MID-TERM INSIGHTS REPORT

Evaluation of the Health and Wellbeing Navigator response model

Dr Vicki Lowik
Dr Liane McDermott

QCDFVR
Queensland Centre for Domestic and Family Violence Research

The Centre

The Queensland Centre for Domestic and Family Violence Research (QCDFVR) has operated since July 2002. Since then, its primary purpose has been to create and share knowledge to influence policy and practice in gendered violence. QCDFVR works across the three areas of research and knowledge creation, service system support, and education and training. We inform policy, strengthen practice, support communities, and drive real-world solutions to the complex challenges of preventing and responding to domestic, family and sexual violence. Our work is informed by the wisdom of practitioners and those who have experienced violence.

Our Mission

Preventing and responding to, gendered violence through research, education and service system support.

Acknowledgement to Country

We proudly acknowledge the Traditional Owners of the lands across Queensland and other Australian states and territories and pay our respects to all First Nations Peoples. We acknowledge that sovereignty over this land was never ceded. We value the ongoing contribution of our many First Nations partners in advising, supporting and contributing to our work and projects – so that your voices and those of your communities are reflected in our work. We thank you with humility.

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Contact

QCDFVR, CQUniversity Mackay, PO Box 135, Mackay MC, Queensland 4741
Phone +61 07 4940 3320 | www.noviolence.org.au

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1. Introduction

Non-fatal strangulation (NFS) in a domestic and family violence (DFV) context is a high-risk, high-harm form of gendered violence with potentially serious health consequences. After surviving a strangulation assault in a DFV context, a woman's risk of becoming a homicide victim is increased 7-fold (Glass et al., 2008). While one NFS assault can significantly harm or kill a woman, some women are subjected to multiple NFS assaults, with this form of violence often experienced concurrently with other forms of domestic abuse (Lovatt et al., 2022; Lowik et al., 2025).

Injuries from NFS may not be visible in some instances. This can result in some women not seeking assistance because they are unaware of the harm they have possibly incurred, while other women may have their NFS assaults minimised by healthcare professionals or the police (Lowik et al., 2025). Concerningly, survivors of NFS can experience immediate and/or delayed physical and neurological consequences (De Boos, 2019). These consequences, though this is not an exhaustive list, can include confusion and brain fog, headaches, vomiting, problems with vision, drooping of the eyelids or face, speech disorders, difficulty breathing, tinnitus, trouble swallowing, weakness in the limbs or muscle tremors, spinal damage, miscarriage, seizures, brain injury, coma, and strokes (Birchard et al., 2021; De Boos, 2019; Douglas & Fitzgerald, 2020). Blood clots and strokes can occur days or weeks after an NFS assault (Carlson, 2014; Douglas & Fitzgerald, 2020). Survivors of NFS are also susceptible to developing post-traumatic stress disorder (PTSD) due to the violence and the trauma of thinking they could die during an assault (De Boos, 2019).

Many survivors of NFS face barriers in accessing appropriate care, with these barriers compounded by systemic gaps in practitioner knowledge, referral coordination, and trauma- and violence-informed responsiveness. The complexity of these barriers can place an increased burden on Aboriginal and Torres Strait Islander women who are overrepresented as victims of NFS and acquired brain injury (Farrugia et al., 2020). The Queensland Law Reform Commission's recent report, *Non-fatal strangulation: Section 315A review* (QLRC, 2025, p. xxi), has recommended measures that recognise the barriers experienced by many NFS survivors:

- Criminal justice personnel

  R11 The QPS [Queensland Police Service], ODPP [Office of the Director of Public Prosecutions], National Judicial College of Australia, Australian Institute of Judicial Administration, Queensland Courts, and restorative justice/dispute resolution providers should regularly review and update their training, policies, guidelines, and resources on non-fatal strangulation and relevant laws, practices, and procedures. All police, prosecutors, judicial officers, and restorative justice/dispute resolution facilitators who deal with non-fatal strangulation matters should be required to complete training and education on non-fatal strangulation.

  R12 The QPS should develop a consistent screening, documentation, and response protocol for non-fatal strangulation.

- Health professionals

R13 Queensland Health, Queensland Hospital and Health Services, Queensland Primary Health Networks and the Queensland Ambulance Service, as well as relevant professional colleges, should: (a) develop, regularly review and update their training, policies, guidelines and resources on non-fatal strangulation and relevant laws, practices and procedures. (b) develop a best practice non-fatal strangulation assessment and documentation protocol, tailored to their operational needs. All Queensland emergency medicine physicians, forensic physicians and nurses, general practitioners, paramedics, and emergency department nurses and social workers should be required to complete training and education on non-fatal strangulation.

The Health and Wellbeing (HWB) Navigator response model is designed to assist survivors of NFS negotiate barriers to support and healthcare by offering tailored support and psychoeducation (a therapeutic intervention for clients that explains their NFS experience, helps them understand their responses, identifies risks, supports decision-making, and reduces fear), along with systems advocacy and workforce capability uplift through trauma- and violence-informed education on NFS and DFV. The data collection sources for the HWB Navigator response model were established in November 2025, signifying the beginning of the 12-month evaluation period.

The evaluation of the HWB Navigator response model will seek to understand the impact of this service on meeting the needs of survivors through advocacy, information provision, psychoeducation, and service collaboration by:

- assessing how the HWB Navigator service supports clients' feelings of safety, wellbeing, and confidence.
- examining the service's influence on service integration, sector education, and strategic alliances.
- identifying barriers and challenges in service delivery, including funding constraints and professional training gaps.
- generating client-informed insights for service/program strengthening, training innovation, and advocacy messaging, and
- informing policy and practice.

Key questions:

- How do survivors of NFS experience the advocacy provided through the HWB Navigator service (e.g., impacts on their safety, clarity of pathways for support moving forward, and cultural wellbeing)?
- In what ways has the HWB Navigator service shifted understandings, practice, and/or collaboration in relation to the needs of survivors of NFS in the Strangulation Trauma Centre (STC), the DFV service sector, and agencies across the health, housing, policing, and/or legal systems during the 12-month evaluation period?

- What insights are emerging about how the HWB Navigator service can continue to work towards improving outcomes for survivors of NFS engaged with the STC (e.g., recommendations for practice changes in the STC, the DFV service sector, and agencies across the health, housing, policing, and/or legal systems more broadly)?

Responses to these questions will be canvassed in the final evaluation report to be provided following the end of the evaluation period on Friday, 30 October 2026. This mid-term insights report focuses on determining whether the data sources for the HWB Navigator service are operational. It will also provide a progress update on the HWB Navigator response model by integrating quantitative data (deidentified administrative data) with qualitative data from reflections and a de-identified case study provided by the HWB Navigator. The final stage of the evaluation will include qualitative data from surveys and interviews with survivors, surveys with representatives from referral agencies, and interviews with STC staff.

Ethics approval for this evaluation was provided by Central Queensland University's Human Research Ethics Committee (no.).

2. Evaluation Approach

2.1 Developmental evaluation

A developmental evaluation provides for a 'more responsive and adaptive approach', which is appropriate as the HWB Navigator service is a new addition to the STC's compendium of responses to NFS. Hence, there may be facets of this service that are still 'in a state of flux' during this evaluation period (see Australian Institute of Family Studies, 2018).

2.2 Realist methodology and participatory approach

This evaluation will draw on a realist methodology. A realist methodology focuses on understanding what works, for whom, in what circumstances, and why (Pawson, 2013); it is often applied to social program/service evaluations.

> Realist evaluation investigations do not answer the question: "Does this programme work?" because this approach does not conceive programmes as entities that can 'work'. Instead, programmes are understood to offer resources to subjects who choose to act on these resources, and these choices end up determining whether the programme works (Manzano, 2024, p. 2).

When combined with a participatory approach, stakeholders (practitioners and service users) become engaged in the evaluation process, to ensure that the:

- evaluation process remained grounded in lived experience and frontline practice; and
- findings would be relevant and actionable (Zukeski & Bosserman, 2018).

Together, these approaches can lead to a more effective and responsive evaluation that addresses the unique needs and contexts of the clients that the program/service aims to assist.

2.3 Program logic model and program theories

When developed through a participatory approach, the program logic model and program theories become tools to ensure the evaluation reflects real-world experience and supports meaningful evidence-informed feedback. The program logic model (see Appendix 1) provided a big picture view of the HWB Navigator response model's intended inputs, activities, outputs, and outcomes. It is essentially a map of how the response model is intended to work. However, as the HWB Navigator response model matures, several factors will continue to emerge. The program logic model will therefore be updated and finalised in the final evaluation report to reflect the evidence base.

Initial program theories were developed from the program logic model. The realist methodology promoted the development of program theories to show how and why the service works, and for whom. The theories describe the conditions that help the service work well; the mechanisms that drive change; and the outcomes that follow. The projected outcomes are not performance measures. Rather, they are hypotheses to be tested and refined through the analysis of evaluation data, resulting in a new set of program theories.

Program theories are dynamic and iterative in nature. They can evolve as the implementation of a service unfolds, contextual conditions change, and new learnings emerge. For this developmental evaluation, the program theories will include:

- Initial program theories (see Table 1) – these theories will provide anticipated outcomes for the HWB Navigator response model to be examined in the mid-term evaluation.
- Mid-term program theories (see section 4.1) – these theories will provide a more evidence-informed explanation of how the HWB Navigator response model is functioning. The mid-term theories will project anticipated longer-term outcomes for the final evaluation phase.

Table 1: Initial program theories

Program theory	Context	Mechanism/s [why outcomes occur]	Outcome/s
Trust and engagement	The HWB Navigator response model is building rapport with survivors and developing an understanding of their needs.	Survivors feel heard, believed, safe, and supported.	Survivors trust the HWB Navigator service and are actively engaging with the agencies to which they are referred.
Interagency coordination and system navigation	Referral agency representatives are becoming aware of the HWB Navigator service and are responding to support requests.	Referral agency representatives recognise the value of the HWB Navigator service in bridging sector and system gaps.	Connections are being established between the HWB Navigator service and other agencies, leading to interagency collaboration and improved support responses for survivors.
Trauma- and violence-informed support	The HWB Navigator response model is providing	Referral agency representatives understand	The HWB Navigator is educating the broader service sector about the

Program theory	Context	Mechanism/s [why outcomes occur]	Outcome/s
	psychoeducation (therapeutic intervention) to clients and is contributing to the workforce capability uplift across systems through trauma- and violence-informed education about DFV and NFS.	the serious nature and impacts of DFV and NFS.	impacts of DFV and NFS. Survivors are being responded to in a trauma- and violence-informed manner.

2.4 Mid-term evaluation data sources

As mentioned in the Introduction chapter, the HWB Navigator response model's mid-term evaluation will draw findings from the triangulation of quantitative and qualitative data. The quantitative data will comprise de-identified administrative data, and the qualitative data will be sourced from reflections and a de-identified case study provided by the HWB Navigator.

2.5 Mid-term data analysis approach

This evaluation adopted a mixed-methods analysis approach to provide a mid-term overview of the HWB Navigator response model. The analysis of administrative data focused on identifying patterns in clients' characteristics and referral pathways. This quantitative analysis was largely descriptive at this mid-term stage, rather than inferential.

Reflections from the HWB Navigator were analysed using a thematic coding approach (Braun & Clarke, 2023). The analysis focused on how the response model was operating in practice. The coding approach was inductive, though the researchers were alert to identifying patterns in practice and system navigation.

The findings from the quantitative and qualitative analyses were then integrated to develop an understanding of the operational dynamics of the HWB Navigator response model at this mid-point of establishment.

3. Findings - mid-term data insights

Twenty women had been referred to the HWB Navigator response model before the evaluation period began on 1 November 2025. Although this pre-evaluation cohort falls outside the evaluation period, providing a high-level overview of this data is relevant to understanding the context of the HWB Navigator service, the workload, and the emerging value of the service.

Most of the pre-evaluation cohort were from the age groups: 31-40, 41-50, and 51-60, with three women identifying as First Nations and two women from culturally and linguistically diverse (CALD) communities. Referrals to the HWB Navigator service were initiated from a broad range of agencies, such as Centrelink (social worker), the Queensland Police Service's Vulnerable Persons Units (VPU) in Logan, Brisbane North, and Ipswich, as well as various

specialist DFV services, including Strong Women Talking - a First Nations DFV support service. Several women also self-referred to the service. The women were living in various regions across Queensland, including South-East Queensland, the Wide Bay-Burnett region, and Central Queensland.

Most of these women were considered to be at the crisis stage of their survivor journey due to recent separation from the abusive partner, safety concerns, and ongoing systems abuse. All women were experiencing serious health consequences directly related to NFS, except for one woman whose health status was not noted. To meet the needs of this cohort, the HWB Navigator conducted safety planning and risk assessments and provided information, psychoeducation, advocacy, and referral pathways, encompassing legal, medical, housing, and disability services.

The diverse characteristics of this cohort suggest the immediate and ongoing system-wide demand for the HWB response model. Engagement and referral patterns in this period highlight early relationship-building, trust, and legitimacy for the service. Four women from the pre-evaluation cohort continue to be supported through the HWB Navigator service; nine women have had their cases closed, citing that their needs have been met; six women disengaged from the service; and one woman did not need referral support at the time of engagement with the service. Reference to this pre-evaluation cohort is provided as context for the development of the HWB Navigator response model.

The following sections provide an overview of the mid-term data collected through the HWB Navigator response model between 1 November 2025 and 28 April 2026.

3.1 Client demographics

Thirteen clients were referred to the HWB Navigator service during the mid-term evaluation period. Consent was sought from clients before their de-identified data was included in this evaluation. One client did not consent to the inclusion of her data. The demographics for the remaining 12 clients are as follows:

3.1.1 Age groups

- 21-25 (1)
- 31-40 (2)
- 41-50 (7)
- 51-60 (1)
- 61-70 (1)

3.1.2 Priority populations

- First Nations (4)
- CALD (0)
- LGBTIQA+ (0) (note: 3 of the 12 clients did not complete this section)

3.1.3 Children

- Four women had children under the age of 18 in their care.
- One woman had two children who were in the full-time care of the person using violence.
- One woman had one child in kinship care.

3.1.4 Housing

- Private rental (4)
- Renting a room (1)
- Social housing (3)
- Transitional housing (1)
- Living with family or friends (3)

3.1.5 Employment status

- Disability Support Pension (4) - with 1 client also working part-time
- Full-time (2)
- Part-time (2)
- Casual (1)
- Parenting full-time (2)
- Centrelink – Job Seeker (1)
- Temporarily unemployed (1)

3.1.6 Geographic region

- Moreton Bay (3)
- Redlands (1)
- Logan (1)
- Brisbane North (1)
- Brisbane West (2)
- Brisbane East (1)
- Brisbane Central (1)
- Ipswich (1)
- Wide Bay (1)

This cohort has various intersecting social and economic vulnerabilities. Most women were in the 41–50 age group, suggesting the HWB Navigator service is engaging with clients who may have cumulative disadvantage and perhaps more complex support needs than women in earlier life stages. Housing stability for this cohort varied. Women were living in private rentals, social housing, and informal arrangements with family or friends, highlighting contrasting levels of housing security and potential uncertainty.

Employment data continues to confirm this complexity, with some women reliant on the disability pension, alongside a small number of women who had full- or part-time

employment, suggesting that disability and financial constraint could be significant factors shaping the circumstances of these clients. There were women in this cohort who also had caregiving responsibilities for children under 18 years of age. These responsibilities may have influenced both the support needs of these women and their capacity to engage with the HWB Navigator service.

The HWB Navigator response model appears to be culturally responsive and regionally adaptable in its service delivery, considering the representation of First Nations clients in this cohort and the geographic positioning of clients across South-East Queensland and the Wide Bay-Burnett region. The demographic data in this section suggest that the HWB Navigator service is supporting clients with layered intersecting needs, including housing insecurity, financial constraint, and caregiving responsibilities.

3.2 Client relationship and legal context at intake

3.2.1 Domestic violence order (DVO)

- No DVO in place (3)
- DVO in place (7)
- DVO has expired (2)
- Criminal charges in progress (2 – also have DVO in place)
- Criminal charges being pursued (1 – also has DVO in place)

3.2.2 Duration of abusive relationship

One client did not refer to the duration they were in the abusive relationship.

- Under 12 months (4)
- 10 years and under (6)
- 20 years (1)

3.2.3 Year separated from person using violence

Eight of the 12 clients provided the year that they separated from person using violence.

- 2025 (2)
- 2024 (2)
- 2023 (1)
- 2019 (1)
- 2018 (1)
- 2014 (1)

Many clients had been entrapped in abusive relationships for extended periods, indicating likely prolonged exposure to coercive control. This aligns with earlier demographic findings showing that most clients were in mid-life, a stage at which long-term patterns of coercion, dependency, and entrapment are more likely to be established. The duration of the abusive relationship, combined with the timing of separation from the person using violence,

highlights the complexity of clients' risk profiles and the intensity of their safety and support needs.

Criminal justice and legal system involvement varied across the cohort. Some clients had current DVOs, while others had expired orders or no legal protections in place at intake with the HWB Navigator response model. Two clients, in addition to having DVOs, were also pursuing or had active criminal charges against the person using violence. Regardless of their legal protection status, the HWB Navigator service provided all clients with safety planning and risk assessment at intake, along with information, psychoeducation, advocacy, and referrals as required. Being able to understand the complexity of clients' presentations and providing trauma- and violence-informed safety planning, legal advocacy, and coordinated multi-system support indicates the value the HWB Navigator response model can potentially bring to effectively meeting the needs of NFS survivors.

3.3 Client health presentation at intake

Clients presented with a range of medical concerns when they initially engaged with the HWB Navigator service. Most clients in this cohort had experienced multiple NFS assaults; nevertheless, clients who had experienced one NFS assault were also dealing with serious health consequences. Health conditions directly associated with NFS were prominent, alongside a broader set of health conditions that shaped the women's overall wellbeing and support needs.

3.3.1 NFS-related health concerns

- Memory loss
- Loss of concept of time
- Difficulty concentrating
- Fatigue
- Episodes of fainting
- Heart rate irregularities
- Headaches
- Neck pain
- Sore throat
- Difficulty swallowing
- Voice changes
- Occasional trouble breathing
- Transient Ischemic Attack (TIA)
- Oesophagus pushed into a bone spur
- Brain and spinal injuries
- Nightmares and flashbacks
- Depression and anxiety
- PTSD
- Panic attacks

3.3.2 Other DFV-related concerns

- Past alcohol and drug use (AOD) while in the abusive relationship
- Foot fracture from DFV assault
- Dental issues linked to DFV assault

3.3.3 Pre-existing or chronic conditions not clearly DFV-related

- Carpal tunnel
- Fibromyalgia
- Hypermobile Ehlers-Danlos syndrome (hEDS)
- Postural Orthostatic Tachycardia Syndrome (POTS)
- Ulcerated vitreous
- Endometriosis
- Arthritis
- Bone spurs
- Sleep apnea
- Diabetes
- Attention deficit hyperactivity disorder (ADHD)
- Learning and intellectual disability

3.3.4 Suicide risk

- Passive (low risk) – protective factors identified (1)
- Moderate (active thoughts, but no plan or intent) – protective factors identified (1)

Women's health presentations at the point of engagement with the HWB Navigator often reflected a high level of complexity due to co-existing physical, neurological, and psychological concerns. A significant proportion of the reported health conditions were consistent with experiencing NFS assaults:

> memory loss, cognitive impairment, headaches, PTSD, depression and anxiety, neck pain, difficulty swallowing, voice changes, episodes of fainting, cardiovascular irregularity, brain and spinal injury, and TIAs.

These presentations are notable, not only for their physical, psychological, and neurological features, but also for their persistence over time, with several clients reporting ongoing or escalating symptoms. Alongside these concerns, women also reported broader DFV-related impacts, such as past alcohol and drug use, along with consequences from other forms of physical violence.

Data in relation to suicidality provide evidence of the significant psychosocial distress experienced by women who have experienced NFS assaults. One woman was assessed as being at passive risk of suicide, and another at moderate risk. In both cases, protective factors were identified. This emphasises the importance of conducting risk assessments that recognise both vulnerability and protective capacity within women's circumstances.

For some women, their health consequences from NFS and DFV were compounded by the presence of chronic and pre-existing medical conditions. The intersecting nature of these health concerns contributes to the complex needs of women in this cohort, highlighting how the HWB Navigator service can operate in this space by providing coordinated and trauma-informed support to clients, and, where required, referrals to responsive health care services.

3.4 Referral pathways

3.4.1 Survivor recovery stage of clients at intake

- Ongoing crisis – often systems abuse (5)
- Healing/recovery (6)
- Not recorded (1)

Many clients were recorded as being in a stage of healing and recovery, with others in a stage of ongoing crisis at intake. The crises were most often related to system abuse. Each of these clients received support from the HWB Navigator service, with little differentiation in clients' support needs, regardless of their stage of recovery.

3.4.2 Safety planning and risk assessments

Safety planning and risk assessments are conducted during the intake process for all clients, and this process is revisited at every point of contact with a client during their engagement with the HWB Navigator service.

3.4.3 Information provision

- NFS health information
- Information relating to Victim Assist Queensland and the Charter of Victims' Rights
- General health information
- Information relating to the crisis support line

3.4.4 Advocacy

- General Practitioners
- Hospital – Royal Brisbane and Women's Hospital
- Queensland Police Service
- Queensland Oral Health
- Additional Child Care Subsidy
- Centrelink
- Neurologist
- Housing support
- ENT specialist

3.4.5 Referrals into the HWB Navigator response model

From 1 November 2025 to 28 April 2026, the HWB Navigator received referrals from the following sources:

- Open Haven (post domestic violence support)
- The Centre for Women Logan – DFV Local Link
- Queensland Police Service – Vulnerable Persons Unit (VPU) North Brisbane
- ACCORAS (early mental health support)
- Mission Australia's Intensive Family Support
- Self-referral

3.4.6 Referrals from the HWB Navigator response model

- Victim Connect referrals
- General Practitioners
- Rebuilding Smiles
- Brisbane Domestic Violence Service
- Basic Rights Queensland
- Internal counselling referrals

3.4.7 Agency collaboration – (advocacy, referrals, workforce capability uplift across systems)

- Bayside Housing – Capalaba
- Basic Rights Queensland (BRQ)
- Forensics Medical Queensland (FMQ)
- Footprints – homelessness
- Kyabra – Sunshine Coast
- Strong Women Talking
- Disability advocacy – Pathways (QAI)
- Redlands Community Centre
- Mater Hospital – Emergency Department social workers
- Victim Assist Queensland – Legal assistance
- SARS – Metro Health QE2
- Tenants Queensland – QSTARS
- ACCORAS
- PHN- Health Community Link-Centre for Women & Co
- CQHHS - regional forensics coordinator (QLD Health)
- Rebuilding Smiles Program
- QLD Oral Health - Metro North and Metro South Health
- Children's Health Queensland
- Queensland Health St George
- Commonwealth Parliamentary Committee - Rural and Regional Affairs and Transport References Committee

Referral pathway data indicate that the HWB Navigator response model is engaging with women across different stages of recovery, with an almost even distribution between those in ongoing crisis and those at the healing or recovery stage. The crises experienced by women were most often associated with system abuse, highlighting the value of having the HWB Navigator service negotiate and enable system engagement for these women. There was little differentiation in the types of support, advocacy, and referrals required by clients in crisis or healing/recovery stages, showing that client needs can be consistently high and complex regardless of where women are positioned in their recovery trajectory.

In practice, the HWB Navigator response model is characterised by a combination of safety planning, risk assessment, information provision, psychoeducation, advocacy, and active referral, with workforce capability uplift through trauma- and violence-informed education about DFV and NFS. Referral pathways into the HWB Navigator response model were diverse, spanning specialist DFV services, policing, mental health supports, family services, and self-referral pathways. Hence, the HWB Navigator response model appears to be embedded within, and responsive to, the cross-sector service system.

While referrals to external services were made, some clients required ongoing information and advocacy rather than service referrals, highlighting this cohort's need for responses that go beyond external referral responses. Information provision and advocacy extended across various government departments, including health, legal, housing, income support, and victim assistance agencies, along with general practice and specialist medical services, reflecting the systemic and interconnected nature of clients' needs.

The HWB Navigator also advocated for changes to Medicare to improve outcomes for DFV survivors by authoring a submission to the Commonwealth Parliament's *Rural, regional and remote Medicare access and funding* inquiry on behalf of the Red Rose Foundation. The submission highlights the critical need for a dedicated Medicare Benefits Schedule (MBS) item to fund diagnostic imaging for survivors of suspected or disclosed NFS in the context of DFV (see Submission 105 to the Rural and Regional Affairs and Transport References Committee Submissions – Parliament of Australia). The activities undertaken through the HWB Navigator response model affirm its potential to be a coordinating instrument in a fragmented service landscape.

3.5 HWB Navigator reflections

3.5.1 Knowledge gap about NFS

A consistent theme appearing across the HWB Navigator reflections was that DFV presents as a complex and highly individualised health issue, with this complexity significantly heightened when NFS is involved. The reflections point to a critical gap in the sector-wide workforce's understanding of DFV and NFS, particularly in relation to it being a high-risk, high-harm form of violence, with potentially serious and delayed health consequences, despite the invisible nature of some injuries. For example, survivor disclosures of NFS were not consistently considered during clinical assessment:

> Survivors with swallowing issues – ENTs tend to rule it down to reflux … They tend not to contextualise the survivor's history of NFS.

A lack of awareness of the risks associated with NFS contributed to its minimisation and, at times, inadequate or delayed health responses. The analysis of the reflections suggests that without sufficient understanding of NFS, health professionals may miss key indicators of escalating risk and fail to respond with the urgency required, as shown by this quote:

> Tendency for health professionals not to account for disclosed strangulation history in their assessment. There is a lack of awareness, comprehension, and understanding of what NFS entails.

The reflections highlight the importance of the HWB Navigator's provision of advocacy, psychoeducation, and referral pathways for survivors, alongside targeted trauma- and violence-informed education on DFV and NFS for the healthcare workforce. (see Appendix 2 HWB Navigator reflections – Primary Healthcare Uplift)

3.5.2 Structural and systemic barriers

Structural and systemic barriers, which in some instances can intersect with the lack of understanding about the high-risk, high-harm nature of NFS, were consistently identified in the HWB Navigator reflections as limiting NFS survivors' access to timely and appropriate health care. Survivors experiencing NFS, as shown in the data, are often navigating various forms of precarity, including unstable housing, financial insecurity, and trauma, which compound existing barriers within the health system.

At a structural level, out-of-pocket costs were identified as a significant barrier to accessing care. The HWB Navigator observed that diagnostic procedures considered important for a survivor of NFS, such as imaging, are not fully bulk billed, requiring upfront payment that many survivors cannot afford.

> There is an out-of-pocket cost. It can be reimbursed, but survivors are unable to pay costs upfront due to already being financially disadvantaged because of DFV. The gap in early intervention access to imaging is placing survivors at extreme health risk, further impacting their recovery journey.

This creates a situation in which those at highest risk of internal injury are least able to access necessary screening, delaying or preventing their diagnosis and treatment.

Systemic barriers were also apparent. Health systems may inadvertently reinforce perpetrator control, for example:

> For survivors who may be subject to extreme coercive control, perpetrators can surveil their Medicare records, therefore discouraging survivors from seeking medical care and adding another barrier for survivors accessing health support.

This highlights how information-sharing functions, while designed for system efficiency and transparency, can create unintended risks for DFV survivors.

In addition, survivors described challenges in their interactions with health professionals, including concerns that their gender and/or age may be underpinning difficulties in having their symptoms understood or taken seriously.

> Lots of women have difficult experiences with neurology, where there is a struggle to understand/comprehend women's presentations. Whether it is health operating from a more bureaucratic framework? It could also be a gender issue. Lots of neurology professionals are mostly men (as reported by survivors). Also, discrimination for the older generation of women.

These structural and systemic factors can act as gatekeepers to care, restricting access at multiple points along the help-seeking pathway. The findings acknowledge the potentially vital role of the HWB Navigator in providing information, advocacy, and referrals, thereby mitigating barriers that survivors may be unable to overcome independently (see Submission 105, Rural, regional and remote Medicare access and funding – the Commonwealth Parliament's Rural and Regional Affairs and Transport References Committee - Submissions – Parliament of Australia).

3.5.3 Multidisciplinary collaboration

The HWB Navigator reflections consistently identified the need for multidisciplinary collaboration, across and within systems, to meet the complex needs of NFS survivors. Siloed responses from government and community agencies can fail to provide the coordinated engagement often required to keep women safe, address their health needs, and provide them with housing, income, or disability support. The HWB Navigator considered:

> Fragmented responses – lack of a multidisciplinary response from health professionals – there needs to be a specialised multidisciplinary response with a multidisciplinary health professionals' team for survivors of NFS that includes ENT, speech pathology, neurology, and GPs. NFS can be understood analogously to cancer: its impacts are often hidden, complex, and progressive, affecting multiple systems and requiring coordinated attention.

Multidisciplinary collaboration can also facilitate information sharing and ongoing care, which are particularly important given the cumulative impacts of trauma and the increased lethality risk associated with NFS. Without such combined engagement, survivors may fall through systemic gaps, with delayed intervention exacerbating their harm. This points to the importance of structured, trauma-informed, and survivor-centred models of care that embed collaboration as a core component of service delivery.

The HWB Navigator reflections acknowledge the challenges experienced by NFS survivors in having their health, safety, and social needs addressed. Healthcare gaps, systemic and structural barriers, and fragmented service delivery continue to limit appropriate and adequate responses to NFS survivors' needs. The themes suggest the importance of a reliable and knowledgeable source of support for survivors of NFS, such as the HWB Navigator response model, as they move through their survivor journey.

3.6 Case study of a survivor's healthcare journey

The following case study provides practitioner insight into a survivor's journey following self-referral to the STC at the Red Rose Foundation (RRF):

> A survivor of non-fatal strangulation (NFS) self-referred to RRF for ongoing health support, reporting persistent neurological and physical symptoms, including difficulty swallowing, voice changes, and transient ischemic attacks (mini strokes). The survivor reported experiences of fragmented care, difficulty being understood by multiple health professionals (GP, speech pathologist, ENT, neurologist), and medical gaslighting, as the survivor's history of NFS was largely ignored in assessments and treatment planning. While engaging with RRF, the survivor suffered a confirmed stroke, which she described as validating her ongoing concerns regarding NFS-related symptoms. Through the HWB Navigator, education on DFV and NFS, and advocacy were provided to her healthcare team, resulting in improved understanding, coordination, and a sense of validation for the survivor.

This case study highlights the lack of NFS awareness, insufficient multidisciplinary responses, and the systemic barriers that survivors face, underscoring the need for coordinated care pathways and specialised navigation, as with other complex health conditions. Early intervention, education, and consideration of the survivor's reported symptoms and their strangulation experiences may have appropriately managed or more appropriately supported the survivor's health needs.

4. Discussion

The findings from this mid-term evaluation demonstrate that the HWB Navigator response model is supporting a cohort with intersecting, cumulative, and often compounding vulnerabilities. Clients commonly presented with layered social and economic disadvantage, including housing insecurity, financial stress, chronic health conditions, and long-term exposure to coercive control. These demographic and contextual factors shaped both the intensity of support required and the complexity of the HWB Navigator's role in coordinating safe and effective responses.

The clients' relationship and legal contexts further amplified their risk profiles. Some clients had been entrapped in abusive relationships for extended periods, and others were navigating post-separation, a period known to be associated with heightened danger. Some clients were supported through having DVOs, while others had no legal protections in place. These patterns highlight the ongoing nature of risk and the need for trauma- and violence-informed safety planning, legal advocacy, and coordinated multi-system engagement.

Clients' health presentations at referral reveal a cohort experiencing significant clinical vulnerability. Most women were managing serious health consequences following one or multiple NFS assaults. For many survivors, the impacts of NFS were compounded by chronic or pre-existing medical conditions, creating a complex interplay of acute and long-term health needs. These findings reinforce the value of the HWB Navigator service in facilitating

access to responsive health care, advocating for timely imaging and assessment, and providing trauma- and violence-informed workforce education on DFV and NFS that is often unavailable elsewhere.

System-level barriers were a consistent feature of clients' experiences. Women frequently encountered siloed responses across health, legal, housing, income support, and community services. Out-of-pocket costs and the limited availability of bulk-billing created significant barriers to accessing appropriate care. A lack of sector-wide understanding of NFS, including inconsistent clinical assessment and minimisation of symptoms, further contributed to delayed or inadequate responses. These systemic issues meant that the women at highest risk of internal injury were often the least able to access timely screening and treatment.

The HWB Navigator's role emerged as a critical mechanism for bridging these systemic gaps. Information provision and advocacy extended across multiple government and community agencies, reflecting the interconnected nature of clients' needs. The HWB Navigator service negotiated access to health care, supported legal processes, coordinated with housing and income support agencies, and provided ongoing emotional and practical support for survivors. Importantly, the mid-term evaluation found little differentiation in the level of support required by clients in crisis versus those in healing/recovery, indicating that high-complexity needs can persist across the recovery trajectory.

Taken together, these findings highlight the essential function of the HWB Navigator response model in supporting women experiencing NFS and DFV. The service is culturally responsive, regionally adaptable, and uniquely positioned to provide the coordinated, trauma-informed, and multi-system engagement required to meet the needs of this cohort. The HWB Navigator service mitigates service and system fragmentation, enhances safety, and improves access to health and legal pathways that would otherwise remain inaccessible or inconsistent. Understanding these intersecting factors is critical for identifying the structural and practice-level improvements needed to strengthen responses to NFS.

4.1 Mid-term program theories

The initial program theory (see section 2.3) anticipated improvements in early engagement, interagency coordination, and trauma- and violence-informed responses. Mid-term findings show that the projected mechanisms are beginning to produce the intended outcomes. The following mid-term program theories refine these assumptions based on the evidence gathered to date.

Table 2: Mid-term program theories

Program theory	Context	Mechanism/s [why outcomes occur]	Outcome/s [intended]
Trust and engagement	The HWB Navigator service has established rapport across the DFV sector and multiple government agencies. The role is increasingly	Clear communication about the HWB Navigator service's purpose, combined with consistent trauma- and violence-informed practice,	Clients experience safe, supported, and timely engagement with the HWB Navigator service, enabling earlier identification of risk,

Program theory	Context	Mechanism/s [why outcomes occur]	Outcome/s [intended]
	understood across systems, resulting in earlier, more consistent, and more appropriate referrals. Clients are engaging with the service sooner in their help-seeking journey.	builds trust among both clients and referring agencies. This trust increases clients' willingness to disclose safety and health concerns and their confidence in engaging with support.	improved access to coordinated support, and stronger continuity of care across systems.
Interagency coordination and system navigation	The HWB Navigator service has established strong working relationships with key agencies, including health, legal, housing, income support, and DFV specialist services. Communication channels have become more stable, and early priority pathways are emerging, enabling more timely interagency engagement.	As agencies develop a clearer understanding of the HWB Navigator service, system navigation becomes more streamlined. Improvements in referral turnaround, reduced disengagement, and consistent follow-through with and by agencies suggest that clients are encountering fewer barriers when moving between services. This reflects increased trust, clearer communication, and more coordinated action across systems.	Clients experience coordinated and timely progression through multiple service systems, reducing the risk of disengagement, unmet needs, or being lost between agencies. Interagency collaboration strengthens continuity of care, enhances safety, and ensures that clients receive the right support at the right time.
Trauma- and violence-informed support	The HWB Navigator service is increasingly advocating for trauma- and violence-informed approaches when coordinating referrals for clients who have experienced NFS. Referral agencies have become more familiar with the HWB Navigator service, and communication pathways are more predictable, allowing for consistent reinforcement of trauma- and violence-informed principles across systems.	As agencies gain a clearer understanding of NFS-related risks and the importance of trauma- and violence-informed practice, their responses become more attuned to client safety and wellbeing. Patterns in referral outcomes and service engagement, including improved referral turnaround and reduced disengagement rates, suggest that agencies are applying trauma- and violence-informed principles more consistently, reducing barriers and minimising re-traumatisation for clients.	Clients receive safe, validating, and appropriately paced support across health, legal, and community systems. Trauma- and violence-informed responses improve the quality and consistency of referrals, reduce the likelihood of clients disengaging due to harmful or inappropriate system interactions, and strengthen access to the coordinated care required to address NFS-related risks.

Consistent with developmental evaluation principles, the program theories underpinning the HWB Navigator response model are treated as iterative and adaptive. Initial program theories informed expectations regarding early implementation processes and anticipated short- to medium-term outcomes. Findings from this present evaluation phase were used to refine the initial theories and identify projected pathways and anticipated outcomes for examination in the final evaluation stage. Further program theories will be developed in the final evaluation

stage to show what mechanisms the HWB Navigator response model has established, the outcomes it can reliably produce, and what it needs to sustain or scale up its impact to improve support for survivors of NFS and DFV.

5. Conclusion

This mid-term evaluation identified that survivors of NFS commonly experienced intersecting health, social, and economic vulnerabilities that complicated recovery trajectories and engagement with healthcare and support systems. Findings to date suggest the HWB Navigator response model may play an important role in supporting survivors through fragmented systems by providing continuity of support, advocacy, information/psychoeducation, referrals, and trauma- and violence-informed education across multiple service sectors.

As a mid-term developmental evaluation, this report presents important insights into the recovery needs of survivors of NFS and DFV and how the HWB Navigator response model is bridging gaps in sector and system responses to these needs. The final evaluation phase will provide the opportunity to examine survivor responses to the support provided through the HWB Navigator service, evolving agency responses to the HWB Navigator service, and the extent to which the refined program theories in this report continue to develop over time.

The practice implications for the HWB Navigator response model, moving toward the final evaluation report, include:

- ongoing evaluation of patterns and trends from survivors of NFS and DFV when navigating the healthcare system.
- continuing to advocate alongside survivors for an improved healthcare response to their needs.
- creating new health resources/information for survivors, community health centres, and other agencies.

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Appendices

Appendix 1. Logic Model – Health and Wellbeing Navigator service - November 2025

1. Inputs

- Trust and engagement
- Interagency coordination and system navigation
- Trauma- and violence-informed support

2. Activities

- Non-judgmental, culturally safe client support
- Advocacy across public, private, and community health settings
- Relationship-building with health, justice, and other service sector representatives
- Training and education delivery
- Contribution to systemic reform and strategic planning

3. Outputs

- Referrals made and tracked
- Professional/agency partnerships recorded
- Training sessions delivered, information shared, and feedback collected
- Resources developed for clients, practitioners, and agency representatives

4. Short-term Outcomes

- Improved coordination across health, justice, and other service sectors
- Greater awareness of strangulation and trauma- and violence-informed care by referral agency representatives
- Clients feeling well supported

5. Medium-term Outcomes

- Greater access to timely, appropriate health care
- Strengthened alliances across health, justice, and other service sectors
- Embedded trauma- and violence-informed practice across the referral sectors
- Clients feeling well supported

6. Long-term Outcomes

- Systemic reform in the health response to strangulation
- Client voice is driving policy and practice
- Red Rose Foundation positioned as a leader in trauma-responsive health advocacy
- Strengthened alliances across health, justice, and other service sectors
- Clients feeling well supported

Appendix 2 – HWB Navigator reflections – Primary healthcare uplift

The idea is to create a dedicated training package for GPs, so they feel confident and well-equipped to provide follow-up care for people who have experienced non-fatal strangulation (NFS). The training would focus not only on the medical impacts but also on trauma-informed care, risk awareness, and clear referral pathways, so patients receive safe and appropriate support after the initial incident.

Once a GP completes the training, they will be recognised as having specialist knowledge in NFS follow-up care. These GPs could then be listed on the RR website, making it easier for community members, victim-survivors, and support services to find a doctor who understands NFS and its risks.

This approach is like the Children by Choice model, where trained and trusted providers are easy to identify on a map. Women can identify GPs who are trauma-informed and offer pregnancy support options. There should be a similar model for survivors of NFS and access to primary healthcare

Overall, the aim is to improve access to informed, compassionate care, reduce the chances of serious health issues being missed, and help people feel safer and better supported in their recovery. Red Rose would be a referral pathway that GPs could refer to or other relevant strangulation centres if relevant

Red Rose would lead the NFS strangulation space and use the training package to support health professionals all over QLD in relation to NFS. This training package could be co-designed with other relevant professionals, advocates, and victim survivors.

Strangulation or health care hubs across QLD that provide support for survivors of NFS and DFV, with the appropriate supports – navigators, DFV workers, case managers, and medical specialists etc. These hubs could be NFS specialised health recovery centres providing multidisciplinary responses.