family safety victoria

ORIMA RESEARCH

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2019-20

# Census of Workforces that Intersect with Family Violence

**Survey Findings Report:**
Primary Prevention Workforce

VICTORIA State Government

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## **Survey Findings Report:** Primary Prevention Workforce

This project was conducted in accordance with the international quality standard ISO 20252, and complies with the Australian Privacy Principles contained in the Privacy Act 1988. ORIMA Research also adheres to the Privacy (Market and Social Research) Code 2014.


### Acknowledgement of Aboriginal Victoria

We pay our respects to Aboriginal and Torres Strait Islander peoples past and present, their cultures and traditions and acknowledge their continuing connection to land, sea and community.

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# 1 Introduction

## Background

In March 2016, the Royal Commission into Family Violence (RCFV) delivered a multi-volume report with 227 recommendations directed at improving the foundations of the system, seizing opportunities to transform the way that the Victorian Government responds to family violence, and building the structures that will guide and oversee a long-term reform program that deals with all aspects of family violence.

The recommendations of the RCFV highlighted the lack of detailed knowledge and systematic collection of data about family violence and related workforces in Victoria, which has made effective industry and workforce planning challenging. The RCFV recommendations also confirmed the important role that these workforces play in identifying and addressing family violence.

In response to these findings, a commitment was made to undertake a family violence workforce census (the Census) every two years in a continued effort to address this gap. The first Census was conducted in 2017, and in July 2019, Family Safety Victoria (FSV) commissioned ORIMA Research to design and deliver the 2019-20 Census.

### Research objectives

The overarching aim of the 2019-20 Census was to assist in deepening the Victorian Government's understanding of a range of issues in the context of reforms recommended by the RCFV.

More specifically, the Census aimed to:

- provide an evidence base for the analysis required to inform the Victorian Government's decisions relating to industry planning and associated workforce reforms; and
- enable a more nuanced understanding of specialist family violence and primary prevention workforces through targeted consultation, surveying and regional analyses of these workforces.

The findings of this Census will help the Victorian Government to better understand the breadth and nature of workforces that come into contact with family violence; identify opportunities to build on knowledge, support and capability; as well as build on what is known in order to maintain its commitment to keep improving family violence prevention and response in Victoria.

Three target groups (workforces) were identified for the Census, as detailed in Table 1 overleaf. This report presents the 2019-20 Census findings for the second target group listed – those who completed the Census in a primary prevention capacity[1].

1. Where respondents indicated that they held paid roles across multiple workforces, the initial screening questions directed them to complete the Census in the capacity of only one of these workforces. Please see Appendix A for the full questionnaire, including screening / routing rules.

| Table 1: Target groups for the Census (workforces) | |
|---|---|
| **Workforce** | **Definition and example roles** |
| **Specialist family violence services** | – Those who work directly with victim survivors, perpetrators or cases of family violence as a family violence response specialist; or<br>– Those who work directly with family violence response specialists as a manager, supervisor or trainer; or in a capacity building, policy or practice development role.<br>*Example roles: family violence or justice case manager, family violence outreach, refuge worker, counsellor / phone support, crisis worker, men's behaviour change practitioner or case manager, RAMP Coordinator, intake or enhanced intake, sexual assault worker, family violence court practitioner or family violence court registrar, etc.* |
| **Primary prevention of family violence** | – Those who work to prevent family violence through systemic / organisational / community-level initiatives.<br>*Example roles: family violence primary prevention officer or practitioner, family violence or respectful relationships educator, gender equity officer, prevention of violence against women officer, family violence health promotion officer, manager or trainer of primary prevention officers or practitioners, etc.* |
| **Broader workforce that intersects with family violence** | – Those who are sometimes in contact with victim survivors or perpetrators of family violence and required to deal with the impacts of family violence, despite this not being a significant focus of their role.<br>– This includes all types of workforces who work with women, families and children (or the broader community) as part of their day to day role even though it is not directly related to family violence.<br>*Example roles: police officer, court registrar, ambulance officer, teacher, nurse, disability services worker, community services or social worker, prison officer, youth worker, residential home worker, developmental support officer, student support, Child & Family Wellbeing / Integrated Family Services worker, etc.* |

**Primary prevention workforce definition**

The primary prevention workforce comprises two groups with varying roles[2]:

– **Practitioners** – Those who specialise in designing, implementing and monitoring actions to prevent family violence. Practitioners must understand the drivers of family violence and are engaged in activity that focuses on actions to prevent violence before it starts. This group was the target audience for the Census.

– **Contributors** – Those located within specific sectors or disciplines where participation in preventing family violence may be a part of their role, but is not their primary focus. This group was not in scope for the Census.

For the purposes of the Census, references to the primary prevention workforce relate only to primary prevention practitioners.

2. https://www.vic.gov.au/sites/default/files/2019-05/Preventing-Family-Violence-and-Violence-Against-Women-Capability-Framework.pdf

## Project development

### Questionnaire development and sector consultation

The questionnaire (see Appendix A) was developed by ORIMA Research and the FSV project team, with content informed by the previous Census. The questionnaire was designed as a single instrument, with screening questions at the start to categorise respondents into one of the three workforces and route them through to the applicable survey questions.

Learnings from the 2017 Census led to the following changes being implemented in the current Census:

- Changes to workforce definition to improve data quality.
  - In 2017, respondents were categorised into four "tiers". For the 2019-20 Census, this approach was carefully revised and replaced with the three workforce categories outlined earlier in Table 1.
  - It should be noted that the current Census results for the primary prevention workforce are unable to be benchmarked against results from the 2017 Census, due to the substantial changes in the way workforces were defined in 2019-20.
- Extensive consultation with the sector to accurately inform the design and development of the questionnaire.
  - ORIMA Research and FSV conducted a series of consultative workshops, meetings and interviews with representatives from the target workforces between August and October 2019 (see Appendix B for a list of the stakeholders consulted).
  - The survey dissemination method and elements of the survey design, including the initial screening questions, were tested amongst the target workforces and iteratively refined.
  - A consultation summary report was prepared in November 2019, summarising participants' feedback and recommendations regarding survey communication, design and dissemination.
  - Sector consultation was made possible with the assistance of the Victorian Council of Social Services, Domestic Violence Victoria and No to Violence.

### Research approvals

Ethics approval was granted for this project by the ORIMA Research Human Research Ethics Committee on Thursday 31 October 2019 (Approval Number: 0112019). Research approvals were also granted by the Victoria Police Research Committee and the Victorian Department of Education and Training Research in Victorian Government Schools and Early Childhood settings committee, to conduct research with their staff.

### Pilot survey

The survey was administered using an online self-completion methodology. As part of the questionnaire finalisation process, a pilot was conducted between Monday 11 November and Friday 15 November 2019, to assess the suitability of survey design and content, and to test the online system and survey length.

Pilot participants were volunteers recruited by the FSV project team, and included individuals representing each of the three workforces. A total of n=16 individuals completed the pilot survey, from a pilot contact list of N=30.

Participants were asked to provide feedback via email. Comments made within the survey were also analysed and feedback was clarified directly with participants as required. Overall, the pilot was assessed as being successful as there were no substantial difficulties raised or improvement suggestions provided in relation to any aspect or question of the survey, and no critical survey issues were uncovered. A pilot testing outcome

summary was provided to the FSV project team which detailed some suggestions for improvement primarily in relation to optimising the clarity of some response options. Some feedback was also provided in relation to accessibility.

Following the pilot survey, the online survey was revised to incorporate pilot feedback, and was finalised in consultation with the FSV project team in preparation for the main fieldwork phase. The online survey underwent comprehensive internal testing by the ORIMA project team, as well as User Acceptance Testing by the FSV project team, prior to launch.

**Main survey**

The main survey was conducted between Monday 18 November 2019 and Friday 28 February 2020. A small extension was also granted for certain workforces until Friday 13 March 2020 in order to boost final response numbers. Participation in the survey was voluntary, and responses to the survey were private and confidential.

*Survey dissemination (via Survey Coordinators)*

The Victorian workforce intersecting with family violence is vast, and there is no central or reliable record of contact details for all individuals employed in this sector. Therefore, in order to conduct the Census, ORIMA Research and the FSV project team relied on sector, departmental, and organisational (or similar) representatives to assist in a controlled dissemination of a generic Census survey link.

These representatives, known as Survey Coordinators, were carefully recruited to ensure good coverage of all areas of the workforces that intersect with family violence in Victoria. Coordinators were asked to either email the survey link directly to their contacts, or act as an intermediary, by asking their contacts to share the link to relevant cohorts within their extended network.

A total of 22 Survey Coordinators assisted in promoting and disseminating the Census across the three workforces. Coordinators were provided with support materials to assist them in both identifying in-scope workforces and participants, and also to share to such individuals. This ensured that a consistent and clear invitation and message was communicated across the sector.

*Pre-registration*

Prior to the main survey period, a Census pre-registration page was set up by ORIMA Research support survey dissemination. This page allowed individuals to voluntarily register their email address to receive an invitation to the survey upon launch.

*Response rate*

In advance of fieldwork, the FSV project team undertook an extensive data collection exercise to estimate the population size for each of the relevant workforces for this project (see details in the following section). Figures were collated via consultation with various organisational representatives across the sector. Estimated headcounts and/or full-time equivalent (FTE) figures were provided by key occupation groups. These figures were used to monitor response rates and are the basis for response rate figures below.

Overall, a total of 5,021 responses were received for the Census, including 517 from the primary prevention workforce **(see Table 2).**

| Table 2: Response rate breakdown (based on population estimates) | | | |
|---|---|---|---|
| **Workforce** | **Population size (approximate)** | **Number of responses** | **Response rate** |
| **Specialist family violence response** | 2,491 | 1,575 | 63% |
| **Primary prevention of family violence** | 352 | 517 | 147% |
| **Broader workforce that intersects with family violence** | 222,070 | 2,929 | 1% |
| **TOTAL** | **224,913** | **5,021** | **2%** |

### Population estimates

As illustrated in Table 2, the number of survey responses received for the primary prevention workforce is greater than the estimated population (147% response rate). This inconsistency may be due to a number of reasons, including:

- **Population figures that were used to calculate response rates are estimates of the true population size.** These figures were collated by the FSV project team via various workforce contacts and do not represent the estimated overall headcount at a single point in time (as different workforce contacts provided figures at different points over 2019). Although the available population figures are assumed to provide a good estimate of the size of the workforce, in the absence of any single and reliable source of data it cannot be known how closely these figures mirror that of the true population.
  - A key consideration regarding the estimated figures is that there is likely to have been some employee turnover or restructuring of roles / organisations since this estimate was collated. There is also a small risk that the original estimates may not have covered all in-scope areas of the workforce (though it should be noted that the FSV project team undertook a substantial amount of work to ensure all areas of the workforce were covered).
- **Respondents were responsible for classifying themselves into the correct survey** (by answering the screening questions), hence there is a risk that incorrect self-classification has occurred for some. The project teams very carefully designed the screening questions in collaboration with the sector and provided a range of key roles as examples to assist respondents in classifying themselves correctly. However, there is still a small risk that this was done incorrectly according to FSV's understanding of in-scope roles. This was further mitigated where possible at the data processing stage, with any respondents who were identified as clearly answering the wrong survey (through their role and organisation type) were allocated back to the correct cohort.
  - It should be noted that respondents' interpretation of their own role may also be misaligned to FSV's understanding / classification. Role examples were provided to mitigate this however some respondents may have disagreed with their classification.
- **Some primary prevention contributors may have also participated in the Census.** It should be noted that practitioners were the key target audience within the primary prevention workforce, and contributors were out of scope.

**Statistical precision**

As this survey was an attempted census of workforces that intersect with family violence (i.e. all those in scope for the survey were assumed to have been invited to participate, via either a personalised or generic survey link), the survey results are not subject to sampling error.

However, the survey is subject to potential non-sampling error, including coverage error and non-response error. Unlike sampling error, non-sampling error is generally not mathematically measurable. ORIMA Research uses several strategies to address sources of non-sampling error to the extent possible, including careful questionnaire construction and data processing quality control.

**Presentation of results**

Percentages in this report are based on the total number of valid responses made to the particular question being reported on. In most cases, results reflect those participants who expressed a view and for whom the questions were applicable. 'Don't know / can't say' and 'prefer not to answer' responses are included only where they aid in the interpretation of results. Results presented as percentages throughout the report may not add up to 100% (particularly where displayed in chart form) due to rounding, or where participants were able to select more than one response.

Results for demographic cohorts (e.g. age, organisation type, etc.) are only presented in this report where notable differences are observed. Suppression rules have been implemented throughout this report whereby groups of individuals with fewer than 10 respondents have not been reported on to protect respondent confidentiality.

Please note that all results are self-reported by respondents and have not been verified against any external secondary data.

# 2 Executive summary

### Role requirements

The Census results identified the diversity of activities undertaken by the primary prevention workforce, and the varying frequencies at which these activities are conducted. The core activities most frequently undertaken by this workforce included developing and maintaining partnerships and networks, project management, and planning / implementing primary prevention initiatives.

### Employment conditions

Both the Census results and findings from the initial sector consultation suggested that workers in the primary prevention workforce were less likely than the average **Victorian to hold a full-time role.** However, almost one-fifth of the workforce reported that they held at least one additional paid role outside of the primary prevention workforce, and one-in-ten held more than one paid role within this workforce. Additionally, many employees reported that they were employed on fixed-term contracts, and many also reported working additional unpaid hours.

### Supervision

The results indicated that the primary prevention workforce was broadly **satisfied with the quality of support** provided by their supervisor or direct manager, and that having the opportunity to regularly discuss their professional development, or their work more generally, were key drivers of this satisfaction.

### Training and confidence

While the primary prevention workforce had completed training across a range of topic areas, overall confidence in their level of training and experience was moderate. The findings highlighted **MARAM** as a priority area for further / improved training and professional development.

### Health and wellbeing

Overall, the results of both the Census and the initial consultation phase of the project suggested that many within this workforce experience **stress due to high workload.** Despite this, few were dissatisfied in their current role and most felt that they made a difference to people affected by family violence.

### Career and future intentions

The results showed that people shared a number of positive reasons for working in the primary prevention workforce, including a strong **commitment** to preventing / responding to family violence and gender equity.

Regarding future intentions, almost half of all primary prevention practitioners reported that they had plans to leave their current role. Although many planned to do so due to an end of contract, others were influenced by better career prospects.

# 3 Profile of respondents

## PRIMARY PREVENTION PRACTITIONERS

work to prevent family violence through systemic, organisational and community-level initiatives

### Where do primary prevention practitioners work?

They work across **a range of different organisation types**, the top 10 being:

| | |
|---|---|
| 23% Community Organisation | 7% Health Promotion |
| 15% Local Council / Government | 7% Legal Services |
| 14% Policy, Research and Advocacy | 3% Multicultural or Settlement Services |
| 13% Community Health | 3% School and Area-Based Health and Wellbeing |
| 13% Women's Health | 3% School Education |

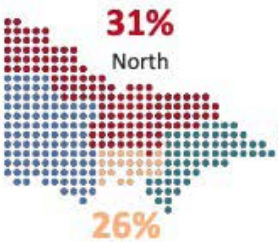
(n=511)

They work for both **large** and **small** organisations ...

- 56% work in organisations with **fewer than 100** individuals
- 43% work in organisations with **100 or more** individuals
- 1% were **self-employed** or had **'other'** circumstances

(n=511)

And **provide services all over Victoria**




(n=302 - 512)

- 29% State-wide / National
- 52% Metropolitan
- 50% Regional

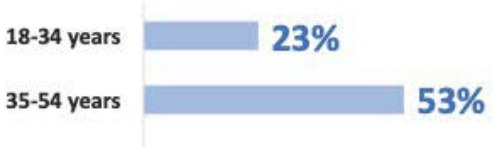
### Who are the individuals in this workforce?

This is a predominantly **female** workforce

- 85% of the workforce identify as **female**
- 13% identify as **male**
- 1% self-described

(n=438)

Over half are **aged between 35 and 54**

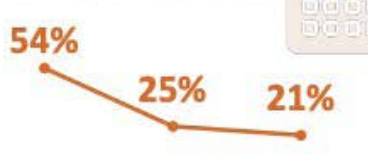



(n=445)

**13%** experience **difficulties or restrictions** which affect their participation in work activities

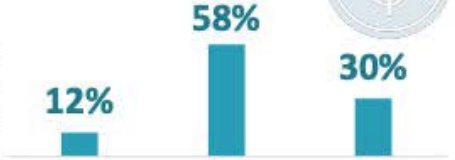
(n=429)

Many are fairly **new** to their current role, while others have been working in their current role for **a number of years**




Years of experience in current role (n=443)

The annual (individual) **income** for this workforce is varied, with over half earning between $51K and $90K a year




Annual (individual) income (n=421)

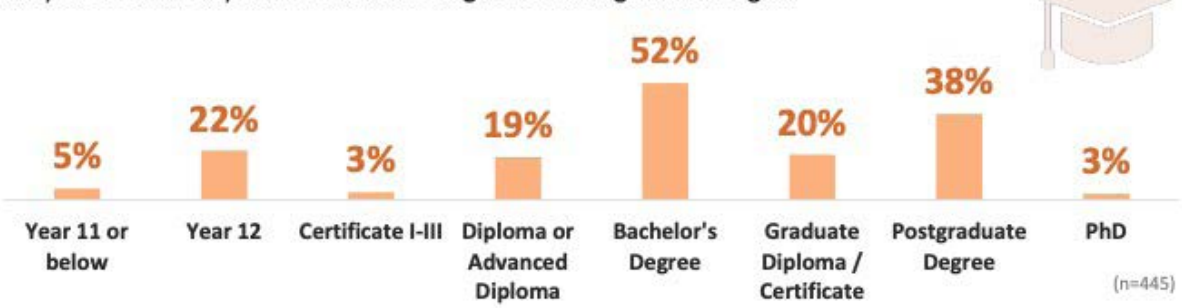
## What level of education does this workforce hold?

This workforce has completed study in **various different fields** , the top 10 being:

| | | | |
|---|---|---|---|
| 17% | Arts / Humanities | 12% | Social Science |
| 17% | Social Work | 12% | Community Services |
| 14% | Health Promotion | 10% | Teaching |
| 13% | Public Health | 9% | Psychology |
| 12% | Community Development | 8% | Counselling |

(n=436)

They most commonly hold a **Bachelor's Degree** or a **Postgraduate Degree**




(n=445)

## What is the cultural diversity of this workforce?

The majority were **born in Australia** ...

*Top 3 places of birth:*

| | | |
|---|---|---|
| 80% | 6% | 3% |
| Australia | United Kingdom | New Zealand |

(n=431)

And **identify as Australian**

*Top 3 cultural backgrounds / ethnicities:*

| | | |
|---|---|---|
| 71% | 10% | 8% |
| Australian | English | Irish |

(n=425)

**35%** use their **cultural or faith-based knowledge and experience** in undertaking their work

(n=387)

**94%** speak English **at home**

**1%** also speak each of the following languages at home: Cantonese, Punjabi or an Aboriginal or Torres Strait Islander language

(n=437)

**99%** use English **to carry out their role**

**2%** also use Hindi, and

**1%** use Punjabi or Italian to carry out their role

(n=440)

**4%** identify as **Aboriginal or Torres Strait Islander**

(n=435)

# 4 Role requirements

Primary prevention practitioners are responsible for designing and implementing projects and programs that aim to prevent or reduce the incidence of family violence. They utilise a variety of approaches in their work, including awareness raising, partnership development, community development, advocacy, and structural, environmental, organisational and systems development.[3]

The primary prevention practitioner workforce comprises a range of roles. This chapter summarises the role requirements of this workforce both generally and as they relate to family violence.

Overall, the Census results identified the diversity of activities undertaken by this workforce, and the varying frequencies at which these activities are conducted. As perhaps expected, respondents were more likely to report that they frequently worked on activities that were core to their primary prevention role (such as partnership development and primary prevention initiatives), and undertook **family violence response**-specific activities less frequently (particularly those related to information requests and client referrals).

## Core activities

Figure 1 illustrates the frequency with which primary prevention practitioners reported that they undertook various core activities as part of their role. Around half of respondents or more indicated that they frequently worked on the following at least weekly:

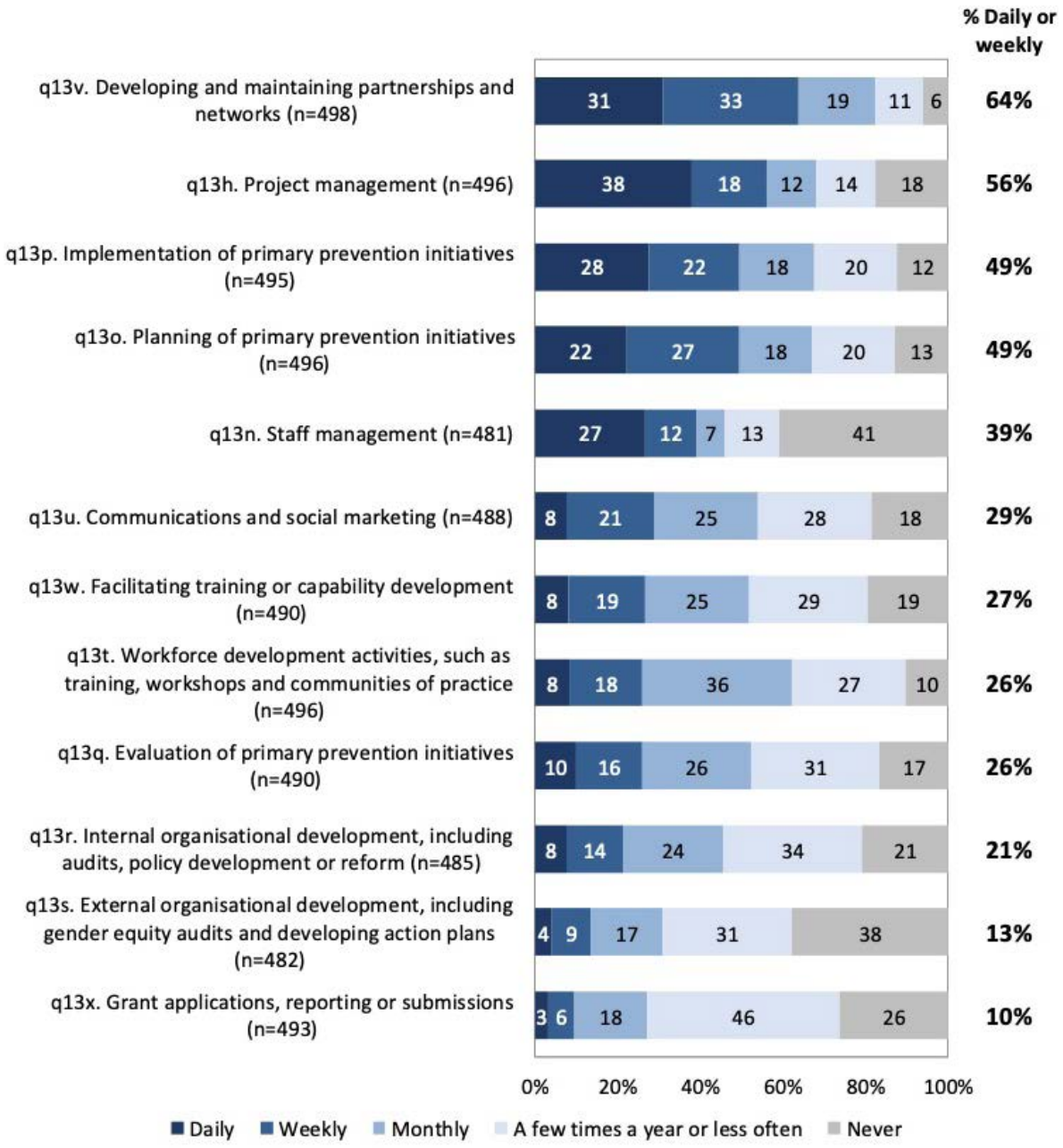
- developing and maintaining partnerships and networks (64%);
- project management (56%);
- implementation of primary prevention initiatives (49%); and
- planning of primary prevention initiatives (49%).

In contrast, over one-in-four respondents reported that they never undertook the following activities:

- staff management (41% – although a notable proportion (39%) indicated that they did this at least weekly, demonstrating the complex and varied nature of roles in this workforce);
- external organisational development, including gender equality audits and developing action plans (38%); and
- grant applications, reporting or submissions (26%).

3. https://www.vic.gov.au/sites/default/files/2019-05/Preventing-Family-Violence-and-Violence-Against-Women-Capability-Framework.pdf

**Figure 1: Role requirements – Core**
Base: All respondents




*Q13. Overall, how frequently do you work on the following activities?*

## Family violence response-specific activities

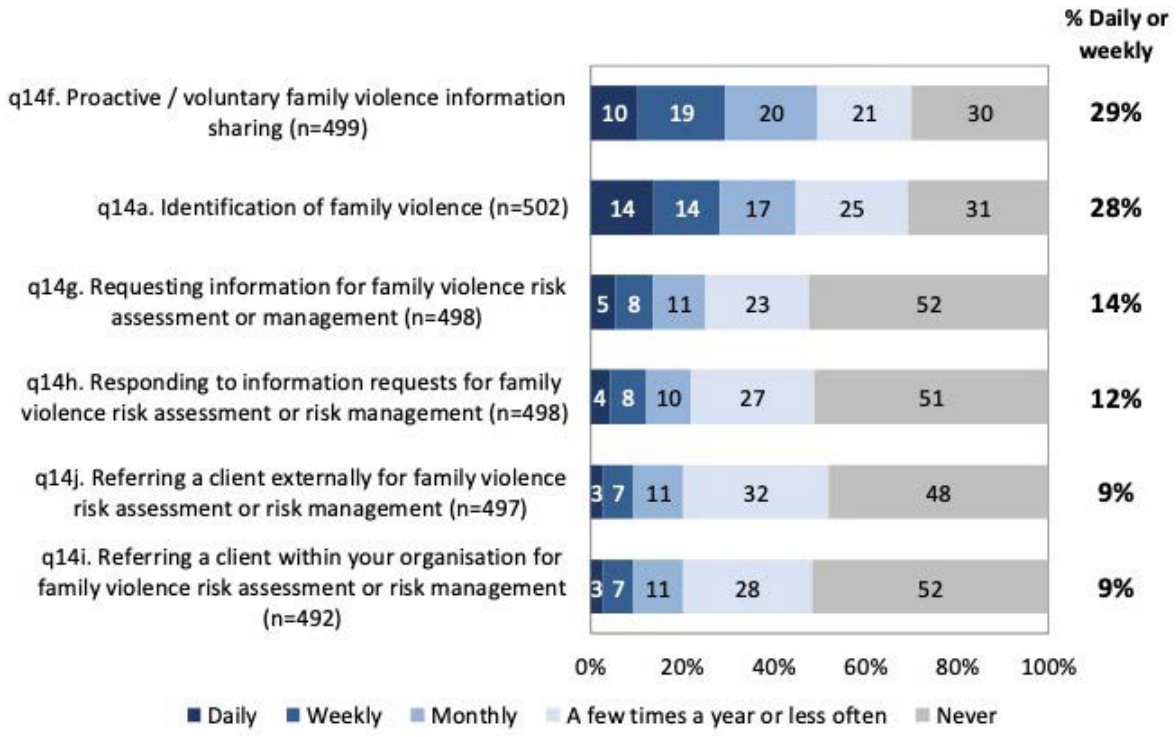
Respondents were also asked about the frequency with which they worked on a number of family violence response related activities as part of their role. As shown in Figure 2, overall, respondents undertook these activities much less frequently (9%-29% daily or weekly) compared to the core activities discussed earlier in this chapter (10%-64% daily or weekly).

Although this workforce reported that they conducted family violence response related activities relat infrequently, over one-quarter reported that they frequently (at least weekly):

- worked on proactive / voluntary family violence information sharing (29%); and
- were responsible for the identification of family violence (28%).

Conversely, around half of respondents (48%-52%) indicated that they never worked on activities related to information requests and client referrals – this may be due to a range of factors, including the ad-hoc nature of these activities which are not core to the primary prevention role, and the possibility that respondents' organisations are not prescribed under the Multi-Agency Risk Assessment and Management (MARAM[4]) framework.

**Figure 2: Role requirements – Family violence**
Base: All respondents




*Q14. Overall, how frequently do you work on the following activities?*

4. See page 24 for more information about MARAM.

# 5 Employment conditions

This chapter details the employment conditions of the primary prevention workforce. This includes the nature of contracts held (full-time, part-time, casual or other; ongoing versus fixed term), average number of hours and days worked, and amount of unpaid work undertaken.

Exploring these conditions can assist in our understanding of any challenges they may face in undertaking their work, and aid in the interpretation of subsequent results throughout this report.

Overall, both the Census results and findings from the initial sector consultation suggested that workers in the primary prevention workforce were less likely than that of the average Victorian to hold a full-time role. Additionally, many employees reported that they were employed on fixed-term contracts, and many also reported working additional unpaid hours.

The Census results indicated that the roles held within the primary prevention workforce were highly varied in terms of working hours and contract conditions (i.e. ongoing versus fixed-term).

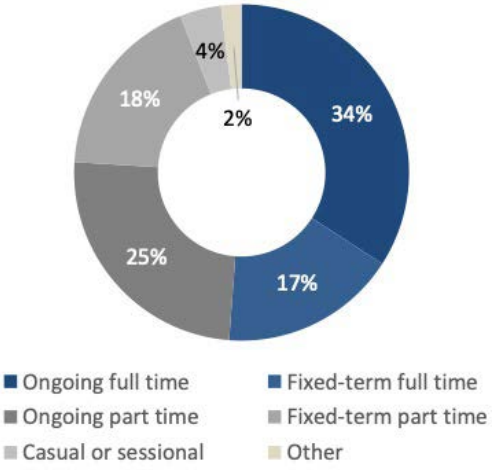
Figure 3 illustrates that just over half of the primary prevention workforce reported that they were employed on a full-time basis (51%) — lower than the average proportion across Victoria as a whole (67% ). Of the remaining 49%, the majority were employed on a part-time basis (43%), and very few were casual or sessional employees (4%).

Furthermore, although 59% were employed in an ongoing capacity, about 35% held fixed-term roles.

While those in the primary prevention workforce were less likely than the average Victorian to hold a full-time role, it should be noted that overall, almost one-fifth of this workforce reported that they held at least one additional paid role outside of the primary prevention workforce (17%), and one-in-ten held more than one paid role within this workforce (10%).

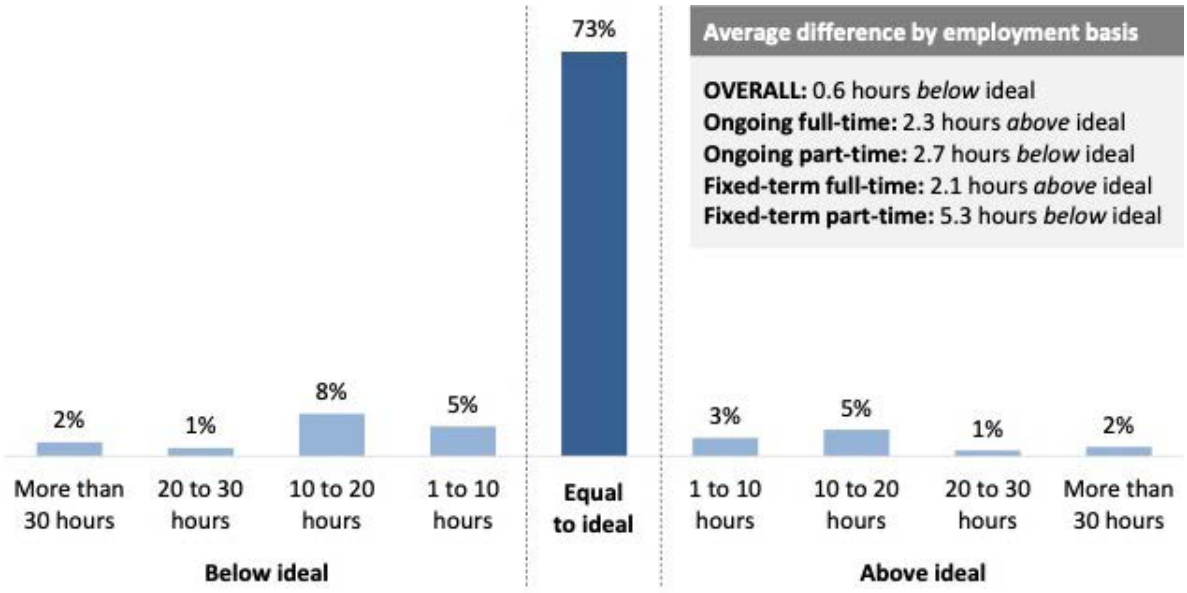
As shown in Figure 4 overleaf, the majority of the workforce (73%) reported that in the past fortnight, the number of hours they were employed to work was equivalent to the number of hours they ideally wanted to be employed to work in this role. The difference between actual and ideal hours worked naturally varied by basis of employment, with part-time employees generally more likely than full-time employees to report a desire to have been employed for a greater number of hours in the last fortnight.

**Figure 3: Basis of employment**
Base: All respondents (n=504)




*Q16. On what basis are you employed in this role?*

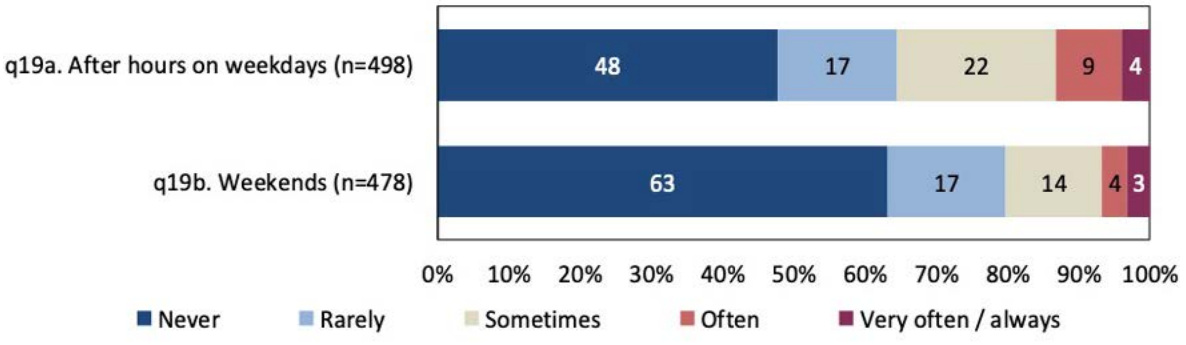
**Figure 4: Difference between actual and ideal hours worked in the past fortnight**
Base: All respondents (n=488)




*Q17 / Q18. In the past fortnight, how many hours were you employed / did you ideally want to be employed to work in this role? (Note: only those who entered a positive numeric response for both questions are included in this analysis)*

Only a relatively small proportion of the primary prevention workforce were employed to undertake their work outside of business hours often or very often / always (7%-13% – see Figure 5), suggesting that only a minority undertake regular shift / evening work, or weekend work.

**Figure 5: Paid work outside of normal business hours**
Base: All respondents




*Q19a/b. How often are you paid to work outside of normal business hours (e.g. shift work / after hours or weekends), if at all?*

Although the majority were paid to undertake their work during normal business hours, one-third of the workforce reported that they often work additional unpaid hours (21% often and 13% very often / always), whilst a further 30% noted that they sometimes do so.

**Employment conditions differed by some demographic cohorts, as follows:**

- **Age** – compared to the overall workforce, those aged 55 or older were more likely to be employed on an ongoing full-time basis (45% versus 34%), those aged 35 to 54 were more likely to be employed part-time (54% versus 43%), and those aged under 35 were more likely than average to be on fixed-term contracts (48% versus 35%).
- **Gender** – although a small proportion of the overall workforce (13%), males were significantly more likely to be employed on a full-time basis (83% versus 51% overall).
  - The results also suggested that males were more likely to have been working in the sector for longer, with 25% having worked in any role within the family violence sector or broader workforce that intersects with family violence for greater than 10 years, versus just 11% of females.
- **Organisation type** – those working in organisations that specialise in women's health and health promotion were more likely than average to be employed on a part-time basis (59%-65%), whilst those employed in school education / school health and wellbeing organisations, and Aboriginal community controlled organisations, were more likely to be employed full-time (80%-93%).

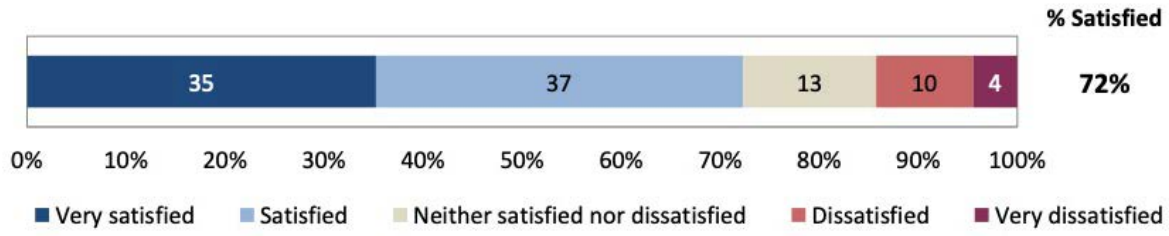
# 6 Supervision

This chapter explores the extent to which the primary prevention workforce felt supported in the workplace, and the nature of their interactions with supervisors or managers.

Overall, the results indicated that the primary prevention workforce were **satisfied with the quality of support** provided to them by their supervisor or direct manager, and that having the opportunity to regularly discuss their professional development, or their work more generally, were key drivers of this satisfaction. Subsequent findings suggested that at least half of the workforce did not feel that their role was well understood or valued by others in their organisation, suggesting that some of this workforce may feel **under-recognised** by their peers.

Overall, the primary prevention workforce was largely happy with the quality of support provided to them by their supervisor or direct manager, with over seven-in-ten reportedly satisfied (72% – see Figure 6).

**Figure 6: Overall satisfaction with support provided by supervisor / manager**
Base: All respondents (n=491)



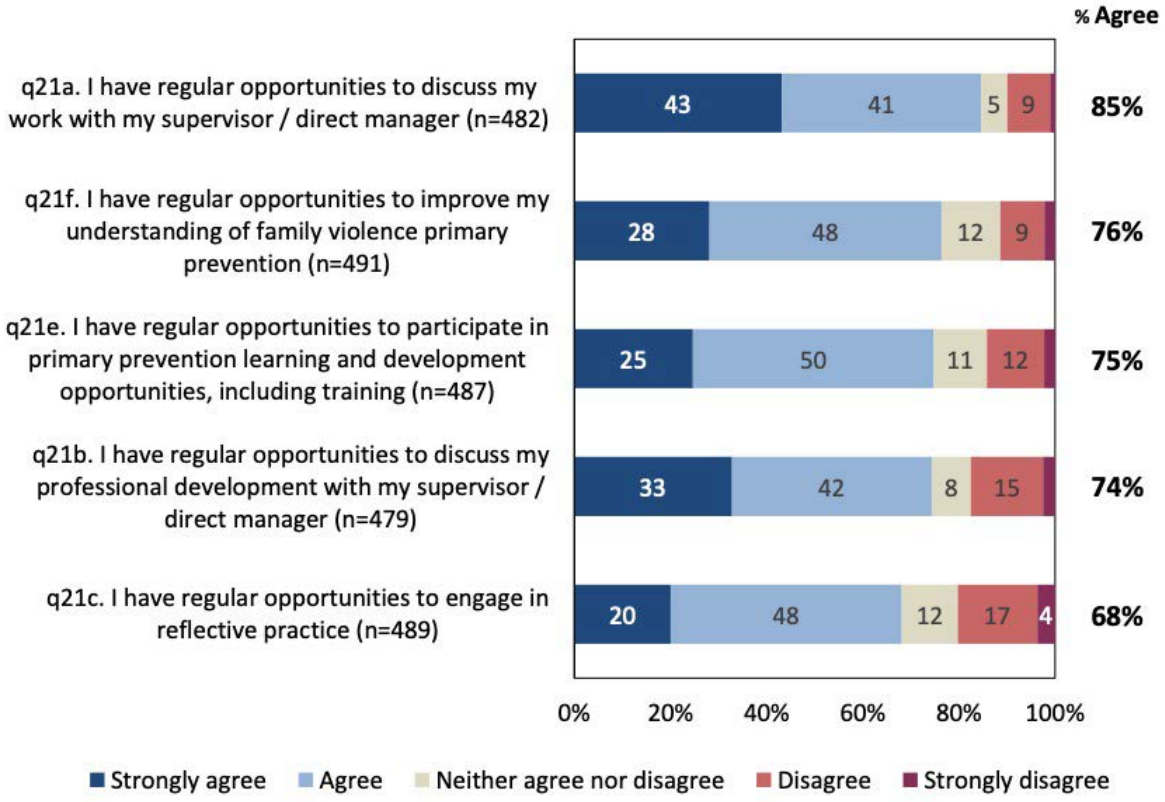

*Q22. Overall, how satisfied are you with the quality of support provided to you by your supervisor / direct manager?*

When asked about a range of more specific metrics associated with the support that their supervisors / managers had provided, 85% agreed that they had regular opportunities to discuss their work with their supervisor or direct manager (see Figure 7). Furthermore, around three-quarters of the workforce also agreed that they have regular opportunities to improve their understanding of family violence primary prevention or upskill through participation in training or discussions regarding their personal development (74%-76%).

Although 68% agreed, the workforce was relatively less likely to feel that they have regular opportunities to engage in reflective practice[6], with 20% disagreeing that they had such opportunities.

6. Reflective practice, also referred to as critical reflection or reflexivity, is a process of self-examination by a practitioner about their own work; becoming self-aware, considering their thoughts, feelings and assumptions, and examining how these impact upon their work.

**Figure 7: Support / opportunity provided by manager**
Base: All respondents




*Q21. Please indicate the extent to which you agree or disagree with the following statements about the level of support and opportunity provided by your supervisor or manager. (Note Q21d not asked of this audience).*

In order to determine what is most important in influencing the overall levels of satisfaction with support provided by supervisors / managers amongst this workforce, regression analysis was undertaken. The results suggest that the key drivers were having regular opportunities to:

- discuss professional development;
- discuss work more generally; and
- participate in primary prevention learning and development opportunities, including training.

**Satisfaction with levels of supervisory / managerial support differed by some demographic cohorts:**

- **Age** – younger members of the workforce (aged under 35) were significantly more satisfied with the quality of support provided by their supervisor or direct manager than their colleagues aged 35 years or older (81% versus 69%-70% of those aged 35 to 54 and 55+).
- A similar trend was reflected in relation to years of experience, with a general reduction in overall satisfaction reported as years of experience in their current role increased.
- **Organisation type** – those working in an organisation that specialises in women's health were more likely than average to be satisfied with the quality of support provided by their supervisor or direct manager (82%).

## Support

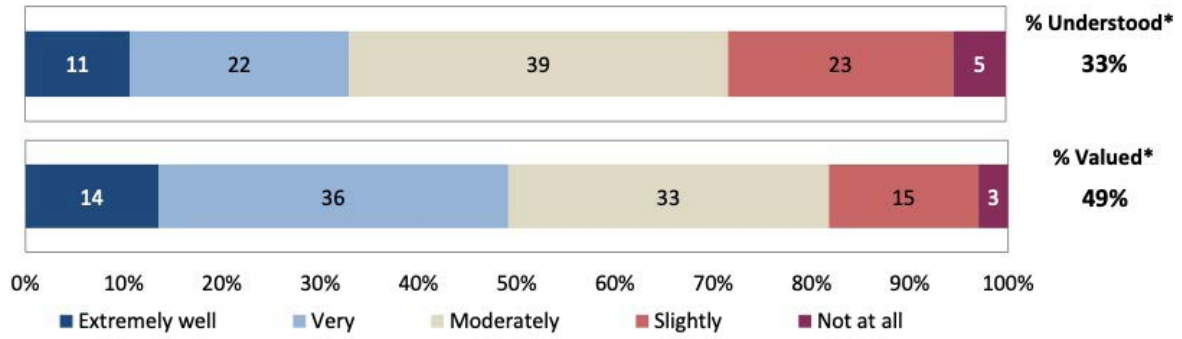
Primary prevention practitioners make up a small workforce within Victoria and are reportedly dispersed across many organisations across the state. They often work alone or in small teams within larger organisations. Of all respondents, 49% reported that there were fewer than five other primary practitioners employed at their organisation; and 29% just worked with one, or no others.

As they often make up a small cohort within their organisations, the primary prevention workforce were also asked a series of additional questions to investigate how supported they feel within their organisations more generally (aside from the support provided by supervisors or managers). Overall, the results suggested that primary prevention practitioners felt that their roles were not particularly well understood or valued within their organisation. As illustrated in Figure 8, just:

- One-third (33%) felt that their role was extremely or very well understood by others; and
- Half (49%) felt that their role was extremely or very well valued by others in their organisation.

However, on a positive note, very few felt that they were not understood or valued at all.

**Figure 8: Extent that role is felt to be understood or valued by others within their organisation**
Base: All respondents (n=466)




*Q33 / Q34. Overall, to what extent do you feel your role is understood / valued by others in your organisation? *% Extremely well or very well.*

When asked about relationships they held with others in the workforce, 46% reported that they were part of a regional primary prevention partnership or network. Additionally, just over half of respondents (51%) reported that they were a part of a community of practice for primary prevention practitioners, most of whom found it useful (85% of those who are part of such a community).

**Results differed by some demographic cohorts, as follows:**

- **Organisation size** – primary prevention respondents working in organisations with fewer staff (< 50) were significantly more likely than those in organisations with more than 200 staff to feel extremely or very well understood (44% versus 16%) and valued (59% versus 33%).
- **Organisation type** – those working in an organisation that specialises in women's health were more likely than average to feel that their role was well understood (64% versus 33% on average) and valued (75% versus 49% on average) by others in their organisation. In contrast, those employed in local council or local government, were less likely to be feel that their role was well understood or valued (16%-33%).

# 7 Training and confidence

This chapter discusses the extent to which primary prevention workforce respondents were confident in their role, as well as any training or professional development they had undertaken in a range of skill and capability areas, generally and as they relate to family violence.

The Census results demonstrated that while the primary prevention workforce had completed training across a range of topic areas, overall confidence in their level of training and experience was moderate. The findings highlighted **MARAM** as a priority area for further / improved training and professional development.

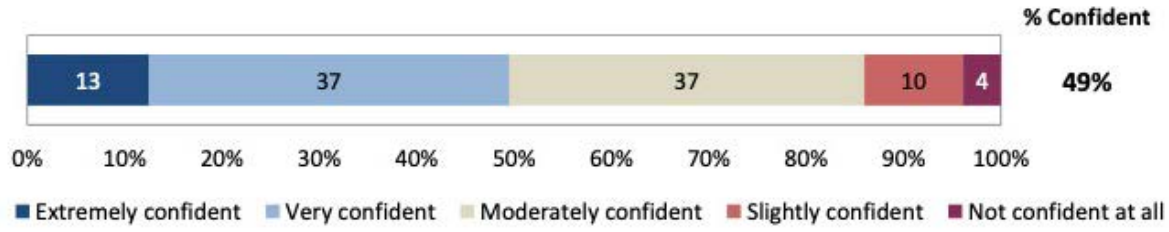
Furthermore, the primary prevention workforce generally believed that **dynamic / collaborative forms of additional support** (i.e. information sharing, community of practice, mentoring / peer support) would be most useful in increasing their confidence in performing their role(s).

In terms of barriers to accessing further training and development, **lack of time** was the most commonly reported barrier, followed by cost of study and location of training facility.

## Confidence

As illustrated in Figure 9, overall, around half of the primary prevention workforce indicated that they were 'extremely' or 'very' confident that they have had enough training and experience to perform their role(s) effectively (49%). In contrast, 14% reported that they were 'slightly' or 'not at all' confident.

**Figure 9: Confidence in level of training and experience**
Base: All respondents (n=463)




*Q39. In relation to primary prevention of family violence, how confident are you that you have had enough training and experience to perform your role(s) effectively?*

**Confidence levels varied by some demographic cohorts, including:**

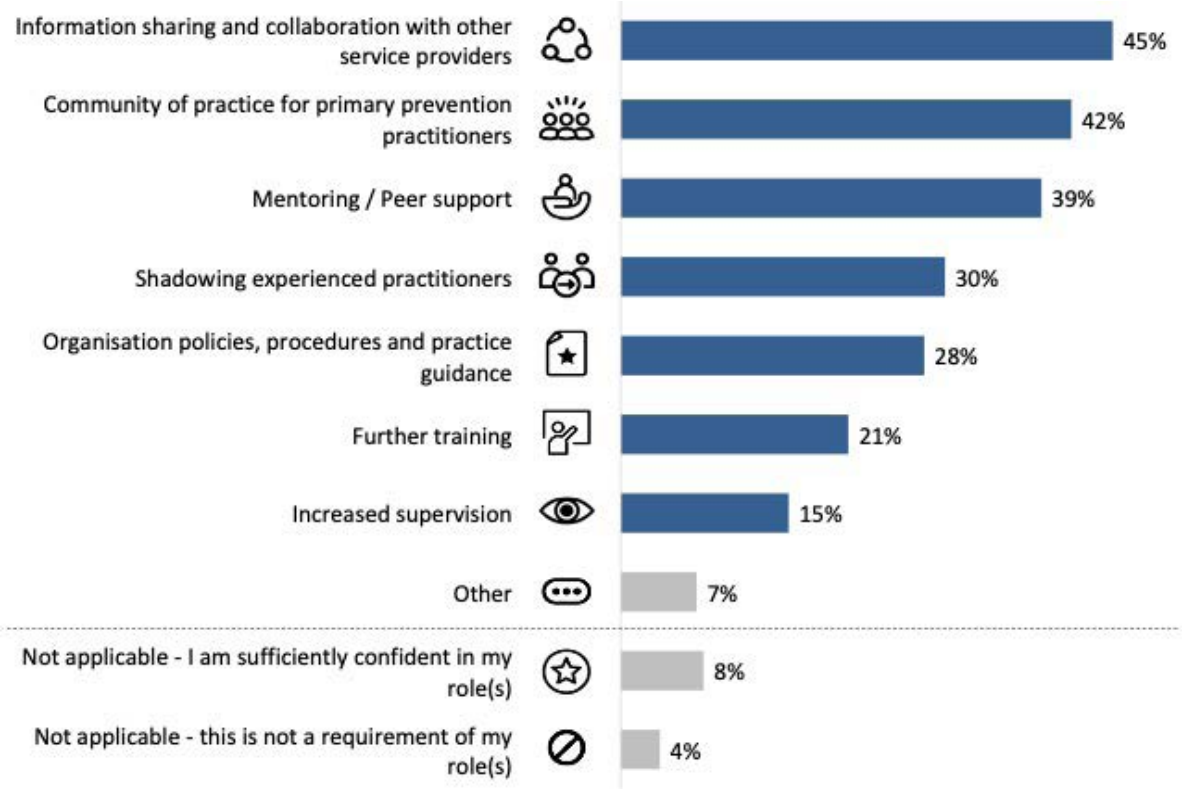
- **Years of experience** – those who had been in their current role for 5 to 10 years were significantly more likely to be confident in their level of training and experience (61%), compared to those with under 5 years (44%-47%) or over 10 years' experience (48%).
- **Organisation type** – respondents working in women's health were generally more confident than others in relation their level of training and experience (68%, compared to 49% overall).

The primary prevention workforce felt that the following additional support would be most useful in increasing their confidence in performing their role(s) (see Figure 10):

- information sharing and collaboration with other service providers (45%);
- community of practice for primary prevention practitioners (42%); and
- mentoring / peer support (39%).

Conversely, respondents were least likely to indicate that further training or increased supervision would be beneficial in this context (21% and 15% respectively).

**Figure 10: Additional support required to increase confidence**
Base: All respondents (n=471); multiple responses accepted

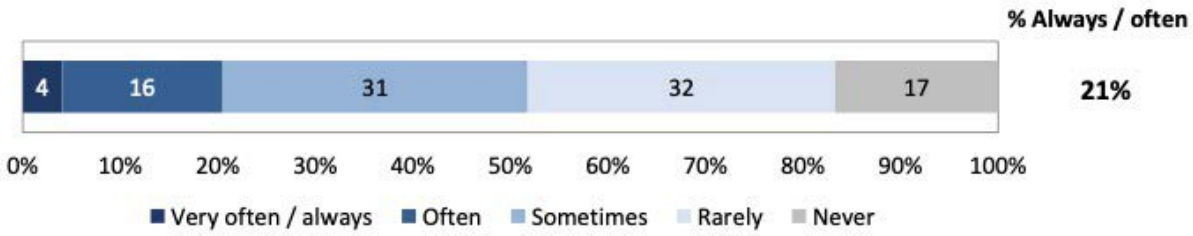



*Q40. In relation to primary prevention of family violence, what additional support would increase your confidence in performing your role(s)?*

Results differed by age – younger respondents aged under 35 were considerably more likely than older respondents aged over 55 to report that they would benefit from shadowing experienced practitioners (45% versus 14%), mentoring / peer support (43% versus 25%), and organisation policies, procedures and practice guidance (34% versus 17%).

Figure 11 shows that overall, around one-fifth of the primary prevention workforce reported that they frequently respond to family violence disclosures (21% always or often).

**Figure 11: Frequency of response to family violence disclosures**
Base: All respondents (n=473)




*Q41. In your primary prevention role, overall, how often do you respond to family violence disclosures?*

**Frequency varied across the following demographic cohorts:**

- **Years of experience** – frequency increased with years of experience (11% for those with 1 year of experience or less, compared to 35% for those with over 10 years' experience).
- **Organisation type** – response to family violence disclosures was most frequent among those employed in legal services (36%), multicultural or settlement services (31%), and community organisations (31%); and least frequent among those working in policy, research and advocacy (7%), and local council / government (10%).

## MARAM

The family violence Multi-Agency Risk Assessment and Management (MARAM) framework provides guidance to organisations prescribed under regulations that have responsibilities in assessing and managing family violence risk[7]. The framework is designed to ensure services are effectively identifying, assessing and managing family violence risk. A range of organisations were prescribed under MARAM in September 2018.

**79%** of the primary prevention workforce indicated that they had heard of the MARAM framework[8]; and of these,

**52%** understood that the organisation that they currently worked for was **prescribed to align with** the MARAM framework[9].

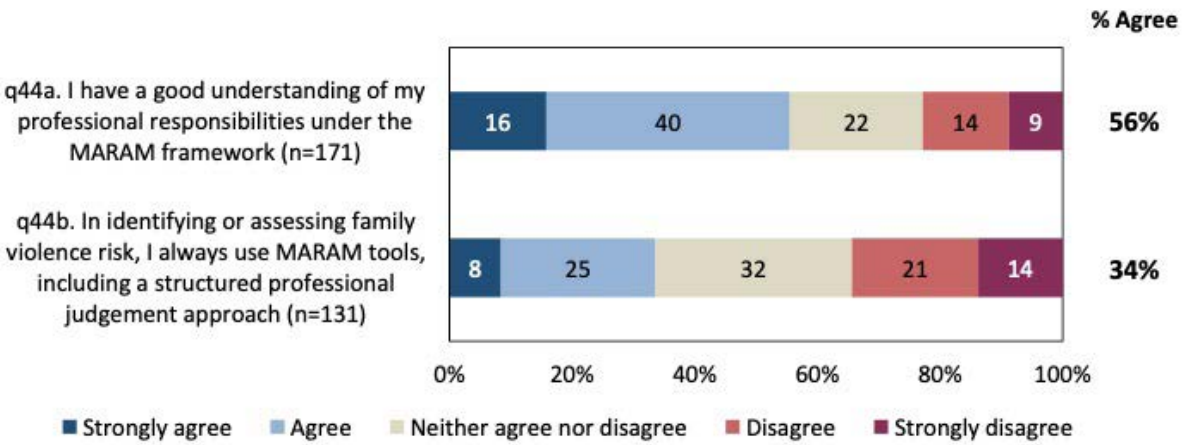
**By organisation type, the proportion of respondents who understood that their organisation was prescribed under MARAM was:**

- **highest** among those working in school education (70%), community organisations (68%) and community health (63%); and
- **lowest** among those employed in health promotion (21%) and women's health (26%).

7. https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management
8. Q42. Before today, had you heard of the Multi-Agency Risk Assessment and Management (MARAM) framework? (n=474)
9. Q43. Is the organisation that you work for in your current role prescribed to align with the Multi-Agency Risk Assessment and Management (MARAM) framework? (n=373)

As illustrated in Figure 12, of those who worked for organisations prescribed to align with the MARAM framework, in relation to identifying risk for victim survivors, understanding of one's professional responsibilities under the framework was moderate (56%). Additionally, consistent usage of MARAM tools (including a structured professional judgement approach) in identifying or assessing family violence risk was relatively low (34%).

**Figure 12: Understanding of MARAM responsibilities and use of MARAM tools**
Base: Respondents working for organisations prescribed to align with the MARAM framework




*Q44. It is understood that not all MARAM tools have been released to date. However, please answer the following in relation to identifying risk for victim survivors by indicating the extent to which you agree or disagree with the following.*

**Understanding and usage levels differed across certain demographic cohorts, including:**

- **Organisation type** – understanding and usage was:
  - generally higher among those working in local council / government; and
  - lower for those employed in community health as well as policy, research and advocacy – noting that these respondents were also more likely than others to understand that their organisation was not prescribed under MARAM.
- **Employment basis** – those employed in ongoing roles generally reported higher understanding and usage compared to those in fixed-term roles.
- **Years of experience** – understanding and usage was highest among those who had been working in their current role for more than 10 years.
- **Organisation size** – those working in medium-sized organisations (50-199 employees) reported higher usage of MARAM tools in identifying or assessing family violence risk, compared to those working in smaller (1-49 employees) and larger (200 or more employees) organisations.

As outlined earlier, in primary prevention roles, employees may identify or receive disclosures of family violence.


of the primary prevention workforce reported that they had made a referral and / or shared information as a result of identifying or receiving a disclosure of family violence[10]; and of these,


felt that they had a 'good' or 'very good' understanding of their responsibilities to share information relating to family violence risk under relevant Information Sharing Schemes and privacy law[11].

**By organisation type, reported understanding of information sharing responsibilities was:**

- **highest** among those employed in community organisations (74%); and
- **lowest** among those working in health promotion (33%) and policy, research and advocacy (35%) – these respondents were also more likely than others to report that they have never made a referral and/or shared information as a result of identifying or receiving a disclosure of family violence.

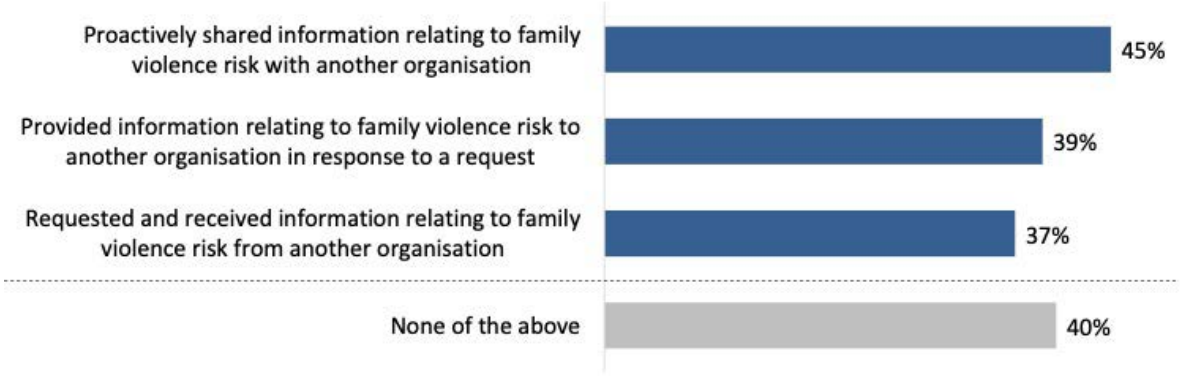
Figure 13 shows that conduct of information sharing activities under the Family Violence Information Sharing Scheme (FVISS) was moderate, with:

- the most common activity undertaken in the past year being the proactive sharing of information with another organisation (45%); and
- two-in-five indicating that they had not undertaken any information sharing activities under the FVISS in the past year (40%).

10. Q45. Have you ever made a referral and/or shared information as a result of identifying or receiving a disclosure of family violence? (n=467)
11. Q46. Please rate your understanding of your responsibilities to share information relating to family violence risk under the Family Violence Information Sharing Scheme (FVISS), Child Information Sharing Scheme (CISS) and relevant privacy law. (n=210)

**Figure 13: Information sharing relating to family violence risk**

Base: Respondents who were responsible for haring information relating to family violence risk under relevant Information Sharing Schemes and privacy law as part of their role, and had made a referral and/or shared information as a result of identifying or receiving a disclosure of family violence (n=163); multiple responses accepted




*Q47. In the past year, which of the following have you done (under the FVISS)?*

**By organisation type, the level of information sharing activity was:**

- **highest** among those working in community organisations (75% had undertaken at least one activity in the past year) – which aligns with this cohort's high understanding of information sharing responsibilities, as discussed earlier; and
- **lowest** among those employed in policy, research and advocacy (69% had not conducted any of the listed activities in the past year) – again aligning with this cohort's relatively low level of understanding of their responsibilities in this area, coupled with the low proportion reporting that they had ever made a referral and/or shared information as a result of identifying or receiving a disclosure of family violence.

Results also differed by **employment basis** – those holding ongoing full-time roles reported higher levels of information sharing activity (73% undertook at least one activity in the past year), while those in fixed-term part-time roles reported the lowest activity (39%).

## Training

The primary prevention workforce was asked to identify both the family violence prevention and response topics they had completed training in, and those they would like further training in.

As illustrated in Figure 14 overleaf, at least half of respondents had completed training in relation to:

- gender equity (59%);
- foundation / introductory primary prevention of violence against women (58%); and
- recognising and responding to disclosures (50%).

The topics which respondents felt they required further training in were generally those with lower completion rates, including training related to:

- working with Aboriginal communities (32% had completed training, 52% desired further training);
- MARAM (19% had completed training, 50% desired further training); and
- managing backlash and resistance (33% had completed training, 49% desired further training).

Those who had completed training in each topic area were then asked to assess the degree to which they believed the training had assisted them in undertaking their work more effectively. Figure 15 (see page 29) shows that perceived helpfulness was relatively high across most topic areas, and was highest in relation to training in:

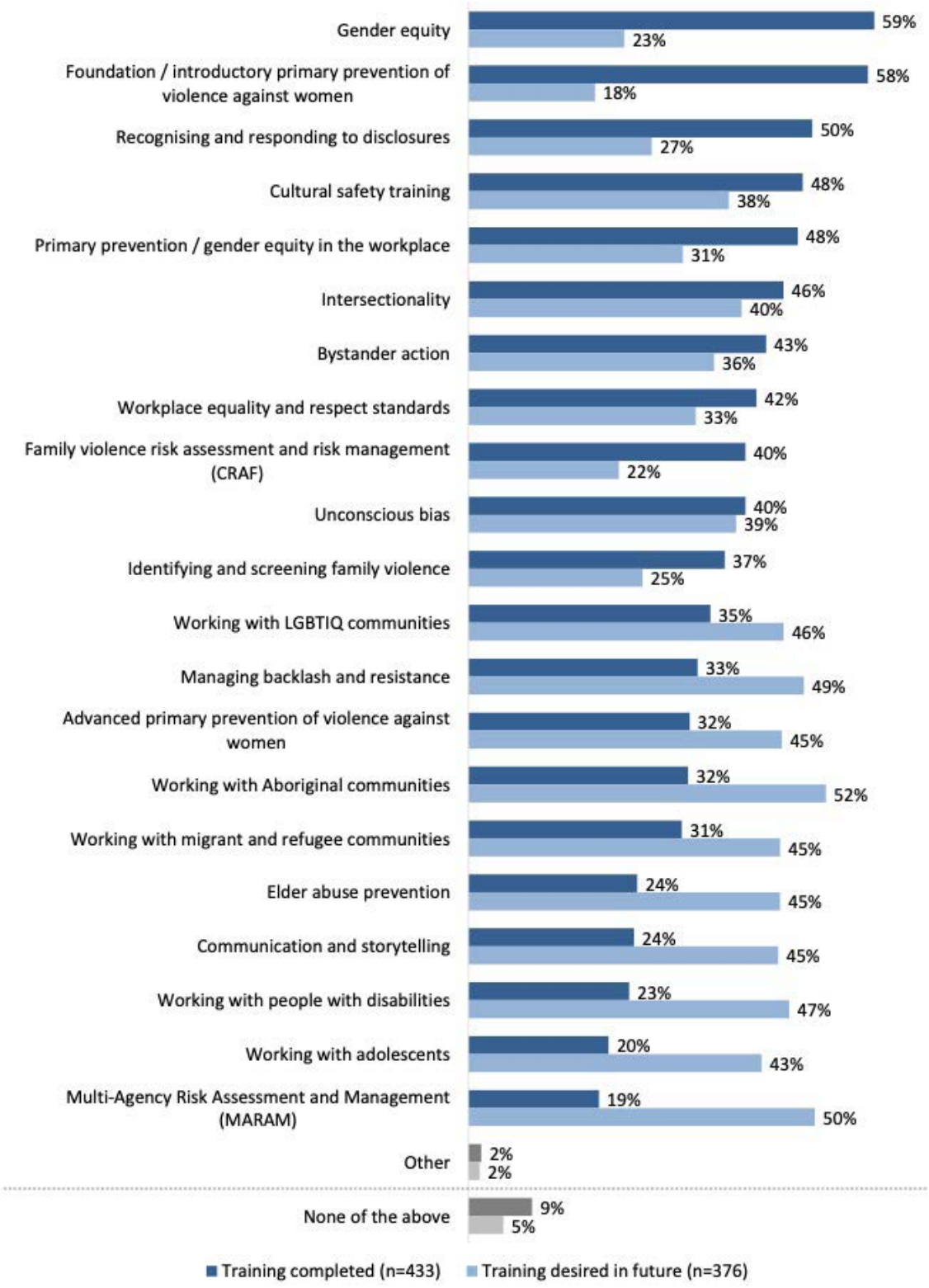
- advanced primary prevention of violence against women (85% found training in this topic to be 'extremely' or 'very' helpful);
- gender equity (80%); and
- working with people with disabilities (80%).

In contrast, respondents were least likely to feel that training undertaken in the following topics was helpful:

- communication and storytelling (66% – although a notable proportion (30%) found training to be 'extremely' helpful);
- family violence risk assessment and risk management (CRAF – 58%); and
- MARAM (54%).

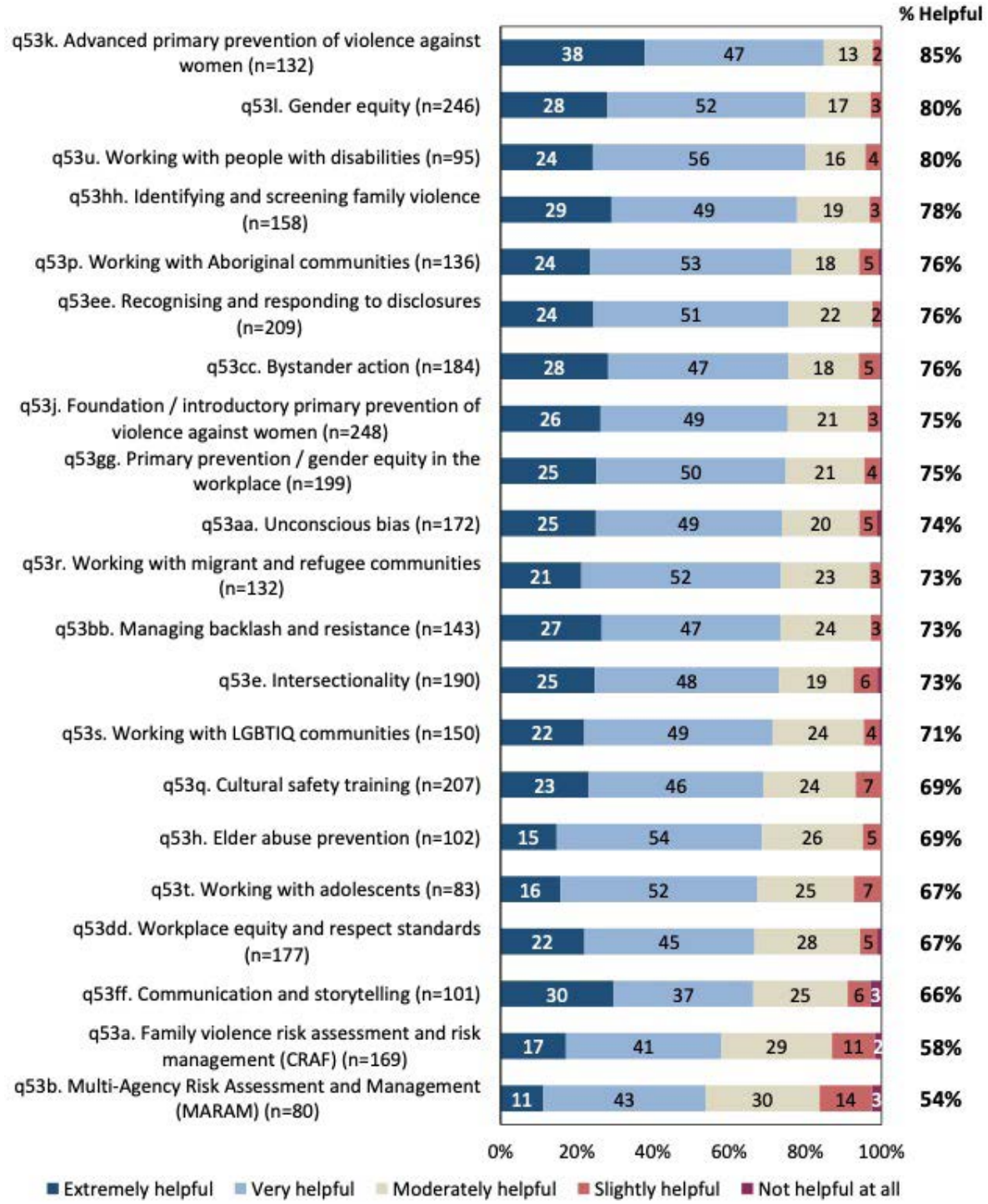
These results suggest that there is an opportunity to review and improve training in various topics, particularly those related to frameworks guiding the primary prevention workforce (e.g. CRAF and MARAM). This review may include further investigation into whether existing training offerings are fit for purpose, or whether they need to be adapted for the primary prevention workforce.

**Figure 14: Training completed / desired**
Base: All respondents; multiple responses accepted




*Q52. In relation to family violence prevention and response, which topics have you completed training in, and which topics would you like further training in?*

**Figure 15: Perceived helpfulness of training**
Base: Respondents who had completed training in each topic area

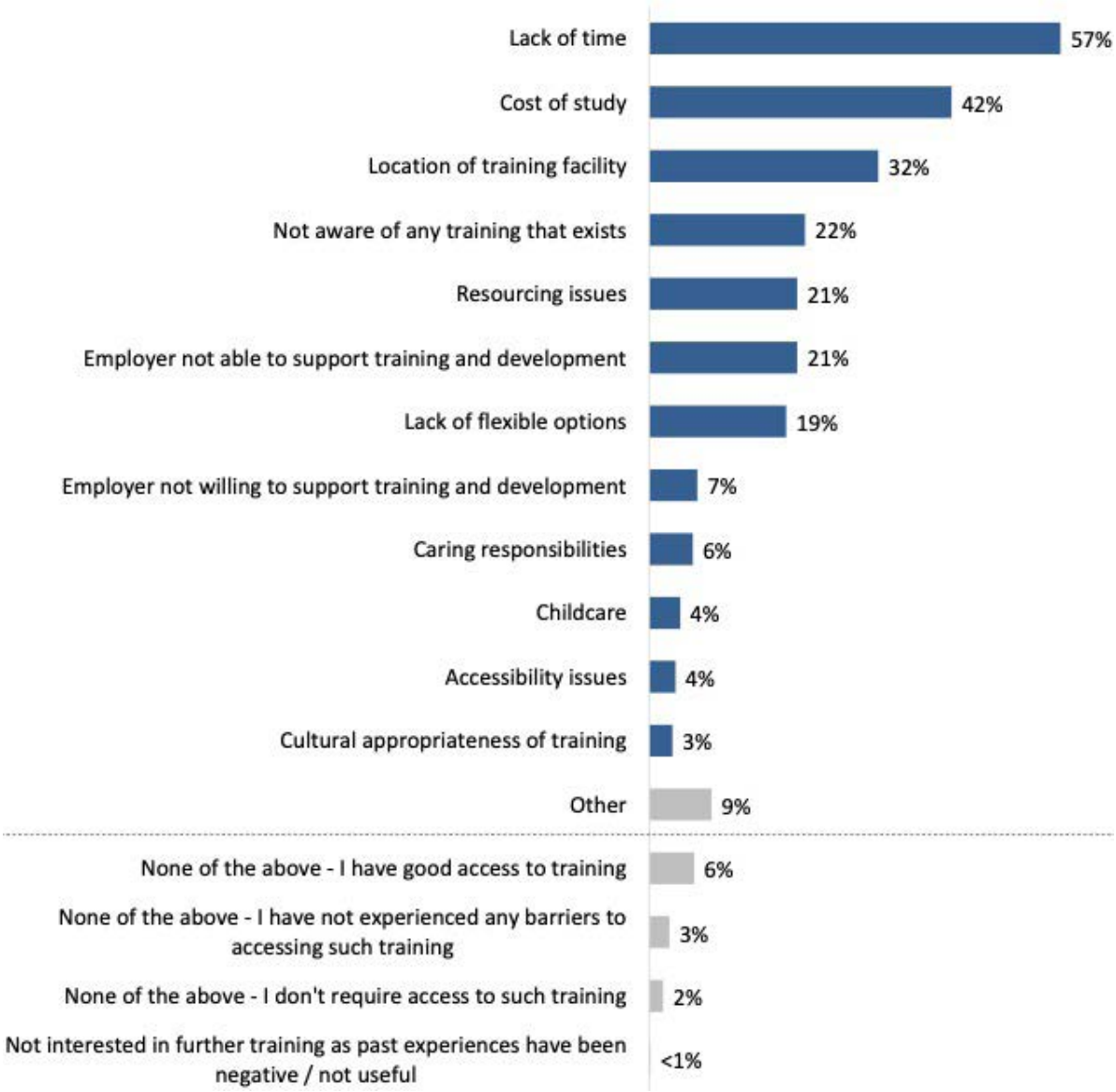



*Q53. In general, how helpful has the training in each of these topics or areas been in assisting you to undertake your work more effectively?*

When asked about barriers to accessing further training and development in relation to family violence response or prevention, the three main barriers identified by respondents were:

- lack of time (57%);
- cost of study (42%); and
- location of training facility (32% – see Figure 16 overleaf).

**Figure 16: Barriers to accessing further training and development**
Base: All respondents (n=461); multiple responses accepted




*Q54. Overall, what are the main barriers for you in accessing further training and development in relation to family violence response or prevention?*

**Reported barriers differed across certain demographic cohorts, including:**

- **Age** – respondents aged under 35 were more likely than older respondents to indicate that they were unable to access further training and development due to lack of time, as well as a lack of awareness about the training available.
- **Employment basis** – those in part-time roles were more likely than those in full-time roles to identify childcare and caring responsibilities as barriers.
- **Organisation size** – those working in larger organisations (200 or more employees) were more likely than those employed in smaller organisations (1-49 employees) to report that their employer was not willing to support training and development.

# 8 Health and wellbeing

This chapter explores the impacts of primary practitioners' work on their health and wellbeing. Health and wellbeing is an important area of focus for all workforce types, however should be of particular focus for this workforce given various work-related stressors they may encounter. The information in this chapter may be used to improve understanding of the health and wellbeing of the workforce as a whole, assist in identifying any specific areas of focus, and inform forward-looking strategies to support its workers.

Overall, the results of both the Census and the initial consultation phase of the project suggested that many within this workforce experience **stress due to high workload,** with around half reporting that they only sometimes had sufficient time to complete their tasks.

Positive findings included the fact that most of the workforce indicated that they felt safe in performing their role, and many felt **respected and fairly consulted** when undertaking their work. Additionally, few were dissatisfied in their current role and most felt that they **made a difference** to people affected by family violence (45% felt they made a significant difference).

## Workplace stressors

Work-related stress is an important consideration when exploring the health and wellbeing of staff, and there are various elements of an individual's role that may contribute to such stress.

**76%** of the primary prevention workforce reported that they experienced at least moderate work-related stress, and 31% experienced high, very high or severe levels[12].

**76%** of those who experienced at least moderate stress reported that this was due to a high volume of work / high demands of their role, whilst 61% also cited poor management or organisational issues[13].

Respondents were asked to comment on the frequency with which they experienced several factors that may contribute to workplace stress (see Figure 17 overleaf for full results).

- In line with the findings above, a high workload was reported to be a frequent issue for almost half of this workforce, with 48% reporting that they only sometimes (or less often) felt that they had sufficient time to complete their tasks.

Despite this, there were also many positive results to note. Overall, almost nine-in-ten of the primary prevention workforce indicated that they felt safe in performing their role (88% always or often – though it should be noted that a minority, 12%, only felt safe sometimes, or less often).

Other positive findings suggested that many felt respected and fairly consulted in undertaking their work, with over three-quarters of this workforce reporting that they always / often felt that:

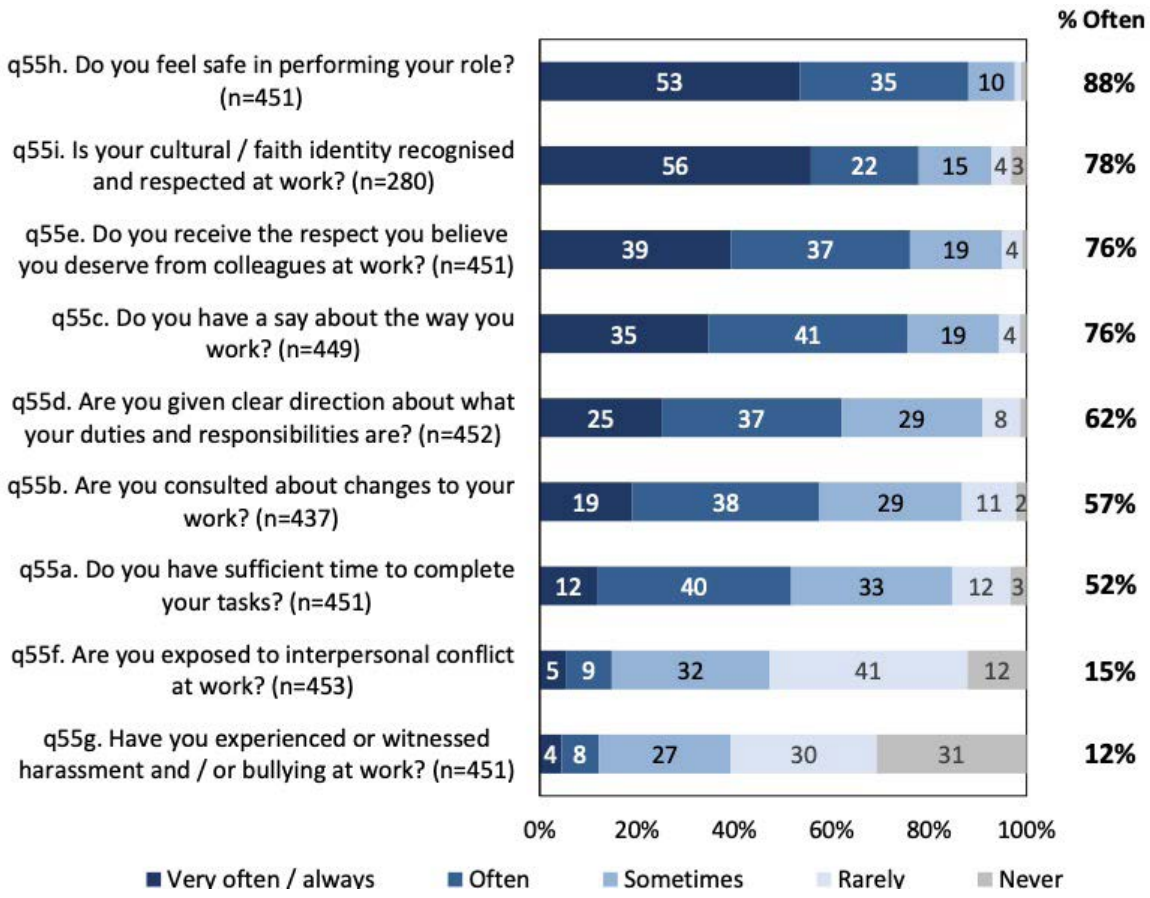
- their cultural identity was recognised and respected at work (78%);
- they receive the respect they believe they deserve from their colleagues (76%); and
- they have a say about the way that they work (76%).

Other encouraging results were reported regarding workplace conflicts and bullying / harassment, with a low incidence of such negative stressors within this workforce, although again a minority did report experiencing these always /often (12%-15%).

12. Q56. On average, how would you rate your level of work-related stress? (n=458)

13. Q57. What is the primary cause(s) of your work-related stress? Multiple responses accepted (n=142)

**Figure 17: Frequency of various workplace wellbeing metrics**
Base: All respondents




*Q55. In performing your duties for this role, how often:*

## Support for negative encounters

Although high volume of work and poor management were the most cited causes of workplace stress, over one-quarter of those who experienced at least high stress also mentioned staff turnover (41%), backlash or resistance (32%), external pressures (30%), and vicarious trauma (27%).

Given the unique type of work that this workforce undertakes, backlash / resistance[14] is a particularly important factor to consider when exploring workplace stress amongst this audience.

**22%** of respondents always / often experienced backlash or resistance in undertaking their work.[15]

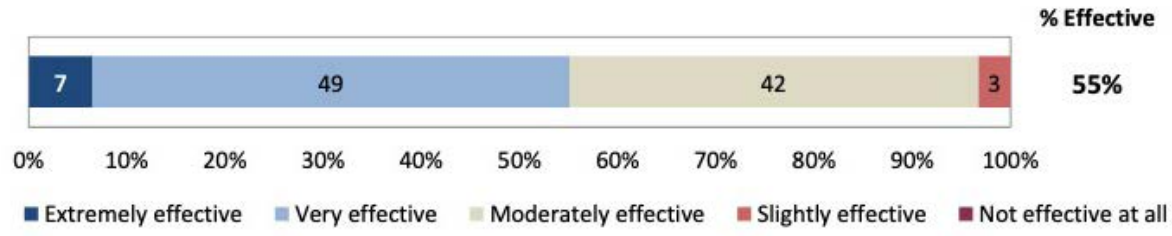
**64%** reported that they have access to support if they encounter resistance or backlash in their work.

Although not a core requirement of their role, primary prevention practitioners may also encounter family violence cases or disclosures in undertaking their work.[16]

**80%** of respondents indicated that they have access to support if they encounter cases of family violence or disclosures in their work.[18]

Although broadly positive, these results suggest that there may be scope to either increase the level of support available or increase the awareness of such support amongst this workforce. Respondents who indicated that they have access to support if they encounter cases of family violence or disclosures, or backlash / resistance were additionally asked how effective they felt this support was. Overall, 55% felt that this support was either very or extremely effective, whilst 42% felt it was moderately effective. None felt that the support provided was ineffective (see Figure 18).

**Figure 18: Effectiveness of support provided**
**Base: All respondents who have access to support**



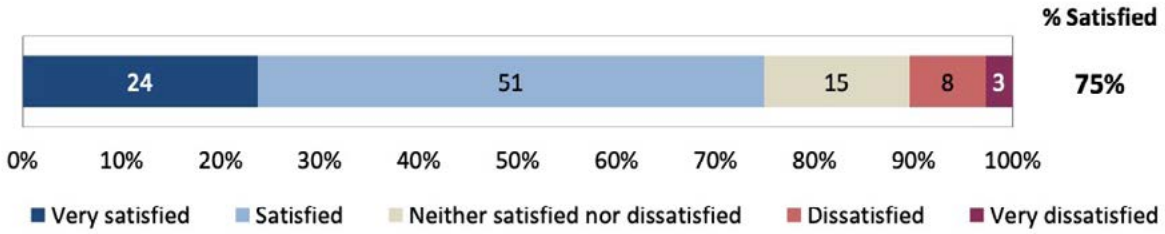

*Q64. Overall, how effective is this support? Don't know / Not applicable excluded*

14. Backlash and resistance refer to any form of resistance toward gender equality.
15. Q61. In your role, how often do you experience resistance or backlash in undertaking your work? (n=454)
16. Q63. Do you have access to support to assist you if you encounter cases of family violence or disclosures, or resistance or backlash in your work? (n=400)

## Satisfaction with role

Overall, three-quarters of the primary prevention workforce indicated that they were satisfied in their current role (75% – see Figure 19). Positively, only a minority expressed dissatisfaction (10%), whilst 15% were neither satisfied nor dissatisfied in their role.

**Figure 19: Overall satisfaction with current role**
Base: All respondents (n=442)




*Q66. Overall, how satisfied are you in your current role in the primary prevention workforce?*

**Overall satisfaction differed by some demographic cohorts, as follows:**

- **Years of experience** – those who had been in their current role for more than 5 years were less likely than those with a shorter tenure to be satisfied in their current role (67% of those with 5 to 10 years' tenure, compared to 78%-80% of those with less than 5 years' tenure).
- **Organisation size** – those working in medium-sized organisations (50-199 staff) were less likely than average to be satisfied in their current role (66% versus 75% on average).

Respondents were additionally asked to comment on how much difference they believe their work makes to people affected by family violence.

**45%** indicated that they felt that their work makes a significant difference to people affected by family violence, whilst 52% felt their work makes a moderate difference.[17]

There was not a strong correlation between overall role satisfaction and whether one felt that their role made a positive difference to people affected by family violence, suggesting that differences in satisfaction levels may be driven by various other factors.

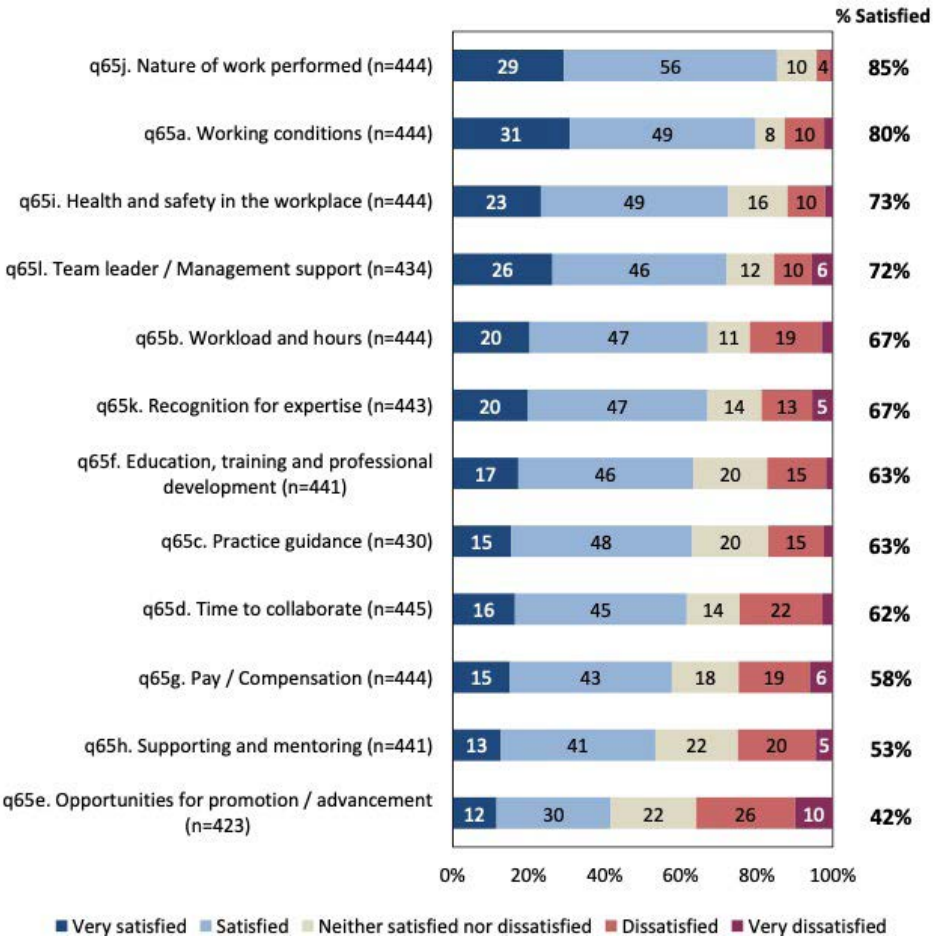
17. Q67. How much difference do you think your work makes to people affected by family violence? (n=397)

**Perceptions of the difference their work made differed by some demographic cohorts, as follows:**

- **Age** – those aged 55+ were more likely than their youngest colleagues to feel that their work made a significant difference to people affected by family violence (53% versus 41% of those aged 18-34).
- **Years of experience** – those who had been in their current role for 2 to 4 years were least likely to feel that their work made a significant difference to people affected by family violence (34%, versus 45% on average).
- **Organisation size** – perceptions that their work made a significant difference to people affected by family violence reduced as organisation size increased, with 52% of those in smaller organisations (1-49 staff) indicating that they felt this way, compared to 38% of staff in organisation with more than 200 staff.
- **Organisation type** – those working in an organisation that specialises in legal services were more likely than average to indicate that they felt their role made a significant difference to people affected by family violence (61% versus 45% on average).

Investigating satisfaction with various elements of their roles revealed that the primary prevention workers were most satisfied with the nature of the work that they perform and working conditions (85% and 80% respectively – see Figure 20).

**Figure 20: Satisfaction with various elements of role**
Base: All respondents




*Q65. How satisfied are you with the following elements of your role?*

In contrast, the main areas for improvement where respondents indicated that they were least satisfied included:

- opportunities for advancement (42% satisfied, 36% dissatisfied);
- supporting and mentoring (53% satisfied, 25% dissatisfied); and
- pay / compensation (58% satisfied, 25% dissatisfied).

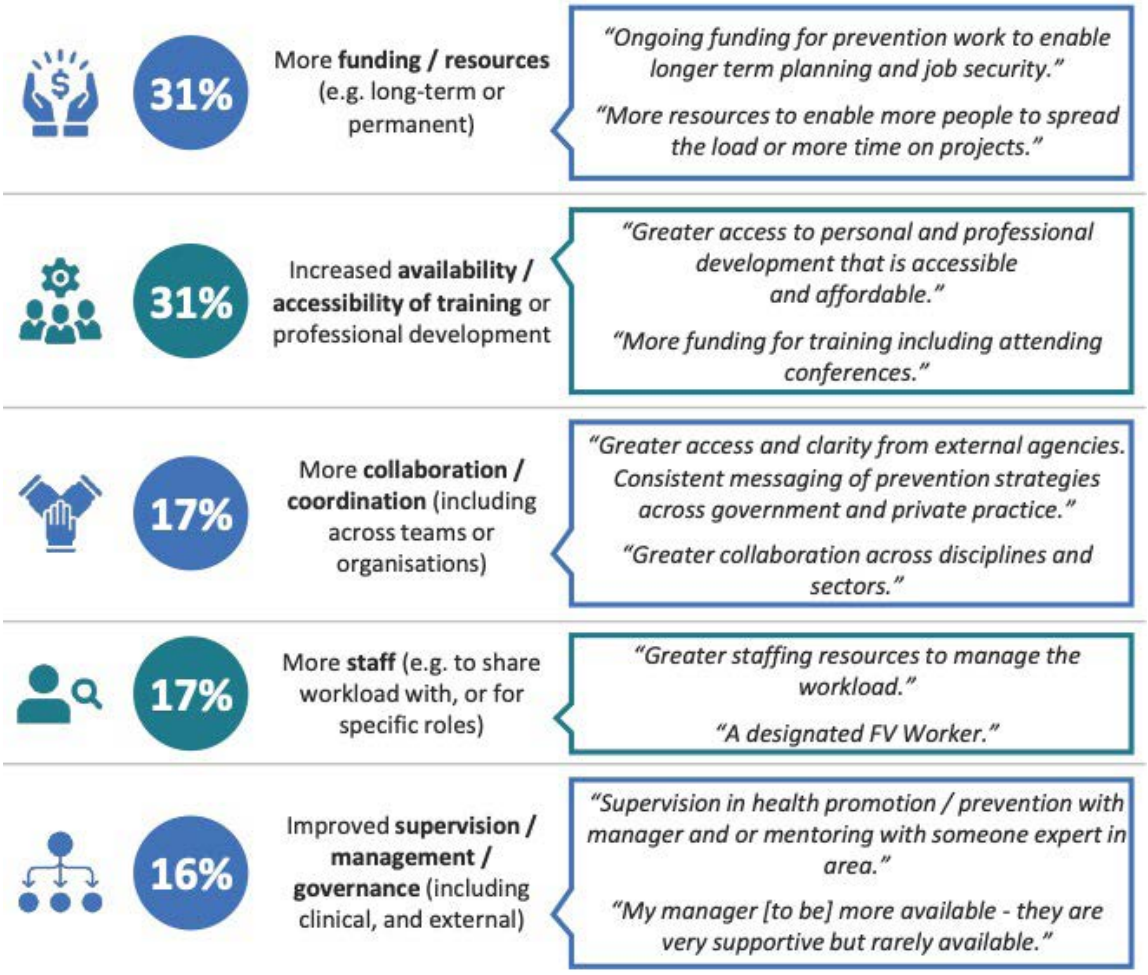
In order to determine what is most important in influencing variation in overall levels of role satisfaction, regression analysis was undertaken. The results suggest that the key drivers were having positive perceptions of:

- practice guidance;
- supporting and mentoring; and
- workload and hours.

## Suggestions for improvement

Respondents were asked to explain what they felt to be the top three most important changes that could be made to enable them to carry out their work more effectively. Free-text comments were coded into themes, with the main themes illustrated in Figure 21.

**Figure 21: Suggestions for improvement (Top 5 themes identified in open-ended responses)**
Base: All respondents




*Q68. What are the top three most important changes that could be made to enable you to carry out your work more effectively?*

# 9 Career and future intentions

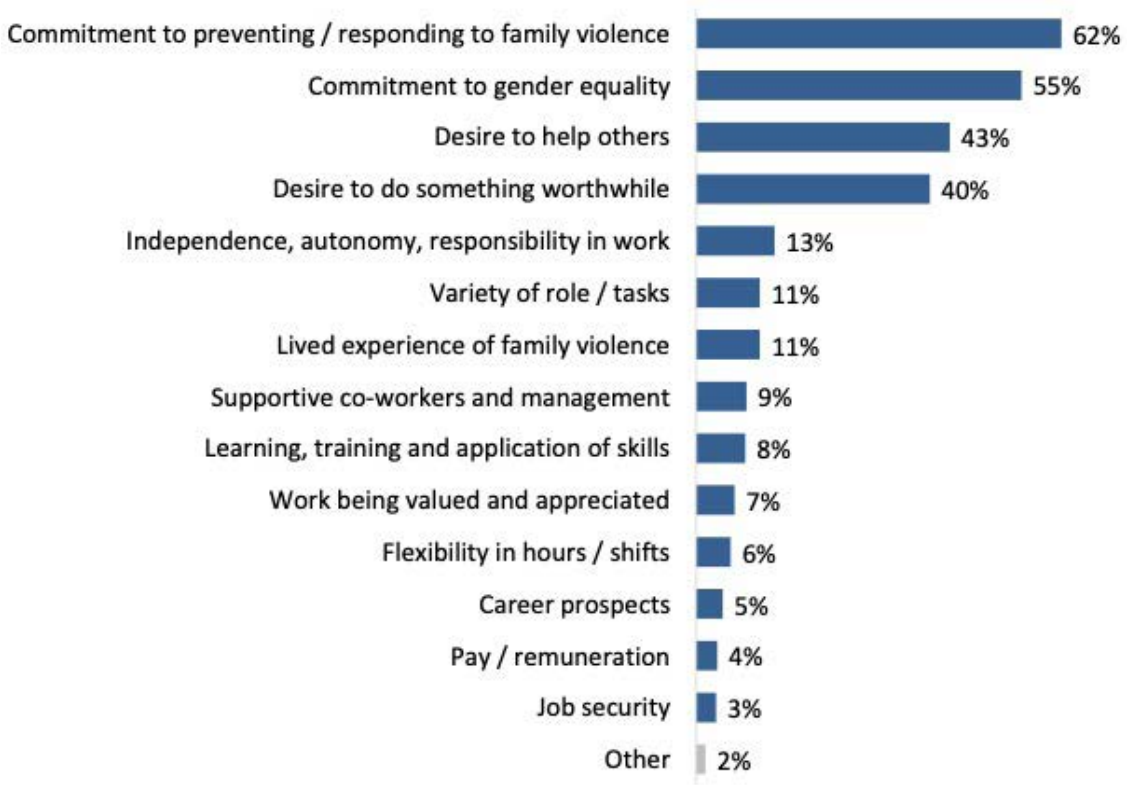
This chapter discusses what it is that motivates the primary prevention workforce in their careers and explores their future plans / intentions. Such information can be useful to inform recruitment and retention strategies to improve the workforce as a whole.

Overall, the results illustrated that the primary prevention workforce shared a number of positive reasons for working in the primary prevention workforce, including a strong **commitment** to preventing / responding to family violence and gender equity.

Regarding future intentions, almost half of all primary prevention practitioners reported that they had plans to **leave** their current role. Although many planned to do so due to an end of contract, others were influenced by better career prospects and lack of advancement opportunities.

When asked what mainly motivates them to work in their primary prevention role, a commitment to preventing and responding to family violence, as well as to gender equity, were the most common reasons cited (55%-62% – see Figure 22). Around four-in-ten respondents were also motivated by a desire to help others (43%) and do something worthwhile (40%). This workforce was least motivated by job security (3%), pay / remuneration (4%) and career prospects (5%).

**Figure 22: Motivators to working in primary prevention**
Base: All respondents (n=444); multiple responses accepted




*Q69. Overall, what mainly motivates you to work in a role in primary prevention of family violence?*

Before commencing their current role in the primary prevention workforce, just over one-third had held a role working for another organisation or agency in the sector (within Victoria – 35%). Around one-quarter (26%) had been working in a related sector, whilst 16% had been working in an unrelated sector, illustrating the diversity of this workforce in terms of career pathways and trajectories.

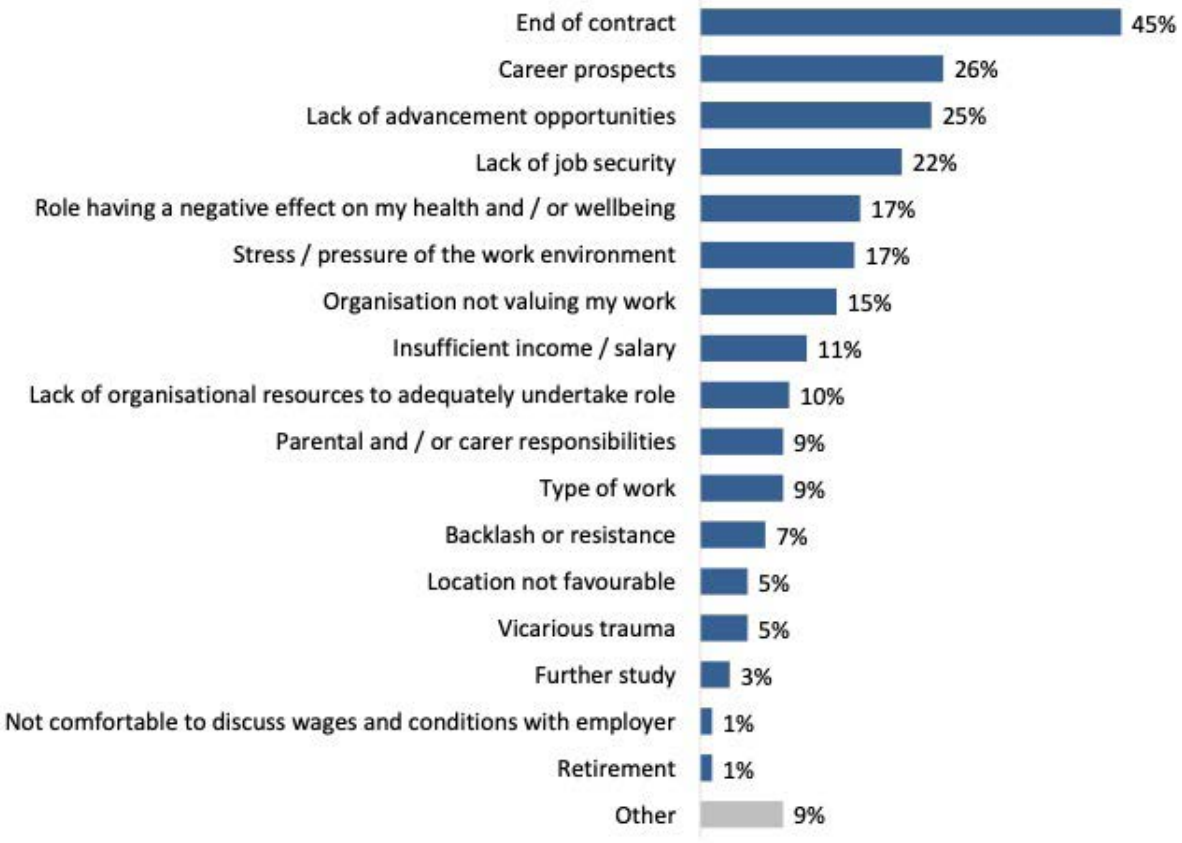
## Future intentions

When asked about their future plans:

**48%** of respondents had plans to leave their current role, 9% were unsure, and 43% did not hold such intentions[18]; and

**75%** of those who planned to leave their current role intended to do so within the next 12 months, mainly due to an end of contract (45% – see Figure 23).

**Figure 23: Reasons for planning to leave current job**
Base: Respondents planning to leave their role in the next 12 months (n=157); multiple responses accepted




*Q74. What are your top 3 reasons for planning to leave your current job in the time frame indicated?*

18. Q71. Thinking about your future, do you have plans to leave your current role? (n=446)

Those who intended to leave their current role also reported differing plans for their next role, with 41% planning to leave their current role for another role outside of the family violence primary prevention workforce; and 31% planning to leave their current role for another role within the family violence primary prevention workforce.

All respondents who did not currently hold any roles in the specialist family violence response workforce were also asked whether they would consider taking on such a role in the future. Just over half reported that they would be open to such a role (53%), whilst 47% said they would not.

**Results differed by some demographic cohorts, as follows:**

- **Age** – younger respondents (aged under 35) were more likely than their older colleagues to:
  - have plans to leave their current role in the next 12 months (45% versus 35% of those aged 35- 54, and 26% of those aged 55+), but were also slightly more likely than others to plan to cease work temporarily; and
  - be open to a role in the specialist family violence response workforce (59% versus 54% of those aged 35 to 54, and 43% of those aged 55+).
- **Years of experience** – those who had been in their current role for more than 5 years were less likely than those with a shorter tenure to have plans to leave their role in the next 12 months (33% of those with 5-10 years' tenure, and 19% of those with over 10 years, versus 42%-43% of those with 2-4 or less than 1 years' tenure).
- **Organisation type** – those working in an organisation that specialises in women's health or policy, research and advocacy were more likely than average to indicate that they had plans to leave their current role (62% and 56%, respectively versus 48% on average).

**2019-20 Census of Workforces that Intersect with Family Violence**

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Primary Prevention Workforce

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