loss of something important	70
Removal of a child from family	24
Loss of land, language, knowledge, spirituality, and culture	30
Loss of a loved one due to suicide	39

Note: Question: In the last 12 months, have you or anyone in your close family experienced any of the following …
Base: All respondents *n = 105*.

The recency of traumatic life experiences pertaining to death, loss and displacement indicates a community under immense emotional hardship, which has negative flow-on impacts for mental health.

Experiences of trauma also emerged during the in-depth yarns (qualitative interviews); numerous community members shared personal stories about the high levels of suicide, death and Sorry Business across the community, and the ongoing impact these circumstances had on those left behind. Several community participants (CPs) talked about their own attempts at suicide or personal battles with mental health, while others lamented the broader hardships faced in their communities and the impact this has on their mental health and self-worth:

> "I have battled with a few things with my health – my mental health. The way I think – I put myself down a lot. Negative self-talk." (CP28)

> "There is too much suicide in this community, too many young people have either the drugs or jail – nothing else to make them feel good about themselves." (CP4)

> "My health was impacted by the early years [Stolen Generation] – it took away my culture." (CP8)

> "I deliberately tried to take my [own] life, something drastic has to change in your life before you start to take care of yourself." (CP26)

> "I have been close to suicide – I just couldn't find what I needed to do. Mental health has been a big issue throughout my life." (CP28)

> "You have to remember that you are a proud strong black man – we forget who we were – because it was beaten out of us – we have got to remember who we are." (CP29)

These findings paint a distinct picture of a community grappling with pervasive and severe determinants of mental (ill) health, which cannot be ignored within a DFSV response.

Engagement with mental health services

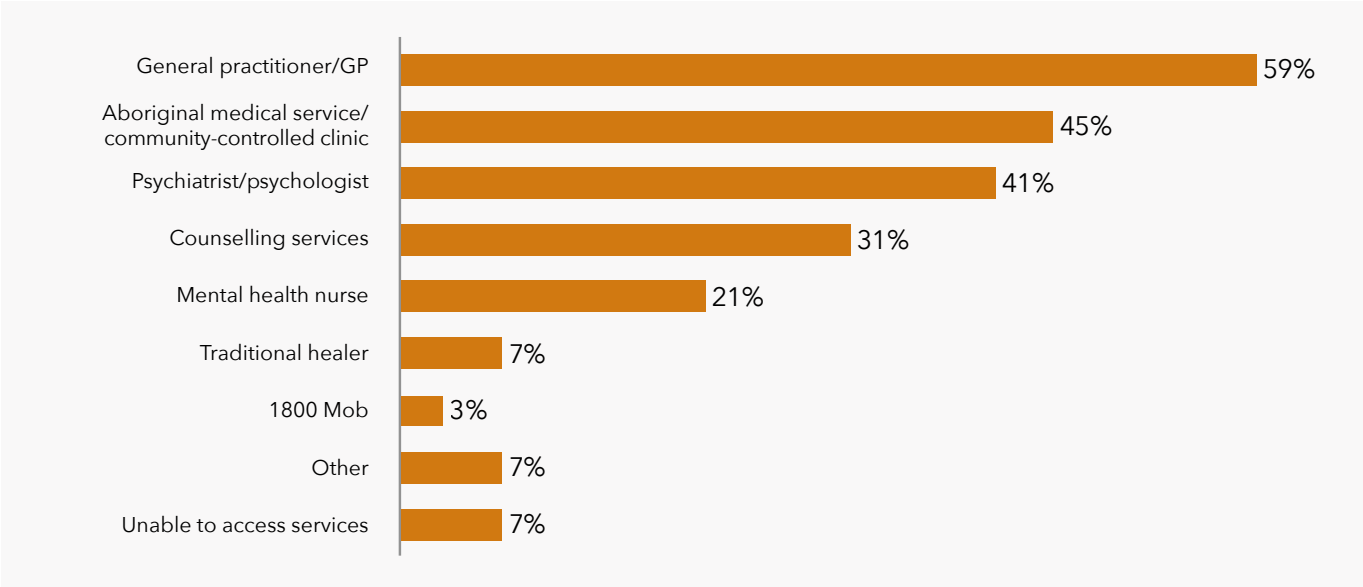
31 per cent of survey respondents reported having used a service for their mental health in the last 12 months (Table 9). Among those who indicated that they had used a service for mental health reasons, 59 per cent indicated that they had seen a general practitioner (GP), 45 per cent had seen an Aboriginal medical service/community-controlled clinic, 41 per cent had seen a psychiatrist/psychologist, 31 per cent had used a counselling service and 21 per cent had visited a mental health nurse (Figure 1).

Table 9 Use of a service for mental health reasons within last 12 months

	Percentage
Yes – used a service for mental health reasons	31
No – did not use a service for mental health reasons	60
Not sure/prefer not to say	9

Note: Question: Have you used a service for your mental health in the last 12 months?
Base: All respondents *n = 93*.

Figure 1 Self-reported use of services for mental health issues in the last 12 months



Note: Question: Please select all the mental health services you have used in the last 12 months (Select all that apply).
Base: Those who used a service for mental health in the past 12 months *n = 29*.*
*Caution: extremely low base size; interpret with caution.

When respondents were asked why they did not access services for their mental health, the main reasons noted were "cost" (21%) and being "too busy (work, personal, family responsibilities)" (18%).

When discussing what may have impeded their access, both interview and focus group participants indicated cost of services, location and lack of transport and access to services, and a lack of culturally safe or appropriate care as prohibitive factors:

> "I would be back down here living on Country tomorrow if these services were offered [in Beaudesert]." (CP26)

> "Beaudesert and [those in the] country need to have the same services as the city mob has – why can't they have the same services – if they had them, I would be back there in a heartbeat." (CP26)

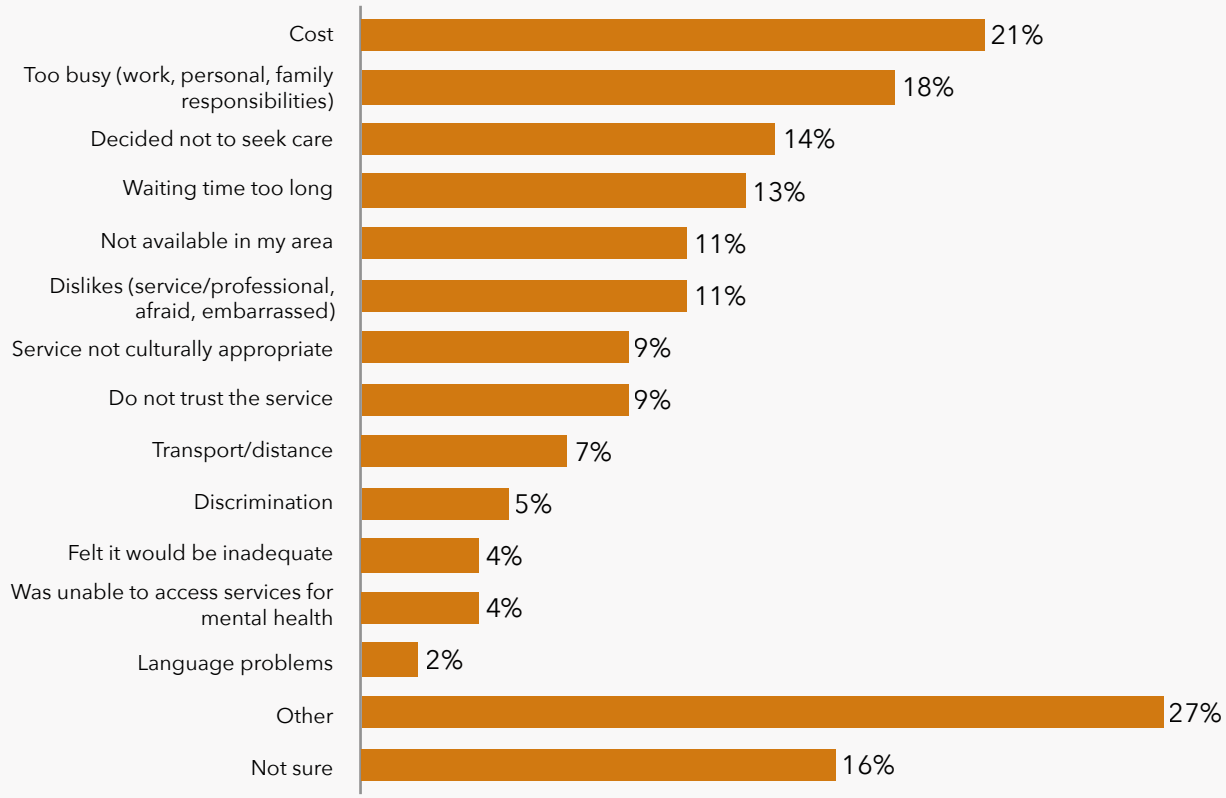
"It would be so much easier for us if services were here and closer – you wouldn't be so hidden away." (CP27)

"Need counselling [services], it's hard to get young men to come and talk about things that they are feeling." (CP25)

"If I knew that there were services, I probably would have used them, I didn't know where in Beaudesert I could get that help." (CP2)

"Mental health services are desperately needed for the young people, and after-hours care through the night. We need counsellors here for domestic and family violence because it is the drugs and the mental health that ends up in the fighting." (CP7)

Figure 2 Self-reported reasons for not using a service for mental health



Note: Question: If you didn't use a mental health service in the last 12 months, what was the reason? (Select all that apply)
Base: Those who did not use a service for mental health in the past 12 months *n* = 56.

There was a consensus among those interviewed that there were no support services and no local First Nations counsellors available who offered culturally safe counselling and support for grief and trauma.

Resilience and coping

Interview and focus group participants spoke about acts of resilience and the measures they had taken to protect their social and emotional wellbeing. For many, immersion in Country, culture, family and connection were sources of strength to draw upon when and where systems failed them:

> "We heal and connect to Country …" (CP29)

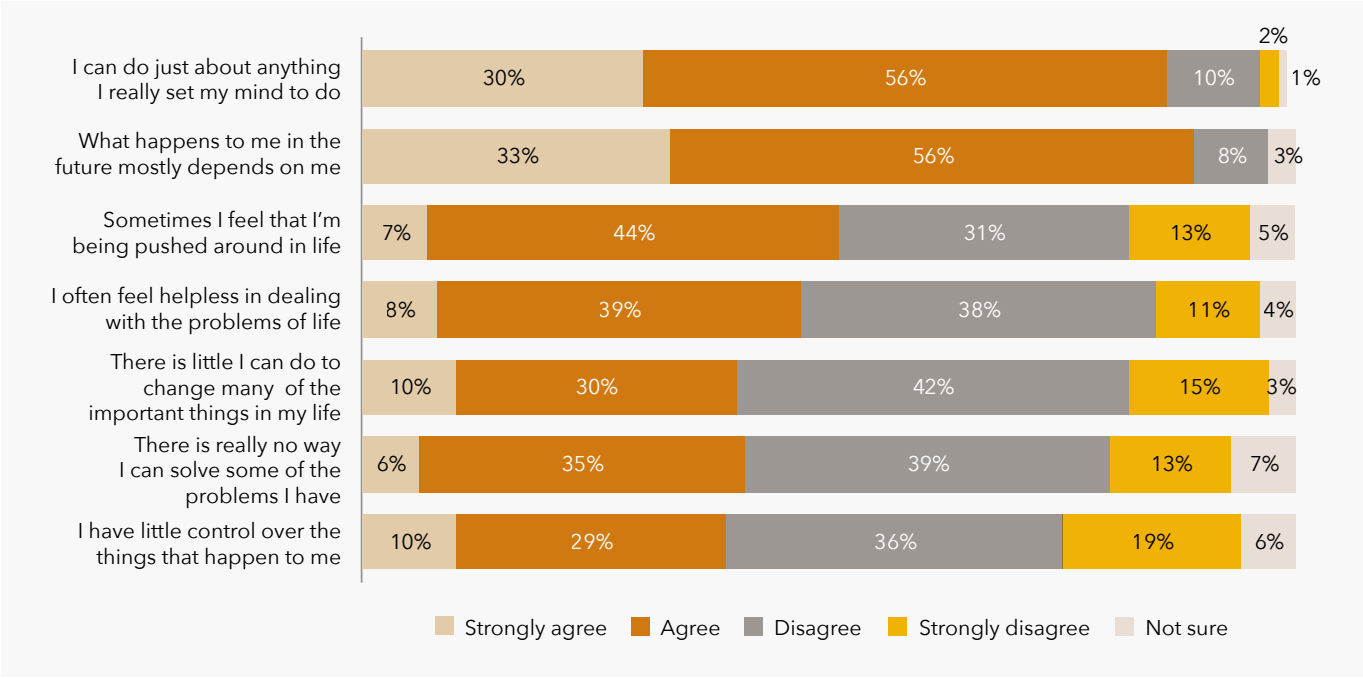
> "Came back to community for family connections." (CP10)

> "Dancing … makes me feel really connected to my culture … just makes me feel really connected to the land. Feel the ancestors behind me." (CP16)

> "I see all the kids come through … you know all the families … very important to live on Country." (CP11)

Despite challenges faced by the community, there is still a lot of optimism around self-reliance, with 89 per cent of survey respondents agreeing (i.e. responding "agree" or "strongly agree") that "What happens to me in the future mostly depends on me", and 86 per cent agreeing that "I can do just about anything I really set my mind to do" (Figure 3).

Figure 3 Self-reported beliefs about resilience and coping



Note: Question: How much do you agree with the following statements …
Base: All respondents *n = 105*.

3.2 Healthy bodies

This section presents findings from the survey and in-depth yarning on the Mununjali community's experiences and needs related to healthy bodies. This includes self-assessed overall health, long-term health conditions, health risk factors, substance use and the acceptance and use of traditional healing practices. Understanding physical and psychosocial health is critical to understanding the health determinants of DFSV and identifying potential responses to address it. We need to understand how an individual's physical and psychosocial health can impact the perpetration of DFSV.

Key takeaways

Mununjali people frequently report chronic health conditions and community perceptions reveal widespread unmet health needs

43 per cent of survey respondents reported their health as fair or poor, with two thirds of respondents reporting at least one chronic health condition, including asthma, arthritis, hearing loss and diabetes.

Widespread substance use elevates lifestyle-related health risks within the community

Survey results revealed high levels of alcohol consumption (62%), cigarette smoking (52%) and marijuana use (20%), while yarns with community members revealed concerns about drug and alcohol consumption driving suicide, violence and poverty.

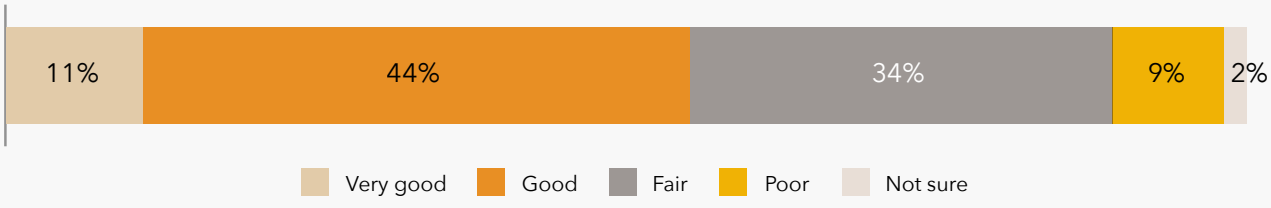
In addition to general health concerns, food and housing insecurity appear to be pervasive

46 per cent of survey participants reported having experienced hunger or not having a proper house to sleep in throughout their life, while 52 per cent reported at least sometimes not having enough food or money to buy food in the past 12 months.

Overall health conditions

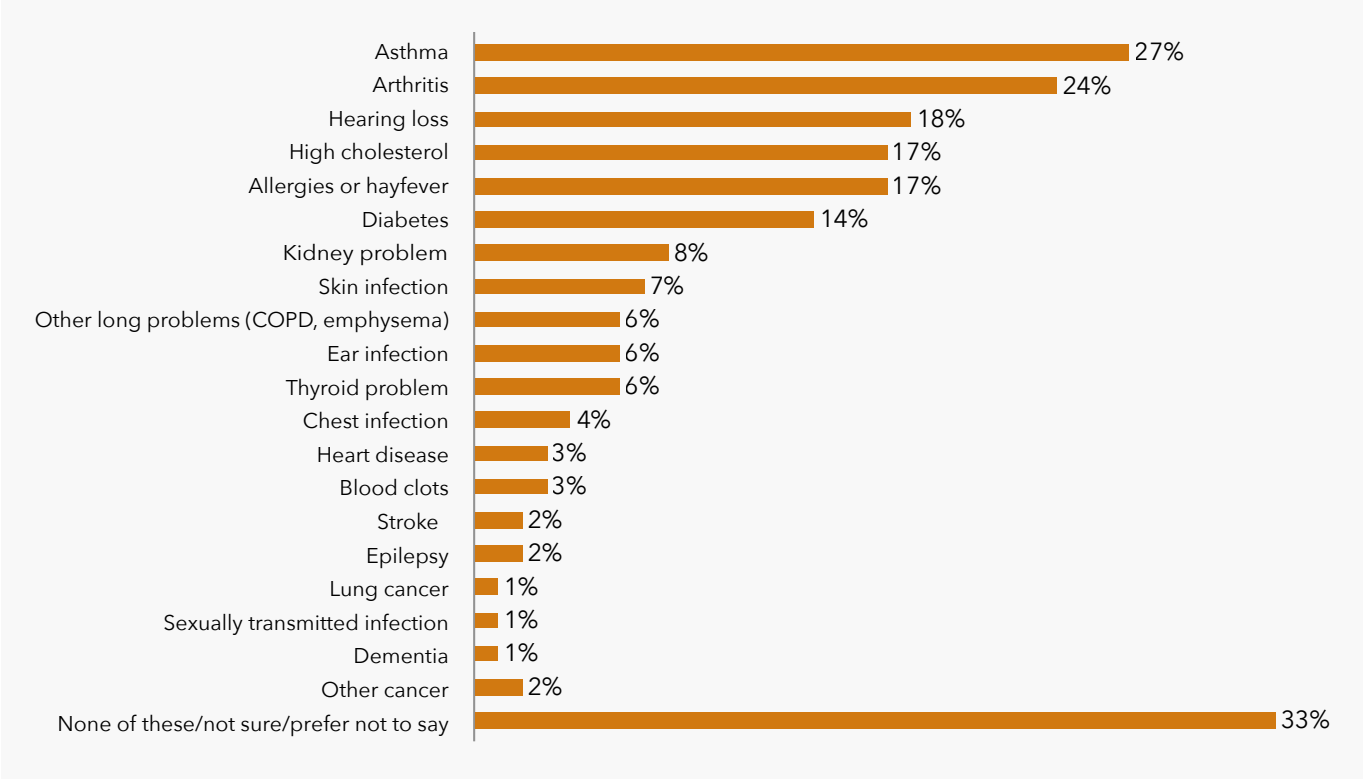
While just over half of survey respondents indicated they were in good or very good health (55%; Figure 4), it should be noted that two thirds (Figure 5) experienced a long-term or chronic health condition like asthma, arthritis or hearing loss. Mununjali people across Beaudesert are as likely to have a long-term health condition as non-Indigenous people (11.3% compared to 12.2%), although First Nations people experience higher rates of asthma (43.7% vs 28.0%) and mental health conditions (47.4% vs 30.7%) than non-Indigenous people (QGSO, 2025).

Figure 4 Self-reported perceptions about overall personal health



Note: Question: How would you rate your overall health?
Base: All respondents *n = 105*.

Figure 5 Self-reported long-term health conditions

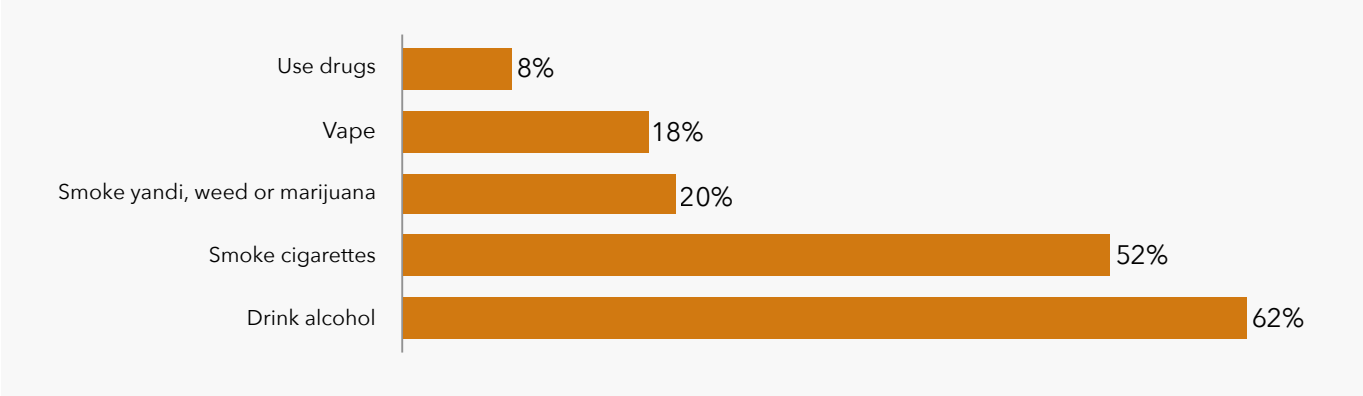


Note: Question: Do you currently have any of the following long-term health conditions? (Select all that apply)
Base: All respondents *n = 105*.
COPD: chronic obstructive pulmonary disease.

Substance use

Most survey participants reported that they drank alcohol (62%) and/or smoked cigarettes (52%), while almost 1 in 5 (20%) smoked yandi (marijuana; Figure 6).

Figure 6 Self-reported substance use



Note: Question: Do you … ?
Base: All respondents *n = 105*.

Food insecurity and poverty

Over half of the survey participants reported experiencing food insecurity in their households over the past 12 months (52%; Figure 7).

Behaviours such as smoking, drinking and drugs and experiences of food insecurity have a direct impact on the lives of the community, with 46 per cent of survey participants reporting "being hungry or not having a proper house to live in", and 50 per cent reported that "bad things happened to [them] from taking drugs and/or alcohol or from being with other people taking them".

Community interactions with alcohol, drugs and other substances; the criminal justice system; homelessness or housing insecurity; food insecurity; child protection services; and DFSV were common across the community. Community members who participated in interviews and focus groups spoke about the clear link between these interactions and a lack of services, support or help:

> "Alcohol is an issue in town – too much drinking. Every weekend there are parties – drinking till they get really drunk. Yandi [weed] is a big issue." (CP16)

> "They [young people] need the spiritual things to heal them otherwise it is just drugs and jail." (CP7)

> "My mental health really got me, I didn't have a stable roof over my head, I was homeless and couch surfing, no services that I could reach out to, I was ashamed of who I was and what I had become." (CP26)

Figure 7 Self-reported experiences of food insecurity among participants and their households

Note: Question: In the last 12 months, did you or your household not have enough food or not have enough money to buy food needed for an active and healthy life?
Base: All respondents *n = 104*.

Table 10 Self-reported experiences of poverty, hunger and negative outcomes from substance use

Experience	Net % with experience	… % in childhood	… % in adolescence	… % in adulthood
Poverty or hunger: "being hungry or not having a proper house to live in"	46	19	21	34
Drugs or alcohol: "bad things happened to you from taking drugs and/or alcohol or from being with other people taking them"	50	6	26	44

Note: Question: Have you ever experienced any of the following events?
Base: All respondents *n = 105*.

"Lots of homelessness – it's a big issue in town. Lots of tents everywhere just out of town. Housing is a big issue." (CP13)

3.3 Healthy relationships

This section presents findings from survey responses and in-depth yarns related to healthy relationships. These include personal and proximate experiences of violence, the types of violence in the community and attitudes towards DFSV.

While this data is presented as stand-alone findings, experiences, perpetration and attitudes related to DFSV are closely linked to the healthy minds and healthy bodies findings. DFSV occurs within a broad constellation of social, cultural and physical determinants. Accordingly, healthy relationships findings must be situated within the everyday realities of trauma, marginalisation, poor health outcomes and service inadequacy experienced in Beaudesert. Without this holistic framing, DFSV interventions risk failing community members.

Key takeaways

DFSV is widespread across the Mununjali community, affecting individuals across all ages and life stages

Survey data shows that 69 per cent of participants reported personally experiencing, witnessing or using violence, and 41 per cent reported that a family member under 18 had been exposed to violence.

Multiple forms of violence co-exist in the community, with physical, emotional and social abuse being most prevalent

Survey responses identified physical violence (62%), emotional abuse (58%) and social abuse (52%) as the most common forms of harm, followed by financial and psychological abuse.

Harmful relationship dynamics are common, with both victimisation and perpetration occurring at notable levels

Half of survey respondents (50%) reported being physically hurt by a partner who was angry, while 25 per cent acknowledged having physically hurt a current or former partner when angry. 42 per cent reported feeling frightened by a partner's behaviour, and 28 per cent reported making a partner feel afraid.

Community narratives highlight the intergenerational and cyclical nature of violence, often linked to trauma, substance use and systemic disadvantage

Yarning interviews revealed repeated exposure to violence in families, public spaces and childhood environments, reflecting long-standing patterns reinforced by trauma, substance use and lack of services.

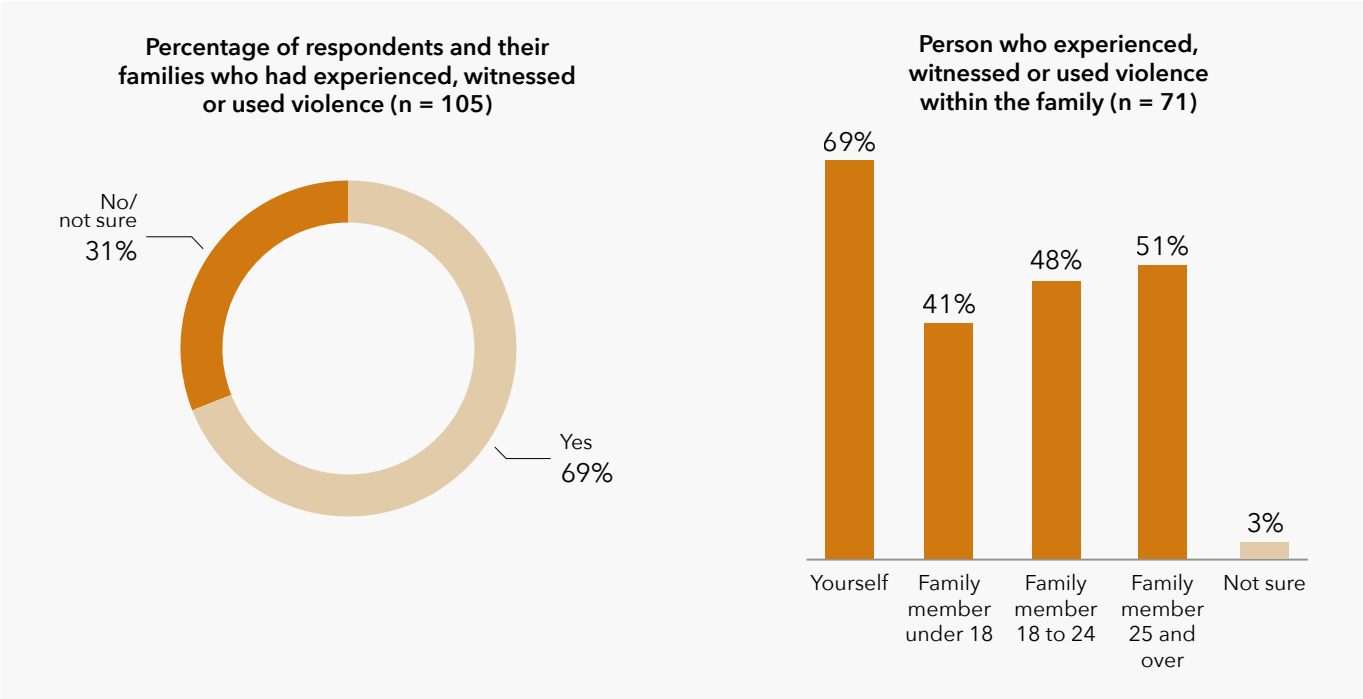
Despite high rates of violence, community attitudes strongly support preventing and speaking out about DFSV

Almost all survey respondents agreed that people should speak up (96–97%) and that violence is never justified in family conflict (95%), signalling strong readiness for culturally safe prevention and intervention supports.

Experiences of violence

Violence is common across the Beaudesert region and within the Mununjali community, with more than 2 in 3 survey participants reporting that they or a family member had experienced, witnessed or used violence (Figure 8). Among those respondents, 69 per cent reported personally experiencing, witnessing or using violence, while 41 per cent said a family member under 18 had experienced, witnessed or used violence. This demonstrates widespread exposure to violence from a young age, with serious implications for potentially perpetrating and/or experiencing violence in adulthood.

Figure 8 Self-reported experiences of violence among survey respondents and/or family members (per cent of survey respondents)

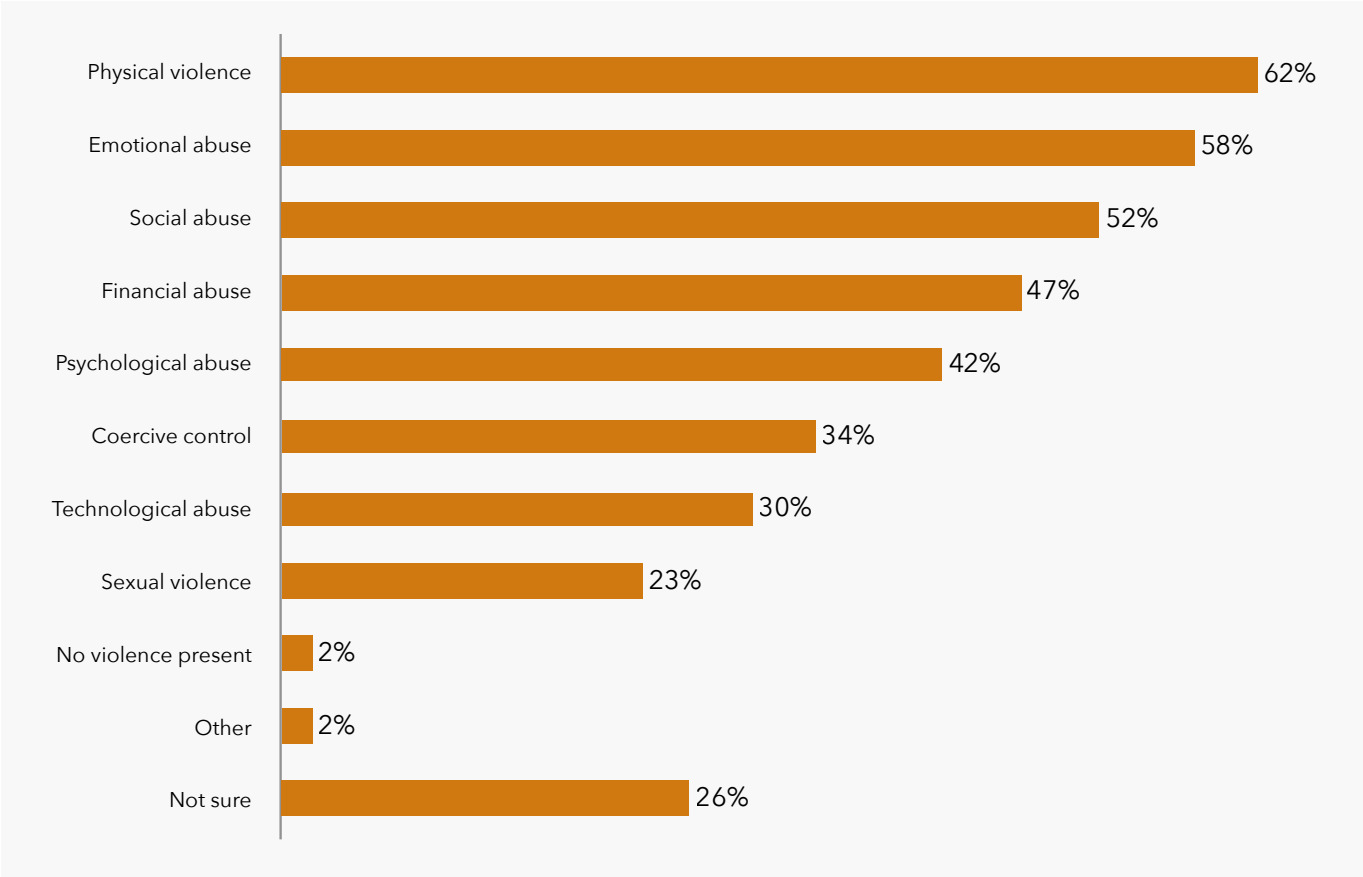


Note: Question: Have you, or your family members experienced/witnessed/used violence?
Base: All respondents *n = 105*.

Note: Question: Which family members have experienced/witnessed/used violence?
Base: Those who experienced/witnessed/used or had family members experience/witness/use violence *n = 71*.

When survey participants were asked which types of violence were most present in their community, physical violence (62%), emotional abuse (58%) and social abuse (52%) were reported most often, with coercive control (34%), technological abuse (30%) and sexual violence (23%) the least reported (Figure 9).

Figure 9 Respondent perceptions of the types of violence most present in the Beaudesert community



Note: Question: Which types of violence are most present in the Beaudesert/Logan/Mununjali community? (Select all that apply)
Base: All respondents *n = 104*.

Responses about participants' own adult relationships underscored the commonality of violent relationship dynamics. 42 per cent reported having "felt frightened or anxious because of the behaviour of a partner", while 50 per cent reported having "been hit, slapped, kicked or otherwise physically hurt by a partner when they were angry" (Table 11). Meanwhile, 28 per cent acknowledged having "behaved in a manner that has made a partner feel frightened or anxious", and 25 per cent reported having "hit, slapped, kicked or otherwise physically hurt a partner when they were angry".

Table 11 Self-reported experiences and behaviour since the age of 18

Behaviour		Yes	No	Not sure
Experienced	Felt frightened or anxious because of the behaviour of a partner	42%	51%	7%
Experienced	Been hit, slapped, kicked, or otherwise physically hurt by a partner when they were angry	50%	43%	8%
Perpetrated	Behaved in a manner that has made a partner feel frightened or anxious	28%	62%	10%
Perpetrated	Hit, slapped, kicked or otherwise physically hurt a partner when you were angry	25%	69%	6%

Note: Question: As an **adult**, have you ever experienced any of the following?
Base: All respondents *n = 105*.

Note: Question: As an **adult**, how have you behaved towards a past or present partner?
Base: All respondents *n = 105*.

Community yarns further revealed the range of violence embedded in the community and recognised the link between service gaps and the likelihood of violence, often grounding its emergence in health, housing and transport needs:

> "We need to encourage the men to go [to health services], they need someone to talk to and work out this violence business." (CP4)

> "Violence in community is due to hard drugs – ice, cocaine, all the stuff they get off the streets, younger people who want to be heroes." (CP8)

> "Relationship violence – it is here – but it can be controlled if you get on to it. The police – need to do a bit more homework – they are doing a good job – but need to keep an eye on them." (CP8)

> "My partner and I were addicts and homeless – we had an outburst [violence], and the police were called – they did a no-contact DVO [domestic violence order]. It was put on me by the police [not my partner]." (CP13)

Interview and focus group participants described an awareness of the dynamics through which violence was reproduced in their community due to historic and ongoing traumas experienced both in family and institutional settings. Several highlighted that violence from a range of perpetrators has been present since colonisation, with these historic experiences altering established ways of being and breeding cyclical intergenerational trauma:

> "I was drinking and then we were arguing – kids don't need to be around that shit – I grew up with it and it's not good." (CP10)

> "I used to be more violent – I stopped drinking hard a while ago – I didn't want to be my dad. I got drunk every day – I used to drink hard." (CP10)

> "I have been punished since I was little – violence and the alcohol [go together]. He [his father] was hard on me growing up – I got flogged all the time." (CP26)

"I witness it at school – between kids to kids and families – witnessed it at local supermarkets and the park … 100% impacts the community." (CP11)

"There was a lot of violence in this community – in the pub and at school. Every week in the pub [there was a fight]." (CP16)

"When I saw the psychiatrist, she asked when the first time was, I experienced violence, I said 5 [years old]. [There were always] big fights at parties between the aunties and uncles, it went all the way through my adolescent life." (CP26)

"In the old days there was violence – generations change, families change, the bad ones move on or have passed away." (CP27)

Interview and focus group participants expressed a need for more services to address the root causes of violence:

"I've experienced violence too often [from a partner] … it's controlling. It's not helping me in getting better … we need that support where we can get help to try and figure out what we need." (CP2)

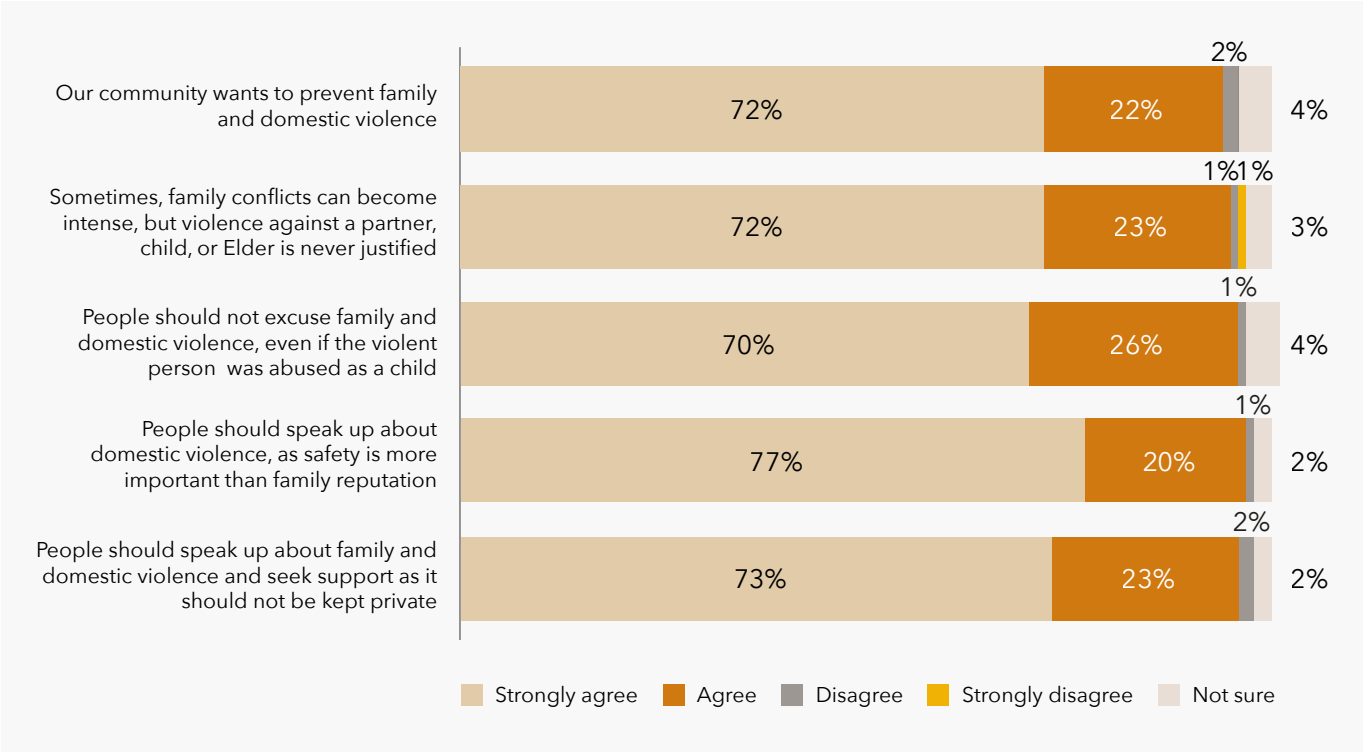
"We need counsellors here for DFV [domestic and family violence] because it is the drugs and the mental health that ends up with fighting." (CP21)

Personal attitudes towards DFSV

Despite the widespread self-reports of violence in the Beaudesert and Mununjali community, survey respondents ultimately rejected DFSV and wanted to work towards its reduction. 96 per cent agreed or strongly agreed that "people should speak up about family and domestic violence and seek support, as it should not be kept private" and 97 per cent agreed or strongly agreed that "people should speak up about domestic violence, as safety is more important than family reputation" (Figure 10). There were similarly high levels of agreement that "people should not excuse family and domestic violence, even if the violent person was abused as a child" (96%) and that "sometimes, family conflicts can become intense, but violence against a partner, child, or Elder is never justified" (95%).

It is worth noting that in sense-making conversations, Elders cautioned that attitudes may not align with reported experiences or perpetration. There is a history of stereotyping First Nations communities as violent, which communities are understandably reluctant to reinforce. As with any population, social desirability bias may skew survey responses about normative rejection of violence despite its presence in a community.

Figure 10 Participant attitudes towards domestic, family and sexual violence



Note: Question: How much do you agree with the following statements …
Base: All respondents *n = 105*.

3.4 Engagement with services and service infrastructure

Conversations with Elders during the project inception and design phase made it clear that addressing DFSV in the Beaudesert and Mununjali community could not be resolved without addressing systemic and structural barriers experienced in the community. Accordingly, understanding these wrap-around issues became an imperative of the research.

This section presents findings from both the survey responses and in-depth yarns regarding barriers, access and other systemic health issues raised by community. This includes data on participants' uptake of the annual 715 health check,[3] perceptions and personal experiences of the health care service system, and accessibility of health services due to limited transport options in Beaudesert.

Key takeaways

The annual 715 health check is a critical but underutilised tool for identifying the health determinants that contribute to DFSV

Despite its role in early detection and referral, 64 per cent of survey participants had not received a 715 health check in the past 12 months. Of those who had, many reported their appointments were shorter than the recommended 45–60 minutes, limiting their effectiveness.

Mununjali community members overwhelmingly prefer culturally safe health services, but mainstream services often fail to provide culturally appropriate or respectful care

While 65 per cent of participants would prefer to use an Aboriginal medical service, only 26 per cent currently do.

Low trust in mainstream health services reflects repeated experiences of discrimination, lack of cultural safety and poor-quality interactions with providers

Between 50 and 64 per cent of survey respondents reported at least sometimes being treated disrespectfully, not being listened to or being exposed to racist comments when accessing care, reinforcing avoidance and service disengagement. Experiences in mainstream settings were marked by disrespect, racism, poor listening and unsafe environments.

Transport limitations create a major barrier to accessing both local and external health services, significantly reducing the community's ability to follow through on referrals

Transport was frequently rated poor or very poor across availability, accessibility and affordability. Many referrals from a 715 health check required travel to Logan or Brisbane, which many community members simply cannot manage.

Systemic service gaps leave the community without reliable, coordinated or culturally grounded support, reinforcing cycles of unmet need

Many services funded to operate in the Beaudesert region do not maintain a regular presence, leaving the Mununjali community without consistent access to specialists, counselling, allied health or culturally appropriate pathways to care.

[3] The "715 health check" refers to the Medicare bulk-billed item number used for an Aboriginal and Torres Strait Islander Health Assessment provided by a general practitioner. For further information, see "Closing the Gap health check – or 715 health check".

Closing the Gap health check – or 715 health check

The Closing the Gap health check or 715 health check (the Medicare bulk-billed item number used for an Aboriginal and Torres Strait Islander Health Assessment provided by a GP and the abbreviation used by local First Nations service providers) helps to identify whether someone is at risk of illness or a chronic condition, and provides up to 10 free follow-up services where required (Department of Health, Disability and Ageing [DHDA], 2022). It is a pivotal service in improving the health of First Nations peoples and a critical touch point for connecting people to other services. In tight-knit rural communities where accessing DFSV-specific services can be accompanied by a sense of shame, the 715 health check presents a powerful opportunity for people to privately bring up DFSV concerns under the guise of a publicly acceptable holistic health assessment.

Concerns around the use and anonymity of DFSV services in tight-knit communities were made clear in conversations with community members:

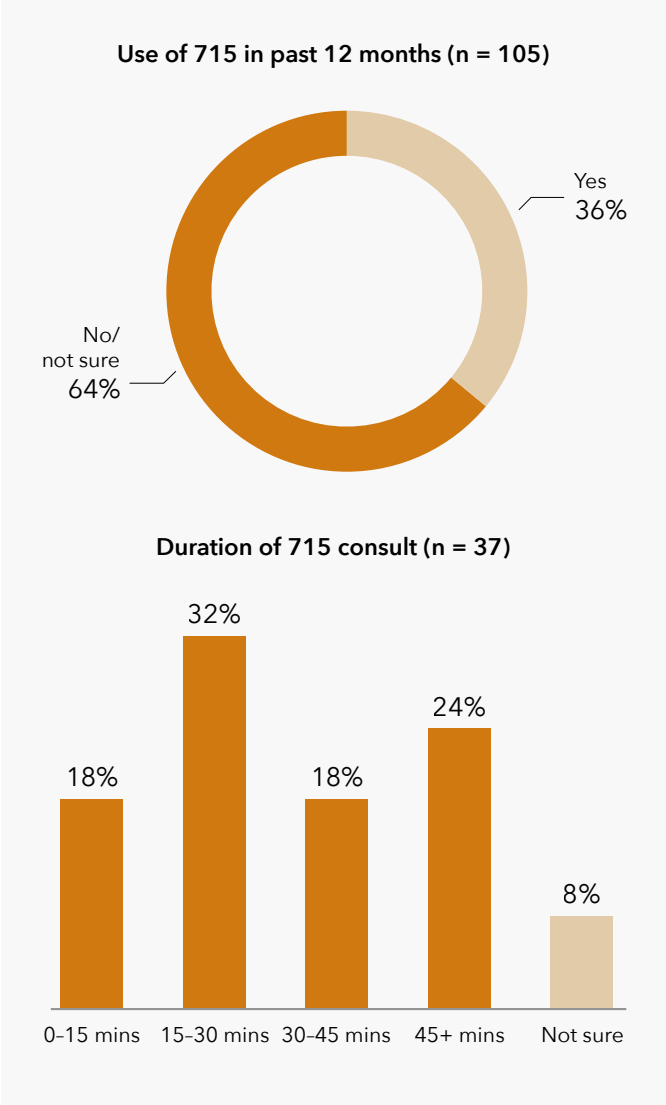
> "You know everyone here … I know the people I am safe with … everybody has their own family and their own problems." (CP2)

> "People know what is happening inside your house … and it's not a good thing … the confidentiality is an issue here [with current services]." (CP14)

Survey data demonstrates, however, that there is a clear opportunity to boost engagement with the 715 health check, with 64 per cent of community members reporting having not accessed the 715 health check in the past 12 months (Figure 11).

The 715 health check is intended to be longer than a standard doctor appointment, typically between 45–60 minutes; however, a third of respondents who had a 715 health check in the previous 12 months indicated that it only lasted 15–30 minutes (32%). The average appointment was estimated to last 26 minutes.[4]

Figure 11 Percentage of participants who had a 715 health check in the past 12 months, and duration of the appointment

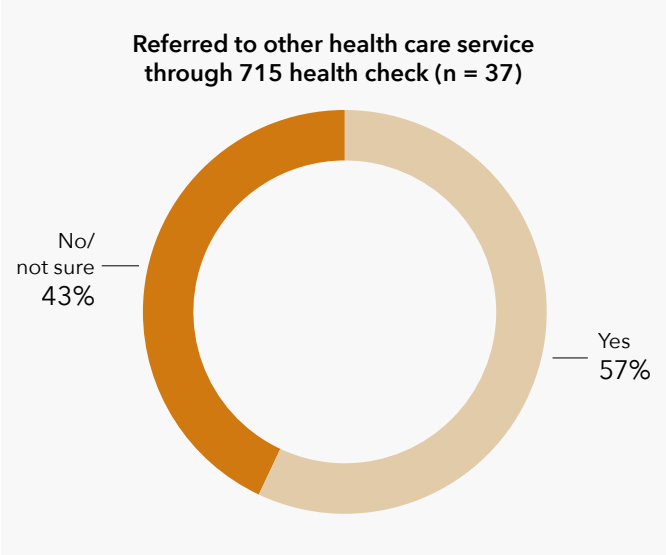


Note: Question: Have you had a Closing the Gap 715 health check in the last 12 months? Question: How long were you with the GP for your 'Closing the Gap 715' health check? Participants could nominate one of the five categories identified in Figure 11. Base: Respondents who had a 715 health check in the past 12 months *n = 38*.

[4] Average appointment length was calculated by assigning a mid-point to each appointment length range and then determining the average: 0–15-minute appointments were assigned a 7.5-minute appointment length, 15–30 minutes were assigned as 22.5 minutes, 30–45 minutes were assigned as 37.5 minutes, and 45+ minutes were assigned as 45 minutes.

Of those who did access the 715 health check, over half (57%) were referred to other services as a result of their appointment (Figure 12) – most commonly to optometrists (45%), as well as specialist (35%) and counselling services (30%; Table 12).

Figure 12 GP referrals to other health care services following a 715 health check



Note: Question: Did your GP provide you with a referral to other health care services?
Base: Respondents who had a 715 health check in the past 12 months *n = 37*.

Table 12 Referrals to other services following a 715 health check

Referral type	%	n
Optometrist	45	9
Specialist	35	7
Dentist	30	6
Counselling	30	6
General practitioner (GP)	*	*
Psychology/psychiatry	*	*
Hearing	*	*
Aboriginal medical service	*	*
Gynaecologist	*	*
Drug and alcohol service	*	*
DFSV service	*	*
Family support services	*	*
Other (e.g. dietician, chiropractor/ physio, pain specialist)	45	9

Note: Question: Please choose which services you were referred to after your 'Closing the Gap' 715 health check. (select all that apply)
Base: Respondents who had a 715 health check in the past 12 months and received a referral *n = 20*.
Note: Paediatrician, Speech pathology, NDIS, and Not sure did not receive responses and have not been included above.
* Cell sizes less than 5 are suppressed to protect privacy.

Experiences of mainstream health care services

Mununjali community members' experiences with mainstream health care services provide considerable insight into why the 715 health check uptake and service use in general is limited – with mistreatment by health care providers appearing, at best, culturally unsafe and, at worst, actively discriminatory.

Survey responses revealed concerning perspectives: 58 per cent of participants reported being "treated with less respect than others" at least sometimes, 64 per cent felt that "health care providers don't listen or assume problems", and 50 per cent experienced "jokes or insults about Aboriginal/Torres Strait Islander people" (Figure 13).

These negative experiences were echoed in qualitative conversations with community members who described feeling unsafe, judged and not listened to by mainstream service providers. These findings demonstrate that the current services and systems are failing the Mununjali people. If services are not culturally fit for purpose, then service-seeking behaviour is an inevitable outcome:

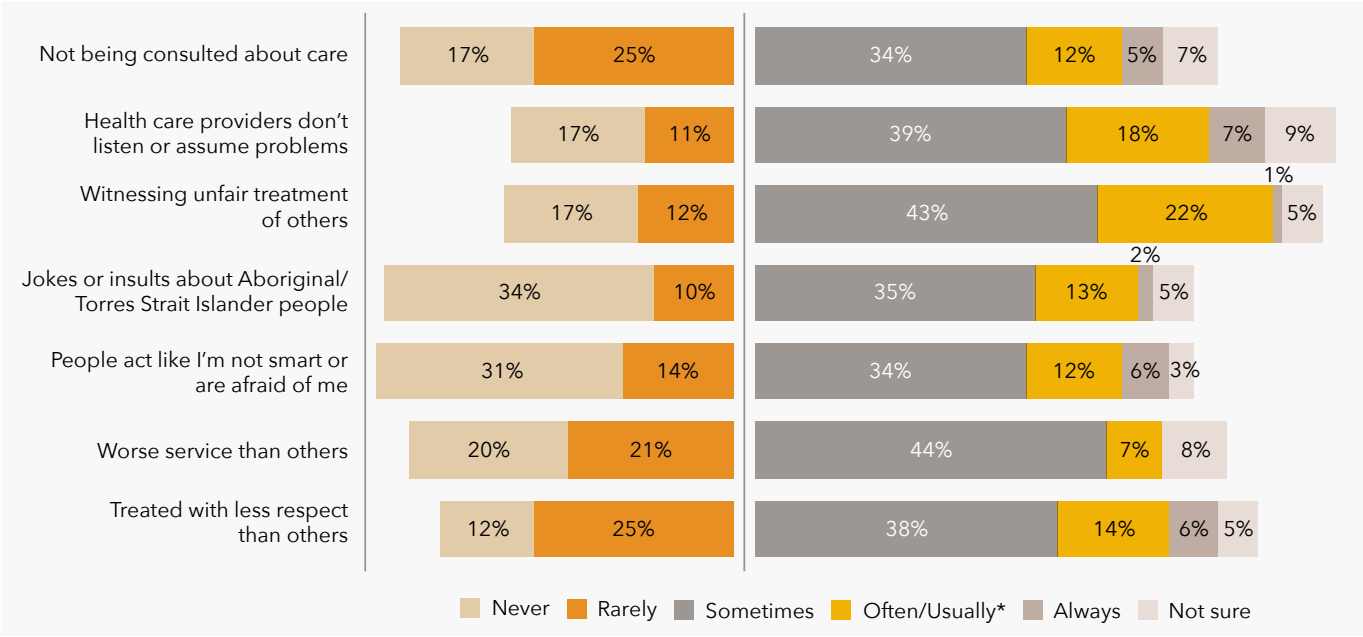
> "I didn't feel listened to at the Beaudesert hospital, but I do when I am at an Aboriginal medical service. I do not feel safe when I go to hospitals. I don't like to air my business in a culture that is not my own." (CP8)

> "I felt judged – it didn't feel right. Racism [was] involved as well." (CP2)

> "I didn't feel heard – I didn't get what I needed because I had to re-tell my story all again …" (CP3)

> "Everything [services] stops at the bridge … it's like nothing goes over the Logan River … they just forget about Beaudesert." (CP15)

Figure 13 Participants' experiences of discrimination when receiving health care: Frequency of experiences



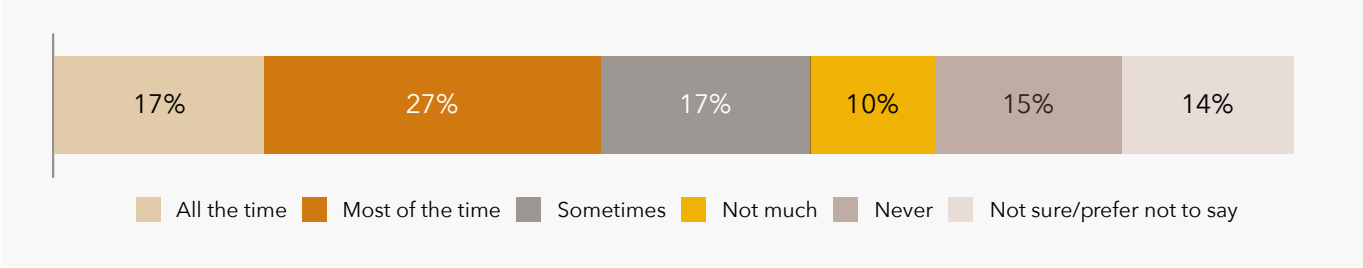
Note: Question: How often do you experience the following when receiving health care?
Base: All respondents *n = 105*.
* "Often" was displayed on the mobile version of the survey and "Usually" was displayed on desktop.
"Followed around in shops" and "Unsafe or misunderstood cultural needs" were only displayed in the mobile version of the survey and have not been reported here.

Community experiences of health care when Aboriginal Health Liaison Officers are available and present

In qualitative discussions, participants expressed how their experiences of health care services were made much easier and more positive when Aboriginal Health Liaison Officers (AHLOs) were available and present. Notably, however, only 44 per cent of participants advised that AHLOs were available and present all or most of the time when they accessed a health care service (Figure 14).

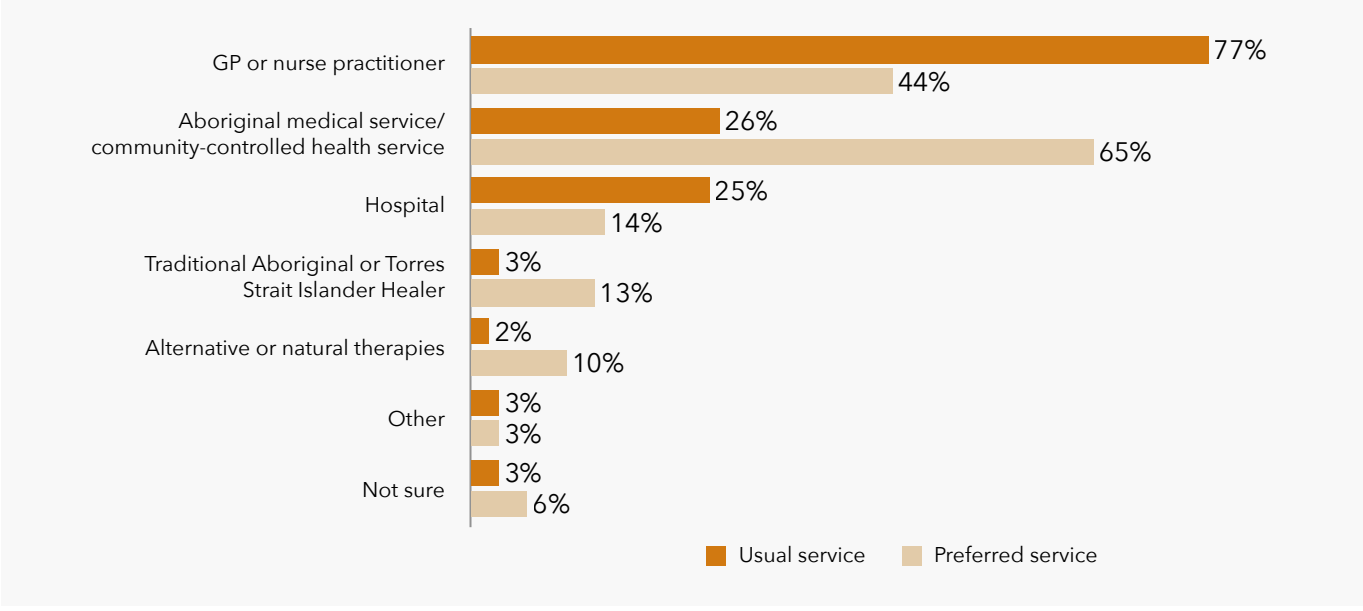
Widespread preference for services run by First Nations people was underscored by survey data that revealed the differences between the usual services people use, and the service they would prefer to use. Mainstream GPs or nurse practitioners were the most commonly used service (76%), while 65 per cent of participants said they would prefer to use Aboriginal medical services or ACCHOs – with just 26 per cent reporting that a First Nations-run service was their usual port of call (Figure 15). Given the widespread negative experiences reported in mainstream services and the clear preference for First Nations–led services, it is concerning that Mununjali community members seem to be "making do" with culturally unsafe or inadequate service provision or, as revealed in community workshops and survey responses, simply not accessing services at all.

Figure 14 Participant views about the availability of Aboriginal and Torres Strait Islander health workers and liaison staff within the community



Note: Question: Do you feel that Aboriginal/Torres Strait Islander health workers and liaison staff are available and connected to your community?
Base: All respondents *n = 105*.

Figure 15 Participants' usual and preferred health services



Note: Question: Where do you usually go for health care? (select all that apply). Question: If you could choose, where would you go for health care?
Base: All respondents *n = 104*.

The in-depth yarns underscored community demand for Aboriginal community-controlled services:

> "Haven't accessed services as there isn't really any [in Beaudesert] … I go to Inala Health [an Aboriginal medical centre] – was good to just touch base with them." (CP1)

> "It would be a good thing to have a health service – I reckon it will change a lot of people's lives." (CP2)

> "There is a gap, and everyone thinks they are closing it – but there is not much getting done." (CP29)

Those seeking culturally safe health care services reported feeling resigned to travelling long distances to access preferred health care providers. The community was of the view that services, although funded to serve the community, did not provide the outreach or tailored support required for Mununjali people. Additionally, they frequently raised concerns about the need for Mununjali community members to "move off Country" or live away from Country to access medical services such as dialysis, speech pathology and occupational therapy, as well as mental health, behavioural and learning support.

Anecdotal evidence gathered during community consultations revealed that only one staff member is embedded in the AHLO role at the Beaudesert Hospital – outside of their remit, this staff member shoulders enormous burden to make up for systemic failings. This AHLO's support activities include visiting people at home to wake them, preparing breakfast, helping them to leave the house, supporting access to transport, providing transport (typically using their own resources) to appointments in Logan and Brisbane, and helping community members to navigate the service system at appointments. This support is provided without additional funding or financial support. The participant stated that they often need to take time off work to ensure Elders and community members meet their appointment schedules:

> "I have [a] 76-year-old who has an [appointment] in Brisbane at 8:30 am – how do they get there? I end up taking an ADO [a day off], I get there around … 4:30 am. I get them up and get them ready, make them a brew – I do all of this on my own. I do it for my own Elders – these aren't my people – but they are my Country men." (CP29)

Participants were concerned that many of the services required by the community were not physically located within the Beaudesert region but were provided via outreach services that visited town on an irregular or ad hoc basis.

These systemic frustrations are compounded by funding being apparently directed to fill gaps in the community with no tangible benefits emerging.

Participants at the sense-making workshops held in Beaudesert in September 2025 discussed services setting up "physical shop fronts" in town but not providing services from these spaces. Participants noted that some of these services were often uncontactable, and if contactable, their head office was "out of town". Furthermore, other service providers and community members spoke of services that were contracted and funded to provide services in Beaudesert yet had made no headway within the community, due to a lack of community ties, cultural awareness or cultural connection. Some service providers spoke of having tried to provide services in the town over and eventually stopping due to a lack of clients and uptake of their services.

Service providers noted the absence of a "central hub" or contact point in Beaudesert where they could advertise their services or meet with clients and community at the same location on a regular basis. Service providers and community members believed that a central hub or centralised contact point with a physical location could help to develop trust and connections across the community and allow for a greater continuity of care and service provision.

A Legal Aid provider spoke of being funded to provide services within the Beaudesert region but having no ongoing access to a confidential physical space to meet with clients. Each time they came to town, they were tasked with finding a physical, confidential and culturally appropriate meeting space.

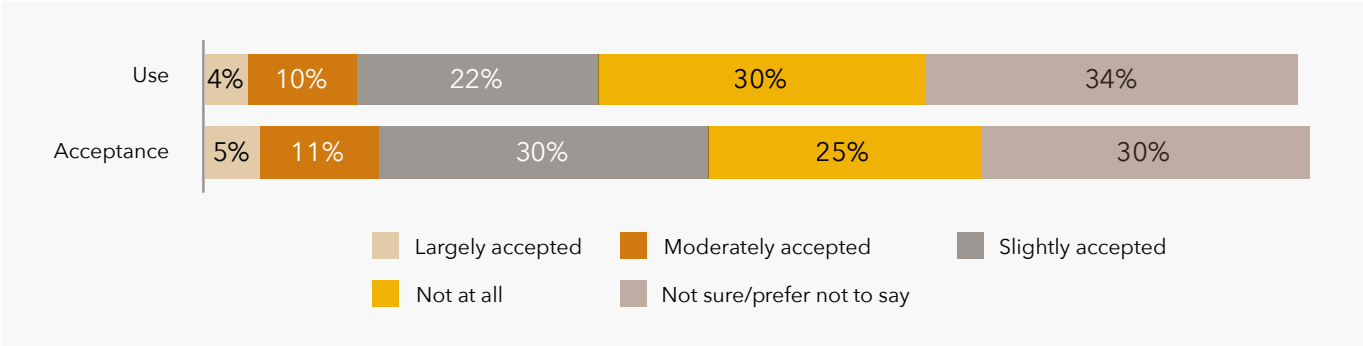
Use of traditional healing

As is common, community members spoke of turning inward to seek the support they needed, and some talked of using traditional healing practices, such as spending time on Country or using smoking practices – the burning of native plants to cleanse and heal. Survey data indicated 46 per cent of participants agreed that traditional healing was ("slightly to largely") *accepted* within their community, with around one third (36%) noting traditional healing was *in use* in their community ("slightly to largely"; Figure 16).

Transport issues

Transport presented a further barrier for many community members seeking health care services. Those interviewed who had accessed a 715 health check felt that while the check had been conducted satisfactorily, they were referred on to services that were inaccessible due to location, capacity, affordability, transport or limited supports.

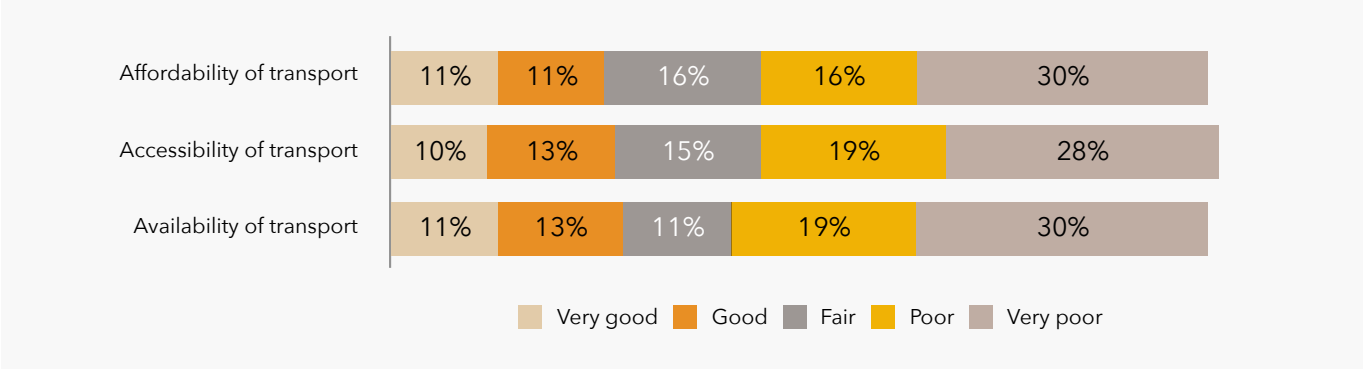
Figure 16 Perceptions of acceptance and use of traditional healing practices by health services



Note: Question: Are traditional healing practices **accepted** by health services in your community?
Base: All respondents *n = 105*.

Note: Question: Are traditional healing practices **used** by health services in your community?
Base All respondents: *n = 103*.

Figure 17 Participants' views about the adequacy of transport to health care services in the community



Note: Question: How would you rate the following aspects of transport to healthcare services in your community?
Base: All respondents *n = 105*.

Chapter 4: Discussion, implementation and recommendations

The findings from this research project underscore that an effective approach to preventing and addressing DFSV for the Mununjali people requires holistic interventions that account for cultural, social and political determinants – including trauma and cycles of violence – and the comprehensive shortcomings of the current service infrastructure in Beaudesert. These findings are also likely to be relevant for similar First Nations communities located outside of major urban areas.

In outlining the value of establishing an Aboriginal community-controlled health hub, we have drawn from the following sources:

- first-hand research findings
- input from the Mununjali people and Beaudesert community
- a sense-making and service model workshop
- evidence from First Nations–led service implementation.

Such a hub would provide the Mununjali people and the broader Beaudesert community with a culturally safe space to access health services and DFSV supports. The design for the hub could also be used as a model for other First Nations communities with similar health and DFSV support needs.

Specifically, we propose improving the implementation and community uptake of annual 715 health checks through the establishment of an Aboriginal medical service or ACCHO as a mechanism that facilitates:

- **healthy minds:** through improved mental health referral systems that address the widespread trauma that contributes to ongoing cycles of violence and feelings of hopelessness and a lack of self-worth
- **healthy bodies:** through improved health service provision that enables First Nations people to have their health needs taken seriously; and ultimately
- **healthy relationships:** by strengthening healthy relationship education, raising community awareness about the use and perpetration of violence, and providing confidential, culturally safe and trauma-informed venues for referrals through the new community health hub.

This chapter covers implications and recommendations for policy and practice (including a proposed theory of change, a draft service model and applicable case studies), strengths and limitations of the proposed model, areas for future research and a draft evaluation framework for future programming.

4.1 Implications and recommendations for policy and practice

Guided by community in participatory analysis and proposed service model development workshops, we propose the following plan for implementing a new Aboriginal community-controlled health service, Mununjali Health Service for the Mununjali people and other First Nations people living in the Beaudesert region. The model holistically addresses the interrelated domains of healthy minds, healthy bodies and healthy relationships. The core aim of both the proposed service and of this research project is to develop a needs-based intervention that addresses DFSV in the Mununjali and Beaudesert community. This model may be useful for consideration in other First Nations communities.

This section provides a narrative theory of change, a proposed logical framework for the proposed model of care, a suggested implementation plan and considerations for future service evaluation.

Revitalising the desert through Mununjali Health Service: A narrative theory of change

Simultaneously addressing the shortcomings of Beaudesert's service landscape and improving DFSV requires an integrated, culturally appropriate service hub that offers holistic, wrap-around supports for the social and emotional wellbeing of the Mununjali people and the Beaudesert community. A narrative theory of change, developed with community, explains how a needs-based intervention could support healthy minds, healthy bodies and healthy relationships, while helping rebuild service ecosystems through community-led, place-based approaches.

Revitalising the desert through community change

Under the hard-packed earth of a long-standing service desert, hardened by decades of historic neglect, lie three underground streams. These streams hold the potential to revitalise the desert and restore wellbeing to the people who live there.

Funding and collective energy, guided by the local people who understand the land best, work like careful excavation, releasing the streams which, once surfaced, converge into an oasis. Over time, channels deepen, tributaries form and the oasis becomes self-sustaining – evidence of what happens when we unlock what is already present within a community and let it flow.

We envisage the oasis as the **Mununjali Health Service**, with the streams that coalesce into it being (Figure 21) inclusive of the three pillars of the proposed Mununjali Health Service (Figure 18):

- **community leadership** of Elders and women's, men's and youth groups acting as key drivers of culturally appropriate preventative health through cultural leadership, wisdom, knowledge and awareness
- **culturally safe outreach work** in local community to provide referral and connection to other health providers and services and address long-standing infrastructural barriers like transport
- **the annual 715 health check** as the driver to set in motion a web of referrals to other allied health providers.

The Mununjali Health Service thus serves the community as a central hub through which a range of interconnected needs can be met and where broader determinants of DFSV can be comprehensively addressed:

- **healthy minds** are restored through mental health service referrals and through a culturally safe place that is controlled and contributed to by the community, rather than settings where Mununjali community members have been treated as lesser
- **healthy bodies** are nurtured through improved delivery of the 715 health check and increased uptake in the community, which addresses critical physical health needs and links people to a range of other allied and culturally appropriate services
- **healthy relationships** are strengthened through culturally responsive support services that improve social, emotional and spiritual wellbeing, and build individual and community capacity to care for and protect their children.

Figure 18 Pillars of Mununjali Health Service

Figure 19 Theory of change: Mununjali Health Service

Draft model of care and program logic

After the sense-making community workshop, and during the proposed service model workshop, participants discussed the proposed model of health care and the elements required to facilitate the development of the model. Following this, researchers noted the required elements and the community discussions and developed the Mununjali Health Service model (Figure 20).

Figure 20 Draft Mununjali Health Service model

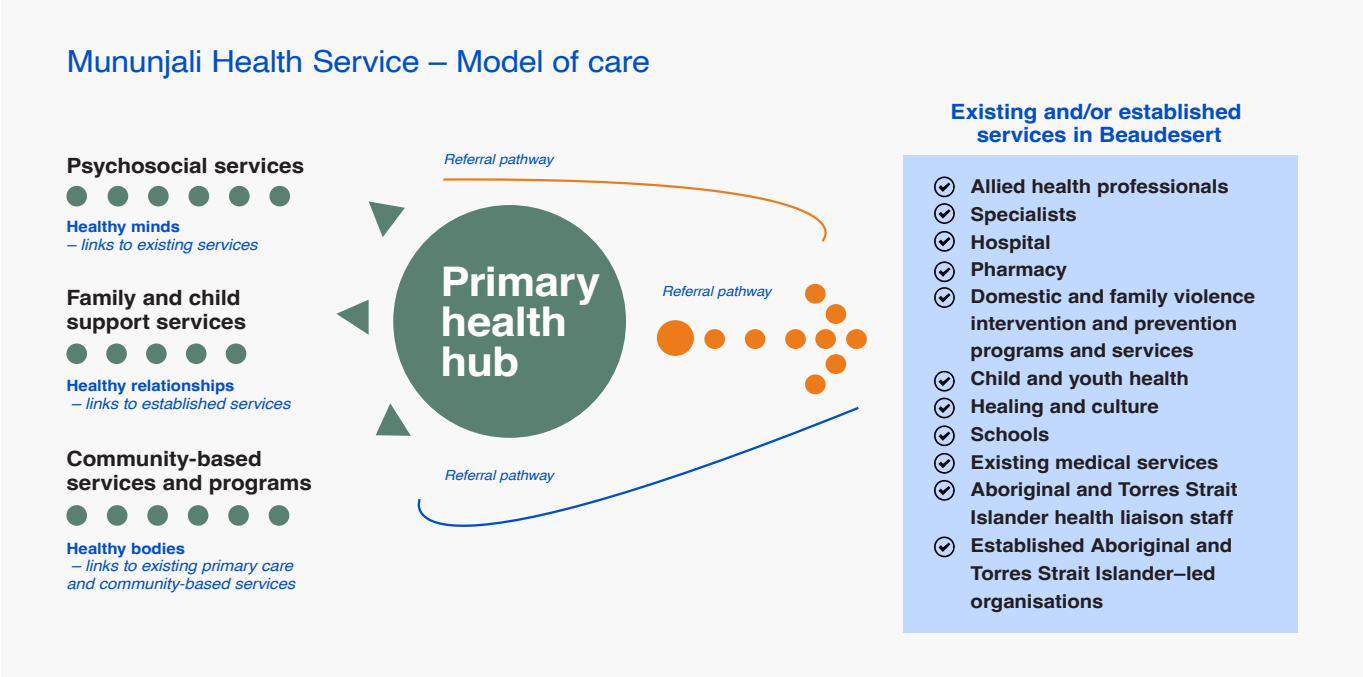
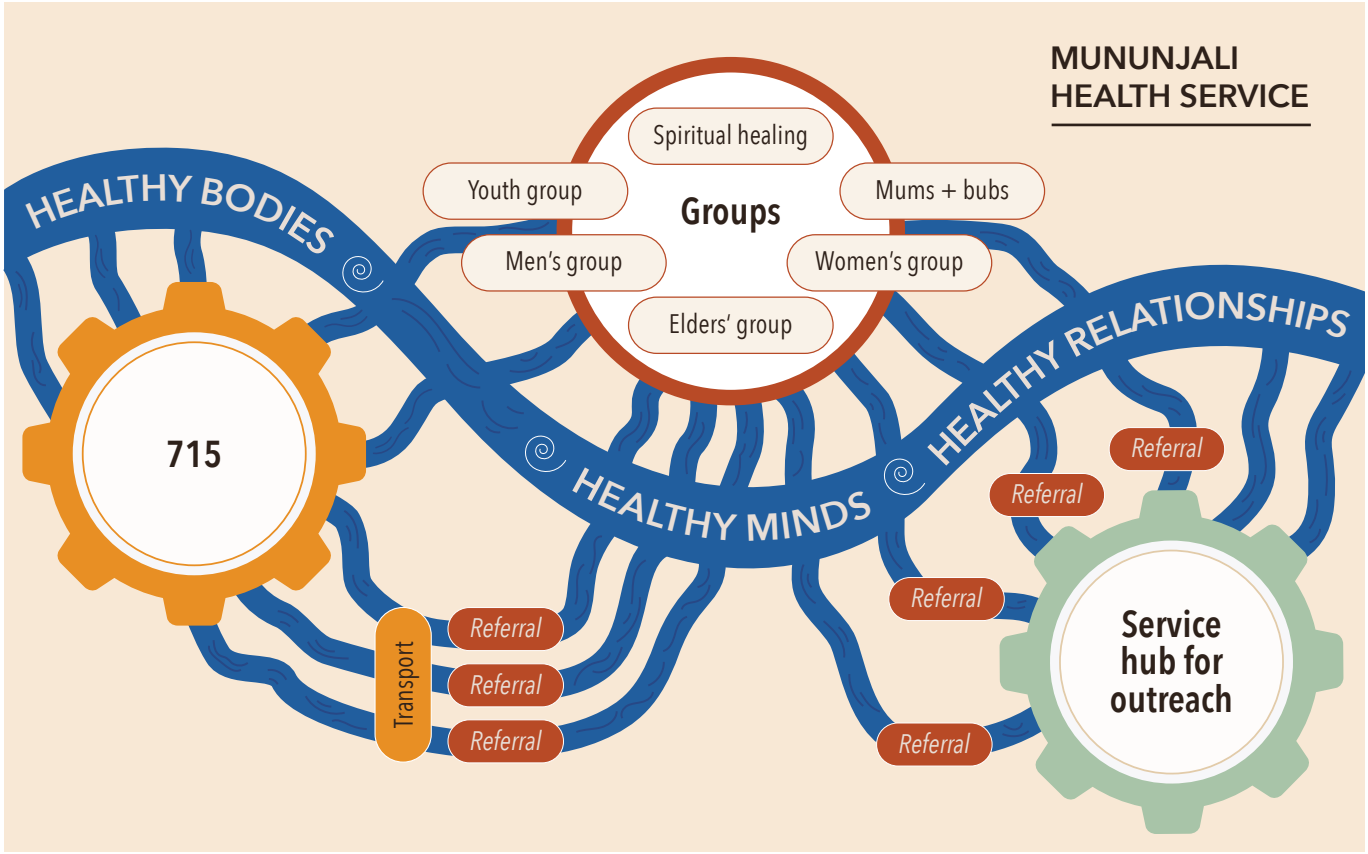


Figure 21 An oasis in the Beaudesert service desert



When discussing the narrative of the Mununjali Health Service health care model, Elders and community members noted the urgent need for a service and spoke of the groundswell of enthusiasm and commitment from community since the project's inception. Elders articulated that the service must be established with clear governance, guidelines and processes to ensure the scalability and longevity of the service. A service timeline was drafted to reflect these requirements (Figure 22).

Working group members agreed to a stepped implementation over 5 years. Critical elements of the service timeline include sourcing seed funding, capacity-building for the Mununjali Health Service, service reputation and building community trust. Elders and working group members noted the results from the qualitative and quantitative data which highlighted transport as the greatest requirement for individuals and communities to access health services. Transport is required for individuals to access health care services (both in and out of town). Sourcing seed funding for a service vehicle would greatly increase service access and connectivity, enhancing overall community engagement with health care services and providers.

Drawing upon collaborative workshops held with community, the research team has devised a proposed program logic (Figure 23) for the implementation of the MHS. This has been adapted from the Indigenous Suicide Prevention Activity Evaluation Framework to serve as the baseline coordination of activity and evaluation planning (Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, 2021). Note that the program logic presented is preliminary; it requires further refinement through community feedback to ensure impacts and outcomes appropriately reflect the values and aspirations relevant to the community. This would be conducted when seed funding for the Mununjali Health Service is secured.

A proposed list of specific service inputs is outlined in Table 13. This list was developed through community engagement.

Figure 22 Mununjali Health Service: A stepped implementation

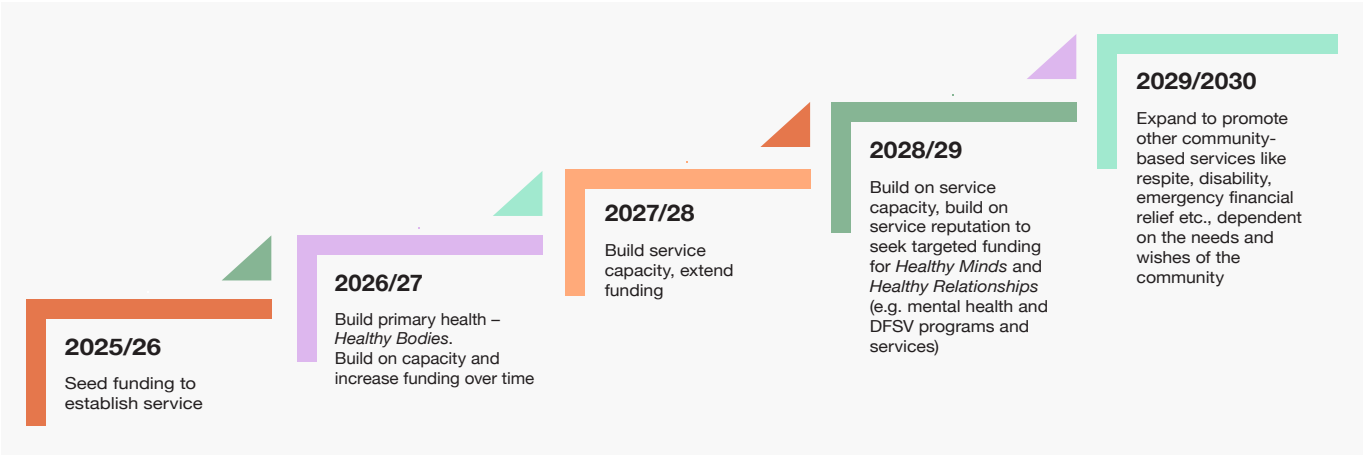


Figure 23 Simplified program logic

Research with the Mununjali people in the Beaudesert region of Qld identified the need for an Aboriginal-controlled health service in Beaudesert.

Operating across three domains of care – healthy minds, healthy bodies and healthy relationships – this service will utilise a stepped implementation approach to provide and facilitate DFSV prevention-focused, culturally safe, responsive, trauma-informed and equitable health care.

Program logic

What will happen?

- Seed funding to establish a service, provide a community space, and set up community transport option
- Build *healthy bodies* primary health offering via the 715 Closing the Gap health check
- Build on service capability and increase funding over time; include traditional healing
- Build on service grounding in community and reputation to seek targeted funding for *healthy minds* and *healthy relationships*
- Expand to promote other community-based services including DFSV, disability, emergency financial relief etc., – dependent on community need

What will occur as a direct result?

- Improved access to referrals and services through reliable transport
- Community enabled to access culturally safe and appropriate health support locally, and on Country
- Increased opportunities for culturally appropriate and warm referrals to other allied health services
- Creation of a culturally safe space for Elders', men's, women's, and mums + bubs groups to come together
- Development of a trauma-informed, holistic intergenerational service
- Identification of abuse and neglect for children, young people and Elders
- The development of a culturally safe service response to address the effects of DFSV for children, young people, intimate partners, and victim-survivors

What will occur as the longer term and overarching outcome?

- Early detection of DFSV leading to effective response interventions and decreased rates of DFSV
- Development of early intervention initiatives and programs to address and prevent DFSV
- Increased rates of social and emotional well-being (SEWB)
- Decreased rates of child, young person and Elder abuse and neglect
- Increased trauma-informed responses
- Development of stronger social connections – to culture, Country and community
- Improved health literacy and greater access to health justice

Evaluation framework aligned to program logic

Process evaluation

- How well is the service being implemented?

What's working?

- Where do opportunities for improvement lie?

Process indicators

- Was an accessible space secured to serve as the in-person location of the health hub?
- Was an ongoing form of transport secured?
- How much funding was secured?
- What awareness-raising activities were undertaken across the community?
- Have DFSV rates decreased?
- Have child abuse and neglect rates decreased for children, young people and Elders?

How will it be measured?

- Secondary data

Impact evaluation

- Is the service achieving what it intended?

Objective indicators

- Number of groups run in hub space
- Number of 715 health checks undertaken in health hub space
- Number of referrals made on basis of 715 health checks
- Service utilisation by community
- Number of referrals for DFSV support
- Number of referrals for child abuse and neglect intervention and support

How will it be measured?

- Mununjali Health Service health hub activity records
- Qualitative and quantitative data collection with community

Outcome evaluation

- Was the overarching purpose of the activity achieved?

Outcome indicators

- Increased rates of community connection and healing
- Decreased rates of DFSV
- Decreased rates of child abuse and neglect notifications
- Job creation for Mununjali people and other First Nations community members
- Improved health outcomes for Mununjali and Beaudesert community members

How will it be measured?

- Mununjali Health Service health hub activity records
- Ongoing use of qualitative and quantitative data collection processes with community
- Social return on investment
- Outcomes harvesting

Contribution to the evidence base

- Contribute evidence for expanded funding and recognition of Mununjali Health Service
- Contribute to the knowledge base of SEWB factors for First Nations communities
- Contribute to the knowledge gaps on the health determinants of DFSV in First Nations communities
- Contribute to the knowledge gaps for child abuse and neglect strategies and supports for children, young people and Elders in First Nations communities
- Creation of a case study on the development of a community-led and -designed, culturally appropriate, trauma-informed health service in a rural First Nations community

Table 13 Critical services to achieve healthy bodies, healthy minds and healthy relationships

Healthy bodies	Healthy minds	Healthy relationships
Primary care includes non-hospital health services provided by: • First Nations health care workers • First Nations health practitioners • Local doctors (general practitioners) • Community nurses – home visits • Allied health professionals (for example, physiotherapists and speech therapists) • Midwives – birthing on Country • Dental practitioners • Psychologist, mental health nurses and support services • Transport – both inside and outside of Beaudesert. Greater access to the Brisbane/Logan region for hospital/ specialists	Psychosocial health comprises four major components: mental, emotional, social and spiritual health for a more holistic model of mental wellbeing. These will be promoted by: • Mum + bubs support groups (antenatal and perinatal) • Rehabilitation services • Caring for and healing on Country • Prevention and intervention strategies and programs to address family and domestic violence • Intergenerational and community-level trauma-informed therapy and support • Mental health counselling services • Mental wellbeing support (i.e. men's groups, women's groups, youth groups) • Indigenous language and culture education programs	Culturally responsive support services to improve social, emotional, physical and spiritual wellbeing, and build individual and community capability to care for and protect children: • Family wellbeing services • Intensive family support services • DFSV prevention and early intervention support services • Playgroups • Early learning development programs • School-based programs and supports • Sports-based early intervention and support programs

Grounding the Mununjali Health Service model of care in best practice

While the Mununjali Health Service's proposed model of care should be highly tailored to meet the specific needs of the Mununjali and broader Beaudesert community, there are numerous evidence-based and government-backed precedents and guidelines for the implementation of such models.

Primarily, it was decided in consultation with the Mununjali community that the preferred approach was a "hub and spoke" model of an ACCHO tailored to meet the needs of the community, with a holistic focus to achieve improved outcomes in the healthy minds, healthy bodies, healthy relationships framework.

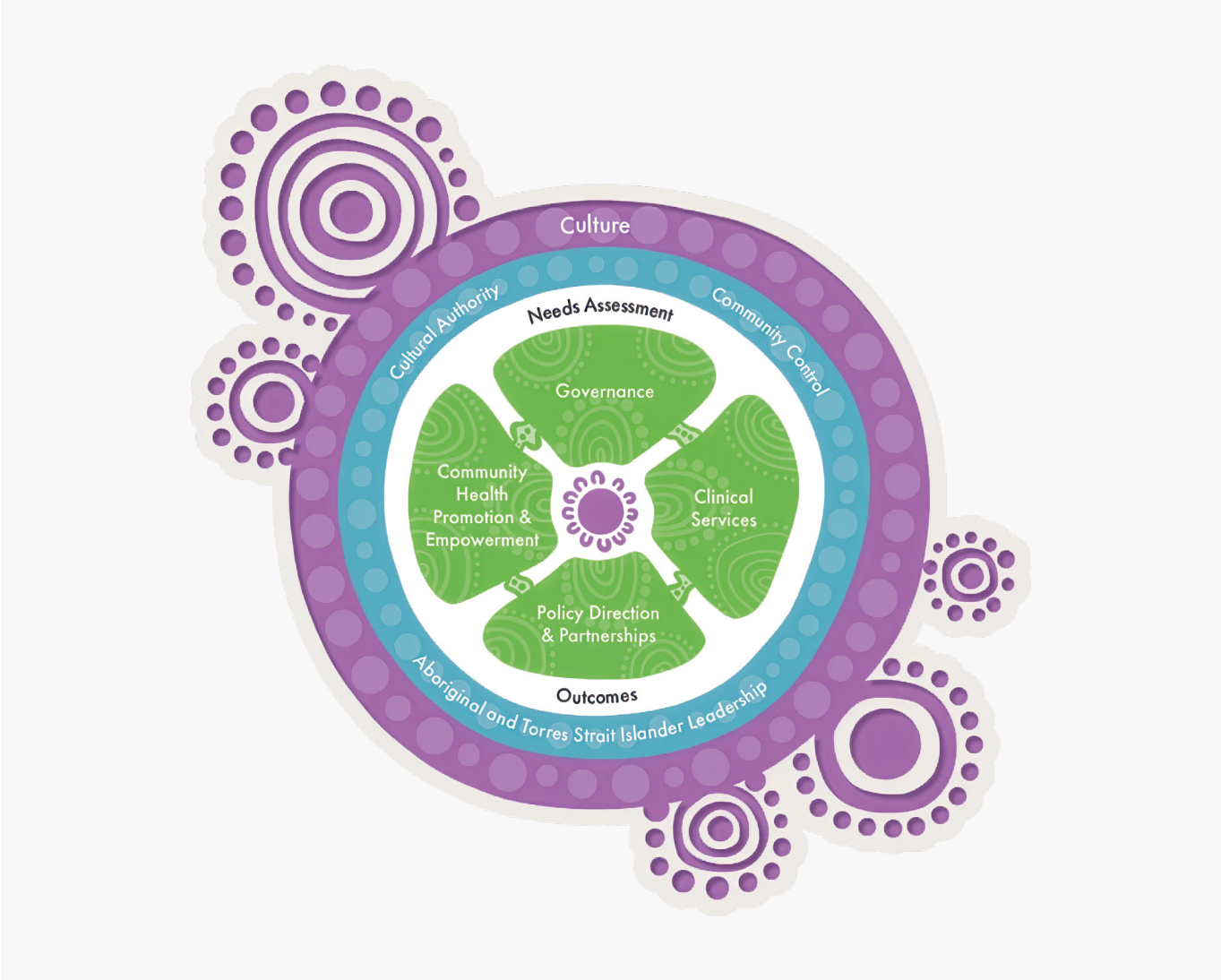
The hub and spoke model is a way of organising services where a central hub acts as the main point for people to access support, information and resources. From this hub, services are shared out to different locations or providers (the spokes). The hub connects with the spokes, allowing information and referrals to flow both ways: out to the community and back.

The National Aboriginal Community Controlled Health Organisation (NACCHO) health model (Figure 24) operates as a hub and spoke model and is flexible and culturally responsive. It is locally defined and integrates traditional knowledge with modern practices, allowing for community-led solutions and better health outcomes. We propose that the Mununjali Health Service borrows from this approach, tailoring as needed for the Beaudesert context.

Key elements of the NACCHO hub and spoke health model include:

- **central hub:** a central community hub or culturally appropriate space for community to gather, with key values of self-determination, kinship and family connections, knowledge and belief, and cultural expression
- **governance:** overarching infrastructure and support systems to provide accountable service delivery
- **clinical services:** preventative, evidence-based and trauma-informed medical and holistic services delivered in culturally appropriate ways
- **community health promotion and empowerment:** prevention and health promotion programs, mental health support, DFSV prevention and response and child and youth wellbeing initiatives
- **policy direction and partnerships:** rights-based strategic policy, partnerships and effective use of shared resources.

Figure 24 Model of needs-based community-controlled care (NACCHO)



Source: NACCHO (2021, p. 15).

Figure 25 Core principles of ACCHOs

Source: Based on Gee et al. (2014, p. 57).

To develop the Mununjali Health Service health care model, researchers also drew on the SEWB framework (Figure 26). This framework aligns with First Nations ways of knowing, being and doing, and recognises the important role of culture and history in the development of health care services for First Nations peoples.

Figure 26 SEWB framework

Source: Adapted from Gee et al. (2014, p. 57).

Alignment with existing government commitments

The proposed model aligns with existing government priorities and policy directions aimed at improving the wellbeing of First Nations communities.

The *Brisbane South Joint Regional Needs Assessment (JRNA) 2025–2027* (State of Queensland & the Australian Government, 2024) identifies inclusive health services for First Nations peoples as a high priority, noting the disparity in health outcomes with the broader population. In addition, domestic and family violence is identified as a priority issue for the Brisbane South region, which includes Beaudesert.

Similarly, *Together: Shaping Regional Wellbeing 2025–2030* (Metro South Health, 2025) emphasises that achieving regional wellbeing requires coordinated, integrated and collaborative approaches across sectors. It also underscores the importance of the coordination, integration and collaboration of all those involved in funding, planning and delivering services, including primary health networks, hospital and health services, and non-government organisations.

People who are using or experiencing DFSV are not well served by existing service systems, as their problems don't fit neatly into separate boxes for coordinated health, legal and social support. The *Health Justice Landscape December (2024) Report* (Health Justice Australia, 2025) identifies 141 national health justice services currently operating across Australia in which legal help is provided in health care settings and teams. These services include both formal health justice partnerships and outreach, integrated or hub services that combine legal assistance with health care services. Health justice partnerships aim to bring together health, legal and other services to address complex problems.

A partnership might include on-site lawyers in health settings for easy warm referrals, secondary consultations to give health and social workers the right advice, or holistic wrap-around services. A health justice service in the region is the OPALS Health Justice Partnership (a collaboration between Caxton Legal Centre and Metro South Health) situated in Jimboomba, approximately 30 minutes from Beaudesert.

The Queensland Government's *Domestic and Family Violence Prevention Strategy 2016–26* (Department of Families, Seniors, Disability Services and Child Safety, 2021) is a vehicle to drive change across all sectors of the Queensland landscape. Under the Fourth Action Plan (Haynes et al, 2017) of the strategy, the Queensland Government will deliver actions that enhance integrated response systems. Further, it commits to working in full and genuine partnership with First Nations peoples, recognising effective services and responses can only be achieved if they are co-designed and community-led, promoting cultural safety to support self-determination.

At the national level, the *Closing the Gap: Commonwealth Annual Report 2025 and Commonwealth Implementation Plan 2026* (Commonwealth of Australia, 2026) continue to prioritise improved health outcomes for First Nations peoples. Funded through Medicare, the annual 715 health check supports their physical, social and emotional wellbeing through early detection and prevention of potential health conditions (DHDA, 2022). The Closing the Gap strategy continues moving towards greater sharing of decision-making with First Nations people and stakeholders by continuing to strengthen partnerships and focusing on co-design and culturally appropriate approaches, First Nations-led research and the transfer of service delivery to Aboriginal community-controlled organisations.

The 2026–36 *Our Ways – Strong Ways – Our Voices* (DSS, 2026, p. 39) is a national Aboriginal and Torres Strait Islander plan to end DFSV. The plan focuses on culturally safe, trauma-informed and community-controlled solutions. It sets a plan for long-term change and calls on industry and the sector to work together for a safer future.

Our Ways – Strong Ways – Our Voices has five key threads (DSS, 2026). When woven together, they will create a future where Aboriginal and Torres Strait Islander women and children live free from violence:

1. Voice, agency and self-determination
    - Every decision is shaped by community voice, leadership and wisdom.
2. Aboriginal and Torres Strait Islander–led solutions that are strengths-based, preventive and healing
    - Support honours story and culture. Approaches to solutions are trauma-responsive and community-led.

3. Reforming the institutions and systems that impact safety
    - Each system is a thread that, when reformed, strengthens the whole:
        - justice
        - health
        - housing
        - family and social supports
        - education
        - disability services
        - child protection.
4. Strengthening evidence, research and data, embedding Indigenous data sovereignty
    - Community owning their data and stories means the research woven into this work is:
        - ethical
        - trustworthy
        - culturally sensitive
        - fit for communities.
5. Breaking the cycle through strengthened housing and financial security
    - Safe housing and fair and equal opportunities are threads for women's and children's safety. They create a strong base that is hard to unravel.

The national plan reflects the collective action and strengths of First Nations people, bringing together knowledge and wisdom to make safety, healing and wellbeing a national priority.

To support and implement *Our Ways – Strong Ways – Our Voices*, the Australian Government has engaged the Coalition of Peaks to help establish a new national peak body. This new national body will:

- provide leadership, advocacy and advice at the national level
- champion rights and interests of Aboriginal and Torres Strait Islander community-controlled organisations.

The proposed Mununjali Health Service model aligns with the vision of the national plan and action plan and is aimed at improving the wellbeing of First Nations communities working with community-controlled organisations.

A health justice partnership lens

People experiencing or using DFSV are not well served by existing service systems, as their problems do not fit neatly into separate boxes for health, legal and other services. A health justice partnership recognises this complexity and provides a collaborative model that brings together legal and health professionals to address the intersecting legal and health needs of people experiencing disadvantage. In this model, legal professionals work alongside health teams and health workers trained to identify legal issues and provide legal assistance on-site or through coordinated referral pathways.

By embedding legal support into health care settings, such as hospitals, community health centres and mental health services, health justice partnerships enable people to access legal help where they are already seeking care. The aim is to improve health and wellbeing by addressing legal issues that impact health (e.g. housing instability, family violence and debt), increase access to justice, support early intervention, and identify systemic barriers within health and legal systems).

A health justice partnership approach has clear application in the proposed Mununjali Health Service model of care as a mechanism for reducing DFSV. In developing a First Nations health service model, the following considerations are central:

- **relevance:** whether the service is wanted and valued by the local community
- **effectiveness:** whether it, through the sum of its parts, brings community together by creating and supporting connection in service of better social and emotional wellbeing
- **efficiency:** whether it, through the sum of its parts, supports the creation of a community hub that facilitates contact, referral pathways and resource sharing
- **impact:** whether it delivers culturally safe and appropriate services for the Mununjali community, building community capability and a future workforce
- **sustainability:** how it will be implemented through shared funding and shared resources, through community-led and -controlled leadership and governance structures.

4.2 Measuring success

Evaluating the implementation plan and ongoing delivery of an ACCHO/health hub in Beaudesert for the Mununjali community will be critical to the successful improvement of health outcomes and DFSV reduction across the community. Any attempt at evaluation would need to be grounded in self-determination and community capacity-building approaches to ensure its cultural appropriateness and ongoing value to community. While the approach to evaluating the intervention would be validated through participatory action research processes with community, an initial approach, developed in line with the research findings, is proposed.

Best-practice principles

Although not an exhaustive list, the following best-practice principles have been drawn from existing Indigenous research practices and literature. These principles will form the foundations of the development, implementation and ongoing monitoring and evaluation of the Mununjali Health Service.

- **Self-determination:** upholding the right of First Nations peoples, including their distinct political status and the right to set priorities, make decisions and freely pursue development on their own terms (AIATSIS, 2020).
- **Holistic view of health:** understanding health as grounded in connection to a range of domains and influenced by social, political, cultural and historical determinants (Gee et al., 2014).
- **Health justice approach:** addressing legal and structural barriers that disempower First Nations peoples from seeking and access to health care (National Justice Project, 2022).
- **Respecting ways of knowing, doing and being:** reflecting Indigenous epistemologies, axiology and ontologies and understanding knowledge as the product of social, political and place-based subjectivities and experiences, privileging the voices, experiences and lives of First Nations peoples (Moreton-Robinson & Walter, 2009).
- **Reflexive practice:** embedding consciousness of power and positionality at every step for non-First Nations peoples participating in the evaluation.
- **Ethical conduct:** upholding the key values of spirit and integrity, reciprocity, respect, equality, survival and protection, and responsibility (Kelaher et al., 2018).
- **Indigenous data sovereignty:** recognising the rights of First Nations peoples to control the use of their own data and the importance of data access for governance and self-determination (AIATSIS, 2020).
- **Capability-building approach:** strengthening ongoing monitoring and evaluation capability within the Mununjali Health Service so there is a shared understanding of priorities for program implementation and delivery (Australian Government Productivity Commission, 2025).

Evaluation approach

It is important to note in this section that the Mununjali Health Service's proposed model of care is in the embryonic stage. Therefore, the following text provides a preliminary example of the evaluation approach. Further community co-design would be required for community acceptance and implementation of a proposed approach.

An evaluation of the proposed model would encompass the process and outcomes of the model's implementation. To conduct both a process and outcomes evaluation would require the assessment of the implementation of the program and ongoing monitoring of changes, through to success (or otherwise) of the intended outcomes.

The approach would need to consider multiple levels and target populations, with achieving consistency and quality in data capture, analysis and assessment a key priority.

A series of conceptual models would be developed and refined in partnership with community, with proposed starting points outlined below. Identified outcomes would align with relevant governance frameworks and policy strategies, including the *National Agreement on Closing the Gap* (Australian Governments and the Coalition of Peaks, 2020) and the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* (Department of Health, 2021).

Data collection

A range of participatory and culturally appropriate methods for gathering data and consulting community would be used to evaluate the implementation, monitoring and ongoing impact of the proposed model.

Primary data collection approaches could include:

- **Social return on investment:** this method is a structured approach to integrating social, environmental, economic and other forms of value into decision-making processes. Previous work by the Victorian ACCO has developed a social return on investment approach that is grounded in First Nations ways of knowing, being and doing through the use of *impact yarns* and *value yarns* (Victorian ACCO, 2023).
- **Outcomes harvesting:** used to retrospectively understand causal pathways through reports, personal interviews and other sources, this method determines whether and how an intervention has contributed to these pathways (Better Evaluation, n.d.). It ensures that outcomes are not purely posited by the program logic, but also emergent from and defined by community experience.
- **Culturally derived health-based survey:** the survey developed as part of this work would be key to the ongoing monitoring of the hub's progress in positively impacting the health outcomes of the Beaudesert community.

Secondary or programmatic data may include funding agreements, financial records, service reporting documentation and administrative data.

4.3 Strengths and limitations

Understanding the strengths and limitations of this research is important for interpreting results. Table 14 provides an overview of the research project's strengths and limitations.

A key limitation to note is the reduced scope of the research in understanding DFSV perpetration. On advice from the AIATSIS ethics committee, the drafted research instrumentation limited the number of questions that explicitly addressed DFSV perpetration within a small First Nations community. While the researchers understood and accepted the rationale for these modifications – namely to reduce negative stereotyping of First Nations communities and to limit any re-traumatisation for victim-survivor participants – the ability to gather deeper insights into understanding the health profile of First Nations people who may use DFSV was unavoidably limited. The project's aims and objectives were adjusted slightly during the ethics phase to account for this.

Table 14 Research project strengths and limitations

Strengths	Limitations
• **Successful** use of participatory action research in a First Nations community • Awareness of research bias and stereotypes, unequal and dependent relationships, and the use of continuous critical reflection for non-First Nations researchers • Engagement with community through deep listening and building ongoing trusting relationships, based on respect with Elders and the Mununjali and broader Beaudesert communities • Effective use of co-design and collaboration, ensuring community control, governance and decision-making • Adherence to First Nations principles of self-determination • Training and upskilling of local community members as community co-researchers • Collaborative analysis centred on Indigenous perspectives and bringing multiple perspectives to bear on the data • Commitment to impact and value, with a focus on real world impacts and value for the community beyond the production of a research report	• Aside from the two Mununjali community co-researchers, the research team was not based within the community; in some instances, the researchers were seen as "outsiders" by some community members • Historical and cultural community relationships (ongoing family feuds) and the negative impact this had on community engagement • The small number of survey respondents ($n = 105$) contributed to a lack of large-scale comparative data analysis • Missed survey responses and questions left unanswered impacted the collection of a larger data set • Ethical approval processes resulted in slight changes to project objectives and the data which could be collected on DFSV

4.4 Directions for future research

Further research to strengthen the implementation of the proposed Mununjali Health Service includes:

- **Regional service mapping** to understand the services currently funded to support the Mununjali people and the broader Beaudesert community.
- **Allied health service audit** to examine currently funded services, service scope and outreach support. Any audit needs to include a detailed summary of which services they are currently funded to provide and how they are to be provided.
- **Ongoing engagement with Elders, community members and stakeholders** to continue to develop and implement the proposed Mununjali Health Service health hub, referral pathways and outreach service design.
- **Engagement with Mununjali children and young people** who are victim-survivors of DFSV to better understand their health, safety and support needs.

Chapter 5: Conclusion

This research took a community-led, participatory approach grounded in First Nations ways of knowing, being and doing to understand the health determinants that present with DFSV for Mununjali people and the broader Beaudesert community. Through mixed methods, including community yarning, participatory workshops and a culturally derived health survey, the project generated a holistic and culturally grounded evidence base. This informed the co-design of a proposed health-centred intervention to address DFSV for Mununjali people in the Beaudesert region.

Each stage of the research involved Elders, community members and MHS representatives to ensure culturally safe engagement, shared decision-making and community ownership of the research process and outcomes.

By listening deeply to the Mununjali people and their community and their experiences, needs and aspirations, we found:

- There is widespread DFSV and comorbidities, such as alcohol and drug use, intergenerational trauma, mental illness and cognitive disabilities, and a service infrastructure that is failing to address these broad and pervasive community needs.
- In spite of historic legacies and ongoing experiences with oppression, violence, and cultural trauma and disruption, there is strong community resilience and desire for change to repair decades of neglect in the community and to commit to the reduction of DFSV.
- The community supports creating an Aboriginal community-controlled health hub in Beaudesert as a solution to address DFSV and broader health needs. Key features should include Elder leadership, holistic and trauma-informed care, culturally safe spaces, phased implementation, comprehensive support services with outreach, transport, and integration with current providers.

The findings paint a clear picture of a community navigating a complex intersection of mental ill health, chronic physical conditions, intergenerational trauma, systemic and structural barriers, and widespread experiences of violence. At the same time, the research highlights profound resilience, cultural strength and a strong community desire for change. The integrated insights across the healthy minds, healthy bodies, healthy relationships framework demonstrate that DFSV cannot be understood or addressed without acknowledging the cumulative impacts of trauma, racism, service gaps, poverty and limited access to culturally safe care. These findings underline the need for responses that move beyond crisis intervention towards prevention, healing and empowerment grounded in culture and self-determination.

This study is significant for the following reasons:

- The healthy body, healthy minds, healthy relationships approach makes a significant contribution to the DFSV evidence base by integrating a range of health and social determinants into how DFSV can be understood and addressed in First Nations communities. The data collected through this research demonstrates poor mental and physical health is widespread across a community troubled by DFSV. The study situates these findings within a broader context of systemic shortcomings and historic traumas experienced by Mununjali people.
- While secure funding and dedicated effort will be required to bring the community's will into life, the project demonstrates the value of a place-based, community–controlled, health-centred approach to illuminate the determinants of DFSV and support the development of a locally designed solution.
- The community's vision – a Mununjali–led health hub providing holistic, culturally safe and trauma–informed care – offers a powerful and actionable model for addressing DFSV through improved mental, physical and relational wellbeing that presents a promising opportunity for replication in other communities.

This research not only supports the case for such a model but also outlines clear pathways for implementation and evaluation.

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APPENDIX A

Literature review

Our understanding

Ending domestic, family and sexual violence (DFSV) in Australia is a national priority, with perpetrator accountability and intervention now a key policy and research focus. Existing efforts to understand, reduce and prevent DFSV centre on victim-survivors, and are supported by a large body of research that focuses on the impacts of violence and risk factors of victimisation (Flood et al., 2022). While the *National Plan to End Violence against Women and Children 2022–2032* and *The Australian National Research Agenda to End Violence against Women and Children ANRA 2023–2028* recognise that DFSV is fundamentally a problem of perpetration, there is limited research about people who use violence in Australia, and in Aboriginal and Torres Strait Islander communities in particular (DSS, 2022a; Lloyd et al., 2023). Even within the small body of research on people who use DFSV, there is a greater focus on risk factors for perpetration rather than a focus on understanding the protective factors to inform early interventions and desistance. It has long been recognised that a broader range of perpetration interventions are needed, with flexibility to address co-occurring issues such as mental health and alcohol and drug use (Chung et al., 2020).

The starting point for this piece of work is the *Aboriginal and Torres Strait Islander Action Plan 2023–2025*, which calls for solutions to DFSV that are strength-based, trauma-informed, community-led and inclusive of Aboriginal and Torres Strait Islander forms of language, healing, support and education (DSS, 2022b). The plan further notes that solutions need to be expanded to include those who use violence, with culturally appropriate responses utilised to support healing as a form of prevention. The present literature review builds the context for why the development of a community-led health response is an appropriate means of addressing these priorities for reform.

Research gaps related to perpetration of domestic, family and sexual violence

Lack of data informing a profile of people who use violence

Data about people who use DFSV is often collected from victim-survivors. This means there can be challenges in using this data to build a profile of those who use DFSV and understand the context of, and risk factors for, perpetration. While a recent review found that experiencing physical, sexual or emotional abuse in childhood was a common risk factor for male perpetration of intimate partner sexual violence, there remain significant gaps in the evidence base (Clare et al., 2021). Notably, in an Australian context, substance use issues, neurological conditions and mental health issues are associated with the perpetration of more severe (predominantly) physical family violence and greater difficulties ensuring internal perpetrator accountability (ANROWS, 2020).

Addressing DFSV research gaps in Aboriginal and Torres Strait Islander communities is a priority

There is a further dearth of research about DFSV perpetration in Aboriginal and Torres Strait Islander communities. The literature consistently recognises that experiences of DFSV in Aboriginal and Torres Strait Islander communities, including access to support services, willingness to seek help and risk factors, are unique and influenced by overlapping forms of discrimination. Numerous studies, reviews and evaluations have identified that justice and legal systems in Australia need to improve responses to and accountability of people using DFSV (Chung et

al., 2020). However, legal accountability cannot be the sole form of response, which is especially relevant for Aboriginal and Torres Strait Islander communities where disproportionate contact with the legal system, fear of children being removed and fear of isolation from family and community deter help-seeking and reporting. These deterrents contribute to the lack of data and prevent policymakers from developing a clear profile of perpetrators and perpetration. With an over-representation of Aboriginal and Torres Strait Islander children in both child protection and youth justice systems, there is some urgency for more research to better understand protective and risk factors to inform a public health approach to prevention and early intervention (Menzies School of Health Research, 2022).

Understanding the relationship between health and likelihood to perpetrate

The link between health status and the likelihood of using violence

Research conducted by ANROWS in 2022 spoke to the health experiences of users of DFSV, noting that those who had used violence against a partner in the previous 12 months were more likely to report poor health and mental health on a range of measures; the same study reported that 25.8 per cent of the sample of Australians who had used DFSV were living with disability (Hegarty et al., 2022, p. 97). Other work by ANROWS found that substance use issues, neurological conditions and mental health issues are associated with more severe (predominantly) physical family violence among Aboriginal perpetrators (Langton et al., 2020).

The association between negative early childhood experiences (particularly abuse), as well as substance misuse, and the likelihood of using violence is well established. Mental health issues are regularly studied in association with the use of DFSV, including post-traumatic stress disorder, depression, anxiety and personality disorders (AIHW, 2024; Salom et al., 2015; Spencer et al., 2019).

A meta-analysis of mental health factors and DFSV perpetration and victimisation found that personality disorders were stronger correlates for perpetration than victimisation regardless of gender (Spencer et al., 2019). For women, borderline personality disorder was a stronger correlate for perpetration, whereas for men there was no statistically significant difference in the link between individual mental health disorders and perpetration. However, an Australian study found that 51 per cent of people (*n = 560*, 93.1% male) who had used DFSV screened positive for post-traumatic stress disorder, whereas only 29 per cent were positive for depression and 30 per cent for anxiety (Hegarty et al., 2022, p. 14).

A study of the relationship between child abuse, poor mental health and use of intimate partner violence found that child trauma is a risk for both poor mental health and use of intimate partner violence by men in South Africa (Machisa et al., 2016, p. 9). The authors identified an "overlap between poor mental health, a history of child abuse, and adult intimate partner violence perpetration, which constitute public health problems" and suggested that prevention efforts need to incorporate strategies aimed at addressing these mental health issues and their sources. A systematic review of mental health treatments in the prevention of intimate partner violence in low- and middle-income countries found that too few studies have been conducted in this field to understand whether such treatments represent a beneficial strategy (Tol et al., 2019). The growing literature around DFSV within Aboriginal and Torres Strait Islander communities renders it an issue not solely of gender inequality and harmful masculinity but rather a confluence of social, historical, political and cultural determinants (Gee et al., 2014). These are determinants that stem from colonisation, systemic disadvantage and cultural disruption, such as alcohol and drug misuse, intergenerational trauma, mental illness and cognitive disabilities (Gallant et al., 2017).

Health responses to DFSV

A public health model conceptualisation of DFSV has been included in Australian and international policies since the 1990s (Tayton et al., 2014). Such conceptualisations tend to broadly address the social determinants of health that are associated with increased risk of DFSV, but do not necessarily promote health-specific prevention activities. For instance, VicHealth's public health approach to

preventing violence against women – the Respect, Responsibility and Equality program – uses an ecological model for understanding violence and where prevention efforts can be directed, largely based on two causes understood by VicHealth to be fundamental: "the unequal distribution of power and resources between men and women" and "an adherence to rigidly defined gender roles" (Kwok, 2013, p. 2). Table A1 describes the five projects funded by the VicHealth program – none of which directly address health determinants of DFSV.

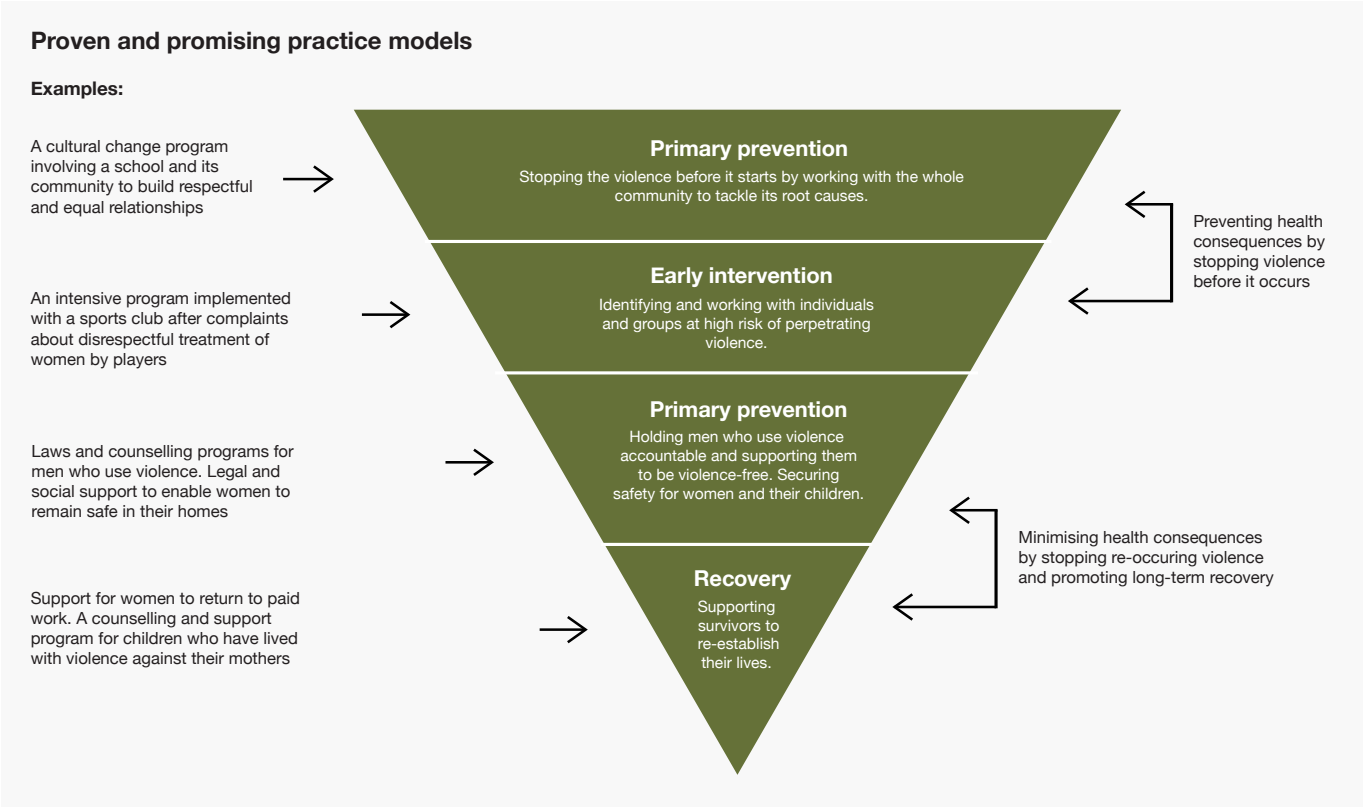
Table A1 Projects under the Respect, Responsibility and Equality program

Projects	Settings	Brief description	Key activities
Working together against violence	Corporate workplace	Built the capacity of a male-dominated workplace with sites (and a head office) in Victoria to promote respectful relationships between men and women	Whole-of-company strategy for organisational culture change (lead, train and promote)
Partners in prevention	Youth-focused practitioner sector	Built the capacity of youth-focused practitioners in Victoria to promote respectful relationships among the young people they work with	Community of practice with opportunities for networking, information-sharing and professional development
Baby makes 3	Maternal and child health services	Engaged maternal and child health services and clients in programs that build equal and respectful relationships in the transition to parenthood	Group work activities for mums and dads that explore gender norms, expectations and roles
Respect and equity (Maribyrnong City Council)	Local government and its community	Strengthened the capacity of a local government to address the underlying causes of violence against women	Comprehensive "culture shift" agenda focusing on local government policy, planning, leadership, and partnership activity
Northern interfaith respectful relationships	Faith organisations	Built the capacity of faith leaders to foster respectful and violence-free relationships between men and women	Mentoring program and other tools and resources for faith leaders

Source: Kwok (2013, pp. 5–9).

Other literature suggests that an effective response to DFSV requires a coordinated, cross-sector approach involving a continuum of strategies, as shown in Figure A1 (Webster, 2016). Integrated, multi-faceted solutions to DFSV that address health outcomes as well as other factors related to perpetration are being thoroughly recommended by reform documents such as the *Aboriginal and Torres Strait Islander Action Plan* (DSS, 2022b), as well as in the literature (Langton et al., 2020).

Figure A1 Levels of prevention and examples of practice



Source: Webster (2016, p. 36).

Health response to DFSV in Aboriginal and Torres Strait Islander communities

This has implications for future research and responses to DFSV, including a greater focus on a health response in prevention and intervention and when people who use DFSV in Aboriginal and Torres Strait Islander communities interact with the legal system. To address the underlying complexities contributing to the perpetration of violence, and to cultivate internal perpetrator accountability, research to date has recommended a health response, in addition to greater Elder involvement in the criminal legal system (Australian Institute of Criminology, 2003; Langton et al., 2020). A health response will need to be supported by community-owned and placed-based approaches and focus on healing by addressing trauma and providing early and holistic support to address associated issues (Blagg et al., 2020). Responses must also build workforce capacity to recognise health drivers of DFSV (Langton et al., 2020).

Domestic, family and sexual violence prevention and intervention in Indigenous communities

Preventing DFSV in Aboriginal and Torres Strait Islander communities

Existing participatory research with Aboriginal and Torres Strait Islander communities shows support for a health response to DFSV and a need to invest in interventions that address co-occurring factors of DFSV use, such as mental health, neurological disability and substance misuse, which are seen as contributing to the frequency or severity of DFSV (Langton et al., 2020).

A systematic review of interventions and approaches to reducing family violence in North American Indigenous communities identified only eight relevant studies (Shea et al., 2010). The authors found that

"most family violence research focuses on tertiary prevention (prevention of recurrence)", which includes health care screenings to detect DFSV and counselling programs. They identified a growing body of evidence for secondary prevention (reducing violence where risk factors exist), which includes behavioural change and substance-use reduction programs, but "only two narrative reviews relevant to, if not actually directed at, primary prevention, the prevention of emergence of risk factors that could lead to family violence" (Shea et al., 2010). This was despite, as they suggest, this being "exactly the upstream prevention where Indigenous strengths are mostly likely to play out" (Shea et al., 2010).

A review of existing knowledge, practices and responses to violence against women in Australian Indigenous communities reviewed a range of programs and approaches implemented over a 15-year period (Menzies School of Health Research, 2022). The following is a list of programs categorised as "proactive" (i.e. that aim to counter violence prior to it occurring), which the authors rated as having moderate or strong evidence of effectiveness and as including Indigenous viewpoints:

- Fitzroy Valley Alcohol Restriction program: restriction of alcohol in two communities
- Central Northern Adelaide Health Service Family and Community Healing Program: an early intervention program aimed at building the capacity of Indigenous families, which included counselling and group activities aimed at building confidence, increasing personal skills in conflict resolution and increasing awareness of forming positive relationships
- Gippsland CommUNITY Walk Against Family Violence: community initiative that brought together Indigenous and non-Indigenous community members to celebrate Indigenous culture, discuss family violence and increase access to a range of services
- "Talk, talk, cry, laugh": training program for Indigenous workers responding to sexual assault and other forms of family violence
- Aboriginal Women Against Violence project: aimed to establish an Aboriginal Women Against Violence Committee and to train local Indigenous women to become trainers, mentors and advocates
- Family Well Being program (as a tool for addressing endemic family violence): participants reported that the program builds personal strength, increases ability to assist others and increases motivation to challenge structural factors impacting on health equality
- Norseman Voluntary Liquor Agreement: community-led restrictions on the sale of take-away alcohol (Menzies School of Health Research, 2022).

A scoping review of programs tackling DFSV with Aboriginal and Torres Strait Islander men specifically spoke to the need for men's programs to address the underlying factors of colonisation in perpetration (Gallant et al., 2017). Most of the programs reviewed broadly had the same aim: "to engage Aboriginal men on a wide range of social and emotional issues, to support the empowerment of men, and to facilitate a journey of healing" (Hegarty et al., 2022, p. 34). It was noted that although DFSV was not the primary focus of some of the programs, a common approach to program elements was noted as being useful to that context. These elements included:

- community buy-in and ownership of programs
- support for the healing of men, grounded in the idea that Indigenous men suffer from low self-esteem and loss of individual, cultural and community identity as a consequence of the trauma wrought by colonialism
- programs supporting healing and covering support for education, employment, health, identity, law, relationships, resources and safety
- holistic approaches that address social and emotional wellbeing
- the meeting of cultural needs through the creation of culturally safe spaces and the strengthening of cultural identity
- education of men on issues of DFSV (Hegarty et al., 2022).

Further, the scoping review identified three central ideas that should be used in the development of programs targeting Aboriginal and Torres Strait Islander men:

- programs targeted at Aboriginal and Torres Strait Islander men need to have components that address multiple power constructs by addressing colonisation
- having a greater understanding of multi-dimensional or holistic approaches to family

violence will better inform policy, program and practice responses

- more in-depth evaluation of men's programs is required to build our understanding of what works in family violence prevention with men who use violence (Gallant et al., 2017).

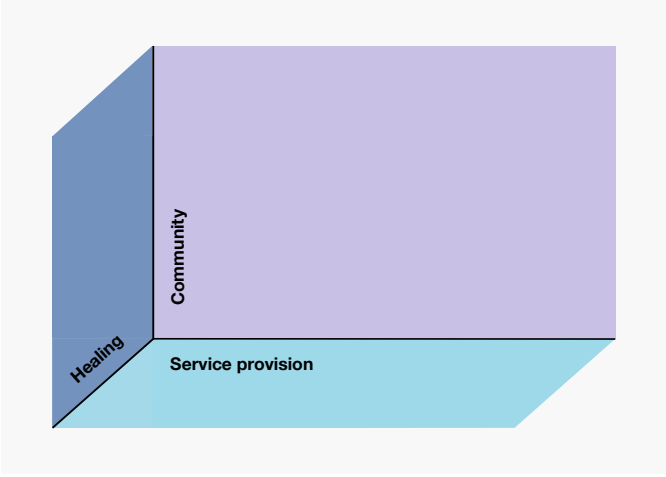
Creating health responses

Considerations

As outlined in the Aboriginal and Torres Strait Islander Action Plan, "men must be supported to lead healing work with men and boys, empowering them to regain their dignity, determination, health and wellbeing, and engagement as positive community role models" (DSS, 2022b, p. 10).

Further, the literature has established a multi-dimensional or holistic approach to dealing with DFSV in the context of Aboriginal and Torres Strait Islander communities. This model looks to tackle the multi-faceted complexities of the issue by situating program delivery at the nexus of community, healing and service provision (see Figure A2).

Figure A2 Approach to Aboriginal family violence



Source: Gallant et al. (2017, p. 41).

Rights-based approaches to health

Rights-based approaches to health entail respect for the right to health of all persons as stated by both the *Universal Declaration of Human Rights* (United Nations General Assembly, 1948) and the *International Covenant on Economic, Social and Cultural Rights* (United Nations General Assembly, 1966). Such approaches require "policymakers to embed fundamental principles of participation and inclusion (particularly of affected and marginalised populations), equality and non-discrimination (reflecting the universality and inalienability of human rights and the equal dignity of all persons), transparency (in health decision-making), and accountability (through the rule of law)" (Bustreo & Doebbler, 2021, p. 89). These four key principles have been confirmed in other literature, with other academics suggesting that, in the Latin American context, "understanding governments as duty bearers and health system users as claims holders has been fundamental to holding governments to account with respect to achieving aspects of universal health coverage equitably" (Yamin & Frisancho, 2015, p. 163).

This framing, with its emphasis on equality, participation and inclusion for marginalised populations, strongly aligns with the United Nations *Declaration on the Rights of Indigenous Peoples,* which not only asserts the right to "the highest attainable standard of physical and mental health" for Indigenous peoples (Article 24[2]) but also the right to self-determination (Article 3) and to improving their economic and social conditions, including health (Article 21[1]; AIHW, 2024; United Nations, 2007). As observed by Mazel (2016, p. 264), "for Indigenous peoples, self-determination is fundamental to improving health outcomes. It is essential to the process of achieving health equality and involves the ability to construct knowledge in and around health systems and practices in accordance with self-determined definitions of what is real and what is valuable."

The literature also suggests that Aboriginal community-controlled health services are practical expressions of these rights regarding Aboriginal self-determination in Aboriginal health, but that this expression is contingent on access to adequate resources (Machisa et al., 2016, p. 40). The authors suggest that, while self-determination is integral to service delivery for Aboriginal and Torres Strait Islander peoples, it is not a determinant of success and "the commitment of resources and good program and service design also play a critical role". This is important with respect to how rights-based approaches position users as "claims holders": through this approach, services and interventions to be funded for health cannot simply be determined and designed "by technocrats behind closed doors" but instead require input from health system users (Yamin & Frisancho, 2015).

Existing measures of social and emotional wellbeing

There are some existing culturally derived tools that are intended for use in Aboriginal and Torres Strait Islander communities to assess domains related to social and emotional wellbeing. These include:

- **Here and now Aboriginal assessment (HANAA):** intended for use in clinical and community settings, administered verbally in yarning and narrative style format across 10 domains of social and emotional wellbeing (physical health, sleep, mood, suicide risk and self-harm, substance use, memory, unusual experiences, functioning, life stressors and resilience). Suitable for people 18 years and over (Janca et al., 2015).
- **Strong souls assessment (SSA):** intended for use in clinical, community and school settings and administered verbally. This 25-item screening tool assesses problems related to depression, anxiety, suicide risk and levels of resilience (Thomas et al., 2010).

Conducting the research

Centring Aboriginal and Torres Strait Islander voices in DFSV research

It is imperative that the experiences and viewpoints of Aboriginal and Torres Strait Islander peoples are centred in the development of tailored policies and community-led programs through participatory approaches to knowledge production. Existing participatory research with Aboriginal and Torres Strait Islander communities shows support for a health response to DFSV. Participatory work with communities in Western Australia, Queensland and the Northern Territory saw participants express a desire to see health approaches embedded in DFSV prevention responses (Blagg et al., 2020). Additionally, Elders emphasised the need for preventative programs directed at young people. Furthermore, Aboriginal and Torres Strait Islander communities and service providers have identified a need to invest in primary prevention interventions that address co-occurring issues, such as mental health, neurological disability and substance abuse, which are seen as contributing to the frequency or severity of DFSV (Langton et al., 2020).

Participatory research with Aboriginal and Torres Strait Islander communities

Participatory action research is an approach that prioritises lived experience in tackling issues stemming from social inequities, and developing solutions (Cornish et al., 2023). It is widely seen as an effective way to engage Indigenous peoples and communities in research that is equitable and produces culturally valid, meaningful knowledge (Dudgeon et al., 2017).

A key example of participatory action research with Indigenous communities in Australia is the National Empowerment Project (NEP), "an innovative Aboriginal and Torres Strait Islander led pilot project working directly with communities to address their cultural, social and emotional wellbeing" (QMHC, n.d.). The NEP involved a partnership between a university-based project team and 11 Aboriginal communities (with 22 community-based researchers) across Australia, and aimed to identify both risk factors (i.e. negative impacts on social and emotional wellbeing) and protective factors (i.e. strategies for helping to strengthen cultural, social and emotional wellbeing) for individuals, families and communities (Dudgeon et al., 2017).

The NEP adopted five Aboriginal and Torres Strait Islander-specific approaches to understanding and responding to local need:

- self-determination: shaping service provision and assessment and management of care through culturally valid understandings
- community-based approach: for solutions to place-based issues to be successful, they must be driven from within the relevant community (externally derived solutions fail to address risk factors or harness protective factors)
- holistic perspectives: understanding Aboriginal and Torres Strait Islander health to encompass mental, physical, cultural and spiritual health
- Aboriginal and Torres Strait Islander diversity: there are many groupings, languages, kinships,

communities and ways of living among Aboriginal and Torres Strait Islander peoples

- acknowledging a history of colonisation: researchers need to appropriately engage local groups in producing cultural knowledge to promote cultural reclamation and Indigenous self-determination (QMHC, n.d.).

The process of implementing participatory action research in the NEP was as follows:

- engage community-based researchers, identified and/or recruited by a local partner organisation, based on a pre-determined set of criteria
- train community-based researchers through a 5-day workshop covering basic project management, participatory action research processes, culturally safe research methods (e.g. yarning), research ethics, qualitative methodologies and critical reflection
- develop a set of project principles, devised with community-based researchers to guide implementation
- deliver community consultations, including interviews and focus groups conducted by community-based researchers, to understand challenges faced by individuals, families and communities, as well as to assess current services and programs and identify gaps and how missing services might be designed and delivered
- produce community reports based on the consultations, which are then disseminated back to the communities and relevant stakeholders
- ensure project support and capacity-building through workshops and mentoring for community-based researchers, a dedicated online platform for community-based researchers to share experiences and suggestions, and a National Advisory Committee made up of relevant Indigenous subject-matter experts (Dudgeon et al., 2017).

Elements of this process were reported in smaller-scale participatory research to collect narratives about Aboriginal peoples' experiences with health care in Western Australia in a culturally appropriate way (Wain et al., 2016). Specifically, the project established an Indigenous reference group to determine the methodology, recruited and trained yarning researchers, and disseminated the narratives via an open-access website. Also, in line with the NEP, the authors stressed the importance of adopting an Indigenous methodology to address incompatibilities inherent in Western approaches to research. This is a consistent focus in the literature on participatory action research with Indigenous communities around the world (Evans et al., 2014; Peltier, 2018).

While methodological studies are strongly represented in the literature, the present review identified fewer outcome studies for participatory action research with Indigenous peoples. Snijder et al. (2015) undertook a systematic review of studies evaluating community participation, methodological quality and outcomes of Australian Indigenous community development projects. The authors identified 31 evaluation studies and noted that, while all reported positive qualitative or quantitative outcomes, only 2 studies reported statistically significant outcomes. They also noted that community participation varied between project phases, tending to be high during implementation but low during evaluation.

Overall, Snijder et al. (2015) found that the methodological quality of these evaluation studies was too weak to clearly determine their effectiveness in improving the health and wellbeing of Indigenous people. The authors suggest that this is consistent with similar reviews, and that future studies would ideally use "rigorous evaluation designs, reliable, valid and culturally appropriate measures, economic analysis and a complex intervention framework to balance standardisation and tailoring" and emphasise the need for better researcher–community partnerships. It is important here to again highlight the tension between Western and Indigenous ways of knowing and approaches to research design and evaluation. As Dudgeon et al. (2017, p. 4) identified regarding the NEP, "participatory research around the factors contributing to Indigenous people's poor social and emotional well-being is itself an end through which Indigenous people can be empowered and feel a sense of control over the conditions that adversely affect their lives".

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APPENDIX B

Health service providers in Beaudesert

Provider name	Service inclusions
Absolute Physio & Rehab	Exercise physiology, chronic disease management, falls prevention and dietetics services
Beaudesert Amcal Pharmacy	Pharmacy, immunisation service
Beaudesert Child Health & Early Years Centre	Maternal, child and family health service
Beaudesert Dental Care Centre	Dental
Beaudesert Family Practice	General practice, immunisation service
Beaudesert General Practice & Skin Cancer Clinic	General practice, skin cancer checks
Beaudesert Hospital	Antenatal clinic, palliative care services, oral health service, early parenting support, drug and alcohol clinics, perinatal, podiatry, physiotherapy, emergency department, Aboriginal and Torres Strait Islander community hospital liaison, community health
Beaudesert Medical Centre	General practice, cardiology service
Beaudesert School Dental Clinic	Dental
BDF Dental	Dental
Caroline Hennessey	Occupational therapy
CBO Psychology	Psychology
Centacare Home Safety Services	Community health
Doctors @ Beaudesert	General practice
Eaglesfield Street Medical Centre	General practice
Hearing Australia	Audiology
Jymbilung House Aged and Disabled Care Services	Physiotherapy, nursing
Lisa Jane Podiatry	Podiatry
Priceline Pharmacy	Pharmacy, immunisation service, needle and syringe program

Provider name	Service inclusions
Scenic Rim Discount Drug Store	Pharmacy
Scenic Rim Optometrist	Optometry
Specsavers Audiology	Optometry, audiology
Wagner Dental Surgery	Dental
Wongaburra Society	Physiotherapy

Aboriginal community-controlled health organisations and Aboriginal medical services available for Beaudesert residents

Service	Location	Travel time via car	Travel time via public transport
Browns Plains Clinic	Browns Plains	44 minutes	1 hour 5 minutes
Inala Community Health Centre	Inala	54 minutes	2 hours 22 minutes
Jajumbora Midwifery Hub	Waterford West	43 minutes	1 hour 52 minutes
Logan Medical Clinic	Logan Central	52 minutes	1 hour 33 minutes
Loganlea Clinic	Loganlea	45 minutes	1 hour 38 minutes
Woolloongabba Medical Clinic	Woolloongabba	1 hour 5 minutes	1 hour 58 minutes
Yulu-Burri-Ba Wynnum	Wynnum	1 hour 14 minutes	2 hours 36 minute
Yulu-Burri-Ba Capalaba	Capalaba	1 hour 10 minutes	3 hours 4 minutes

APPENDIX C

Expression of interest form for community co-researchers

Healthy Minds, Healthy Bodies, Healthy Relationships Research Project

We are seeking expressions of interest to be a paid Community Co-researcher for an upcoming study in the Beaudesert and Logan area

What is the research about?

Mununjali Health Service (MHS) has received a grant ***to conduct a research project to understand the health needs of the local Beaudesert & Logan community***. The grant was received from Australia's National Research Organisation for Women's Safety (ANROWS).

Who is doing this research?

Mununjali Health Service is partnering with the Social Research Centre to conduct this research. Mununjali Health Service (Est 2021) an ORIC registered ICN 9596 independent indigenous organisation which focuses on Aboriginal & Torres Strait Islander advocacy, research and training in the health field. The Social Research Centre is an independent Australian social research organisation owned by the Australian National University.

How can I be involved in this project?

We are seeking expressions of interest from First Nation community members (in Logan and Beaudesert) who wish to be involved in the project as a **Community Co-researcher**. The project will run from September 2024 to August 2025.

What is involved?

The Community Co-researchers will assist the research team to engage with Elders, local community, key stakeholders, and young people during the research project. Community Co-Researchers will be trained to undertake research in their community and will be paid for their time.

If you are interested in participating in the research as a Community Co-researcher please click this link, https://forms.office.com/r/b2nTR4WSn4 and you will be directed to our Expression of Interest form.

Queries and concerns

If you have any questions about this project, please don't hesitate to the project manager below. All contact will be treated confidentially.

Ms Ally Cahill – Senior Research Consultant,
Social Research Centre
Phone: +61 3 9236 8500 (reception)
Email: ally.cahill@srcentre.com.au

What's next?

Please complete the expression of interest link. It will be automatically returned to our researchers. Alternatively email via research.evaluation@srcentre.com.au. If you are selected as a Community Co-researchers, you will receive an email from the research team. If you are not selected, you will not be contacted by our team.

Expression of interest form (to be provided and completed through Microsoft Forms)

Mununjali Health Service – Community Researcher Position

Required

1. **Your First Name**
2. **Your Last Name**
3. I identify my gender as:

Woman

Man

Non-binary

4. Do you identify as Aboriginal or Torres Strait Islander?

Yes – Aboriginal

Yes – Torres Strait Islander

Yes – Both Aboriginal and Torres Strait Islander

No

5. **How old are you?**
6. **Do you have access to a mobile phone?**

Yes

No

7. **Your best contact number**
8. **Your best contact email**
9. **Please tell us why you want to work on the Healthy Bodies, Healthy Minds, Healthy Relationships project**
10. **Have you worked on any research projects previously? {if not this is not a problem}**

Yes

No

11. **Do you have your own transportation?**

Yes

No

12. **Do you have access to a laptop and internet connection?**

Yes

No

13. **Are you able to work after 5pm and available for work on a Saturday for a couple of hours if required?**

Yes

No

Submit

APPENDIX D

Discussion guide for in-depth yarns

This is an internal document for researchers only

Project title: Healthy Minds, Healthy Bodies, Healthy Relationships

Background note

The Mununjali Health Service has partnered with the Social Research Centre to conduct a research project focused on understanding the health needs of First Nation peoples in the Beaudesert/Logan/Mununjali community.

The project will explore social and emotional well-being and individual and community experiences relating to domestic, family and sexual violence. The findings will provide an evidence base for the need for a culturally appropriate health service in the Beaudesert/Logan/Mununjali community.

This research will focus on the following key outcome areas:

- Social and emotional wellbeing
- Healthy Minds, Healthy Bodies, Healthy Relationships
- Individual experiences of health care service
- Individual experiences of family, domestic, and sexual violence
- Access to health services, and
- Culturally safe health care services.

Order of the guide: 45–60 minutes in total

Description	Duration
Welcome and introduction	(10 mins)
Experience of health care services (health story)	**(15 mins)**
Improving health care services	**(15 mins)**
Wrap up	**(10 mins)**

Quick demographics – no need to ask the following questions directly, the demographic questions can be woven into the interview [Circle or add text response below]

Where do you currently live?	Beaudesert/Logan/Other. If other, please state where:
I am	1. Man, or Male 2. Woman, or Female 3. Non-binary 4. I identify another way
Age	1. 18-34 years 2. 35-54 years 3. 55+ years, please specify:
I am	1. Aboriginal 2. Torres Strait Islander 3. Aboriginal and Torres Strait Islander 4. Neither Aboriginal or Torres Strait Islander 5. Prefer not to say/Other

Explanation to participants

- Introduce yourself and explain that you work as a researcher at the Social Research Centre
- Introduce the name of the research project Healthy Minds, Healthy Bodies, Healthy Relationships
- Introduce the purpose of the research:
  - To understand the health profile of the Beaudesert/Logan/Mununjali First Nation community
  - Produce an evidence base for a culturally appropriate health service in Beaudesert/Logan/Mununjali and surrounding regions, and
- State that the project has been funded by the Australia's National Research Organisation for Women's Safety (ANROWS).
- **Purpose of interview:**
  - To hear directly from Beaudesert/Logan/Mununjali community members about their health care experiences in their local region.
- Explain:
  - the importance of honest opinions, that there are no right or wrong answers.
  - the presence/role of third party (if applicable – e.g. Community co-researcher or project team member) to support the process
  - that they do not have to participate and are able to withdraw from the research at any time. Emphasise that they do not need to answer questions if they don't want to.
  - that the interview will be audio recorded and seek all parties consent to be recorded
  - how the information will be used and stored. Collect consent forms (if in person) or seek verbal consent (if online).
  - that all participants will receive $50 Giftpay card as thank you for their time.
- Ask the participants to sign the Consent Form
- Housekeeping matters – duration of yarn (45–60 mins), need for breaks, etc.
- Make sure you have a separate copy of the support services – hand this to the participant now

- Ask if they have any questions before starting?

1. Introduction (10 mins)

The purpose of today's yarn is to learn more about the Beaudesert/Logan/Mununjali community members and their experiences of health care services in the region and surrounds.

To begin with, it would be great to learn a little more about you and your community.

- Could you tell me a bit about yourself and your family?
- How long you have been living in Beaudesert/Logan/on Mununjali Country? If you aren't living on Country – where do you live now?
- Can you tell me about your local community?
    - What do you like about it? What could be improved?
        - [Prompt: connected, good/poor services available, crime/safety, discrimination, health].

2. Experiences of accessing health care services (health story) (15 mins)

Your health story

Now, we would like to hear about your health care experiences as a Beaudesert/Logan/Mununjali community member.

- What does health and well-being mean to you and your community?
- Could you share a time when you or your family needed health care?
    - [Prompt -]. Did you feel you were able to access the services you needed?
    - If yes, how?
    - If not, what were some of the reasons why you couldn't?

Experience of trauma and their relationship with health

- Have you, or any family members experienced violence in your community?
  [Prompt – can you describe the ways in which these experiences have affected your physical or mental health]?

Culturally safe health care services

- Based on your personal experiences, do you feel safe and respected when accessing health care services?
    - [Prompt –]. Have you experienced any forms of discrimination or racism when accessing health care services? If yes, what were they?
- Based on your health care experiences, have you ever felt uncomfortable, or felt that your voice was not heard in a health care setting?
- Have you ever been supported by an Aboriginal Health Liaison Officer/worker when accessing health care services? If yes, how? If no, why not?
    - How did this make you feel?
    - [Prompt – How important is it to have Aboriginal Health Liaison officers/workers involved in your healthcare]?
- How do culture and community support your physical and mental health?

Challenges

- Could you tell me about some of the challenges you have faced when you have tried to access health care service in your community?
- What did you do when faced with these challenges? Can you share some of your experiences.

3. Improving health care services (15 mins)

Now I'd like to turn your thoughts to the health care needs of your community

- What would an ideal health care service look like for you and your family?
- Are there specific cultural support/s which you need from a health care services?
    - [Prompt – could you share these with me?]
- How could a specific Aboriginal and Torres Strait Islander health care service better support your community?

4. Wrap up (10 mins)

- We have finished the interview.
- Before we finish up, and thinking about what has been discussed today, is there anything that you've reflected on that you would like to share or discuss?
    - Thank participant for the interview
    - Provide participant with GiftPay voucher as a thank you for their participation
    - Provide the participant with the post yarn support services information sheet
    - Close the interview and commence filed note write up

Support services

Information and contact information for participants

Beyond Blue:
1300 224 636

Lifeline:
13 11 14

13 YARN:
13 92 76

DVConnect Women's Line:
1800 811 811

DVConnect Men's Line:
1800 600 636

Sexual Assault Helpline:
1800 010 120

ParentLine – Queensland and Northern Territory:
1300 301 300

National Indigenous Critical Response Service & Standby Support After Suicide Service:
1800 805 801 or
0499 333 132

If you need an interpreter to help speak with any of the above services, call the **Translating and Interpreting Service on 131 450.**

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children