



**RACGP**

Royal Australian College of General Practitioners

Healthy Profession.  
Healthy Australia.

# Abuse and violence - Working with our patients in general practice

---

Last updated: 13 04 2022

Preamble.....	1
About this guideline.....	3
What is interpersonal abuse and violence? .....	6
'Domestic' or intimate partner abuse/violence .....	20
Intimate partner abuse and violence: Identification and initial response .....	21
First-line response to intimate partner abuse and violence: Safety and risk assessment.....	39
Intimate partner abuse and violence: Ongoing support and counselling.....	52
Working with men who use intimate partner abuse and violence.....	73
Supporting men who experience intimate partner abuse and violence .....	84
Trauma and violence informed care.....	89
Trauma-informed care in general practice .....	90
Keeping the health professional safe and healthy: Clinician support and self-care...	108
Children and young people .....	119
Child abuse and neglect .....	120
Sibling and peer bullying.....	151
Adolescent-to-parent violence .....	188
Dating violence and technology-facilitated abuse.....	198
Specific abuse issues for adults and older people .....	208
Adult survivors of child abuse.....	209
Adult sexual assault.....	234
Abuse of older people.....	250
Specific populations.....	265
Aboriginal and Torres Strait Islander communities .....	266
Working with migrant and refugee communities.....	283
Working with violence and abuse in people with disabilities .....	304
LGBTIQ+ Family abuse and violence.....	322
System issues.....	338
Violence and the law.....	339
Intimate partner abuse and violence: Education and training for healthcare professionals.....	355
Supplementary materials.....	364
Disclaimer.....	365
Acknowledgements .....	366
Acronyms .....	370
Resources .....	372
Useful tools .....	373
Resources.....	382
Supplementary chapter for primary care providers in Victoria .....	408
Introduction.....	409
Implementing Victorian information sharing schemes in primary care .....	414
Referrals and resources .....	426
Acknowledgement.....	427
Provided under licence.....	428

# Preamble

We offer up our admiration for all the members of the RACGP White Book 5th edition Expert Advisory Group.

The dedication and commitment to create a resource for GPs to address the complex and systematic abuse of people in intimate partner and family settings has been exceptional.

This has been one of the most profound opportunities that we have had as advocates for lived experience survivors to bring about real change. It represents a lifetime of dealing with the consequences of abuse, and the opportunity to work alongside each other as survivor advocates with a group of compassionate, determined health experts.

We recognise the constraints that GPs face. Hopefully this new edition of the White Book can further contribute to removing these obstacles and support GPs in their indispensable role in the health response to domestic abuse and family violence.

AW and ZDS,

[The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

# About this guideline

*Abuse and violence: working with our patients in general practice*, 5th edition (the White Book), was developed by general practitioners (GPs) and subject matter experts to ensure that the content is the most valuable and useful for health practitioners. The guideline is a practical resource and is based on the best-available current evidence.

The update of the White Book was supported with funding from the Australian Government Department of Health.

## What's new in the 5th edition

All chapters in the 5th edition have been updated with new guidance based on the latest evidence. This edition has been expanded to include six new chapters:

- Supporting men who experience intimate partner abuse and violence
- Trauma-informed care in general practice
- Adolescent-to-parent violence
- Dating violence and technology-facilitated abuse
- LGBTIQ+ family abuse and violence
- Intimate partner abuse and violence: Education and training for healthcare professionals

In this edition, the term 'victim/survivor' is used for patients who experience abuse and violence, and 'perpetrator' for patients who use abuse and violence (although we acknowledge these terms are not always preferred by some people).

Chapters are presented under six topics:

- 'Domestic' or intimate partner abuse/violence
- Trauma- and violence-informed care
- Children and young people
- Specific abuse issues for adults and older people
- Specific populations
- System issues

## Development of the guideline

The Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach was used in the development of this guideline. The RACGP commissioned the Safer Families Centre of Research Excellence at the University of Melbourne to conduct the evidence review and update the evidence base.

A systematic search of the literature was conducted for each clinical question. The results are presented in GRADE 'summary of findings' tables. These tables provide a synthesis of findings along with a rating of certainty of evidence (also referred to as quality or confidence in evidence) and clinical importance.

'Summary of findings' tables were presented to the Expert Advisory Group and relevant chapter authors to move from the synthesised research evidence to formulate practice recommendations. All relevant research findings are considered in the formulation of recommendations. Additional research findings (eg qualitative, quantitative and/or mixed method) and practice consensus were also considered, where possible, when formulating recommendations and ensuring transparent and practice-based recommendations.

The [technical report of evidence reviews and summary of findings \(https://www.racgp.org.au/cms/getattachment/8c26df40-4ef8-48bd-bf32-213855868ffa/WhiteBook-Technical-Report.pdf.aspx?versionhistoryid=88204&chset=d3dd1f17-dcfa-4ec6-ae1b-aafbe20d673c&disposition=attachment\)](https://www.racgp.org.au/cms/getattachment/8c26df40-4ef8-48bd-bf32-213855868ffa/WhiteBook-Technical-Report.pdf.aspx?versionhistoryid=88204&chset=d3dd1f17-dcfa-4ec6-ae1b-aafbe20d673c&disposition=attachment) contains further information on the evidence review, a description of the methods, assessment of the risk of bias, data extraction, synthesised results per outcome, a 'summary of findings' table per clinical question, including a rating of certainty in the evidence, and additional relevant findings, which complement the GRADE process.

## Levels of evidence and strength of recommendations

The GRADE process provides a system for classifying the **certainty of the overall body of evidence** into:

- **High:** Additional research is unlikely to change confidence in the estimate of a treatment effect
- **Moderate:** Additional research will impact on confidence in the estimate and could change this estimate.
- **Low:** Additional research is very likely to change the estimate
- **Very low:** Any estimate of a treatment effect is uncertain

The GRADE approach is then used to rate the quality of the evidence and inform **strength of recommendations**:

---

Recommendation	Description
Strong recommendation for the intervention	The working group is very confident the benefits of an intervention clearly outweigh the harms (or vice versa)
Strong recommendation against the intervention	The working group is very confident that the harms of an intervention clearly outweigh the benefits

---

---

Conditional recommendation for the intervention

Denotes uncertainty over the balance of benefits, such as when the evidence quality is low or very low, or when personal preferences or costs are expected to impact the decision, and as such refer to decisions where consideration of personal preferences is essential for decision-making

---

Conditional recommendation against the intervention

Denotes uncertainty over the balance of harms, such as when the evidence quality is low or very low, or when personal preferences or costs are expected to impact the decision, and as such refer to decisions where consideration of personal preferences is essential for decision-making

## Practice point

Where there was insufficient evidence to formulate a recommendation, the considered opinions based on the clinical experience of experts on the Expert Advisory Group and chapter authors were used. These are referred to as a 'practice point', based on the consensus of experts.

# What is interpersonal abuse and violence?

'GPs don't need to be afraid that they don't have enough training in DV, what is so important is to listen and ask questions like "what can I do for you" or "how can I help".'  
Fiona, victim/survivor, [The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

## Key messages

- Interpersonal abuse and violence includes intimate partner abuse/violence (IPAV), the effects of child abuse for adult victims/survivors, sexual assault, child abuse, sibling bullying and elder abuse. Violence is not just physical; it includes emotional, sexual, economic and social abuse, in person or through technology.<sup>1</sup>
- Interpersonal abuse and violence is very common, with the main perpetrators of such violence being men, but women can also use abuse and violence.<sup>2</sup>
- Abuse and violence is an issue for the whole community. Health practitioners have a role in dealing with these issues and need to play their part in prevention, identification and response.<sup>3</sup>

## Recommendations

Emotional and physical safety are concepts that should be foremost when working with patients experiencing abuse and violence.<sup>3</sup>

**(Practice point: Consensus of experts)**

Reference

3. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.

Health practitioners should have a system in place that includes the whole of practice and referral pathways to safety and healing.<sup>3</sup>

**(Practice point: Consensus of experts)**



Reference

3. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.

It is important to receive training that includes reflecting on our own attitudes and assumptions about abuse and violence, as they can affect the way we respond to patients experiencing abuse and violence.<sup>3</sup>

**(Practice point: Consensus of experts)**

Reference

3. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.

## Overview and scope

Welcome to the fifth edition of *Abuse and violence: Working with our patients in general practice* (White Book). We have added six new chapters since the fourth edition and updated all chapters with the latest evidence on abuse and violence, most of which occurs within the family or by someone the victim/survivor knows.

In this edition we use the term 'victim/survivor' for patients who experience abuse and violence and 'perpetrator' for patients who use abuse and violence (although we acknowledge these terms are not always preferred by some people).

Chapters are presented under six topics:

- 'domestic' or intimate partner abuse/violence
- trauma- and violence-informed care
- children and young people
- specific abuse issues for adults and older people
- specific populations
- system issues.

The World Health Organization (WHO) categorises interpersonal violence into that perpetrated by family, partners, community, acquaintances or strangers across the life course (Figure 1.1).

The White Book focuses on family violence across the life course, which is a broader term than IPAV or child abuse. Family violence also includes any violence or abuse occurring within a family – between, for example, siblings, uncles, aunts, cousins, grandparents and in-laws. The White Book does not address acquaintance or stranger violence to any great extent (apart from sexual assaults by acquaintances and strangers). It also does not cover the large burden of abuse and violence that occurs in global conflict zones, refugee camps and asylum-seeker detention centres.

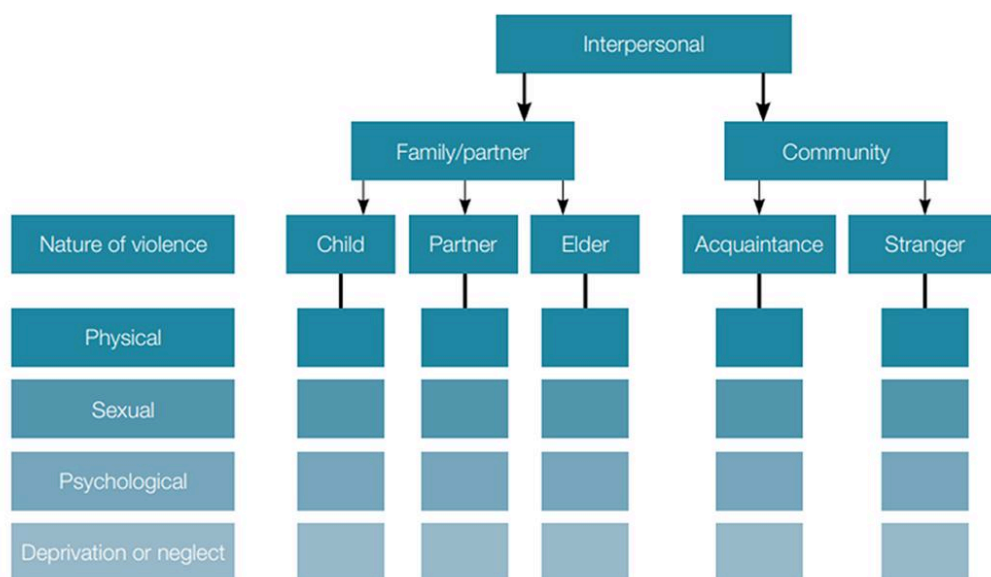


Figure 1.1. Typology of interpersonal violence<sup>1</sup>

Reproduced with permission from: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. [World report on violence and health \(https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615\\_eng.pdf\)](https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf). Geneva: WHO, 2002. [Accessed 25 August 2021].

The White Book concentrates on the more prevalent form of interpersonal violence – that of violence against women by someone they know. A national survey conducted in Australia indicated both men and women were more likely to experience physical violence than sexual violence. Sexual violence was four times more common for women than men. Adult women were more likely to have experienced violence from someone they knew than by a stranger, while the reverse was true for men. Perpetrators of violence were more likely to be male than female, with one in three Australians experiencing violence by a male perpetrator compared to one in 10 by a female perpetrator.<sup>2</sup>

In particular, the White Book addresses specific populations, including women with disability, women from culturally and linguistically diverse (CALD) populations, and Aboriginal and Torres Strait Islander women, all of whom may be subjected to a higher prevalence of abuse and violence.<sup>2</sup> The complex and cumulative way in which the effects of multiple forms of discrimination (eg racism, sexism and classism) combine, overlap or intersect – especially in the experiences of marginalised individuals or groups – should be acknowledged.

The White Book provides guidance on different types of abuse and violence, as discussed below.

### ‘Domestic’ or intimate partner abuse/violence

IPAV is any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and/or social harm to those in the relationship.<sup>4</sup> It may include a current or former intimate relationship and includes heterosexual, same-sex and gender-diverse relationships. Chapters on this topic are:

- [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)
- [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety)
- [Chapter 4: Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel)
- [Chapter 5: Working with men who use intimate partner abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse)
- [Chapter 6: Supporting men who experience intimate partner abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/supporting-men-who-experience-intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/supporting-men-who-experience-intimate-partner-abuse)

### Trauma- and violence-informed care

Trauma- and violence-informed care enacts policies and practices that recognise the connections between violence, trauma, negative health outcomes and behaviours. These approaches increase safety, control and resilience for staff who are delivering care and people who are seeking care in relation to experiences of violence and/or have a history of experiencing violence.<sup>5</sup> Chapters on this topic are:

- [Chapter 7: Trauma-informed care in general practice \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice)
- [Chapter 8: Keeping the health professional safe and healthy: Clinician support and self-care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care)

### Children and young people

Child abuse and neglect includes any type of abuse involving physical, emotional, sexual, economic abuse or neglect of a child under 18 years of age (16 years in New South Wales, 17 years in Victoria). It may include children exposed to IPAV. Chapters on this topic are:

- [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect)
- [Chapter 10: Sibling and peer bullying \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying)

[people/sibling-and-peer-bullying\)](#)

- [Chapter 11: Adolescent-to-parent violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/adolescent-to-parent-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/adolescent-to-parent-violence)
- [Chapter 12: Dating violence and technology-facilitated abuse \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse)

### Specific abuse issues for adults and older people

- Adult survivors of child abuse are adults who experienced physical, sexual or emotional abuse or neglect during their childhood or adolescence. Refer to [Chapter 13: Adult survivors of child abuse \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse)
- Sexual violence is any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim/survivor, in any setting. This includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.<sup>2</sup> Refer to [Chapter 14: Adult sexual assault \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault)
- Abuse of older people is any type of abuse (physical, emotional, sexual, economic) or neglect of a person 65 years of age or over, either in a residential aged care facility, in private care, or living independently. It can be a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Refer to [Chapter 15: Abuse of older people \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people)

### Specific populations

The White Book also provides guidance on abuse and violence in specific communities:

- [Chapter 16: Aboriginal and Torres Strait Islander communities \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities)
- [Chapter 17: Working with migrant and refugee communities \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities)
- [Chapter 18: Working with violence and abuse in people with disabilities \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-violence-and-abuse-in-people-with-disabilities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-violence-and-abuse-in-people-with-disabilities)
- [Chapter 19: LGBTIQ+ family abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence)

## System issues

The White Book also provides guidance on system issues, notably the law, and education and training:

- [Chapter 20: Violence and the law \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law)
- [Chapter 21: Intimate partner abuse and violence: Education and training for healthcare professionals \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/intimate-partner-abuse-education-and-training-for\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/intimate-partner-abuse-education-and-training-for)

## Abuse and violence is more than physical violence

Abuse and violence can take many forms (Figure 1.2).

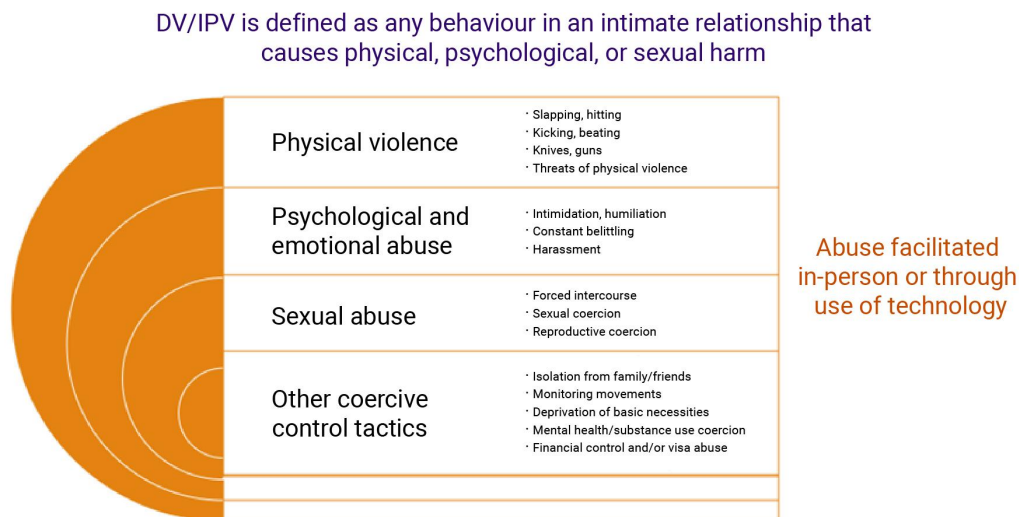


Figure 1.2. Forms of abuse and violence

Source: World Health Organization.<sup>3</sup>

Using the example of domestic violence or IPAV, violence can be severe and leave obvious injuries, but many victims/survivors may be subject to more subtle abuse that may not leave physical injuries. This is sometimes called 'coercive control', which can be divided into tactics used to hurt and intimidate victims/survivors (coercion) and those designed to isolate and regulate them (control).<sup>6</sup>

Coercive control may be defined as an ongoing pattern of domination by which male abusive partners primarily interweave repeated physical and sexual violence with intimidation, sexual degradation, isolation and control. The primary outcome of coercive control is a condition of entrapment that can be hostage-like in the harms it inflicts on dignity, liberty, autonomy and personhood as well as to physical and psychological integrity.<sup>6</sup>

Women as well as men physically assault their partners. But coercive control is 'gendered' because it is used to secure male privilege and its regime of domination/subordination is constructed around the enforcement of gender stereotypes.

This pattern, which may include but is not limited to physical violence, has been variously termed 'psychological' or 'emotional' abuse, 'patriarchal' abuse or 'intimate terrorism'.<sup>7</sup> The major outcome is a hostage-like condition of entrapment that arises from the suppression of a victim/survivor's autonomy, rights and liberties through coercive control.

Abuse and violence can take many forms in intimate relationships, and is often not recognised as such by the victim/survivor. For example:

'At the time I felt that it was not really abuse but the longer I thought about it the more that I felt it was abuse. Emotional abuse is more severe than physical abuse as there are no outward marks or bruises. When this was realised by myself, I got out. Living alone is far better than what was happening in the relationship.'

Abuse can occur across all populations and ages, cultures, religious groups and socio-economic groups. What is common is that all of them involve an abuse of power. The next section illustrates how a partner uses power.

## Intimate partner abuse – not just an argument

'So if I argue with my partner and we push each other around, that's intimate partner abuse?'

Not always. Some couples have arguments that may involve some physical contact without an imbalance of power in the relationship. Generally, IPAV occurs where one partner is being abused by the other partner and because of a power imbalance in their relationship, the victim/survivor lives in fear of being exposed to that abuse again (Figure 1.3). Fear experienced by the abused partner may be constant or episodic and is often used by the perpetrator to control the victim/survivor. Regardless of the frequency with which abuse occurs, it is still abuse.

Many IPAV victims/survivors say that arguments did not precede the violent episodes or that the perpetrator often provoked the confrontation deliberately.

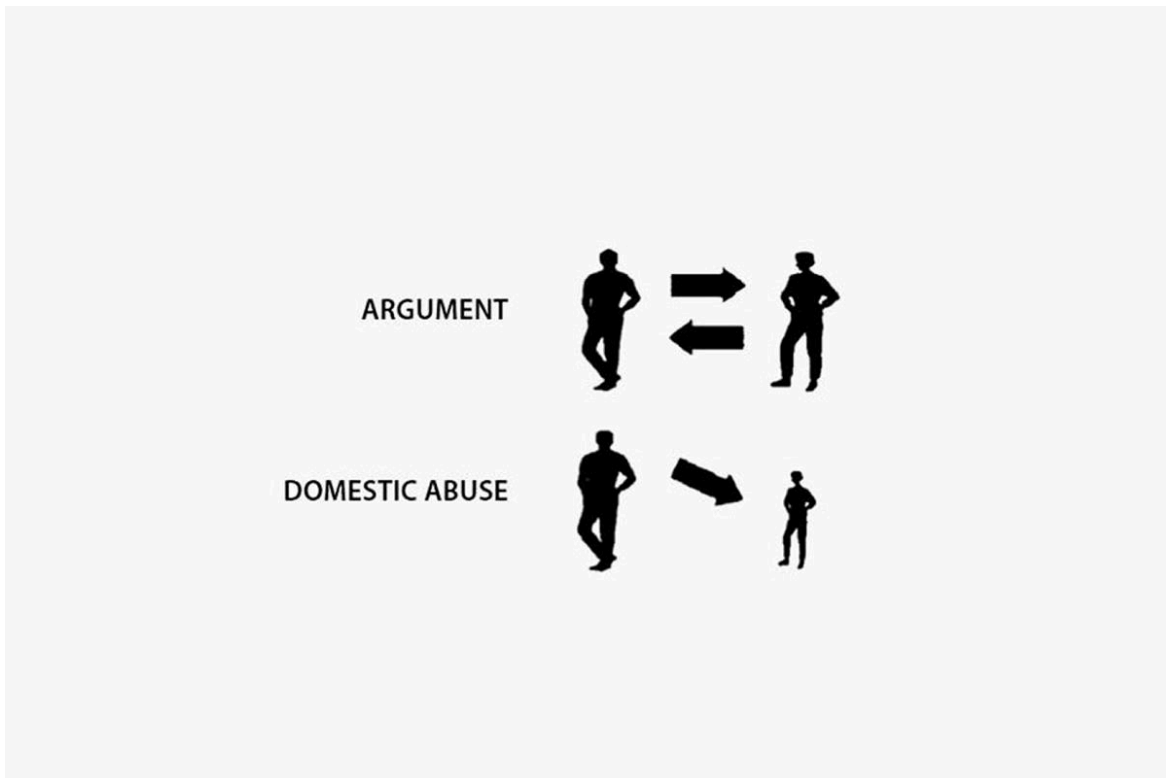


Figure 1.3. Intimate partner abuse

*Power imbalance in an abusive relationship*

## Types of abuse and violence

Abuse and violence more generally may be any of the following:

- **Physical abuse** – injuries may range from minor trauma, which may or may not be visible, to broken bones and lacerations, non-fatal strangulation, head injuries and injuries to internal organs. For many victims/survivors, the abuse occurs regularly. Some are threatened with weapons, such as knives, or household items such as a hot iron, cigarettes or a length of rubber hose. Physical abuse can take many forms such as smashing property and killing or hurting family pets.
- **Emotional/psychological abuse** – may include subtle or overt verbal abuse, humiliation, threats or any behavior aimed at scaring or terrorising the person experiencing the abuse. The victim/survivor may lose their confidence, self-esteem or self-determination. Emotional abuse can take many forms including threats of suicide, extreme jealousy, and stalking or harassment at work or through the use of technology. This may also include coercive control, a pattern of acts which aims to cause fear through manipulation and controlling behaviours.
- **Economic abuse** – restricting access to money and essential needs, fraudulently using another's money for personal gain, or stealing from the victim/survivor; the illegal taking, misuse or concealment of funds, property or assets.
- **Social abuse** – isolating the victim/survivor from family and friends, and other contacts in the

community. This may form part of coercive control.

- **Neglect** – the persistent failure to meet the basic physical and/or psychological needs of a person for whom you are caring, such as failing to protect from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, the other person's basic emotional needs.
- **Spiritual abuse** – abuse related to a person's beliefs; can include the misuse of power under the guise of religious belief.

## What part does the community play?

Society condones violence in overt and subtle ways by failing to recognise and acknowledge that IPAV, child abuse, sexual assault and elder abuse exist. We turn a blind eye to family abuse and violence, preferring not to be involved, believing it to be a private family matter. This has been described as a 'conspiracy of silence'. Unfortunately, this has meant the problem often seems to be no-one's responsibility.

Other factors influence community responses:

- We expect the family to nurture, protect, guide and provide refuge for all its members.
- Family violence forces us to acknowledge that for some families this is not the case and that, for many victims/survivors, the greatest danger lies in the home itself.<sup>8</sup>
- As a community, we believe that the family is the building block of our community and our nation. The existence of family violence challenges our sense of security.
- The high level of violence we tolerate as a society – for example, in some sports, in film and television – can be seen as normalising this behaviour.
- The broader context of community gender norms of discrimination against women and men controlling women's behaviour.

The WHO endorses an ecological multidimensional framework of risk factors for family violence (Figure 1.4). A society that endorses rigid gender roles or male entitlement and ownership of women, and communities that experience high rates of unemployment, poor health, overcrowding, alcoholism and few support services are most at risk. Male dominance within the family, male control of wealth, use of alcohol and marital conflict can be risk factors in relationships, while experiencing abuse as a child or witnessing abuse as a child can be individual risk factors.<sup>9</sup>



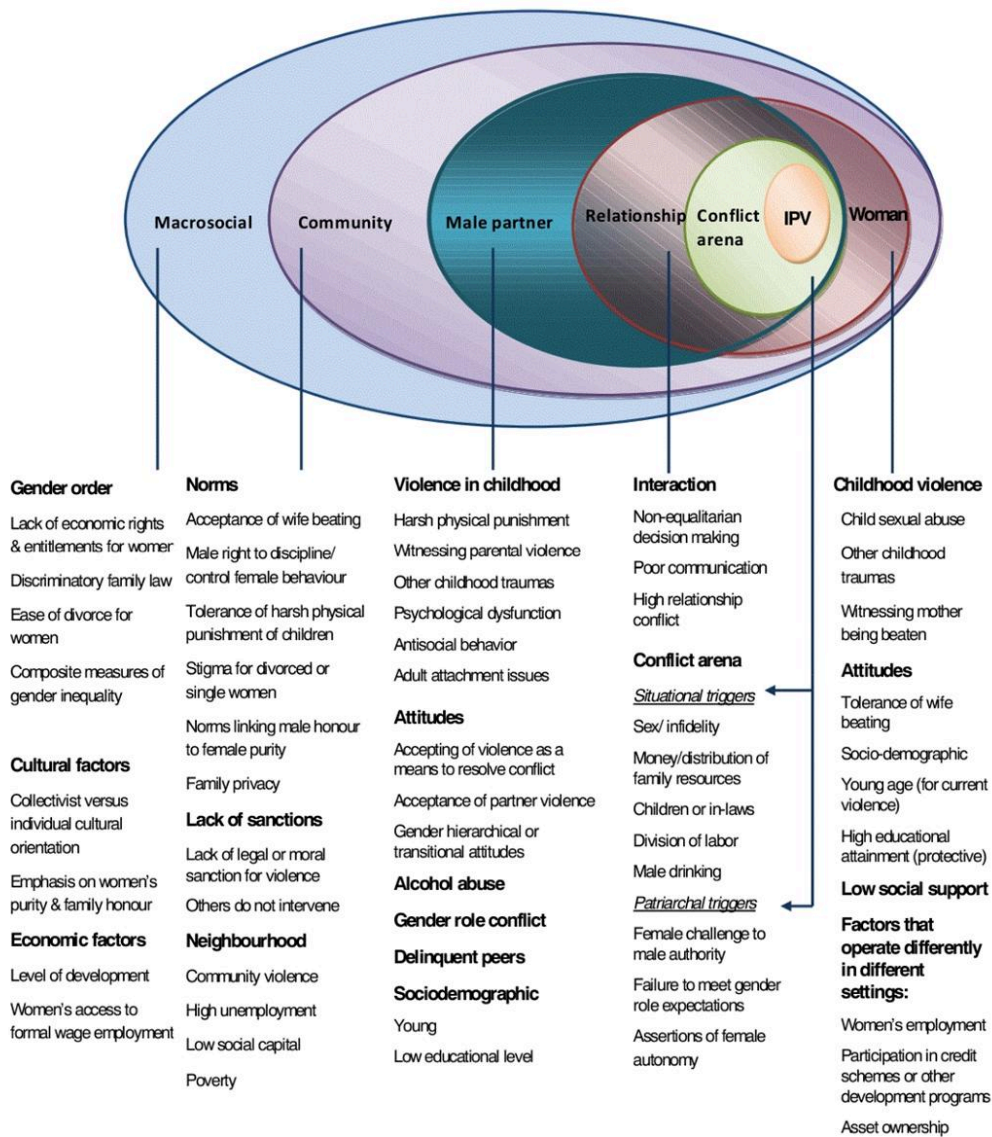


Figure 1.4. Factors associated with violence<sup>10</sup>

Reproduced with permission from: Heise LL. [What works to prevent partner violence? An evidence overview \(http://www.oecd.org/derec/49872444.pdf\)](http://www.oecd.org/derec/49872444.pdf). London: STRIVE Research Consortium, 2011.

## Attitudes in society

There has been an increase in understanding throughout the Australian community about violence towards women over time. Concerningly, young people within the Australian community have a lower level of understanding of violence against women than those aged 25 and over. The 2017 National Community Attitudes towards Violence against Women Survey<sup>11</sup> explored attitudes towards violence in Australia. The strongest predictors for holding violence-supportive attitudes were having low levels of support for gender equity or equality, low levels of understanding about violence against women and high level of support for violence in general. Men were more likely to hold violence-supportive attitudes than women.

Attitudes regarding sexual assault:

- 95% of people agreed that forced sex is violence against women.
- 14% of men believed that women often say 'no' when they mean 'yes'.
- 28% of people believed 'rape results from men being unable to control need for sex'.
- 32% of men believed that women who had been raped had led a man on and then had regrets.

Attitudes regarding IPAV:

- 34% of people believed that female victims/survivors were partly responsible for continuing abuse if they did not leave.
- 19% of people believed domestic violence could be excused if the perpetrator later regretted what they had done.
- 16% of people regarded domestic violence as a private matter.
- 20% of men believed that domestic violence is just a normal reaction to day-to-day stressors.

In this community survey, women were more likely than men to be aware that IPAV could consist of both psychological and physical abuse. Women were much more likely to believe that violence towards women was common (78% compared with 57%).<sup>11</sup>

## Impact on people's lives and the role of GPs

Any form of abuse and violence has implications for the health of our patients, both physically and emotionally. Health outcomes may also be affected by the quality of care received, which in turn will affect the health of the entire family. Recent research shows that children who live in abusive families experience negative effects on their health, wellbeing and ongoing relationships.<sup>12</sup>

Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early years shapes brain and psychological development, sets up vulnerability to stress and to a range of mental health problems.<sup>13,14</sup> GPs need to understand the nature of violence and abuse so that they can help break this intergenerational cycle of abuse.

The role of primary care includes all the following points to address family violence across the lifecycle:

- identifying predisposing risk factors
- noting early signs and symptoms and asking directly
- assessing for violence and safety within families
- managing consequences of abuse to minimise morbidity and mortality
- knowing and using referral and community resources
- advocating for changes that promote a violence-free society.

Health practitioners need to understand the eight steps to intervention – the 8 Rs (Tool 1.1).

### Tool 1.1. Eight steps to intervention – the 8 Rs

- Be **ready** to identify and respond to intimate partner abuse
- **Recognise** symptoms of abuse and violence, ask directly and sensitively
- **Respond** to disclosures of violence with empathetic listening
- Explore risk and safety issues
- **Review** the patient for follow-up and support
- **Refer** appropriately
- **Reflect** on your own attitude, management and limitations to addressing abuse and violence
- **Respect** your patients, your colleagues and yourself. This is an overarching principle of this sensitive work.

## What makes health practitioners ready to do this work?

A recent systematic review<sup>15</sup> exploring health professionals' readiness to address domestic violence provides some insight into areas which you could concentrate on to enable this complex work. Five themes are identified in the CATCH (Commitment/Advocacy/Trust/Collaboration/Health system) model (refer to Figure 1.5):

- having a personal commitment from human rights, child rights or a feminist lens or personal experience
- adopting an advocacy or LIVES (Listen, Inquire, Validate, Ensure safety, Support) and CARE (Consider, Acknowledge, Respond, Empower) approach with feedback from patients to reinforce this approach
- trusting the relationship in the health setting is the right place to address the issue
- collaborating with a team such as the family violence worker – follow up with them recommended
- being supported by the health system, including utilising Medical Benefits Schedule (MBS) item numbers such as those for mental health care treatment plans and antenatal attendance, booking double follow-up appointments, and secondary consults from family violence services and clear referral pathways.

### CATCH model

Commitment/advocacy/trust/collaboration/health system

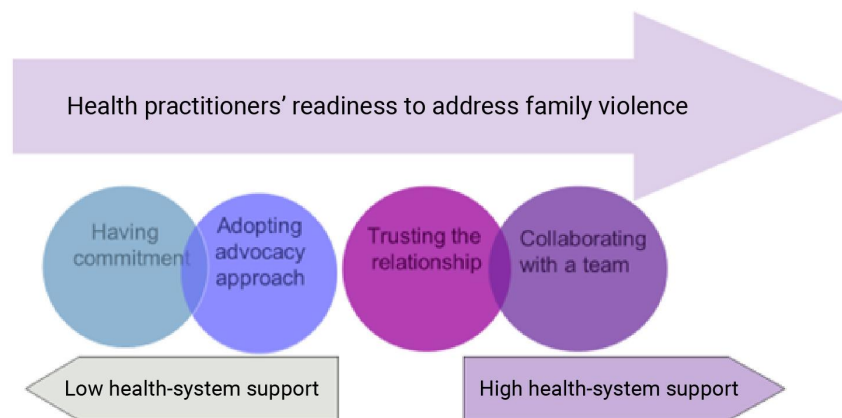


Figure 1.5. CATCH model<sup>15</sup>

Reproduced from: Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067.

## Resources

Resources available nationally and in your state.

- Further information [1800RESPECT \(http://www.1800respect.org.au\)](http://www.1800respect.org.au) – a phone line and website providing information, advice and connection to resources in your area.
- [Australia's National Research Organisation for Women's Safety \(http://www.anrows.org.au\)](http://www.anrows.org.au) (ANROWS) – an independent, not-for-profit company, ANROWS delivers research evidence to drive policy and practice aimed at reducing violence against women and children.
- [National Community Attitudes towards Violence against Women Survey 2017 \(https://ncas.anrows.org.au/wp-content/uploads/2019/05/2017NCAS-Youth-SubReport.pdf\)](https://ncas.anrows.org.au/wp-content/uploads/2019/05/2017NCAS-Youth-SubReport.pdf) – this report presents findings from a community survey conducted by VicHealth. It provides a comprehensive insight into community attitudes towards violence and how this has changed over the past decade.
- [See what you made me do: Power, control and domestic abuse \(https://www.blackincbooks.com.au/books/see-what-you-made-me-do\)](https://www.blackincbooks.com.au/books/see-what-you-made-me-do) – book by Jess Hill, Black Inc Books, 2019.

## References

1. Krug EG, Mercy JA, Dahlberg LL, et al. The world report on violence and health. *Lancet* 2002;360:1083–88.
2. Australian Bureau of Statistics. Personal Safety Survey. Canberra: ABS, 2017.

3. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
4. World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013.
5. [Government of Canada. Trauma and violence-informed approaches to policy and practice. Government of Canada, 2018 \(http://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html\)](http://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html) [Accessed 25 August 2021].
6. Stark E. Coercive control. New York: Oxford University Press, 2007. [Accessed 25 August 2021].
7. Johnson M. A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence. University Press of New England, 2008. [Accessed 25 August 2021].
8. United Nations Office on Drugs and Crime. Global Study on Homicide: Gender-related killing of women and girls. Vienna: UNODC, 2018. [Accessed 25 August 2021].
9. Heise LL. Violence against women: An integrated, ecological framework. *Violence Against Women* 1998;4:262–90. [Accessed 25 August 2021].
10. [Heise LL. What works to prevent partner violence? An evidence overview. Working paper 2.0. 2011 \(http://www.oecd.org/derec/49872444.pdf\)](http://www.oecd.org/derec/49872444.pdf) [Accessed 25 August 2021].
11. Politoff V, Crabbe M, Honey N, et al. Young Australians' attitudes to violence against women and gender equality: Findings from the 2017 National Community Attitudes towards Violence against Women Survey. Sydney: Australia's National Research Organisation for Women's Safety, 2019. [Accessed 25 August 2021].
12. Kitzmann KM, Gaylord NK, Holt AR, et al. Child witnesses to domestic violence: A meta-analytic review. *J Consult Clin Psychol* 2003;71:339–52. [Accessed 25 August 2021].
13. Felitti V, Anda R. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behaviour: Implications for healthcare. In: Lanius R, Vermetten E, Pain C, editors. *The impact of early life trauma on health and disease*. Cambridge: Cambridge University Press, 2010:77–87. [Accessed 25 August 2021].
14. Kezelman C, Stavropoulos P. 'The last frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. Sydney: Adults Surviving Child Abuse, 2012. [Accessed 25 August 2021].
15. Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067. [Accessed 25 August 2021].

# ***'Domestic' or intimate partner abuse/violence***

# Intimate partner abuse and violence: Identification and initial response

'You may be the first person the woman tells about her domestic violence so imagine the fear and how courageous she is.' Fiona, victim/survivor, [The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

## Key messages

- The majority of intimate partner abuse/violence (IPAV) survivors are women in heterosexual relationships; however, men and non-binary people can experience IPAV, and IPAV also occurs in same-sex and gender-diverse relationships.<sup>1</sup>
- IPAV is common. It is one of the leading contributors to death and disability for women of childbearing age and has major effects on the health of children exposed to it.<sup>2</sup>
- Most women are open to inquiry about IPAV<sup>3</sup>, and the gender of a patient's health professional does not affect disclosure of IPAV.<sup>4</sup>

## Recommendations

Ask all patients who present with clinical indicators (eg depression and anxiety) (refer to Table 2.2, particularly psychological symptoms) about possible experiences of IPAV.

**(Strong recommendation; Moderate certainty of evidence)**

Routinely screen for IPAV in all pregnant women attending a practice or clinic.

**(Strong recommendation; Low certainty of evidence)**

It is not recommended to routinely screen all patients for IPAV.  
**(Strong recommendation; Moderate certainty of evidence)**

Provide first line support to women who disclose IPAV. This includes listening, inquiring about needs, validating women's disclosure, enhancing safety and providing support/referrals – the LIVES approach (refer to Box 2.2)  
**(Practice point: Consensus of experts)**

## Introduction

This chapter focuses on identifying IPAV and how to respond initially to a disclosure of IPAV. Safety and risk assessment are important parts of the [initial response](https://www.racgp.org.au/clinical-resource/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety) (<https://www.racgp.org.au/clinical-resource/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety>). Ongoing care, including counselling strategies, is covered in [Intimate partner abuse and violence: Ongoing support and counselling](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel>).

Other forms of family violence, such as [child abuse and neglect](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect>), [abuse of older people](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people>), [sibling abuse](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying>), and [child/adolescent violence against a parent](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/adolescent-to-parent-violence) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/adolescent-to-parent-violence>), are discussed in this volume; the principles outlined here can be used in these cases.

Globally, one in three women ever experience physical or sexual abuse by their partners.<sup>5</sup> Women are much more likely to experience violence by their partners than are men.<sup>1</sup> Thus, this chapter focuses on women as victims/survivors and men as perpetrators of abuse; however, the overarching messages of the chapter can be applied to [men](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/supporting-men-who-experience-intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/supporting-men-who-experience-intimate-partner-abuse>) and [non-binary people](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence>). This chapter focuses on heterosexual relationships; IPAV also affects those in [same-sex and gender diverse relationships](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence>).



## What is intimate partner abuse/violence?

The World Health Organization (WHO) defines IPAV as any behaviour within an intimate relationship that causes physical, psychological or sexual harm.<sup>5</sup> It may involve either current or former partners. IPAV remains a silent epidemic, as it often occurs in the privacy of homes.

IPAV is an abuse of power. It is the domination, coercion, intimidation and victimisation of one person by another, by physical, sexual or emotional means, within intimate relationships. It is a pattern of behaviours, not just isolated incidents of physical violence, that is about power and control, rather than about conflict and anger. It stems from societal gender role ideologies that give men power and control over women. It can include physical or sexual violence, emotional abuse and other controlling behaviours that constitute coercive control (refer to Table 2.1).<sup>5</sup>

Coercive control is a pattern of acts that aim to cause fear and may include social control, whereby a survivor is isolated from friends or family, and technology-facilitated abuse, which could involve a survivor's movements being tracked, their messages and emails being monitored, or sexting. Mental health coercion may involve threatening suicide to manipulate a victim/survivor. Migrant and refugee women may be manipulated by their partners based on their visa status.

Financial control occurs where the woman is not given access to money and may be deprived of basic necessities or prevented from accessing employment.

Emotional/psychological abuse includes intimidation, belittling and harassment. A woman may be blamed by her partner for the violence. Emotional abuse has significant long-term sequelae for survivors, with many survivors saying it is worse than physical violence.<sup>5</sup>

'You're lucky to have me, no-one else would have you.' 'You're a hopeless mother.' 'I'll smash your face in if you do that again.' 'If you leave, I'll kill you.' 'If you leave, you'll never see the kids again.' 'I married you and brought you to this country. You'd be nothing without me.'

Physical violence may include slapping, hitting, kicking, beating or using a weapon. Women live in fear that the next violent episode may be the last. On average, one woman per week in Australia is killed by a partner or former partner.

'You don't know what the limit is when he's attacking you. It is very frightening.' 'Each time you think: This will be the last. He's going to kill me.' 'If you leave, I will kill myself.'

Sexual abuse includes forced intercourse, sexual coercion and reproductive coercion. Forcing a woman to have sex may include forcing her to perform sex acts that she does not like or want to do. An example of reproductive coercion is where a man does not allow his partner to use contraception or forces her to have an abortion. Sexual abuse rarely happens in isolation and most often [physical or emotional abuse occur concurrently](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault>).<sup>6</sup>

**Table 2.1. Types of intimate partner abuse**

Type of abuse	Example behaviours
Physical	<ul style="list-style-type: none"> <li>• Slapping, hitting</li> <li>• Kicking, beating</li> <li>• Using knives or guns</li> <li>• Strangulation</li> </ul>
Emotional	<ul style="list-style-type: none"> <li>• Intimidation</li> <li>• Constant belittling</li> <li>• Harassment</li> </ul>
Sexual	<ul style="list-style-type: none"> <li>• Forced intercourse</li> <li>• Sexual coercion</li> <li>• Reproductive coercion</li> </ul>
Coercive control	<ul style="list-style-type: none"> <li>• Isolating from family and friends</li> <li>• Monitoring movements</li> <li>• Obsessive jealousy and possessiveness</li> <li>• Controlling daily activities (eg where they go and what they do)</li> <li>• Threats to harm victim/survivor, their children, pets or themselves</li> <li>• Deprivation of basic necessities such as food, employment, health services, finances, liberty</li> <li>• Mental health or substance-use coercion such as convincing others that the victim/survivor is crazy, controlling medication and drug use</li> <li>• Visa abuse</li> </ul>

The Royal Australian College of General Practitioners (RACGP) Professional Development Program on Family Violence provides further information about types of IPAV in Module 1: The role of general practice in responding to family violence (from 2.46–3.23 minutes).

Video available at: [YouTube \(https://www.youtube.com/embed/Yr0QgTJofzE?start=166\)](https://www.youtube.com/embed/Yr0QgTJofzE?start=166)

## How common is intimate partner abuse?

The Australian Bureau of Statistics's 2016 Personal Safety Survey collected information from men and women over the age of 18 about the extent of violence experienced since the age of 15 years.<sup>1</sup> An estimated 2.2 million had experienced physical and/or sexual violence from a partner, with one in six women compared with one in 16 men experiencing this form of IPAV. Figure 2.1 further shows how the prevalence of partner abuse is gendered.

When looking at a person's most recent incident of physical assault by a male, the most likely location for women was in their home; for men, it was at a place of entertainment or recreation.<sup>2</sup>

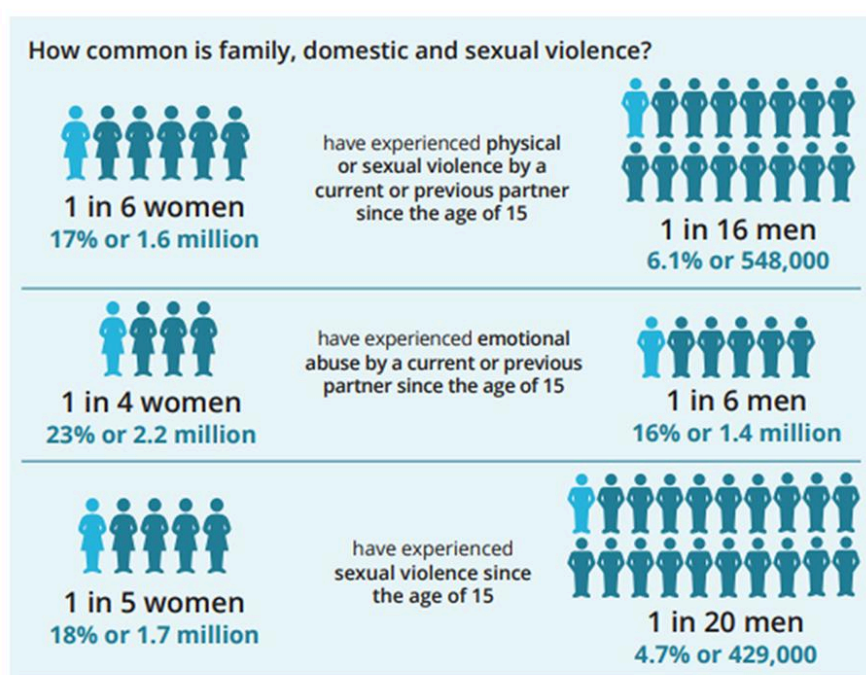


Figure 2.1. Prevalence of lifetime intimate partner abuse

Source: Australian Institute of Health and Welfare.<sup>1</sup>

## Risk factors for intimate partner abuse

Women from every race, religious group, age and socioeconomic status can experience IPAV. Those most at risk include:

- Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse (CALD) backgrounds, women with intellectual or physical disabilities and women who are in the process of separating from their partners<sup>5</sup>
- pregnant women – it is not uncommon for abuse to either commence or escalate during

pregnancy. The incidence of IPAV during pregnancy has been reported to be 4–8% of all pregnant women<sup>8</sup>

- women who are recently separated or divorced, or who are on low incomes<sup>9</sup>
- women who are younger than 25 years<sup>1</sup>
- women who have experienced child abuse or have come from a violent family.<sup>1</sup>

Women don't enter a relationship expecting it to become violent. One survivor of IPAV reported:

'People say to me, "I just can't believe an intelligent woman like you could be in such a situation. You just aren't the type I picture tolerating such madness". My answer is this: "It can happen to anyone".'

## How does intimate partner abuse change in the time of COVID-19 and other natural disasters?

Studies have consistently shown that IPAV increases after large-scale disasters or crises. IPAV escalates as catastrophic events destroy social networks that usually provide safety nets, and this escalation often continues post-disaster.<sup>10</sup>

In response to the COVID-19 pandemic, governments all over the world instituted lockdowns of their citizens to contain the virus. In this situation, women may be isolated at home with their abusers for prolonged periods of time, with factors such as economic instability, unemployment and uncertainty serving to increase the violence. Isolation makes it more difficult for women to call for help and hides abuse from friends, family members and services who may have previously noticed it.<sup>9</sup>

The Australian Institute of Criminology conducted survey-based research of 15,000 female respondents. Of those who had previously experienced physical or sexual violence, 65% reported an increase in either the frequency or severity of violence during the COVID-19 pandemic.<sup>11</sup> Among the women who had experienced physical and sexual violence, one in three said that this was the first time their partner had been violent to them.<sup>11</sup>

The COVID-19 pandemic has also brought about new forms of psychological abuse: perpetrators telling their partner they have the virus so they can't leave the house, increases in surveillance and control, withholding essential items such as cleaning equipment and hand sanitiser, and deliberately giving partners misinformation about quarantine measures.<sup>12</sup> Women have reached out to helplines and services in increased numbers; however, this is likely to be the tip of the iceberg, and many services are concerned that social distancing has made it difficult to engage with women who need their help.<sup>11</sup>

## Clinical Context

### The role of general practice

The majority of current IPAV is disclosed to a GP or other health practitioner and is not reported to the police (refer to Figure 2.2).<sup>10</sup>

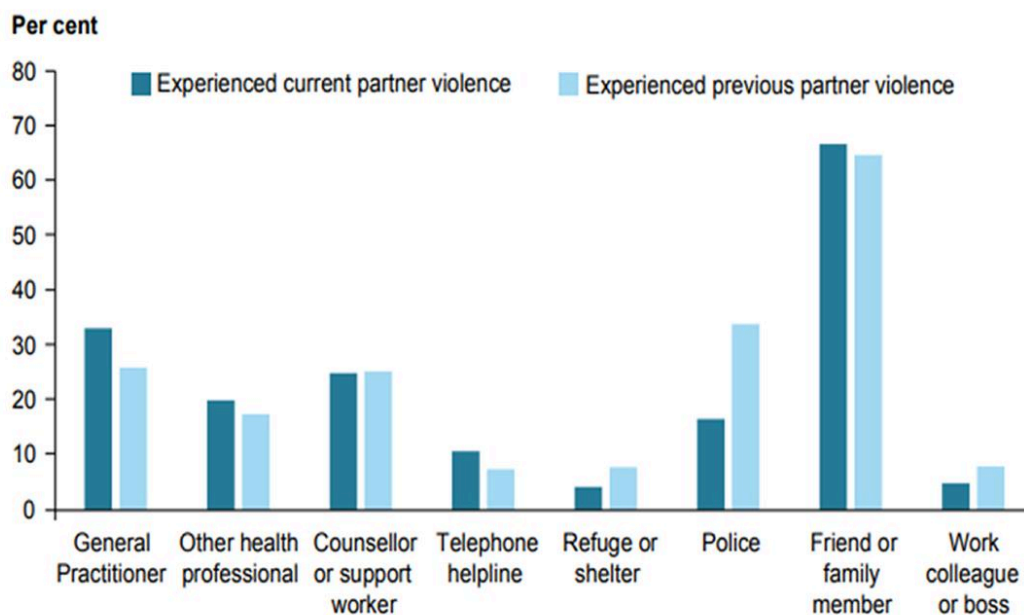


Figure 2.2. Victim/survivors' disclosures of intimate partner abuse to services and people

Based on: Australian Institute of Health and Welfare<sup>1</sup>

The role of the health practitioner is important, as IPAV is the leading contributor to poor health in women of childbearing age, more than smoking, alcohol use and increased body weight.<sup>2</sup> GPs often say that they do not see many cases of IPAV in their clinics. It is much more common than many GPs realise.

'It's not like they come with domestic violence written on their foreheads. It's not always obvious, and we have to pick up on sometimes subtle clues.'

It is estimated that a full-time GP sees around five women per week who have experienced IPAV in the last 12 months.<sup>13</sup> One in three women have ever experienced IPAV in their lifetime.<sup>14</sup> This is more common than the prevalence of rheumatoid arthritis, diabetes or asthma. However, only around one in 10 women have ever been asked by their GP about IPAV.

There are many barriers to GPs identifying people experiencing IPAV, including:<sup>14,15</sup>

- lack of time or skills
- belief it is not common
- fear of offending the patient or belief it is a private matter
- fear of the perpetrator
- belief that it won't change anything, as the patient is returning to the relationship anyway.

Despite these barriers, GPs are in a unique position to be able to identify and support women who are experiencing IPAV. They have a duty of care to identify situations of abuse so they can intervene early.

GPs are accessible, are often the first port of call for their patients and are in a position to have continuity of care with them. Because of this, they are able to build a trusting long-term supportive relationship with victims/survivors. An Australian study revealed that women feel comfortable disclosing to their GP, whether they are male or female, provided they have good communication skills and a patient-centred approach.<sup>4</sup> Although some consider communication skills to be innate, it is possible to learn and improve these skills to facilitate an environment in which a woman is more likely to be able to disclose.

GPs need to understand the eight steps to intervention – the 8 Rs:

- Be **ready** to identify and respond to IPAV
- **Recognise** symptoms of abuse and violence, ask directly and sensitively
- **Respond** to disclosures of violence with empathetic listening
- Explore **Risk** and safety issues
- **Review** the patient for follow-up and support
- **Refer** appropriately
- **Reflect** on their own attitude, management and limitations to addressing abuse and violence
- **Respect** your patients, your colleagues and yourself. This is an overarching principle of this sensitive work

## In practice

### Identifying intimate partner abuse in practice

It is important to consider IPAV in all women, as it is a hidden epidemic that can happen to women from every socioeconomic status, postcode, race, religion and age. Refer to Risk factors for intimate partner abuse in this chapter.

Women can present in many ways, and GPs should have a high index of suspicion for signs and symptoms to inquire about the possibility of IPAV. A large number of health conditions and issues are strongly associated with IPAV (refer to Figure 2.3),<sup>5</sup> including physical presentations such as chronic

pelvic pain or chronic headaches, obvious injuries and bruises, psychological presentations such as depression or anxiety, and emotional presentations such as anger or irritability (refer to Table 2.2). It is possible that a victim/survivor may show no signs or symptoms at all.

**Abuse during pregnancy**

Abuse during pregnancy is associated with suboptimal weight gain, preterm delivery and having lower birthweight babies, kidney infections, as well as injuries to the mother and maternal mortality.<sup>16</sup> Pregnant women experiencing abuse are twice as likely to miscarry than non-abused pregnant women. Pregnancy and the immediate postpartum period deliver new challenges for a household, including financial issues, stress and sexual pressures. Some partners may become jealous and possessive of their partners as they now have to ‘share’ them with the pregnancy and/or new baby. Often abuse starts in the first pregnancy and may lead to women avoiding antenatal visits. Women who do not seek antenatal care until late in the pregnancy should raise suspicion.

Given the high incidence of IPAV in pregnancy, it is recommended to routinely ask about violence at antenatal visits. GPs who provide antenatal care should inquire about IPAV.

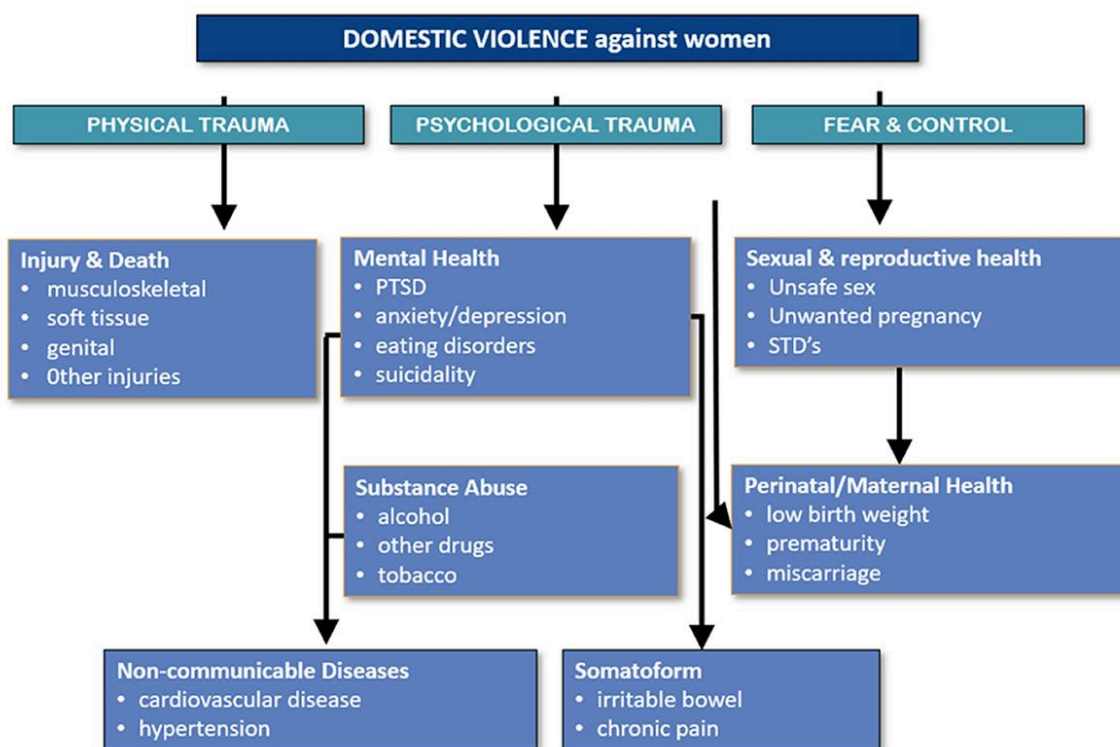


Figure 2.3. Health outcomes associated with different types of intimate partner abuse

Source: World Health Organization.<sup>5</sup>

**Table 2.2. Clinical indicators of intimate partner abuse**

Physical	Psychological	Emotional

**Table 2.2. Clinical indicators of intimate partner abuse**

• Obvious injuries	• Insomnia	• Anger
• Bruises at various stages of healing	• Difficulty concentrating and making decisions	• Irritability
• Sexual assault	• Confusion	• Feeling of overwhelm
• Sexually transmitted infections	• Memory issues	• Hyper-alertness and hypervigilance
• Chronic pelvic pain	• Anxiety and panic disorder	
• Chronic abdominal pain	• Depression	
• Chronic headaches	• Suicidal ideation	
• Fatigue	• Somatoform disorder	
• Miscarriage and stillbirth	• Post-traumatic stress disorder	
• Nausea,	• Eating disorders	
• Change in appetite	• Drug and alcohol use	
	• Poor self-esteem	
	• Nightmares	

### Depression and anxiety

IPAV, including physical, emotional and sexual abuse, is strongly associated with depression in women attending general practice, remaining significant when adjusted for sociodemographic variables and physical health.<sup>17</sup> Mental health symptoms are among the strongest clinical predictors of IPAV, and all women should be asked about IPAV as part of a mental health assessment.

### Physical signs

In addition to being more likely to experience psychological symptoms, women who are victims/survivors of domestic violence are more likely to experience a range of physical symptoms. In an Australian study in general practice, women who reported a greater number of physical symptoms, like tiredness, chronic headaches, diarrhoea and chronic abdominal pains, were also more likely to have experienced IPAV in the last 12 months.<sup>9</sup>

### Behavioural signs

Women who experience violence may present with behavioural signs such as delays in treatment, inconsistent explanation of injuries, frequent presentations to general practice, non-compliance with treatment or attendances, and/or an accompanying partner who is overattentive and may answer for the woman.



## Post-traumatic stress disorder and complex PTSD

[Post-traumatic stress disorder \(PTSD\) and complex PTSD \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) is a common outcome of being subjected to IPAV. In a 2001 systematic research synthesis, between 31% and 84% of IPAV victims/survivors were found to be experiencing PTSD.<sup>18</sup> PTSD occurs when there is exposure to actual or threatened death, serious injury or sexual violence, either by directly experiencing the traumatic event or by witnessing a traumatic event. In many cases of domestic violence, women are repeatedly exposed to trauma, which puts them at risk of PTSD and complex PTSD. Because of this, it is vital that GPs universally respond with a trauma-informed approach to avoid retraumatising victims/survivors. [Trauma-informed care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) focuses on understanding impacts of trauma and creating an environment that promotes emotional and physical safety for all patients.

## Traumatic brain injury and family violence

Injuries to the head, neck (including strangulation) and face area are major causes for traumatic brain injury, especially for victims/survivors attending the emergency department.<sup>19</sup> Over a decade, 40% of 16,000 victims/survivors of IPAV (including children) attending Victorian hospitals had sustained a brain injury.<sup>20</sup> Victims/survivors can present with dizziness and headaches consistent with post-concussive syndrome.<sup>21</sup>

## Presentation of children

Children may experience IPAV in a number of ways. They may see abuse, hear abuse or be aware of the abuse or potential abuse. In households where IPAV occurs it is common for children to witness violence or to be victims/survivors of abuse themselves.<sup>22</sup> The ABS Personal Safety survey found that one in 10 men and one in eight women had witnessed violence towards their mother by a partner when they were children (before the age of 15).<sup>10</sup> In addition, male to female IPAV has been shown to increase the potential for child abuse perpetrated by both fathers and mothers.<sup>11</sup> Child abuse is discussed in [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect).

Children who are exposed to IPAV may present in the following ways.<sup>22,23</sup> Effects may be seen both at home and at school:

- chronic somatic problems and frequent presentations
- anxiety
- depression
- withdrawal
- aggressive behaviour and language, problems at school
- drug and alcohol abuse
- lower self-worth

- suicidal ideation (adolescents)
- homelessness (adolescents)
- academic failure
- bedwetting, sleeping disorders, stress, behavioural problems (younger children).

## Inquiring about abuse

The majority of victims/survivors of IPAV would not object to being asked about domestic violence, but only a minority of women are actually asked. In a Brisbane study, 28% of abused women had told a GP about the abuse, while only 13% had been asked about it by a doctor.<sup>14</sup>

Raising the issue can be challenging, but women are significantly more likely to disclose if they are asked by their doctor about abuse.<sup>24</sup> There is insufficient evidence to support screening for all women (with the exception of antenatal domestic violence screening), so GPs should ask women who present with the psychosocial and physical conditions as outlined in Identifying intimate partner abuse in practice.<sup>3</sup>

There should be a low threshold for asking about abuse, especially with some typical presentations. For example, in a patient you have seen for years for depression or anxiety, persistent headaches or vague somatic complaints, begin to explore the possibility that they are experiencing abuse or have experienced abuse in the past with general and then specific questions. It may be important that you simply suggest the possibility of a connection between what may be happening at home or in the past and their presenting symptoms.

The gender of a doctor does not affect disclosure, provided communication skills are good.

Health practitioners may inadvertently discourage disclosure by communicating attitudes like, 'It's not my role to ask', 'Asking will invade her privacy' or 'She will not want to leave anyway'.

When asking about possible abuse, ensure that the woman is alone. If she is with her abuser, she will either not disclose, or if she does disclose, it could put her in danger. Ask a woman's accompanying partner to wait in the waiting room and explain that it is usual for a health practitioner to spend time alone with their patients.

Telehealth has increased the accessibility of health professionals for victims/survivors of IPAV; however, it is not always possible to be certain who is present at the other end of the telephone or video call. It is advisable to start with yes/no questions to ensure the safety of the telehealth consult, for example, 'Is it safe for me to ask you how you are going?' or 'Are you alone at the moment?' If the answer is 'No', tell them that you will call back the next day, and give them some times that they can answer 'Yes' or 'No' to in order to find a safe time to call. If they are alone, establish a code word or phrase for if they need to suddenly end the call (eg if they think they will be overheard), such as 'Thanks, but I'm not interested'.

It is important to explain confidentiality and information-sharing procedures, which differ across states/territories. The only state or territory to require mandatory reporting of domestic violence is the Northern Territory. In other states and territories, the doctor could explain that 'I don't routinely share information without your consent. However, if you tell me that you or someone else is at a serious risk of harm, I can't always keep that information to myself' ([refer to Chapter 3: First-line response to](#)

[intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety).

When inquiring about abuse, start with general questions that will then lead into more specific questions. 'How are things at home?' or 'Do you feel safe at home?' may then lead into 'Are you afraid of your partner?' and 'Has your partner ever physically harmed you?'

Another approach is to say, 'Violence is very common in the home. I ask a lot of my patients about abuse because no-one should have to live in fear of their partners'. The benefit of such a statement is that will allow the woman to see that this is a common presentation that the health professional has seen before and that the health professional won't be shocked or judgemental when disclosing to them. For further examples of questions to ask if you suspect IPAV, refer to Box 2.1.

#### **Box 2.1. Questions and statements to make if you suspect IPAV**

- 'How are things at home?'
- 'Do you feel safe at home?'
- 'Often people who have these types of health problems are experiencing difficulties at home. Is this happening to you?'
- 'Sometimes these symptoms can be associated with having been hurt in the past. Did that ever happen to you?'
- 'Has your partner physically threatened or hurt you?'
- 'Is there a lot of tension in your relationship? How do you resolve arguments?'
- 'Sometimes partners react strongly in arguments and use physical force. Is this happening to you?'
- 'Are you afraid of your partner? Have you ever been afraid of any partner?'
- 'Have you ever felt unsafe in the past at home?'
- 'Violence is very common in the home. I ask a lot of patients about abuse because no-one should have to live in fear of their partners.'
- 'Has your partner ever controlled your daily activities?'
- 'Has your partner ever threatened to physically hurt you?'

To hear a GP inquire about abuse using some of the above questions, visit the RACGP Professional Development Program on Family Violence – Module 2: Identifying and responding to family violence (from 9.03–13.52 minutes).

Video available at: [YouTube \(https://www.youtube.com/embed/Hu06nVCzih0?start=543\)](https://www.youtube.com/embed/Hu06nVCzih0?start=543)

Note: If the physical harm was to the head, face or neck, ask the following questions:

- 'Have you ever been hit in the head or face?'
- 'Have you ever been pushed or shoved and banged your head against something?'
- 'Have you ever lost consciousness?'

**Table 2.3. Strategies to increase disclosure and engagement in women who experience IPAV**

<b>Component</b>	<b>Aim</b>	<b>Strategy</b>
Healthcare worker characteristics	Ensure helpful GP attitudes, judgements and behaviours	<ul style="list-style-type: none"> <li>• Be non-judgemental, empathetic, use active listening, be respectful and compassionate. There must be development of trust</li> <li>• Recognise/support patient autonomy</li> </ul>
Raising the issue	Setting the agenda, communication and counselling skills	<ul style="list-style-type: none"> <li>• Use open questions, reflection and active listening, sensitivity, non-judgemental inquiry, express empathy</li> </ul>
Inquiry	Ask about emotions and safety	<ul style="list-style-type: none"> <li>• Ask about the woman's fears and concerns</li> <li>• Anxiety, shame, self-blame, loneliness, humiliation and embarrassment are commonly associated with a reluctance to disclose</li> <li>• Assess safety (woman and any children)</li> <li>• What does she need in order to feel safe? How safe does she feel? Has the violence been escalating?</li> </ul>
Reluctance to disclose	Explore links to the presenting complaint	<ul style="list-style-type: none"> <li>• Increase awareness of how IPAV is a contributor to the woman's presenting complaint</li> <li>• Have a suspicion of IPAV when women present with anxiety, depression, substance abuse and chronic pain</li> </ul>
Complexity	Insight	<ul style="list-style-type: none"> <li>• Women want GPs to have a deeper understanding of the complexities of their situation and circumstances</li> <li>• GPs need to gain an understanding of how the woman views IPAV and what are their identified supports</li> </ul>

**Table 2.3. Strategies to increase disclosure and engagement in women who experience IPAV**

Validation	Legitimisation of experiences	<ul style="list-style-type: none"> <li>• Affirm experiences – address misconceptions. For example:</li> <li>• Woman: ‘It’s my fault, I deserve it.’</li> <li>• GP: ‘You do not deserve this and it is not your fault.’</li> </ul>
------------	-------------------------------	---

### Barriers to women reporting abuse

Many women do not report abuse because they fear reprisals from their partner if they found out that they had disclosed, or they may feel that the abuse is normal. There are many other barriers to disclosure.<sup>12</sup> They may fear judgemental attitudes by the doctor or that they will not be believed. There may be particular barriers to disclosure for women in small, rural or remote communities, such as not wanting the GP to think badly of the perpetrator or fear of repercussions and consequences in communities where anonymity cannot be maintained. Other barriers include:

- a lack of access to services
- concerns about maintaining confidentiality and anonymity
- the stigma attached to the (public) disclosure of violence
- a lack of transport and telecommunications.<sup>25,26</sup>

Further, as Judith Herman says in her book, *Trauma and recovery*:<sup>27</sup>

‘People who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner that undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy. When the truth is finally recognized, survivors can begin their recovery. But far too often secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom. The psychological distress symptoms of traumatized people simultaneously call attention to the existence of an unspeakable secret and deflect attention from it. This is most apparent in the way traumatized people alternate between feeling numb and reliving the event.’

If the violence is mainly emotional, they may not see it as serious enough and may minimise the violence, particularly if they come from families where IPAV might have occurred.

For these and other reasons, disclosure may not be immediate, and is often sporadic. This is called the ‘dance of disclosure’, where a woman partially discloses, then becomes reluctant to disclose for a while, then discloses again later.

Women experiencing abuse may be unable to recognise the cycle of violence that they are in. They may feel that each act of violence is a discrete event 'caused' by a specific event. Women may also often be too terrorised to protect their children or too worn down by repeated violence to seek help. They may live in fear that if they report to authorities, their children will be taken away. Further, some children who are exposed to IPAV grow up to also be more likely to experience or use IPAV.

## Responding to disclosure, including validation

One of the many barriers to GPs asking about IPAV is that they do not know what to do if a woman discloses abuse. The WHO 'LIVES' (Listen, Inquire, Validate, Ensure safety, Support) model is a useful tool to guide doctors in their response (see Box 2.2).<sup>28</sup>

The immediate response to disclosure should be to listen empathetically and hear the woman's story. The response should be non-judgemental, supportive and believing of her experiences.

Following this should come an inquiry as to her current needs and concerns. These may be quite different to what the health professional thinks are her needs. Health professionals should put the patient-identified needs first, especially ensuring social and psychological needs are addressed.

Validation will assure her that violence is never okay and that it is not her fault that the violence is occurring. Again, it is vital that she is believed. It is also important to acknowledge the complexity of the situation and respect the patient's choices, even if that means going back to her abusive partner.

It is ineffective at this point to suggest leaving the relationship, but any message of support and identifying that alternatives exist, may be a trigger for action.<sup>23,29</sup> Remember that women are at greatest risk of being a victim of homicide around the time of leaving. Therefore, planning when, and how, to leave needs to be done carefully to maintain safety.

Validation statements include:

- 'What is happening to you is not okay, and it is not your fault.'
- 'Everyone deserves to be safe at home.'
- 'I am concerned about your safety and wellbeing.'
- 'It took you a lot of courage to discuss this with me.'
- 'You are not alone. I will be with you through this, whatever you decide.'
- 'You are not to blame; abuse is common and happens in all types of relationships.'

Elsewhere in this resource we discuss [enhancing safety \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety) and providing [ongoing support \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) according to the LIVES model.

When a woman returns for a subsequent visit, it is important to recognise the chronicity of the problem, and, as with any chronic condition, to offer ongoing follow-up and support. Continue to believe and validate the woman. Be patient and supportive and respect her wishes.

Never say, 'Why don't you just leave your partner?' Never pressure her into making decisions. Allow her to progress at her own pace. The supportive space that we are making may well contribute to her being able to change her situation in the future. The [readiness to action model \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) can be very helpful in understanding a patient's current position within the journey of change.

### Box 2.2. The WHO LIVES model of first-line response to IPAV

**Listen:** Listen to the person closely, with empathy, and without judging  
**Inquire:** Assess and respond to their various needs and concerns – emotional, physical, social and practical  
**Validate:** Show that you understand and believe the person – assure them that they are not to blame  
**Enhance safety:** Discuss a plan for the person to protect themselves from further harm if violence occurs again  
**Support:** Support the person by helping them connect to information, services and social support

## Resources

- [See what you made me do: Power, control and domestic abuse \(https://www.blackincbooks.com.au/books/see-what-you-made-me-do\)](https://www.blackincbooks.com.au/books/see-what-you-made-me-do) – book by Jess Hill, Black Inc Books, 2019.
- [See what you made me do: Power, control and domestic abuse \(https://www.sbs.com.au/ondemand/program/see-what-you-made-me-do-1/?cid=sbs:search:sem:aw:swymmd::prog&gclid=EA1alQobChMlrve34-zX8gIVDTErCh3VQQRyEAAAYASAAEgKo1fD\\_BwE&gclsrc=aw.ds\)](https://www.sbs.com.au/ondemand/program/see-what-you-made-me-do-1/?cid=sbs:search:sem:aw:swymmd::prog&gclid=EA1alQobChMlrve34-zX8gIVDTErCh3VQQRyEAAAYASAAEgKo1fD_BwE&gclsrc=aw.ds) – documentary series by Jess Hill, SBS, 2021.

## References

1. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia: Continuing the national story 2019. Cat. no. FDV 3. Canberra: AIHW, 2019.
2. Ayre J, Lum On M, Webster K, et al. Examination of the burden of disease of intimate partner violence against women in 2011: Final report. Sydney: Australia's National Research Organisation for Women's Safety, 2016.
3. O'Doherty L, Hegarty K, Ramsay J, et al. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev* 2015:CD007007.
4. Tan E, O'Doherty L, Hegarty K. GPs' communication skills: A study into women's comfort to disclose intimate partner violence. *Aust Fam Physician* 2012;41:513.
5. World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013.
6. Potter L, Morris R, Hegarty K, et al. Categories and health impacts of intimate partner violence in the World Health Organization multi-country study on women's health and domestic violence. *Int J Epidemiol* 2021;50:652–62.
7. Cox P. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. Sydney: Australia's National Research Organisation for Women's Safety, 2016.
8. Gazmararian JA, Lazorick S, Spitz AM, et al. Prevalence of violence against pregnant women. *JAMA* 1996;275:1915–20.

9. Hegarty K, Gunn J, Chondros P, et al. Physical and social predictors of partner abuse in women attending general practice: A cross-sectional study. *Br J Gen Pract* 2008;58:484–87.
10. Campbell AM. An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic Sci Int Reports* 2020:100089.
11. Boxall H, Morgan A, Brown R. The prevalence of domestic violence among women during the COVID-19 pandemic. *Statistical Bulletin* no. 28. Canberra: Australian Institute of Criminology, 2020.
12. Usher K, Bhullar N, Durkin J, et al. Family violence and COVID-19: Increased vulnerability and reduced options for support. *Int J Ment Health Nurs* 2020;29:549–52.
13. Roberts G, Hegarty K, Feder G. *Intimate partner abuse and health professionals: New approaches to domestic violence*. London: Elsevier, 2006.
14. Neil J. Domestic violence and COVID-19: Our hidden epidemic. *Aust J Gen Pract* 2020;49. doi: 10.31128/AJGP-COVID-25. Online ahead of print.
15. Tarzia L, Cameron J, Watson J, et al. Personal barriers to addressing intimate partner abuse: A qualitative meta-synthesis of healthcare practitioners' experiences. *BMC Health Serv Res* 2021;21:567.
16. Boy A, Salihu HM. Intimate partner violence and birth outcomes: A systematic review. *Int J Fertil Womens Med* 2004;49:159–64.
17. Hegarty K, Gunn J, Chondros P, et al. Association between depression and abuse by partners of women attending general practice: Descriptive, cross sectional survey. *BMJ* 2004;328:621–24.
18. Jones L, Hughes M, Unterstaller U. Post-traumatic stress disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma Violence Abuse* 2001;2:99–119.
19. St Ivany A, Schminkey D. Intimate partner violence and traumatic brain injury: State of the science and next steps. *Fam Community Health* 2016;39:129–37.
20. Gabbe B, Ayton D, Pritchard E, et al. *The prevalence of acquired brain injury among victims and perpetrators of family violence*. Putney, NSW: Brain Injury Australia, 2018.
21. Kwako LE, Glass N, Campbell J, et al. Traumatic brain injury in intimate partner violence: A critical review of outcomes and mechanisms. *Trauma Violence Abuse* 2011;12:115–26.
22. Bedi G, Goddard C. Intimate partner violence: What are the impacts on children? *Australian Psychologist* 2007;42:66–77.
23. De Bellis MD. Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Dev Psychopathol* 2001;13:539–64.
24. Hegarty K, O'Doherty L, Astbury J, et al. Identifying intimate partner violence when screening for health and lifestyle issues among women attending general practice. *Aust J Primary Health* 2012;18:327–31.
25. Alston M, Allan J, Dietsch E, et al. Brutal neglect: Australian rural women's access to health services. *Rural Remote Health* 2006;6:475.
26. Mitchell L. *Domestic violence in Australia – an overview of the issues*. Canberra: Parliament of Australia, Department of Parliamentary Services, 2011.
27. Herman J. *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books, 1997.
28. [Australian Bureau of Statistics. Personal safety, Australia. Canberra: ABS, 2016 \(http://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release#key-findings\)](http://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release#key-findings) [Accessed 30 August 2021].
29. Chang JC, Dado D, Hawker L, et al. Understanding turning points in intimate partner violence: Factors and circumstances leading women victims toward change. *J Womens Health* 2010;19:251–59. [Accessed 30 August 2021].



# First-line response to intimate partner abuse and violence: Safety and risk assessment

'Woman want to be listened too and I mean really listened to, to be validated and understood. To be seen as a collaboration with the woman, to walk the journey together to get the best outcomes for her and her children.' **Fiona, victim/survivor, [The WEAVERs Group](https://www.saferfamilies.org.au/weavers)** (<https://www.saferfamilies.org.au/weavers>)

## Key messages

- As part of the first-line response to intimate partner abuse and violence (IPAV), health practitioners should express concern about a patient's safety and likelihood of risk; however, it is a woman's right to decide her own pathways to safety.
- Mandatory reporting of child abuse is required throughout Australia (refer to chapter [Legal](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence-working-with-our-patients-in-ge/violence-and-the-law) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence-working-with-our-patients-in-ge/violence-and-the-law>) or [Child abuse](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence-working-with-our-patients-in-ge/child-abuse-and-neglect) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence-working-with-our-patients-in-ge/child-abuse-and-neglect>)).
- In the context of intimate partner abuse, where the child or young person does not appear to have experienced or been exposed to any violence, you may consider a referral to a vulnerable children's organisation (refer to [Resources](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources>)).

## Recommendations

Refer patients to specialist services for advocacy to enhance safety and mental health.  
**(Strong recommendation: Very low certainty of evidence)**

Conduct a safety/risk assessment and a brief safety plan for any patient who is experiencing IPAV and their children.

**(Practice point: Consensus of experts)**

Document carefully what a patient says about IPAV in their patient record, to ensure clear communication with others, and potentially for [legal processes \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law).

**(Practice point: Consensus of experts)**

## Introduction

This chapter outlines how to assess the safety of a woman who is a victim/survivor of intimate partner abuse/violence (IPAV) and any [children who might be exposed to that abuse \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect). Assessing safety is a key step in responding to and managing a disclosure, and should take place in some form in every consultation. The chapter also outlines safety planning.

Health professionals need to understand that there is great complexity in relationships that are abusive, and there are many barriers to women leaving.<sup>1</sup> It is important to realise that a woman's leaving does not necessarily stop the abuse and may escalate it. For some women, leaving may not be what they want, and it should not be positioned as the only or primary goal.<sup>2</sup> The chronic nature of domestic violence means that becoming safe is an ongoing process, and health professionals need to understand that it can take time for women to navigate a pathway to safety and healing.<sup>3</sup>

Note that the brief safety assessment and planning process outlined here does not preclude the need for input from specialist services such as police and domestic violence services. Referral to domestic violence services should take place wherever possible, in response to the needs of the women. It is acknowledged that some women may not take up a referral to specialist services.<sup>3</sup>

### Why don't women just leave?

It is easy to look at the cycle of violence that sometimes happens in relationships and wonder why a woman doesn't leave an abusive relationship. However, it is a myth that abused women can 'just leave'. There are multiple, complex reasons why women often stay in abusive relationships.

- The most dangerous time for a woman in an abusive relationship is when she leaves, and many victims/survivors live in fear of reprisals if they were to leave. Approximately 40–50% of women killed by their spouse are separated or in the process of separating.<sup>4</sup>

- Having dependent children is a barrier. If a woman were to leave, she may not have housing appropriate for her and her children. This may be in part because she may also be isolated from friends and family if she were to leave. It is common for abused women to have no-one to turn to and to be unaware of services available.
- To leave may substantially reduce a woman's standard of living. Women often do not have the equivalent earning capacity of men, and where financial abuse is taking place, a woman may not have access to money.
- After years of abuse, many victims/survivors have low self-esteem and doubt their ability to cope on their own. They also may have committed emotionally to the relationship and may be hoping that their partner will change. In some relationships after each cycle of violence comes an apology and a promise it will never happen again and often victims/survivors will cling to that promise even when the next cycle of violence occurs. Some partners even make threats of suicide if the woman were to leave, leaving her fearful that she will be the cause of his death.
- Some [migrant and refugee women \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities) may experience significant family pressure to stay in the relationship or pressure over their visa status.

Overall, a woman should never be told to 'just leave', or asked, 'Why don't you just leave?' This implies that she has some responsibility for the violence that has been perpetrated towards her. [Chapter 4: Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) outlines how to use motivational interviewing techniques to help women weigh up their relationships and choose options in a non-judgemental way.

## Clinical context: Assessing safety

The World Health Organization (WHO) LIVES response (see [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) ) involves listening, inquiring about needs, validating, enhancing safety and supporting a victim/survivor of IPAV.

Enhancing safety within general practice and primary care involves a brief risk assessment and safety planning with women who have been subjected to abuse. A professional judgement needs to be made around a woman's safety needs, based on three domains:

1. The woman's own judgement of her safety
2. The presence of evidence-based risk factors (refer to Tool 3.1)
3. Information-sharing with other health professionals or services, as appropriate (eg police, domestic violence case workers). This might involve seeking information from other services or discussing the case with other workers.



Tool 3.1. Evidence-based risk factors

Source: State Government of Victoria.<sup>5</sup>

### Conducting an assessment

It is important to understand that women are experts in their own safety, as they have a lived experience with their abuser. A key question to ask when assessing safety is, 'Do you feel safe to go home today?' Many doctors feel very concerned for a woman's wellbeing; however, the woman is often the best judge about whether it is safe to go home.

If there are children involved, consider whether or not the situation falls under [mandatory reporting laws \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse). The safety of children should be assessed along with the woman's safety, by asking her 'Are you concerned about any safety issues for your children or other family members?'

A number of evidence-based risk factors put a woman at increased risk of serious harm or death, which should be explored with a woman when assessing her safety. Factors that pose particularly high risk are:<sup>6</sup>

- previous violence against the victim/survivor by the perpetrator
- leaving the relationship – this is one of the riskiest times for victims/survivors of IPAV, and women should be informed of that
- planning to leave or having recently separated is a dangerous time
- a history of strangulation or choking<sup>7</sup>
- previous intimate partner sexual violence

- obsessive, jealous or controlling behaviour, including stalking
- threats to kill
- access to weapons, or previous use of weapons by the perpetrator
- being physically assaulted while pregnant
- increasing frequency and severity of abuse.

Other risk factors from the perpetrator perspective for IPAV include:<sup>6</sup>

- perpetrator history of violent behaviour outside the household, as well as within, including violence towards animals
- self-harm, suicide attempts or threats of suicide by the perpetrator
- perpetrator history of witnessing or being the victim of family violence as a child
- evidence of mental health problems (eg personality disorders, drug and alcohol misuse) in perpetrator
- perpetrator attitudes that support violence towards women
- perpetrator unemployment.

A risk assessment tool may be used to help assess risk. The Victorian Government's [Family Violence Multi-Agency Risk Assessment and Management Framework \(https://www.vic.gov.au/maram-practice-guides-and-resources\)](https://www.vic.gov.au/maram-practice-guides-and-resources) provides several guides and tools for risk identification, screening and assessment.

Some questions to ask when assessing a women's safety are shown in Box 3.1.

The Royal Australian College of General Practitioners (RACGP) [Professional Development Program on Family Violence \(https://www.racgp.org.au/familyviolence/index.htm\)](https://www.racgp.org.au/familyviolence/index.htm) provides further information about IPAV. To see a GP do a safety assessment, see Module 2 (from 17.46–20.26 minutes).

A brief risk assessment (10 minutes) is also illustrated in this video.

### Box 3.1. Questions to assess safety briefly

General questions include:

- 'Do you feel safe to go home today?'
- 'What do you need in order to feel safe?'
- 'How safe do you feel?'
- 'How safe do you think the children are?'

More specific questions might include:

- 'Has the frequency and severity of the violence increased?'
- 'Have you been to hospital because of the violence?'
- 'Is your partner obsessively jealous about you?'
- 'Did your partner physically assault you while you were pregnant?'
- 'Has your partner threatened to kill you or the children?'

### Traumatic brain injury and strangulation

Traumatic brain injury (TBI) can be described as changes in brain function or detecting any brain pathology due to an external force, with head trauma and neck strangulations by perpetrators common as an injury mechanism for TBI. Thus, it is important to ask victims/survivors who have experienced physical violence if they remember times that they have reduced or lost consciousness, or had difficulty breathing, speaking or pre-syncopal symptoms from choking. The patient may also have gaps in memory and be unable to describe a clear sequence of events, with lack of awareness of their own loss of consciousness.

You could ask the following questions:

- 'Have you ever been choked or strangled?'
- 'Have you ever been hit in the head or face?'
- 'Have you ever been pushed or shoved and banged your head against something?'
- 'Have you ever lost consciousness?'

IPAV victims/survivors who experience anxiety, depression, dizziness and headaches show symptoms that are consistent with a post-concussive syndrome or lingering mild TBI.<sup>10</sup> After any head injury, the victim/survivor may experience focal neurological symptoms and signs, altered consciousness and subtle cognitive deficits. After strangulation the survivor may experience the above as well as respiratory difficulties, a hoarse or husky voice, pain or difficulty on swallowing, and possibly bruising or petechiae above the pressure on the neck. TBI can also occur from recurrent mild injuries or concussions, or major injuries where they lose consciousness. Hypoxia puts the survivor at risk of an acquired brain injury, particularly with recurrent strangulations in the context of ongoing violence from the perpetrator.

Strangulation causes compression and potential occlusion of the great vessels or airway<sup>11</sup> and loss of consciousness typically occurs within 5–10 seconds and death can occur within minutes.<sup>12</sup>

Strangulation is an important indicator of increased homicide risk, with survivors having a 7.48 times increased risk of being killed by that partner.<sup>7,13</sup> Around half of patients with strangulation will have no external sign of injury, but internal injuries (including subtle fractures to the larynx, carotid or vertebral artery dissection) should be considered if the history suggests a more serious strangulation. Red flag features suggesting the need for immediate referral to the emergency department after recent strangulation include any new or evolving neurological deficits, neck bruising especially if located over the carotid arteries, carotid bruits, history of loss of consciousness (particularly if associated with incontinence), and ongoing difficulty swallowing or breathing.<sup>14</sup> Patients without red flag physical symptoms may be managed in the general practice setting after clinical assessment including neurological examination and examination of the head and neck.

Each victim/survivor should also be advised of risks of future harm if in an ongoing relationship with the perpetrator. It is important to ask about and document reported mechanisms of injury, physical observations, and any previous head injuries, strangulations, patterns of increasing frequency of strangulation, concussions or other extreme violence.<sup>7</sup>

### **After the assessment**

Suggested pathways for how to respond following a risk assessment are shown in Figure 3.1.

Most women will feel safe to go home on the day of the consultation. A woman who does not feel safe to go home should be referred to domestic violence services for urgent crisis accommodation (refer to Resources). This should ideally take place with a 'warm referral', whereby the doctor assists the woman in making the referral; if the woman is not keen on this or is unable to go, phone numbers or brochures should be provided so that she can refer herself in her own time. Care must be taken to ensure that these materials are not discovered by her partner, and safety planning should be undertaken (refer to Figure 3.1).

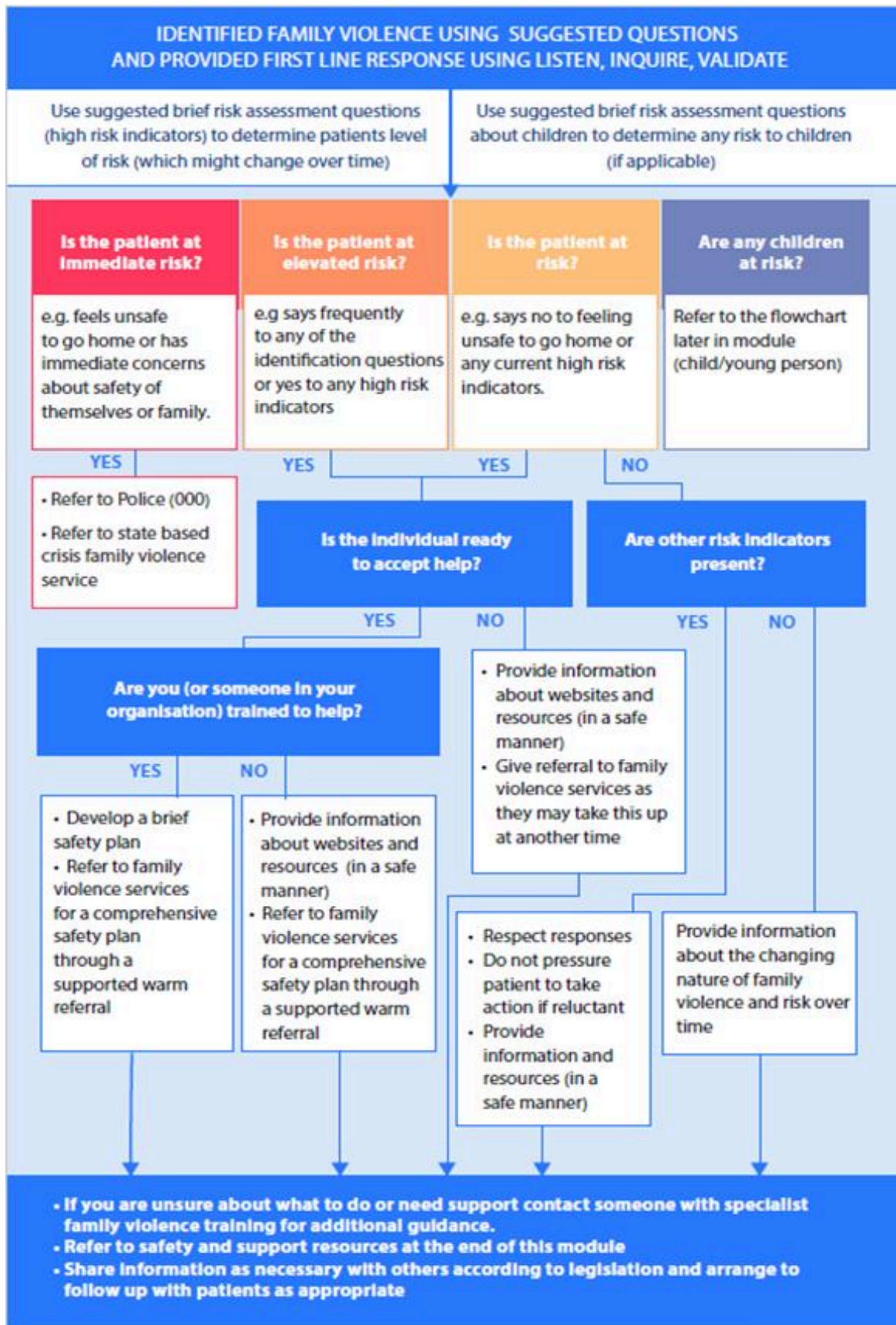


Figure 3.1. Responding to a risk assessment<sup>15</sup>



In the event that a woman is deemed to be at imminent risk of violence (if multiple recent risk factors are present – refer to earlier in this chapter), but she does not want to be referred to or go to a shelter or refuge, consent should be sought to refer her to the police.

If she does not consent, it may be necessary to seek [legal advice from a medical defence organisation \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law). Common sense should apply, and if the woman is at very high risk of being physically harmed, a referral to police should be made to safeguard her immediate wellbeing. Difficult situations such as these may require advice and input from colleagues, especially specialist domestic violence services.

If a woman is being repeatedly assaulted but is not willing to call the police, it is important to still provide her with appropriate information such as contacts for domestic violence or sexual assault services.

### Information sharing

GPs are able to share information about a patient under certain permissions, such as in accordance with Australian Government privacy laws,<sup>16</sup> which allow the disclosure of information with consent, or without consent in other circumstances such as to lessen or prevent a serious threat to the life, health, safety or welfare of a person. These permissions can be used to facilitate referrals, provide information to other services assisting the patient or notify appropriate services about information that is pertinent to preventing serious risk.

The Victorian Government has enacted a legal framework for information sharing in cases of domestic violence, to allow domestic violence services, police and child services to share information about cases to adequately manage the risk of violence. It is known as the [Family Violence Multi-Agency Risk Assessment and Management Framework \(http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management\)](http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management).

### Safety planning

Safety planning involves developing a plan for a woman to follow should the violence escalate. The purpose of a safety plan is to outline escape and help-seeking strategies.<sup>6</sup> It is essential to plan for the safety of both women and children.

Safety plans should be developed for every victim/survivor and should be specific to each woman's circumstances. Working to keep victims/survivors safe has been shown to be the best way to keep children safe.<sup>17</sup>

A checklist for safety planning is shown in Box 3.2.

Safety planning needs to continue and evolve, as a woman's circumstances may change, even after leaving her abuser. Mothers may have ongoing contact with their abuser through acts of the court or through a belief that continuing contact with the father is in the best interests of the children. It is therefore very common for women to have continued exposure to her abuser post-separation.<sup>18</sup> As discussed, leaving or having recently left a partner is the most dangerous time for a victim/survivor of IPAV.

### Box 3.2. Safety planning checklist

This list can be worked through with each woman as part of their safety plan.

- 'Where will you go in an emergency and who will come (eg children)?'
- 'How will you get there?'
- 'Which friends, family or neighbours can be contacted in an emergency?'
- Hide money and an extra set of house and car keys.
- Establish code words or code clothing colour to signal that you need help.
- Remove any weapons from house.
- Ensure you have quick access to the following:
  - money
  - Medicare and tax file numbers
  - rent and utility receipts o birth certificates (or copies) for you and children
  - ID and/or driver's licence for you and children
  - bank account and insurance policy numbers
  - marriage certificate o valuable items like jewellery
  - hidden bag with extra clothing and other essential items.
- Ensure important phone numbers and documents are stored in a safe place.
- Obtain a new phone that the perpetrator has no knowledge of so you are untraceable. May need to be hidden with other objects.

## Documenting intimate partner abuse and violence

GPs should document a patient's history and examination findings, including every injury – as they would for any assault.

- Describe every injury, including its location, size and age. This is important not only in case you later need to write a police report about the injuries, but also as a reminder of what has happened or to alert another health professional in the clinic about the woman's history.
- Statements from the woman about the abuse should be documented word for word, using quotation marks.
- Any behaviour that you witness should be recorded, such as 'The patient cried when she said that ...'
- Document the management plan and any referrals that have been made.

Good documentation, provided confidentiality can be assured, is important for any legal processes that may occur. It is not always possible to predict which patients may be involved in legal processes in the future. Practices that cannot maintain confidentiality should take [measures to ensure they can. \(http://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information\)](http://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information)

Some women may be concerned about confidentiality and may request that you do not keep notes. In addition, there may be occasions where confidentiality cannot be assured (eg if you know that a perpetrator is capable of hacking into private websites). In both these cases, avoid documenting the management plan any referrals, safety planning or other interventions, to reduce the risk of harm.

Some practices use codes in their electronic record, in the 'reason for visit' or other locations, to indicate an IPAV case without overtly saying so in the notes. Practices using paper records could use a coloured sticker.

## Safety of children and mandatory reporting

Children who are exposed to domestic violence are at risk of behavioural, emotional, social, cognitive and physical issues.<sup>19,20</sup> Exposure to domestic violence tends to mean seeing and/or hearing the violence but can be witnessed in other ways, such as the aftermath of violence (eg seeing their injured mother).

In some states of Australia, where a child is a witness to violence and abuse but is not deemed to have experienced violence themselves and is not at immediate risk, [the child can be referred to support services such as a vulnerable children's organisation \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect). It is important to reassure children that the violence is not their fault and to safety plan with them, if age-appropriate, for the next episode of violence.<sup>21</sup> A child's mother should be involved in the safety planning process and outside sources of support should be considered.<sup>18</sup>

There is considerable evidence that child abuse and IPAV co-occur.<sup>22,23</sup> Health professionals who see families in which IPAV occurs should be aware of and ask about child abuse. For more information, refer to [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect).

It is important for health professionals to be aware of mandatory reporting laws in relation to child abuse.

The Northern Territory requires any adult to report to police if they believe on reasonable grounds that a child has been, is, or is likely to be at risk of a sexual offence or to experience harm or exploitation. In all states and territories, medical practitioners are required to report any assault perpetrated against people under the age of 18 years (under 16 years in New South Wales and 17 years in Victoria).

Each Australian state and territory has different legislation regarding what must be reported by whom (refer to [Table 9.3 in Chapter 9 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect)). When in doubt, it is always best to check with your medical defence organisation or with the reporting agency, initially without mentioning the child's name.

For more information visit the [Australian Government Australian Institute of Family Studies \(http://www.aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect\)](http://www.aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect).

## Dealing with men who use intimate partner abuse and violence

GPs often see the whole family and may also manage cases of men who are violent towards women. This raises issues of safety and confidentiality. It is not recommended that one GP provides care for both a woman who is experiencing IPAV and her partner. This is discussed further in [Chapter 5: Working with men who use intimate partner abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse).

## Conclusion

GPs often have to hold risk and support safety at times for families over a period of time, similar to how they often need to in areas such as suicide, mental health and cancer. This does not mean that they do not need to get support for themselves and their patients from specialists in the area. The next chapter outlines some techniques for an ongoing response when working with patients over time.

## References

1. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Women & Health* 2012;52:587–605.
2. Rivas C, Ramsay J, Sadowski L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev* 2015:CD005043.
3. Feder G, Hutson M, Ramsay J, et al. Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals – A meta-analysis of qualitative studies. *Arch Intern Med* 2006;166:22–37.
4. Australia's National Research Organisation for Women's Safety. Domestic and family violence lethality: The facts about intimate partner homicide. Sydney, NSW: ANROWS, 2019.
5. [State Government of Victoria. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne: State Government of Victoria, 2021 \(https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management\)](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) [Accessed 25 August 2021].
6. [Backhouse C, Toivonen C. National risk assessment principles for domestic and family violence: Companion resource. A summary of the evidence base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence. Sydney: Australia's National Research Organisation for Women's Safety, 2018 \(https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2018/07/ANROWS\\_NRA\\_P\\_Companion-Resource.1.pdf\)](https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2018/07/ANROWS_NRA_P_Companion-Resource.1.pdf) [Accessed 13 May 2021].
7. Pritchard AJ, Reckdenwald A, Nordham C. Nonfatal strangulation as part of domestic violence: A review of research. *Trauma Violence Abuse* 2017;18:407–24. [Accessed 13 May 2021].
8. [Domestic Violence Service Management. DFV/ABI Resource 03: Domestic and Family Violence & Strangulation. NSW: DVSM, 2021 \(https://dvns.wsm.org.au/wp-content/uploads/2021/02/DFV-ABI-Responder-Resource-03-DFV-Strangulation.pdf\)](https://dvns.wsm.org.au/wp-content/uploads/2021/02/DFV-ABI-Responder-Resource-03-DFV-Strangulation.pdf) [Accessed 24 August 2021].
9. Monahan K, Purushotham A, Biegon A. Neurological implications of nonfatal strangulation and intimate partner violence. *Future Neurology* 2019;14:FNL21. [Accessed 24 August 2021].
10. St Ivany A, Schminkey D. Intimate partner violence and traumatic brain injury: State of the science and next steps. *Fam Community Health* 2016;39:129–37. [Accessed 24 August 2021].

11. De Boos J. Tracheal perforation from non-fatal manual strangulation. *J Forensic Leg Med* 2019;66:1–3. [Accessed 24 August 2021].
12. Rossen R, Kabat H, Anderson J. Acute arrest of cerebral circulation in man. *Archives of Neurology & Psychiatry* 1943;50:510–28. [Accessed 24 August 2021].
13. Glass N, Laughon K, Campbell J, et al. Non-fatal strangulation is an important risk factor for homicide of women. *J Emerg Med* 2008;35:329–35. [Accessed 24 August 2021].
14. De Boos J. Review article: Non-fatal strangulation: Hidden injuries, hidden risks. *Emerg Med Australas* 2019;31:302–8. [Accessed 24 August 2021].
15. Readiness Training Program SFC, The University of Melbourne. Identified family violence using suggested questions and provided first line response using listen, inquire, validate. Melbourne: The University of Melbourne 2021. [Accessed 24 August 2021].
16. [Office of the Victorian Information Commissioner. IPP 2: Use and disclosure. Melbourne: OVIC, 2019 \(https://ovic.vic.gov.au/book/ipp-2-use-and-disclosure/#IPP\\_2.1\(d\):\\_Necessary\\_to\\_lesser\\_or\\_prevent\\_serious\\_threats\\_to\\_health\\_or\\_safety\)](https://ovic.vic.gov.au/book/ipp-2-use-and-disclosure/#IPP_2.1(d):_Necessary_to_lesser_or_prevent_serious_threats_to_health_or_safety) [Accessed 30 August 2021].
17. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: WHO, 2013. [Accessed 30 August 2021].
18. Hardesty JL, Campbell JC, Jaffe PJ, et al. Safety planning for abused women and their children. *Protecting children from domestic violence: Strategies for community intervention*. The Guilford Press, 2004:89–100. [Accessed 30 August 2021].
19. Kolbo JR, Blakely EH, Engleman D. Children who witness domestic violence: A review of empirical literature. *J Interpers Violence* 1996;11:281–93. [Accessed 30 August 2021].
20. Edleson JL, Ellerton AL, Seagren EA, et al. Assessing child exposure to adult domestic violence. *Children and Youth Services Review* 2007;29:961–71. [Accessed 30 August 2021].
21. Ernst AA, Weiss SJ, Enright-Smith S, et al. Positive outcomes from an immediate and ongoing intervention for child witnesses of intimate partner violence. *Am J Emerg Med* 2008;26(4):389–94. [Accessed 30 August 2021].
22. Renner LM, Slack KS. Intimate partner violence and child maltreatment: Understanding intra-and intergenerational connections. *Child Abuse Negl* 2006;30:599–617. [Accessed 30 August 2021].
23. Herrenkohl TI, Sousa C, Tajima EA, et al. Intersection of child abuse and children's exposure to domestic violence. *Trauma Violence Abuse* 2008;9:84–99. [Accessed 30 August 2021].

# Intimate partner abuse and violence: Ongoing support and counselling

'Look at what I have been through, instead of what you think is wrong with me, don't pathologise me when it's not helpful to me, and remember that medicine doesn't have all the answers' Cina, victim/survivor, [The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

## Key messages

- Intimate partner abuse/violence (IPAV) is strongly associated with mental health issues for victims/survivors, which requires a therapeutic response.<sup>1</sup>
- Health practitioners have a role in addressing IPAV<sup>2</sup> and need to see themselves as part of the wider intervention – including domestic violence, legal, police and housing services – required to support victims/survivors.

## Recommendations

Depending on individual needs, offer psychological therapies, including motivational interviewing, trauma-informed and mindfulness-based cognitive therapies, as these have been shown to provide support and improve women's mental health in the short term (less than six months).

**(Strong recommendation: Moderate certainty of evidence)**

Offer to refer women who have post-traumatic stress disorder (PTSD) and who are no longer experiencing violence for trauma-informed therapy.

**(Practice point: Consensus of experts)**

## Clinical context

After identification and providing a first-line response of LIVES (Listen, Inquire, Validate, Ensure safety, Support) as outlined in [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](#) and [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](#), there is a role for ongoing follow-up, support and referral. This should follow [trauma-informed care principles and practice \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](#).

This chapter outlines some general approaches (based on the woman's expectations) that practitioners can take for women who have experienced IPAV, followed by specific counselling techniques using motivational interviewing. This chapter outlines how we can respond to, follow up and counsel our patients in a time-efficient manner. It also addresses how to work appropriately with other services and refer to other practitioners to enable pathways to safety and healing. Finally, we outline a whole-of-practice approach needed to support health practitioners to be ready to address the issue of abuse and violence in their patients.

## What women want from their GP

'Please seek to understand my own personal circumstances ... I am not a number ... and a pill isn't always the answer!'

**Sharon, victim/survivor, [The WEAVERs Project \(https://socialequity.unimelb.edu.au/projects/the-weavers-project\)](https://socialequity.unimelb.edu.au/projects/the-weavers-project)**

When disclosure occurs, victims/survivors want connection through kindness and care. A 2020 meta-synthesis<sup>3</sup> of women's expectations after they disclose IPAV to a healthcare provider found that women consistently want a compassionate, non-judgemental response and active support from their doctor, during and after questioning about abuse. Key themes are shown in Table 4.1.

This can also be summarised as the CARE model (refer to Figure 4.1):<sup>3</sup>

- **C**hoice and control
- **A**ction and advocacy
- **R**ecognition and understanding
- **E**motional connection.

When providing this support to women, it is important to:

- not pressure women to disclose, and be aware that they may prefer to disclose at a different time
- build a trusting doctor–patient relationship to maintain support for the victim/survivor
- ensure that the environment is private and confidential, and provide sufficient time for consultations
- endeavour to understand the woman’s situation and acknowledge the complexity of the issues
- respect a woman’s choices and decisions and empower them to have control of their own life and circumstances (refer to [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)).

**Table 4.1. What women want from their health professionals<sup>3</sup>**

Theme	Health professional actions
Connection through kindness and care	<ul style="list-style-type: none"> <li>• Demonstrate kindness, caring, empathy and respect to build trust</li> <li>• Sustain personal engagement to maintain support</li> </ul>
See the evil, hear the evil, speak the evil	<ul style="list-style-type: none"> <li>• When listening to women, strive to understand the dynamics and context of their situation</li> <li>• Name the abuse and validate experiences</li> </ul>
Do more than just listen	<ul style="list-style-type: none"> <li>• Ensure action and advocacy are guided by women’s needs</li> <li>• Connect women with services in the community for health safety and wellbeing</li> </ul>
Planting the right seed	<ul style="list-style-type: none"> <li>• Tailor responses to women’s individual circumstances</li> <li>• Facilitate women’s empowerment, choice and control</li> </ul>

Adapted with permission from BMJ Publishing Group Ltd: Tarzia L, Bohren M, Cameron J, et al. Women’s experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339.



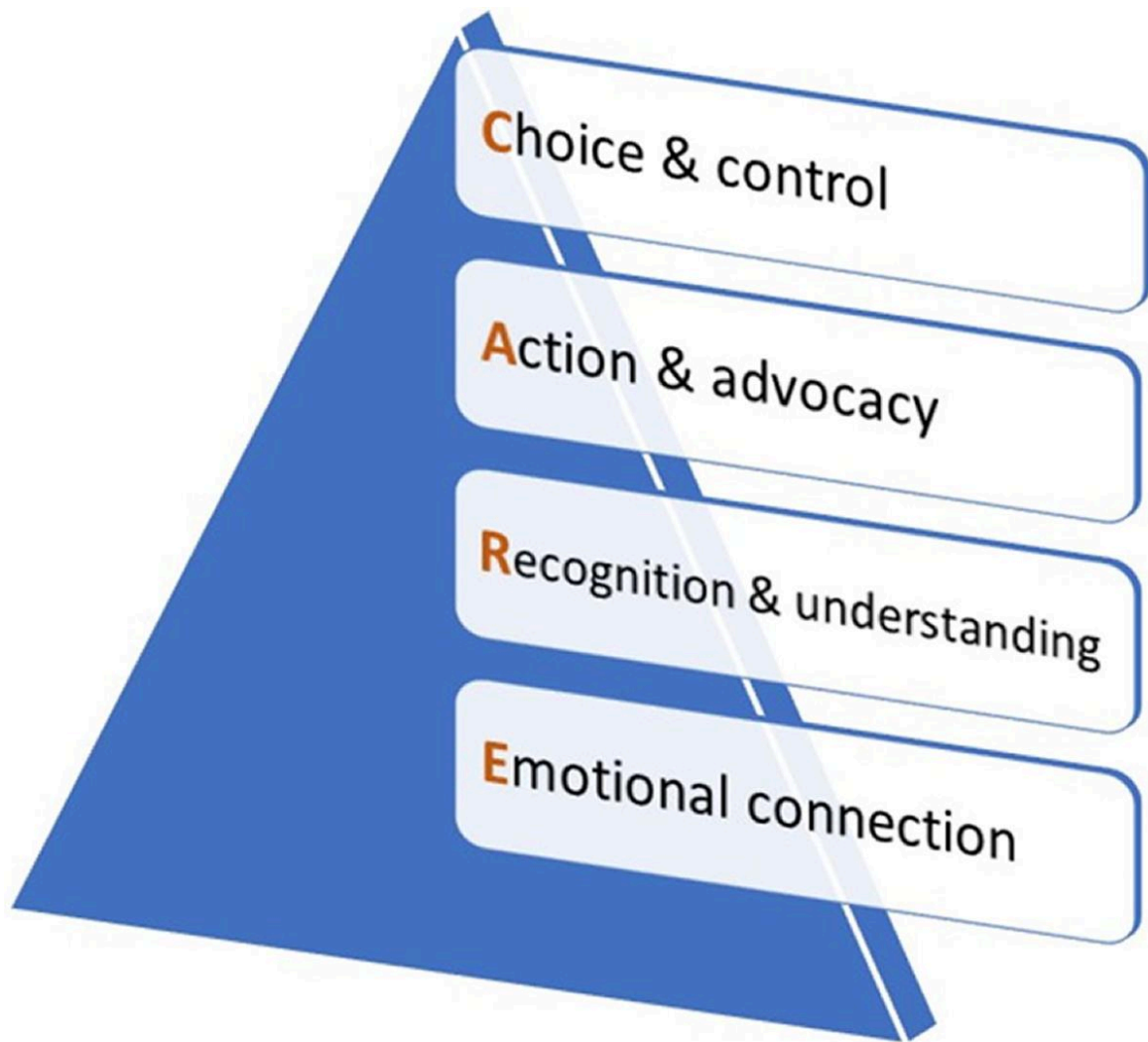


Figure 4.1. The CARE model<sup>3</sup>

In addition to the above, a range of responding and counselling strategies may assist people experiencing IPAV. GPs who are interested in mental health may undertake this work themselves, while other GPs will prefer to refer patients to domestic violence services, social workers, psychologists, women's services or other community workers.

GPs need to decide on their own skill and comfort level in this area and seek further training and resources. GPs working in rural areas, with fewer services, might offer their patients phone counselling through the national telephone service [1800RESPECT \(http://www.1800respect.org.au\)](http://www.1800respect.org.au) or telehealth services with mental health.

## Counselling approaches

'Please don't forget I am more than just a 10 min timeslot ... Please look at me and remember I am a person with a story.' **Emily, victim/survivor, The WEAVERs Project (<http://socialequity.unimelb.edu.au/projects/the-weavers-project>)**

In addition to [safety assessment and planning \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety), effective counselling strategies that may assist victims/survivors include cognitive behavioural therapy (CBT),<sup>1</sup> motivational interviewing<sup>4-7</sup> and an understanding of the behaviour-change process.<sup>8-17</sup> For longer-term healing after IPAV, victims/survivors need access to appropriate therapeutic counselling and peer support if available, which may include trauma-focused and non-trauma-focused CBT.<sup>18</sup>

A systematic review<sup>1</sup> of motivational interviewing, humanistic, CBT, third-wave CBT and other psychological-oriented interventions from middle- to high-income countries showed that therapies work to some extent in the context of IPAV. Psychological therapies ranged from two to 50 sessions and were delivered by a variety of staff (eg social workers, nurses, psychologists, community health workers, family doctors and researchers). The therapies showed a probable reduction in depression (moderate-certainty evidence) and anxiety (low-certainty evidence), but did not increase self-efficacy or safety planning, or reduce PTSD or IPAV.

### Motivational interviewing

Motivational interviewing (MI) is a patient-centred clinical intervention intended to strengthen motivation and readiness for action.<sup>5</sup> With IPAV, a woman's ability to change her situation may be very limited. It is important that the foremost concern with MI is the safety of women and their children.

One goal of MI is to elicit and reinforce 'change talk' from the patient.<sup>5,7,19</sup> In MI, the focus is on reflections and questions on topics that relate to ambivalence and action – what might promote action and what makes it difficult or inhibits it. The skillful MI counsellor is attuned to change-relevant content in the patient's behaviour and communication. Their thoughtful, reflective listening statements facilitate action. At the same time, adopting the spirit of MI helps to affirm explicitly the client's autonomy and choice with respect to what, whether and how to change.

A core component of the MI approach is the MI spirit – a mix of skillful counselling style blended with a clear patient-centred approach. Key elements of the MI spirit include:<sup>7</sup>

- A collaborative, rather than authoritarian, approach – the GP actively fosters and encourages power sharing in the interaction in such a way that the patient's ideas substantially influence the direction and outcome of the interview. Gaining a better understanding of the patient's ideas, concerns, expectations and preferences through the MI approach increases shared

decision making. Information is actively shared, and the patient is supported to consider options and to achieve informed preferences.

- Evocation – the focus is on the patient’s own motivation rather than trying to instil it. The GP works proactively to evoke the patient’s own reasons for action and ideas about how change should happen. All patients have goals, values and aspirations. Part of the MI approach is to connect health-related behaviour with the things that patients care about.
- Honouring and respecting the patient’s autonomy – the MI process actively supports autonomy by building good relationships, respecting individual expertise and competence and interdependence on others. Patients can and do make choices and it is ultimately their right to choose what they wish to do – patient self-determination is respected. Specifically, patients have the right to follow their own preferences and make their own decisions even if these are regarded as problematic by others.

The transtheoretical model of behaviour change that MI uses is commonly referred to as the ‘stages of change’ model. It has been used in many clinical settings to determine patient’s readiness for action, including IPAV and other types of abuse and violence.<sup>20-23</sup>

While the stages of change model can be useful, transition through the model is not usually linear. External factors, for example, social isolation or a lack of finances, may inhibit a woman being able to make any changes to her situation. More importantly, there is limited rigorous evidence of the effectiveness of the stages of change approach as the preferred counselling approach for women who are victims/survivors of IPAV.<sup>2,22,23</sup> It is preferable to maintain a degree of flexibility rather than adopting a rigid approach when choosing intervention strategies.<sup>24</sup>

The stages of change, as applied to IPAV, can be categorised into six components (refer to Box 4.1). It is important to keep in mind the limitations outlined above and also the ways of engaging women that are needed for this type of counselling (refer to Table 4.2).

**Box 4.1. Working with the stages of change model in IPAV**

**Pre-contemplative** – the woman is not aware that she has a problem, or she holds a strong belief that it is her fault. Awareness is a key issue that GPs will wish to work on with their patient.

- Suggest the possibility of a connection between symptoms and feelings of fear, using the woman’s terms.

**Contemplation** – the woman has identified a problem, but remains ambivalent about whether or not she wants to or, more importantly, is able to make changes. If the perpetrator is also a patient of the GP, this may generate ambivalence in the GP.

- Encourage possibilities for change should the woman decide she needs them. Point out that you are available to help and support her on the journey.

**Preparation/decision** – the catalyst for change has arisen, whether it is concern for children or a realisation her partner won’t change. Change talk is more apparent.

- Explore resources. Respect the woman’s decision about what she wants to do – for example, if she wants to talk to family, friends or a counsellor; leave the relationship; or obtain a restraining order.

**Action** – a plan devised in the previous stage is put into action.

- Offer support to carry out the plan and ensure safety planning is in place.

**Maintenance** – the woman’s commitment to the above actions is firm.

- Praise whatever she has managed to do and support her decision.

**Returning/relapsing** – the woman may feel compelled to reverse action. Reasons include finding life too stressful and having limited or no access to children or resources.

- Support the woman, even if she returns to the relationship, doesn’t see a counsellor or fails to report abuse. Reassure her that this pattern of behaviour is common for women.

**Table 4.2. Strategies to increase disclosure, engagement in women who experience IPAV (Practice point)**

Target area	What is required	Strategies	References
-------------	------------------	------------	------------

**Table 4.2. Strategies to increase disclosure, engagement in women who experience IPAV (Practice point)**

Strengths and vulnerability	Asking about and acknowledging vulnerability	<ul style="list-style-type: none"> <li>• Cognitive behavioural strategies and motivational interviewing techniques</li> <li>• Promotion of patient autonomy, empowerment</li> </ul>	<a href="#">6, 20, 25–27</a> <a href="#">26, 28, 29</a>
Time	Sufficient time to discuss	<ul style="list-style-type: none"> <li>• Even brief interventions are valued, allowing the woman to progress at her own pace</li> </ul>	<a href="#">30, 31</a>
Decision making	Collaborative approach	<ul style="list-style-type: none"> <li>• Shared decision making, identifying turning points: <ul style="list-style-type: none"> <li>◦ protecting others from the abuse/abuser</li> </ul> </li> </ul>	<a href="#">9, 32, 33</a>
Ambivalence	Exploration of the value of changing and eliciting change talk	<ul style="list-style-type: none"> <li>• Inquiring about ambivalence and motivation to do something</li> <li>• Change talk includes: <ul style="list-style-type: none"> <li>◦ desire to change ('I wish ...', 'I would like to ...')</li> </ul> </li> </ul>	<a href="#">7</a>
Privacy and confidentiality	Secure environment	<ul style="list-style-type: none"> <li>• Reassurance of privacy and confidentiality, ensuring continuity of care</li> </ul>	<a href="#">16, 31, 33</a>

## In practice

### Engaging women in care

There are key activities to keeping women engaged in ongoing support, they include exploring ambivalence, paying attention to turning points, action planning and facilitating referrals.

## Exploring ambivalence

Many women who are abused express ambivalence about taking action, even if they have identified a concern (or perhaps even a problem).

'Yes, I know my husband beats me occasionally, but in between he's okay. He's not nasty to the children and he treats me well.' 'Yes, my father was very hard on us ... but we were really a happy family.'

'Yes, but ...' is the classic phrase associated with ambivalence. Part of the person wants to acknowledge the abuse and another part does not.

It is useful to encourage patients to look at possibilities should they decide to do something. Just pointing out that there are options, that violence in any form is wrong and that they do not have to put up with it will help to establish trust, build self-esteem and identify you as a supportive agent.<sup>33</sup>

'Whatever you decide to do about the situation, if you think I can help, please let me know. I am happy to discuss this with you and we can explore the options together.'

To gain some understanding of how a relationship is perceived by your patient, you could get her to fill out a healthy relationship tool (refer to Tool 4.1) and motivational interviewing tool (refer to Tool 4.2 (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/useful-tools>)). Ask her to rate how the relationship is going, on a scale from 1 to 10. If she rates it as only 1 or 2, ask what she would need to happen to change this to a 4 or 5. This should provide some insight into what the woman thinks might contribute to a turning point.

Similarly, if she rates it as a 7 or more out of 10, try to get a more complete picture of her situation by asking her why the rating was a 7 and not a 2 or 3. This should give you a sense of why this relationship is important to the patient. Asking what would make it a 9 or 10 may also shed light on what else needs to happen.

**Tool 4.1. Healthy relationships tool**

The health of an adult relationship encompasses a spectrum ranging from positive to negative. Positive relationship health involves mutual trust, support, investment, commitment and honesty. It involves the exchange of words and actions in which there is shared power and open communication. Negative relationship health involves unhealthy and abusive interactions with varying exchanges of emotional, physical and sexual violence. It involves words and actions that misuse power and authority, hurt people, and cause pain, fear or harm.

**How healthy is your relationship with your current/ex partner?**

Place an X on the point on the line that most closely reflects how you feel. (The X can slide along the scale)

Negative  
abuse

Positive  
healthy

Unhealthy

**Tool 4.2. Motivational interviewing tool**

Women may be anywhere along a spectrum of how they feel about their partner or ex-partner. Some may have left the relationship, with or without recognising that their partner's behaviour was abusive. Other women may continue in relationships that are unhealthy or abusive. It is most likely that fear of their partner will have affected their emotional health, although some will not see that connection.

**Example of written tool for motivational interviewing**

This is a tool you can use with your patient.

**GP:** Taking action is often challenging for people. Below is a set of steps for examining your current situation to decide on what action you might like to take and then how motivated and confident you feel at the moment about carrying out that action.

<b>Step 1</b>	What do you like about your relationship or current situation?
<b>Step 2</b>	What are the things you don't like about your relationship or current situation?
<b>Step 3</b>	[Summarise – GPs understanding of the woman's pros and cons]
<b>Step 4</b>	Where does this leave you now?
<b>For women who are ready to change to some extent:</b>	
<b>Step 5</b>	

For Steps 1 and 2, you may like to ask your patient to use the box below to write down her responses.

	Like	Dislike
<b>Relationship</b>		
<b>Action (Specify)</b>		

For step 5, women may choose a whole range of actions and we have listed some likely options below:

- Feel better about themselves eg do more exercise, take up yoga
- Manage finances better
- Become less isolated eg go to social group activity
- Have better parenting strategies with their children
- Improve their physical health eg. cut down on alcohol
- Leave their partner
- Get more understanding/affection from their partner
- Get their partner to go to anger management classes
- Get their partner to stop drinking/get a job/stop gambling.

These last three are obviously out of the woman's control as it involves influencing their partner's behaviour. Acknowledging this difficulty is important. Next, you may ask your patient how motivated they are to carry out the actions they have suggested and what they feel they need in order to carry them out. How motivated do you feel to carry out .....?



You can ask your patient to place an X on the point on the line that most closely reflects how you feel.

Not at all  
motivated

100%  
motivated

What would have to happen for your motivation score to increase? How confident do you feel that you would succeed in carrying out...? Place an X on the point on the line that most closely reflects how you feel.

Not at all  
confident

100%  
confident

How can I help to increase your confidence?

A decision–balance matrix is also a constructive tool to explore a patient’s ambivalence about her partner and the relationship.<sup>19</sup> Emphasise that the reasons entered in the boxes should be her own reasons, not what someone else has told her.

Consider both the emotional and cognitive dimensions when exploring a ‘decision balance’. On an intellectual level, the woman may have a clear understanding of her circumstances and may acknowledge that she should leave. However, the fear associated with leaving the relationship and coping alone may be incredibly strong, and she may feel emotionally ill-equipped for the enormous physical and emotional effort involved in making the changes.

Fear and the sense of powerlessness engendered by IPAV can be prevailing deterrents for victims/ survivors trying to move forward and away from abusive partners. Regaining confidence and emotional strength is often a gradual process, so that even small advances are initially viewed as real hurdles. Be aware that moving out of an abusive relationship may take quite some time, sometimes years. A woman’s GP or other healthcare professionals can be important sources of ongoing support and strength, if they are non-judgemental of the rate of change and supportive of the decisions and choices the victim/survivor makes along the way.

Useful interventions include:

- affirming the abuse is occurring – that is, believing the patient
- assessing the risk to safety of the patient and any children
- assessing the level and quality of social support available
- documenting the abuse • educating the patient about abuse, the cycle of violence and how it affects health
- exploring options
- discussing a safety plan
- knowing resources for domestic violence support agencies
- making appropriate referrals.

### What finally prompts women to move from precontemplation to action (eg take legal action, leave or change)?

Most victims/survivors have to begin to reject their own reasons for staying in the relationship. The abused woman needs to stop believing that violence is normal. This may be a greater problem with women whose own parents have been violent. In order to be able to leave or take legal action a woman needs to:

- stop excusing her partner of being sick, mentally ill, alcoholic, unemployed or under great stress
- stop blaming herself, and stop believing she is bad, provocative or responsible for the violence
- stop believing and hoping that if she is good her partner will not abuse her
- stop pretending that nothing is wrong, and hiding or minimising her injuries
- stop believing her children would be disadvantaged if she and they were to leave
- stop believing that her partner will change
- start believing that there are other options.

Often something happens to tip the scales in favour of taking action. This may be triggered by a specific event or just an accumulation of experiences.

Common reasons given for reaching a turning point include:<sup>32</sup>

- protecting others (eg children) from the abuse and the abuser. It may be that the perpetrator has started to hit the children. Many women in abusive home situations tolerate the violence 'for the sake of the children', but when the children too are subjected to it, this can be the catalyst for change
- increased severity or humiliation with abuse. The abuse may have escalated to a 'new' level. It may be that the first incidence or a more serious episode of physical abuse has occurred, causing injury, or a serious threat has been made which leads to a change in the woman's sense of her and her family's personal safety if she does nothing
- increased awareness of options and access to support and resources
- fatigue or recognition that the abuser is not going to change
- partner betrayal or infidelity.

Common 'change talk' statements when a women has reached a turning point may relate to desire to change ('I would like to ...'), ability ('I can ...', 'I might be able to ...'), reasons ('I would probably feel better if I ...', 'I've had enough'), need ('I ought to ...', 'I really should ...'), commitment ('I am going to', 'Something has got to change') and taking steps ('This week I started to ...').

## Action planning

It is important that the GP is aware of local and other resources the patient may have within their own social network and family. It is good to clarify:

- What is it that the patient wants to do? Is this realistic and possible? The patient may need to explore alternative options.
- How does she intend to go about it? Assess current level of risk and discuss a safety plan.

- What role does she want you to play? Consider the legal issues (eg documenting injury and impact and referrals to IPAV counselling and services).

The GP has a role when the patient has decided to act and taken some initial steps. Non-directive problem-solving techniques can help at this time (refer to Tool 4.3).

### **Tool 4.3. Non-directive problem-solving/goal-setting tool**

Non-directive problem solving assists individuals to use their own skills and resources to function better. For women who have decided that the abuse is damaging to their health and wellbeing, but whose intentions are not translated into action due to perceived external barriers, then problem-solving techniques may be helpful.

Remembering of course that as GPs we should not problem-solve for the patient.

Goal setting occurs in the following stages:

- clarification and definition of problems
- choice of achievable goals
- generation of solutions
- implementation of preferred solutions
- evaluation.

When used by GPs, this technique engages the patient as an active partner in their care. It creates a framework for individuals to re-focus on practical approaches to perceived problems and learn new cognitive skills.

Whether the solution chosen by the patient is successful is not as important as what the patient learns during the process to apply in other situations. A written example of how a structured approach to problem solving can be applied with an individual is detailed on the next page.

#### **Example of written plan for goal setting**

Non-directive problem solving aims to help you:

- recognise the difficulties that contribute to you feeling overwhelmed
- become aware of the support you have, your personal strengths and how you coped with similar problems in the past
- learn an approach to deal with current difficulties and feel more in control
- deal more effectively with problems in the future.

You are asked to follow six steps:

#### **Step 1**

Identify the issues/problems that are worrying or distressing you.

#### **Step 2**

Work out what options are available to deal with the problem.

#### **Step 3**

List the advantages and disadvantages of each option, taking into account the resources available to you.

Problem	Options	Advantages	Disadvantages
<b>Step 4</b>			
Identify the best option(s) to deal with the problem.			
<b>Step 5</b>			
List the steps required for this option(s) to be carried out.			
<b>Step 6</b>			
Carry out the best option and check its effectiveness.			
Best option = -----			
What steps are required to do this?			
1.-----			
2.-----			
3.-----			

Understanding and discussing her plan is helpful. Actions may include:

- talking to family and friends
- changing the locks on the house
- going to see a counsellor
- talking to someone at a refuge or shelter
- leaving the relationship
- taking out an intervention order
- reporting the abuse to the police.

Maintaining change is often extremely difficult. Most of the time it does not become apparent what change actually means until it has been achieved. For example, if a woman leaves and finds it emotionally more difficult to be on her own than to deal with violence, she is likely to return. If, through leaving, she has been denied access to her children, she may also feel compelled to return.

Providing ongoing support and assistance is vital.

There are many reasons why people return to violent situations, but enjoyment of the violence is not one of them. It may be that several attempts to leave are made before long-term success is achieved. While it may seem that the patient is making an unwise choice, it is more productive to get a better understanding of why the patient chooses to stay. There may be very compelling reasons why the victim/survivor believes they cannot leave. Making judgements about the merit of the decision is rarely useful and may alienate the victim/survivor. It is useful for GPs to understand the circumstances that have led to the decision and what the woman wants.

### What happens to women after they leave?

Some women receive help from family and friends. Women's shelters or refuges are available, although this support may be limited depending on location and whether a bed is available. In the situation of a patient leaving her partner, it may be at this point that you lose contact with the patient. The patient may move to safety at a friend or relative's home, a refuge or out of the area, and there may be extremely good reasons why a victim/survivor needs to sever links with her GP.

Problems experienced by women once they leave an abusive partnership include:

- risk of further abuse
- financial – many women experience a dramatic fall in living standard (eg they have to claim the Supporting Parent's Benefit)
- loneliness – the need for companionship and a sense of belonging is important to most women
- the need to rebuild their lives and those of their children.

Many women re-partner, but the longer a woman stays in an abusive relationship, the harder it becomes to leave and re-establish a normal life. Some women carry the scars of physical, sexual and emotional abuse into the future. Anecdotally, around 50% of women who leave a relationship will return to that relationship at some point. Some may enter another abusive relationship. Few will recover totally from the experience.

Beyond first-line and ongoing patient-centred support, advocacy by healthcare providers<sup>29</sup> with additional training or by specialist family violence services appears to be beneficial for some women. Advocacy involves providing women with information and psychological support to help them further access community resources, including justice response (eg linking victims/survivors with legal, police, housing and financial services). Trials of advocacy<sup>34</sup> or support interventions for women who have sought help from shelters report some reduction in violence and possible improvement in mental health outcomes.<sup>35</sup>

### Facilitating referrals

Many women do not follow through with GP referrals. There are some things you can do to make it more likely that a woman seeks the help you have recommended. If she accepts a referral, here are some things you can do to make it easier for her:

- Offer to call to make an appointment for her if this would be of help (eg if she doesn't have a phone or a safe place to make a call).
- Provide her with the written information she needs (eg time, location, how to get there, name of the person she will see).
- Tell her about the service and what she can expect from it.

If she expresses problems with going to a referral for any reason, help her to decide using non-directive problem-solving techniques. Barriers may include childcare, transport and fear that the partner may find out. Always check to see if she has questions or concerns, and to be sure she has understood.

## Whole-of-practice system support

The World Health Organization has outlined what factors need to be in place to support practitioners in their clinical work.<sup>36</sup> In addition to women- or patient-centred care, a whole-of-system response<sup>37</sup> involves promoting at the healthcare provider level:

- a culture of gender equitable attitudes
- trauma-informed principles (respect, privacy, confidentiality, safety)
- a context of sufficient time allowed in consultations
- a supportive environment, with leaflets and posters
- an awareness about protocols and referrals.

At the practice level there needs to be:

- coordination of internal and external referrals
- protocols
- workforce support and mentoring
- appointment of champions
- advocacy for finances allocated to services for family violence
- leadership and governance, demonstrated by policies
- appropriate design of spaces to ensure privacy
- data information systems for evaluation.

The importance of workplace support is highlighted by a systematic review of 47 qualitative studies of how health practitioners are enabled to address IPAV.<sup>38</sup> Practitioners who collaborated within a team and worked within a health organisational system that was supportive were more likely to want to participate in identifying and responding to IPAV.<sup>38</sup> Two other elements that were important were that they had tried a patient-centred approach and received positive feedback from patients, resulting in them trusting that the healthcare setting was a place to address IPAV.

Finally, the review showed increased engagement among providers who have a personal commitment to addressing IPAV, either because of their personal experience or because of their human or child rights or feminist lens, areas which are not often addressed in training. Many healthcare professionals will have experienced IPAV, and support should include training for the leadership team in the primary care setting. While professionals often erroneously are not considered to be traumatised themselves, and while they benefit from this in appearing well-adjusted, it also denies an important part of their experience that can enhance their practice if used carefully.<sup>39,40</sup> A 2019 study showed that providers with a personal experience of IPAV are more likely to attend training and provide more effective care for victims/survivors.<sup>41</sup>

Supervision and reflective practice are useful when doing this challenging work; questions that providers may wish to consider as part of regular reflective practice and to enhance trauma-informed approaches to IPAV (refer to Tool 4.1).<sup>42</sup>

#### Tool 4.4. Practitioner reflective questions<sup>42</sup>

'What kinds of power and privilege do I have? How do these shape my life and world view?'

'Have I considered how experiencing trauma and violence may have contributed to the development of the presenting complaint or reason for referral?'

'How do his coercive and controlling behaviours constrict her and her children's lives and her ability to do what she wants to do, including ability to engage in any mental healthcare plans?'

'What do I know about what safety strategies she previously tried, how these worked, if services were helpful, her partner's reactions, and what, if any, access she has to financial, family, social and cultural supports?'

'Are she and her family experiencing systemic barriers (eg lack of stable housing, limited access to money and transport, poverty, language barriers and dismissive racist responses from services)? How is this impacting her, her children and family's safety and wellbeing?'

'Who is working with her partner? What strategies are in place to support him and address his use of violence?'

'Comprehending all of this, what actions can I take as a 'safety ally', as part of my treatment plan?'

'How and with whom will I review whether what we are doing is supporting safety for her, the children and her family?'

Adapted from: Short J, Cram F, Roguski M, et al. Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context. *Int J Mental Health Nurs* 2019;28:1209–19.

## Resources

Please refer to [Resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources) for state and national information.

- [Acquired brain injury and family violence \(https://www.braininjuryaustralia.org.au/wp-content/uploads/acquired-brain-injury-and-family-violence.pdf\)](https://www.braininjuryaustralia.org.au/wp-content/uploads/acquired-brain-injury-and-family-violence.pdf) – a resource from Brain Injury Australia,



Vic

- [When she talks to you about the violence \(http://itstimetotalk.net.au/gp-toolkit\)](http://itstimetotalk.net.au/gp-toolkit) – a toolkit for GPs on domestic violence, Women’s Legal Service NSW.
- [Supporting patients experiencing family violence \(https://ama.com.au/article/ama-family-violence-resource\)](https://ama.com.au/article/ama-family-violence-resource) – a resource from the Australian Medical Association (AMA), 2015.
- [When she talks to you about the violence \(https://vimeo.com/105645549\)](https://vimeo.com/105645549) – a video resource developed by AMA NSW, 2014.

## References

1. Hameed M, O’Doherty L, Gilchrist G, et al. Psychological therapies for women who experience intimate partner violence. *Cochrane Database Syst Rev* 2020;CD013017.
2. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
3. Tarzia L, Bohren M, Cameron J, et al. Women’s experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339.
4. Neighbors C, Walker D, Roffman R, et al. Self-determination theory and motivational interviewing: Complementary models to elicit voluntary engagement by partner-abusive men. *Am J Fam Ther* 2008;38:126–36.
5. Rollnick S, Miller W, Butler C. *Motivational interviewing in health care*. New York: Guilford Press, 2008.
6. Arkowitz H, Westra H. Introduction to the special series on motivational interviewing and psychotherapy. *J Clin Psychol* 2009;65:1149–55.
7. Miller W, Rose G. Towards a theory of motivational interviewing. *Am Psychol* 2009;64:527–37.
8. Zalmanowitz SJ, Babins-Wagner R, Rodger S, et al. The association of readiness to change and motivational interviewing with treatment outcomes in males involved in domestic violence group therapy. *J Interpers Violence* 2013;28:956–74.
9. Sheehan KA, Thakor S, Stewart DE. Turning points for perpetrators of intimate partner violence. *Trauma Violence Abuse* 2012;13:30–40.
10. Schragger JD, Smith LS, Heron SL, et al. Does stage of change predict improved intimate partner violence outcomes following an emergency department intervention? *Acad Emerg Med* 2013;20:169–77.
11. Kistenmacher BR, Weiss RL. Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence Vict* 2008;23:558–70.
12. Johnson NL, Johnson DM. Correlates of readiness to change in victims of intimate partner violence. *J Aggress Maltreat Trauma* 2013;22:127–44.
13. Jewkes R. Intimate partner violence: The end of routine screening. *Lancet* 2013;382:190–91.
14. Frasier PY, Slatt L, Kowlowitz V, et al. Using the stages of change model to counsel victims of intimate partner violence. *Patient Educ Couns* 2001;43:211–17.
15. Chang JC, Dado D, Ashton S, et al. Understanding behavior change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. *Patient Educ Couns* 2006;62:330–39.
16. Chang JC, Cluss PA, Ranieri L, et al. Health care interventions for intimate partner violence: What women want. *Womens Health Issues* 2005;15:21–30.
17. Burke J, Denison J, Gielen A, et al. Ending intimate partner violence: An application of the transtheoretical model. *Am J Health Behav* 2004;28:122–33.
18. Stewart D, Chandra P. WPA International Competency-Based Curriculum for Mental Health Providers on Intimate Partner Violence and Sexual Violence Against Women. *World Psychiatry* 2017;16:223.
19. Apodaca T, Longabaugh R. Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction* 2009;104:705–15.
20. Taft A, O’Doherty L, Hegarty K, et al. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev* 2013;CD007007.

21. Burke J, Mahoney P, Gielen A, et al. Defining appropriate stages of change for intimate partner violence survivors. *Violence Vict* 2009;24:36–51.
22. Alexander P, Tracy A, Radek M, et al. Predicting stages of change in battered women. *J Interpers Violence* 2009;24:1652–72.
23. Burkitt K, Larkin G. The transtheoretical model in intimate partner violence victimization: Stage changes over time. *Violence Vict* 2008;23:411–31.
24. West R. Time for a change: Putting the Transtheoretical (Stages of Change) Model to rest. *Addiction*;100:1036–39.
25. Klevens J, Kee R, Trick W, et al. Effect of screening for partner violence on women's quality of life: A randomized controlled trial. *JAMA* 2012;308:681–89.
26. Kiely M, El-Mohandes A, El-Khorazaty M, et al. An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. *Obstet Gynecol* 2010;115:273–83.
27. Musser PH, Murphy CM. Motivational interviewing with perpetrators of intimate partner abuse. *J Clin Psychol* 2009;65:1218–31.
28. Tetterton S, Farnsworth E. Older women and intimate partner violence: Effective interventions. *J Interpers Violence* 2011;26:2929–42.
29. Tiwari A, Leung WC, Leung TW, et al. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG* 2005;112:1249–56.
30. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Women & Health* 2012;52:587–605.
31. Feder G, Hutson M, Ramsay J, et al. Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Arch Intern Med* 2006;166:22–37.
32. Chang JC, Dado D, Hawker L, et al. Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change. *J Womens Health* 2010;19:251–59.
33. Battaglia TA, Finley E, Liebschutz JM. Survivors of intimate partner violence speak out. *J Gen Intern Med* 2003;18:617–23.
34. Ramsay J, Carter Y, Davidson L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev* 2009:CD005043.
35. McFarlane J, Malecha A, Gist J, et al. An intervention to increase safety behaviors of abused women: Results of a randomized clinical trial. *Nurs Res* 2002;51:347–54.
36. World Health Organization. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. Geneva: WHO, 2017.
37. Garcia-Moreno C, Hegarty K, d'Oliveira A, et al. The health systems response to violence against women. *Lancet* 2014;385:1567–79.
38. Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067.
39. Sweeney A, Filson B, Kennedy A, et al. A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Adv* 2018;24:319–33.
40. McLindon E, Humphreys C, Hegarty K. 'It happens to clinicians too': An Australian prevalence study of intimate partner and family violence against health professionals. *BMC Womens Health* 2018;18:113.
41. McLindon E, Humphreys C, Hegarty K. Is a clinician's personal history of domestic violence associated with their clinical care of patients: A cross-sectional study. *BMJ Open* 2019;9:e029276.
42. Short J, Cram F, Roguski M, et al. Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context. *Int J Mental Health Nurs* 2019;28:1209–19.

# Working with men who use intimate partner abuse and violence

'Men's use of IPAV is a serious health issue for the entire family. It impacts the woman, any children in the family, and the man himself.'

## Key messages

- Both men and women may experience or use abuse in adult intimate relationships; however, men use abuse more frequently and severely.
- Men who use intimate partner abuse/violence (IPAV) are not a homogenous group; they come from all socioeconomic, cultural and social groups.
- It is not recommended for one health practitioner to counsel both a woman who is experiencing abuse and her male partner who uses abuse.

## Recommendations

Consider asking men who are experiencing substance misuse and mental health concerns about possible use of IPAV.

**(Practice Point: Consensus of Experts)**

Men's behavioural change programs are the referral options of choice for men who use IPAV.

**(Conditional Recommendation: Low Certainty of Evidence)**

Any psychological therapies should be delivered by people who are experienced IPAV, and should have a trauma-informed focus.

**(Practice point: Consensus of Experts)**

## Clinical context

This chapter discusses working with men who use IPAV, including identification, safety and management. See other chapters for information about [identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety), [safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety), and [ongoing support and management \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) for women who experience IPAV.

Note that this chapter focuses on men's use of IPAV in heterosexual adult intimate relationships. For details about IPAV in same-sex relationships, see the chapter on [LGBTIQ+ family abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence).

## Prevalence

Self-report questionnaires used to identify men who use IPAV<sup>1</sup> often lead to issues of under-reporting. The most consistent figures for prevalence come from reports by women who experience IPAV. These figures place prevalence rates of use of IPAV in Australia at 20–25% of the general population.<sup>2,3</sup>

While both men and women use IPAV in relationships, men use IPAV more frequently and severely, so that women who experience IPAV are more likely to fear for their lives.<sup>4</sup>

Men's use of IPAV is a serious health issue for the entire family. It impacts the woman,<sup>2</sup> any children in the family,<sup>5</sup> and the man himself.<sup>6</sup>

## Which men use intimate partner abuse?

There are no distinguishing characteristics of a man who uses or is likely to use IPAV: men who use IPAV come from all socioeconomic, cultural and religious backgrounds.

GPs need to be aware that individuals who use IPAV tend to minimise responsibility for their use of IPAV, blame their partner or other issues, and greatly under-report their use of IPAV. They generally have developed ways of convincing themselves and others that they aren't responsible for their use of IPAV and often invite GPs and other practitioners to collude with those attitudes and beliefs.

Nevertheless, GPs have a unique opportunity to identify their male patients who use or are at risk of using IPAV and provide appropriate support and care.<sup>7,8</sup>

## Why do men use intimate partner abuse?

To understand why particular men use IPAV, it is important to understand that there are larger community and societal issues – norms and expectations – that create a complex framework in which men operate. Men may use physical, sexual, emotional, social, financial and other forms of violence to maintain their power and control in adult intimate relationships. This is often based on societal acceptance of male dominance, stereotyping of gender roles, linking masculinity to dominance and acceptance of violence to resolve conflict. These are all attitudes that are associated with IPAV.<sup>9</sup>

While gender-based power and control is an underlying factor in men's use of IPAV, other factors are involved. Men who use IPAV are more likely to come from families where their father used IPAV, where they experienced child abuse or where they had an absent or rejecting father. However, some men who use IPAV report well-adjusted childhoods and peaceful family-of-origin environments.<sup>5</sup>

Other factors that have been linked to IPAV are psychiatric disorders and substance abuse<sup>10-12</sup> and these have also been correlated with more significant risk of injury to women partners experiencing IPAV.<sup>13,14</sup> Poverty, unemployment and associating with delinquent peers in the community are also risk factors for use of IPAV. Individual, relationship, community and societal factors all play a part in shaping men's use of IPAV,<sup>15</sup> so it is important for GPs to view a clinical intervention as only one tool in a wider response. Legislation, policing, social sanctions and community attitudes are also critical to ending the man's violence.<sup>16,17</sup>

It is extremely important to qualify that while some of the factors outlined above and in Box 5.1 may be risk factors for IPAV, they are not causal. The majority of men who use IPAV are neither mentally ill nor substance abusers. Profiling the characteristics of men who use IPAV is an emerging field of research.

### Box 5.1. Risk factors associated with use of IPAV (these are not causal)

- Attitude that supports violence towards women
- Mental health problems
- Drugs or alcohol misuse
- Stressful events
- Recent separation
- History of abusive and violent behaviours
- Adverse childhood experiences (eg child abuse and neglect)

## In practice

### The role of GPs

GPs, unlike other healthcare providers, focus on the care of all family members. Therefore, GPs may come into contact with:

- individuals who experience IPAV
- individuals who use IPAV
- children who witness and/or experience abuse and violence
- young people who use violence in the home.

Research shows that men who use IPAV present to general practice for healthcare needs more often than men who do not use IPAV.<sup>18</sup> This can be for a range of issues including injuries, anxiety or depression.

Although men who use IPAV are often reluctant to seek help or disclose their behaviours, it is still necessary for GPs to ask about any potentially abusive behaviour.<sup>19</sup> Indeed, GPs were viewed as the next most likely source of support for men who use IPAV, after friends and family. Men viewed GPs as a trustworthy source of help due to the reassurance that any disclosed information would remain confidential.<sup>19</sup> A caveat to this confidentiality is if there is a risk to the safety of the (ex) partner and/or children. If there is a risk of safety to the (ex) partner, the man's confidentiality can be breached if the GP believes this will increase the safety of the (ex) partner; with children this is covered by [mandatory reporting \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect). The known facilitators of help-seeking include a trusting patient–doctor relationship, the appropriate timing of questions about use of IPAV, and a non-judgemental attitude by the GP.<sup>20</sup>

It is not recommended for one GP to provide care to both the woman partner who experiences IPAV and the male partner who uses it.<sup>17</sup> This can be managed by referral to another GP within the practice or by referral to another agency. Doctors in rural areas may find this particularly difficult and may need to refer patients to services in neighbouring towns.

Separate GPs are recommended to protect the woman's safety and confidentiality. It is possible that a GP might inadvertently reveal information provided by a woman experiencing IPAV to her partner. Many men who use IPAV are extremely alert and attuned to what they think their partner is telling other people. If the GP 'lets something slip', even subtly, about the partner who is experiencing IPAV, the man may 'punish' the woman – assault her – for daring to discuss this with someone.

## Identification

Although men who use IPAV need help to address their use of it, these men are often reluctant or unwilling to disclose.<sup>8</sup>

Use of IPAV is linked with increased rates of alcohol and substance misuse, mental health concerns and use of health services.<sup>11,18</sup> While not all men with these factors will use IPAV, GPs need to be aware of the possibility of IPAV use among men who present with these concerns.

Again, although use of IPAV is linked with mental illness and substance misuse, it is important to not over-pathologise men who use IPAV. Abandoning generalisations and negative attitudes, along with being open to providing non-judgmental support to men who use IPAV, is important in providing successful treatment.<sup>20</sup>

Broaching the subject of IPAV with men may be difficult for several reasons, including:

- trouble viewing the patient as someone who uses violence or abuse

- concern about damaging the patient–doctor relationship for ongoing care
- the practitioner feeling at risk from the man if they raise the topic
- concerns that broaching the subject will add extra stress to the relationship
- not wishing to invade the man’s privacy
- the need to manage confidentiality and privacy issues when managing an entire [21,22](#)

Remember, addressing the issue may help reduce the risk for other family members, but it may also increase the risk, so great care is needed when raising this subject.<sup>[17](#)</sup> Broaching the subject of IPAV with men is possible with the use of funnelling questions (refer to Figure 5.1).<sup>[17](#)</sup> This requires starting with a broad subject and becoming more specific. The efficacy of these queries is increased if you ask the questions in a caring, rather than accusatory, tone. Initial questions may include:<sup>[23](#)</sup>

- How are things at home?
- Have you or your partner ever been injured?

Then, after you have established some trust, you may wish to move onto more specific questions, such as:

- When you feel angry, what do you do?
- Do you think she is ever scared or frightened of you?
- Do you do things that you later regret?
- How do your children react when you get angry?
- If there was a fly on the wall in your home, when you feel angry, what would that fly be seeing about your behaviour?



Figure 5.1. Funnelling questions to identify men who may use abuse and violence in intimate relationships<sup>17</sup>

Reproduced with permission from: Hegarty K, Forsdike-Young K, Tarzia L, Schweitzer R, Vlasis R. Identifying and responding to men who use violence in their intimate relationships. *Aust Fam Physician* 2016;45(4):176–81.

## Management

Immediate safety of the partner and any children who may have experienced and/or witnessed IPAV is the first priority when a man is identified to have used IPAV. Management objectives also include:

- taking a history – especially suicidality, substance misuse, mental health and access to weapons
- reinforcing that abuse and violence are not okay – condemn the actions, not the person
- encouraging ownership of the behaviour – help the man who uses IPAV to take responsibility for his behaviour
- encouraging active change.



## Emotional regulations

Men do not use IPAV only when they are angry. They might be feeling a range of emotions when they use IPAV. Many men use IPAV when they are calm – controlling tactics used to restrict the woman's life and to instil fear. Most men who use IPAV choose not to use IPAV in other settings even if they feel anger, such as in the workplace, in a major shopping centre or if the police are present. Many men will try to direct the conversation back to blaming their partner:

'You don't live with her; she keeps screaming at me and is hopeless with the finances ...'

It is important not to allow the man who uses IPAV to rehearse his violence-supporting narratives like this for too long, and to assertively yet calmly bring the attention back to him. Some simple questions to ask the man regarding this include:

'How would your reaction have been different if the police had been present?' 'If you were about to yell at her, how would your response change if the doorbell rang?'

## Treatment and support

In Australia, Men's Behaviour Change Programs (MBCPs), rather than anger-management programs, are the preferred referral option for men who use IPAV.<sup>24</sup> MBCPs have been shown to have positive effects,<sup>25,26</sup> helping some, but not all men, to stop using IPAV.

For some men, these programs work well to reduce or even stop their use of IPAV. For others, the programs produce mixed results, such as benefits that do not sustain over time, or a man stops using some forms of IPAV but not others. For other individuals, these programs produce little discernible benefit.<sup>24,27</sup>

In healthcare settings, interventions to target IPAV use (including cognitive behavioural therapy and motivational interviewing-based interventions) that are combined with alcohol treatment show some promise.<sup>28</sup>

Referral should be to an MBCP delivered by an accredited agency, which may have a drug/alcohol rehabilitation program and/or a mental health specialist. Such agencies will also contact and provide support for the woman (refer to [Resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources)).

MBCPs are the referral option of choice even for men with substance misuse or mental health concerns. MBCPs include a thorough assessment and can work with, or refer men to, accompanying substance misuse or mental health services. If the substance misuse or mental health concerns are urgent, or if the man is not ready to accept a referral to an MBCP, then a referral to a drug/alcohol rehabilitation or mental health service is certainly better than no referral at all.

### Telephone services

Most states have a [telephone information, referral and counselling service for men who use IPAV \(http://ntv.org.au\)](http://ntv.org.au).

Men who do not appear ready to attend an MBCP might be more comfortable taking the initial step of calling such a service. The service will then attempt to motivate them to attend a program.

GPs can also phone any of these services for information about local MBCP referral options.

### Providing ongoing support

Referring men who use IPAV to an MBCP is not the end of the GP's involvement. Supporting the man's change and monitoring the safety of the family is an important and ongoing task. It is also very important to do the best possible to ensure that the woman receives counselling and support from a specialist family violence service, remembering that the same GP should not be the GP for both partners. Indeed, this should be the first priority – that the woman is receiving specialist family violence services. Permission should be asked from the man to allow the sharing of this information.

The importance of this ongoing care is underscored by the fact that MBCPs have a low success rate.

### Couples or family counselling

Referral for couple or family counselling is not appropriate until the man has ceased using violent and abusive behaviours.<sup>29</sup> Couple therapy requires people to open up and disclose important thoughts. If the woman does this while her partner is still being abusive, it may put her at increased risk. Alternatively, she may be forced to lie to protect her safety.

## Case study: Gabby and Nick

Nick is a patient of the practice and he comes to see the GP saying he has some issues with anger. When asked about his home circumstances he tells the GP he is married to Gabby and they have a small child, Jane who is 10 months.

The GP asks about how things are at home and at work. He is not very forthcoming with his answers. The GP wonders what is happening with this family and if Nick is using abuse or violence.

The GP asks about his 'problems with anger' and Nick says he is not very happy with things at home and sometimes gets upset.

After some more questions about how things are at home, Nick is asked: 'Do you think Gabby is ever scared or frightened of you?' After some thought Nick says Gabby is very disorganised and this upsets him. The GP notices that Nick has not answered the question and has shifted responsibility onto Gabby. The GP decides not to press Nick further yet.

The GP asks can you tell me more about this? Nick talks about how things are different since Jane was born. Nick says that Gabby has been paying less attention to him and is not keeping up with the housework "despite being at home all of the time". The GP asks 'are you reacting to this by becoming angry?' 'Maybe' says Nick.

The GP notices that Nick has limited understanding of the workload of being a stay at home parent with a small baby. The GP recognises that supporting Nick to build his understanding and insight about Gabby's workload will take time.

The GP now thinks Nick may be abusive towards Gabby and Jane and wonders about his actions and how they might be impacting the family.

The GP again asks 'Do you think Gabby is ever scared or frightened of you when you get angry?'

Nick thinks about this and admits that Gabby may in fact be scared of him, and says that he has never thought of this before.

Nick is then asked: 'What do you think of Gabby being scared of you?' After some thought, Nick looks upset, and admits that he is not happy with Gabby being scared of him but that her behaviour has driven him to this.

The GP notices again that Nick is trying to shift responsibility for his actions onto Gabby and is clear that Nick's behaviour is Nick's responsibility.

The GP and Nick talk about how Nick can keep his family safe in the next week. Nick agrees to review the [No to Violence \(https://ntv.org.au/get-help/\)](https://ntv.org.au/get-help/) website and leave the house if he is becoming angry.

The GP recognises that this is a long-term problem and makes another appointment with Nick in a week.

During the next week, the GP considers how they might help Nick. The GP reads the chapter in the RACGP White Book – '[Working with men who use intimate partner abuse and violence](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse/)' (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse/>).

The GP also looks at the Health Pathways about Perpetrators for local information.

The GP considers seeking a secondary consult with Men's Referral Service 1300 766 491.

The GP feels better prepared for the next appointment with Nick. The GP understands that Nick is likely to invite the GP to collude by minimising the impact of his behaviour on Gabby and Jane and by shifting responsibility for his actions onto others.

The GP looks for resources to discuss with Nick and finds '[Changing for Good \(https://mensline.org.au/family-violence/changing-for-good/\)](https://mensline.org.au/family-violence/changing-for-good/)' on the Mens Line website.

The GP discusses these suggestions with Nick and they make a plan to keep working on the issues and keeping the family safe

## Resources

- Please also refer to [Resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/provided-under-licence-1\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/provided-under-licence-1) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources>) for services nationally and in your state.
- [Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians \(https://www.latrobe.edu.au/\\_data/assets/pdf\\_file/0008/580265/Management-of-the-whole-family-when-intimate-partner-violence-is-present-guidelines-for-primary-care-physicians.pdf\)](https://www.latrobe.edu.au/_data/assets/pdf_file/0008/580265/Management-of-the-whole-family-when-intimate-partner-violence-is-present-guidelines-for-primary-care-physicians.pdf) – outlines information relating to management of the entire family, Council against Violence, Victorian Government, 2006.
- *Intimate partner abuse and health professionals: New approaches to domestic violence* – book by G Roberts, KL Hegarty, G Feder (eds), Churchill Livingstone Elsevier,

## References

1. Davis M, Padilla-Medina DMJT, Brief intimate partner violence perpetration screening tools: A scoping review. *Trauma Violence Abuse* 2019;1524838019888545.
2. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia: Continuing the national story 2019. Cat. no. FDV 4. Canberra: AIHW, 2019.
3. Australian Bureau of Statistics. Personal safety, Australia. Canberra: ABS, 2017.
4. World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013.
5. Campo M. Children's exposure to domestic and family violence: Key issues and responses. Melbourne: Australian Institute of Family Studies, 2015.
6. Walker DD, Neighbors C, Mbilinyi LF, et al. Evaluating the impact of intimate partner violence on the perpetrator: The Perceived Consequences of Domestic Violence Questionnaire. *J Interpers Violence* 2010;25:1684–98.
7. Hashimoto N, Radcliffe P, Gilchrist G. Help-seeking behaviors for intimate partner violence perpetration by men receiving substance use treatment: A mixed-methods secondary analysis. *J Interpers Violence* 2021;36:3142–67.
8. Morgan K, Williamson E, Hester M, et al. Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role. *Aggression and Violent Behavior* 2014;19:637–42.
9. Stewart DE, MacMillan H, Kimber M. Recognizing and responding to intimate partner violence: An update. *Can J Psychiatry* 2021;66:71–106.
10. Danielson KK, Moffitt TE, Caspi A, et al. Comorbidity between abuse of an adult and DSM-III-R mental disorders: Evidence from an epidemiological study. *Am J Psychiatry* 1998;155:131–33.
11. Humphreys C, Regan L, River D, et al. Domestic violence and substance use: Tackling complexity. *Br J Soc Work* 2005;35:1303–20.
12. Oram S, Trevillion K, Khalifeh H, et al. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. *Epidemiol Psychiatr Sci* 2014;23:361–76.
13. Sharps PW, Campbell J, Campbell D, et al. The role of alcohol use in intimate partner femicide. *Am J Addict* 2001;10:122–35.
14. Thompson MP, Kingree JB. The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. *J Interpers Violence* 2006;21:163–77.

15. Tarzia L. Toward an ecological understanding of intimate partner sexual violence. *J Interpers Violence* 2020;886260519900298.
16. Taft A, Shakespeare J. Managing the whole family when women are abused by intimate partners: Challenges for health professionals. In: *Mother and Child Health Research Centre*. Edinburgh: Churchill Livingstone, 2006.
17. Hegarty K, Forsdike-Young K, Tarzia L, et al. Identifying and responding to men who use violence in their intimate relationships. *Aust Fam Physician* 2016;45:176–81.
18. Coben J, Friedman D. Health care use by perpetrators of domestic violence. *J Emerg Med* 2002;22:313–17.
19. Morgan K, Williamson E, Hester M, et al. Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role. *Aggression and Violent Behavior* 2014;19:637–42.
20. Penti B, Tran H, Timmons J, et al. Physicians' experiences with male patients who perpetrate intimate partner violence. *J Am Board Fam Med* 2017;30:239–47.
21. Taft A, Broom DH, Legge D. General practitioner management of intimate partner abuse and the whole family: Qualitative study. *BMJ* 2004;328:618.
22. Miller D, Jaye C. GPs' perception of their role in the identification and management of family violence. *Fam Pract* 2007;24:95–101.
23. Helfritz LE, Stanford MS, Conklin SM, et al. Usefulness of self-report instruments in assessing men accused of domestic violence. *The Psychological Record* 2006;56:171–80.
24. Mackay E, Gibson A, Lam H, et al. Perpetrator interventions in Australia: Part Two: Perpetrator pathways and mapping. Sydney: Australia's National Research Organisation for Women's Safety, 2015.
25. Arce R, Arias E, Novo M, et al. Are interventions with batterers effective? A meta-analytical review. *Psychosocial Intervention* 2020;29:153–64.
26. Westmarland N, Kelly L. Why extending measurements of 'success' in domestic violence perpetrator programmes matters for social work. *Br J Soc Work* 2013;43:1092–110.
27. Day A, Vlasis R, Chung D, et al. Evaluation readiness, program quality and outcomes in men's behaviour change programs. Research report. Sydney: Australia's National Research Organisation for Women's Safety, 2019.
28. Tarzia L, Forsdike K, Feder G, et al. Interventions in health settings for male perpetrators or victims of intimate partner violence. *Trauma Violence Abuse* 2020;21:123–37.
29. Karakurt G, Whiting K, van Esch C, et al. Couples therapy for intimate partner violence: A systematic review and meta-analysis. *Journal of Marital and Family Therapy* 2016;42:567–83.

# Supporting men who experience intimate partner abuse and violence

'IPAV can happen to men and that they (as victim/ survivor) need to be asked, believed, validated, and their safety and that of their children explored.'

## Key messages

- Health practitioners, including GPs and practice nurses need to ensure they acknowledge and are aware that men may also experience IPA and how they might present to general practice.

## Introduction

Intimate partner abuse and violence (IPAV) is described as a major social and health problem,<sup>1</sup> which encompasses physical, psychological, sexual and financial abuse<sup>2</sup> characterised by a pattern of fear and control.<sup>3</sup> Refer to previous chapters for an [introduction to IPAV \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence), details on [identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse), [safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety), and [ongoing support and management \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) for women who experience IPAV. While both men and women may use IPAV, men use violence more frequently and severely so that females are more likely to fear for their lives, be injured or killed (50 women die due to IPAV per year in Australia).<sup>1</sup>

To date, the primary focus when it comes to IPAV identification and response has been on the safety of women and children.<sup>4</sup> Men who experience IPAV from women partners have not been researched as comprehensively as women who experience IPAV from male partners.<sup>5,6</sup> It is becoming increasingly acknowledged that men's experiences of IPAV remains an important issue of concern for health

professionals, including GPs.<sup>5</sup> While men's experience of IPAV is an under-researched topic,<sup>7</sup> health practitioners, including GPs and practice nurses, need to ensure they acknowledge and are aware that men also experience IPAV and how they might present to general practice.

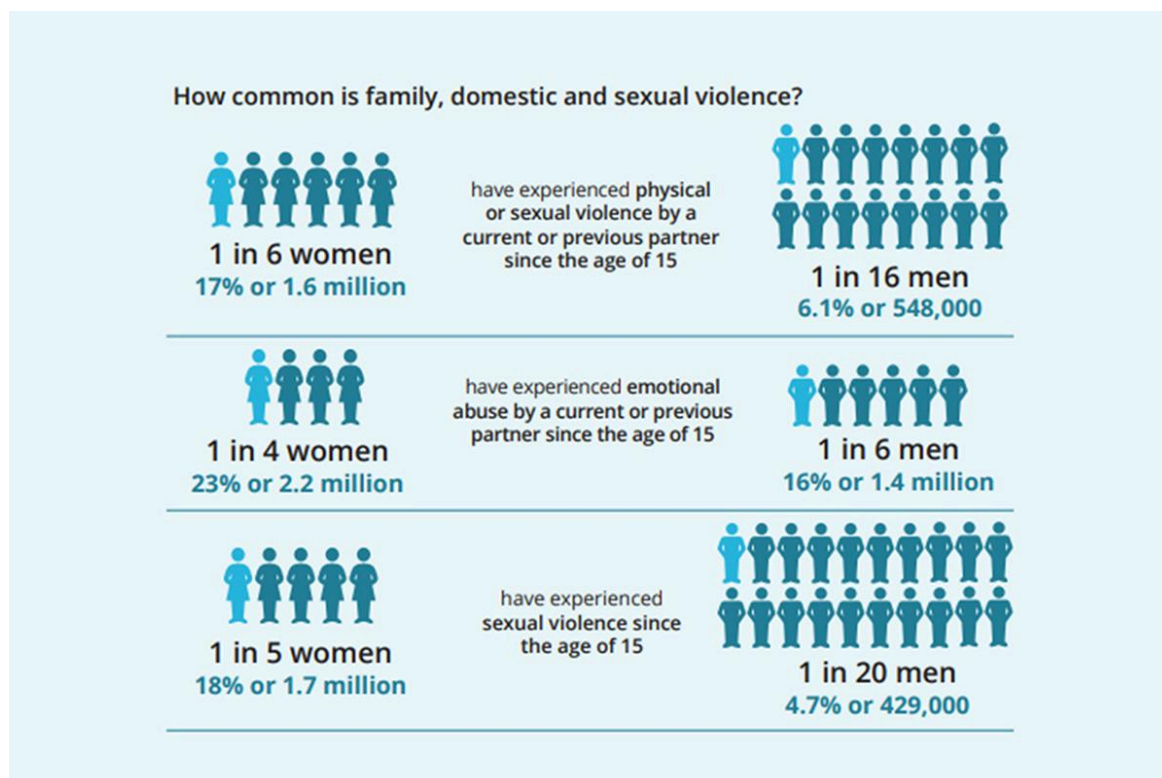


Figure 6.1. Prevalence of lifetime intimate partner abuse<sup>8</sup>

Source: Australian Institute of Health and Welfare.

## Men's experience of intimate partner abuse by women

Men's experience of IPAV by women is a relatively controversial issue. This controversy is due in part to conventional theories that conceptualise IPAV to be the result of patriarchal norms,<sup>9</sup> and the use of IPAV to maintain men's dominance over women within intimate relationships.<sup>10</sup> There have been conflicting findings of IPAV prevalence by women against men, raising questions about the methodologies employed, sampling methods and instruments used to obtain data.<sup>11</sup>

Nevertheless, an Australian-based qualitative study indicated that men reported experience of a range of physical, sexual, verbal, coercive-controlling and manipulative behaviours by their female partners.<sup>6</sup> Some men have reported that they did not retaliate due to fear of being arrested, fear of seeking help, fear of losing custody of their children or because of moral objections to using physical force against women.<sup>12</sup> In terms of the impact of men's experience of IPAV, research<sup>13</sup> has found a negative impact on physical and mental health, development of future relationships, and relationships with their children.

## Male help-seeking behaviour

A 2019 systematic review of 12 qualitative studies explored help-seeking experiences and interactions with support services of men who experience IPAV.<sup>5</sup> This review highlighted that ‘barriers to help-seeking are complex, but fear of disclosure is central, overlapping with the challenge to both men’s personal sense of and societal interpretations of masculinity and the importance of the relationship with the abuser’.<sup>5</sup>

Men were less likely to seek help due to commitment to intimate relationships and keeping the family intact.<sup>12</sup> Furthermore, societal attitudes and perceptions of men as abusers were among barriers to help-seeking or leaving the abusive relationship.<sup>13</sup> While some men who disclosed abuse received support from family and friends, other men reported secondary abusive experiences, with police and other support services responding with ridicule, doubt, indifference and victim/survivor arrest.<sup>6</sup>

The following barriers to help-seeking were identified:<sup>5,14</sup>

- social (traditional gender roles and norms, challenge to masculinity),
- personal (shame, identity impacts) and commitment to relationship
- practical (cost, fit) barriers to support service access
- further victimisation from services
- fear of disclosure and seeking help
- having nowhere to go (lack of services).

While most research studies about male help-seeking behaviour for IPAV have only used qualitative methodologies with a relatively small sample sizes, there are various resources available for men. For example, the Domestic Violence Resource Centre Victoria provides [information about services that may help men who experience IPAV \(https://www.dvrcv.org.au/help-advice/men\)](https://www.dvrcv.org.au/help-advice/men).

## Health professionals working with men who experience IPAV

There are recommendations<sup>15</sup> for the need for health practitioners working with men who experience IPAV to recognise the significance of resistance to men’s help-seeking. Some of the key barriers to help-seeking or leaving the abusive relationship include inappropriate service responses, further victimisation from services, and inappropriate responses from friends and family members.<sup>13</sup> A 2020 Australian study indicated that following disclosure, men who experience IPAV reported secondary abusive experiences, with police and other support services responding with ridicule, doubt, indifference and victim/survivor arrest.<sup>6</sup> Another issue that arises with men who experience IPAV is the fact that many health practitioners are not trained to accept a referral with this gender of ‘victim/survivor’ due to lack of skill set or knowledge.<sup>16</sup>

The first step in dealing with this issue is to acknowledge that IPAV can happen to men and that they (as victim/ survivor) need to be asked, believed, validated, and their safety and that of their children explored.



Some men who use violence (perpetrators) will sometimes present themselves as 'victims'. This is a strategy that [may take time to sort through \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse).

There is a need for more training in managing men who experience IPAV who present to primary health, and more research exploring how the health system can respond in a believing, supportive and healing manner.

## Case study: Peter

Peter, age 35 years, had been married 10 years to Susan. They had two children aged 8 and 4. The relationship had not been good for some time, with Peter doing much of the cooking and housework. Susan was often verbally abusive. Susan was starting to drink more and one evening she hit out at Peter and he put up his arm to defend himself. Susan hit his arm and fell, hurting her arm. She rang the police and went to the hospital and was found to have a fractured wrist. He was accused by the police of being the perpetrator. He went before a magistrate, who listened to his story. The magistrate referred him for an assessment. The assessor saw him and informed the magistrate that in his opinion Peter was not a perpetrator. This was very helpful and supportive to Peter.

By then the relationship had broken down completely and Peter had left the house. The arrangement was that the children would be with Susan during the week and with Peter at the weekend.

The children were neglected and not being cared for or fed. The school reported the children to the children's protection services, but nothing really changed until Susan was caught driving under the influence of alcohol by the police with the children in the car. She was admitted to detox and the children went to live permanently with Peter, to the relief of the extended family.

The children were traumatised and very angry with their mother. They are gradually healing and their schoolwork is improving. They are refusing to go to her house or drive anywhere with her in the car. They are seeing her once a week for one to two hours. They too have been believed, validated and provided with a safe place.

If this family was presenting to the GP, then there would be an opportunity to inquire about the family circumstances and to hear Peter's story and to believe him, validate him, and check on his and the children's safety.

## Resources

Some family violence services will be willing to see men who are victims/survivors – refer to [resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/abuse-and-violence/resources-1/resources\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/abuse-and-violence/resources-1/resources).

---

## References

1. World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013.
2. Krug EG, Mercy JA, Dahlberg LL, et al. The world report on violence and health. *Lancet* 2002;360:1083–88.
3. Stark E. *Coercive control*. New York: Oxford University Press, 2007.
4. Kaura SA, Lohman BJ. Dating violence victimization, relationship satisfaction, mental health problems, and acceptability of violence: A comparison of men and women. *Journal of Family Violence* 2007;22:367–81.
5. Huntley AL, Potter L, Williamson E, et al. Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. *BMJ Open* 2019;9:e021960.
6. Walker A, Lyall K, Silva D, et al. Male victims of female-perpetrated intimate partner violence, help-seeking, and reporting behaviors: A qualitative study. *Psychology of Men & Masculinities* 2019;21:213–23.
7. Chaudhuri T. Patterns of male victimization in intimate relationships: A pilot comparison of academic and media reports. *Journal of Men's Studies* 2012;20:57–72.
8. Australian Institute of Health and Welfare. *Family, domestic and sexual violence in Australia: Continuing the national story 2019*. Cat. no. FDV 3. Canberra: AIHW, 2019.
9. Hines DA, Douglas EM. Women's use of intimate partner violence against men: Prevalence, implications, and consequences. In: *Female offenders of intimate partner violence*. Routledge, 2014:32–46.
10. Hines D, Douglas E. Intimate terrorism by women towards men: Does it exist? *J Aggress Confl Peace Res* 2010;2:36–56.
11. Simmons J, Swahnberg K. Can nonresponse bias and known methodological differences explain the large discrepancies in the reported prevalence rate of violence found in Swedish studies? *PLoS One* 2019;14:e0216451.
12. Lysova A, Hanson K, Dixon L, et al. Internal and external barriers to help seeking: Voices of men who experienced abuse in the intimate relationships. *Int J Offender Ther Comp Criminol* 2020:306624X20919710.
13. Bates EA. 'No one would ever believe me': An exploration of the impact of intimate partner violence victimization on men. *Psychology of Men & Masculinities* 2020;21:497–507.
14. Delle Donne M, DeLuca J, Pleskach P, et al. Barriers to and facilitators of help-seeking behavior among men who experience sexual violence. *Am J Mens Health* 2018;12:189–201.
15. Zverina M, Stam HJ, Babins-Wagner R. Managing victim status in group therapy for men: A discourse analysis. *J Interpers Violence* 2011;26:2834–55.
16. Williamson E, Jones SK, Ferrari G, et al. Health professionals responding to men for safety (HERMES): Feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. *Prim Health Care Res Dev* 2015;16:281–88.

# ***Trauma and violence informed care***

# Trauma-informed care in general practice

'I am a DV survivor, but trauma does not define me. I am much more than that.' **Sanda**, victim/survivor, [The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

## Clinical context

Good quality general practice care is trauma informed. Generalist approaches to whole-person care integrate sensitive awareness of lived experience, relationships and context, with an understanding of the acute and chronic physiological impact of threat. This awareness influences how we interact in the clinical encounter, how we understand the range of human behavioural and relational defences against threat, how we direct our interventions, and how broadly we watch for patterns of threat.

## Defining trauma and abuse for the GP

From the Greek word for 'wound', 'trauma' is defined in the dictionary as 'a deeply distressing or disturbing experience'. In medicine, 'trauma' also implies acute bodily injury, while in psychiatry, for insurance, legal and research purposes the definition is often limited to a verifiably life-threatening event. These definitions have inadvertently prioritised attention to objective physical and life-threatening events (including violence and disaster) in a way that may ignore more subjective processes that 'wound'.

The focus on trauma as an event means that processes that wound humans – such as neglect, betrayal, confusion, loss of identity, ostracism, rejection, and even loss of self-respect and existential meaning – may be ignored. The distinction between trauma as an observable event (eg motor vehicle accident, life-threatening wartime or family violence incident) and trauma as process or experience (a subjective personal process of overwhelm or hopelessness) has fragmented the research and practice of trauma-informed care.

Research in child development, adult attachment, psychophysiology, interpersonal neurobiology, psychoneuroimmunology and physiological stress have firmly established the impact of subjective experience of threat on bodily health.<sup>1,2</sup> Building on the event-based diagnosis of post-traumatic stress disorder (PTSD), which was first described because of the Vietnam War, traumatic processes in the home were named by psychiatrist, Judith Herman.<sup>3</sup> Their lifelong impact on physical and mental health was initially confirmed by population studies conducted by Vincent Felitti and Robert Anda.<sup>4</sup>

People can be traumatised by chronic negative interpersonal processes in their homes, schools or workplaces, and/or by single incidents of assault or accident. Events and experiences can be repetitive or chronic, so both can impact physiology, autonomic arousal and sense of capacity. If an event is interpersonal, it can impact a person's capacity to self-regulate, be soothed and be comfortable with other people.

Trauma has far-reaching impacts on physiology, meaning, relationships, sense of self, affect regulation, somatic awareness, arousal, consciousness, attention, memory and behaviour, which are relevant in general practice.<sup>5</sup> GPs who seek to care for the whole person need to remain aware of all the ways that lived experience impacts physical and mental health – both complex processes and the more easily identified events.

### Trauma as a whole-person legacy

Trauma-informed approaches facilitate a coherent, whole-person framework that understands how social determinants of health, environmental threats (including racism and other forms of injustice) and relationship dynamics are translated into health outcomes, including multimorbidity and medically unexplained symptoms.

Trauma-informed care is not simply being willing to document life events that have been traumatic; it is care that attends to events and experiences of trauma and their sequelae or legacy.<sup>2</sup> Trauma-informed care acknowledges subjective experiences of overwhelm, disconnection or invasion that are wounding and cause complex physiological and intrapersonal dysregulation.<sup>5</sup> Unlike victims/survivors of single-incident trauma – where the threat is external – those who have survived chronic traumatising homes also experience internal threat, including the threat of shame. Complex trauma has been described as not only causing 'hyperarousal and hypervigilance in relation to external danger', but also 'the internal threat of being unable to self-regulate, self-organise, or draw upon relationships to regain self-integrity'.<sup>6</sup>

In a situation where the person is severely overwhelmed, dissociative processes also produce shut-down, or hypo-arousal, which can be easily missed if the GP is not watching for subtle changes in affect, loss of relational connection and loss of coherence of experience.

For the GP, trauma-informed care involves awareness of relationships, development, attachment and physiology, as well as intrapsychic changes to sense of self and meaning.

Safe relationships have a central role in mediating, buffering or repairing<sup>7</sup> the physiological impact and personal meaning of trauma. Some children never experience the restorative experience of feeling safe. Trauma can be defined as a 'violation of an expectancy to be safe with another'<sup>8</sup> or 'repeatedly being left psychologically alone in unbearable emotional pain'.<sup>9</sup> Past negative relationships directly affect the therapeutic alliance – making it both more difficult and more important to offer a restorative, safe relationship with clear boundaries in each clinical encounter. GPs offer a unique opportunity for relational repair as they can offer reliable connection over time, allowing a gradual increase in trust and safe connection.

GPs are also uniquely positioned to attend to the physical element of trauma-informed care. As well as direct injury to the body, chronic impacts of trauma leave a legacy of physiological arousal, changes in autonomic tone and consciousness, stress modulation,<sup>10</sup> and adaptive changes in neural architecture and connectivity.<sup>11-13</sup> As the body attempts to adapt to threat or perceived threat, especially when it is repeated (the process of allostasis),<sup>14</sup> endocrine and cellular dysregulation, known as allostatic

overload,<sup>15</sup> contribute to long-term ill-health.<sup>16</sup> This is directly relevant to understanding somatisation, chronic pain, inflammatory disorders, a range of other physical and mental health impacts, and unexplained symptoms.

Behavioural attempts to cope with being overwhelmed and distressed and to modulate physiological arousal due to trauma include addictions, self-harming, suicidality, obsessions, lifestyle choices (including routines and risk taking), particular romantic and parenting attachment behaviours, and attitudes towards the self. Awareness of the effects of trauma on physiological arousal has influenced the rise of somatosensory and creative approaches to trauma therapy that utilise integration of so-called 'right' and 'left' brain networks.<sup>17</sup>

Rather than seeking to document and define traumatic content, GPs can instead look for patterns that reveal the whole-person biological and biographical legacy of trauma.<sup>1</sup> This allows the GP to identify and better attend to its various complex presentations and implications without getting distracted by its nomenclature. For GPs, recognising these patterns and using them to inform appraisal, therapeutic process, prevention and intervention is more important than documenting causality (a research task) or culpability (a legal task).

## What is happening to me? The legacy of trauma in everyday practice

Seeing trauma as potentially being associated with a complex physical and relational legacy enables the GP to recognise patterns that reveal the signs of wounding or trauma, as well as the strengths of the person experiencing them, including possibilities for recovery.

The trauma-informed framework calls for a move from a pathological approach to the person ('What is wrong with you?') towards an acknowledgement that something has harmed the person ('What happened to you?').<sup>18</sup> This has been an important distinction to make – rather than classifying disorder, this acknowledges that those who are traumatised have normal physiological, relational and intrapersonal responses to abnormal experiences.

For the GP, perhaps an additional empowering and attuned appraisal would be for both GP and patient, when safe and supported enough, to gain an understanding of these normal responses: to be alert to physical responses and ask 'What is happening to me?' in the present. This approach can build empathy and understanding, and allows GP and patient to attend to the present physiological and relational distress, without undue attention being placed on the search for the causative event or person. As long as safety is kept pre-eminent, this shifts priorities towards soothing, understanding and supporting current distress.

Once soothing is established, and capacity for physiological calm and restorative rest is there, then other goals of therapy become more important – these include autobiographical coherence,<sup>19</sup> capacity for relational connection, increase in self-compassion<sup>20</sup> and personal meaning-making in the face of traumatic experience. Again, the GP can contribute to each of these through the way they remember the person's whole story, offer reliable relational connection, and allow existential concerns to be expressed and explored as part of ordinary care.

It is important to note that providing trauma-informed care is different from providing trauma-specific therapy with people who have experienced trauma, especially complex trauma. Therapy requires additional knowledge and training to ensure a safe therapeutic alliance and the processes needed to support recovery.

## First principles of trauma-informed care

The first principles of trauma-informed care that facilitate pattern recognition and treatment priorities in general practice are outlined below. The principles are designed to facilitate GP skills and are built on the foundational first principles of trauma-informed care developed by the Blue Knot Foundation, which include safety, trustworthiness, choice, collaboration and empowerment:

- Prioritise safety
- Foster capacity to soothe physiological arousal
- Validate person and perceptions
- Collaborate and empower
- Connect and stay involved

### Prioritise safety

Safety is the overarching priority in both assessment and care-planning for those who are wounded physically, psychologically and/or relationally. This includes optimising safety in their environment (place), relationships (people), intrapersonal experiences (personhood), body (physiology) and meaning (perspective). Experienced trauma GPs would warn that safety takes precedence over detailed history-taking, and would caution against clinical processes that cause distress through retelling or reliving of traumatic experiences,<sup>21</sup> especially for those with limited access to self-soothing or relational support.

The initial phase of any trauma-informed care involves stabilisation – facilitating safety in finances, housing and relationships, intrapersonal connection, affect regulation and even existential support.

As safety is the overarching principle of trauma-informed care and medical care, many GPs are wary of patients' disclosing of trauma, concerned it may trigger re-experiencing and overwhelm. In every situation (even the 'past history' section of an assessment), the most important consideration is safety. This includes supporting stabilisation or grounding of physiological arousal in each clinical encounter and careful boundary-setting that facilitates choice and empowerment at each step of clinical conversation.

Given the prevalence of trauma in our community and its often long-term impact on health, it is important to consider trauma and to explore a person's safety if they present with vague symptoms, multimorbidity, frequent accidents, chronic pain, hypervigilance, shut-down, hopelessness or relational distress.

It is also important for safety to identify current risks (eg are they currently in a traumatising home or peer relationship at school) or longer-term risks to their physical and mental health (including suicide risk) if they have experienced adverse childhood experiences or intimate partner abuse.

Potential questions include:

- 'Is there anyone in your world who invades you, disconnects from you or confuses you?'<sup>5</sup>
- 'How do you help yourself feel safe?'<sup>5</sup>
- 'Often people who have these types of health problems are experiencing difficulties at home. Is that happening to you?'<sup>22</sup>

- ‘Sometimes these symptoms can be associated with having been hurt in the past. Did that ever happen to you?’<sup>22</sup>

## Foster capacity to soothe physiological arousal

Because a key impact of trauma is dysregulation of biological stress modulation, all approaches to traumatised people should maintain awareness of physiological arousal. Helping patients learn how to self-regulate arousal, balancing input from both the rational mind and the sensory or emotional body (also called the ‘therapeutic window’,<sup>23</sup> or ‘window of tolerance’), helps the GP and patient connect with others and self.

Physiological experiences of being overwhelmed can dysregulate a person’s capacity to self-soothe, at both a neurological and relational level. Therefore, all clinical care needs to offer an attuned responsive presence and skills-training to foster capacity to self-soothe.

Physiological regulation and affect regulation can be facilitated using both ‘bottom-up’ and ‘top-down’ approaches to soothing.

- Bottom-up approaches start with the body, and aim to soothe physiological signs of distress using techniques such as sensorimotor grounding, rhythm and movement.
- Top-down approaches work from ‘brain to body’, through techniques such as cortical use of story, dialogue, ritual and metaphor.

Therapeutic relationships are part of physiological soothing – they offer an alternative for those who may have lived their developmental years in chronic arousal, with no reliable buffering relationships that could calm them, or that could support them to calm themselves.

### Bottom-up tools to soothe physiological arousal

GPs can attend to signs of physiological arousal, such as cardiac and respiratory rate, prosody (tone of voice), bodily movements and muscle tension. These signs offer natural biofeedback that can guide management of the window of tolerance.<sup>23</sup> These physiological signs can help the GP and patient to fine-tune bodily approaches to soothing, known as grounding. Grounding uses attention to the senses of sight, sound, touch, taste, smell, interoception (perception of the body’s internal sensations) and proprioception<sup>5</sup> to settle bodily arousal or distress.

Practical tools for grounding include mindfulness, naming sights and sounds out loud, holding an object and describing it to manage attention. Rhythmic tapping, drumming, dancing and singing can also be used to teach self-soothing – giving afferent nervous system input that is reliable and predictable and bilateral.<sup>17</sup> The natural ways that we soothe babies through sounds, touch, rocking and patting remind us of how grounding works to soothe distress. The GP needs to be attuned to their own and their patient’s respiratory rate and subtle changes in affect, tone of voice, gaze or arousal. This tuning-in can help GPs to co-regulate patient distress. Measuring blood pressure and heart rate are practical ways GPs can appraise distress and soothe it through the ritual of medical touch.



In the consulting room, in dialogue, GPs can also use what Fisher calls 'empathic interrupting'<sup>24</sup> to manage storytelling intensity and content – intentionally slowing down, shifting the focus, narrowing attention or changing the topic all help the speaker manage their levels of arousal and distress. Bottom-up tools are useful for all forms of distress, including pain.

Emerging evidence of the link between physiological arousal and life story is shifting psychotherapeutic practice towards somatic or sensorimotor therapies.<sup>1</sup> These approaches tune in to and soothe physical signs of distress from the bottom up (from the body to the brain). Therapeutic approaches that attend to physiological soothing include somatic experiencing or sensorimotor psychotherapy, eye movement desensitisation and reprocessing, brain-spotting (which uses visual fields), emotion freedom techniques (which use tapping), hypnotherapy, equine therapy and emotion-focused couple therapy.<sup>25-30</sup> These approaches can be useful for those with linear single incident and complex trauma.

### Top-down tools to soothe physiological arousal

Settling someone in distress from the 'top-down' (brain to body) includes the ordinary use of language and reason (so-called 'left' brain) and art and metaphor (so-called 'right' brain) to calm. When we comfort someone, we sometimes help them to organise their thinking through questions, careful listening (including noticing what is not said), tuning in to their resources or what has gone well and reflection. At other times we use distraction, or focus on a detail to move the mind away from something overwhelming.<sup>31</sup>

Top-down tools orient attention to soothe and regulate. They can widen perspective and remind of capacity – attending to positive memories, people, accomplishments, and images that are resources and strengths. Reading, writing, story-telling, dialogue and reflection are natural top-down tools that can be used every day in general practice to calm patients in distress.

### Validate person and perceptions

Whole-hearted validation of the person and tuning in to their perceptions builds dignity.<sup>32</sup> Because altered sense of self, including shame and self-loathing, is such a dominant part of the legacy of trauma, especially complex trauma, validation is a very important element of treatment. Validation does not require unquestioning belief. The priority of care is to focus on how the person's experience (whatever they offer as their experience) has affected them, and to support them to work through the impacts of that experience.

Offering trustworthy availability for that journey is a key element of trauma-informed care.<sup>18</sup> It is important to support the person to disclose as much or as little as they choose at any time. GPs can also provide an anchor as they clearly affirm that violence or neglect is never acceptable and reveal their concern for what the person is experiencing. They can also offer dignity, share hope and inspire the possibility of healing, based on anecdotal experience and research.

Validation can also occur as the GP repeatedly offers connection and positive regard towards parts of the person that they experience as shameful or disgusting.

When a person experiences threat to relational connection (eg in misattuned connection, disapproval, disgust, as well as violence and neglect) it causes physiological changes that are often called shame. These physical changes impact autonomic arousal that causes blushing, downward eye gaze and

submissive posture. Unremitting experiences of relational disconnection or violation are neurodevelopmentally toxic.<sup>33</sup> Without relational repair and attuned connection between parent and child, children become hypervigilant for social disconnection and lose capacity to utilise other relationships for self-soothing. They often also associate the physiological experience of shame with mistaken personal meanings that they are defective, inadequate, disgusting, 'too much' or 'not enough'. Understanding shame as a result of relational disconnection helps to direct treatment towards connection, relational repair and belonging.

Therapeutic approaches that acknowledge and treat shame are central to trauma-specific therapies including self-compassion<sup>34</sup> and internal family systems therapies.<sup>35</sup> Trauma-specific therapies offer expertise and skills for long-term treatment of shame.

For the GP, being aware of shame-proneness as a legacy of trauma can help to manage and understand processes such as self-loathing, repeated cycles of relational breakdown and enmeshment, difficulty in bonding and attuned parenting (including breastfeeding), and [cycles of perfectionism or unrelenting standards \(https://self-compassion.org/self-compassion-scales-for-researchers/\)](https://self-compassion.org/self-compassion-scales-for-researchers/).

GPs are skilled in not shaming their patients – validating the personhood of each patient is part of the GP philosophy of care to 'rehabilitate the patient's sense of self'.<sup>36</sup> Validation and connected relationship with a GP can offer a steadying relationship as the patient faces the challenge of finding a trauma-specific therapist with whom they feel safe.

## Collaborate and empower

Many people who have been traumatised have had experiences of being dominated, trapped or neglected and have been abused or violated by people in a position of power. GPs need to be very mindful of maintaining interactions that offer choice, collaboration and empowering approaches.<sup>18</sup> These approaches address a fundamental wound to personhood that can be part of the legacy of trauma. Moving from a passive sense of self to an active sense of self or agency<sup>37</sup> contributes to recovery. This is about supporting a person to identify their strengths and enabling them to build on them. This aligns with the generalist literature that speaks of 'enablement' as a key goal of GP care.<sup>38</sup>

A part of empowerment is to see coping and defence mechanisms (including addictions and compulsions) as active (and often creative and determined) attempts to manage overwhelm and keep themselves safe. They make sense as ways to regulate and tolerate overwhelming physiological and relational distress. Rather than evidence of disorder, attempts to cope (no matter how successful) are evidence of bravery, determination and clever resourcefulness in that person. They can be seen as resources for recovery. They can also contribute to post-traumatic growth.<sup>39</sup>

Another aspect of empowerment includes walking with a patient through ambivalence. Any form of violation that occurs in the setting of relationship is fundamentally confusing and incoherent – 'Why would someone who loves me or values me hurt me?'

Someone may say, for example:

'Yes, I know my husband beats me occasionally, but in between he's okay. He is not nasty to the children and he treats me well.'

The process of facing the reality of violation within valued connections can include denial, idealisation and defending the perpetrator; crippling self-blame, powerlessness and hopelessness; and minimising your own experience, needs or insights. Internal fragmentation and loss of trust within the self can cause even more confusion, as parts of the self cannot agree on a way forward. Part of the person wants to acknowledge the abuse and another part does not. If the perpetrator switches between different states of minds, confusion can be amplified. Fears of capacity to face life alone, longstanding endurance of violation since childhood, fears for children's safety on custody visits after separation, and practicalities of living arrangements and finances also contribute to ambivalence about change.

Rather than judging or being demoralised by a person's choice to stay or return to a perpetrator, GPs can seek to understand the underlying ambivalence. There may be very compelling reasons why the victim/survivor believes they cannot leave. GPs can establish trust, build self-esteem, and identify themselves as supportive agents.<sup>40</sup> A key healing process in primary care relationships is 'abiding' – staying with people when others have nothing more to offer.<sup>41</sup> Regaining confidence and emotional strength can be a gradual process, so moving out of an unsafe relationship may take years. Therefore we can say:

'Whatever you decide to do about the situation, I will remain with you on this journey. I will keep on reminding you of your worth and offering options for help that we can explore together.'

## Connect and stay involved: Healing through relationship

One of the key gifts that GPs can offer their patients is attuned, available, accessible therapeutic relationships. This involves both micro-connections in building rapport and trust, and macro-connections through planned regular appointments and practice systems that maintain relationship over time. Providing relationships with clear boundaries, tuning in to the person irrespective of their presentation and initiating connection (not just responding in crisis) all offer a healing presence.<sup>41</sup> Relationships that offer safe, reliable and attuned connection offer an antidote to shaming, disconnecting, confusing, poorly attuned or unreliable relationships.

GPs can offer approaches to distress that acknowledge (and do not avoid) life experiences of trauma and neglect. They acknowledge the impact on physiology and health, as well as relationships and meaning. The underlying philosophy of generalism is also healing-oriented,<sup>5</sup> pragmatic and strengths-based – seeking to 'rehabilitate the sense of self'<sup>36</sup> and reconnect with living life.<sup>42</sup> Overall, GPs therefore have the capacity to offer trauma-informed care that concurrently builds safety, acknowledges

and grieves pain, and seeks ongoing growth for each person. Generalist approaches to trauma can be framed as a process of building sense of safety across the whole person (from their environment to their inner-world).<sup>5</sup>

## When to refer

Good-quality trauma-specific therapy is becoming more available.

Because threat is physiologically encoded, some would argue that even asymptomatic victims/survivors of trauma should be offered trauma-specific therapy. It is certainly indicated if there is physiological hyper- or hypo-arousal, chronic suicidality, self-harming, addictive processes, repeated relational breakdown, or if there is amnesia or avoidance of knowing their own pain and grief.

Any process of trauma-informed care should involve intentional connected relationships among the therapeutic team. This models reliable, attuned connection between the patient and the members of the team, which includes good-quality communication, repair of any misunderstandings, clear boundaries and roles, and resisting the process of 'splitting of care' around the person who is traumatised. Having good relationships with your local referral network also means that when a therapeutic relationship is not going well, you can offer planned warm referral to someone else, to prevent re-traumatising due to therapeutic rupture, or you can seek help from another member of the team to facilitate therapeutic repair.

When a patient is referred to psychological help, domestic violence social workers, counsellors or psychiatrists, their GP should remain involved in their care, just as in all other referral processes to specialists. GPs remain the generalist who continues to care for the whole person. GPs who are more skilled in psychological medicine need to carefully define their role with regard to both the patient and other team members. Sometimes GPs with a specific interest in psychological medicine may seek to offer shared care with another GP who does the more physical generalist work.

## Definitions of PTSD and complex PTSD

As outlined in Table 7.1, the definition of PTSD in both the *Diagnostic and statistical manual of mental disorders*, 5th edition (DSM-5) and International Classification of Diseases, 11th edition (ICD-11) is limited to a linear causal link between event and symptoms. The definition of complex PTSD (CPTSD), which is found only in the ICD-11, is intentionally widened to notice the processes that traumatise, and attends to the impact on sense of self, relationships, connection to the body and meaning. This definition still does not include processes of neglect, including emotional neglect, that cause similar symptoms.

ICD-11 defines PTSD as comprised of three symptom clusters:

1. Re-experiencing of the trauma in the here and now
2. Avoidance of traumatic reminders
3. A persistent sense of current threat that is manifested by exaggerated startle and hypervigilance

The DSM-5 PTSD diagnosis also acknowledges negative alterations in cognitions and mood and has a dissociative specification that acknowledges altered consciousness.

The ICD-11 CPTSD diagnostic framework adds three additional clusters to the PTSD definition that reflect ‘disturbances in self-organisation’:

1. Affect dysregulation
2. Negative self-concept
3. Disturbances in relationships

Although the definition of CPTSD acknowledges the developmental disruption of self-organisation, it does not include disturbances in arousal or consciousness and memory captured in the concept of dissociation. This limitation is important to the GP, who at times needs to interpret unspoken bodily signs of distress, or care for memorial experiences that are reactivated when there is a loss of explicit or narrative memory of the original stressor.

Current single-incident (PTSD) and complex (CPTSD) trauma frameworks also do not acknowledge the physiological stress impacts of trauma on the body and long-term health. As more becomes known about biomarkers of allostatic overload<sup>43</sup> as a side effect of chronic threat, the GP needs to be aware of the physiological impact of trauma on their patient’s lifetime health risks.

**Table 7.1. Comparison of the definitions of post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD) and the characteristics of trauma experienced as linear events compared with experiences**

PTSD (trauma as an event)	Complex PTSD (trauma as an experience)
Life-threatening incident: ‘actual or threatened death, serious injury, or sexual violence’ <sup>(a)</sup>	Chronic threatening process: ‘sustained, repeated or multiple forms of traumatic exposure (eg genocide campaigns, childhood sexual abuse, child soldiering, severe domestic violence, torture or slavery) reflecting loss of emotional, psychological and social resources under conditions of prolonged adversity’ <sup>44</sup>
Can include disasters or accidents that do not involve people	Usually happens within relationships and impacts development and self-organisation
Usually noticed as an incident of invasion or threat to integrity	Can also be processes of disconnection or confusion that threaten belonging
Dominant emotion of fear reported using explicit memory	Dominant experience of shame that is often encoded as implicit bodily memories
Avoidance of reminders (including thoughts or feelings or external reminders, including dissociation) <sup>(a),(b)</sup>	Avoidance is also a subconscious process of inattention, minimising, numbing, altered states of consciousness, <sup>45</sup> amnesia and dissociation <sup>(d)</sup>
Hypervigilant arousal <sup>(a),(b)</sup>	Hypervigilant arousal <sup>(c)</sup>

**Table 7.1. Comparison of the definitions of post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD) and the characteristics of trauma experienced as linear events compared with experiences**

Re-experiencing of memories and intrusion of symptoms <sup>(a),(b)</sup>	Re-experiencing of memories and unconscious triggering of memorial experiences <sup>(c)</sup>
Negative alterations in cognitions or mood <sup>(a)</sup> Self-organisation may not be affected at all	<ul style="list-style-type: none"> <li>• Affect dysregulation<sup>(c)</sup></li> <li>• Negative self-concept<sup>(c)</sup></li> <li>• Relationship disturbances<sup>(c)</sup> that includes altered trust and sense of belonging across generations</li> <li>• Connection to the body altered, including altered sensory awareness<sup>29</sup> and somatisation<sup>(d)</sup></li> <li>• Altered systems of meaning, including hopelessness and despair and post-traumatic growth<sup>39,(d)</sup></li> </ul>

Altered physiology – endocrine, autonomic nervous system, immunology, cellular glucose use, DNA epigenetics, ‘multisystem physiological dysregulation’<sup>46</sup>

- a. PTSD as defined in DSM-5
- b. PTSD as defined in ICD-11
- c. CPTSD as defined in ICD-11
- d. CPTSD as defined in Courtois 2004<sup>21</sup>

DSM-5, Diagnostic and statistical manual of mental disorders, 5th edition; ICD-11, International Classification of Diseases, 11th edition

## Adverse childhood experiences to be aware of

Although the field is expanding rapidly, and there is growing awareness of complex attachment disorders that can have lifelong impacts, at a minimum there are established adverse childhood experiences that all GPs should be aware of (refer to Table 7.2). Longitudinal prospective studies and functional brain imaging studies confirm their far-reaching impact on health.

The Adverse Childhood Experiences Study<sup>4</sup> and the Maltreatment and Abuse Chronology of Experiences studies<sup>47</sup> have documented these insights. Increased types, incidence or dose of adverse childhood experiences causes increased disease as a direct result of chronic physiological stress and an indirect result of coping mechanisms that attempt to reduce that arousal.

Chronic physiological arousal of the autonomic nervous system, immune and endocrine systems causes headaches, back pain, pulmonary fibrosis, osteoporosis, coronary artery disease, irritability, panic, insomnia, impaired memory and unexplained symptoms.<sup>48</sup>

Coping mechanisms that attempt to decrease arousal include overeating, alcohol and drug use, smoking, promiscuity, risk-taking, self-harm, obsessions and suicidality.<sup>4,49</sup>

**Table 7.2. Adverse childhood experiences with proven physiological impacts<sup>5</sup>**

Disconnection	Invasion	Loss of safe caregiver
<ul style="list-style-type: none"> <li>• Physical neglect<sup>(a)</sup></li> <li>• Emotional neglect<sup>(a)</sup></li> <li>• Non-verbal emotional abuse<sup>(b)</sup></li> <li>• Peer physical bullying<sup>(b)</sup></li> <li>• Emotional abuse<sup>(a)</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Physical (including intimidation) abuse<sup>(a)</sup></li> <li>• Sexual abuse<sup>(a)</sup></li> <li>• Witnessing violence against siblings<sup>(b)</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Absent parent<sup>(a)</sup></li> <li>• Intoxicated (alcohol or drugs) parent<sup>(a)</sup></li> <li>• Mentally unwell parent<sup>(a)</sup></li> <li>• Incarcerated parent<sup>(a)</sup></li> <li>• Witnessing interparental violence<sup>(a)</sup></li> <li>• Witnessing violence against siblings<sup>(b)</sup></li> </ul>

a. Direct evidence<sup>4,50,51</sup>

b. Direct evidence<sup>13</sup>

Adapted with permission from: Taylor & Francis Group. Lynch JM. A whole person approach to wellbeing: Building sense of safety. London: Routledge, 2020.

## Intergenerational trauma

Intergenerational trauma has been studied extensively in the attempt to understand the poor health outcomes of Indigenous and oppressed peoples worldwide. The impact of trauma across generations includes the complex trauma legacy already discussed alongside individual, family, community and national factors (Table 7.3).<sup>52</sup>

**Table 7.3. Factors that impact intergenerational trauma**

Factor	Legacy
--------	--------

**Table 7.3. Factors that impact intergenerational trauma**

Individual	<ul style="list-style-type: none"> <li>• Epigenetic changes<sup>53</sup></li> <li>• Poor sense of belonging to family, community and culture</li> <li>• Feeling of abandonment by caregivers</li> <li>• Experiences of violence</li> <li>• Loss of relationship</li> <li>• Low self-esteem</li> <li>• Unhelpful interactions with education, health and legal structures</li> </ul>
Family	<ul style="list-style-type: none"> <li>• Relational disconnection and confusion</li> <li>• Stories and metaphors of threat<sup>54</sup></li> <li>• Chronic use of violence, alcohol</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Lack of cultural transmission of culture, language, spirituality, history and traditional values</li> <li>• Low levels of communal trust and engagement</li> </ul>
National	<ul style="list-style-type: none"> <li>• Popularisation of negative stereotypes through mainstream media</li> <li>• Social policies that perpetuate colonialism</li> <li>• Lack of support for community self-determination</li> </ul>

Reproduced from Menzies P. Developing an Aboriginal healing model for intergenerational trauma. *International Journal of Health Promotion and Education* 2008; 46: 41-8, with permission from Taylor and Francis Group.

For more information refer to this four-minute [intergenerational trauma animation \(https://www.youtube.com/watch?v=vlqx8EYvRbQ\)](https://www.youtube.com/watch?v=vlqx8EYvRbQ).

## Self-care for vicarious trauma

It is normal for those in the caring profession to have experienced some form of trauma or neglect in their own past. Those experiences can lead to achieving and helping as coping mechanisms that naturally lead to the helping professions. As outlined in the [chapter on self-care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care), it is important for each GP to acknowledge their own trauma story and the need for self-care – this might include personal therapy, creativity, movement and reflection.



It is important to build a sense of your life beyond your role as reliable helper, and beyond the experiences of your own patients. Spending time away from work, investing in other people, belonging in your wider community, and increasing your capacity to reflect through movement, nature, music, art and language are all inherently healing.

It is also important to consider your own physiological arousal – that your body will become distressed and aroused (including numbed hyperarousal or hypo-arousal) after repeatedly hearing stories of threat. Key questions (refer to Figure 7.1) you can ask to monitor your own needs when on the frontline of distress in our community include:<sup>5</sup>

- Do you have anywhere to rest where you are not feeling threatened?
- Do you have any online community space where you are free from threatening or distressing content?
- In your closest relationships, is there fun, safe and warm connection?
- Can you help your body feel calm for moments in your day?
- Can you find comfort to still your mind and see things in perspective calmly?
- Are you feeling safe enough in yourself to face your life tasks?
- Do you have any meaningful way to hold onto hope in the midst of your day-to-day life?

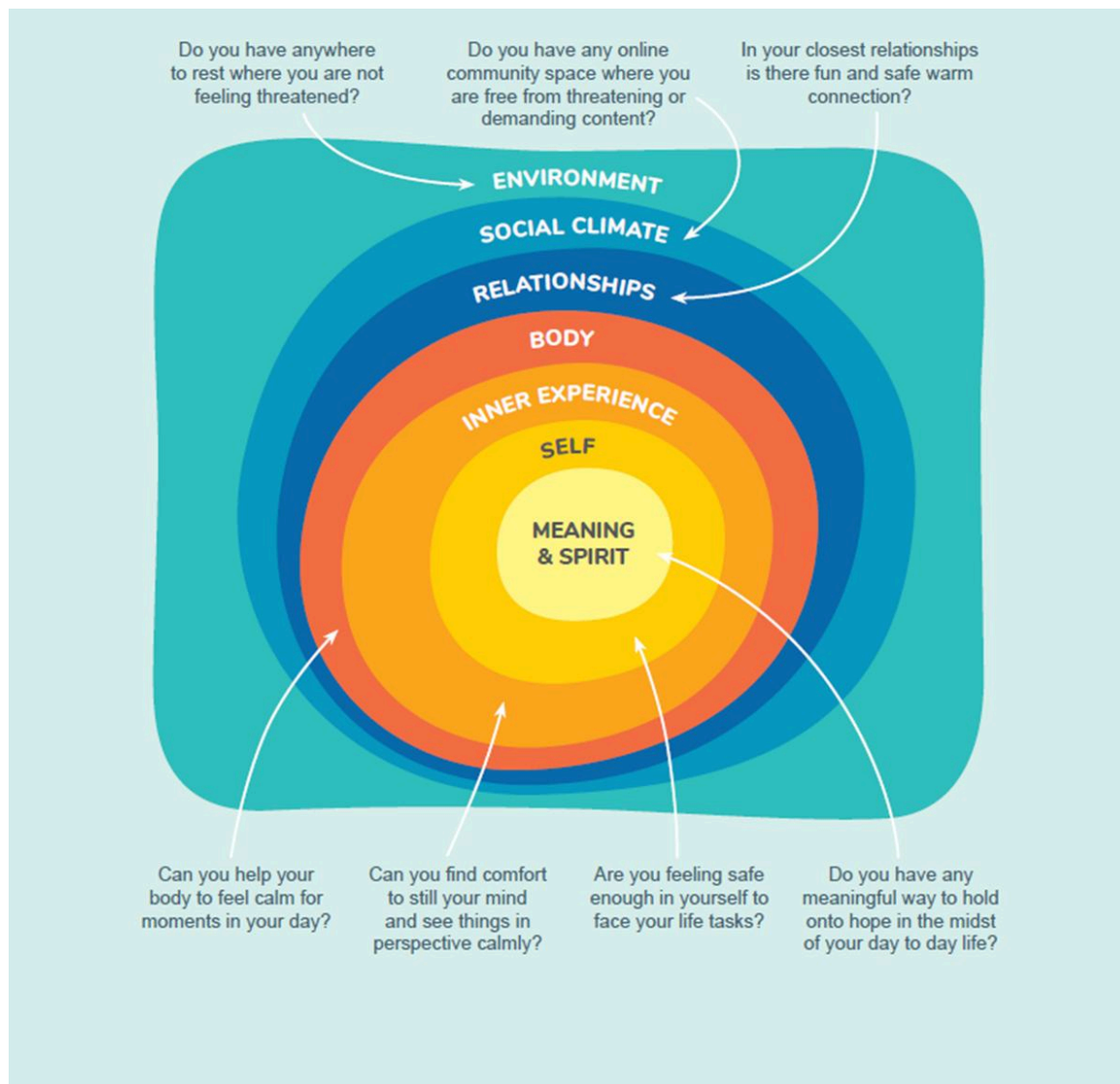


Figure 7.1. Model of self-care<sup>5</sup>

Adapted with permission from: Taylor & Francis Group. Lynch JM. *A whole person approach to wellbeing: Building sense of safety*. London: Routledge, 2020.

Finally, as other helping professions routinely do, GPs, whose work is so interpersonal, can support and strengthen their own practice and personal health through regular supervision or case consultation – either within a community of practice, with a trusted psychotherapist, or with a trained generalist mental health trainer or facilitator.

- Refer to [Chapter 8: Keeping the health professional safe and healthy: Clinician support and self-care](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care>).
- The Black Dog Foundation provides access to [communities of practice](https://medcast.com.au/communities/black-dog-institute) (<https://medcast.com.au/communities/black-dog-institute>).
- Generalist mental health trainers can be accessed through the Australian Society for [Psychological Medicine](https://www.aspm.org.au/aspm-training/case-consultations) (<https://www.aspm.org.au/aspm-training/case-consultations>).

- [Blue Knot Foundation \(http://blueknot.org.au\)](http://blueknot.org.au) provides an extensive suite of training around trauma-informed practice, including vicarious trauma and clinical treatment for GPs.

## Resources

- [How childhood trauma affects health \(https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime?language=en\)](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en) – TED talk by paediatrician Nadine Burke Harris.
- [The deepest well: Healing the effects of childhood adversity \(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6443356/\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6443356/) – book by Burke Harris, Houghton Mifflin Harcourt, 2018.

## References

1. Kezelman C, Stavropoulos P. Practice guidelines for treatment of complex trauma. Sydney: Blue Knot Foundation, 2019.
2. Lynch JM, Kirkengen AL. Biology and experience intertwined: Trauma, neglect and physical health. Benjamin R, Haliburn J, King S, editors. Humanising mental health care in Australia: A guide to trauma-informed approaches. Sydney: CRC Press Taylor and Francis Group, Routledge, 2019.
3. Herman JL. Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. New York: Basic Books, 2015.
4. Feletti V, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med* 1998;14:245–58.
5. Lynch JM. A whole person approach to wellbeing: Building sense of safety. London: Routledge, 2020
6. Courtois C, Ford J, editors. Treating complex traumatic stress. An evidence based guide. New York: The Guilford Press, 2009.
7. Shonkoff JP, Garner AS, Siegel BS, et al. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 2012;129:e232-e46.
8. Porges S. Connectedness as a biological imperative. Presentation at the Australian Childhood Foundation Conference, Melbourne, 2014.
9. Allen JG. Restoring mentalizing in attachment relationships: Treating trauma with plain old therapy. Washington: American Psychiatric Publishing, 2013.
10. McEwen BS. The neurobiology and neuroendocrinology of stress: Implications for post-traumatic stress disorder from a basic science perspective. *Psychiatr Clin North Am* 2002;25:469–94.
11. Carrion VG, Wong SS. Can traumatic stress alter the brain? Understanding the implications of early trauma on brain development and learning. *J Adolesc Health* 2012;51:S23–S28.
12. Shonkoff J, Boyce W, Cameron J, et al. Excessive stress disrupts the architecture of the developing brain. Centre on the Developing Child, Harvard University: National Scientific Council on the Developing Child, 2014.
13. Teicher MH, Samson JA, Anderson CM, et al. The effects of childhood maltreatment on brain structure, function and connectivity. *Nat Rev Neurosci* 2016;17:652–66.
14. McEwen BS, Wingfield JC. The concept of allostasis in biology and biomedicine. *Horm Behav* 2003;43:2–15.
15. Sarnyai Z, Berger M, Javan I. Allostatic load mediates the impact of stress and trauma on physical and mental health in Indigenous Australians. *Australas Psychiatry* 2016;24:72–75.
16. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 2019;56:774–86.
17. Porges SW, Dana DA. Clinical applications of the polyvagal theory: The emergence of polyvagal-informed therapies. New York: WW Norton & Company, 2018.

18. Kezelman C, Stavropoulos P. 'The Last Frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. Sydney: Adults Surviving Child Abuse, 2012.
19. Waters TE, Fivush R. Relations between narrative coherence, identity, and psychological well-being in emerging adulthood. *J Personality* 2015;83:441–51.
20. Neff KD, Kirkpatrick KL, Rude SS. Self-compassion and adaptive psychological functioning. *J Res Personality* 2007;41:139–54.
21. Courtois CA. Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, research, Practice, Training* 2004;41:412–25.
22. The Royal Australian College of General Practitioners. Abuse and violence: Working with our patients in general practice. East Melbourne, Vic: RACGP, 2014.
23. Briere J, editor. Treating adult survivors of severe childhood. Thousand Oaks, CA, US: Sage Publications, 2002.
24. Fisher J. Transforming trauma-related shame and self loathing. Centre D, editor. Overcoming trauma-Related Shame and Self-Loathing Conference. Brisbane: Delphi Institute, 2014.
25. Phillips M, Frederick C. Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions. New York: WW Norton & Co, 1995.
26. Shapiro F, Maxfield L. Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *J Clin Psychol* 2002;58:933–46.
27. Flint GA, Lammers W, Mitnick DG. Emotional freedom techniques: A safe treatment intervention for many trauma based issues. *J Aggression Maltreatment Trauma* 2006;2:25–50.
28. Corrigan F, Grand D, Raju R. Brainspotting: Sustained attention, spinothalamic tracts, thalamocortical processing, and the healing of adaptive orientation truncated by traumatic experience. *Medical Hypotheses* 2015;84:384–94.
29. Payne P, Levine PA, Crane-Godreau MA. Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Front Psychol* 2015;6:93.
30. Buck PW, Bean N, De Marco K. Equine-assisted psychotherapy: An emerging trauma-informed intervention. *Adv Soc Work* 2017;18:387–402.
31. Stroebe M, Schut H. The dual process model of coping with bereavement: A decade on. *Omega* (Westport) 2010;61:273–89.
32. Jacobson N. Dignity and health: A review. *Soc Sci Med* 2007;64:292–302.
33. Cozolino L. The neuroscience of psychotherapy: Healing the social brain. New York: WW Norton & Company, 2010.
34. Ford EE. A test of self-compassion as a mediator of the beneficial effects of mindfulness on wellbeing. UQ Theses: The University of Queensland, School of Psychology, 2015.
35. Sweezy M. The teenager's confession: Regulating shame in internal family systems therapy. *Am J Psychother* 2011;65:179–88.
36. Stone L. Reframing chaos: A qualitative study of GPs managing patients with medically unexplained symptoms. *Aust Fam Physician* 2013;42:1–7.
37. Jacobson N, Greenley D. What is recovery? A conceptual model and explication. *Psychiatric Services* (Washington, DC) 2001;52:482–85.
38. Howie J, Heaney D, Maxwell M. Quality, core values and the general practice consultation: Issues of definition, measurement and delivery. *Fam Pract* 2004;21:458–68.
39. Calhoun LG, Tedeschi RG, editors. Handbook of posttraumatic growth. Research and Practice. Mahwah, New Jersey: Lawrence Erlbaum Associates, 2006.
40. Battaglia TA, Finley E, Liebschutz JM. Survivors of intimate partner violence speak out. *J Gen Intern Med* 2003;18:617–23.
41. Scott JG, Cohen D, DiCicco Bloom B, Miller W, Stange K, Crabtree B. Understanding healing relationships in primary care. *Ann Fam Med* 2008;6:315–22.
42. Reeve J. Scholarship-based medicine: Teaching tomorrow's generalists why it's time to retire EBM. *Br J Gen Pract* 2018;68:390–91.
43. Juster R-P, McEwen BS, Lupien SJ. Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neurosci Biobehav Rev* 2010;35:2–16.
44. Karatzias T, Murphy P, Cloitre M, et al. Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. *Psychol Med* 2019;49:1761–75.
45. Frewen P, Hegadoren K, Coupland NJ, et al. Trauma related altered states of consciousness (TRASC) and functional Impairment 1: Prospective study in acutely traumatized persons. *J Trauma Dissociation* 2015;16:500–19.

46. Wiley JF, Gruenewald TL, Karlamangla AS, et al. Modeling multisystem physiological dysregulation. *Psychosom Med* 2016;78:290–301.
47. Teicher MH, Parigger A. The 'Maltreatment and Abuse Chronology of Exposure' (MACE) Scale for the retrospective assessment of abuse and neglect during development. *PLoS One* 2015;10:e0117423.
48. Felitti VJ. Adverse childhood experiences and adult health. *Academic Pediatrics* 2009;9:131–32.
49. Hughes K, Bellis M, Hardcastle K, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Publ Health* 2017;2:e356–66.
50. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci* 2006;256:174–86.
51. Felitti V, Anda R. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behaviour: Implications for healthcare. Lanius R, Vermetten E, Pain C, editors. *The impact of early life trauma on health and disease*. Cambridge: Cambridge University Press;2010:77–87.
52. Menzies P. Developing an Aboriginal healing model for intergenerational trauma. *Int J Health Promot Educ* 2008;46:41–48.
53. Harper L. Epigenetic inheritance and the intergenerational transfer of experience. *Psychol Bull* 2005;131:340.
54. Connolly A. Healing the wounds of our fathers: Intergenerational trauma, memory, symbolization and narrative. *J Anal Psychol* 2011; 56:607–26.

# Keeping the health professional safe and healthy: Clinician support and self-care

'When we are working in difficult areas, we can begin to feel overloaded, frustrated and even hopeless. Pulling ourselves together and pushing through might seem helpful in the short-term, but it's a slippery slope into compassion fatigue and burnout' **Associate Professor Jill Benson, General Practitioner**

## Key messages

- Staying safe and healthy is essential for all healthcare workers including GPs, practice nurses, support staff and Aboriginal and Torres Strait health workers who care for patients who are, or have been, involved in abuse and violence. This includes when caring for people who inflict abuse and violence as well as caring for those to whom it is happening.
- It is important to be aware of the early signs of stress, compassion fatigue, burnout and vicarious trauma. Clinicians should have a personal and professional management plan to prevent progression.
- Stress can be reduced by personal actions, increased social connectedness, professional development, working as part of a supportive team and engaging other agencies.

## Introduction

This chapter highlights the importance of staying safe and healthy for the GP, practice nurse or Aboriginal health worker when working with families experiencing violence and abuse. It encourages self-reflection, peer support and working as a part of a wider team with these families.

## The impact of working with abuse and violence

Managing patients who have been involved in situations of domestic abuse or violence with compassion and empathy can be stressful, and a health professional's own health can suffer because of compassion fatigue, burnout or vicarious traumatisation.<sup>1</sup>

## Stress and burnout

A generic definition of stress is the physical, mental or emotional response to outside circumstances that are too overwhelming for our personal resources, a common scenario for health professionals when working with patients who have been involved in abuse or violence. Burnout has been defined as a syndrome of emotional exhaustion, depersonalisation, and a sense of lowered personal accomplishment that leads to a decreased effectiveness at work.<sup>2</sup>

Dealing with the effects of stress is important, not just for the health professional's own health, but also so that they can maintain as objective a stance as possible to facilitate a successful outcome for the patient, and maintain good relationships with their own family, friends and community. Dealing with the effects of stress also enables the healthcare team to work together more effectively.

The trauma that many patients have been through constantly challenges the health professional's individual limits and drains personal and professional resources.<sup>2,3</sup> The health professional may feel personally frustrated, helpless and hopeless, which can lead to substance abuse, broken relationships and even suicide, and may also face professional stress leading to important professional consequences such as 'lower patient satisfaction, impaired quality of care, even up to medical errors, potentially ending up in malpractice suits with substantial costs for caregivers and hospitals'.<sup>2</sup>

Health professionals can begin to address chronic stress by asking for assistance in dealing with any stressors outside of their work and working to enhance their personal and professional resources.

## Vicarious traumatisation

Vicarious traumatisation is a particular danger when an empathic health professional is dealing with people who are experiencing or have experienced abuse and violence. It involves the inner transformation of the carer's view of themselves and their world as a result of listening to the patient's stories and empathic engagement with their trauma.<sup>4</sup>

Vicarious traumatisation manifests as a spectrum of symptoms, including loss of appetite, fatigue, irritability, inattention, numbness, sleep disorders, fear, and despair. Frequently, these symptoms are accompanied by trauma responses and interpersonal conflicts. However, the symptoms often remain at subclinical level.<sup>5,6</sup>

Vicarious traumatisation can be similar in its symptomatology to post-traumatic stress disorder (PTSD) and can also resemble burnout in its symptoms and the effects it has on the personal and professional life of the health professional.<sup>7</sup> Hypervigilance, nightmares, avoidance and fatigue can be combined with a lack of motivation, cynicism, sense of failure, lack of accomplishment and emptiness, leading to lower job satisfaction, increased job turnover, absenteeism and decreased quality of patient care.<sup>1</sup>

Burnout and vicarious trauma can also be associated with 'self-medicating' with substances, interpersonal conflict, disrupted relationships and a poor quality of life.

## Compassion fatigue

Compassion is a 'sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it'. It is an essential characteristic to successfully work with patients who have been victims of domestic abuse.<sup>8</sup>

It is important to maintain an environment where there is adequate protection from the 'compassion fatigue' that may come from actively listening to the stories of patients involved in abuse and violence. 'Compassion fatigue is characterised by exhaustion, anger and irritability, negative coping behaviours including alcohol and drug abuse, reduced ability to feel sympathy and empathy, a diminished sense of enjoyment or satisfaction with work, increased absenteeism, and an impaired ability to make decisions and care for patients and/or clients.'<sup>9</sup>

Health professionals with compassion fatigue will have a depleted emotional reserve and have difficulty experiencing or expressing empathy and effectively responding to it. Along with emotional exhaustion and a lessened sense of accomplishment, such detachment is a symptom of burnout, and if not addressed, may also lead to vicarious trauma.<sup>10</sup>

## Positive effects of working with these patients

Working to help patients and their families be safe and resilient can also lead to health professionals feeling energised, empowered and hopeful. It can align with their personal values and give a sense of purpose, which can further enhance the doctor–patient interaction and relationships with colleagues.<sup>11</sup>

'Compassion satisfaction' derives from an alignment of values and work, a feeling of self-respect and being able to do work effectively.<sup>11</sup> 'Vicarious post-traumatic growth' and 'vicarious resilience' can occur when health professionals' self-perception, interpersonal relationships and philosophy of life are positively affected by the resilience of their patients, usually in the setting of supportive social and organisational environment.<sup>12</sup> Some of the professional and organisational factors that can contribute to this enhancement are ongoing training, clearly delineated practice policies, case management supervision, clear doctor–patient boundaries, and a developed network of resources and referrals.

## Considerations for healthcare professionals of specific backgrounds

Health professionals who have a similar background to the community they serve are at a higher risk of burnout and vicarious trauma.<sup>7</sup> This includes those of Aboriginal or refugee background, international medical graduates, and doctors who themselves have experienced child abuse or intimate partner abuse/violence (IPAV). Recent pandemics and environmental crises such as bushfires have also impacted health professionals and can add to the burden of traumatic events faced by many.<sup>6</sup>

GPs who work in rural areas are also at a higher risk of problems with stress, compassion fatigue, burnout and vicarious trauma.<sup>13</sup> They are highly likely to find it difficult to access locums, peer support and ongoing training, usually have more after-hours work, are more isolated and find it more difficult to maintain clear boundaries between themselves and their patients.<sup>14,15</sup>



Many rural GPs are international medical graduates, who have the added burden of having to negotiate different cultures, ethnicities, language, religion, and rural and urban differences in Australia. They will also have to learn about the expectations Australian patients have of their doctor and about a new health system with its attendant bureaucracy. As well as the risk of 'culture shock', their anxiety, isolation and insecurity in the face of all these differences is likely to be much higher.<sup>16</sup>

Younger doctors and doctors in training are at higher risk of stress, depression, burnout and vicarious trauma; those with more training, familiarity with workplace expectations and increased years of service have a lower risk.<sup>11,12</sup>

Many health professionals themselves may have experienced abuse, or have family or friends in that situation: doctors and nurses have been found to have a rate of family and domestic violence that is at least as high as the rest of the population.<sup>17</sup>

On the one hand, personal experience of abuse or violence may make health professionals more understanding and willing to ask about it; on the other hand, such personal experience may cause them distress. Health professionals therefore need to be aware of how personal experiences may affect their own health and wellbeing and how to seek help to deal with what is happening in their own lives.<sup>17,18</sup>

## Strategies for self-care

'You cannot give to others out of emptiness in yourself.' – A GP

The medical profession has a 'long and admirable, but often unhealthy, tradition of self-sacrifice to work'.<sup>14</sup> Those who work in this field need to be vigilant about ways to overcome corrosive issues such as being the 'messiah' ('I'm here to fix all your problems'), presenteeism (going to work when unwell) and imposter syndrome (insecurity for fear 'someone will find out that I'm not perfect').

It is also important to develop ways to renew the joy in practice, create work/non-work balance, and adequately care for their own physical, mental, social, emotional and spiritual health.<sup>19,20</sup>

A useful concept is self-compassion. This involves:

- self-kindness, rather than self-judgement
- an awareness of a common human fragility, rather than suffering in isolation
- acknowledging difficult thoughts and emotions, rather than over-identifying with them.

Self-compassion and mindfulness can de-activate the internal threat system and activate the internal caregiving system. This can lead to self-healing, acceptance and joy with decreased risk of compassion fatigue, burnout and vicarious trauma.<sup>11</sup>

## The ABC model

Saakvitne and Pearlman developed a model for self-care whereby health professionals can explore their situation and think about solutions.<sup>4</sup> This occurs by identifying issues of awareness, balance and connection (ABC) in each of the health professional's 'realms':

- personal
- professional

Using this model and the strategies shown in Table 8.1 may help set the stage for good self-care.<sup>3,21</sup>

**Table 8.1. Example ABC strategies**

	Personal	Professional and organisational
Awareness	<ul style="list-style-type: none"> <li>• Reflect on realistic self-care strategies</li> <li>• Understand and improve your awareness of the early signs that you are stressed, tired, overwhelmed or burning out</li> <li>• Practise mindfulness, cognitive behavioural therapy and meditation techniques</li> </ul>	<ul style="list-style-type: none"> <li>• Find a suitable mentor or supervisor who is willing to give feedback about your needs for professional development</li> <li>• Ensure that you have adequate training in dealing with trauma</li> <li>• Consider formal or informal debriefing for yourself and in your practice</li> <li>• Cultivate open and supportive dialogue with your colleagues and practice team</li> <li>• Ensure organisational boundaries are known and understood by patients and supported by the organisation (eg home visits, consultation length)</li> </ul>
Balance	<ul style="list-style-type: none"> <li>• Review your lifestyle and consider realistic healthy options for sleeping enough, eating well, moderate exercise, hobbies and humour</li> <li>• Seek work/non-work balance in all spheres of your life</li> </ul>	<ul style="list-style-type: none"> <li>• Review workload regularly to ensure that all members of the practice team are adequately supported</li> <li>• Take care in scheduling patients with complex care needs with adequate time and breaks between</li> </ul>

**Table 8.1. Example ABC strategies**

<p>Connection</p>	<ul style="list-style-type: none"> <li>• Consider joining a social action group where your passion for change can have a different outlet</li> <li>• Talk to selected others about work and the effect it has on your life</li> <li>• Nurture and make time for positive relationships with family and friends</li> </ul>	<ul style="list-style-type: none"> <li>• Join a peer support or Balint group, or find a mentor to share experiences in a safe environment where you are understood and your work valued</li> <li>• Undertake regular continuing professional development with your colleagues</li> </ul>
-------------------	---	--

The following explores the ABC model more specifically in relation to managing people who are experiencing or have experienced abuse or violence.

## Awareness

### Personal

- Health professionals of a similar background to the patient might find the possibility of family violence more difficult to consider, as they may have ‘normalised’ the abuse and therefore disregard it.<sup>5,22</sup>
- Some health professionals may feel more personally vulnerable or uncomfortable when abuse is disclosed. It is important that GPs are aware of this and do not ignore their own feelings.
- The health professional can be drawn into a patient’s difficulty acknowledging the abuse, the shame and secretiveness about what is happening, or even the deceit that can build up around the circumstances, and hence develop an unwillingness to openly discuss or report the violence.<sup>22</sup>
- The health professional may feel powerless and fearful for a patient’s safety when that patient chooses a path that the health professional considers dangerous. The patient could remain at risk and the health professional has to learn to live with that concern.<sup>22</sup>
- It is a difficult and stressful path to support and empower a patient while resisting the temptation to direct and ‘take over’.<sup>22</sup>
- Dealing with complex and seemingly hopeless situations over and over again can erode the health professional’s ability and self-confidence and diminish their sense of purpose and enjoyment of their career.<sup>23</sup>
- It is important for the health professional to stay connected with their values and core reasons for choosing to work in a challenging area and to maintain a respect for the patients themselves.<sup>20</sup>
- Health professionals need to recognise their own early signals of distress and find ways to articulate the feelings and act to redress the distress.<sup>20</sup> This may include seeking formal help despite fears of stigma or of showing weakness or vulnerability.

- The lack of safety and security in the lives of patients can confront the health professional's own beliefs about the family and the world. The health professional may also be left with the same feelings of physical and emotional perceptions of alarm, danger and its impact, a personal sense of vulnerability and an intolerance of violence.
- Courage involves health professionals stepping outside their comfort zone and persisting even though the results are not what they hoped for, but not so far that they lose their own sense of safety.<sup>15</sup>

### Professional

- Dealing with a perpetrator can be even more difficult than dealing with a victim/survivor, especially in rural practices or Aboriginal medical services, where the entire family is likely to be well known to the health professional.<sup>22</sup>
- Health professionals are likely to feel at risk, especially if they are drawn into the power dynamics of the violence or if they are dealing with a perpetrator.<sup>22</sup>
- Maintaining an 'intellectual engagement' with difficult work can be protective.<sup>20</sup>
- It is important for health professionals to recognise their own limitations and those of their practice or organisation and ask for professional support appropriately

### Organisational

- Health professionals, doctors in particular, are trained to deal with individuals and to take personal responsibility rather than delegate; however, shared responsibility and a therapeutic alliance with a patient-centred team is likely to be more successful in challenging areas such as family and domestic violence.<sup>24</sup>
- The organisation or practice should be aware if health professionals are struggling with maintaining boundaries, or if they are dealing with both a victim/survivor and perpetrator.<sup>22</sup> It is recommended that the same health worker does not manage the perpetrator, victim/survivor and children in the family (refer to [Chapter 2: Intimate partner abuse: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) ).
- Dealing with abuse and violence as a team will mean reflecting together on the need to develop new skills.
- Organisations and staff should be aware of the risks to staff of stress, burnout and vicarious trauma and deal with any organisational issues involved.<sup>13</sup>
- Addressing issues of burnout at an organisational level will include an awareness of the administrative burden placed on health professionals, as this gives little workplace satisfaction. On the other hand, improving the meaning of work and ensuring transparent communication and collaboration can be protective.<sup>25</sup>

### Balance

### Personal

- Lifestyle choices that promote 'wellness' include supportive relationships, religion or spirituality, focusing on even small successes, and a positive outlook, as well as simple measures such as getting enough sleep, exercise, good nutrition, meditation and laughter.<sup>19</sup>
- There is a need for flexibility, adaptability and tolerance of uncertainty, and purposeful physical,

intellectual, spiritual and relationship sustenance.<sup>19</sup>

- Without a positive countervailing exposure to human good and world order, health professionals may experience the same loss of a sense of personal control, freedom and trust as their patients.<sup>7</sup>
- The health professional needs to balance their own expectations with the expectations of the patient, the organisation, their colleagues and their own family and find a practical path through the conflicting priorities of each.

### Professional

- Appropriate support for the doctor in both training and clinical practice needs to be readily available, especially considering that up to 24% of male doctors and 42% of female doctors have a personal history of child abuse or IPAV.<sup>26</sup>
- Health professionals with less perceived control, greater stress from uncertainty, higher job demands and fewer social supports are at greater risk of burnout.<sup>27,28</sup>
- Professional development and specialised trauma training will decrease the risk of vicarious trauma.<sup>11</sup>
- One of the difficult balances in abuse and violence is the tension between maintaining confidentiality and still receiving added support from other health professionals.
- Learn to celebrate small achievements, rather than feel overwhelmed by the big picture.<sup>5,20</sup>
- As with other complex and time-consuming occupations, it is important to have clear boundaries between work and home, find role models and mentors, attend peer support groups, and maintain professional development and training activities.<sup>23</sup>
- As a defence against the sometimes-intense feelings of helplessness, a health professional may take on the role of a rescuer or saviour. There is a fine line between caring for someone and disempowering them from finding their own solutions.<sup>20</sup> The use of motivational interviewing techniques<<link to chapter 4>> will assist the health professional to explore the patient's solutions and ensure that the patient is empowered.
- Mindfulness training is associated with a lower reactivity to stressful situations and negative emotional stimuli and increases the health professional's ability to judge a situation more objectively and in a more positive light.<sup>8</sup>

### Organisational

- It is important to provide necessary organisational support services to health professionals providing care for patients in crises. Organisational balance involves a sense of control over the practice environment, social support from colleagues, and satisfaction with work demands and resources.<sup>27</sup>
- Many organisations seem to be caught in a struggle between promoting the wellbeing of their patients and trying to cope with policies and structures in a system that tends to stifle the empowerment and wellbeing of their staff.<sup>13</sup> It has been noted that too much emphasis has been placed on the individual healthcare worker, rather than supportive organisational processes, to recognise and manage distress, burnout and negative mental health consequences of work circumstances.<sup>6</sup>
- There needs to be a balance between caring for patients appropriately by giving them the time they need, earning a reasonable income and satisfying the organisation's requirements for performance.<sup>5</sup>
- Health professionals need physical security and a safe, confidential workplace, support for

continuing education, and adequate vacation and sick leave.

- A 'problem-solving' culture rather than one of blaming others helps both patient and health professional be more objective and balanced.<sup>16</sup>
- Staff will be supported by a shared aim and purpose, adequate staffing and a sense of team management. This will decrease the risk to individuals within the practice, as well as to the organisation.
- Providing a peer support or supervision group for the staff can make a positive contribution.
- Control working hours in the challenging area and if possible, balance this with other less challenging jobs.<sup>20</sup>
- Devote at least 20% of time to work activities that are especially meaningful.<sup>29</sup>
- For women health professionals, particularly doctors, addressing organisational barriers to career progression and to a balance between career and family can be helpful in preventing burnout (eg family leave, lactation and childcare policies and support).<sup>30</sup>

## Connection

### Personal

- Working in a supportive team is associated with being better able to cope with stress.<sup>31</sup>
- If a health professional is becoming burnt out, there may be increased substance use, pessimism or suspiciousness of both patients and colleagues.<sup>23</sup>
- If a health professional is aware that they are suffering from compassion fatigue or burnout they may need to ask for professional help<sup>11</sup> and find activities that connect with mind, body and support networks.<sup>23</sup>
- Social support systems can provide understanding and renew emotional reserves.<sup>23</sup>

### Professional

- Confidentially debriefing with colleagues can reduce stress levels by sharing the experience, and colleagues can enable help-seeking when necessary.
- Peer support groups, professional development and training activities can also be replenishing and reinforce the value and meaning of work.

### Organisational

- Working and communicating well as a team with the GPs, practice nurses, Aboriginal health workers and receptionists within the practice or Aboriginal health service, and with public health nurses, teachers, police and other agencies, is very important in the identification and management of abuse and violence.<sup>22</sup>

## Resources

- [DRS4DRS \(https://www.drs4drs.com.au\)](https://www.drs4drs.com.au) – an independent, safe, supportive and confidential doctor-to-doctor service, providing online resources, referral and help finding a GP. Includes a confidential telehealth service for doctors and medical students who are struggling with their mental health.
- [Self-care and mental health resources for general practitioners \(https://www.racgp.org.au/FSDE\)](https://www.racgp.org.au/FSDE)

[DEV/media/documents/Clinical%20Resources/Resources/Self-care-and-mental-health-resources-for-general-practitioners.PDF](#) – an RACGP guide to resources and services.

- General practice – a safe place: A guide to preventing and managing patient-initiated violence – an RACGP guide providing tips and tools.
- *First do no harm: Being a resilient doctor in the 21st century* (<https://srh.bmj.com/content/37/2/116.1>) – a book by L Rowe and M Kidd, McGraw-Hill Australia, 2009.
- [Understanding and addressing vicarious trauma](https://www.headington-institute.org/resource/understanding-vt-reading-course/) (<https://www.headington-institute.org/resource/understanding-vt-reading-course/>) – a course of online self-study from the Headington Institute.
- [RACGP GP support Program](https://www.racgp.org.au/membership/the-gp-support-program?utm_source=Mem_land_page&utm_medium=web&utm_campaign=GP_support_program) ([https://www.racgp.org.au/membership/the-gp-support-program?utm\\_source=Mem\\_land\\_page&utm\\_medium=web&utm\\_campaign=GP\\_support\\_program](https://www.racgp.org.au/membership/the-gp-support-program?utm_source=Mem_land_page&utm_medium=web&utm_campaign=GP_support_program)) – a free service offered to RACGP members, providing access to professional advice to help cope with stressors such as handling work pressures; managing conflict, grief and loss; relationship issues; concerns about children; anxiety and depression; alcohol and drug issues; and traumatic incidents.
- The following helplines are available in each state or territory:
  - NSW and ACT: Doctors Health Advisory Service, 02 9437 6552
  - Queensland: Doctors' Health in Queensland, 07 3833 4352
  - South Australia and Northern Territory: Doctors' Health SA, 08 8366 0250
  - Tasmania and Victoria: Victorian Doctor's Health Program, 03 9280 8712
  - Western Australia: Doctors Health Advisory Service WA, 08 9321 3098

## References

1. Baird S, Jenkins S. Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence Vict* 2003;18:1.
2. De Hert S. Burnout in healthcare workers: Prevalence, impact and preventative strategies. *Local Reg Anesth* 2020;13:171–83.
3. Hudnall-Stamm B. Secondary traumatic stress: Self-care issues for clinicians, researchers and educators. Lutherville: Sidran Press; 1995.
4. Saakvitne K, Pearlman L. Transforming the pain: A workbook on vicarious traumatization. London: Norton; 1996.
5. Bloom S. Caring for the caregiver: Avoiding and treating vicarious traumatization. In: Giardino A, Datner E, Asher J, editors. *Sexual assault, victimization across the lifespan*. Maryland Heights: GW Medical Publishing; 2003.
6. Søvold LE, Naslund JA, Kousoulis AA, et al. Prioritizing the mental health and well-being of healthcare workers: An urgent global public health priority. *Front Public Health* 2021;9:679397.
7. Jenkins S, Mitchell J, Baird S, Whitfield S, Meyer H. The counselor's trauma as counseling motivation: Vulnerability or stress inoculation? *J Interpers Violence* 2011;26:2392–412.
8. Conversano C, Ciacchini R, Orru G, et al. Mindfulness, compassion, and self-compassion among health care professionals: What's new? A systematic review. *Front Psychol*;11:1683.
9. Cocker F, Joss N. Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *Int J Environ Res Public Health* 2016;13:618.
10. Dattilio F. The self-care of psychologists and mental health professionals: A review and practitioner guide. *Aust Psychologist* 2015;50:393–99.
11. Smith K. Self-care practices and the professional self. *J Soc Work Disabil Rehabil* 2017;16:186–203.
12. Frey L, Beesley D, Abbott D, Kendrick E. Vicarious resilience in sexual assault and domestic violence advocates. *Psychol Trauma* 2017;9:44–51.

13. Bugaj T, Valentini J, Miksch A, Schwill S. Work strain and burnout risk in postgraduate trainees in general practice: An overview. *Postgrad Med* 2020;132:7–16.
14. Rowe L, Kidd M. *First do no harm: Being a resilient doctor in the 21st century*. North Ryde: McGraw-Hill Australia; 2009.
15. Konkin J, Grave L, Cockburn E, et al. Exploration of rural physicians' lived experience of practising outside their usual scope of practice to provide access to essential medical care (clinical courage): An international phenomenological study. *BMJ Open* 2020;10: e037705
16. Benson J, Thistlethwaite J. *Mental health across cultures. A practical guide for health professionals*. Abingdon: Radcliffe Publishing; 2009.
17. Reibling E, Distelberg B, Guptill M, Hernandez B. Intimate partner violence experienced by physicians. *J Prim Care Community Health* 2020;11:DOI: 10.1177/2150132720965077.
18. Carmona-Torres J, Recio-Andrade B, Rodriguez-Borrego M. Violence committed by intimate partners of physicians, nurses and nursing assistants. *Int Nurs Rev* 2018;65:441–49.
19. Weiner E, Swain G, Wolf B, Gottlieb M. A qualitative study of physicians' own wellness-promotion practices. *West J Med* 2001;174:19–23.
20. Stevenson A, Phillips C, Anderson K. Resilience among doctors who work in challenging areas: A qualitative study. *Brit J Gen Prac* 2011;404–10.
21. [National Center for Posttraumatic Stress Disorder. Working with trauma survivors: What workers need to know \(http://www.ptsd.va.gov/professional/treat/type/work\\_with\\_survivors.asp\)](http://www.ptsd.va.gov/professional/treat/type/work_with_survivors.asp) [Accessed 13 April 2021].
22. Miller D, Jaye C. GPs' perception of their role in the identification and management of family violence. *Fam Pract* 2007;24:95–101. [Accessed 13 April 2021].
23. Snowden T, Benson J, Proudfoot J. Capacity and the quality framework. *Aust Fam Physician* 2007;36:12–4. [Accessed 13 April 2021].
24. Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS one* 2020;15(6):e0234067. [Accessed 13 April 2021].
25. Andolsek K. Physician wellbeing: Organisational strategies for physician burnout. *FP Essent* 2018;471:20–24. [Accessed 13 April 2021].
26. Candib L, Savageau J, Weinreb L, Reed G. Inquiring into our past: When the doctor is a survivor of abuse. *Fam Med* 2012;44:416–24. [Accessed 13 April 2021].
27. Freeborn D. Satisfaction, commitment, and psychological well-being among HMO physicians. *West J Med* 2001;174:13–28. [Accessed 13 April 2021].
28. Prentice S, Dorstyn D, Benson J, Elliott T. Burnout levels and patterns in postgraduate medical trainees: A systematic review and meta-analysis. *Academic Med* 2020;95:1444–54. [Accessed 13 April 2021].
29. Rothenberger D. Physician burnout and well-being: A systematic review and framework for action. *Diseases Colon Rectum* 2017;60:567–76. [Accessed 13 April 2021].
30. Chesak D, Boldero J. *Keeping the doctor alive – A self care guide book for medical practitioners*. Melbourne: The Royal Australian College of General Practitioners, 2005. [Accessed 13 April 2021].
31. Edwards N, Kornacki M, Silversin J. Unhappy doctors: What are the causes and what can be done? *BMJ* 2002;324:835–38. [Accessed 13 April 2021].



# *Children and young people*

# Child abuse and neglect

'Responding to child abuse and neglect is a shared responsibility in our community. Everyone plays a role across the education, social and health sectors in recognising and responding to this issue.'

## Key messages

- Child abuse is common, and most commonly perpetrated by someone within the family, or by a person known to the child.<sup>1</sup> Children less than one year of age are particularly vulnerable, especially to physical abuse and poor attachment to parents.<sup>2</sup>
- Child abuse is a major health issue causing immediate problems and often long-term serious health problems that continue into adult life. Health practitioners have a professional responsibility to be aware of services that help to prevent child abuse, and to detect and refer families at risk to appropriate services.<sup>3</sup>
- All health practitioners need to be aware of their legal obligations under state or territory mandatory reporting requirements when they suspect child abuse (refer to Table 9.5).<sup>4</sup>
- Health practitioners can play a crucial role in providing support to families affected by adverse circumstances through offering ongoing supportive and trauma-informed care and linking to services as required.

## Recommendations

Health practitioners have a role in prevention of child abuse and neglect by identifying families at risk where domestic violence is co-occurring. Refer to parent training programs and nurse home visitation programs.

**(Strong recommendation: Moderate certainty of evidence)**

Harmful alcohol and drug use has a strong link with child abuse and neglect. It is therefore

recommended that practitioners work to reduce alcohol consumption in adults with children in their care, using evidence-based methods such as alcohol screening and brief interventions.

**(Practice point: Consensus of experts)**

## Clinical context

### Definitions and terminology

In this guide, the term 'child abuse and neglect' is used to refer to:

- any act or omission of care by a parent or other caregiver that results in harm, the potential for harm or the threat of harm to a child<sup>5</sup>

or

- any intentional and non-intentional behaviours by parents, caregivers or other adults considered to be in a position of responsibility, trust or power that results in a child being harmed physically or emotionally.<sup>6</sup>

The terms 'child maltreatment' and 'non-accidental injury' are also often used in the literature.

There are five types of child abuse and neglect:<sup>5</sup>

- **Physical abuse** – intentional use of physical force or objects against a child that results in, or has the potential to result in, physical injury.

This includes hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, shaking, strangling, smothering, burning, scalding and poisoning.

2. **Emotional abuse** – behaviour that conveys to a child that they are worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs.

This includes blaming, belittling, degrading, intimidating, terrorising, isolating or otherwise behaving in a manner that is harmful, potentially harmful or insensitive to the child's developmental needs, or can potentially damage the child psychologically or emotionally.

Threatening, yelling, taunting and debasing (eg 'You're worthless', 'You're dumb', 'No-one likes you') constitute emotional abuse. Witnessing intimate partner abuse/violence (IPAV) can also be classified as exposure to emotional or psychological abuse.

3. **Sexual abuse** – any completed or attempted sexual act, sexual contact, or non-contact sexual interaction.

This includes penetration, touching a child inappropriately and exposure to sexual activity, filming or prostitution.

4. **Neglect** – failure to meet a child’s basic physical, emotional, medical/dental, safety or educational needs. This includes:
  - failure to provide adequate nutrition, hygiene or shelter
  - failure to ensure a child’s safety, which can include failure to provide adequate food, clothing or accommodation
  - not seeking medical attention when needed
  - allowing a child to miss long periods of school
  - failure to protect a child from violence in the home or neighbourhood or from avoidable hazards.
  
5. **Exposure to domestic and family violence** – children living in families where domestic and family violence occurs (any incident of threatening behaviour, violence or abuse that is psychological, physical, sexual, financial or emotional) are considered victims of child abuse. Clinicians need to ensure, where possible, that the child or children and the non-abusive parent are in a safe environment. Depending on your state or territory law, mandatory reporting may be required in this situation if safety cannot be ensured. State and territory laws on what forms of abuse are mandated to be reported can be found [here \(https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect).

## Adverse childhood experiences

Experiencing any of these types of abuse is classed as an adverse childhood experience (ACE). ACEs are stressful and potentially traumatic events that a child or young person experiences before the age of 18. In addition to child abuse and neglect, ACEs include other potentially traumatic experiences such as maladaptive parenting practices, divorce or separation, having a mentally ill caregiver or a caregiver who engages in substance abuse, or experiencing socioeconomic adversity.<sup>7</sup>

Population studies suggest that 40–60% of adults have experienced at least one ACE, and 25% of adults have experienced at least three ACEs.<sup>8</sup>

ACEs can have lasting negative impacts on health and wellbeing.<sup>9-11</sup> Higher ACE scores have been associated with poorer physical and mental health and with greater use of health-harming behaviours such as substance abuse.<sup>9,12</sup> Considering any potential ACEs occurring within a family may be a useful framework for assessing for abuse. To learn more about the ACEs study, refer to [this presentation by Dr Vince Felitti MD \(https://www.youtube.com/watch?v=ns8ko9-ljU\)](https://www.youtube.com/watch?v=ns8ko9-ljU). Also refer to [this discussion of ACEs by the US Centers for Disease Control and Prevention \(https://www.cdc.gov/violenceprevention/aces/index.html\)](https://www.cdc.gov/violenceprevention/aces/index.html).

## Effects of child abuse and neglect

Experience of child abuse or neglect is linked to many conditions in babies, children and young people. Babies and children may experience detrimental effects in their cognitive, emotional, behavioural and social development.<sup>13</sup> This can undermine a child’s capacity for trust, intimacy, agency and sexuality. A study of adolescents found that experiencing child abuse and neglect primarily accounted for their mental health symptoms.<sup>14</sup>

Adult victims/survivors of child abuse and neglect are more likely than the general population to experience physical health conditions such as obesity and heart disease.<sup>9,12</sup> Adult victims/survivors are also twice as likely than the general population to experience serious depression, and are 12 times more likely to commit suicide.<sup>9-11,15,16</sup>

For more information, refer to the chapter on [adult survivors of child abuse \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse).

## Prevalence

Internationally, nearly three in four children aged two to four years regularly suffer physical punishment and/or psychological violence at the hands of parents and caregivers. One in five women and one in 13 men report having been sexually abused as a child aged 0–17 years.<sup>17</sup> Approximately 2.5 million Australian adults (13%) have experienced abuse during their childhood. This includes 1.6 million adults (8.5%) who experienced childhood physical abuse and 1.4 million adults (7.7%) who experienced childhood sexual abuse.<sup>18</sup>

In Australia from 2017–18, approximately 26,400 children aged up to 12 years had one or more child protection notification substantiated (excluding New South Wales as data were not available).<sup>6</sup> While notification rates fluctuated during the COVID-19 pandemic, substantiation rates remained stable.<sup>19</sup> These figures are likely an underestimate of the prevalence of child abuse and neglect in Australia. Children aged under one were around twice as likely as other age groups to have at least one child protection substantiation.<sup>6</sup> Family violence is a factor in more than half of the substantiated child protection cases and children are present at more than half of police attendances in Victoria.<sup>20</sup>

In 2017–18, 14% of reports that were substantiated came from medical or health personnel.<sup>6</sup> Medical and health personnel are the third most common source of notifications for investigated cases, after police and school personnel.<sup>6</sup>

The most common form of substantiated childhood abuse is emotional abuse (59%), followed by neglect (18%), physical abuse (15%) and sexual abuse (8%).<sup>6</sup>

Between 2000 and 2012, 284 children and young people were victims of filicide (death caused by parent or parent equivalent).<sup>21</sup> Filicides constituted 18% (238 of 1356) of domestic homicide incidents.<sup>21</sup>

## Risk factors for child abuse and neglect

### Babies

Children who experience abuse and neglect within the first two years of life can experience significant developmental consequences.<sup>22</sup> Several factors can contribute to risk in this age group, many of which may be identified during routine care, particularly in the care of pregnant women.

Risk factors include:<sup>22</sup>

- use of hazardous drugs or alcohol during pregnancy
- a family violence situation

- mental health problems or intellectual disability, which can compromise a parent's ability to care for their child
- poor attachment to the infant
- absence of social supports or isolation
- unstable housing or financial situation
- history of own abuse or neglect or that of another child in the family.

The baby's health needs may compound these difficulties.

Supporting families during this early stage of childhood, particularly during the antenatal period, can provide opportunities to identify special needs and assist families to plan for the care of their baby. In some contexts, this may involve referring the child or family to support services, or making a report to the appropriate [child protection service in your state or territory \(https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect).

### Children

Once a child's mobility increases and they begin to explore and learn about their environment, they are at greater risk of accidental trauma and therefore require close supervision.<sup>22</sup> Behaviours such as substance abuse or conditions like mental illness or intellectual disability can hinder a caregiver's ability to provide appropriate supervision and care.<sup>22,23</sup> Inadequate supervision and neglect can lead to physical harm and, in extreme cases, fatality.<sup>22</sup> Emotional neglect can negatively impact on children's development and ability to form intimate relationships.<sup>13,22,23</sup>

It can be difficult to distinguish between injuries resulting from using force with a child and accidental injuries. It can also be difficult to determine whether or not an accidental injury is a result of neglect. Questions to ask yourself that may help in distinguishing between accidental and non-accidental injury include:

- Does the story support the injury? Does the story change over the course of the discussion?
- Is there a pattern of 'accidental injury'? This may indicate ongoing neglect.
- Is the child placid and passive during the examination?

Maladaptive parenting practices resulting in punitive disciplinary parenting practices can increase children's risk of physical harm. It is important to be aware of the dynamic between child and caregiver to help you identify behaviour that may be concerning.

### A shared responsibility

Responding to child abuse and neglect is a shared responsibility in our community. Everyone plays a role across the education, social and health sectors in recognising and responding to this issue. It is important to remember that collaboration across these sectors creates the multidisciplinary response needed to effectively respond to child abuse and neglect.

## The role of GPs

GPs play a special role in maintaining the health of individuals and families over time. Through this ongoing relationship with families, GPs are often aware of changing dynamics, circumstances and stresses within a family unit. As such, GPs are uniquely placed to identify situations that may give rise to child abuse and neglect.

GPs can intervene at three levels:

1. Recognise risk factors and intervene early to reduce risk of abuse and neglect and prevent harm (primary prevention).
2. Recognise harm and respond appropriately to mitigate future harm (secondary prevention).
3. Support the ongoing wellbeing of both the child and the family to manage the long-term negative impacts of harm.

## In practice

The case studies at the end of the chapter provide examples of recognising and responding to child abuse in general practice. The case studies and characters are fictitious but have been based on the collective experiences of 38 GPs and nurses who participated in a PhD study.<sup>24</sup>

We strongly recommend registering with the [VEGA \(Violence, Evidence, Guidance and Action\) Project](https://vegaproject.mcmaster.ca/) (<https://vegaproject.mcmaster.ca/>) and undertaking the free short training module, 'Recognising and responding safely to child maltreatment'. This is a Canadian website created by experts in prevention of family violence and it has excellent demonstrations of how to approach this issue in clinical practice.

## Recognising and responding to child abuse and neglect: A stepped approach

When working with children and families, the key steps in recognition and response are:

- Recognising vulnerability and risk
- Assessing harm
- Providing an initial response and intervention
- Seeking additional advice
- Notifying the appropriate child protection service in your state or territory
- Ongoing care

### Recognising vulnerability and risk

Many families experience vulnerability at some stage.<sup>25</sup> This vulnerability may be time limited or it can be significant and long-lasting, and its effects can stay with a child through adulthood.<sup>25</sup>

GPs and other primary care clinicians are often the first point of contact for families under stress and for children at risk of abuse.<sup>26</sup> It is important to remain aware of the possibility of abuse when caring for children, particularly children with emotional or behavioural issues or unexplained injuries, or when their parent is experiencing IPAV.

Child abuse can present in myriad ways, and its effects vary from child to child. While some children may present with bruising or injuries that raise suspicion, most do not. In the majority of children, direct physical injuries cause less morbidity than the long-term effects of the violence on the child's neurological, cognitive and emotional development and health.<sup>10</sup>

Therefore, when seeing a child, it can be very difficult to know whether the root cause of a presentation is definitively abuse or neglect. The family may also be actively trying to hide the abuse or neglect.

Be alert to adults whose children may be at risk. Children in families where one or both caregivers are abusing alcohol are at high risk of neglect and other forms of abuse.<sup>27</sup>

Other commonly cited risk factors for child abuse and neglect include:<sup>17,28</sup>

- children with medical needs or a disability
- risky social or family context (including family violence, poverty or poor housing or social contexts involving intergenerational trauma)
- lack of social support
- children of caregivers with a mental illness, intellectual disability or substance abuse issues that impact upon the tasks of parenting.

If concerned about a child being vulnerable to or at risk of abuse and/or neglect, consider engaging the child and their family with support services as appropriate to address vulnerabilities. This may mean referring the child or family to, or working with, social or welfare, financial, legal or mental health support services within the community in an integrated care model.

Also consider services that can respond within the context of the family's cultural needs. For example, Aboriginal and Torres Strait Islander services such as Orana Gunyah Victorian Aboriginal Child Care Agency, or culturally and linguistically diverse services such as InTouch Multicultural Centre Against Family Violence are available for referral. For more recommendations on preventive services for Aboriginal and Torres Strait Islander communities, refer to the RACGP's [National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people \(https://www.racgp.org.au/FSDEDEV/media/documents/Clinical\\_Resources/Resources/National-guide-3rd-ed-Sept-2018-web.pdf\)](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical_Resources/Resources/National-guide-3rd-ed-Sept-2018-web.pdf), page 44.

Your state or territory child protection service, Primary Health Network or even local council may have suggestions for where to find support services for vulnerable families. Some examples of support services or where to find them for each state are included in Table 9.1.

**Table 9.1. Where to find support services**

State or territory	Service or relevant website



Table 9.1. Where to find support services

<b>Australian Capital Territory</b>	<a href="https://www.communityservices.act.gov.au/women/womens_directory/domestic_and_family_violence">Domestic and sexual violence - community services (https://www.communityservices.act.gov.au/women/womens_directory/domestic_and_family_violence)</a>
<b>New South Wales</b>	<a href="https://www.facs.nsw.gov.au/domestic-violence/services-and-support/contacts/a-z#3">Domestic violence services and support contact list/Family and community services (https://www.facs.nsw.gov.au/domestic-violence/services-and-support/contacts/a-z#3)</a>
<b>Northern Territory</b>	<a href="https://nt.gov.au/law/crime/domestic-family-and-sexual-violence/get-help-for-domestic-family-and-sexual-violence">Get help for domestic, family and sexual violence (https://nt.gov.au/law/crime/domestic-family-and-sexual-violence/get-help-for-domestic-family-and-sexual-violence)</a>
<b>Queensland</b>	<a href="https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence/find-local-support">Find local support/Community support (https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence/find-local-support)</a>
<b>South Australia</b>	<a href="https://www.childprotection.sa.gov.au/child-protection-initiatives/support-services-for-children,-young-people-and-families/family-support-services">Family support services/Department for Child Protection (https://www.childprotection.sa.gov.au/child-protection-initiatives/support-services-for-children,-young-people-and-families/family-support-services)</a>
<b>Tasmania</b>	<a href="https://www.safechoicestas.org.au/safe-choices">Safe Choices (https://www.safechoicestas.org.au/safe-choices)</a>
<b>Victoria</b>	Orange Door: <a href="https://orangedoor.vic.gov.au/">Family violence support and extra help for children and families (https://orangedoor.vic.gov.au/)</a>
<b>Western Australia</b>	<a href="http://www.wa.gov.au">Family and domestic violence services and resources (http://www.wa.gov.au)</a>

It is important to consider cumulative harm when responding to the wellbeing of the child and family and intervene early (refer to Case study: Michael).

When working with any adult patient, not only those with risk factors such as substance abuse, consider any children for whom the adult may be responsible. If you believe the adult is not capable of caring for their children at that time (eg because of physical or mental health problems, disabilities or substance abuse), early, supportive intervention may reduce any harm to the children.

In cases where you have serious concern for the immediate safety of a child, a report is mandatory (refer to Case study: Sarah). If an adult discloses abuse or neglect of a baby or child, GPs are not required to examine the baby or child before making a report to a child protection service.

A report to the appropriate [child protection service \(https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect) is mandatory when you have serious concerns for the immediate safety of the child. Refer to Table 9.5 for more information.

Table 9.2. details the physical and behavioural signs of abuse that require a response to mitigate future harm (secondary prevention).

---

**Table 9.2. Possible signs, symptoms and presentations of abuse<sup>29</sup>**

---

Type of abuse	Physical signs	Behavioural signs
---------------	----------------	-------------------

---

**Table 9.2. Possible signs, symptoms and presentations of abuse<sup>29</sup>**

Physical abuse	<ul style="list-style-type: none"> <li>• Bruising of soft tissue (eg head, neck, trunk, arms)</li> <li>• Imprint of large, multiple, clustered bruises; bruises at different stages of healing</li> <li>• Burns (eg on hands, feet, genitalia)</li> <li>• Inadequately explained bone fractures</li> <li>• X-ray evidence of a history of multiple fractures</li> <li>• Head injuries, especially bleeding into the brain</li> <li>• Retinal bleeding</li> </ul>	<p>The behavioural signs listed below are not specific to any one type of child abuse or neglect. A child may show behavioural or emotional changes such as:</p>
Emotional abuse	<ul style="list-style-type: none"> <li>• Speech problems</li> <li>• Developmental delay</li> <li>• Unexplained physical symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• anxiety, depression, low self-esteem</li> <li>• disruptive or aggressive behaviour</li> <li>• hyperactivity</li> <li>• sleep disorders or nightmares</li> <li>• loss of skills (eg bedwetting)</li> <li>• unusual fear of physical contact with others</li> <li>• lack of emotional expression when hurt</li> <li>• unusual shyness, withdrawal, passivity</li> <li>• suicidal ideation or behaviour</li> <li>• sucking, rocking, biting</li> <li>• poor social skills or interpersonal relationships</li> <li>• school absenteeism, running away, prostitution.</li> </ul>
Neglect	<ul style="list-style-type: none"> <li>• Child found unsupervised, medical needs not met</li> <li>• Abandonment</li> <li>• Malnutrition, poor growth</li> <li>• Untidy appearance, poor hygiene</li> </ul>	<p>Children who have been neglected may beg for food or steal food. Children who have been sexually abused may show abnormal sexualised behaviour, but this can also occur as a result of other types of maltreatment, such as neglect.</p>
Sexual abuse	<ul style="list-style-type: none"> <li>• Trauma to genital or anal area</li> <li>• Unexplained sexually transmitted infection, vaginal/urethral infection or discharge</li> <li>• Pregnancy</li> </ul>	
Exposure to family violence	<p>Increased risk of physical harm or injury due to proximity to an act of family violence</p>	

Source: Child maltreatment: A 'what to do' guide for professionals who work with children. Public Health Agency of Canada, modified 2012. Adapted and reproduced with permission from the Minister of Health, 2021.

## Assessing harm

### Asking children about possible harm

For comprehensive guidance on the practice of asking children about possible harm, access the free short training module, 'Recognising and responding safely to child maltreatment' on the [VEGA \(Violence, Evidence, Guidance and Action\) Project website \(https://vegaproject.mcmaster.ca/\)](https://vegaproject.mcmaster.ca/). The following text is based on this module.

Some points to note:

- To move from **considering** child abuse in a list of differential diagnoses for a sign/symptom to **suspecting** child abuse has occurred (ie having a serious level of concern), further inquiry about a sign or symptom is often required.
- You may not be able to rely solely on information from the caregiver when asking about signs and symptoms.
- Healthcare providers should inquire about child abuse only to the extent needed to determine that there is a reason to suspect child abuse.
- It is not the healthcare provider's role to confirm or investigate whether child abuse has occurred; this is the role of child protection services.
- Forming a suspicion that child abuse has occurred means that a mandatory report to the relevant child protection service must be made in accordance with the laws in your state or territory.

**Before** asking a child about signs and symptoms of abuse it is important to:

- Have sufficient training and support on how to provide a safe response to a child's potential disclosure. If you do not feel able to ask the questions, seek support or consult with child health experts such as paediatricians or social workers.
- Create a private safe space for the consultation in the care setting and allow adequate time.
- Have an established approach at your clinic for making referrals to external services, including support or child protection services.
- Use professional interpreters if required and not family, friends, or other staff.

The VEGA training identifies four key strategies for making an inquiry about child abuse with a child:

1. Separate the child from the caregiver
2. Discuss the limits of confidentiality with children
3. Conduct a phased inquiry
4. Understand how children tell

## Separating the child from the caregiver

- Children need privacy; ensure the conversation cannot be overheard, even by the caregiver.
- Seeing the child alone depends on their developmental stage and age to be interviewed – some child experts indicate this may be from about eight years of age.
- It is important that you are practised in what to say to the caregiver about this step of seeing the child alone. For example, 'It is part of my practice to see children alone for part of the consultation to get their views and so I can do the best job for you and your child'.
- It is important not to imply to the caregiver that you have suspicion of abuse as this may lead to the caregiver leaving prematurely and increasing risk to the child.

## Discuss the limits of confidentiality with children

- Children should not be assured absolute confidentiality.
- Inform the child in developmentally appropriate terms that what is discussed is confidential except if someone's safety is at risk (eg someone is hurting themselves or others or is not being looked after). Check they understand the term 'safety'.

## Conduct a phased inquiry

- Begin with the presenting concern, then proceed to inquire about the child's wellbeing, finally inquire about safety in the home.
- Remember you only need to ask questions to the point where you have enough information to suspect abuse. Do not ask further questions of the child once you have this information. It is up to child protection workers to fully investigate the abuse.
- Thank the child for sharing the information and say you will be getting help for the child and family.
- If you are suspicious but the child does not disclose or denies problems, you may need to follow up or seek advice if the child's behaviour is very high risk (eg running away).
- The VEGA training has many examples of questions to use. An important principle is to avoid asking leading questions such as, 'I see a bruise on your eye – did your dad hit you?' as this assumes the bruise was caused by hitting and hitting was done by dad.

## Examples of questions

### Physical/emotional abuse/neglect

- 'How do the people in your family get along?'
- 'Has anyone made you feel afraid? Can you tell me about that?'
- 'What happens when you get into trouble or don't listen to your [caregiver]'
- 'I notice you have a bruise on your [body part]. Tell me about that. How did it happen?'
- 'Do people in your family ever make you feel bad about yourself?' 'Tell me what that looks like; does anything else happen? What's the worst thing that happens?'

- 'Who takes care of you?'

### **Sexual abuse**

- 'My job is to keep children safe. Some kids have worries about their bodies. Do you have any worries about yours?'
- 'Parts of our bodies are sometimes called private parts. Do you know where your private parts are [may need to explain parts where you pee or poo]. What do you call yours?'
- 'Has any child or adult touched or hurt your private parts?' 'Has anyone made you touch or look at their private parts?'
- 'Sometimes teenagers are asked to do sexual behaviours they don't really want to. Has that ever happened to you?'

### **Third person technique**

Suggestions using the 'third person' technique – talking about others first before the child/adolescent – are:

- 'Sometimes children are good at keeping secrets. What type of secrets do you think children are good at keeping?'
- 'Sometimes I see children I worry about. I saw someone else who was sore like you, what do you think happened to them?'
- 'Some children can get scared at home, what do you think makes them scared?'
- 'Sometimes kids worry about a lot of things, like when they have a fight with their friend, or when someone was mean to them. Kids also worry about things in their home, maybe about mum and dad fighting or when their mum or dad was mean to them. Sometimes kids are scared and don't know what to do. Do you sometimes worry about things like that?'
- 'Does anything happen that makes it hurt for you to wee?'

### **Questions to ask older children**

- 'Growing up can be a really tough time. Sometimes parents and kids don't see eye to eye on the same things and that can be really difficult. How are things going with your parents?'
- 'Do you ever compare how your parents treat you with how your friend gets treated by their parents? How do they compare?'
- 'What happens when people disagree with each other in your house?'
- 'What happens when things go wrong at your house?'
- 'What happens when your parents or carers are angry with you?'
- 'Who makes the rules? What happens if you break the rules?'
- 'How good are the good days? What makes them so good?'
- 'How bad are the bad days? What makes them so bad?'

It is also important to ask the caregivers when you see them on their own about how the family is getting along and fear and safety in the home (refer to [VEGA training \(https://vegaproject.mcmaster.ca/\)](https://vegaproject.mcmaster.ca/)).

### **Understand how children tell**

Children may minimise what is happening and find it difficult to tell someone what is happening for the first time because they:

- feel shame or guilt
- do not recognise their experiences as abuse
- are coerced or attached to the person who is abusing them
- fear the consequences of telling (eg abuse worsens, family might split up, no-one will believe them, they might go into care)
- have communication difficulties.

It is important to recognise that children may not tell even if asked, they may communicate their abuse indirectly (eg by their appearance), and they may spontaneously disclose maltreatment. Children's communication of abuse may refer to recent or past events and may occur gradually over time. Children may not disclose if they feel unsafe (eg are in an unsafe environment or with the unsafe perpetrator).

**Document information using verbatim quotes whenever possible.**

Ensure you document what is observed and heard from whom, when and why this is of concern. Document all actions taken and the outcome.

Children need to be asked age-appropriate questions in a safe environment without hint of judgement toward the child or their caregiver who may be the abuser (refer to Case study: Michael).

**Note: It is important to remember *not* to provide absolute assurances to children that you can keep them safe. For example, you should not say, 'I promise this will not happen to you again'. It is not necessarily within your control.**

**Asking questions of caregivers**

If your suspicions of abuse or neglect are strengthened after further questioning, consider gently discussing the behaviour of the caregiver in a supportive way that recognises the challenges of family life and the current stresses within the household. There is no obligation to discuss these behaviours with the caregiver. Only do so if you feel that the environment is safe and calm. However, where you become seriously concerned for the immediate safety of the child, a report to the relevant child protection service in your state or territory is mandatory and caregivers do not need to be informed of this.

To open a discussion with a caregiver who uses abusive behaviours, you may like to gently encourage reflection on what they need to help them behave in a way that makes them feel good about their role as caregiver and partner (refer to Table 9.3 and Case study: Sarah).

Table 9.3 contains some questions you might ask a caregiver who uses abusive behaviours or a protective caregiver. A protective caregiver is one that does not behave abusively towards their child and uses their resources to actively protect the child from perpetrators of abuse.

---

**Table 9.3. Information-gathering questions directed at parents**

---

**Questions for a protective caregiver**

**Questions for a caregiver suspected of using abusive behaviour**

---

**Table 9.3. Information-gathering questions directed at parents**

<ul style="list-style-type: none"> <li>· ‘Have you noticed patterns in what or who triggers worrying behaviour in your child?’</li> <li>· ‘Do you ever fear for your child’s safety? Do you ever see them fear for their safety?’</li> <li>· ‘Have you ever been worried that someone was going to hurt your children?’</li> </ul>	<ul style="list-style-type: none"> <li>• ‘Children can be really frustrating sometimes. What happens when your child misbehaves and you start to feel that frustration?’</li> <li>• ‘How do you think your child reacts when they see you frustrated or angry?’</li> <li>• ‘What sort of parent do you see yourself being? What support would you like to help you achieve that vision of yourself?’</li> </ul>
--	---

## Providing an initial response and intervention

If a child or young person, parent or caregiver discloses child abuse and neglect, it is important to:

- be aware that the child may be feeling scared, guilty, ashamed, angry, powerless and responsible for the abuse
- be aware of the potential shame, guilt and helplessness the caregiver may be feeling about the situation
- show your care and concern by validating their feelings and reassuring them that they are safe with you and they have done the right thing.

You can use the LIVES acronym to help guide your initial response:<sup>30</sup>

- **Listen** with empathy. You can use non-verbal communication such as eye-contact and nodding to convey your attention.
- **Inquire** about a patient’s needs and concerns. It is important to show respect for a patient’s assessment of their own needs. Use open-ended question to ascertain needs, and address these needs in a treatment plan. This will help the patient to feel empowered.
- **Validate** a patient’s experience and feelings. Try not to minimise their experience by using ‘it could be worse’ statements. Validating the severity of a patient’s experience can help build trust and willingness to open up. It can also provide the patient with reassurance.
- **Enhance safety** by undertaking safety planning. You can use the safety planning guide in Box 9.1 to help you frame a discussion around safety planning. This may be a particularly useful exercise to do with a protective caregiver.
- **Support** by determining what resources and referrals are needed to respond to the patient’s individual needs.



**Box 9.1. WHO safety planning guide, modified for children**

Safe communication

- ‘Who has access to your phone and social media? Do you have a code word to let people know you need help?’

Safe place to go

- ‘If you had to leave home in a hurry, or if you needed to spend a few days away, where would you go? Is there a friend or relative’s place you feel safe at?’

Transport

- ‘How will you get there? Can your protective caregiver take you? Can you be picked up from a safe location?’

Items to take with you

- ‘Can someone help you put a bag together in a safe place with clothes, a toothbrush and the things that make you feel safe at home (eg soft toys or books)?’

Support of someone close by

- ‘Is there a neighbour or a parent of a close friend who can help you when things get really scary at home?’

Other initial interventions are outlined in Table 9.4.

**Table 9.4. Other interventions that form part of the initial response**

Physical abuse	Conduct an X-ray and/or skeletal survey, refer to emergency in severe cases
Sexual abuse	Refer directly to your region’s forensic unit (eg Victorian Forensic Paediatric Medical Service at the Royal Children’s Hospital in Melbourne)
Neglect	In severe cases at high-risk ages (eg babies), refer to emergency

## Evidence-based recommendations for preventing child abuse

When discussing evidence-based interventions that may help with children, parents and carers, provide an explanation of what the intervention will involve and how you think it may help.

### Interventions for a child under five years

Various strategies that promote early and secure infant–parent attachment, promote non-violent modes of discipline and create family conditions for the positive mental health development of the child are effective in preventing child abuse.<sup>31</sup>

Offer an attachment-based intervention (eg SafeCare) to parents or carers who have neglected or physically abused a child under age five. Ideally these programs aim to:

- improve the way the parents nurture their child
- improve understanding of what their child’s behaviour means
- help them respond positively to cues and expressions of child’s feelings
- improve how they manage their feelings when caring for their child.<sup>31</sup>

Consider child–parent psychotherapy for parents who have physically or emotionally abused or neglected their child or where the child has been exposed to domestic violence.

Offer an attachment-based intervention to foster carers looking after children under five years who have been abused or neglected.<sup>31</sup>

There is a high level of evidence to support home visiting programs for parents with babies and infants (aged 0–2 years) with suspected child abuse or in circumstances where the child may be exposed to domestic violence.<sup>32</sup> Examples include:

- community child health nurse home visiting program (number of visits per family range from 18–34 sessions)
- Right@home (25 sessions of approximately 60–90 minutes, delivered by specially trained maternal child health nurse and social worker)
- Parents as teachers (at least 12–24 one-hour home visits annually for at least two years depending on the level of risk and needs delivered by specially trained educators).<sup>32</sup>

### Interventions for a child or young person aged 12 or under

There is strong evidence that programs focusing on parenting improvement and support are effective in preventing child abuse. The two most widely evaluated and widely applied models for delivering these strategies are training in parenting programs and home visitation programs.<sup>32</sup>

Consider a comprehensive parenting intervention for parents and children under 12 if the parent or carer has physically or emotionally abused or neglected the child. Ideally it should address:

- parent–child interactions
- caregiving structures and parenting routines
- parental stress

- home safety.

Examples of programs with a **very high level of evidence** that are available in Australia are:<sup>32</sup>

- [Triple-P program \(https://www.triplep-parenting.net.au/vic-uk/en/triple-p/\)](https://www.triplep-parenting.net.au/vic-uk/en/triple-p/) for parents of children aged 0–16 years
- [Incredible Years \(https://incredibleyears.com/\)](https://incredibleyears.com/) for parents of children aged 0–12 years.

Examples of programs with a **high level of evidence** that are available in Australia are:<sup>32</sup>

- [SafeCare \(https://www.parentingrc.org.au/programs/safecare/\)](https://www.parentingrc.org.au/programs/safecare/) for parents of children aged 0–5 years
- [Circle of Security Parenting Intervention \(http://circleofsecuritynetwork.org/index.html\)](http://circleofsecuritynetwork.org/index.html) for parents of children aged 0–6 years (different languages are available for this program)
- [Tuning in to Kids \(https://tuningintokids.org.au/\)](https://tuningintokids.org.au/) for parents of children aged 18 months – 18 years.

There is a **medium level of evidence** to support psychological therapy for children exposed to trauma.<sup>32</sup> These interventions focus on enhancing mother–child interactions, enhancing the mother’s sensitivity to her child and positive parenting. They are delivered by a psychologist or nurse and in individual or group settings. An example is [Parents Under Pressure \(https://www.pupprogram.net.au/\)](https://www.pupprogram.net.au/) for parents of children aged 0–12 years.

An evaluation of [Caring Dads \(https://caringdads.org/\)](https://caringdads.org/), an evidence-based behaviour change program, was conducted by the University of Melbourne.<sup>33</sup> The evaluation found that there is promising evidence of positive behaviour change in fathers who have abused, neglected or exposed their children to domestic violence. The program is delivered by an accredited facilitator and is available in multiple locations across Australia.

There is a **high level of evidence** to support school-based education programs to prevent sexual abuse and tackle bullying.<sup>32</sup>

For interventions relevant to particular age groups, refer to the [NICE guideline on child abuse and neglect \(https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#therapeutic-interventions-for-children-young-people-and-families-after-child-abuse-and-neglect\)](https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#therapeutic-interventions-for-children-young-people-and-families-after-child-abuse-and-neglect)

## Notifying child protection services

GPs and nurses have a legal responsibility to report child abuse and neglect. If you believe the child has suffered, or may suffer, significant harm as a result of abuse or neglect and are in need of protection, you must notify the relevant child protection service in your state or territory. This may be clear immediately or only after monitoring a situation over time (eg initial warning signs in the child’s behaviour may not warrant a report, but later information – such as a crisis event – may clarify the situation).

It is important for health professionals to be aware of mandatory reporting laws in relation to child abuse. Each Australian state and territory has different legislation regarding what must be reported by whom (refer to Table 9.5).

## Seeking additional advice and information when unsure about reporting

Where you are unsure of whether abuse is taking place, but are concerned about a child or their family, you may need to seek additional advice and information by way of secondary consultation. Part of forming a reasonable belief is believing that another reasonable person in your situation would reach the same conclusion.

Secondary consultation may be obtained by speaking with colleagues in your practice, paediatricians or social workers to review the case and reach a consensus. You can also call a child protection service or your medical defence organisation and ‘test’ the case, without disclosing the child’s identity, to establish whether it requires reporting. However, this option may not be available for every child protection regional intake service.

Some states provide an alternative service for clinicians to obtain advice about whether a mandatory report should be made. For example, in Victoria [The Orange Door \(https://orangedoor.vic.gov.au\)](https://orangedoor.vic.gov.au) is a state-based child service that provides support to vulnerable families and secondary consultation to assist clinicians with management options, including mandatory reporting.

If you seek additional advice but are still unsure about whether to report, the general advice is to make a report regardless of any uncertainty.

For more information see information from the [Australian Government Australian Institute of Family Studies \(http://www.aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect\)](http://www.aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect).

**Table 9.5. Key features of legislative reporting duties for doctors and nurses: ‘State of mind’ and abuse and neglect types that activate reporting duty and extent of harm<sup>4</sup>**

Jurisdiction	State of mind	Abuse and neglect types that must be reported	Extent of harm
Australian Capital Territory	Belief on reasonable grounds	<ul style="list-style-type: none"> <li>• Physical abuse</li> <li>• Sexual abuse</li> </ul>	Not specified: ‘sexual abuse ... or non-accidental physical injury’

**Table 9.5. Key features of legislative reporting duties for doctors and nurses: 'State of mind' and abuse and neglect types that activate reporting duty and extent of harm<sup>4</sup>**

New South Wales	Suspects on reasonable grounds that a child is at risk of significant harm	<ul style="list-style-type: none"> <li>• Physical abuse</li> <li>• Sexual abuse</li> <li>• Emotional/psychological abuse</li> <li>• Neglect</li> <li>• Exposure to domestic violence</li> </ul>	A child or young person is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs that are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm
Northern Territory	Belief on reasonable grounds	<ul style="list-style-type: none"> <li>• Sexual abuse</li> </ul>	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child
Queensland	Has reasonable suspicion	<ul style="list-style-type: none"> <li>• Physical abuse</li> <li>• Sexual abuse</li> </ul>	Significant detrimental effect on the child's physical, psychological or emotional wellbeing
South Australia	Suspects on reasonable grounds	<ul style="list-style-type: none"> <li>• Physical abuse</li> <li>• Sexual abuse</li> <li>• Mental or emotional abuse</li> <li>• Neglect</li> </ul>	Any sexual abuse; physical or psychological abuse or neglect to extent that the child has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy

**Table 9.5. Key features of legislative reporting duties for doctors and nurses: ‘State of mind’ and abuse and neglect types that activate reporting duty and extent of harm<sup>4</sup>**

Tasmania	Believes, or suspects, on reasonable grounds, or knows	<ul style="list-style-type: none"> <li>• Sexual abuse (any)</li> <li>• Physical abuse</li> <li>• Emotional/psychological abuse</li> <li>• Neglect</li> <li>• Exposure to family violence</li> </ul>	Any sexual abuse; physical or emotional injury or other abuse, or neglect, to extent that the child has suffered, or is likely to suffer, physical or psychological harm detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy
Victoria	Belief on reasonable grounds	<ul style="list-style-type: none"> <li>• Physical injury*</li> <li>• Sexual abuse where the child's parents have not protected, or are unlikely to protect, the child from harm of that type</li> </ul>	Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type
Western Australia	Belief on reasonable grounds	<ul style="list-style-type: none"> <li>• Sexual abuse</li> </ul>	Not specified: any sexual abuse
Australia	Suspects on reasonable grounds		Not specified: any assault or sexual assault, sexual abuse, serious psychological harm, serious neglect

Source: Heyes N. Mandatory reporting of child abuse and neglect. Melbourne: Australian Institute of Family Studies, 2020.

## Making the decision to report

Making a report can be a very challenging and conflicting time for a GP or nurse. There are many factors that you might weigh as you make the decision to report. Following are some questions you may ask yourself when considering whether to report.

### Is reporting actually needed for this situation?

There may be situations where the abuse and neglect you suspect is not mandated to be reported. The threshold of suspected abuse that needs to be reported differs across states and territories (refer to Table 9.5). For example, New South Wales mandatory laws specify a report for all types of abuse and neglect where there has been or will be significant harm. Victoria requires reporting only for physical and sexual abuse where at least one of the child's caregivers have not and are not likely to protect the child from harm. Therefore, a report is mandated in New South Wales for a child who is experiencing serious emotional abuse, but a report would not be mandated if that child were living in Victoria.

If reporting is not required, you can still make a voluntary report; however, be aware that this type of report may be a lower priority for child protection services. In this case, you can help the child and the family engage with support services and monitor the situation. You can notify child protection services if the situation evolves to require mandatory reporting.

### I'm worried about how the family will react if I make a report. What strategies can I use to help me manage this?

You are not required to let a family know if you are making a report to a child protection service, and the service is mandated not to reveal the source of the report. However, there may be some cases where your anonymity cannot be guaranteed. In these cases, some GPs have felt that a safer option, both for maintaining the relationship with the family and for the GP's own safety, is to cautiously let the family know about intention to report. Previous and ongoing research suggests that a family's negative reactions can be managed and the relationship between family and practice can remain intact.<sup>34-36</sup> However, if it is unsafe to continue the relationship, you can give the family options about seeing another GP within the clinic or in another clinic altogether. A discussion about your decision to report can be undertaken in the following ways:

- Engaging the protective caregiver and working with them to make a report. It is important to make it clear to the child protection service that the caregiver working with you is protective.
- Framing it as your legal responsibility – you can cite the mandatory reporting laws as 'forcing your hand' to make a report to the child protection service. You can do this in the following way:

'I can see you're going through a really hard time, and it must be so difficult for you. There are things we can do to work on how you're managing. One of those things is letting a welfare service know you're in need of help. Unfortunately, I do have to let Child Protection know. I understand that you might not want to, but because of mandatory reporting laws, my hands are tied. It doesn't mean I think you're a bad parent/your parents are bad. Everyone just needs help sometimes. But you and I can work together to come up with some other strategies for helping you cope with what's going on and how you're feeling'.

- Framing it as an avenue to get help for the family:

'Things seem so tough for you right now that I don't think anyone can handle doing it on their own. I have decided to let Child Protection know what's going on, they may be able to help you access some services that can help you cope with the situation. It doesn't mean I think you're a bad parent. It means that you're in a situation where you can't be the best parent you want to be/your parent can't be at their best. That's not your fault.'

If the family does have a negative reaction, it's important to put your safety first. You may like to call in a colleague as a witness and to help you feel safer about the confrontation. You might like to ask the family to sit in an area where they can calm down before you discuss the matter with them further.

### **Do I have any potential biases?**

When dealing with abuse, it can be difficult to lay aside your feelings and view the situation objectively.

Some GPs worry about how their relationship with the family may influence their suspicion of abuse and neglect.<sup>37</sup> The relationship with the family seems to have a dual effect: knowing about family dynamics may alert a GP or nurse to a potential abuse situation, but on the other hand, some GPs or nurses may not feel able to accept that abuse is happening in a patient's family.<sup>37</sup>

Factors like your relationship with the patient's family can influence your personal threshold of suspicion. The 'personal threshold of suspicion' refers to the level of suspicion a GP would need before they felt their reporting duty was activated.<sup>37</sup> This threshold of suspicion can vary between individuals and may or may not align with the threshold of the law.<sup>37</sup> The personal threshold of suspicion is dynamic and can be influenced by different factors, as seen in Figure 9.1. It is important to reflect on what your personal threshold might be and how it aligns with the law. You can find out about your personal threshold of suspicion by considering or discussing with others what behaviours, signs or symptoms would trigger you to report.





Figure 9.1. Factors influencing the personal threshold required to identify or report child abuse<sup>37</sup>

Source: Kuruppu J, McKibbin G, Humphreys C, et al. *Tipping the scales: Factors influencing the decision to report child maltreatment in primary care. Trauma Violence Abuse* 2020;21:427–38. Reproduced with permission from SAGE Publications.

### Making the report

When you feel a report is appropriate, call your centralised Child Protection helpline or local Child Protection Division Intake Service. The contact details for of the reporting authority in each Australian state and territory are listed [here \(https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect). Some states such as Western Australia and New South Wales have an online reporting option.

If you, as the GP, have concerns and are also aware that another team member or agency has made a report, it is still important to make your own an independent report. This report may add weight of evidence or contribute additional information not previously made known to the child protection service.

### After making the report

If a family is aware or becomes aware that you have made a report to the child protection service, be mindful of the possibility that you may lose the family as patients. This is a commonly reported outcome of making a report. However, there are situations where GPs have maintained their relationship with the family following a report (refer to Case study: Sarah). The suggestions in this guide

have been made with the intention of helping you maintain your therapeutic relationship with the family. If this relationship remains intact, the GP's ongoing roles and responsibilities after making a report may include:

- continuing to monitor the child's behaviour in relation to ongoing harm, through follow-up appointments
- continuing to assess and respond to the child's physical and mental health needs
- coordinating care, helping families access appropriate services and supports, including Aboriginal and Torres Strait Islander or culturally and linguistically diverse services
- liaising with other professionals and child protection workers in relation to a child's wellbeing
- providing written reports for case planning meetings or court proceedings in relation to a child's wellbeing or progress.

The child or young person may feel distressed, guilty, ashamed, confused or frightened, and will need support throughout the protective intervention. Professionals involved with the family may be in a position to offer ongoing support by:

- liaising with child protection workers to ensure they are giving appropriate support to the child or young person
- providing support to the family where appropriate
- dealing sympathetically and effectively with changes to the child's behaviour that may occur in response to intervention.

### Ongoing care

Beyond the initial stages, GPs play an important role in providing support to manage the impact and longer-term effects of harm related to child abuse and neglect. This role may be carried out as part of continuous and ongoing care over time or for a new patient presenting with historic, imminent or ongoing abuse and neglect.

As discussed earlier, if not already in place, consider engaging the child and their family with support services as appropriate to address vulnerabilities (eg social or welfare, financial, legal or mental health services within the community). Refer also to the section, Evidence-based recommendations for preventing child abuse<<link to section earlier in this chapter>>.

The dynamic of vulnerability and risk of abuse and neglect can change over time. Therefore, working with the patient's family to build an ongoing relationship can allow you to provide support, advice and problem-solving around the health issues associated with child abuse and neglect.

There may have been a scenario where an initial report did not lead to allocation of a child protection worker. If you have ongoing concerns, it may be necessary to make a new report. In the case where the child and family are engaged with a child protection service but concerns about abuse remain, it may be possible to ask to speak to the child protection worker to raise any new or ongoing concerns.

## Managing GP safety

Recognising and responding to child abuse and neglect can be an emotionally taxing task. You may find yourself managing families' emotions, as well as your own, when dealing with an issue as sensitive as child abuse and neglect. Deciding to report a case against a child or family's wishes can be particularly difficult. Some GPs and nurses fear retaliation from the family on a personal or professional level. These are common and valid concerns. Take the time to work through any personal conflict and fears and consider your own physical and emotional safety. Some strategies that may help include:

- coming to the decision to report within a team environment (ie with colleagues in your practice) as this may help reassure you of the decision and alleviate the emotional burden
- seeking supervision from a colleague or from an external source
- engaging in a de-identified debriefing with a trusted colleague, friend or family member
- reflectively reassuring yourself of the 'evidence' and the importance of responding to child abuse and neglect
- considering having a colleague with you if you decide to tell a family about a report and you are concerned about their reaction
- increased engagement in your usual self-care routine
- consulting your medical defence organisation for decision support.

Remember that if you make a report in good faith that is not substantiated, the law protects you professionally as a mandated reporter.

If you experience a response from the family that makes you fear for your safety or the safety of those around you, inform police and take out an intervention order. Please note that this situation is rare.

Refer also to the [chapter on self-care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care).

## Case study: Sarah

My name is Sarah and I'm a GP working in a small private clinic in Victoria. I have a patient base that I know well. The other day, a patient of mine with an intellectual disability who recently had a baby missed her appointment. I was keen to see her to make sure things were going okay as I knew she was part of a vulnerable population experiencing a situation that can be highly stressful. I usually communicate with her through her case worker but when I rang, it was clear her case worker was on holidays. I was sure this was why my patient had missed the appointment and it increased my concern about her vulnerability. I rang my patient personally and made another booking, hoping she would turn up. She didn't and I was worried but I didn't get a chance to follow up. A couple of days later, she came in of her own accord. Her baby was extremely unwell. I saw she was distressed but I felt the confusion under her distress. She didn't understand why he was in the state he was in. The child had lost weight, was minimally responsive to interaction and did not smell or look clean. I immediately sent him to hospital with my patient.

While I knew reporting was mandated for a case of significant harm, I debated about making a report to Child Protection. I felt this was a case of significant harm resulting from neglect due to my patient's intellectual disability. However, I knew the system was already heavily involved with my patient's situation and I knew that support had been stepped up when she had her baby. I was aware that she was getting the most support possible from an overloaded system. I also knew that any neglect that resulted was not intentional and she was not being malicious. She loved her baby. I understood that she was simply ignorant, and I felt guilty about reporting her to the authorities.

That said, I had read that a report must be made for every new incident that occurs or if new information comes to light, even if Child Protection was already involved. I assuaged my guilt by reminding myself that the life of the child is the priority and that making a report is not a judgement. It is a means of accessing further support for my patient to prevent the situation from happening again. My thoughts were backed up by a few close colleagues I decided to talk to. Talking to them helped me feel secure in my belief that neglect had occurred, whether or not it was intentional. Additionally, I had witnessed the Child Protection system provide support for my patient in the past so I was confident in my belief that I needed to let them know what had happened to ensure they provided more support. >

I decided to follow up with my patient and her baby a few days after her baby was discharged from hospital. In my follow-up, I decided to explain my decision to report the incident to Child Protection. I felt that complete transparency would help me maintain my relationship with her to ensure she kept receiving care. She was pretty upset with me at first because she believed I was making judgements about her as a parent. I repeated to her the assurances that I gave myself – that her child and support for her was the priority. I also described how impressed I was that she recognised the warning signs and had brought the child to me on her own. I made sure to recognise the progress she had made in this respect and invited her to come to regular appointments with me so we could practise those skills together. She calmed down when she saw that I wasn't trying to judge her and that I wanted to continue my help and care.

I've been seeing my patient regularly for several weeks now. Each appointment, we focus on a different care-giving skill around baby's health that is quick and easy to learn in a 15-minute appointment. I know my help is supplemented by that of her case worker and a maternal child health nurse. I can see she's becoming more confident in her parenting skills and her baby is now thriving. Child Protection have yet to follow up on my report but I relayed all events to my patient's case worker when she returned from holidays. The two of us have decided to keep an eye on my patient, especially during periods where her child's needs are changing. We've worked out a management plan, one that my patient was a part of developing. I feel more confident in my support for her through motherhood.

## Case study: Michael

I'm Michael and I'm a GP working in a large community practice clinic in New South Wales. I'm currently seeing a family who I met recently. The family is composed of a mother and her two sons, one aged 10 and the other 6. I've been seeing a lot of this family because of the 10-year-old boy. In the last few months, he's been engaging in physically dangerous behaviour at school and has needed to come in for his injuries. I'm seeing him now with a similar presentation.

I've been consistently building rapport with the 10-year-old boy, and I decide to see him alone to explore what might be behind his behaviour. I explain to his mother that it's part of my practice to see kids on their own because I want to encourage confidence in seeking medical care on their own.

I explain to the boy that, only if he feels comfortable, we are just going to have a five-minute chat. He says he feels comfortable and his mother, while a little wary, accepts. When she leaves, I tell the boy in an age-appropriate way about his rights to confidentiality. I ask him to tell me again how his injury happened. There's no variation from the story he gave me previously, he seems confident in explaining it and the story does tally with his injuries.

Now I want to find out why he's behaving in such a risky manner. I ask him how things are going at home. He says, 'They're okay, but it's just different since mum and dad split.' I ask him how things are different, and I'm surprised by his answer. He doesn't say much but he talks about feeling more responsible. I ask him what makes him feel more responsible and he replies, 'Just some things mum says.' I ask him how he feels if he doesn't meet those responsibilities and he replies, 'Like I failed and I'm worthless'. I ask him what helps him to feel better and he talks about his risky activities at school – it's a place where he doesn't have to act responsibly. I decide to stop the questioning there because I feel he is becoming tense. I remind him that he is safe and it's okay to talk about how things feel. When he's ready I call his mother back into the consultation room. After hearing what the boy had to say, I feel I need some time to think through what I should do next. I ask to see the family again and finish the appointment.

Upon reflecting on the consultation, I'm more concerned than before. I suspect that this boy might be feeling pressured by his situation to take on more responsibilities in a way that makes him feel worthless if he doesn't meet his mother's needs. I think about his words 'just some things mum says', and I feel like there are elements of poor parenting technique at play. I wonder when poor parenting crosses the line into emotionally abusive behaviour.

To answer this question, I decide to consider the cumulative harm on the 10-year-old boy. I try to take stock of what I've noticed about the family. There are a few things about their family dynamics that concern me. The mother went through a divorce a little over a year ago and in the few months I've been seeing them, she's had three partners. In my discussions about coping mechanisms with the mother, I can see she is beginning to rely more heavily on alcohol. She tells me her consumption has risen since the divorce but it's not yet at a concerning level. I worry about what effect her coping mechanism is having on her two boys. I know the six-year-old is displaying behavioural problems. As for the 10-year-old boy, I've noticed how very protective he is of his younger brother. I've noticed how anxious he is generally and how he seems to constantly scan his environment. I've also noticed that his school uniform, which has been torn for weeks from his risk-taking behaviours, has not been replaced. Despite all this, I can see that the mother clearly loves her boys but it's obvious that she's going through a difficult time. The boys seem to be in a bit of a risky situation that may be escalating but I'm not sure if there's anything else going on.

I consider making a report to Child Protection. On the one hand, given the boy's risk-taking behaviour and constant low-level distress, there is the potential for significant harm over time. However, after careful consideration and speaking to my colleagues, I feel that my suspicions and the current severity of the harm from any potential abuse does not reach the threshold of the law. I decide to monitor the situation and place some supports around the family to respond to the risk of harm. If the family does not respond to the supports well, I can re-visit the idea of reporting in order to access more support for the family.

At the next appointment, I speak to the mother about some of my concerns around the boys' health and behaviour. I explain the precautionary measures I want to take including engaging her and the boys in therapy, engaging her in some help for her increased alcohol consumption and possibly attending a

parenting program to help her with strategies to meet her children's needs on her own. We develop a plan together. I invite the boys to add pictures of things they'd like to do for fun. I tell them that participating in those activities can be part of the plan to help everyone stay on track. While the boys are busy drawing outside the consultation room, I have a kind but frank discussion about the possible emotional state of her boys following the divorce and the instability new partners might bring. The mother is defensive at first, but I keep approaching her from a place of wanting what is best for her boys. I try to pose myself as part of her support team and eventually she calms down and understands my points. We arrange several follow-up appointments. I make it clear that I will speak to the boys individually as part of their care. She agrees. I'm confident that these measures will help the situation, but I am also confident in my decision to report if the situation deteriorates.

## Resources

- [Mandatory reporting guide for New South Wales \(https://reporter.childstory.nsw.gov.au/s/mrg\)](https://reporter.childstory.nsw.gov.au/s/mrg)
- [Preparing to report child abuse in South Australia \(https://www.childprotection.sa.gov.au/reporting-child-abuse/preparing-report-child-abuse\)](https://www.childprotection.sa.gov.au/reporting-child-abuse/preparing-report-child-abuse) (the tips here can be used for other states and territories)
- [National Institute for Health and Care Excellence \(NICE\) guidelines on recognising child abuse and neglect \(https://pathways.nice.org.uk/pathways/child-abuse-and-neglect#path=view%3A/pathways/child-abuse-and-neglect/recognising-child-abuse-and-neglect.xml&content=view-node%3Anodes-response-to-alerting-features\)](https://pathways.nice.org.uk/pathways/child-abuse-and-neglect#path=view%3A/pathways/child-abuse-and-neglect/recognising-child-abuse-and-neglect.xml&content=view-node%3Anodes-response-to-alerting-features)
- [Free educational resources for health professionals recognising and responding to child abuse and neglect \(https://vegaproject.mcmaster.ca/\)](https://vegaproject.mcmaster.ca/)

## References

1. Hanson RF, Kievit LW, Saunders BE, et al. Correlates of adolescent reports of sexual assault: Findings from the National Survey of Adolescents. *Child Maltreat* 2003;8:261–72.
2. Australian Institute of Health and Welfare. *Child protection Australia 2019–20*. Canberra: AIHW, 2021.
3. World Health Organization and International Society for Prevention of Child Abuse and Neglect. *Preventing child maltreatment: A guide to taking action and generating evidence*. Geneva: World Health Organization, 2006.
4. Heyes N. *Mandatory reporting of child abuse and neglect*. Melbourne: Australian Institute of Family Studies, 2020 ([https://aifs.gov.au/cfca/sites/default/files/publication-documents/2006\\_mandatory\\_reporting\\_of\\_child\\_abuse\\_and\\_neglect.pdf](https://aifs.gov.au/cfca/sites/default/files/publication-documents/2006_mandatory_reporting_of_child_abuse_and_neglect.pdf)) [Accessed 22 July 2021].
5. Gilbert R, Widom C, Browne K, et al. Burden and consequences of child maltreatment in high-income countries. *Lancet* 2009;373:68–81. [Accessed 22 July 2021].
6. Australian Institute of Health and Welfare. *Australia's children 2020*. Canberra: AIHW, 2021 (<http://www.aihw.gov.au/reports/children-youth/australias-children>) [Accessed 10 May 2021].
7. Karatekin C, Hill M. Expanding the original definition of adverse childhood experiences (ACEs). *J Child Adolesc Trauma* 2019;12:289–306. [Accessed 10 May 2021].
8. Merrick M, Ford D, Ports K, et al. Prevalence of adverse childhood experiences from the 2011–2014 behavioral risk factor surveillance system in 23 states. *JAMA Pediatrics* 2018;172:1038–44. [Accessed 10 May 2021].
9. Feletti V, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med* 1998;14:245–58. [Accessed 10 May 2021].

10. Norman R, Munkhtsetseg B, Rumma D, et al. The long-term health consequences of child physical abuse, emotional abuse and neglect: A systematic review and meta-analysis. *PLoS One* 2012;9:e1001349. [Accessed 10 May 2021].
11. Hailes HP, Yu R, Danese A, et al. Long-term outcomes of childhood sexual abuse: An umbrella review. *Lancet Psychiatry* 2019;6:830–9. [Accessed 10 May 2021].
12. Hughes K, Bellis M, Hardcastle K, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health* 2017;2:e356–66. [Accessed 10 May 2021].
13. Streeck-Fischer A, van der Kolk B. Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Aust N Z J Psychiatry* 2000;34:903–18. [Accessed 10 May 2021].
14. Negriff S. ACEs are not equal: Examining the relative impact of household dysfunction versus childhood maltreatment on mental health in adolescence. *Soc Sci Med* 2020. doi:10.1016/j.socscimed.2019.112696. [Accessed 10 May 2021].
15. Pournaghash-Tehrani S, Zamanian H, Amini-Tehrani M. The impact of relational adverse childhood experiences on suicide outcomes during early and young adulthood. *J Interpers Violence* 2019. doi: 10.1177/0886260519852160. [Accessed 10 May 2021].
16. Salokangas R, Schultze-Lutter F, Schmidt S, et al. Childhood physical abuse and emotional neglect are specifically associated with adult mental disorders. *J Mental Health* 2019. doi: 10.1080/09638237.2018.1521940. [Accessed 10 May 2021].
17. [World Health Organization. Child maltreatment 2020. Geneva: WHO, 2020 \(http://www.who.int/news-room/fact-sheets/detail/child-maltreatment\)](http://www.who.int/news-room/fact-sheets/detail/child-maltreatment) [Accessed 10 May 2021].
18. [Australian Bureau of Statistics. Characteristics and outcomes of childhood abuse 2019. Canberra: ABS, 2019 \(http://www.abs.gov.au/articles/characteristics-and-outcomes-childhood-abuse\)](http://www.abs.gov.au/articles/characteristics-and-outcomes-childhood-abuse) [Accessed 23 July 2021].
19. Australian Institute of Health and Welfare. Child protection in the time of COVID-19. Canberra: AIHW, 2021. [Accessed 23 July 2021].
20. Shlonsky A, Ma J, Jeffreys C, et al. Pathways of children reported for domestic and family violence to Australian child protection. *Australian Social Work* 2019;72:461–72. [Accessed 23 July 2021].
21. [Brown T, Bricknell S, Bryant W, et al. Filicide offenders. Trends and issues in crime and criminal justice. Canberra: Australian Institute of Criminology, 2019 \(http://www.aic.gov.au/publications/tandi/tandi568\)](http://www.aic.gov.au/publications/tandi/tandi568) [Accessed 10 May 2021].
22. Victorian Government. Vulnerable babies, children and young people at risk of harm: Best practice framework for acute health services. Melbourne: Department of Human Services, 2006. [Accessed 10 May 2021].
23. [Hunter C. Effects of child abuse and neglect for children and adolescents. Melbourne: Australian Institute of Family Studies, 2014 \(https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents\)](https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents) [Accessed 4 June 2021].
24. Kuruppu J. Exploring the response to child abuse and neglect in primary healthcare settings. PhD thesis. The University of Melbourne, 2018. [Accessed 4 June 2021].
25. Victorian Government. Healthcare that counts: A framework for improving care for vulnerable children in Victorian health services. Melbourne: Department of Health and Human Services, 2017. [Accessed 4 June 2021].
26. [Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2012–13. Canberra: ABS, 2013 \(http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features32012-13\)](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features32012-13) [Accessed 30 May 2021].
27. Meredith V, Price-Robertson R. Alcohol misuse and child maltreatment. Melbourne: Australian Institute of Family Studies, 2011. [Accessed 30 May 2021].
28. [Smart J. Risk and protective factors for child abuse and neglect. Melbourne: Australian Institute of Family Studies, 2017 \(https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect) [Accessed 4 June 2021].
29. [Government of Canada. Child maltreatment: A 'what to do' guide for professionals who work with children. Government of Canada, 2012 \(http://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/children/child-maltreatment-what-guide-professionals-who-work-children.html#ln1\)](http://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/children/child-maltreatment-what-guide-professionals-who-work-children.html#ln1) [Accessed 7 June 2021].
30. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: WHO, 2014. [Accessed 7 June 2021].
31. National Institute for Health and Care Excellence. Child abuse and neglect: NICE guideline [NG76]. London: NICE, 2017. [Accessed 7 June 2021].

32. Sahle B, Reavley, Morgan A, et al. Summary of interventions to prevent adverse childhood experiences and reduce their negative impact on children's mental health: An evidence based review. Melbourne: Centre of Research Excellence in Childhood Adversity and Mental Health, 2020. [Accessed 7 June 2021].
33. Diemer K, Humphreys C, Fogden L, et al. Caring dads program: Helping fathers value their children. Three Site Independent Evaluation 2017–2020. Melbourne: University of Melbourne, 2020. [Accessed 7 June 2021].
34. Kuruppu J, McKibbin G, Humphreys C, et al. Emotional labour in responding to child abuse and neglect in primary healthcare settings. Unpublished. Department of General Practice, The University of Melbourne [Accessed 7 June 2021].
35. Flaherty EG, Sege R, Price LL, et al. Pediatrician characteristics associated with child abuse identification and reporting: results from a national survey of pediatricians. *Child Maltreat* 2006;11:361–69. [Accessed 7 June 2021].
36. Flaherty EG, Sege RD, Griffith J, et al. From suspicion of physical child abuse to reporting: Primary care clinician decision-making. *Pediatrics* 2008;122:611–19. [Accessed 7 June 2021].
37. Kuruppu J, McKibbin G, Humphreys C, et al. Tipping the scales: Factors influencing the decision to report child maltreatment in primary care. *Trauma Violence Abuse* 2020;21:427–38. [Accessed 7 June 2021].



# Sibling and peer bullying

In memory of Stephen Rigby

'If I had been the clinician to write Stephen's death certificate I would have added sibling bullying as a contributing cause'

## Key messages

- Bullying (either between peers<sup>1</sup> or siblings<sup>2</sup>) is a common experience for many Australian children and young people. Both kinds of bullying are physically harmful, socially isolating and psychologically damaging.<sup>3-9</sup>
- Sibling bullying is one of the most common types of abuse and violence within families.<sup>10</sup> If a child is bullied at home it is very likely that they are also bullied at school and therefore have no safe place.<sup>11</sup>
- Both peer and sibling bullying remain hidden from both parents, teachers and healthcare workers<sup>12-14</sup> and are under-recognised as being harmful.<sup>15-19</sup>
- Sibling bullying can be normalised and stigmatised. Although many schools are aware of peer bullying, there is less recognition of the need to watch out for children who are bullied by their siblings.

## Recommendations

Maintain an awareness about the possibility of both peer<sup>12,20</sup> and sibling<sup>9,21-23</sup> bullying in children

**(Practice point: Consensus of experts)**

### References

12. Bjereld Y. The challenging process of disclosing bullying victimization: A grounded theory study from the victim's point of view. *J Health Psychol* 2016;1359105316644973.
20. Holt KE, Kantor, Finkelhor D. Parent/child concordance about bullying involvement and family characteristics related to bullying and peer victimization. *J School Violence* 2008;8:42-63.

19. Kiselica N, Morrill-Richards M. Sibling maltreatment: The forgotten abuse. *J Counseling and Development* 2007;85:148–60.
21. Caffaro J, Conn-Caffaro A. Treating sibling abuse families. *Aggression and Violent Behavior* 2005;10:604–23.
22. Krienert J, Walsh J. My brother's keeper: A contemporary examination of reported sibling violence using national level of reported sibling violence using national level data, 2000–2005. *J Fam Violence* 2011:331–42.
23. Yu J, Gamble W. Familial correlates of overt and relational aggression between young adolescent siblings. *J Youth Adolesc* 2008;37.

Develop a brief approach to asking about bullying when seeing children that may be at increased risk. [24–35](#)

**(Practice point: Consensus of experts)**

References

24. Ashraf IJ, Pekarsky AR, Race JE, Botash AS. Making the most of clinical encounters: Prevention of child abuse and maltreatment. *Pediatr Clin North Am* 2020;67:481–98.
25. Committee on Injury Violence and Poison Prevention. Policy statement – Role of the pediatrician in youth violence prevention. *Pediatrics* 2009;124:393–402.
26. Condon L, Prasad V. GP views on their role in bullying disclosure by children and young people in the community: a cross-sectional qualitative study in English primary care. *Br J Gen Pract* 2019;69:e752–e9.
27. Dale J, Russell R, Wolke D. Intervening in primary care against childhood bullying: An increasingly pressing public health need. *J R Soc Med* 2014;107:219–23.
28. Dawkins J. Bullying in schools: doctors' responsibilities. *BMJ* 1995;310:274–75.
29. Hickner J. It's time to screen for bullying. *J Fam Pract* 2017;66:66.
30. Lyznicki JM, McCaffree MA, Robinowitz CB. Childhood bullying: Implications for physicians. *Am Fam Physician* 2004;70:1723–28.
31. McClowry RJ, Miller MN, Mills GD. What family physicians can do to combat bullying. *J Fam Pract* 2017;66:82–89.
32. Moon DJ, Damman JL, Romero A. The effects of primary care-based parenting interventions on parenting and child behavioral outcomes: A systematic review. *Trauma Violence Abuse* 2020;21:706–24.
33. Scott E, Dale J, Russell R, Wolke D. Young people who are being bullied – do they want general practice support? *BMC Fam Pract* 2016;17:116.
34. Srabstein JC, Leventhal BL. Medical recognition of bullying and its related morbidity. *Lancet Psychiatry* 2015;2:858–59.
35. Stephens MM, Cook-Fasano HT, Sibbaluca K. Childhood bullying: Implications for physicians. *Am Fam Physician* 2018;97:187–92.

## Clinical context

This chapter outlines the adverse health effects associated with peer and sibling bullying, definitions, risk factors, and challenges in recognising and addressing bullying. It includes a brief approach to asking and advising about both peer and sibling bullying.

### Definitions

Bullying is defined as ‘any unwanted aggressive behaviour(s) by a peer or sibling that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated’.<sup>10</sup>

Bullying, either by a sibling<sup>36-40</sup> or peer,<sup>5-9,15,18,41,42</sup> often causes harm or distress in the child targeted, including physical, psychological or social harm.

Key elements that define bullying include:

- an unwanted, aggressive attack or intimidation tactic that is intended to cause fear, distress or harm to the victim
- an imbalance of power between the bully and victim
- repetitive occurrences of the behaviours.

Intention can be hard to establish, even in older children. The bully’s harmful intention and the victim’s perception of harmful intention are important when considering whether a peer interaction constitutes bullying.<sup>43</sup>

Bullying (both sibling and peer) can be:

- direct (physical or verbal)
- indirect (relational/social, social exclusion, spreading rumours, psychological/stalking).

Bullying categories include:

- bully (instigator)
- victim (recipient)
- both bully and victim.

Four types of bullying are typically described: physical, verbal, relational, and damage to property.<sup>10,44-46</sup>

- Relational bullying/aggression refers to deliberate social exclusion of children, such as ignoring, excluding them from games or parties, spreading gossip or humiliation.
- Relational aggression seeks to damage the relationships and social reputation of the victim.<sup>47</sup>
- Cyberbullying is performed via electronic or digital means. Repetition is not a prerequisite for the behaviour to count as bullying, as a post on social media can potentially be seen by many individuals. Cyberbullying is discussed in more depth in [Chapter 12: Dating violence and technology-facilitated abuse \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse).

Sibling rivalry can be defined as: 'competition between siblings for the love, affection, and attention of one or both parents or for recognition or gain'.<sup>48</sup> It is common and can lead to ongoing conflict between siblings.<sup>49</sup>

Examples include:

- verbal or physical fighting
- name-calling, teasing, squabbling or arguing among themselves
- telling tales and bickering

The rivalry is two-way (ie both given and received). Distinguishing sibling rivalry from sibling bullying can be difficult. It can be categorised as sibling bullying if it:<sup>10,19,49</sup>

- becomes more one-sided
- is part of an escalating and repeating pattern of sibling aggression
- is associated with undesirable or harmful effects.

## Prevalence

The severity, frequency, pervasiveness and chronicity of bullying varies partly with context, definitions of bullying<sup>2</sup> and victim age. Estimates of prevalence of bullying vary depending on the types of bullying considered: victim only, bully only or bully–victim (ie someone who is both a bully and is bullied).

A 2019 meta-analysis found that the lifetime prevalence of 'traditional' (non-cyber) peer bullying among children and adolescents in the Australian setting is 25.1% for victimisation and 11.6% for bullying perpetration. The 12-month prevalence of bullying victimisation was 15.2% and bullying perpetration was 5.3%.<sup>1</sup>

Sibling bullying prevalence estimates vary from 15–50% for victimisation and 10–40% for perpetrating.<sup>2,10,50</sup> Sibling bullying can start in toddlers (typically aged two to five years) and is common between the ages of six and nine years.<sup>51,52</sup> Sibling bullying can involve two-way sibling bullying, with both parties being a bully and a victim.<sup>50,53</sup>

## Risk factors and predictors

Table 10.1 provides information on risk factors for peer and sibling bullying

Aggressive behaviour in pre-school years strongly predicts later aggression and bullying.<sup>54,55</sup> Environmental factors (including the nature and quality of parenting) play an important role in the persistence or remission of aggression/bullying through primary school and adolescence.<sup>55,56</sup>

Children and adolescent bully is a complex issue.<sup>57</sup>

In two recent longitudinal cohort studies, structural family-level characteristics (eg birth order, ethnicity, and number of siblings, being the firstborn and having older brothers) were found to be the strongest predictors of sibling bullying involvement. Bullying is more likely between siblings close in age, and even more likely between consecutive siblings. Child-level individual differences (eg [emotional dysregulation](https://aifs.gov.au/cfca/publications/developmental-differences/emotional-dysregulation) (<https://aifs.gov.au/cfca/publications/developmental-differences/emotional-dysregulation>) and gender) were also important risk factors for sibling bullying.<sup>50,58</sup>

Parenting style (eg harsh parenting) has a variable impact on the likelihood of sibling bullying.<sup>50,58</sup> although poor relationships with parents and harsh parenting behaviour predicted greater sibling aggression.<sup>59-61</sup> In some studies, bullies commonly exhibit low levels of empathy<sup>62,63</sup> and poor theory of mind skills<sup>64</sup> (which refers to the ability to understand the desires, intentions and beliefs of others, and is a skill that develops between three and five years of age in typically developing children).

**Table 10.1 Risk factors for peer and sibling bullying**

	Risk factors	Bullying			
		Peer	Reference	Sibling	Reference
Individual	Physical (eg overweight, disability, chronic illness)	Moderate association	<a href="#">65-68</a>		
	Social (eg poorer social cognition, theory of mind)	Moderate association	<a href="#">62, 64</a>	Strong association	<a href="#">50</a>
	Behavioural (eg externalising and disruptive behaviours <sup>(a)</sup> including aggression, learning disability)	Strong association	<a href="#">69, 70</a>	Strong association	<a href="#">50</a>
	Gender (eg LGBTQIA+)	Strong association	<a href="#">71</a>	Moderate association	<a href="#">72</a>
	Emotional dysregulation <sup>(b)</sup> (eg impulsivity)	Moderate association	<a href="#">73, 74</a>	Moderate association	<a href="#">58</a>

**Table 10.1 Risk factors for peer and sibling bullying**

	Adverse childhood experiences <sup>(c)</sup>	Strong association	<a href="#">75–78</a>	Strong association	<a href="#">79</a>
Family	Structural family characteristics (eg first born, having an older brother, having step-siblings)			Strong association	<a href="#">50, 58</a>
	Domestic violence	Moderate association	<a href="#">80</a>	Strong association	<a href="#">36, 50, 81</a>
	Financial difficulties	Moderate association	<a href="#">82</a>	Moderate association	<a href="#">10, 50, 61</a>
	Socio-economic status	Inconsistent association	<a href="#">83</a>	Inconsistent association	<a href="#">61</a>
	Negative family dynamics (eg conflicting partnerships, arguing, hostile communication), interparental conflict	Strong association	<a href="#">84</a>	Strong association	<a href="#">50, 79</a>
	Parenting quality (eg harsh discipline or failure to discipline, lack of parental warmth, neglect, interparental hostility and abuse)	Moderate association	<a href="#">85</a>	Moderate–strong association	<a href="#">50, 58–60, 79, 86, 87</a>

- a. 'Disruptive behaviour in children' refers to behaviours that occur when a child has difficulty controlling their actions. Examples of disruptive behaviours include temper tantrums, interrupting others, impulsiveness with little regard for safety or consequences, aggressiveness, or other socially inappropriate acts. Further information is available at [Disruptive behaviours in children: What parents should know \(https://www.schn.health.nsw.gov.au/fact-sheets/disruptive-behaviours-in-children-what-parents-should-know\)](https://www.schn.health.nsw.gov.au/fact-sheets/disruptive-behaviours-in-children-what-parents-should-know).
- b. 'Emotion regulation' refers to the dynamic interaction of multiple behavioural, psychophysiological, attentional and affective systems that allow young children to participate effectively in their social world.<sup>88</sup> The definition of 'emotional dysregulation' includes five overlapping not mutually exclusive dimensions – decreased emotional awareness, inadequate emotional reactivity, intense experience and expression of emotions, emotional rigidity, and cognitive reappraisal difficulty.<sup>89</sup>
- c. Adverse childhood experiences include physical, emotional and sexual abuse or neglect, bullying, parent mental health problems, harsh parenting, parent substance abuse and housing problems.<sup>90</sup>

## Burden of morbidity

In Australia, it is estimated that more than 8% of annual mental health expenditure,<sup>18</sup> 7.8% of the burden of anxiety disorders and 10.8% of the burden of depressive disorders<sup>6</sup> can be attributed to bullying victimisation.

Three UK longitudinal cohort studies have investigated sibling bullying and subsequent adverse health outcomes. [11,36–39,58,91](#)

Experience of sibling bullying:

- increased the risk of involvement in bullying in school. A clear dose–effect relationship of involvement of bullying at home and at school and behavioural or emotional problems was demonstrated in a review of sibling bullying studies.<sup>92</sup> Those involved in both settings were at significantly increased risk of behavioural or emotional problems compared to those involved in only one setting or not at all
- increased the risk of subsequent behaviour problems
- increased the risk of subsequent mental health disorders.<sup>11,91</sup> Children who were frequently bullied by their siblings were approximately twice as likely to have depression, self-harm and have anxiety compared to children who were not bullied by siblings.<sup>36</sup>

It is perhaps not surprising that the adverse consequences are significantly higher for children who are bullied both at home and at school; they have no safe haven.<sup>11</sup> Likewise, adolescents involved in bullying perpetration in multiple contexts (home and school) have higher odds of engaging in antisocial behaviour, criminal involvement, and illicit drug use, compared with bullying in only one context.<sup>38</sup>

## Case study: David

Names have been changed in this case study, which was written by the GP who first learned

---

about David's case from a patient, David's sister Denise.

David never really talked with his GP about the bullying he was subjected to over his lifetime. His sister, Denise, who was a patient of mine, outlined most of the events after it became clear that David's plight was having a major impact on her mental health. She felt powerless to change things for the better for David. I did see David on two occasions when he was persuaded by his sister to come along to see me.

David's earliest memories were of being regularly punched, kicked and demeaned by his older brother and his father. He was beaten either with a leather belt buckle or a bamboo cane with nails attached by his father. David grew up with a sense that he was unworthy and deserving of his treatment. He had a strong feeling that nobody liked him and that he was unlovable.

His mother and older sister were intimidated daily by his father and David's older brother, Mike; both David and Denise recalled that their mother never intervened on behalf of either David or his sister. David reported that the abuse and violence was both physical and emotional from a very early age. He never felt safe and lived in fear until he left home. Despite this, his older sister remembers David as a bright very funny boy with an acute sense of humour that made all around him laugh.

David initially did well in school until suddenly in grade four his school started reporting that he lacked attention, was easily distracted and his grades started to drop. David had a few friends but not a lot, being shy and a bit withdrawn with strangers. David told me he found it difficult to make friends easily. His sister felt he had limited skills at social interaction, was withdrawn and that he passively responded to bullying in the school yard as he did at home.

David said that his de facto partner (and the mother of his two boys) was demeaning of his behaviour and regularly verbally bullied him. David's partner had numerous affairs, including with his best friend. David was separated from his partner in his 50s, when he was 'kicked out' of the house with only a few possessions (despite David paying the deposit for the house).

David had limited contact with his older sister when he grew up. He reconnected with his sister after his myocardial infarction in his 50s but had only intermittent contact; he allowed a relationship to flourish between her and his children, who would stay with his sister. David was estranged from his parents after the one time he had allowed his parents to see his children and his father abused the older child physically. David ended up being a bit of a loner. He said he 'didn't trust folk'. He felt he never was able to achieve anything academically but others saw him as a talented writer and he enjoyed painting, which provided great solace to him.

David had a history of heavy marijuana use and alcohol abuse starting in his 30s. He also became quite overweight at this time. The marijuana and alcohol use had largely stopped when he developed type 2 diabetes in his 40s although he was initially poorly adherent to lifestyle advice and taking medication.

In his 40s David became quite depressed and attempted suicide. He was admitted to a psychiatric inpatient unit for a number of weeks.

David had a large myocardial infarction in his early 50s. He ignored chest pain for six hours before attending the emergency department; he subsequently had a three-vessel coronary bypass artery bypass. In the subsequent six years he was fully adherent to treatment and medical advice. David moved around GPs and was an infrequent attender. He subsequently admitted to his older sister that he had never told any GPs about his bullying in the family. On Christmas day in 2014, his oldest son, then age 18 years, visited David's home for a planned Christmas drink with his father that afternoon. His son



found David slumped in a chair, dead. A subsequent coroner’s investigation found that David had died at least two days before Christmas day of an arrhythmia associated with a heart attack. There were no suspicious circumstances.

**Postscript**

In the last contact with his sister in October, David stated that he was okay and he was happy for the first time in his life as he was pursuing his art, felt better without daily contact with anyone and he did not deserve anything better. Despite all that happened to David, he is remembered as having been a bright lad with an acute sense of humour that made all around him laugh. He was gentle, giving and generous throughout his life. If I had been the GP signing his death certificate, I would have added life-long bullying and abuse as a significant contributing factor. As a GP, I wish I had heard about David’s sibling bullying much earlier so that I could have tried to intervene. The sibling bullying compounded the issues associated with parental abuse within the family.

Whether earlier intervention would have made any difference is speculative but in more recent times, I make a point of asking children about bullying more routinely, both within and external to the family.

**Table 10.2. Short- and long-term impacts of peer and sibling bullying**

		Peer bullying		Sibling bullying	
Short-term impacts					
		Impact	Reference	Impact	Reference
Physical health		Injury	<a href="#">22</a>	Injury	<a href="#">79</a>
		Headaches	<a href="#">93</a>	Most studies have not separated out sibling aggression/ bullying from peer bullying	
		Abdominal pain	<a href="#">93</a>		
		Repeated sore throats	<a href="#">94</a>		
		Recurrent colds and breathing problems	<a href="#">94</a>		

**Table 10.2. Short- and long-term impacts of peer and sibling bullying**

Social health	Loneliness and isolation through a more limited ability to make friends	<a href="#">95, 96</a>	Increased likelihood of being bullied at school	<a href="#">10, 11, 61, 97, 98</a>
	Decline in school performance/ functioning, absenteeism from school/ home, withdrawal/avoidance	<a href="#">16</a>	Decline in school performance/ functioning	<a href="#">99</a>
Mental health	Psychosomatic symptoms (eg bedwetting, sleeping problems, abdominal pain, difficulty concentrating, dizziness, poor appetite, and feelings of tension or tiredness)	<a href="#">94, 100</a>	Mental health distress	<a href="#">101–103</a>
<b>Long-term impacts</b>				
Mental health	Anxiety, depression, self-harm, increased suicide ideation and suicide	<a href="#">6, 8, 104, 105</a>	Anxiety, depression, psychotic symptoms	<a href="#">36, 37, 39, 98, 106</a>
	Eating disorders	<a href="#">22, 107</a>		
	Obesity	<a href="#">108, 109</a>		
	Smoking	<a href="#">110</a>		
	Drug and alcohol problems	<a href="#">111, 112</a>	Substance abuse	<a href="#">38, 81</a>

**Table 10.2. Short- and long-term impacts of peer and sibling bullying**

	Low self-esteem/ withdrawal	<a href="#">95, 113</a>	Dose–response association	<a href="#">10, 37, 101, 103, 114</a>
Behavioural problems	Aggressiveness and conduct problems <sup>(a)</sup>	<a href="#">115</a>	Sibling bullying victims exhibit bullying behaviour at school	<a href="#">10, 116, 117</a>
	Criminal activities	<a href="#">7</a>	Criminal activities	<a href="#">38</a>
	Perpetrating violence (eg dating, intimate partner abuse)	<a href="#">99</a>	Dating violence	<a href="#">49, 118</a>
	Anti-social behaviour	<a href="#">38</a>	Anti-social behaviour	<a href="#">38, 49, 51</a>

## The role of the GP

There are a number of reasons why GPs should be alert to bullying and respond to it.

### Opportunity in a ‘neutral’ environment

GPs are a trusted and important source of information and support for helping children and young people tackle bullying, by both young people and their parents.<sup>[32](#)</sup>

Eighty-three per cent of children attend a GP at least once in each year: the average visit rate per head of population is 3.8 visits per year.<sup>[120](#)</sup> Parents can attend primary care without the stigma that may be associated with attending welfare or mental health services. A number of studies have indicated that caregivers would like GPs to be more involved in identifying and supporting children and young people who disclose to being bullied.<sup>[26,33](#)</sup>

Any approach to address bullying should be exploratory with focus on the family, with extra effort to consolidate rapport with both the parents and the children.<sup>[19](#)</sup> Parents may be sensitive to perceived criticism of their parenting skills and may respond defensively.<sup>[33](#)</sup> This requires additional sensitivity in use of language and avoiding potential value judgements or blame.

### The burden of morbidity

Bullying has a consistent, strong and graded association with a many physical and psychological symptoms which are common presentations in general practice (refer to Table 10.2). Children bullied by their siblings are much more likely to be bullied in other settings (eg school).<sup>97</sup>

Sibling bullying is the most common form of family violence.<sup>10</sup> Sibling bullying is widespread and experienced by a large proportion of children and adolescents.

### The cumulative impact of poly-victimisation

A child who is bullied at home by siblings or abused by parents is more likely to be bullied or abused in other settings.<sup>37,54,121,122</sup> Peer bullying is generally focused on by schools, meaning that bullying within the family is often in the remit of the GP and not either identified or addressed by the school.

Early recognition and intervention can reduce future harms associated with sibling bullying and bullying in other settings.

GPs need to consider bullying from a lifespan perspective. A child who bullies is learning to achieve dominance over others through the misuse of power.<sup>28</sup> Children do not just 'grow out of it'.<sup>123</sup> Children who learn how to acquire power through aggression at home or on the playground often transfer these strategies to sexual harassment, dating violence, intimate partner abuse, workplace bullying and abuse, child abuse and abuse of older people.<sup>38,124-126</sup>

Early intervention provides an opportunity to 'break the cycle' and minimise the longer-term harms and associated costs. To use a banking metaphor, early intervention can turn around negative compounding associated with early bullying (either as victim or instigator) into a positive balance. The seriousness of the bullying behaviour can be gauged by the level of distress it causes the victimised child.<sup>15</sup>

GPs need to be careful to focus on the behaviour rather than the label. Labelling a child a bully can be both harmful and imply that the behaviour is fixed and cannot be changed. It also suggests that the person who bullies is the main problem, when other factors may be more important. Further information is available [here \(http://stopbullying.gov\)](http://stopbullying.gov).

Bullying has been added to the indicators of adverse childhood experience. The Centre of Research Excellence in Childhood Adversity and Mental Health has highlighted a number of anti-bullying interventions that can be offered by a range of groups and service providers to offset the harms associated with adverse childhood experience, although most of the focus has concentrated on school-based anti-bullying programs.<sup>90</sup>

## Understanding sibling bullying

Given that fighting or repeated conflict among siblings is one of the most common issues that parents express concerns about their children, it is worth trying to understand such behaviour at a deeper level.

There are a number of reasons why siblings may engage in conflictual exchanges, including resources such as competing for parental attention, affection, love, and other material gains.<sup>127</sup> Children are often expected to share lots of things, but that does not make it an easy task to do and they therefore may revert to arguing or fighting, both to express themselves or to compete for resources to get their own way. The 'forced' contact of siblings in an intense, complex long-term relationship before sufficient social competence has developed can compound the tension in the relationship. As Dunn summarises: 'The emotional intensity, and the intimacy of the relationship, the familiarity of children with each other, and the significance of sharing parents mean that the relationship has considerable potential for affecting children's well-being'.<sup>128</sup>

Some have suggested that there are many potential positives that can emerge from sibling conflictual exchanges such as an increase in children's social and emotional competence, the development of self and identity formation, and a more robust sibling relationship quality, and the subsequent parenting of one's own children.<sup>129</sup> Others have highlighted that sibling aggression/conflict and bullying can have a significant long-term detrimental impact on health.<sup>36,38-40,130</sup>

Most would agree that siblings need to learn to be able to effectively manage conflict in relationships.<sup>129,131,132</sup> The challenge is for siblings to learn:

- how to do this fairly<sup>133,134</sup>
- empathy, respect and seeing things from another person's point of view<sup>62,135,133</sup>
- about how to negotiate and compromise<sup>133,134</sup>
- through reflection and practice to working it out themselves,<sup>133</sup> eg what worked and what didn't work?
- problem-solving skills (further information available at [Ages & stages: How children learn to solve problems \(https://www.scholastic.com/teachers/articles/teaching-content/ages-stages-how-children-learn-solve-problems\)](https://www.scholastic.com/teachers/articles/teaching-content/ages-stages-how-children-learn-solve-problems))<sup>136,137</sup>
- strategies that avoid any persistent harms.

If children think they are not being treated fairly (or equally) by their parents then they may act out their frustrations on their sibling.<sup>138</sup> That fact that sibling dyads are hierarchical in nature, unless they are twins, with age difference and order of appearance in the family dictates a formal rank ordering. This often means that older siblings are considered to be physically, socially and cognitively advantaged over their younger siblings. As younger siblings become more equally matched in these capacities with their older siblings, with age and development, then it is likely that interactions will become more equal<sup>139</sup> although this may not occur if one sibling establishes dominance over the other.<sup>140</sup>

While 'normal' sibling conflict usually consists of a mutual disagreement over the various resources in the family (eg parental attention), sibling abuse or maltreatment consists of one sibling taking on the role of a persistent aggressor in relation to another sibling.<sup>19</sup>

### Quality and style of parenting influences the likelihood of sibling bullying and abuse

While sibling bullying can occur in all families, there is an increased risk for both peer and sibling bullying/abuse<sup>50,58,79,116,141</sup> when the family structure and processes support power imbalances,<sup>50,58</sup> rigid gender roles, differential treatment of siblings,<sup>138,142-145</sup> and lack of parental supervision.<sup>146</sup> Inquiry about sibling bullying may be difficult in these contexts. Parents may be embarrassed by asking

about sibling bullying. They may also minimise or even dismiss any likelihood of it occurring in their family. All of these factors can contribute to a general lack of awareness of aggression or bullying between siblings.<sup>147</sup>

Parental neglect is insinuated when the sibling abusive relationship is undetected or unaddressed.<sup>14</sup> At the same time, a GP asking about sibling bullying as an issue may help to heighten the parents' awareness of their children's behaviour to consider behaviours that may go beyond sibling rivalry.<sup>148</sup>

## Challenges for identifying and managing sibling bullying

### Lack of awareness and recognition of sibling bullying

Without familial or external validation, most cases of sibling bullying do not come to the attention of healthcare practitioners.<sup>14</sup> Many parents clearly uphold different norms of acceptability regarding conflict management and resolution and aggressive behaviour in sibling compared with peer or other kinds of relationships.<sup>132</sup>

For example, in the scenarios in Box 10.1, the parental reaction to similar behaviour is quite different – the behaviour is acceptable between siblings, but not between one of their children and another child. However, the adverse impact of such behaviour in both settings is very similar, as discussed earlier in this chapter.

#### Box 10.1. Different parental reaction to similar scenarios

##### Scenario 1

Shane, aged eight years, is playing in the school playground. An older boy, Bruce, approaches him from behind and deliberately trips him up while they are playing soccer. Shane, who didn't have the ball at the time, falls awkwardly and hurts his wrist. He goes to the nursing station at the school. The nurse looks at his wrist and puts on a bandage. She then calls his parents, who are incensed that this could happen and demand to see the school principal to get something done.

##### Scenario 2

Shane, aged eight years, is playing soccer in his backyard with his older brother. Bruce approaches him from behind and deliberately trips him up in a tackle when Shane doesn't have the ball. Shane falls awkwardly and hurts his wrist. He goes inside to tell his mother what happened and after examining his wrist and putting a bandage on it, tells him off, indicating that he should get on with his brother better and 'boys will be boys'.

### Normalisation of sibling bullying by parents

Siblings often engage in 'rough and tumble' type activities, and sibling bullying behaviours can be regarded as a normal part of learning to manage conflict or rivalry. Some even see it as a rite of passage.<sup>22</sup> However, although such activities may be seen as a part of growing up and learning to manage conflict and relationships,<sup>129</sup> parents often express considerable concern about these aggressive behaviours and wonder how to intervene in order to foster more positive relationships between their children.<sup>149</sup>

Parents often have difficulty identifying or managing aggressive behaviour, especially when there is a clear dominance in the sibling relationship.<sup>55</sup> The situation can be confusing for parents because the individual with less power also acts aggressively towards the more powerful sibling.<sup>150</sup>

### Normalisation of sibling bullying among children

Sibling bullying is accepted as normal among most sibling pairs.<sup>151</sup> This is a further extension of the normalisation process that occurs with aggression between siblings.

Victims of bullying often do not identify their experience (sibling bullying) as a form of abuse or violence, even when it is repeated, further downplaying its impact.<sup>152</sup> One consequence of this is that up to 50% of children say they would rarely, or never, tell their parents, while between 35% and 60% would not tell their teacher.<sup>122</sup> Children are even less likely to disclose to parents:

- who are either harsh in their parenting<sup>59,61</sup>
- whose own behaviour role models aggressive or bullying behaviour<sup>10,50</sup>
- who are over-protective.<sup>146</sup>

Parental behaviour further complicates the situation when there is a taboo surrounding sibling bullying.<sup>153</sup> This norm of acceptance compounds other factors that contribute to disclosing bullying.

Young people are often reluctant to disclose that they are being bullied, either at home or at school, because they are ashamed, think it is their fault, may fear retaliation, or regard disclosure as 'dobbing'.<sup>154</sup> Ironically, many victims of bullying don't see themselves as a victim. Without a greater societal recognition of both sibling and peer bullying, victims are prone to perceive and accept their experience as normative.<sup>155</sup>

## In practice

### Primary prevention

Primary bullying prevention programs are generally population-based and engage the community. These may include home visits from a nurse<sup>156-158</sup> and/or provision of parenting information, education and training.<sup>32,159-161</sup> (Note: Most of the home visit programs had a general focus on parenting and aiming to reduce child abuse. Addressing bullying is often a very minor component.)

Parenting programs tend to have a broad focus, with sibling aggression/bullying rarely being a significant component. Furthermore, while behavioural parenting interventions can enhance positive parenting practice, there is very limited evidence that there is much improvement in child behaviour outcomes when such programs are delivered in the primary care setting.<sup>32,159-163</sup>

Many health professional groups recommend that GPs screen for bullying in children directly<sup>25,29,164</sup> or as part of identifying child abuse/maltreatment,<sup>165</sup> although others have found insufficient evidence for GPs or other primary care professionals to screen for child abuse.<sup>166,167</sup> (Note: In the Australian Government Department of Health Action plan for the health of children, while bullying is acknowledged as a significant health issue for children and that an important action was 'work with partners to identify and promote effective anti-bullying strategies', healthcare workers receive little mention'.<sup>121,168</sup>)

Some studies have suggested that bullying/abuse/violence among siblings may be a better predictor of later adult violence than observing violence between parents.<sup>169</sup>

### **Brief and early interventions**

Brief and early interventions programs can be either general (ie focus on parenting skills) or specific and target families with specific risk factors for bullying (both peer and sibling). If counselling is anticipated, then it is important to be aware that abusive siblings are infrequently challenged or confronted by parents.<sup>170</sup>

Indicators for when to ask about bullying are shown in Box 10.2. A brief intervention for bullying might then be as follows:

#### **Ask**

- Request permission to ask about bullying.
- Have a high index of suspicion if a child presents with a psychosomatic problem.

#### **Assess**

- Assess nature, extent and severity of the bullying.
- Inquire about what the victim and parents have done to address the bullying.
- Explore parent's perceptions of discipline and managing sibling rivalry or aggression.

#### **Advise**

- Highlight possible short- and long-term impact.
- Stress the importance of parental awareness, surveillance and support as well as parents modelling effective strategies to deal with conflict and aggression.
- Provide websites that can provide parent education, parenting programs, support and strategies to promote child-parent relationships and child resilience (refer to Resources).
- Offer to speak with or contact the school principal if peer bullying.



### Box 10.2. When to ask children about bullying

Given the prevalence of bullying, it is reasonable to ask most children whether they are being bullied. A number of factors may indicate that a child is being bullied.

#### Psychosocial

- Evidence of mood changes (eg anxiety, depression, low self-esteem, withdrawal)
- Psychosomatic symptoms (eg problems with sleep, eating, bedwetting, headaches, stomach aches)
- Children with externalising behaviours (eg aggression, impulsivity)

#### Physical

- Unexplained (+/- repeated) injuries
- Chronic illness, marginalised groups (eg LGBTQIA+), physical or other disability (eg learning difficulty)
- Repeated vague complaints
- Recurrent colds and sore throats

#### Social

- Difficulty and/or withdrawal in relating to siblings and friends
- Fears of rejection
- Being tense, tearful and unhappy before or after school
- Shyness or awkwardness with others

#### School

- Fear or loss of interest in going to school
- Decline in school performance

### Asking about bullying

- Open the lines of communication around bullying and signal that you are prepared to discuss it. Stress the importance of parental awareness, surveillance and support as well as parents modelling effective strategies to deal with conflict and aggression.
- With adolescents, use the [HEEADSSS assessment \(https://www.rch.org.au/clinicalguide/guideline\\_index/Engaging\\_with\\_and\\_assessing\\_the\\_adolescent\\_patient/\)](https://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient/),<sup>171-175</sup> in which the patient is asked about home life, education/employment, eating habits, activities, drug and alcohol use, sexuality, personal safety and suicidal ideation/depression (refer to Appendix 1).
- With young children, it is always useful to attempt to talk to the child alone; however, it will usually be difficult to talk to them without the parents being present. Most parents will defend the aggressive child, or minimise their behaviour. Some believe that the victim of the bullying must have done something to deserve it.<sup>176</sup>

- For very young children, the GP may need to rely more on their own and parental observations.

Suggested questions to help this process are shown in Table 10.3.

---

**Table 10.3. Sample questions to ask children about bullying**

---

Peer bullying

Sibling bullying

---

**Table 10.3. Sample questions to ask children about bullying**

'I'd like to ask you some questions about what school is like.'

- 'Have you ever been teased (or picked on) at school?'
- 'What kinds of things do children tease you about? Have you ever been teased because of your illness/handicap/disability? Do you have any nicknames?'
- 'What do you do when others pick on you?'
- 'Have you ever told your teacher or other adult? What happened?'
- 'Do you know of other children who have been teased?'
- 'At recess, do you usually play with other children or by yourself?'

'I'd like to ask you some questions about life at home with your brother(s) and/or sister(s).'

- 'How do you get on with your brother(s) and/ or sister(s)?'
- 'Sometimes brothers and sisters hit, bite, or kick each other when they are feeling mad or frustrated. They might pick on you, call you names or exclude you from things. Does that happen to you with your brother(s) or sister(s)?'

If child answers in affirmative or says 'sometimes', ask follow-up questions to gather information about frequency, types of bullying, severity, how long has it been occurring and the impact:

- 'How often that does happen? (help the child to quantify): Does it happen every day? Every week? Or just sometimes?'
- 'How long has this been going on for?'
- 'What do you do to try to stop the bullying? Does it work? If not, what else can you do to stop the bullying?'
- 'Can you tell them to stop? Can you escape when this happens?'
- 'How do you feel when you are bullied?'
- 'Do you have anyone you can talk to about this?'
- 'Some kids say it's scary when they fight with their brother(s)/sister(s). Do you feel like it is scary when you fight with your brother(s) or sister (s), like you might get hurt really bad?'

If child answers in the affirmative or sometimes, ask questions to gather additional information such as:

- 'Do you feel scared lots of times or just sometimes? Tell me about that.'

Questions for children suspected (or identified) of bullying behaviour

- 'Have you been involved in bullying others at school, in sports or in your neighbourhood?'
- If yes, continue with the following questions:
- 'How long have you been bullying?'
- 'How often do you bully?'

- 'Are you involved in bullying just at school or in other places, such as at home, on a sports team or at a community centre?'
- 'Can you tell me about the types of bullying that you have used? How do the kids you bully feel?'
- 'Have any adults talked with you to help you stop bullying?'

### Questions for parents

Identify the type of sibling bullying and the extent of involvement: bully only, victim only and bully–victim, and ask about the child's social skills. Social skills relates to a child's ability to get along with family, peers and other adults, and a child's knowledge of what is expected in social interactions. It includes abilities like making eye contact, listening and taking turns, and recognising emotions in themselves and in others.<sup>122</sup>

### Parent of victim of bullying

- 'Are you concerned that your child is having problems with other children at school?'
- 'Has your child's teacher ever mentioned that your child is often by themselves at school?'
- 'Does your child visit the school nurse frequently or have they come home with unexplained injuries?'
- 'Has your child ever said that other children were bothering him or her?'
- 'Do you suspect that your child is being harassed or bullied at school for any reason? If so, why?'

### Parent of a child who is bullying

- 'How does your child get along with other children/their siblings?'
- 'When conflict arises, how does your child typically approach it? Do you think your child is a bully?'

If there is a pattern of repeated aggressive behaviour by the child towards their siblings or other children, then consider the following questions. It may be helpful to support the parent to put themselves in the younger child's shoes. Parents may react strongly to any questions that imply judgement or labelling. The aim is to get more information and insight into what is happening to try and help the child and the parents.

- 'What do think is going on in your child? I wonder if you think it is affecting them emotionally?'
- 'Do you have any ideas of what may be contributing to your child's behaviour?'
- 'It can be hard to children to change their behaviour. What have you done to try and deal with or address this behaviour?'

The following questions may generate a negative reaction. It is worth making it clear you do not know the answer to the questions and it will help you to understand if the following are issues that need to be considered.

- 'Do think your child is mean or cruel to other children?'
- 'Do you think your child is trustworthy?'
- 'Do you think your child is manipulative?'
- 'Do you believe that your child lacks guilt?'

## Sibling bullying

Many parents are concerned and frustrated about how often their children argue, tease each other or even fight.

- 'Is this an issue for you?'
- 'Can you tell me what happens?'
- 'Do you have any ideas about why they fight or argue?'
- 'What strategies, if any, do you use to stop this behaviour?'
- 'How well do your children get on with each other?'
- 'Do you think that there is a lot of teasing and pushing/shoving that occurs between them?'
- 'Do you think that this goes both ways (like sibling rivalry) or is it more one-sided?'
- 'Do you have any concerns that one child may be more often on the receiving end?'

## Interventions and strategies to manage bullying

A number of professional groups have highlighted a range of strategies that healthcare professionals can offer [24,26,27,29,31,35,154,178-180](#) that can be effective in helping to address bullying. Bullying and aggression are behaviours learned through the observation, role modelling and reinforcement of aggression (eg where such behaviour enables the child to get their own way).<sup>57</sup> Similarly, the abusive sibling will have learned that there is a payoff for the bullying behaviour.<sup>19</sup> These learned behaviours can be 'unlearned' and replaced with more effective strategies to deal with conflict. [57,127,132](#)

### Interventions targeted to children

Target those who bully and those who are victims of bullying.

For the bully:

- Use interventions to stop the aggression/bullying, promote empathy and prosocial skills and reduce peer pressure to engage in bullying. These include: teaching the child about emotional regulation, [137,181-184](#) conflict management [132,156,185,186](#) and mediating techniques. [132,186](#)
- Identify and managing comorbid emotional and developmental disorders in the bullying child. [55](#)

For the victim:

- Highlight to the child and the parents that any form of bullying is unacceptable. [31](#)
- Provide support for the child to develop assertive strategies and friendship skills. [32,66,80,132,156,160,161,163,185,187-199](#)
- Work with the parents to develop a plan of action for peer bullying at school. [28,30,31,154,178,180](#)
- Parents should meet with the school counsellor/teacher or principal to discuss the bullying.
- Clarify with the school:
  - how this matter will be investigated
  - how long the investigation will take
  - when a follow-up meeting can be arranged to discuss how the situation will be addressed/resolved.

### **Interventions targeted to parents**

Parenting interventions for youth mental, emotional and behavioural disorders have not been sufficiently tested to be adopted and sustained in primary care.<sup>161</sup> However, a range of parenting behaviours can help to ameliorate aggression/bullying in children.

### **Promoting greater parental awareness**

It may help to promote parental awareness of whether the child is being bullied, either at home<sup>14</sup> or in other settings (eg online<sup>200</sup> and at school<sup>20,154</sup>). Understanding why children do not report bullying to their parents is required.<sup>12,14</sup> Older children might be fearful of the consequences of disclosing bullying to an adult. They may:

- fear they will not be believed or taken seriously
- fear they will be made a scapegoat (either in the family or at school)<sup>201</sup>
- feel ashamed of being a victim (ie it is actually their problem or they should have been able to deal with it)
- feel inadequate or like it is their fault
- believe it is normal or that nothing will be done anyway.

Children are more likely to have positive experiences when they are believed and emotionally or practically supported by the adult.<sup>12,14</sup>

### **Help parents to take any bullying seriously**

Parents can highlight to the sibling bully that their behaviour is not acceptable and has consequences. This can include withdrawal of privileges, additional 'tasks' or time out.

Provide strategies parents can use to help children learn to deal with conflict, for example, IDEAL:

- Identify: learn to identify the problem
- Determine: possible solutions getting the child involved in this identification
- Evaluate: look at the pros and cons of possible solutions
- Act: choose the best solution
- Learn: what worked, what didn't work, what would you do next time?

### **Encourage and assist**

Encourage parents to:

- Avoid 'negative' labels that become truisms (eg the child is labelled a 'whiner' by their parents). The child labelled in this way will often then feel bad about themselves. The siblings will pick up on the label and repeat it. The label is often hard to shake off.
- Be careful when making comparisons between children. Children are very sensitive to any perception of favouritism<sup>138,202</sup> and dislike being compared to a sibling who is seen as the 'standard'. For example, avoid saying things like, 'Why don't you try as hard as your older brother?'
- Praise cooperative behaviour between siblings when parents observe it. It helps to reward such behaviour.

- Develop, with assistance, skills that promote positive parent–child interactions (eg demonstrating enthusiasm, following child’s interests, offering appropriate recreational options, providing positive attention<sup>160,161,190</sup> and improving communication with their children<sup>190</sup>). These can be effectively achieved by both face-to-face and online participation.<sup>198</sup> Quality time with their children can give the child a ‘boost’ and also gives the parent a good opportunity to better understand their child (eg what they like, how they deal with issues).
- Become involved in school-based anti-bullying programs, as such involvement has a significant impact on reducing bullying perpetration and victimisation.<sup>203</sup>

Highlight to parents:

- the need to believe the child if the child tells you they are being bullied
- how to recognise the physical and psychological symptoms associated with both being the victim or instigator of the bullying
- the importance of ensuring the child has a trusted adult to turn to if bullying occurs, who will take positive and appropriate action and believes them.

### Further assistance

For the bully: Interventions to stop the aggression/bullying, promote empathy and prosocial skills and reduce peer pressure to engage in these activities include teaching the child about emotional regulation,<sup>137,181–184</sup> conflict management<sup>132,156,185,186</sup> and mediating techniques.<sup>132,186</sup>

For the victim of bullying: Provide support for the child to develop assertive strategies and friendship skills.<sup>32,66, 80,132,156,160,161,163,185,187–199</sup>

Identifying and managing comorbid emotional and developmental disorders in the aggressive/bullying child are essential.<sup>55</sup>

Work with the parents to development a plan of action for peer bullying at school.<sup>28,30,31,154,178,180</sup>

- Parents should meet with the school counsellor/teacher or principal to discuss the bullying.
- Clarify with the school:
  - How will this matter be investigated?
  - How long will this investigation take?
  - When can they have a follow-up meeting to discuss how the situation will be addressed/resolved?

## Case study: Addressing sibling bullying

Names have been changed in this case study.

Stephen (aged 10 years) and John (aged 7 years) were brothers. Stephen was a lot bigger and stronger than John. They would come to stay with their aunt Kate and uncle Charlie in Melbourne.

In the last few visits, John seemed a bit withdrawn, hard to engage and appeared to be distressed a lot of the time. The behaviour seemed out of character. John's father had mentioned that John had truanted from school a few times in the last 12 months and that his grades had declined in the last six months. John's dad wasn't sure whether John was being bullied at school as John had denied any bullying.

One day the boys were building card houses. Whenever Kate left the room, John's card house collapsed with a complaint and tears from John that Stephen had nudged the carpet.

Kate began paying closer attention. The final straw was when Stephen did a judo manoeuvre on John and John fell awkwardly to the floor. Stephen hadn't noticed that Kate had seen the incident through the doorway.

Kate and Charlie did not have their own children and were hesitant about speaking about the behaviour with John and Stephen's parents (who had recently separated).

Kate spoke with her GP when she was seeing them for a blood pressure review. The GP told Kate that this behaviour indicated that John was being bullied by Stephen. The GP explained that bullying was unacceptable, but it could be managed. The GP suggested that they implement a reward system (points) for treats that both boys would enjoy together. The GP also suggested that the behaviour that they wanted to extinguish (eg the niggling or unnecessary rough play) would be penalised by withdrawal of points. Kate asked the boys what special treat they would like.

They both agreed on doing a quad bike ride. Kate and Charlie set a target number of points needed and made it clear to both boys that points would be deducted for any evidence of niggling or uncooperative behaviour.

Kate felt that over the following two weeks of the boys' stay that there seemed to be less aggravating behaviour.

### Postscript

The boys, now in their teens, get on quite well. Much of the niggling stopped completely after John had a growth spurt and ended up being taller and stronger than Stephen. John did say recently that he had been bullied at school but when he grew a lot taller, that stopped. In his mid-teens, John told Kate that he had appreciated her intervention and that it had given him confidence. Kate told her GP how things had ended up and also her appreciation for the advice. Kate reflected that John might have been in a situation where he had no safe place.

## Refer/recommend

Where there is evidence of abuse or long-term sibling bullying:

- Recommend parenting programs that have good evidence of effectiveness in a range of parenting skills, including bullying. [162,185,198,204,205](#)
- Refer to local services (eg psychologists, family therapists) and connect children and their parents with available community resources (refer to [Resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-vi](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-vi)



[olence/resources-1/resources](#)).

### Interventions for the general practice

Make the practice more accessible and friendly to young people.<sup>206-209</sup> Strategies include:

- accessibility
- appointment flexibility
- staff attitude (ie child and youth friendly – someone who treats them ‘like a friend’ and is interested in non-medical aspects of their lives)
- communication that is direct and includes clear technical information but without lecturing
- age-appropriate environment
- confidentiality – assure these groups it is safe to talk with their GP
- involvement in healthcare – young people stress their need to be involved in their healthcare.

### Strategies for the wider setting

Given that bullying occurs in multiple settings (eg internet, families, schools and workplaces), the need for a public health approach will be important and likely more effective and efficient.<sup>210-212</sup>

## Resources

### General

- [National Centre against Bullying \(ncab.org.au\)](http://ncab.org.au) – provides useful resources and tips for health professionals, parents and young people.
- [No way! \(https://bullyingnoway.gov.au/\)](https://bullyingnoway.gov.au/)
- [Australian Childcare Alliance: Be You \(https://childcarealliance.org.au/blog/195-kids-matter-has-become-be-you\)](https://childcarealliance.org.au/blog/195-kids-matter-has-become-be-you) (previously KidsMatter) – the Australian Government’s renewed and expanded investment in children’s mental health and wellbeing, covering the early years through school and up to the age of 18.
- [Child and Adolescent Psychological and Educational Resources \(https://www.caper.com.au/\)](https://www.caper.com.au/)
- [Blue Knot \(https://www.caper.com.au/\)](https://www.caper.com.au/) – a support organisation for people who have experienced childhood trauma or abuse, for their families and close friends, and for professionals who would like to learn how to more effectively work with these people.
- [Emerging Minds \(emergingminds.com.au\)](http://emergingminds.com.au) – develops mental health policy, services, interventions, training, programs and resources in response to the needs of professionals, children and their families.

### Prevalence and impact

- [Australia’s Children \(https://www.aihw.gov.au/reports/children-youth/australias-children/contents/justice-and-safety/bullying\)](https://www.aihw.gov.au/reports/children-youth/australias-children/contents/justice-and-safety/bullying) – a 2020 report from the Australian Institute of Health and Welfare.

### Myths about bullying

- [National Centre against Bullying \(https://www.ncab.org.au/bullying-advice/myth-busters/\)](https://www.ncab.org.au/bullying-advice/myth-busters/)
- [Myths about Bullying \(http://www.ncdsv.org/images/SBN\\_MythsAboutBullying.pdf\)](http://www.ncdsv.org/images/SBN_MythsAboutBullying.pdf)

### Cyberbullying

- [eSafety Commissioner \(https://www.esafety.gov.au/key-issues/cyberbullying\)](https://www.esafety.gov.au/key-issues/cyberbullying) – has good information and resources on how to keep children safe when they are online.
- [Australian Federal Police Child Protection \(https://www.thinkuknow.org.au/index.php\)](https://www.thinkuknow.org.au/index.php) – is involved in many prevention and awareness raising initiatives, particularly in relation to keeping young people safe online.

### Outside Australia

- [Stop Bullying \(https://www.stopbullying.gov/\)](https://www.stopbullying.gov/) (United States)
- [Child Mind Institute \(childmind.org\)](http://childmind.org) (United States)
- [Promoting relationships and eliminating violence network \(https://www.prevnet.ca/\)](https://www.prevnet.ca/) (PREVNet) (Canada)
- [Bullying tip sheet from family physicians and primary care \(https://www.prevnet.ca/sites/prevnet.ca/files/family\\_doctors\\_and\\_primary\\_care-bullying\\_tip\\_sheet.pdf\)](https://www.prevnet.ca/sites/prevnet.ca/files/family_doctors_and_primary_care-bullying_tip_sheet.pdf)
- [Anti-Bullying Alliance \(https://www.anti-bullyingalliance.org.uk/\)](https://www.anti-bullyingalliance.org.uk/) (United Kingdom)
- [How to talk to your children about bullying: Tips for parents \(https://www.unicef.org/end-violence/how-talk-your-children-about-bullying\)](https://www.unicef.org/end-violence/how-talk-your-children-about-bullying) (UNICEF)

### For GPs

- [HEADSS: Psychosocial interview for adolescents \(https://www.rch.org.au/clinicalguide/guideline\\_index/Engaging\\_with\\_and\\_assessing\\_the\\_adolescent\\_patient/\)](https://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient/)
- [Australian Medical Association Guidance for Doctors on Childhood Bullying \(https://ama.com.au/articles/ama-guidance-doctors-childhood-bullying\)](https://ama.com.au/articles/ama-guidance-doctors-childhood-bullying)
- [Anti-Bullying Alliance advice for GPs \(https://www.anti-bullyingalliance.org.uk/sites/default/files/field/attachment/Advice-for-GPs-final-November-2015.pdf\)](https://www.anti-bullyingalliance.org.uk/sites/default/files/field/attachment/Advice-for-GPs-final-November-2015.pdf) (United Kingdom)
- [Generation Next \(generationnext.com.au\)](http://generationnext.com.au) – education, seminars and resources for health professionals, parents and teachers about the prevention and management of mental illness in children and youth.
- [Building resilience in children aged 0–12: A practice guide \(https://resources.beyondblue.org.au/prism/file?token=BL/1810\\_A\)](https://resources.beyondblue.org.au/prism/file?token=BL/1810_A) – from Beyond Blue, 2017.
- [e-Mental health in practice \(https://www.emhprac.org.au/\)](https://www.emhprac.org.au/) – provides a range of resources including brochures, factsheets, videos, webinars and modules.

### For parents

- [Australian Institute for Family Studies, Child Family Community Australia \(https://aifs.gov.au/cfca/\)](https://aifs.gov.au/cfca/) – an information hub for evidence, resources and support for professionals working in the child, family and community welfare sector. It provides a summary of many of the parenting programs on offer to address children's behaviour problems.
- [Parenting Research Centre \(https://www.parentingrc.org.au/\)](https://www.parentingrc.org.au/) – helps children and families thrive by driving improved ways of supporting parenting by helping governments and community agencies to put best-practice parenting support into action. They have also developed a [tool kit for health workers and other professionals \(https://raisingchildren.net.au/for-professionals/mental-health-resources\)](https://raisingchildren.net.au/for-professionals/mental-health-resources)

- [Triple P: Positive Parenting Program \(https://raisingchildren.net.au/for-professionals/mental-health-resources\)](https://raisingchildren.net.au/for-professionals/mental-health-resources)
- [Incredible Years \(https://apps.aifs.gov.au/cfca/guidebook/programs/incredible-years\)](https://apps.aifs.gov.au/cfca/guidebook/programs/incredible-years)

#### For patients and parents/carers/teachers

- [Kids Helpline \(https://kidshelpline.com.au\)](https://kidshelpline.com.au) – phone or online support for kids from age five years.
- [Reach Out \(https://issuu.com/reachoutaustralia\)](https://issuu.com/reachoutaustralia) – information on mental health and wellbeing resources and services, as well as bullying and friendship issues and their impact on young people’s mental health and wellbeing.
- [Disruptive behaviour in children: What parents should know \(https://www.schn.health.nsw.gov.au/fact-sheets/disruptive-behaviours-in-children-what-parents-should-know#:~:text=Examples%20of%20disruptive%20behaviours%20include,occur%20some%20of%20the%20time\)](https://www.schn.health.nsw.gov.au/fact-sheets/disruptive-behaviours-in-children-what-parents-should-know#:~:text=Examples%20of%20disruptive%20behaviours%20include,occur%20some%20of%20the%20time) – a NSW Government resource.
- [Helping your child stop bullying: A guide for parent \(https://aifs.gov.au/cfca/publications/helping-your-child-stop-bullying-guide-parents\)](https://aifs.gov.au/cfca/publications/helping-your-child-stop-bullying-guide-parents) – from the Australian Institute of Family Studies.
- [Teasing versus bullying tip sheet \(https://www.prevnet.ca/bullying/educators/the-difference-between-teasing-and-bullying\)](https://www.prevnet.ca/bullying/educators/the-difference-between-teasing-and-bullying) – from PREVNet.

#### Other resources

- Dr Deborah Temkin talks about [bullying in childhood with a focus on peer bullying \(https://www.pta.org/center-for-family-engagement/notes-from-the-backpack/how-to-handle-bullying\)](https://www.pta.org/center-for-family-engagement/notes-from-the-backpack/how-to-handle-bullying) : identification, context and strategies to manage
- [Strategies to manage sibling bullying \(https://www.youtube.com/watch?v=IQ3nMfRqsYQ&feature=youtu.be\)](https://www.youtube.com/watch?v=IQ3nMfRqsYQ&feature=youtu.be)
- [Distinguishing sibling rivalry from sibling bullying \(https://www.youtube.com/watch?v=\\_V2zKkUiXE0\)](https://www.youtube.com/watch?v=_V2zKkUiXE0)
- [What can be done to manage sibling rivalry \(https://www.youtube.com/watch?v=\\_gtVLO57h0Q\)](https://www.youtube.com/watch?v=_gtVLO57h0Q)

**Tool 10.1: The HEADSSS psychosocial interview for adolescents**

[A resource from the Royal Children's Hospital \(https://www.rch.org.au/clinicalguide/guideline\\_index/Engaging\\_with\\_and\\_assessing\\_the\\_adolescent\\_patient\)](https://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient)

Home:	who, where, recent changes (moves or new people), relationships, stress or <a href="https://www.rch.org.au/clinicalguide/guideline_index/Family_Violence/">violence (https://www.rch.org.au/clinicalguide/guideline_index/Family_Violence/)</a> , smartphone or computer use (in home versus room)
Education and employment:	where, year, attendance, performance, relationships and bullying, supports, recent moves, disciplinary actions, future plans, work details
Eating and exercise:	weight and body shape (and relationship to these), recent changes, eating habits and dieting, exercise and menstrual history
Activities:	extra-curricular activities for fun: sport, organised groups, clubs, parties, TV/computer use (how much screen time and what for)
Drugs and alcohol:	cigarettes, alcohol and illicit drug use by friends, family and patient. Frequency, intensity, patterns of use, payment for, regrets and negative consequences
Sexuality and gender:	gender identity, romantic relationships, sexuality and sexual experiences, uncomfortable situations/sexual abuse, previous pregnancies and risk of pregnancy, contraception and STIs
Suicide, depression and self-harm:	presence and frequency of feeling stressed, sad, down, 'bored', trouble sleeping, online bullying, current feelings (eg on scale of 1 to 10), thoughts or actions of self-harm/ hurting others, suicide risk: thoughts, attempts, plans, means and hopes for future
Safety:	serious injuries, online safety (eg meeting people from online), riding with intoxicated driver, exposure to violence (school and community), if high risk – carrying weapons, criminal behaviours, justice system

## References

1. Jadambaa A, Thomas HJ, Scott JG, Graves N, Brain D, Pacella R. Prevalence of traditional bullying and cyberbullying among children and adolescents in Australia: A systematic review and meta-analysis. *Aust N Z J Psychiatry* 2019;53:878–88.
2. Tucker CJ, Finkelhor D, Shattuck AM, Turner H. Prevalence and correlates of sibling victimization types. *Child Abuse Negl* 2013;37:213–23.
3. Fry D, Fang X, Elliott S, et al. The relationships between violence in childhood and educational outcomes: A global systematic review and meta-analysis. *Child Abuse Negl* 2018;75:6–28.
4. Gini G, Pozzoli T. Association between bullying and psychosomatic problems: A meta-analysis. *Pediatrics* 2009;123:1059–65.
5. Heerde JA, Hemphill SA. Are bullying perpetration and victimization associated with adolescent deliberate self-harm? A meta-analysis. *Arch Suicide Res* 2019;23:353–81.
6. Jadambaa A, Thomas HJ, Scott JG, Graves N, Brain D, Pacella R. The contribution of bullying victimisation to the burden of anxiety and depressive disorders in Australia. *Epidemiol Psychiatr Sci* 2019;29:e54.
7. Klomek AB, Sourander A, Elonheimo H. Bullying by peers in childhood and effects on psychopathology, suicidality, and criminality in adulthood. *Lancet Psychiatry* 2015;2:930–41.
8. Moore SE, Norman RE, Suetani S, Thomas HJ, Sly PD, Scott JG. Consequences of bullying victimization in childhood and adolescence: A systematic review and meta-analysis. *World J Psychiatry* 2017;7:60–76.
9. van Geel M, Goemans A, Vedder P. A meta-analysis on the relation between peer victimization and adolescent non-suicidal self-injury. *Psychiatry Res* 2015;230:364–68.
10. Wolke D, Tippet N, Dantchev S. Bullying in the family: Sibling bullying. *Lancet Psychiatry* 2015;2:917–29.
11. Wolke D, Skew A. Bullied at home and at school: Relationship to behaviour problems and unhappiness. In: Mcfall S, editor. *Understanding society: Early findings from the first wave of the UK's household longitudinal study*. London: Economic and Social Research Council, 2011.
12. Bjereld Y. The challenging process of disclosing bullying victimization: A grounded theory study from the victim's point of view. *J Health Psychol* 2016;1359105316644973.
13. Larrañaga E, Yubero S, Navarro R. Parents' responses to coping with bullying: Variations by adolescents' self-reported victimization and parents' awareness of bullying involvement. *Social Sciences* 2018;7.
14. Meyers A. Notes from the field: understanding why sibling abuse remains under the radar and pathways to outing. *Professional Development: The International Journal of Continuing Social Work Education* 2015;18:24.
15. Arseneault L. Annual Research Review: The persistent and pervasive impact of being bullied in childhood and adolescence: implications for policy and practice. *J Child Psychol Psychiatry* 2018;59:405–21.
16. Flannery DJ, Todres J, Bradshaw CP, et al. *Bullying Prevention: A summary of the report of the National Academies of Sciences, Engineering, and Medicine Committee on the Biological and Psychosocial Effects of Peer Victimization: Lessons for Bullying Prevention*. *Prev Sci* 2016;17:1044–53.
17. Hayes C, Kelly D, Taut C, et al. Health care utilisation by bullying victims: A cross-sectional study of a 9-year-old cohort in Ireland. *Healthcare (Basel)* 2018;6.
18. Jadambaa A, Brain D, Pacella R, et al. The economic cost of child and adolescent bullying in Australia. *J Am Acad Child Adolesc Psychiatry* 2020;60:367–76.
19. Kiselica N, Morrill-Richards M. Sibling maltreatment: The forgotten abuse. *J Counseling and Development* 2007;85:148–60.
20. Holt KE, Kantor, Finkelhor D. Parent/child concordance about bullying involvement and family characteristics related to bullying and peer victimization. *J School Violence* 2008;8:42–63.
21. Caffaro J, Conn-Caffaro A. Treating sibling abuse families. *Aggression and Violent Behavior* 2005;10:604–23.
22. Krienert J, Walsh J. My brother's keeper: A contemporary examination of reported sibling violence using national level of reported sibling violence using national level data, 2000–2005. *J Fam Violence* 2011:331–42.

23. Yu J, Gamble W. Familial correlates of overt and relational aggression between young adolescent siblings. *J Youth Adolesc* 2008;37.
24. Ashraf IJ, Pekarsky AR, Race JE, Botash AS. Making the most of clinical encounters: Prevention of child abuse and maltreatment. *Pediatr Clin North Am* 2020;67:481–98.
25. Committee on Injury Violence and Poison Prevention. Policy statement – Role of the pediatrician in youth violence prevention. *Pediatrics* 2009;124:393–402.
26. Condon L, Prasad V. GP views on their role in bullying disclosure by children and young people in the community: a cross-sectional qualitative study in English primary care. *Br J Gen Pract* 2019;69:e752–e9.
27. Dale J, Russell R, Wolke D. Intervening in primary care against childhood bullying: An increasingly pressing public health need. *J R Soc Med* 2014;107:219–23.
28. Dawkins J. Bullying in schools: doctors' responsibilities. *BMJ* 1995;310:274–75.
29. Hickner J. It's time to screen for bullying. *J Fam Pract* 2017;66:66.
30. Lyznicki JM, McCaffree MA, Robinowitz CB. Childhood bullying: Implications for physicians. *Am Fam Physician* 2004;70:1723–28.
31. McClowry RJ, Miller MN, Mills GD. What family physicians can do to combat bullying. *J Fam Pract* 2017;66:82–89.
32. Moon DJ, Damman JL, Romero A. The effects of primary care-based parenting interventions on parenting and child behavioral outcomes: A systematic review. *Trauma Violence Abuse* 2020;21:706–24.
33. Scott E, Dale J, Russell R, Wolke D. Young people who are being bullied – do they want general practice support? *BMC Fam Pract* 2016;17:116.
34. Srabstein JC, Leventhal BL. Medical recognition of bullying and its related morbidity. *Lancet Psychiatry* 2015;2:858–59.
35. Stephens MM, Cook-Fasano HT, Sibbaluca K. Childhood bullying: Implications for physicians. *Am Fam Physician* 2018;97:187–92.
36. Bowes L, Wolke D, Joinson C, Lereya ST, Lewis G. Sibling bullying and risk of depression, anxiety, and self-harm: A prospective cohort study. *Pediatrics* 2014;134:e1032–39.
37. Dantchev S, Hickman M, Heron J, Zammit S, Wolke D. The independent and cumulative effects of sibling and peer bullying in childhood on depression, anxiety, suicidal ideation, and self-harm in adulthood. *Front Psychiatry* 2019;10:651.
38. Dantchev S, Wolke D. Sibling bullying at 12 years and high-risk behavior in early adulthood: A prospective cohort study. *Aggress Behav* 2019;45:18–32.
39. Dantchev S, Zammit S, Wolke D. Sibling bullying in middle childhood and psychotic disorder at 18 years: A prospective cohort study. *Psychol Med* 2018;12:1–8.
40. Gallagher AM, Updegraff KA, Padilla J, McHale SM. Longitudinal associations between sibling relational aggression and adolescent adjustment. *J Youth Adolesc* 2018;47:2100–113.
41. Takizawa R, Maughan B, Arseneault L. Adult health outcomes of childhood bullying victimization: evidence from a five-decade longitudinal British birth cohort. *Am J Psychiatry* 2014;171:777–84.
42. van Geel M, Vedder P, Tanilon J. Relationship between peer victimization, cyberbullying, and suicide in children and adolescents: A meta-analysis. *JAMA Pediatr* 2014;168:435–42.
43. Thomas HJ, Connor JP, Baguley CM, Scott JG. Two sides to the story: Adolescent and parent views on harmful intention in defining school bullying. *Aggress Behav* 2017;43:352–63.
44. Englander E, Donnerstein E, Kowalski R, Lin CA, Parti K. Defining cyberbullying. *Pediatrics* 2017;140(Suppl 2):S148–S51.
45. Smith PK, Cowie H, Olafsson RF, et al. Definitions of bullying: A comparison of terms used, and age and gender differences, in a fourteen-country international comparison. *Child Dev* 2002;73:1119–33.
46. Volk A, Veenstrab R, Espelage D. So you want to study bullying? Recommendations to enhance the validity, transparency, and compatibility of bullying research. *Aggression and Violent Behavior* 2017;36:34–43.
47. Liu J, Graves N. Childhood bullying: A review of constructs, concepts, and nursing implications. *Public Health Nurs* 2011;28:556–68.
48. Taylor E. *Dorland's Illustrated medical dictionary*. Philadelphia: WB Saunders Company, 1988.
49. Eriksen S, Jensen V. A push or a punch: Distinguishing the severity of sibling violence. *J Interpers Violence* 2009;24:183–208.
50. Dantchev S, Wolke D. Trouble in the nest: Antecedents of sibling bullying victimization and perpetration. *Dev Psychol* 2019;55:1059–71.
51. Ensor R, Marks A, Jacobs L, Hughes C. Trajectories of antisocial behaviour towards siblings predict antisocial behaviour towards peers. *J Child Psychol Psychiatry* 2010;51:1208–16.

52. Garcia MM, Shaw DS, Winslow EB, Yaggi KE. Destructive sibling conflict and the development of conduct problems in young boys. *Dev Psychol* 2000;36:44–53.
53. Finkelhor D, Turner H, Ormrod R. Kid's stuff: The nature and impact of peer and sibling violence on younger and older children. *Child Abuse Negl* 2006;30:1401–21.
54. Logan-Greene P, Nurius PS, Hooven C, Thompson EA. Life course associations between victimization and aggression: Distinctive and cumulative contributions. *Child Adolesc Social Work J* 2015;32:269–79.
55. Scott JG, Tunbridge M, Stathis S. The aggressive child. *J Paediatr Child Health* 2018;54:1165–69.
56. Pepler D, Jiang D, Craig W, Connolly J. Developmental trajectories of bullying and associated factors. *Child Dev* 2008;79:325–38.
57. Thomas HJ, Connor JP, Scott JG. Why do children and adolescents bully their peers? A critical review of key theoretical frameworks. *Soc Psychiatry Psychiatr Epidemiol* 2018;53:437–51.
58. Toseeb U, McChesney G, Dantchev S, Wolke D. Precursors of sibling bullying in middle childhood: Evidence from a UK-based longitudinal cohort study. *Child Abuse Negl* 2020;108:104633.
59. Bouchard G, Plamondon A, Lachance-Grzela M. Parental intervention style and adult sibling conflicts: The mediating role of involvement in sibling bullying. *Journal of Social and Personal Relationships* 2019;36:2584–602.
60. Kim J, Kim E. Bullied by siblings and peers: The role of rejecting/neglecting parenting and friendship quality among Korean children. *J Interpers Violence* 2016;34:2203–26.
61. Tippett N, Wolke D. Aggression between siblings: Associations with the home environment and peer bullying. *Aggress Behav* 2014;41:14–24.
62. van Noorden TH, Haselager GJ, Cillessen AH, Bukowski WM. Empathy and involvement in bullying in children and adolescents: a systematic review. *J Youth Adolesc* 2015;44:637–57.
63. Zych I, Ttofi MM, Farrington DP. Empathy and callous-unemotional traits in different bullying roles: A systematic review and meta-analysis. *Trauma Violence Abuse* 2019;20:3–21.
64. Shakoor S, Jaffee SR, Bowes L, et al. A prospective longitudinal study of children's theory of mind and adolescent involvement in bullying. *J Child Psychol Psychiatry* 2012;53:254–61.
65. Alhaboby ZA, Barnes J, Evans H, Short E. Cyber-victimization of people with chronic conditions and disabilities: A systematic review of scope and impact. *Trauma Violence Abuse* 2019;20:398–415.
66. Earnshaw VA, Reisner SL, Menino D, et al. Stigma-based bullying interventions: A systematic review. *Dev Rev* 2018;48:178–200.
67. Pinquart M. Systematic Review: Bullying involvement of children with and without chronic physical illness and/or physical/sensory disability—a meta-analytic comparison with healthy/nondisabled peers. *J Pediatr Psychol* 2017;42:245–59.
68. Tucker CJ, Finkelhor D, Turner H. Victimization by siblings in children with disability or weight problems. *J Dev Behav Pediatr* 2017;38:378–84.
69. Cook C, Williams K, Guerra N, Kim T, Sadek S. Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School Psychology Quarterly* 2010;25:65–83.
70. Kljakovic M, Hunt C. A meta-analysis of predictors of bullying and victimisation in adolescence. *J Adolesc* 2016;49:134–45.
71. Earnshaw VA, Reisner SL, Juvonen J, Hatzenbuehler ML, Perrotti J, Schuster MA. LGBTQ bullying: Translating research to action in pediatrics. *Pediatrics* 2017;140(4).
72. McGeough BL, Sterzing PR. A systematic review of family victimization experiences among sexual minority youth. *J Prim Prev* 2018;39:491–528.
73. Hanish LD, Eisenberg N, Fabes RA, Spinrad TL, Ryan P, Schmidt S. The expression and regulation of negative emotions: Risk factors for young children's peer victimization. *Dev Psychopathol* 2004;16:335–53.
74. McLean S. McLean Developmental differences in children who have experienced adversity- Emotional dysregulation. Melbourne: Australian Institute of Family Studies, 2018.
75. Afifi TO, Taillieu T, Salmon S, et al. Adverse childhood experiences (ACEs), peer victimization, and substance use among adolescents. *Child Abuse Negl* 2020;106:104504.
76. Forster M, Gower AL, McMorris BJ, Borowsky IW. Adverse childhood experiences and school-based victimization and perpetration. *J Interpers Violence* 2020;35:662–81.
77. Hughes K, Bellis M, Hardcastle K, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health* 2017;2:e356–66.

78. Nocentini A, Fiorentini G, Di Paola L, Menesini E. Parents, family characteristics and bullying behavior: A systematic review. *Aggression and violent behavior* 2019;45:41–50.
79. Tucker CJ, Finkelhor D, Turner H, Shattuck AM. Family dynamics and young children's sibling victimization. *J Fam Psychol* 2014;28:625–33.
80. Fong VC, Hawes D, Allen JL. A systematic review of risk and protective factors for externalizing problems in children exposed to intimate partner violence. *Trauma Violence Abuse* 2019;20:149–67.
81. Button D, Gealt G. High risk behaviors among victims of sibling violence. *J Fam Violence* 2010;25:131–40.
82. Bowes L, Arseneault L, Maughan B, Taylor A, Caspi A, Moffitt TE. School, neighborhood, and family factors are associated with children's bullying involvement: A nationally representative longitudinal study. *J Am Acad Child Adolesc Psychiatry* 2009;48:545–53.
83. Tippett N, Wolke D. Socioeconomic status and bullying: A meta-analysis. *Am J Public Health* 2014;104:e48–59.
84. Noventini A, Fiorentini G, Di Paola L, Menesini E. Parents, family characteristics and bullying behavior: A systematic review. *Aggression and Violent Behavior* 2019;45:41–50.
85. Labella MH, Masten AS. Family influences on the development of aggression and violence. *Curr Opin Psychol* 2018;19:11–6.
86. Plamondon A, Bouchard G, Lachance-Grzela M. Family dynamics and young adults' well-being: The mediating role of sibling bullying. *J Interpers Violence* 2018;886260518800313.
87. Tippett N, Wolke D. Aggression between siblings: Associations with the home environment and peer bullying. *Aggress Behav* 2015;41:14–24.
88. Cole PM, Martin SE, Dennis TA. Emotion regulation as a scientific construct: methodological challenges and directions for child development research. *Child Dev* 2004;75:317–33.
89. D'Agostino A, Covanti S, Rossi Monti M, Starcevic V. Reconsidering emotion dysregulation. *Psychiatr Q* 2017;88:807–25.
90. Sahle B, Reavley, Morgan A, et al. Summary of interventions to prevent adverse childhood experiences and reduce their negative impact on children's mental health: An evidence based review. Melbourne: Centre of Research Excellence in Childhood Adversity and Mental Health, 2020.
91. Chrysanthou GM, Vasilakis C. Protecting the mental health of future adults: Disentangling the determinants of adolescent bullying victimisation. *Soc Sci Med* 2020;253:112942.
92. Wolke D, Skew AJ. Bullying among siblings. *Int J Adolesc Med Health* 2012;24:17–25.
93. Fekkes M, Pijpers FI, Fredriks AM, Vogels T, Verloove-Vanhorick SP. Do bullied children get ill, or do ill children get bullied? A prospective cohort study on the relationship between bullying and health-related symptoms. *Pediatrics* 2006;117:1568–74.
94. Wolke D, Woods S, Bloomfield L, Karstadt L. Bullying involvement in primary school and common health problems. *Arch Dis Child* 2001;85:197–201.
95. Hawker DS, Boulton MJ. Twenty years' research on peer victimization and psychosocial maladjustment: a meta-analytic review of cross-sectional studies. *J Child Psychol Psychiatry* 2000;41:441–55.
96. Hong JS, Kral MJ, Sterzing PR. Pathways from bullying perpetration, victimization, and bully victimization to suicidality among school-aged youth: A review of the potential mediators and a call for further investigation. *Trauma Violence Abuse* 2015;16:379–90.
97. Foody M, Samara M, O'Higgins Norman J. Bullying by siblings and peers: Poly-setting victimization and the association with problem behaviours and depression. *Br J Educ Psychol* 2020;90(Suppl 1):138–57.
98. Wang Q. Association of childhood intrafamilial aggression and childhood peer bullying with adult depressive symptoms in China. *JAMA Netw Open* 2020;3:e2012557.
99. Wolke D, Lereya ST. Long-term effects of bullying. *Arch Dis Child* 2015;100:879–85.
100. Gini G, Pozzoli T. Bullied children and psychosomatic problems: A meta-analysis. *Pediatrics* 2013;132:720–29.
101. Liu X, Peng C, Yu Y, et al. Association between sub-types of sibling bullying and mental health distress among chinese children and adolescents. *Front Psychiatry* 2020;11:368.
102. Tucker CJ, Finkelhor D, Turner H, Shattuck A. Association of sibling aggression with child and adolescent mental health. *Pediatrics* 2013;132:79–84.
103. Tucker CJ, Finkelhor D, Turner H, Shattuck AM. Sibling and peer victimization in childhood and adolescence. *Child Abuse Negl* 2014;38:1599–606.



104. Holt MK, Vivolo-Kantor AM, Polanin JR, et al. Bullying and suicidal ideation and behaviors: A meta-analysis. *Pediatrics* 2015;135:e496–e509.
105. McMahon EM, Reulbach U, Keeley H, Perry IJ, Arensman E. Bullying victimisation, self harm and associated factors in Irish adolescent boys. *Soc Sci Med* 2010;71:1300–7.
106. Waldinger RJ, Vaillant GE, Orav EJ. Childhood sibling relationships as a predictor of major depression in adulthood: a 30-year prospective study. *Am J Psychiatry* 2007;164:949–54.
107. Sansone RA, Sansone LA. Bully victims: Psychological and somatic aftermaths. *Psychiatry (Edgmont)* 2008;5:62–4.
108. Sutin AR, Robinson E, Daly M, Terracciano A. Parent-reported bullying and child weight gain between ages 6 and 15. *Child Obes* 2016;12:482–7.
109. Takizawa R, Danese A, Maughan B, Arseneault L. Bullying victimization in childhood predicts inflammation and obesity at mid-life: a five-decade birth cohort study. *Psychol Med* 2015;45:2705–15.
110. Niemela S, Brunstein-Klomek A, Sillanmaki L, et al. Childhood bullying behaviors at age eight and substance use at age 18 among males. A nationwide prospective study. *Addict Behav* 2011;36:256–60.
111. Thomas HJ, Connor JP, Lawrence DM, Hafekost JM, Zubrick SR, Scott JG. Prevalence and correlates of bullying victimisation and perpetration in a nationally representative sample of Australian youth. *Aust N Z J Psychiatry* 2017;51:909–20.
112. Ttofi MM, Farrington DP, Losel F, Crago RV, Theodorakis N. School bullying and drug use later in life: A meta-analytic investigation. *Sch Psychol Q* 2015;31:8–27.
113. Arseneault L. The long-term impact of bullying victimization on mental health. *World Psychiatry* 2017;16:27–8.
114. Renner LM, Schwab-Reese LM, Coppola EC, Boel-Studt S. The contribution of interpersonal violence victimization types to psychological distress among youth. *Child Abuse Negl* 2020;106:104493.
115. Gini G. Associations between bullying behaviour, psychosomatic complaints, emotional and behavioural problems. *J Paediatr Child Health* 2008;44:492–97.
116. Bowes L, Maughan B, Caspi A, Moffitt TE, Arseneault L. Families promote emotional and behavioural resilience to bullying: evidence of an environmental effect. *J Child Psychol Psychiatry* 2010;51:809–17.
117. Wolke D, Samara MM. Bullied by siblings: Association with peer victimisation and behaviour problems in Israeli lower secondary school children. *J Child Psychol Psychiatry* 2004;45:1015–29.
118. Simonelli C, Mullis T, Elliott A, Pierce T. Abuse by siblings and subsequent experiences of violence within the dating relationship. *J Interpers Violence* 2002;17:103–21.
119. Sartore G-M, Macvean, M, Devine B, Pourliakas. A. Interventions for parents and families-evidence for improving emotional outcomes for children. Melbourne: Parenting Research Centre for the Benevolent Society, 2016.
120. Bayram C, Harrison C, Charles J, Britt H. 'The kids are alright' - Changes in GP consultations with children 2000–15. *Aust Fam Physician* 2015;44:877–79.
121. Finkelhor D, Turner H, Hamby S, Omrod R. Polyvictimization – Children's exposure to multiple types of violence, crime, and abuse. *Juvenile Justice Bulletin* 2011;;1–12.
122. Radford L, Corral S, Bradley C, Fisher HL. The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults. *Child Abuse Negl* 2013;37:801–13.
123. Pepler DJ, Craig W. Making a difference in bullying. Toronto: LaMarsh Centre for Research on Violence and Conflict Resolution, York University, 1988.
124. Ehrensaft MK, Cohen P, Brown J, Smailes E, Chen H, Johnson JG. Intergenerational transmission of partner violence: A 20-year prospective study. *J Consult Clin Psychol* 2003;71:741–53.
125. Herrenkohl TI, Fedina L, Roberto KA, et al. Child maltreatment, youth violence, intimate partner violence, and elder mistreatment: A review and theoretical analysis of research on violence across the life course. *Trauma Violence Abuse* 2020;1524838020939119.
126. Taylor LK, Merrilees CE, Goeke-Morey MC, Shirlow P, Cummings EM. Trajectories of adolescent aggression and family cohesion: The potential to perpetuate or ameliorate political conflict. *J Clin Child Adolesc Psychol* 2016;45:114–28.
127. Campione-Barr N. The changing nature of power, control, and influence in sibling relationships. *New Dir Child Adolesc Dev* 2017;2017:7–14.
128. Dunn J. State of the art: Siblings. *The Psychologist* 2000;13:244–8.
129. Bedford VH, Volling BL, Avioli PS. Positive consequences of sibling conflict in childhood and adulthood. *Int J Aging Hum Dev* 2000;51:53–69.

130. Toseeb U, McChesney G, Oldfield J, Wolke D. Sibling bullying in middle childhood is associated with psychosocial difficulties in early adolescence: The case of individuals with autism spectrum disorder. *J Autism Dev Disord* 2019;50:1457–69.
131. Perozynski L, Kramer L. Parental beliefs about managing sibling conflict. *Dev Psychol* 1999;35:489–99.
132. Tucker CJ, Finkelhor D. The state of interventions for sibling conflict and aggression: A systematic review. *Trauma Violence Abuse* 2017;18:396–406.
133. Malti T, Peplak J, Zhang L. The development of respect in children and adolescents. *Monogr Soc Res Child Dev* 2020;85:7–99.
134. Warneken F. How children solve the two challenges of cooperation. *Annu Rev Psychol* 2018;69:205–29.
135. Anwar F, Fry DP, Grigaitytė I. Aggression prevention and reduction in diverse cultures and contexts. *Curr Opin Psychol* 2018;19:49–54.
136. Blake CS, Hamrin V. Current approaches to the assessment and management of anger and aggression in youth: A review. *J Child Adolesc Psychiatr Nurs* 2007;20:209–21.
137. Sukhodolsky DG, Smith SD, McCauley SA, Ibrahim K, Piasecka JB. Behavioral interventions for anger, irritability, and aggression in children and adolescents. *J Child Adolesc Psychopharmacol* 2016;26:58–64.
138. Buist KL, Dekovic M, Prinzie P. Sibling relationship quality and psychopathology of children and adolescents: A meta-analysis. *Clin Psychol Rev* 2013;33:97–106.
139. Dunn J. *Sibling relationships*. Hoboken, NJ: Blackwell Publishing, 2002.
140. Halpern J, Jutte D, Colby J, Boyce WT. Social dominance, school bullying, and child health: What are our ethical obligations to the very young? *Pediatrics* 2015;135(Suppl 2):S24–S30.
141. Bar-Zomer J, Brunstein Klomek A. Attachment to parents as a moderator in the association between sibling bullying and depression or suicidal ideation among children and adolescents. *Front Psychiatry* 2018;9:72.
142. Gilligan M, Suito JJ, Kim S, Pillemer K. Differential effects of perceptions of mothers' and fathers' favoritism on sibling tension in adulthood. *J Gerontol B Psychol Sci Soc Sci* 2013;68:593–8.
143. Jensen AC, McHale SM, Pond AM. Parents' social comparisons of siblings and youth problem behavior: A moderated mediation model. *J Youth Adolesc* 2018;47:2088–99.
144. Peng S, Suito JJ, Gilligan M. The long arm of maternal differential treatment: Effects of recalled and current favoritism on adult children's psychological well-being. *J Gerontol B Psychol Sci Soc Sci* 2018;73:1123–32.
145. Richmond MK, Stocker CM, Rienks SL. Longitudinal associations between sibling relationship quality, parental differential treatment, and children's adjustment. *J Fam Psychol* 2005;19:550–59.
146. Lereya ST, Samara M, Wolke D. Parenting behavior and the risk of becoming a victim and a bully/victim: A meta-analysis study. *Child Abuse Negl* 2013;37:1091–108.
147. Litt J, Scott J. Sibling bullying: The elephant in the room. *International Domestic Violence and Health Conference, Melbourne 2018*.
148. Shadik J, Perkins N, Kovacs P. Incorporating discussion of sibling violence in the curriculum of parent intervention programs for child abuse and neglect. *Health and Social Work* 2013;28:53–57.
149. Pickering JA, Sanders MR. Integrating parents' views on sibling relationships to tailor an evidence-based parenting intervention for sibling conflict. *Fam Process* 2017;56:105–25.
150. Dirks MA, Recchia HE, Estabrook R, et al. Differentiating typical from atypical perpetration of sibling-directed aggression during the preschool years. *J Child Psychol Psychiatry* 2018; 60:267–76.
151. Skinner JA, Kowalski RM. Profiles of sibling bullying. *J Interpers Violence* 2013;28:1726–36.
152. Kettrey H, Emery B. The discourse of sibling violence. *J Fam Violence* 2006;21:407–16.
153. Lucas S, Jernbro C, Tindberg Y, Janson S. Bully, bullied and abused. Associations between violence at home and bullying in childhood. *Scand J Public Health* 2016;44:27–35.
154. Carr-Gregg M, Manocha R. Bullying – effects, prevalence and strategies for detection. *Aust Fam Physician* 2011;40:98–102.
155. Meyers A. *Sibling abuse: Understanding developmental consequences through object relations, family systems, and resiliency theories*. New York City: Hunter College School of Social Work, 2011.
156. Chen Q, Zhu Y, Chui WH. A meta-analysis on effects of parenting programs on bullying prevention. *Trauma Violence Abuse* 2020;1524838020915619.

157. Munns A, Watts R, Hegney D, Walker R. Effectiveness and experiences of families and support workers participating in peer-led parenting support programs delivered as home visiting programs: A comprehensive systematic review. *JBI Database System Rev Implement Rep* 2016;14:167–208.
158. van der Put CE, Assink M, Gubbels J, Boekhout van Solinge NF. Identifying effective components of child maltreatment interventions: A meta-analysis. *Clin Child Fam Psychol Rev* 2018;21:171–202.
159. Leslie LK, Mehus CJ, Hawkins JD, et al. Primary health care: Potential home for family-focused preventive interventions. *Am J Prev Med* 2016;51(4 Suppl 2):S106–S18.
160. Shah R, Kennedy S, Clark MD, Bauer SC, Schwartz A. Primary care-based interventions to promote positive parenting behaviors: A meta-analysis. *Pediatrics* 2016;137:e20153393.
161. Smith JD, Cruden GH, Rojas LM, et al. Parenting interventions in pediatric primary care: A systematic review. *Pediatrics* 2020;146.
162. Brown CM, Raglin Bignall WJ, Ammerman RT. Preventive behavioral health programs in primary care: A systematic review. *Pediatrics* 2018:e20180611.
163. Rojas LM, Bahamón M, Wagstaff R, et al. Evidence-based prevention programs targeting youth mental and behavioral health in primary care: A systematic review. *Prev Med* 2019;120:85–99.
164. Eisenberg ME, Aalsma MC. Bullying and peer victimization: Position paper of the Society for Adolescent Medicine. *J Adolesc Health* 2005;36:88–91.
165. Australian Medical Association. AMA guidance for doctors on childhood bullying. Canberra: AMA, 2012.
166. USPSTF. Interventions to prevent child maltreatment: Recommendation statement. *Am Fam Physician* 2019;100:110–12.
167. Viswanathan M, Fraser JG, Pan H, et al. Primary care interventions to prevent child maltreatment: Updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA* 2018;320:2129–40.
168. Australian Government Department of Health. National Action Plan for the Health of Children and Young People. Canberra: Department of Health, 2019.
169. Noland VJ, Liller KD, McDermott RJ, Coulter ML, Seraphine AE. Is adolescent sibling violence a precursor to college dating violence? *Am J Health Behav* 2004;28(Suppl 1):S13–S23.
170. Fekkes M, Pijpers FI, Verloove-Vanhorick SP. Bullying: Who does what, when and where? Involvement of children, teachers and parents in bullying behavior. *Health Educ Res* 2005;20:81–91.
171. Ho J, Fong CK, Iskander A, Towns S, Steinbeck K. Digital psychosocial assessment: An efficient and effective screening tool. *J Paediatr Child Health* 2020;56:521–31.
172. Saw C, Smit A, Silva D, Bulsara MK, Nguyen E. Service evaluation and retrospective audit of electronic HEEADSSS (e-HEADSSS) screening device in paediatric inpatient service in Western Australia. *Int J Adolesc Med Health* 2020. doi: 10.1515/ijamh-2020-0120..
173. Smith GL, McGuinness TM. Adolescent Psychosocial Assessment: The HEEADSSS. *J Psychosoc Nurs Ment Health Serv* 2017;55:24–27.
174. Thabrew H, D'Silva S, Darragh M, Goldfinch M, Meads J, Goodyear-Smith F. Comparison of YouthCHAT, an electronic composite psychosocial screener, with a clinician interview assessment for young people: Randomized controlled trial. *J Med Internet Res* 2019;21:e13911.
175. Thabrew H, Kumar H, Goldfinch M, Cavadino A, Goodyear-Smith F. Repeated psychosocial screening of high school students using YouthCHAT: Cohort study. *JMIR Pediatr Parent* 2020;3:e20976.
176. Randall T. Adolescents may experience home, school abuse; their future draws researchers' concern. *JAMA* 1992;267:3127–8, 3131.
177. Sartore G-M, Macvean M, Devine B, Pourliakas A. Interventions for parents and families: The evidence for improving social outcomes for children. Melbourne: Parenting Research Centre for the Benevolent Society, 2016.
178. Lamb J, Pepler DJ, Craig W. Approach to bullying and victimization. *Can Fam Physician* 2009;55:356–60.
179. Ramya SG, Kulkarni ML. Bullying among school children: Prevalence and association with common symptoms in childhood. *Indian J Pediatr* 2011;78:307–10.
180. Scott EJ, Dale J. Childhood bullying: Implications for general practice. *Br J Gen Pract* 2016;66:504–5.
181. Gartland D, Riggs E, Muyeen S, et al. What factors are associated with resilient outcomes in children exposed to social adversity? A systematic review. *BMJ Open* 2019;9:e024870.

182. Kramer L. Learning emotional understanding and emotion regulation through sibling interaction. *Early Education and Development* 2014;25:160–84.
183. Schlesier J, Roden I, Moschner B. Emotion regulation in primary school children: A systematic review. *Children and Youth Services Review* 2019;100:239–57.
184. Thompson RA. Emotion dysregulation: A theme in search of definition. *Dev Psychopathol* 2019;31:805–15.
185. Furlong M, McGilloway S, Bywater T, Hutchings J, Smith SM, Donnelly M. Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review). *Evid Based Child Health* 2013;8:318–692.
186. Siddiqui A, Ross H. Mediation as a method of parent intervention in children's disputes. *J Fam Psychol* 2004;18:147–59.
187. Bayer J, Hiscock H, Scalzo K, et al. Systematic review of preventive interventions for children's mental health: What would work in Australian contexts? *Aust N Z J Psychiatry* 2009;43:695-710.
188. Flujas-Contreras JM, García-Palacios A, Gómez I. Technology-based parenting interventions for children's physical and psychological health: A systematic review and meta-analysis. *Psychol Med* 2019;49:1787–98.
189. Hendriks AM, Bartels M, Colins OF, Finkenauer C. Childhood aggression: A synthesis of reviews and meta-analyses to reveal patterns and opportunities for prevention and intervention strategies. *Neurosci Biobehav Rev* 2018;91:278–91.
190. Kaminski JW, Valle LA, Filene JH, Boyle CL. A meta-analytic review of components associated with parent training program effectiveness. *J Abnorm Child Psychol* 2008;36:567–89.
191. Kingsley K, Sagester G, Weaver LL. Interventions supporting mental health and positive behavior in children ages birth–5 yr: A systematic review. *Am J Occup Ther* 2020;74:7402180050p1.
192. Leijten P, Gardner F, Melendez-Torres GJ, et al. Meta-analyses: Key parenting program components for disruptive child behavior. *J Am Acad Child Adolesc Psychiatry* 2019;58:180–90.
193. Limbos MA, Chan LS, Warf C, et al. Effectiveness of interventions to prevent youth violence a systematic review. *Am J Prev Med* 2007;33:65–74.
194. Lindert J, Jakubauskiene M, Natan M, et al. Psychosocial interventions for violence exposed youth – A systematic review. *Child Abuse Negl* 2020;108:104530.
195. McGuire J. Review. A review of effective interventions for reducing aggression and violence. *Philos Trans R Soc Lond B Biol Sci* 2008: 18467276.
196. Ng ED, Chua JYX, Shorey S. The effectiveness of educational interventions on traditional bullying and cyberbullying among adolescents: A systematic review and meta-analysis. *Trauma Violence Abuse* 2020: 32588769.
197. Sancassiani F, Pintus E, Holte A, et al. Enhancing the emotional and social skills of the youth to promote their wellbeing and positive development: A systematic review of universal school-based randomized controlled trials. *Clin Pract Epidemiol Ment Health* 2015;11(Suppl 1 M2):21–40.
198. Spencer CM, Topham GL, King EL. Do online parenting programs create change?: A meta-analysis. *J Fam Psychol* 2020;34:364–74.
199. Townshend K, Jordan Z, Stephenson M, Tsey K. The effectiveness of mindful parenting programs in promoting parents' and children's wellbeing: A systematic review. *JBIG Database System Rev Implement Rep* 2016;14:139–80.
200. Uludasdemir D, Kucuk S. Cyber bullying experiences of adolescents and parental awareness: Turkish example. *J Pediatr Nurs* 2019;44:e84–e90.
201. Hamilton-Giachritsis CE, Browne KD. A retrospective study of risk to siblings in abusing families. *J Fam Psychol* 2005;19:619–24.
202. Jensen AC, Apsley HB, Rolan EP, Cassinat JR, Whiteman SD. Parental differential treatment of siblings and adolescents' health-related behaviors: The moderating role of personality. *J Youth Adolesc* 2020;49:150–61.
203. Huang Y, Espelage DL, Polanin JR, Hong JS. A meta-analytic review of school-based anti-bullying programs with a parent component. *International Journal of Bullying Prevention* 2019;1:32–44.
204. Sanders MR, Kirby JN, Tellegen CL, Day JJ. The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clin Psychol Rev* 2014;34:337–57.
205. Wilson P, Rush R, Hussey S, et al. How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P. *BMC Med* 2012;10:130.
206. Ambresin AE, Bennett K, Patton GC, Sanci LA, Sawyer SM. Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. *J Adolesc Health* 2013 Jun;52(6):670–81.

207. Muir K, Powell A, McDermott S. 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation. *Health Soc Care Community* 2012;20:181–89.
208. Thomsen EL, Hertz PG, Blix C, Boisen KA. A national guideline for youth-friendly health services developed by chronically ill young people and health care professionals – a Delphi study. *Int J Adolesc Med Health* 2020. doi: 10.1515/ijamh-2020-0185.
209. Tylee A, Haller DM, Graham T, Churchill R, Sanci LA. Youth-friendly primary-care services: How are we doing and what more needs to be done? *Lancet* 2007;369:1565–73.
210. Rivara F, S. LM. Preventing bullying through science, policy, and practice. Washington, DC: National Academies Press, 2016.
211. Srabstein J, Joshi P, Due P, et al. Prevention of public health risks linked to bullying: A need for a whole community approach. *Int J Adolesc Med Health* 2008;20:185–99.
212. Srabstein JC, Berkman BE, Pyntikova E. Antibullying legislation: A public health perspective. *J Adolesc Health* 2008;42:11–20.

# Adolescent-to-parent violence

'The role of GPs is to identify affected families, build a rapport with them and support them to seek help in managing adolescent-to-parent violence.'

## Key messages

- Adolescent-to-parent violence is a serious and gendered problem.<sup>1</sup> The majority of victims/survivors are mothers, and perpetrators are usually young men.<sup>1-3</sup> Fathers can also be victims/survivors and young women also use violence towards parents.<sup>2</sup>
- Young people who use violence have often experienced or witnessed violence in the family home.<sup>3-5</sup>
- The pattern of violence used is similar to that of adult family violence, in that young people use violence to obtain power and control.<sup>1</sup>
- Unlike adult perpetrators, young people who use violence against their parents are legally children and therefore their protection, safety and developmental needs need to be taken into consideration.<sup>2,3,5</sup>
- Health practitioners should adopt a youth friendly, developmentally appropriate and trauma-informed approach<sup>2,5,6</sup> and focus on building a good rapport to increase the likelihood of the young person engaging in regular review and therapy.

## Recommendations

Be aware of adolescent violence towards parents and how it might present to general practice.

**(Practice point, consensus of experts)**

Young people's violence against their parents may be associated with other forms of family violence; therefore, family violence should be sensitively inquired about.

**(Practice point, consensus of experts)**

Offer young people with behavioural concerns, and other family members, referral for psychological therapy.

**(Practice point, consensus of experts)**

## Clinical context

### Definitions

Adolescent-to-parent violence and child-to-parent violence are terms used interchangeably to describe violence that is initiated by a child or adolescent (aged 12–18 years) against their parent(s) with the intent to cause them psychological, physical or financial harm and/or to gain power and control over them.<sup>1,2,7,8</sup>

### Prevalence

Adolescent-to-parent violence is a significant but underreported issue.<sup>8</sup> Data from Victoria shows that approximately 10% of family violence call-outs to police were due to young people aged 19 years or under perpetrating violence,<sup>3</sup> and 7% were children aged 17 years or younger.<sup>9</sup> However, the true prevalence is not really known, due to underreporting, inconsistent definitions of 'adolescent' used by the police and children's court, and omission of the age of victims/survivors or perpetrators in data recording.<sup>3</sup>

Parents often struggle to recognise an adolescent's behaviour as abusive, instead minimising it, or labelling it as 'challenging'.<sup>1,3</sup> Parents also hesitate to report adolescent-to-parent violence due to shame, stigma or fear of repercussions for their child's future, such as involvement with child protection or the youth justice system resulting in a criminal record.<sup>1–3,5,8,10</sup> When parents do decide to report adolescent-to-parent violence to police, it has usually been going on for years.<sup>8</sup>

### Risk factors

A number of family and individual factors are associated with adolescent-to-parent violence.

Family factors include:

- adverse childhood experiences, including poor family relationships, parent-to-child violence and witnessing family violence in the home<sup>3–5,8,11–13</sup>
- White or European ethnicity, although the evidence is weak.<sup>12</sup>

The role of socioeconomic status is unclear.<sup>12</sup>

Individual factors include:

- mental illness and use of alcohol and drugs<sup>2,3,8,14</sup>

- having a disability, including acquired brain injury<sup>3</sup>
- having learning and behavioural difficulties<sup>3</sup>
- poor school attachment and running away from home<sup>8,14</sup>
- poor emotional regulation, including experiencing high levels of hostility and anger,<sup>14-16</sup> and low self-esteem and self-worth<sup>12</sup>
- problematic use of social media<sup>15</sup>
- attentional and motor impulsiveness<sup>15</sup>
- exposure to a peer who uses violence at home<sup>15</sup>
- other antisocial behaviour outside the home<sup>15</sup>
- a lower positive attitude towards authority figures such as teachers and police.<sup>17</sup>

Interestingly, a 2020 study found that the relationship between child abuse and adolescent-to-parent violence was moderated by positive peer attachment.<sup>18</sup>

## In practice

### Presentation

GPs should be aware of adolescent-to-parent violence within families, know the risk factors and how to identify young people and their parents dealing with adolescent-to-parent violence. It is unknown whether screening for adolescent-to-parent violence is helpful, but we recommend case finding.

For young people, adolescent-to-parent violence can present in the following ways:

- mental health concerns, including threats to harm self or others<sup>8</sup>
- a history of intellectual disability<sup>3</sup>
- use of alcohol and drugs<sup>3</sup>
- behavioural concerns, including trouble at school, and the adolescent causing damage to the victim/survivor's belongings and property<sup>3,5,8</sup>
- a history of having experienced family violence, child abuse or bullying.<sup>3</sup>

Parents may present with health issues, such as substance abuse or mental illness, that could be related to adolescent violence in the home.<sup>1</sup> GPs should investigate the surrounding factors that may be contributing to adolescent-to-parent violence so that appropriate referrals can be made.

### Working with adolescents and young people

It would be helpful to adopt a youth-friendly,<sup>19</sup> developmentally appropriate and trauma-informed approach<sup>5,6,8,20</sup> with the young person (and/or parent) who might be experiencing adolescent-to-parent violence. A trauma-informed approach or trauma- and violence-informed approach is patient-centred and acknowledges the role of trauma and violence in patients' lives while being focused on improving wellness rather than treating a mental illness.<sup>6,20</sup> Further information can be found in [Chapter 7: Trauma-informed care in general practice \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice). Young people who use violence against their parents sometimes become isolated from the family,<sup>1,8</sup> but also tend to lack empathy for the victims/survivors.<sup>2</sup>



Box 11.1 outlines some practice points for working with young people who might be using adolescent-to-parent violence at home, and Box 11.2 outlines examples of specific questions that you could ask a young person who you suspect was using violence towards their parents.

### Box 11.1. Working with adolescents who might be using violence at home

- Incorporate a youth-friendly<sup>19</sup> and trauma-informed care approach.<sup>5,6</sup>
- Explain confidentiality and the exceptions to this, including risk of harm to the young person or risk of the young person causing harm to others.<sup>19</sup> It is acknowledged that this may be challenging to do given the context of adolescent-to-parent violence and while attempting to build a good rapport and trust.
- Build a good rapport with the young person and thank them for coming in to seek help; this is a good investment in the therapeutic relationship to engage the young person and their family in the long term.
- Conduct a thorough [HEEADSSS assessment](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/dating-violence-and-technology-facilitated-abuse>).<sup>21</sup> A young person might be using violence at home if they present with risk-taking behaviours<sup>8,22</sup> or mental health issues.<sup>1,23</sup>
- Ask open-ended questions.
- When safe and appropriate to do so, inquire about family violence, sibling violence and dating violence, and manage as appropriate.
- Use the [LIVES framework](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse>)<sup>24</sup> where appropriate with the [CARE approach](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel>),<sup>25</sup> particularly for family members experiencing violence.
- Educate the young person about types of violence and emphasise that violence is not acceptable.
- Assess risk of harm to self and others.
- Assess the young person's support network.
- Consider referral to appropriate psychologist for counselling. Family therapy may not be appropriate, particularly if there is a power imbalance that may put the victim at risk of further violence.
- Don't forget routine care, including preventive healthcare<sup>19</sup> (eg screening for sexually transmitted infections).
- Organise extended consultations and regular follow-up.
- Continue consultations over telehealth when safe and appropriate to do so.
- Manage patient expectations and make a plan together.

**Box 11.2. Example questions to ask adolescents using violence towards parents**

- ‘What or who made you come in today?’
- ‘Have you talked about this to anyone else? Did you find this helpful? How did you feel?’
- ‘Are you worried about your behaviour?’
- ‘What happens when you get angry?’
- ‘Do you ever regret some of the things you have done?’
- ‘What would you like to change?’

## Working with parents or carers

If there is high clinical suspicion that a parent is experiencing violence or abuse from a child or young person, asking sensitively about adolescent violence in the home can be helpful.

As with suspicion of intimate partner abuse, broad questions can be asked first, such as, ‘How are things at home?’, followed by a statement to encourage the parent to talk, such as, ‘It can be challenging parenting a young person sometimes – how is it going for you?’

If adolescent-to-parent violence is still suspected, more-detailed questions can be asked about the violence, such as those listed in [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) and Box 11.3.

Conducting a safety and risk assessment is very important – for both the young person, and their parent, if both are in your care. Ways to inquire about safety are outlined in [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety).

**Box 11.3. Example questions to ask parents about adolescent-to-parent violence**

- ‘How are things at home?’
- ‘It can be really tough sometimes parenting young people. How are you going?’
- ‘Do you feel safe at home?’
- ‘What happens when your child does not get what they want?’
- ‘What happens when you set rules or boundaries around the house (eg screen time)?’
- ‘Do you feel afraid when your child feels out of control?’
- ‘Do you feel the need to protect siblings at home?’
- ‘What is the worst thing that has happened?’
- ‘Are you worried about your child’s behaviour?’
- ‘What would you like to change?’

## Response and referral

While there have been years of studies into adolescent-to-parent violence, the evidence is of poor quality,<sup>12</sup> and therefore there is no thorough understanding of how young people and their families can best be supported, and no evidence-based, developmentally appropriate interventions for young people who use violence against their parents.<sup>2,6,8</sup>

The lack of evidence-based knowledge in dealing with young people using violence at home from Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities adds further challenges in management of this problem.<sup>5</sup> Additionally, young people with a history of undiagnosed disabilities who use violence already experience the increased burdens of these disabilities, while their families are also already struggling to cope, without appropriate supports to address issues associated with the disability.<sup>3</sup>

There is little available help and support for adolescents and their families affected by adolescent-to-parent violence,<sup>5</sup> with services having limited understanding of the impact on carers and parents.<sup>8,10</sup> This can leave parents feeling frustrated and isolated in their attempts to seek help.<sup>8</sup>

The role of GPs is to identify affected families, build a rapport with them and support them to seek help in managing adolescent-to-parent violence. Patients may benefit from GPs adopting a trauma- and violence-informed approach, which includes recognising the impact of trauma and violence on patient behaviour and presentation, being flexible with consultation length according to the patient’s needs, creating a physically and emotionally safe environment, creating opportunities for collaboration and choice in healthcare and using a strengths-based approach.<sup>6,20,26</sup> Part of this trauma-informed approach includes building positive and emotionally supportive connections and this might include the GP speaking to the adolescent about nurturing positive peer attachments, which have been shown to be useful.

There is some evidence that targeted psychosocial interventions delivered by specialised facilitators could be helpful for high-risk adolescents who exhibit a range of aggressive behaviours (not necessarily adolescent-to-parent violence).<sup>13</sup>

The 2015 Royal Commission into Family Violence emphasised that a therapeutic approach is needed for adolescent violence in the home, noting that targeted counselling and family therapy might be the most effective means to manage young people's use of violence towards their parents.<sup>3</sup> It is therefore suggested that young people who use violence in the home be referred to a youth-friendly psychological service for targeted counselling and family therapy that is trauma informed. Evidence-based interventions that address the multiple determinants of the adolescent-to-parent violence with a focus on promoting healing and good social connections is recommended.<sup>6</sup>

Victoria's Adolescent Family Violence Program, which includes cognitive behavioural therapy, skill development and family involvement, is available to limited adolescents and their families in Victoria.<sup>3</sup> Initial evaluation findings are positive, showing that the program improved adolescents' violent behaviours and their overall wellbeing, and also increased parent confidence in managing the young person's behaviour.<sup>3</sup> Maintaining these good outcomes poses a challenge.

It would also be worthwhile exploring other forms of family violence in the home and addressing those on their own merit. Addressing substance abuse and mental illness would also be valuable in the primary care response to adolescent-to-parent violence.

## Practitioner self-care

It is acknowledged that looking after families experiencing adolescent violence in the home can be exhausting mentally and physically for the health professional. Therefore it is important that you look after yourself and debrief with colleagues. Have a look at [Chapter 8: Keeping the health professional safe and healthy: Clinician support and self-care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care) and the resources for health practitioners listed in the resource section.

## Case study: Brad

Brad, aged 15 years, has been booked in by his father, Tim, to see the family GP for a general health check and review of his mental health.

Tim is a construction worker. Tim and his wife, Claire, separated about 11 years ago, and it was decided that Brad would live with his father, as he was always 'difficult to handle' and had 'angry outbursts', where he would throw things around. He visits Claire on some weekends, and she allows him to drink alcohol and smoke marijuana with her. Brad has had learning difficulties since primary school, and began attending a 'special school' in Grade 6 to address his learning difficulties and challenging behaviour. After attending several different primary schools and secondary schools he eventually dropped out of school in Year 8, aged 14 years, after being threatened with expulsion for his behaviour.

At the first consultation with the GP, Brad is reluctant to participate. The GP asks about his interests and manages to learn that he enjoys computer games, follows unpopular political leaders and dislikes the school system. He has no friends. At the end of the consult, the GP offers to call him on his mobile for a follow-up telehealth consult and encourages an open-door policy.

Brad does not return for several weeks, but meanwhile, Tim presents on several occasions following this initial appointment with Brad. Tim wants to be a good parent and get the right support for his son. In one appointment, Tim concedes that Brad has been violent towards him on several occasions but used no weapons. Brad also threatened to kill him on one occasion several months ago. Tim is often afraid for his own safety, and has set up his own escape strategy, which is to leave the house and ring the police.

The GP supports Tim with regular follow-up appointments and referrals for mental health support and support. A program at Berry Street (in consortia with other services), the [Northern Healing and Recovery Program \(https://www.berrystreet.org.au/what-we-do/trauma-services/therapeutic-services-for-children-young-people-and-families/supporting-families-with-adolescents-using-family-violence\)](https://www.berrystreet.org.au/what-we-do/trauma-services/therapeutic-services-for-children-young-people-and-families/supporting-families-with-adolescents-using-family-violence), has an adolescent family violence program that would provide support to Brad to address his behaviours. Tim might want to engage in two other Berry Street programs, the [Matters program and their Teenage Aggression Responding Assertively workshop \(https://www.berrystreet.org.au/what-we-do/parenting-and-family-services/family-therapy-matters\)](https://www.berrystreet.org.au/what-we-do/parenting-and-family-services/family-therapy-matters).

A couple of months later, Brad is brought in again by his father, who is becoming increasingly concerned for Brad's mental health. Brad is feeling very depressed and suicidal and his angry outbursts have increased. He is increasingly threatening his father and throwing furniture around the house.

The GP makes referrals to the local youth mental health organisation and the mental health crisis team. However, Brad does not attend all of his appointments. He says he doesn't want to speak to any more psychologists or psychiatrists, as he finds them to be unhelpful and feels that they don't understand him.

One day the violence escalates so much that Tim has no choice but to call the police for protection. Following several such incidents, a referral is made to the juvenile court system.

The GP continues to offer support wherever possible and refers Brad to a paediatrician. The GP repeats a HEEADSSS screen to address any additional issues that might need to be addressed. Diagnoses of attention deficit hyperactivity disorder and Asperger syndrome are also queried.

Brad continues to return to the GP on an ad hoc basis, while the GP focuses on building trust and rapport in order to invest in a long-term therapeutic relationship. Appointments are kept flexible and last for at least 30 minutes so that consultations are not rushed. Telehealth is also utilised when appropriate but Brad does best when he comes in in person. A couple of years down the track, Brad has formed trust and a good rapport with the GP and has also started engaging with a psychologist more regularly. Tim is managing a bit better now and is able to recognise the warning signs and de-escalate the situation by prompting Brad with the appropriate advice from the psychologist to self-manage his outbursts. Calls to the police have not happened for a year. Tim continues to visit the GP fortnightly to seek support for his own mental health and coping strategies.

## Resources

- [Reachout Australia \(au.reachout.com\)](http://au.reachout.com) – an online mental health service for young people and their parents.
- [Domestic Violence Resource Centre Victoria \(https://www.dvrcv.org.au/\)](https://www.dvrcv.org.au/)
- [Inner South Community Health Service \(https://childhub.org/sites/default/files/library/attachments/adolescent-violence-to-parents-inner-south-community-health.pdf\)](https://childhub.org/sites/default/files/library/attachments/adolescent-violence-to-parents-inner-south-community-health.pdf) – this booklet aims to help parents and professionals understand adolescent violence in the home and consider strategies to increase family safety and stop a violent adolescent’s abusive behaviour.
- [Principles of trauma- and violence-informed care \(https://apsc-equip.sites.olt.ubc.ca/files/2020/01/EQUIP\\_GTV\\_TVIC\\_Principles.pdf\)](https://apsc-equip.sites.olt.ubc.ca/files/2020/01/EQUIP_GTV_TVIC_Principles.pdf) – by the Canadian EQUIP Health care group.
- [Health professional support from the Black Dog Institute \(https://www.blackdoginstitute.org.au/the-essential-network/\)](https://www.blackdoginstitute.org.au/the-essential-network/)
- [Case consultation groups with the Australian Society of Psychological Medicine \(https://www.aspm.org.au/events/\)](https://www.aspm.org.au/events/)

## References

1. Fitz-Gibbon K, Elliott K, Maher J. Investigating adolescent family violence in Victoria: Understanding experiences and practitioner perspectives. Melbourne: Monash University, 2018.
2. Howard J. Adolescent violence in the home: How is it different to adult family violence? Melbourne: Australian Institute of Family Studies, 2015.
3. [State of Victoria. Royal Commission into Family Violence: Summary and recommendations 2014–16 \(http://www.parliament.vic.gov.au/file\\_uploads/1a\\_RFV\\_112ppA4\\_SummaryRecommendations.WEB\\_DXQYLhqv.pdf\)](http://www.parliament.vic.gov.au/file_uploads/1a_RFV_112ppA4_SummaryRecommendations.WEB_DXQYLhqv.pdf) [Accessed 4 October 2021].
4. Gallego R, Novo M, Fariña F, et al. Child-to-parent violence and parent-to-child violence: A meta-analytic review. *European Journal of Psychology Applied to Legal Context* 2019;11:51–59. [Accessed 4 October 2021].
5. Campbell E, Richter J, Howard J, et al. The PIPA project: Positive interventions for perpetrators of adolescent violence in the home (AVITH). Sydney: Australia’s National Research Organisation for Women’s Safety, 2020. [Accessed 4 October 2021].
6. Nowakowski-Sims E, Rowe A. Using trauma informed treatment models with child-to-parent violence. *Journal of Child and Adolescent Trauma* 2015;8:237–44. [Accessed 4 October 2021].
7. Walsh JA, Krienert JL. A decade of child-initiated family violence: Comparative analysis of child-parent violence and parricide examining offender, victim, and event characteristics in a national sample of reported incidents, 1995–2005. *J Interpers Violence* 2009;24:1450–77. [Accessed 4 October 2021].
8. Howard J. Addressing adolescent violence. *DVRCV Advocate* 2014:24–27. [Accessed 4 October 2021].
9. [Crime Statistics Agency. Victoria Police family violence data dashboards, 2018 \(http://www.crimestatistics.vic.gov.au/family-violence-data-portal/family-violence-data-dashboard/victoria-police\)](http://www.crimestatistics.vic.gov.au/family-violence-data-portal/family-violence-data-dashboard/victoria-police)
10. Howard J, Abbott L. *The last resort: Pathways to justice*. Melbourne: Digital Reprographics, 2013.
11. Nowakowski-Sims E, Rowe A. The relationship between childhood adversity, attachment, and internalizing behaviors in a diversion program for child-to-mother violence. *Child Abuse Neglect* 2017;72:266–75.
12. Simmons M, McEwan TE, Purcell R, et al. Sixty years of child-to-parent abuse research: What we know and where to go. *Aggression and Violent Behavior* 2018;38:31–52.
13. Castillo-Eito L, Armitage CJ, Norman P, et al. How can adolescent aggression be reduced? A multi-level meta-analysis. *Clin Psychol Rev* 2020;78:1–45.

- 
14. Moulds LG, Day A. Characteristics of adolescent violence towards parents – A rapid evidence assessment. *Journal of Aggression, Conflict and Peace Research* 2017;9:195–209.
15. Martinez-Ferrer B, Romero-Abrio A, Moreno-Ruiz D, et al. Child-to-parent violence and parenting styles: Its relations to problematic use of social networking sites, alexithymia, and attitude towards institutional authority in adolescence. [References]. *Psychosocial Intervention* 2018;27:163–71.
16. Contreras L, Leon SP, Cano-Lozano MC. Socio-cognitive variables involved in the relationship between violence exposure at home and child-to-parent violence. *J Adolesc* 2020;80:19–28.
17. Del Moral G, Suárez-Relinque C, Callejas JE, et al. Child-to-parent violence: Attitude towards authority, social reputation and school climate. *Int J Environ Res Public Health* 2019;16:2384.
18. Nam B, Kim JY, Bright CL, et al. Exposure to family violence, peer attachment, and adolescent-to-parent violence. *J Interpers Violence* 2020:0886260520960109.
19. Chown P, Kang M, Sancu L, et al. Adolescent health GP resource kit. 2nd edition. North Sydney, NSW: NSW Health, 2016.
20. Brooks M, Barclay L, Hooker C. Trauma informed care. *Aust J Gen Pract* 2018;47:370–75.
21. Klein DA, Goldenring JM, Adelman WP. Probing for scars: Ask the essential questions. *Contemporary Pediatrics* 2014;31:16–28.
22. Calvete E, Orue I, Gamez-Guadix M. Child-to-parent violence: Emotional and behavioral predictors. *J Interpers Violence* 2013;28:755–72.
23. Routt G, Anderson L. Adolescent violence towards parents. *J Aggression Maltreatment Trauma* 2011;20:1–19.
24. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
25. Tarzia L, Bohren M, Cameron J, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339.
26. Levine S, Varcoe C, Browne AJ. 'We went as a team closer to the truth': Impacts of interprofessional education on trauma- and violence- informed care for staff in primary care settings. *J Interprof Care* 2021;35:46–54.

# Dating violence and technology-facilitated abuse

'I was so inexperienced, I didn't know really what to think about it. And I was like, is this normal? Like, I didn't know ... so, I knew that I really hated it and it was a horrible experience, but I think I, like, rationalised it in my head.'

## Key messages

- Dating violence is a serious, important and prevalent public health problem among Australian young people.<sup>1</sup>
- A young person who is experiencing or using violence in their intimate relationships may present with physical health problems, mental health issues, risk-taking behaviour or other social and behavioural issues.<sup>2,3</sup>
- While it is acknowledged that young women experience violence from male as well as female partners, there is evidence that dating violence is most likely to be perpetrated by a young man towards a young woman.<sup>1</sup>
- Technology-facilitated abuse is an important form of abuse experienced by young as well as older women and can affect a victim/survivor's access to social networks and seeking help.<sup>4</sup>
- Victims/survivors can be supported through supportive counselling, education and addressing health concerns.

## Clinical context

### Dating violence

Dating violence is under-researched, particularly in Australia, with little known about its prevalence or the young people who use or experience dating violence in Australia. While it is acknowledged that dating can occur at all ages and stages of life, we will focus here on dating within young people's relationships, typically in the age range of 16–25 years. Young people experiencing dating violence may be younger or older than this age group.



Similar to the definition of adult intimate partner abuse/violence (IPAV) described in [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](#), dating violence is defined as any form of IPAV within young people's relationships, excluding marriage or cohabitation.<sup>5</sup> The abuse may be physical, emotional, sexual or coercive control.

Technology-facilitated abuse also commonly occurs within young people's dating and casual relationships and is discussed in this chapter.

In Australia, the term 'dating violence' is not commonly used, and violence within young people's relationships tends to be embedded within the definitions of IPAV and domestic violence.<sup>1,6,7</sup> However, there are significant differences between adult IPAV and dating violence among young people.

Dating violence is unique because of the various developmental stages that young people are at and because dating partners do not usually have shared assets or children, although some couples may be cohabiting if they are in a committed stage of their relationship.<sup>8</sup> As with adult IPV, dating violence is usually gendered within heterosexual relationships, with young women mostly being the victims/survivors and young men the perpetrators of violence.<sup>1</sup>

Dating violence is a serious, important and prevalent public health problem in Australia.<sup>1</sup> It is estimated to affect around one in four young women, although figures could be higher due to under-recognition, underreporting<sup>9,10</sup> and inconsistencies in defining and measuring it.<sup>11,12</sup> Dating violence is important to identify and manage in the health system due to its associations with poor short- and long-term physical and mental health<sup>2,13</sup> and risk-taking behaviours<sup>2,14</sup> and sometimes even death.<sup>15,16</sup> Further, there is a longitudinal risk of IPAV in future relationships<sup>13,17</sup> with potential intergenerational impacts on the wellbeing of young children.<sup>18</sup> Thus, appropriately addressing dating violence may have an impact in reducing violence in future relationships.

Those experiencing dating violence will present to general practice in a variety of ways. Most will present with mental health concerns such as depression, anxiety or risk-taking behaviours. Some may present with physical health concerns such as chronic headaches or other somatic symptoms. The role of the GP is to be aware of the possibility of dating violence in a young person and provide ongoing health advice, support and referrals.

## Technology-facilitated abuse

Technology-facilitated dating abuse, or digital dating abuse, includes the use of digital media to 'monitor, control, threaten, harass, pressure, or coerce a dating partner',<sup>19</sup> although definitions and measurement of this type of abuse are not clear or consistent.<sup>20,21</sup>

Australians are among the highest users of technology in the world,<sup>22</sup> and technology is deeply embedded in the day-to-day lives of young people's sexual and romantic relationships.<sup>23</sup> It is used to find romantic partners, to get to know each other, to initiate relationships and end them.<sup>8,23</sup>

Within this context, 'sexting' is a popular way of sharing intimacy. Although the definition of sexting is not very clear, it involves dating partners sharing mutually consented sexual photographs or videos with each other.<sup>24</sup> However, sexting often falls within the realm of technology-facilitated abuse.

A qualitative Australian study found that young people aged 15–20 years felt pressure to use sexting with their partners, with young women facing more pressure to send sexual images of themselves compared with young men.<sup>25</sup> Another Australian study found young women experienced technology-facilitated sexual coercion as part of a pattern of abusive technology behaviours, more often than young men.<sup>26</sup> These findings are mirrored in American studies, which also found that young women experienced more technology-facilitated abuse when compared with young men<sup>27</sup> and also suffered more negative and serious consequences as a result.<sup>19</sup> Recent Australian studies showed gendered differences in the way young women and young men experience, perpetrate and are impacted by technology-facilitated abuse.<sup>26,28</sup>

Technology-facilitated abuse is an important form of abuse to be aware of and understand, as it can occur even when the couple are not physically with each other,<sup>27</sup> which affects prevention and management. Recent evidence shows that not only dating violence, but also domestic and family violence, are perpetrated using technology.<sup>4,29</sup> In a Queensland study, adult women reported extensive use of technology by perpetrators, including the use of smartphones, social media accounts, computers, GPS devices and recording devices, to control, isolate, monitor and harass them.<sup>4</sup> An Australian qualitative study of frontline IPAV practitioners described technology as a powerful tool for gaining control, engaging others in abuse and amplifying victim/survivors' levels of fear.<sup>29</sup>

Therefore, health practitioners need to be aware that while young and older women find technology to be a useful and covert means of seeking help for IPAV,<sup>30,31</sup> this may be hampered by technology-facilitated abuse. Perpetrators' close monitoring of a woman's use of the internet and sometimes even destroying her technological devices<sup>4</sup> may get in the way of her seeking help and staying in touch with family and friends. This is important for the health practitioner to understand and take into consideration when suggesting avenues to young and older women to seek help and support for dating or family violence. Thus, apart from referring the woman to websites and apps for support and help, traditional methods of seeking help and support must also be offered.

The use of technology-facilitated abuse against children in the context of child pornography or otherwise is not included here but there is further guidance in [Chapter 9: Child abuse and neglect \(http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect).

## In practice

Evidence-based information on managing dating violence in the Australian general practice setting is currently lacking. Therefore, the approaches to identifying and responding to dating violence are based on consensus of experts.

While it is acknowledged that young women experience violence from male as well as female partners, there is overwhelming evidence that the majority of IPAV among young people is perpetrated by young men against young women.<sup>1</sup> The guidance here focuses on young women; however, it can be applied to young men experiencing dating violence too, whether perpetrated by male or female partners. Information regarding people in same-sex relationships is given in [Chapter 19: LGBTIQ+ family abuse and violence \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence).

## Identification and case-finding

It is uncertain whether it is worth screening all young people for dating violence. It could be argued that dating violence should be routinely incorporated into the HEEDSSS assessment (Box 12.1) when asking about sex and relationships, as there is no published evidence of harm in doing this. However, the literature on adult IPAV recommends that we must not universally screen adult women for IPAV as this could cause more harm than benefit.<sup>32</sup> Therefore, the GP needs to use their discretion.

As with adult women, we would usually recommend case-finding for dating violence, for example, when young women present with health concerns or risk-taking behaviours. Table 2.2 in [Chapter 2 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) outlines a comprehensive list of possible physical, psychological and emotional presentations of IPAV in clinical practice.

There is plenty of evidence that dating violence is associated with:

- mental health problems, including depression, anxiety, eating disorders and suicidal ideation<sup>13,33,34</sup>
- risk-taking behaviours, including substance abuse and risky sexual behaviour<sup>13,33,35,36</sup>
- physical health problems, including adverse reproductive outcomes (unwanted pregnancy, miscarriage, termination of pregnancy, sexually transmitted infections).<sup>3,37,38</sup>

## Asking about dating violence

When inquiring about dating violence it is recommended that the young person is alone and not with their partner or others who could be condoning the violence, as outlined in [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse). Confidentiality and its exceptions need to be explained and the young person should be encouraged to discuss their concerns with a parent or other trusted adult.<sup>39</sup>

Begin with broad questions, such as asking if they feel afraid or unsafe in their relationship with their boyfriend/girlfriend or partner. Box 12.2 outlines some questions you could ask a young person about dating violence. These are similar to the questions asked to adult women about IPAV (refer to Box 2.1, [Chapter 2 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)).

Dating violence needs to be carefully asked about, as there is evidence that young women struggle to recognise it and will usually minimise and normalise dating violence experiences, due to societal norms.<sup>37,40</sup>

'I was so inexperienced, I didn't know really what to think about it. And I was like, is this normal? Like, I didn't know ... so, I knew that I really hated it and it was a horrible experience, but I think I, like, rationalised it in my head.'

If dating violence is highly suspected, it is then worth asking about more specific experiences of abuse, as outlined in Box 2.1, [Chapter 2 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)).

A safety and risk assessment should be conducted in all suspected or confirmed dating violence cases. A risk assessment tool may be used to help assess risk. The Victorian Government's [Family Violence Multi-Agency Risk Assessment and Management Framework \(https://www.vic.gov.au/maram-practice-guides-and-resources\)](https://www.vic.gov.au/maram-practice-guides-and-resources) provides several guides and tools for risk identification, screening and assessment.

#### **Box 12.1. The HEEDSSS psychosocial assessment<sup>41</sup>**

- **H**ome environment
- **E**ducation and employment
- **E**ating and exercise
- **P**eer-related **A**ctivities
- **D**rugs, tobacco and alcohol
- **S**ex and sexuality
- **S**uicide, depression and other mental health issues
- **S**afety from injury, violence and abuse, and safety precautions to reduce sun damage and vaccine-preventable infections

**Box 2. Examples of questions to ask young people about their dating relationships**

- ‘How are things in your relationship with your partner (or say ‘boyfriend’ or ‘girlfriend’ as appropriate)?’
- ‘Do you feel safe in your relationship? Have you ever felt unsafe in the past?’
- ‘Are you afraid of your partner? Have you ever been afraid of any partner?’
- ‘Has your partner physically threatened or hurt you?’
- ‘Does your partner control what you wear? Who do you hang out with?’
- ‘Does your partner check your phone or keep a tab on who you are texting or talking to?’
- ‘Does your partner ever send you images you are not comfortable with or expect you to do the same?’
- ‘Is there a lot of tension in your relationship? How do you resolve arguments?’
- ‘Sometimes partners react strongly in arguments and use physical force. Is this happening to you?’
- ‘Violence is very common in young people’s relationships. I ask a lot of patients about abuse because no-one should have to live in fear of their partners.’
- ‘Do you have a trusted adult who you can go to for help if you feel unsafe?’

## Telehealth

While telehealth can be a useful way to overcome certain barriers to consulting with young people, it also poses risks, as privacy (particularly from the perpetrator) cannot be guaranteed.<sup>42</sup> While young people in Australia overwhelmingly welcome telehealth consultations, some also voiced concerns about privacy and safety;<sup>43</sup> therefore, it is important to first check that the young person is alone and feeling safe to proceed with the telehealth consultation. It is recommended that we start with asking closed questions such as, ‘Are you alone?’ or ‘Is it safe for me to ask you how you are going?’.<sup>44</sup> If concerns about the patient’s safety continue, it is worth making an excuse for the patient to come in for face-to-face assessment. During face-to-face appointments with the woman alone, it is worthwhile arranging ‘code words’ or other signals that might indicate to the GP that the patient is not feeling safe or to alert the GP to ring the police.<sup>44,45</sup>

## Management

Due to the lack of evidence in managing dating violence in primary care, we recommend following the same advice as for adult women, but with a youth-friendly approach.<sup>39</sup> Refer to [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) and [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/c](https://www.racgp.org.au/clinical-resources/c)

[linical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety](#)). Tips for working with young people experiencing dating violence are given in Box 12.3.

In the first instance we suggest using the [LIVES framework \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)<sup>5</sup> as you would with adult women, along with the [CARE approach \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel).<sup>46</sup> We recommend approaching the young person with a trauma- and violence-informed approach; this includes acknowledging the role of trauma and violence in the young person's presentation and behaviours, allowing for extended consultation time, focusing on wellness and positive social and emotional connections and using a collaborative approach to care.<sup>47,48</sup>

Referral to a psychologist specialising in young people's health would be ideal, importantly, someone trained in trauma- and violence-informed practice.<sup>47</sup> If the young person experiencing dating violence attends school it may also be worthwhile connecting with the high school nurse or counsellor to support the young person, if this was deemed to be a safe approach for the young person and the young person feels comfortable with this approach. There is, however, limited evidence on the types of interventions that might work to address dating violence.

It is important to also ask young people under 18 years about the age of their dating partner, as there could be potential for child abuse, which requires mandatory notification. The legal requirement for mandatory notification varies from state to state and is detailed in Table 9.5.

### **Box 12.3. Tips for identifying and managing dating violence in general practice**

- Adopt a youth-friendly, developmentally appropriate approach to care. Explain confidentiality and the exceptions (see the adolescent health GP resource kit<sup>39</sup> for in-depth guidance).
- Adopt a trauma- and violence-informed approach to care.<sup>47,48</sup>
- Establish a good rapport.
- Adopt a non-judgemental approach.
- Conduct a HEEADSSS assessment.
- Ask open-ended questions.
- Allow adequate time for consultations.
- Encourage the young person to involve a trusted adult for support.
- Use the LIVES framework and CARE approach to respond to dating violence.
- Complement face-to-face appointments with telehealth to ensure continuity of care.

## Case study: Mia

A 19-year-old young woman, Mia, attended her GP on multiple occasions for pelvic pain, abnormal bleeding and vaginal discharge. On multiple occasions she was found to have chlamydia and was treated appropriately and given advice on safe sex, contact tracing and mandatory notification.

Several months later she presented with chest pains and shortness of breath. All routine tests were normal and she was diagnosed with anxiety. The young woman declined to see a counsellor at this point and agreed to try lifestyle advice. She then returned two months later with her boyfriend, having missed her period. She was found to be pregnant and was referred for a termination. Following the termination Mia was lost to follow-up for several months.

Aged 21 years, Mia returned with symptoms of panic attacks and insomnia. She was referred to a psychologist. After several months of intermittent psychology sessions, Mia was returned to her GP, who took a detailed social history. It was revealed that Mia had been in two consecutive relationships involving dating violence. In the first relationship she experienced reproductive coercion where her boyfriend refused to wear a condom and disallowed Mia from using other methods of contraception. In the second relationship, Mia's boyfriend controlled what she wore and who she saw and when she suggested they break up, her boyfriend threatened to share her nude images with his friends.

With support from her GP, psychologist and parents, Mia reported her boyfriend to the police and broke up with him. She needs ongoing psychological support and a good therapeutic relationship with her GP.

## Resources

- [Reachout Australia \(au.reachout.com\)](http://au.reachout.com) – an online mental health service for young people and their parents.
- [ibobbly \(https://www.blackdoginstitute.org.au/resources-support/digital-tools-apps/ibobbly\)](https://www.blackdoginstitute.org.au/resources-support/digital-tools-apps/ibobbly) – an app for Aboriginal and Torres Strait Islander young people.
- [Domestic Violence Resource Centre Victoria \(https://www.dvrcv.org.au/\)](https://www.dvrcv.org.au/)
- [InTouch \(https://intouch.org.au/\)](https://intouch.org.au/) – a resource for culturally and linguistically diverse young people.
- [Esafety \(https://www.esafety.gov.au/key-issues/domestic-family-violence/technology-facilitated-abuse\)](https://www.esafety.gov.au/key-issues/domestic-family-violence/technology-facilitated-abuse) – provides (<https://www.esafety.gov.au/key-issues/domestic-family-violence/technology-facilitated-abuse%3e%3e%20-%20provides>) tips for young people, women and families on staying safe online and managing technology-facilitated abuse.

## References

1. Australian Bureau of Statistics. Personal Safety Survey, Australia, 2016. Canberra: ABS, 2016.
2. Bonomi A, Anderson M, Nemeth J, et al. History of dating violence and the association with late adolescent health. *BMC Public Health* 2013;13:821.
3. Copp JE, Giordano PC, Longmore MA, et al. Dating violence and physical health: A longitudinal lens on the significance of relationship dynamics and anti-social lifestyle characteristics. *Criminal Behaviour and Mental Health* 2016;26:251–62.

4. Douglas H, Harris BA, Dragiewicz M. Technology-facilitated domestic and family violence: Women's experiences. *British Journal of Criminology* 2019;59:551–70.
5. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
6. Sety M. What do we know about dating violence among Australian adolescents? Sydney: Australian Domestic & Family Violence Clearinghouse, 2012.
7. Cox P. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. Sydney: Australia's National Research Organisation for Women's Safety, 2016.
8. Iyer D. Australian young women's perceptions of dating and dating violence. Melbourne: University of Melbourne, 2019.
9. Helms SW, Sullivan TN, Corona R, et al. Adolescents' recognition of potential positive and negative outcomes in risky dating situations. *J Interpers Violence* 2013;28:3084–106.
10. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia 2018. Canberra: AIHW, 2018.
11. Exner-Cortens D, Gill L, Eckenrode J. Measurement of adolescent dating violence: A comprehensive review (Part 1, behaviors). *Aggression & Violent Behavior* 2016;27:64–78.
12. Exner-Cortens D, Gill L, Eckenrode J. Measurement of adolescent dating violence: A comprehensive review (Part 2, attitudes). *Aggression and Violent Behavior* 2016;27:93–106.
13. Exner-Cortens D, Eckenrode J, Rothman E. Longitudinal associations between teen dating violence victimization and adverse health outcomes. *Pediatrics* 2013;131:71–78.
14. Shorey RC, Fite PJ, Choi HJ, et al. Dating violence and substance use as longitudinal predictors of adolescents' risky sexual behavior. *Prev Sci* 2015;16:853–61.
15. Lum On M, Ayre J, Webster K, et al. Examination of the health outcomes of intimate partner violence against women: State of knowledge paper. Sydney: Australia's National Research Organisation for Women's Safety, 2016.
16. Australian Domestic and Family Violence Death Review Network. Data report 2018. Sydney: ADFVDRN, 2018.
17. Ahmadabadi Z, Najman JM, Williams GM, et al. Does leaving an abusive partner lead to a decline in victimization? *BMC Public Health* 2018;18:404.
18. [Campo M. Children's exposure to domestic and family violence: Key issues and responses. Melbourne: Child Family Community Australia Information Exchange, Australian Institute of Family Studies, 2015 \(https://aifs.gov.au/cfca/publications/childrens-exposure-domestic-and-family-violence\)](https://aifs.gov.au/cfca/publications/childrens-exposure-domestic-and-family-violence). [Accessed 16 July 2019].
19. Reed LA, Tolman RM, Ward LM. Gender matters: Experiences and consequences of digital dating abuse victimization in adolescent dating relationships. *J Adolesc* 2017;59:79–89. [Accessed 16 July 2019].
20. Brown C, Hegarty K. Digital dating abuse measures: A critical review. *Aggression and Violent Behavior* 2018;40:44–59. [Accessed 16 July 2019].
21. Rocha-Silva T, Nogueira C, Rodrigues L. Intimate abuse through technology: A systematic review of scientific constructs and behavioral dimensions. *Computers in Human Behavior* 2021;122:106861. [Accessed 16 July 2019].
22. Poushter J. Smartphone ownership and internet usage continues to climb in emerging economies. Washington DC: Pew Research Center, 2016. [Accessed 16 July 2019].
23. Meenagh J. Flirting, dating, and breaking up within new media environments. *Sex Education: Sexuality, Society and Learning* 2015;15:458–71. [Accessed 16 July 2019].
24. Barrense-Dias Y, Berchtold A, Surís J-C, et al. Sexting and the definition issue. *J Adolesc Health* 2017;61:544–54. [Accessed 16 July 2019].
25. Walker S, Sanci L, Temple-Smith M. Sexting and young people. *J Adolesc Health* 2013;52:697–701. [Accessed 16 July 2019].
26. Brown C, Sanci L, Hegarty K. Technology-facilitated abuse in relationships: Victimization patterns and impact in young people. *Computers in Human Behavior* 2021;124:106897. [Accessed 16 July 2019].
27. Zweig JM, Dank M, Yahner J, et al. The rate of cyber dating abuse among teens and how it relates to other forms of teen dating violence. *J Youth Adolesc* 2013;42:1063–77. [Accessed 16 July 2019].
28. Brown C, Flood M, Hegarty K. Digital dating abuse perpetration and impact: The importance of gender. *Journal of Youth Studies* 2020:1–16. [Accessed 16 July 2019].



29. Fiolet R, Brown C, Wellington M, et al. Exploring the impact of technology-facilitated abuse and its relationship with domestic violence: A qualitative study on experts' perceptions. *Glob Qual Nurs Res* 2021;8: 23333936211028176. [Accessed 16 July 2019].
30. Tarzia L, Murray E, Humphreys C, et al. Gender-Based Violence: I-DECIDE: An online intervention drawing on the psychosocial readiness model for women experiencing domestic violence. *Women's Health Issues* 2016;26:208–16. [Accessed 16 July 2019].
31. Tarzia L, Iyer D, Thrower E, et al. "Technology doesn't judge you": Young Australian women's views on using the internet and smartphones to address intimate partner violence. *Journal of Technology in Human Services* 2017;35:199–218. [Accessed 16 July 2019].
32. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: WHO, 2014. [Accessed 16 July 2019].
33. Silverman JG, Raj A, Mucci LA, et al. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *JAMA* 2001;286:572–79. [Accessed 16 July 2019].
34. Gallaty K, Zimmer-Gembeck M. The daily social and emotional worlds of adolescents who are psychologically maltreated by their romantic partners. *J Youth Adolesc* 2008;37:310–23. [Accessed 16 July 2019].
35. Roberts T, Klein J, Fisher S. Longitudinal effect of intimate partner abuse on high-risk behavior among adolescents. *Arch Pediatr Adolesc Med* 2003;157:875–81. [Accessed 16 July 2019].
36. Alleyne B, Coleman-Cowger VH, Crown L, et al. The effects of dating violence, substance use and risky sexual behavior among a diverse sample of Illinois youth. *J Adolesc* 2011;34:11–18. [Accessed 16 July 2019].
37. Ismail F, Berman H, Ward-Griffin C. Dating violence and the health of young women: A feminist narrative study. *Health Care Women Int* 2007;28:453–77. [Accessed 16 July 2019].
38. Taft AJ, Watson LF. Termination of pregnancy: Associations with partner violence and other factors in a national cohort of young Australian women. *Aust N Z J Public Health* 2007;31:135–42. [Accessed 16 July 2019].
39. Chown P, Kang M, Sancu L, et al. Adolescent health GP resource kit. 2nd edition. North Sydney, NSW: NSW Health, 2016. [Accessed 16 July 2019].
40. Chung D. Making meaning of relationships: Young women's experiences and understandings of dating violence. *Violence Against Women* 2007;13:1274–95. [Accessed 16 July 2019].
41. Klein DA, Goldenring JM, Adelman WP. Probing for scars: Ask the essential questions. *Contemporary Pediatrics* 2014;31:16–28. [Accessed 16 July 2019].
42. Simon MA. Responding to Intimate partner violence during telehealth clinical encounters. *JAMA* 2021;325:2307–8. [Accessed 16 July 2019].
43. Headspace. Young people's experience of telehealth during COVID-19. Headspace, 2020. [Accessed 16 July 2019].
44. Neil J. Domestic violence and COVID-19: Our hidden epidemic. *Aust J Gen Pract* 2020;49. [Accessed 16 July 2019].
45. Hegarty K. How can general practitioners help all members of the family in the context of domestic violence and COVID-19? *Aust J Gen Pract* 2020;49. [Accessed 16 July 2019].
46. Tarzia L, Bohren M, Cameron J, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339. [Accessed 16 July 2019].
47. Brooks M, Barclay L, Hooker C. Trauma informed care. *Aust J Gen Pract* 2018;47:370–75. [Accessed 16 July 2019].
48. Levine S, Varcoe C, Browne AJ. 'We went as a team closer to the truth': Impacts of interprofessional education on trauma- and violence- informed care for staff in primary care settings. *J Interprof Care* 2021;35:46–54. [Accessed 16 July 2019].

## ***Specific abuse issues for adults and older people***

# Adult survivors of child abuse

'I would like GPs and health professionals to recognise the long-term impacts of the trauma on my physical health, chronic infections, and living with complex medical conditions. I feel the violence and living as a torture survivor is the root cause of my physical health issues but most practitioners fail to see the links or how they're related at all' Cina, victim/survivor, [The WEAVERs Group \(https://www.saferfamilies.org.au/weavers\)](https://www.saferfamilies.org.au/weavers)

## Key messages

- Child abuse and adult victims/survivors of child abuse are common.<sup>1</sup>
- Many people who were abused as children have never told anyone about their abuse,<sup>2</sup> or if they have, have not been believed. Many also are not aware that there might be a link between current health issues and their childhood abuse.<sup>3</sup>
- People who were abused as children often experience a diverse range of ongoing mental and physical health problems,<sup>4</sup> which increases their healthcare utilisation rate compared with those who have not been abused.<sup>4</sup>
- Some adult victims/survivors of childhood abuse may experience symptoms of post-traumatic stress disorder (PTSD) or complex PTSD. These symptoms are treatable.<sup>5</sup>

## Recommendations

There is a strong link between past experiences of child abuse and neglect and conditions such as mental health issues, suicidality, drug and alcohol problems, and chronic disease.<sup>4,6</sup> Therefore, consider the need to address past experiences of child abuse and neglect in adult patients presenting with these conditions.

**(Strong recommendation: Moderate level of evidence)**

### References

4. Hailes HP, Yu R, Danese A, Fazel S. Long-term outcomes of childhood sexual abuse: an umbrella review. *Lancet Psychiatry* 2019 Oct;6(10):830–9.
6. Cattaneo A, Macchi F, Plazzotta G, et al. Inflammation and neuronal plasticity: a link

between childhood trauma and depression pathogenesis. *Front Cell Neurosci* 2015;9:40.

Offer patients with a history of past child abuse psychological therapy to reduce PTSD, depression and anxiety.

**(Conditional recommendation: Moderate level of evidence)**

## Clinical context

This chapter explores the possible presentations and management in general practice of adults who experienced abuse as children. This includes people who experienced physical, emotional or sexual abuse, and people who experienced neglect or grew up in situations of domestic violence.

Note that this chapter focuses on people who have experienced child abuse and neglect. The Centers for Disease Control and Prevention has more information about the [effects and management of other kinds of adverse childhood experiences \(https://www.cdc.gov/violenceprevention/aces\)](https://www.cdc.gov/violenceprevention/aces).

Definitions, health consequences, identification and management of child abuse in children are outlined in detail in [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect), including mandatory reporting requirements regarding children.

Child abuse and neglect often occur in multiple forms, and they frequently have long-term effects on victims/survivors. A number of state investigations into institutional child abuse, and the National Royal Commission into Institutional Responses to Child Sexual Abuse, have established that child abuse and its impact can remain hidden for long periods. Many victims/survivors have been unable to disclose, or if they have, were often not believed, either as a child or an adult.

## Effects of child abuse on later life

The Australian Institute of Health and Welfare estimated that 'there would have been 26% less suicide and self-inflicted injuries, 20% less depressive disorders and 27% less anxiety disorders in 2015 if no one in Australia had ever experienced child abuse and neglect during childhood'.<sup>1</sup>

Child sexual abuse is associated with a range of adverse outcomes in adulthood, including substance misuse, mental health issues, suicidality and chronic disease.<sup>4</sup>

There is some evidence to suggest that non-sexual childhood abuse is also associated with a range of mental health outcomes, drug use, suicide attempts, risky sexual behaviour<sup>2</sup> and with physical health outcomes including arthritis, ulcers and headache/migraine in adulthood.<sup>4</sup> Furthermore, multiple

adverse childhood experiences are associated strongly with mental ill-health, problematic alcohol or drug use and interpersonal or self-directed violence; moderately with smoking, cancer, heart disease and respiratory disease; and weakly with overweight or obesity, physical inactivity and diabetes.<sup>8</sup>

We are starting to better understand the mechanisms underlying the effect of childhood abuse on long-term health (refer to Figure 13.1). Trauma is linked to a number of biological pathways, such as the hypothalamic–pituitary–adrenal axis (the stress response), neuroplasticity (how neural tissue changes in response to stress and therapy), serotonergic transmission, immunity, circadian rhythms and epigenetics.<sup>6</sup>

There is increasing research in the link between inflammatory conditions and early trauma, with potentially a bi-directional relationship between mental illness and inflammatory conditions, and strong heritable associations.<sup>9</sup>

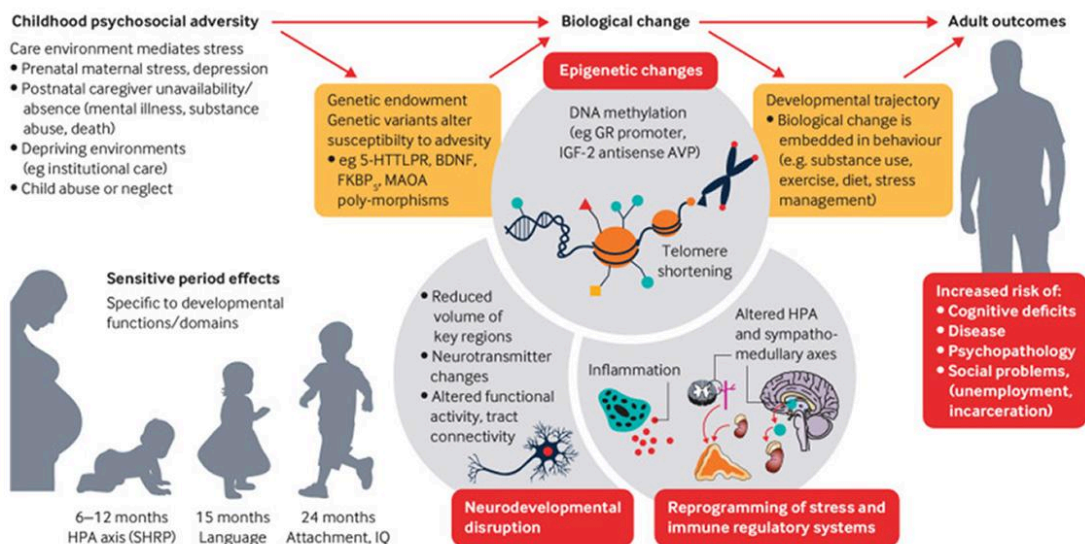


Figure 13.1. The interaction of childhood adversity and biology<sup>10</sup>

Along with other characteristics, such as a child’s sex or the psychosocial environment, particular genetic polymorphisms are associated with various outcomes following exposure to adverse childhood events. Exposure to adversity can itself lead to biological changes, including epigenetic, neurological and immune regulatory changes. These changes, in turn, influence adult outcomes <sup>10</sup> HPA axis (SHRP), hypothalamic pituitary adrenal axis (stress hyporesponsive period) Reproduced with permission from: Berens AE, Jensen SKG, Nelson CA. Biological embedding of childhood adversity: from physiological mechanisms to clinical implications. BMC Medicine. 2017;15(1):135. Some people who have been abused as children may have adopted strategies to enable them to ‘survive’, for example, smoking, alcohol and substance abuse, risk-taking behaviours,<sup>7, 11</sup> physical inactivity and disordered eating. Other

strategies can include psychological mechanisms such as dissociation (refer to Box 13.1), or behavioural disturbances such as self-harm. The younger the age of abuse, and the greater the sense of helplessness associated with it, the more likely an individual is to have dissociation.<sup>12</sup>

### Box 13.1. Emotional dysregulation

Emotional dysregulation can present as strong physical and emotional responses, heightened and rapidly fluctuating emotions, which can be triggered in a hypervigilant state. When someone is emotionally triggered, cognitive functioning can be impaired, which can make it more challenging to make sense of and manage their emotional state.

Some people may react to extreme distress by dissociating, where they 'disconnect' from their thoughts, emotions, physical feelings, memories or sense of self. A mood state incongruent with the subject matter being discussed might be observed, and the person may be unable to make sense of or describe their internal state. This is described as 'alexithymia'.

Dissociation may occur adaptively. In adult victims/survivors, dissociation is often an enduring, persistent mechanism which occurs by default in times of stress and can interfere with the person developing a reflective understanding of their psychopathology and alternative coping mechanisms. Mindfulness can assist to re-engage with external and internal sensation and stimuli.

[Refer to Chapter 7: Trauma-informed care in general practice](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice>) for more information about managing emotional dysregulation.

Although these strategies may have been necessary for the person in the past, many are risk factors for adult health issues, and in the long term can contribute to morbidity and mortality.

Research suggests that adults abused as children are at increased risk of further victimisation as adults.<sup>13, 14</sup> This means that a patient's current victimisation could be compounding their history of childhood abuse.

Those who engage in violent and criminal offending are significantly more likely to have a diagnosis of PTSD.<sup>15, 16</sup> Trauma-informed therapies may have a role in treatment for violent behaviours.<sup>14</sup> Refer to 'Risk of harm to others' below, and [Chapter 5: Working with men who use intimate partner abuse and violence](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse>).

Adults who have experienced adverse childhood events, especially cumulative adverse events, are more vulnerable.<sup>8, 13</sup> However, exposure to adverse events does not mean a child will necessarily experience negative outcomes. With the right support, children exposed to adverse childhood events may have increased resilience later in life.<sup>17, 18</sup> Treating adult victims/survivors of childhood abuse may help not just the individual but also address the cycle of intergenerational abuse.<sup>17, 19</sup>

A number of factors may be protective against mental ill-health and substance use in children who experience adverse childhood events. These positive childhood experiences include:<sup>20</sup>

- opportunities to use their abilities (academic, athletic, extracurricular activity, leadership, work, hobby, household responsibilities and popularity)<sup>20</sup>
- protective internal cognitive (eg neurotypical intelligence) or psychological functioning (eg temperament)<sup>21</sup>
- external contemporaneous supports such as being treated fairly, and kind supportive friends.<sup>22</sup> (This may include professional services such as social or health services.<sup>22</sup>)

GPs may have a role in promoting and advocating positive childhood experiences for their patients.

Some groups are more likely to have experienced adverse childhood events, for example those from [Aboriginal and Torres Strait Islander backgrounds \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities), and those in families with a parent with alcohol dependence or who has a background of intergenerational abuse.

## Prevalence

### National prevalence

It is estimated that 2.5 million Australian adults (13%) experienced physical and/or sexual abuse during childhood.<sup>23</sup>

Girls are more vulnerable to sexual abuse. Some studies in Australia estimate the prevalence of child sexual abuse at up to one in four girls and one in eight boys.<sup>1</sup> International studies show one in five women and one in 13 men report having been sexually abused as a child.<sup>24</sup>

Children are most likely to be abused within the family or by people known to them.

Where family abuse occurs within the home, even if the abuse is not directed at the child, children are still vulnerable and may be affected by the abuse.

More on prevalence is discussed in the [child abuse and neglect chapter \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect).

### Prevalence in general practice

Women with a history of child sexual abuse are more likely to utilise medical care at a greater frequency than women who have not been abused.<sup>25</sup> There is more robust data within tertiary level settings, specifically emergency presentations; there is some suggestion and anecdotal reports this is also applicable in the general practice setting. They may also have complicated presentations and not respond easily to treatment.<sup>26</sup>

Some smaller studies in general practice demonstrate up to one-third of patients have experienced any adverse childhood event, with potentially one in four reporting symptoms also of PTSD.<sup>27</sup>

As there is a level of under-reporting that occurs in relation to abuse, these statistics reveal that a substantial percentage of children and young people are abused. Consequently, a significant number of Australian adults who were abused as children may still be experiencing the ongoing effects of their abuse.

## In practice

### The role of general practice and the GP

Child abuse in all its forms often has long-term sequelae and health implications. Health practitioners should consider the need to address possible past experience of child abuse and neglect with adult patients who present with conditions such as mental health issues, suicidality, drug and alcohol problems, and chronic disease.

The effects of childhood trauma are something that belongs to the whole community. There is not an expectation for the individual GP to be responsible for solving or holding the entirety of the distress or journey. However, this chapter aims to empower the GP and support team to be able to do their part well – to ask, believe and listen.

A trauma-informed approach to patients by GPs can help minimise the risk of re-traumatisation and enable pathways to recovery through appropriate referrals to health practitioners with specialist skills in supporting adult victims/survivors.

Good trauma-informed care is team based. Those who work in this area should consider accessing peer support, mentorship or supervision.



**Box 13.2. Principles for working with people who have experienced childhood trauma<sup>28</sup>**

When working with people who have experienced childhood trauma, the principles are:

- safety – ensuring physical and emotional safety
- trustworthiness – maximising trustworthiness through task clarity, consistency and interpersonal boundaries
- choice – maximising consumer choice and control
- collaboration – maximising collaboration and sharing of power
- empowerment – prioritising empowerment and skill-building.

### **The therapeutic relationship**

Disclosure only occurs in a relationship of trust.<sup>29</sup> However, trust may take some time to develop, as adult victims/survivors of child abuse have been abused, rather than cared for, in prior relationships of 'trust'.

Patients who have been abused tend to have a very negative sense of self and for many, shame is often predominant. This makes it more difficult for them to care for themselves, seek help and follow advice, a pattern of interaction that may impair the therapeutic relationship. A history of re-traumatisation from health services may complicate further health interactions.

The GP's own beliefs and experiences can influence interactions and become part of the challenge of working with adult victims/survivors. The prevalence of trauma in the population means that GPs may have their own trauma histories and may need [information on how to stay safe and healthy \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care).

GPs approaching this work with an attitude of trying to 'fix' a patient or problems can foster impatience and dissatisfaction in both parties. It is a more helpful attitude to 'sit' with distress and the recovery journey and recognise the patient's autonomy in their care journey. More on this is discussed in 'Telling the Story', later in this chapter.

### **Working with boundaries**

People who have been abused as children have often had their boundaries violated. All workers and practitioners engaging with victims/survivors, including GPs, need to model clear boundaries.

So those patients feel and are safe, GPs must be respectful of a patient's physical and emotional space. Intrusion on a patient's boundaries may replicate aspects of prior abuse, which can be re-traumatising.

Maintaining a clear role as a GP while the patient seeks help from a counsellor, psychologist or psychiatrist further models good boundaries and helps provide the comprehensive model of care many victims/survivors need. This is the model of working as a team to care for adult victims/survivors (or patients).

GPs can make an important contribution, but they may not always be able to provide everything a patient needs. Some patients might be in counselling or might need therapeutic support but are unable or unprepared to access it. Either way, patients with a history of child abuse are likely to be facing a number of challenges and will often require support. A listening empathic ear, respect and validation coupled with a sense of hope and optimism for future recovery are invaluable.

## Identification

### How a person who has experienced childhood trauma may present

Patients who are victims/survivors of child abuse may present to general practice in the following ways. These conditions have been found to have a much higher incidence in this group.<sup>4, 7, 25, 30</sup>

- anxiety, panic attacks
- chronic depression
- obesity
- chronic gastrointestinal distress
- eating disorders
- personality disorders
- multiple somatic symptoms
- drug and alcohol abuse/smoking
- suicidality
- chronic pain
- sexually transmitted diseases
- self-harm.

### Understanding the presentation

A victim/survivor of childhood trauma may present with complex PTSD (CPTSD).<sup>31</sup> Figure 13.2 represents the complex symptomatology that may occur in an adult victim/survivor of childhood trauma.

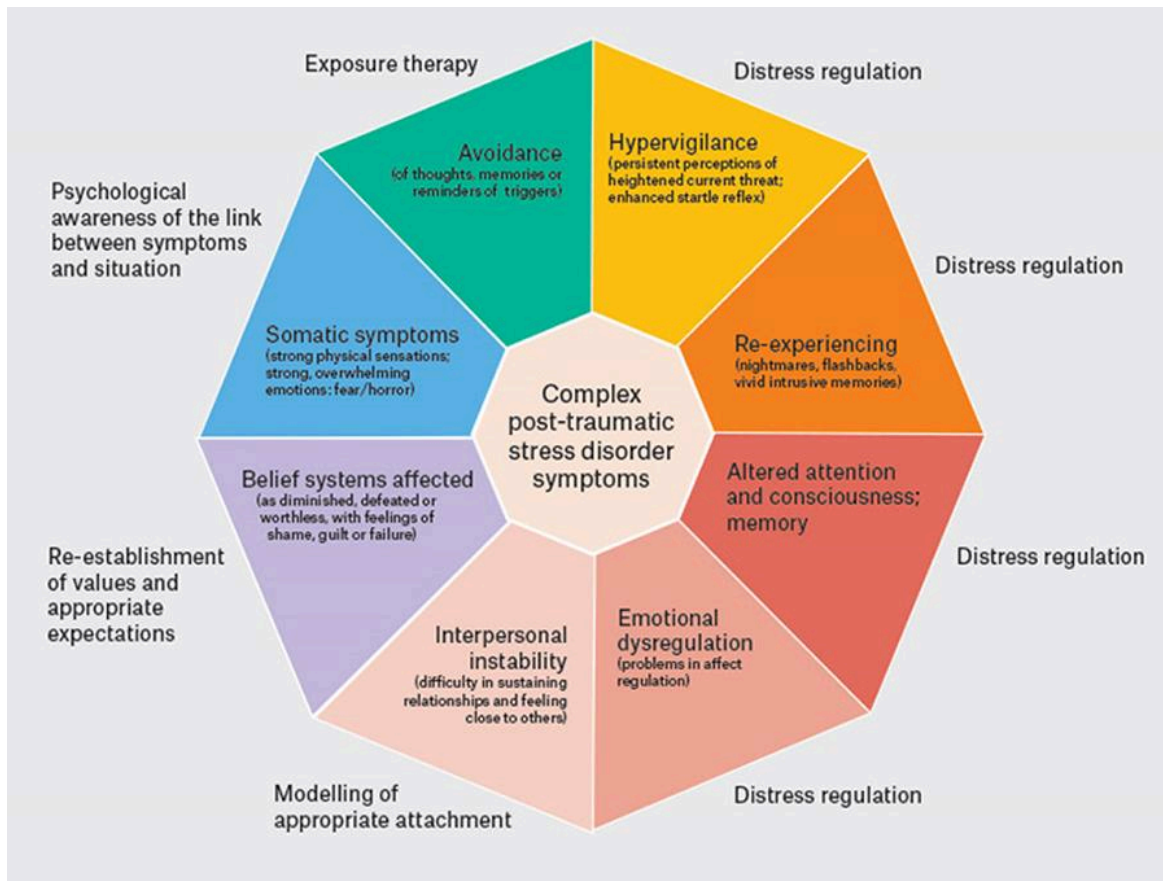


Figure 13.2. A model of complex post-traumatic stress disorder with potential general practice interventions<sup>5</sup>

Reproduced with permission from: Su WM, Stone L. Adult survivors of childhood trauma: Complex trauma, complex needs. *Aust J General Practice*. 2020;49(7):423–30.

Hypervigilance, re-experiencing and flashbacks can mimic paranoia or other anxiety disorders. Flashbacks may also be associated with depression, nightmares or sleep disturbance, perceptual disturbances or anxiety at times of sexual activity. Strong physical or emotional responses can present as somatic symptom disorder or stronger responses to physical illness or treatment.

The overly ‘resilient’ individual who throws themselves into work, can be just as much a manifestation of ‘avoidance’ as a person who copes with disordered eating, substance use and gambling. It may become maladaptive if the apparent ‘helpful’ strategy also avoids emotional and interpersonal difficulties. Conflict within the doctor–patient relationship occurs when the person is misunderstood or misheard with their presentation.

Survivors often report low self-esteem and difficulties with trust, particularly when the abuse has occurred from betrayal from a trusted figure. There can be a sense of false culpability related to their own abuse. These feelings can be further eroded by the cognitive impairments of concentration and memory that can occur with those who are experiencing heightened distress. Some of these people did not have a reliable model of attachment in childhood, and this can interfere with normal processes of interpersonal interaction into adulthood.

Underpinning these symptoms is often profound shame. This is discussed in greater depth in the [Trauma-informed care in general practice \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) chapter.

The complexity of presentation may explain why some victims/survivors accumulate multiple diagnoses, including depression, anxiety, panic disorder, psychosis and borderline personality disorder.<sup>26</sup> Many patients experience stigma and discrimination from these diagnoses, notably borderline personality disorder.

Anecdotally, it has been suggested that some adult victims/survivors appear to have experienced little or even no effect from the abuse; however, many will be profoundly affected in many aspects of their lives. Without the right treatment, these effects can last their whole life. Many elements influence how well a victim/survivor copes, including the type(s) of abuse experienced, its frequency and duration, the person's family life, the response to disclosure, and adult experiences of abuse and violence.

### Events that may trigger or pre-empt presentation

PTSD is characterised by flashbacks of the prior traumatic events, which might occur at any time.<sup>31</sup> Certain events are more likely to trigger symptoms of distress.<sup>5</sup> For victims/survivors of child abuse, these may include:

- marriage
- the birth of a child<sup>32</sup>
- themselves or their child reaching a certain age
- the death of the perpetrator (eg family member)<sup>33</sup>
- watching a television program relating to incest
- a particular place or smell.<sup>34</sup>

### How to ask about past child abuse

Most patients will be unlikely to disclose their traumatic experience to health professionals unless they are asked. Yet health professionals may not ask, because of an overestimation that it will lengthen or complicate the consultation.<sup>35, 36</sup> or a mistaken belief in the futility of treatment for adult victims/survivors, or barriers to access additional care.

Patients do believe that GPs are able to help with their symptoms,<sup>27</sup> and they are receptive to being asked sensitively about adverse childhood experiences. Asking insensitively can re-traumatise the victim/survivor (refer to Box 13.2 and Box 13.3).

Advice for asking questions about childhood trauma is shown in Box 13.3.

To optimise patient care, GPs and all the healthcare team need to keep the possibility of trauma in mind in all presentations, to case-find or ask if there are clinical indicators and respond appropriately when patients do disclose a history of abuse.<sup>2</sup> This may include validation, hearing the story and collaboratively addressing concerns.

Many behaviours and comorbidities associated with trauma (refer to earlier section titled 'Effects of child abuse on later life') are stigmatised. When health professionals are not educated about the purpose of these strategies, they often perceive the patients as being manipulative or attention seeking. A trauma-informed lens enables health professionals to understand patients' presentations in the context of their lived experience and respond appropriately. Asking about family relationships when they were children and the abuse of alcohol by their parents may provide clues.

Health professionals may be able to help by providing a safe space in which the person can discuss their needs and which over time, can help establish trusting relationships. This can be valuable for the adult victim/survivor.

More on this is discussed in the [Trauma-informed care in general practice chapter \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice).

### **Box 13.3. Asking about childhood trauma<sup>5</sup>**

As a result of the disordered memory associated with childhood trauma, it can be challenging to ask appropriate questions. Many adults who have experienced severe trauma will not remember or recognise their childhood as abusive.

#### **Asking difficult questions about adverse childhood experiences**

- 'Was your home a safe and secure place?'
- 'What were you like as a young child?' (Children who have been abused often have a highly negative self-image of themselves, such as 'My mother said I was born angry' or 'I was ugly and everyone said I was stupid'.)
- 'Were you asked to keep any secrets as a child?'
- 'What happened when you were punished as a child?'
- 'Did anything happen to you in childhood that hurt you?'
- 'Did anything happen around you that made you feel unsafe?'
- 'Was there someone you could turn to when life was difficult?'

#### **Identifying a person's strengths**

- What coping strategies have they found helpful in the past?

If the coping strategies are maladaptive (eg substance abuse, food restriction/purging, self-harm or other risky behaviour), then explore further until a coping strategy that is less maladaptive has been identified.

Potential coping strategies include lifestyle factors (sleep, exercise, diet), distraction, connection with others, pursuing meaning and purpose in life (eg meaningful work, volunteering, advocacy, caring for others), creative pursuits and various forms of therapy.

#### **Identifying a person's supports**

- Who have they found helpful in the past?

Troubleshooting involves the following types of questions:

- At times when support can be variable, what factors have made the support more helpful?
- At times when there are limited personal supports, what professional supports have been helpful in the past?
- If the patient does not think their supports (personal and/or professional) have been helpful in the past, what type of support do they need now?

The aim is to help them construct a list that is specific and achievable. This may take some time; trust will develop slowly.

Identifying a person's strengths and supports can assist the person with emotional dysregulation to identify coping strategies that are more helpful.

## Management

Figure 13.3 outlines management strategies for adult victims/survivors of childhood trauma, including how to approach consultations with patients.

### Telling the story

Sometimes the challenge is the consultation itself. This may be because of difficulty understanding the story or telling the story, or the GP hearing the story.

GPs may have their own trauma stories, which can affect the doctor–patient interaction. They may also have preconceptions of what constitutes 'recovery' for the patient, or of what the 'problem to fix' is. If the GP and the patient's agendas don't align, the patient may disengage. Financial and perceived time constraints have further impact.

Listening to the patient's story is critical. Allowing their distress to be present as part of the journey can be powerful and engaging, and meaningful therapeutically. Patients can initiate their own solutions that are person-centred and individualised.

Adult victims/survivors, particularly those with the most severe trauma, may have never had relational or personal strengths in the first place and may have to 'learn' rather than 're-learn' coping strategies. Dissociation may mean they are still learning to connect with thought, feelings and identity even before they are in a place to work on their emotions. Consider dissociation when the story or reason of presentation doesn't all fit together (refer to Figure 13.3). It may be that there is paucity of information, discrepancy or emotional incongruity to presentation – either too much reactivity or too little.

Hyperarousal (or hypo-arousal) can indicate the material is emotionally triggering. It is particularly important during these times to ensure the person is safe in the process.

Just as not enough empathy can interfere with patient engagement, sometimes too much empathy can too. It can leave a person stuck in the emotional quagmire of distress without allowing them to move on. Acknowledge distress, but also focus on ensuring that the patient conveys appropriate information and is listened to.

In a practical sense, this may mean that you may need a checklist to ensure crucial elements of the story are not missed – sometimes information may not follow a sequential or logical sequence, or be overwhelming in its detail. When listening to the story, be aware that the specifics of the trauma may be less important than just knowing it exists and its effects on the individual. This may take multiple sessions, so it is important to set expectations for this, particularly the more complex the issue.

The consultation can sometimes be derailed by emotional dysregulation (refer to Table 13.1), or relational difficulties, either within the consult or influenced by interactions with family or friends. A person who has experienced childhood trauma is more vulnerable to subsequent trauma, so may also present with acute stressors or distress.

As health professionals, we sometimes forget that part of the whole story includes social, cultural, economic and psychological influences. These are part of the pieces of the story we need to listen out for, and become part of the story that can enrich, support or hinder recovery.

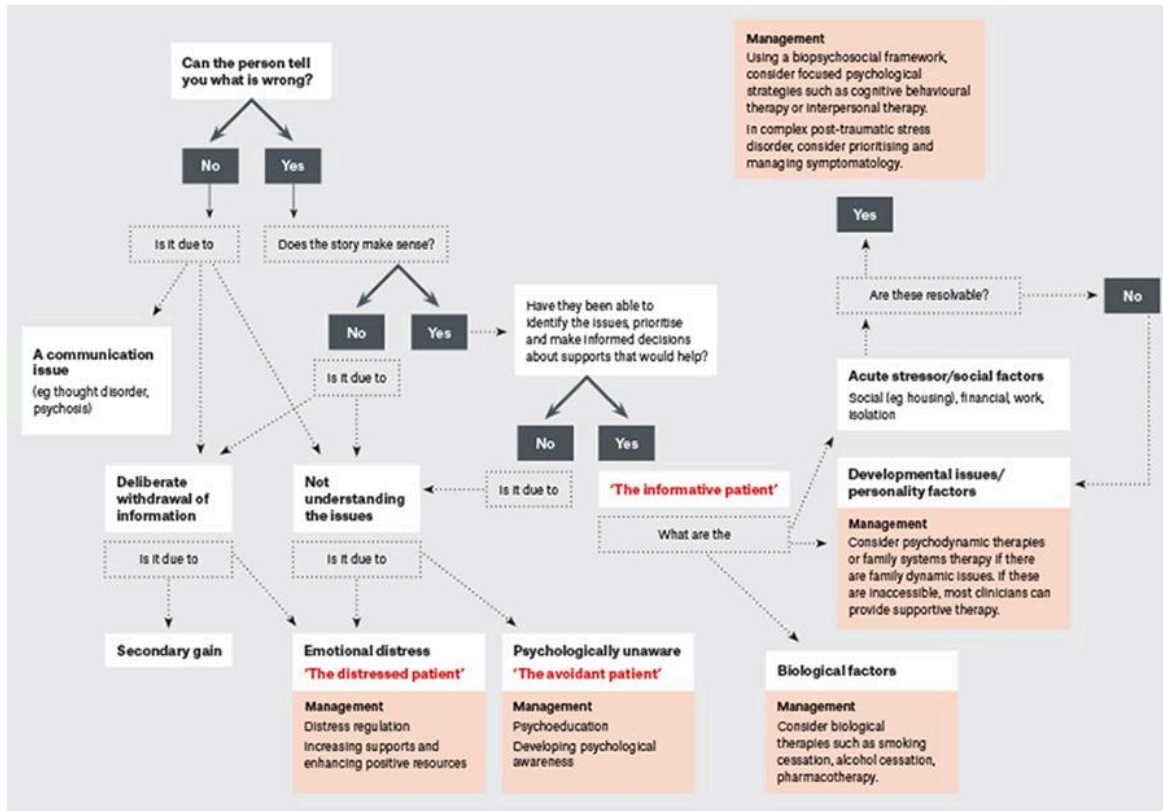


Figure 13.3. Roadmap to recovery: A flowchart for the management of adult victims/survivors of childhood trauma<sup>5</sup>

Reproduced with permission from: Su WM, Stone L. Adult survivors of childhood trauma: Complex trauma, complex needs. Aust J General Practice. 2020;49(7):423–30.

Reproduced with permission from: Su WM, Stone L. Adult survivors of childhood trauma: Complex trauma, complex needs. Aust J General Practice. 2020;49(7):423–30.

### Specific interventions for common symptomatology

Table 13.1 summarises interventions that may be helpful for symptoms commonly seen in people who are victims/survivors of childhood trauma.



**Table 13.1. Common symptomatology seen in victims/survivors of childhood trauma, linked to intervention<sup>5</sup>**

Symptom type	Common symptomatology seen in victims/survivors of childhood trauma	Targeted intervention
<b>Somatic symptoms</b>	<ul style="list-style-type: none"> <li>• Medically unexplained symptoms</li> <li>• Syndromes such as irritable bowel syndrome, chronic fatigue and fibromyalgia</li> <li>• Chronic pain</li> <li>• Consequences of maladaptive coping (eg substance abuse, eating disorders)</li> <li>• May be associated with strong emotional states</li> </ul>	<ul style="list-style-type: none"> <li>• Validation of the patient's physical distress and appropriate investigation</li> <li>• Psychoeducation regarding the psychological awareness of the link between symptoms and situation</li> </ul>
<b>Emotional dysregulation</b>	<ul style="list-style-type: none"> <li>• Irritability and chronic hyperarousal</li> <li>• Recurrent or chronic suicidal ideation</li> <li>• Self-harm</li> <li>• Maladaptive coping strategies (eg addictions, eating disorders)</li> </ul>	<ul style="list-style-type: none"> <li>• Distress regulation<sup>(a)</sup></li> <li>• Psychoeducation regarding the psychological awareness of the link between distress and situation</li> </ul>
<b>Interpersonal instability</b>	<ul style="list-style-type: none"> <li>• Re-enacting unhelpful relationships from the past (eg becoming abusive themselves, or partnering with an abusive partner)</li> <li>• Poor parenting skills</li> </ul>	<ul style="list-style-type: none"> <li>• Modelling of appropriate attachment</li> <li>• Offering a stable and supportive therapeutic relationship</li> </ul>

**Table 13.1. Common symptomatology seen in victims/survivors of childhood trauma, linked to intervention<sup>5</sup>**

**Avoidance**

- Gaps in the history-taking or the story
- Diversion or distraction associated with a specific theme
- Behaviours associated with avoidance. These may include substance use, eating disorders or disruptive behaviours. Avoidant behaviours may also be traditionally considered as ‘positive’ behaviours until they become maladaptive. An example could include distraction into work rather than addressing the issues most triggering the emotional distress.

- Validation and acknowledgement of the patient’s distress and what they have been able to achieve
- Supportive therapy to build on other resiliences
- Exposure therapy, once the patient is ready

Note: If a person is using avoidance as a coping mechanism, they may be feeling too overwhelmed at this time. Go slow. Engaging the patient may require identification of what they are avoiding, drawing links between the distress and current management style (avoidance) and exploration of alternatives. This should be patient-centred, or otherwise risks alienating the patient.

**Re-experiencing and dissociation**

- Post-traumatic stress disorder symptoms, including nightmares, flashbacks and re-experiencing
- Flashbacks may be predominantly emotional (ie feeling acutely distressed, anxious or fearful for no apparent reason and with no obvious narrative)
- Dissociation, where victims/survivors lose track of time and place, or have an intense experience of depersonalisation or derealisation

- Distress regulation
- Exposure therapy

**Table 13.1. Common symptomatology seen in victims/survivors of childhood trauma, linked to intervention<sup>5</sup>**

<b>Disorders of memory</b>	<ul style="list-style-type: none"> <li>• Fragmented memories from childhood</li> </ul>	<ul style="list-style-type: none"> <li>• Psychoeducation</li> <li>• Distress regulation</li> </ul>
<b>Shame</b>	<ul style="list-style-type: none"> <li>• Poor sense of self, including beliefs that they are fundamentally defective, toxic or worthless</li> </ul>	<ul style="list-style-type: none"> <li>• Establishment of values and appropriate goal setting<sup>(b)</sup></li> </ul>

- Further ways to manage distress regulation are considered in Asking difficult questions – Identifying a person’s strengths and supports (refer to Box 13.3).
- Achieving a sense of purpose or meaning is an important aspect of self-actualisation. This concept is known by various names in different forms of psychotherapy. For example, in cognitive behavioural therapy, it can be called ‘schema therapy’. In acceptance and commitment therapy, it can be the ‘values’ and ‘goal setting’ arms of therapy. The goal of psychodynamic therapy is for the patient come to an understanding of their sense of purpose or meaning through exploration of their self-belief within a consistent, respectful and empathic therapeutic relationship. Self-actualisation and changing belief settings may only be possible once other needs, such as safety and security, are met.

Reproduced with permission from: Su WM, Stone L. Adult survivors of childhood trauma: Complex trauma, complex needs. Aust J General Practice. 2020;49(7):423–30.

## Managing risk

The unfortunate reality is that trauma is a risk factor for suicide<sup>37</sup> and self-harm,<sup>38</sup> and a history of child abuse may put some people at higher risk of harming others.<sup>39</sup>

Managing adult victims/survivors of child abuse, as for all survivors of trauma, should include an assessment for and management of these risks. Refer to [Chapter 5: Working with men who use intimate partner abuse and violence](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse>) and [Chapter 7: Trauma-informed care in general practice](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice>).

For more information on suicide prevention and management, including safety planning, refer to [Sane Australia’s suicide prevention and recovery guide](https://www.sane.org/images/PDFs/2779_SANE_SP_RG_2016_06.pdf) ([https://www.sane.org/images/PDFs/2779\\_SANE\\_SP\\_RG\\_2016\\_06.pdf](https://www.sane.org/images/PDFs/2779_SANE_SP_RG_2016_06.pdf)) and [Suicide prevention and first aid: A resource for GPs](https://gpmhsc.org.au/guidelinessection/index/fd093e3b-ceff-4e0d-81c0-b04dfba936d1/suicide-prevention-and-first-aid) (<https://gpmhsc.org.au/guidelinessection/index/fd093e3b-ceff-4e0d-81c0-b04dfba936d1/suicide-prevention-and-first-aid>).

## Therapy and treatments

### Psychological therapy

There is a moderate level of certainty in the evidence that any psychological therapy will reduce PTSD or trauma symptoms, depression and anxiety in adults who have experienced child abuse. Trauma-focused therapies appear to have a larger effect size on symptom levels of depression and dissociation, but not anxiety (refer to the White Book technical report for more information.)

It is therefore recommended that adult victims/survivors of child abuse are offered psychological therapy to reduce PTSD, depression and anxiety.

Appropriate treatment options to consider with the patient may include individual counselling/therapy, referral to specialist service, therapeutic groups and self-help groups.

Sometimes choice of therapy is based on accessibility, for example, access to specialised services or long-term psychotherapy. Many victims/survivors have increased vulnerabilities that may further compound access difficulties. GPs can fill the gap where services don't exist, or advocate for localised services. Understanding the [processes and principles of trauma-informed care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) may be crucial to ensure that the GP is providing the best care within the limits of their capacity.

For some adult victims/survivors, sharing their story and psychotherapy can be an important part of the process. For others, it can be re-traumatising. Fitting the therapy to the person and their stage of recovery is important. Emotional distress may occur with specific triggers, during transitions and during recovery. Emotional distress does not necessarily mean relapse. Supporting the victim/survivor to elucidate antecedents to the distress and develop strategies for emotional regulation may assist. Care should focus on self-empowerment and choice.

For patients who have been disempowered in childhood as a result of their abuse, the trauma-informed principle of being able to choose from a range of treatment options is an important part of their care.

Being open and non-judgemental to therapy options is important. However, the evidence for some therapies is still emerging, and the primary principle should still be to do no harm. This is particularly important for therapies where there is controversy and potential risk. Therapies that are under debate include retrieved memory, dissociative identity disorder and more novel therapies involving the use of psychoactive substances. Emerging therapies with low risk, such as exercise and social integration, are reasonable to promote, although further research into these areas is still necessary.

### Pharmacotherapy

In principle, pharmacotherapy assists with emotional regulation, but it should be used as an adjunct, not as the whole of therapy for a victim/survivor of complex PTSD.<sup>40</sup>

#### Box 13.4. Current Australian guidelines for treatment of trauma

The [Australian guidelines for the prevention and treatment of acute stress disorder, post-traumatic stress disorder and complex PTSD](https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/) (https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/) were updated in 2020.<sup>41</sup> These 'living guidelines' outline best practice mental healthcare for people who have developed, or are at risk of developing, symptoms of acute stress disorder or PTSD. They have been designed for use by general and mental health practitioners, among other users.

The Blue Knot Foundation's [Practice guidelines for clinical treatment of complex trauma](https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019) (https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019)<sup>42</sup> provide helpful ways to work with victims/survivors of complex trauma. Refer also to the complementary guidelines, and guidelines on dissociation.

## Self-care for the health professional

Many of us do compassionate work due to a sense of altruism, but can get burnt out when the systems around us don't support us.

GPs may find that at different stages of their professional development, they may have the capacity to 'hold' a person with complex needs, to contain and facilitate the individual to develop strategies to manage the emotional distress, and share the care with other health professionals who have expertise in this area. GPs may find that their level of involvement within the care team may evolve as their skills and situation does.

As discussed previously, the effects of childhood trauma belong to the whole community. There is not an expectation for the individual GP to be responsible for solving or holding the entirety of the distress or journey. However, this chapter aims to empower the GP and support team to be able to do their part well – to ask, believe and listen.

Good trauma care is team based. All team members involved should have access to peer support, mentorship or supervision. Refer to [Chapter 8: Keeping the health professional safe and healthy: Clinician support and self-care](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care) (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care) for more information on self-care strategies.

## Providing ongoing general practice care

Certain procedures and investigations – for example, cervical screening – may be especially challenging for some patients. Providing a choice about having or not having these procedures is empowering for people who have previously been disempowered.

It may be appropriate to use the concept of 'continual consent' if you think a patient may feel uncomfortable with a particular procedure or investigation. Using this technique, the doctor talks through a procedure, letting the patient know what they are about to do. Throughout the dialogue, the doctor asks the patient if they are comfortable and happy to proceed. This provides the patient with the freedom to stop the procedure at any time.

Survivors may present with physical symptoms that need to be explored, but some of these may be triggered by or stem from the actual abuse. Examples include a sore throat, gagging related to former oral sex, or pelvic pain. Such possible symptoms of prior abuse need to be kept in mind, as does the need to minimise any potential for re-traumatising patients with particular sensitivities.

## Referrals and team care

Resources will vary from one area to another, and it is often difficult to find sufficient, adequate or appropriate resources. Information from [Blue Knot \(http://www.blueknot.org.au\)](http://www.blueknot.org.au) or the professional support line (1300 675 380) may be of assistance. The Blue Knot professional support line has a referral database of practitioners and agencies with expertise and experience for working with adult victims/survivors of child abuse.

Referrals could be to:

- another GP with training and experience in supporting adult victims/survivors
- a psychologist or psychotherapist with experience and training in working with adult victims/survivors
- an appropriately trained and experienced social worker or counsellor
- a sexual assault service, if it is resourced to see patients who have experienced childhood sexual assault
- a psychiatrist with experience and expertise in working with adult victims/survivors.

Check with the patient whether the gender of the therapist is of concern to them, and if so, which gender they would prefer to see. It is ideal to provide a choice of referrals and give the patient the option of returning should the referral not be suitable. It is also important to offer to continue to see the patient in the role of GP while the patient is in counselling/therapy.

## Case study: John

John, aged 35, presents to his GP with his wife, Judy, and 5-month-old son, James. Judy says that she has been asking John to see a doctor for some time as she is worried about his anxiety. He has seen a locum doctor, who prescribed benzodiazepine. John found the medication helped with symptoms but made him feel sluggish. He has also found over the past few weeks that he needs to take more to get the same effect, and he feels more unwell when he doesn't take it. Judy says, 'I don't like him taking the medication; it seems to make him more withdrawn and unhappy.'

John is reluctant to talk, but with encouragement from Judy says that he is really stressed at work. His job as a computer analyst has always been busy, but lately he is feeling very overwhelmed and is worried he is not performing well.

He is irritable and finds himself 'flying off the handle' more easily. His colleagues at work have asked him a few times if he is okay. He has had some disagreements with his boss. He says that, while he has generally interacted well with his boss, he isn't a very good manager and that this has recently been bothering him. He is finding it difficult to get to work in the mornings and dreads getting out of bed.

Judy says she has noticed that John is not sleeping well, and he agrees, saying that he is having trouble getting to sleep and wakes early, feeling tired. He has bad dreams that often wake him and he then finds it hard to get back to sleep. These symptoms started about four to five months ago.

John reveals that his father had a problem with alcohol and was violent towards John's mother. He left the family home when John was nine years old, and John has had little contact with him since. John appears to become increasingly distressed through the consult and says, 'There was some stuff that happened to me when I was young. I thought I'd dealt with it, but it seems to be haunting me now. My mum did her best, but she couldn't keep me safe and my dad didn't care enough'.

John says he worries about his son and fears for his safety. He says, 'James just seems so small and I'm worried I won't be able to protect him from the world'.

Over a number of consultations, John discloses that as a child he was sexually assaulted over a number of months by a neighbour. This abuse only stopped when John and his mother moved house. Despite his early childhood trauma, John appeared to manage life well, completing his tertiary education, working full time and creating a close nurturing relationship with his wife and close friends. The life stage of becoming a father appears to have triggered symptoms consistent with PTSD, related to his past trauma. The prescription of benzodiazepine, while providing some short-term relief, has led to dependence and tolerance and it has not treated the underlying cause of the distress.

## Discussion

This case illustrates a scenario in which the effects of past abuse appear to have been triggered by having a child. This has presented as nightmares and anxiety. John seems also to be having some problems with authority figures – his boss at work, for example – and this would be consistent, as abuse occurs in situations of inherent power imbalance.

The benzodiazepine, while providing short-term symptom relief for his anxiety, has not addressed the true cause of the symptoms, which at the time was not identified.

John is ultimately helped by sessions with a psychologist. As he works through his abuse issues, he comes to understand what was contributing to his anxiety and how it was linked to the birth of his son. He is able to stop using the benzodiazepines.

## Case study: Susan

Susan is 21 years of age and living in a country town. She presents to your practice requesting a cervical screening test (CST). When you take her history, Susan reveals that she broke up with her most recent partner because she was dissatisfied with the sexual relationship: she says she doesn't enjoy sex, feels uncomfortable and finds it very hard to relax. She asks you if this is normal. Her reason for

wanting a CST is that she has been talking with her friends about women's issues and they seemed to think that regular tests were a good idea. Although she is not sexually active at the moment, she says she would feel happier to have a full check-up.

As you perform the examination, Susan is extremely tense, and performing the vaginal examination is difficult. You stop the examination, concluding that to proceed would be detrimental to Susan. Susan is upset and once she is dressed, you reflect to her that the examination was anxiety provoking. She calms down and says that she will come back in a couple of weeks now she knows what is involved. Before she leaves, you inquire about any past unpleasant sexual experiences. She repeats that she doesn't enjoy sex, but that she can't remember anything of a frightening or threatening nature.

One week later, Susan reappears at your surgery saying she has been disturbed since the attempted CST. She is having strange dreams and has a feeling that something happened when she was younger. She grew up on a small property out of town. After some discussion she says she thinks something happened with her older brother and some of his friends, but the memories are unclear. She is obviously distressed.

You consider the following to be the most likely diagnosis for Susan:

- sexual dysfunction
- child sexual

You explore some options for counselling or therapy with Susan, either individually or in a group, and discuss whether she wants to see a counsellor at the local sexual assault centre, or an allied health practitioner with expertise and experience in supporting patients with past abuse.

Susan opts to see a counsellor at the local sexual assault service. As the waiting period is three months, you offer to see Susan weekly for support. She agrees and you are able to work with her to help her feel safe and improve her capacity for self-care. You discuss strategies that might provide some relief to her sleep disturbance, explore her diet, exercise and self-care, and assess her supports by way of friends and relatives, encouraging her to reach out to those she trusts and with whom she feels safe.

Nine months later she comes to see you for a CST. Although Susan is slightly tense, she can relax sufficiently for the examination to be performed successfully. Susan is relieved and says that in counselling she has been feeling that she is making good progress, and being able to have a CST is indicative of her progress as well. She thanks you for your involvement.

## Resources

Refer to [resources \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources) nationally and in your area.

- *The hidden factor: the effects of child abuse on adults* – this DVD is a resource for GPs and other health professionals. Three women tell their stories of abuse to give doctors and other health professionals a better understanding of the factors that helped with the healing process. Available for loan to RACGP members from the RACGP library: email [library@racgp.org.au](mailto:library@racgp.org.au), (<mailto:library@racgp.org.au>) or phone 03 8699 0519.
- *A whole person approach to wellbeing: Building sense of safety* (<https://www.routledge.com/A-Whole-Person-Approach-to-Wellbeing-Building-Sense-of-Safety/Lynch/p/book/978036749157>)



- 4) – book by Australian GP psychotherapist, Dr Johanna Lynch, Routledge, 2021.
- [Practice guidelines for clinical treatment of complex trauma \(https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019\)](https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019) – a guide from the Blue Knot Foundation.
  - [Australian guidelines for the prevention and treatment of acute stress disorder, post-traumatic stress disorder and complex PTSD \(phoenixaustralia.org/australian-guidelines-for-ptsd\)](http://phoenixaustralia.org/australian-guidelines-for-ptsd).
  - [The body keeps the score: Brain, mind and body in the healing of trauma \(https://www.newsscientist.com/article/mg22429941-200-the-lifelong-cost-of-burying-our-traumatic-experiences/\)](https://www.newsscientist.com/article/mg22429941-200-the-lifelong-cost-of-burying-our-traumatic-experiences/) – book by psychiatrist Bessel Van der Kolk, which explores different models of trauma therapy, Penguin 2015.
  - *After abuse* – by Victorian psychiatrist Dr Gita Mammen, this book outlines types of treatment and may be helpful to GPs trying to find an appropriate referral or seeing patients in a counselling role, ACER Press, 2006.
  - [Better Access Initiative \(https://www.racgp.org.au/education/gps/managing-mental-health/better-access-initiative\)](https://www.racgp.org.au/education/gps/managing-mental-health/better-access-initiative) – the MBS item relating to the GP Mental Health Treatment Plans may be useful for patients wanting to initiate ongoing mental healthcare.
  - Victims services – these are state/territory-based services, funded by the Department of Communities and Justice, to support those who have experienced crime, including family and domestic violence. They provide counselling and financial assistance.
  - Primary Health Networks – may provide training and education, and coordination and collaboration with local services.
  - [Living well \(https://www.racgp.org.au/education/gps/managing-mental-health/better-access-initiative\)](https://www.racgp.org.au/education/gps/managing-mental-health/better-access-initiative) – a website for men who were sexually abused as children or who have been sexually assaulted as adults.
  - [See what you made me do: Power, control and domestic abuse \(https://www.blackincbooks.com.au/books/see-what-you-made-me-do\)](https://www.blackincbooks.com.au/books/see-what-you-made-me-do) – book by Jess Hill, Black Inc Books, 2019.

## References

1. [Australian Institute of Health and Welfare. Australia's children2020: \(http://www.aihw.gov.au/reports/children-youth/australias-children\)](http://www.aihw.gov.au/reports/children-youth/australias-children) [Accessed 10 May 2021].
2. Lee A, Coles J, Lee SJ, Kulkarni J. Women survivors of child abuse - Don't ask, don't tell. *Aust Fam Physician* 2012 Nov;41(11):903–36. [Accessed 10 May 2021].
3. Ziadni MS, Carty JN, Doherty HK, et al. A life-stress, emotional awareness, and expression interview for primary care patients with medically unexplained symptoms: A randomized controlled trial. *Health Psychol* 2018 Mar;37(3):282–90. [Accessed 10 May 2021].
4. Hailes HP, Yu R, Danese A, Fazel S. Long-term outcomes of childhood sexual abuse: an umbrella review. *Lancet Psychiatry* 2019 Oct;6(10):830–9. [Accessed 10 May 2021].
5. Su WM, Stone L. Adult survivors of childhood trauma: Complex trauma, complex needs. *Aust J Gen Pract* 2020 Jul;49(7):423–30. [Accessed 10 May 2021].
6. Cattaneo A, Macchi F, Plazzotta G, et al. Inflammation and neuronal plasticity: a link between childhood trauma and depression pathogenesis. *Front Cell Neurosci* 2015;9:40. [Accessed 10 May 2021].
7. Norman R, Munkhtsetseg B, Rumma D, et al. The long-term health consequences of child physical abuse, emotional abuse and neglect: A systematic review and meta-analysis. *PLoS One* 2012;9:e1001349. [Accessed 10 May 2021].
8. Hughes K, Bellis M, Hardcastle K, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health* 2017;2:e356–66. [Accessed 10 May 2021].

9. D'Elia ATD, Matsuzaka CT, Neto JBB, Mello MF, Juruena MF, Mello AF. Childhood sexual abuse and indicators of immune activity: A systematic review. *Front Psychiatry* 2018;9:354. [Accessed 10 May 2021].
10. Berens AE, Jensen SKG, Nelson CA. Biological embedding of childhood adversity: From physiological mechanisms to clinical implications. *BMC Medicine* 2017 2017/07/20;15(1):135. [Accessed 10 May 2021].
11. Oral R, Ramirez M, Coohey C, et al. Adverse childhood experiences and trauma informed care: The future of health care. *Pediatric Research* 2016 2016/01/01;79(1):227–33. [Accessed 10 May 2021].
12. Vonderlin R, Kleindienst N, Alpers GW, Bohus M, Lyssenko L, Schmahl C. Dissociation in victims of childhood abuse or neglect: A meta-analytic review. *Psychol Med* 2018 Nov;48(15):2467–76. [Accessed 10 May 2021].
13. Feletti V, Anda R, Nordenberg D, Williamson D, Splitz A. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med* 1998;14:245–58. [Accessed 10 May 2021].
14. Marshall AD, Roettger ME, Mattern AC, Feinberg ME, Jones DE. Trauma exposure and aggression toward partners and children: Contextual influences of fear and anger. *J Fam Psychol* 2018 Sep;32(6):710–21. [Accessed 10 May 2021].
15. Gillikin C, Habib L, Evces M, Bradley B, Ressler KJ, Sanders J. Trauma exposure and PTSD symptoms associate with violence in inner city civilians. *J Psychiatr Res* 2016 Dec;83:1–7. [Accessed 10 May 2021].
16. Krause-Utz A, Mertens LJ, Renn JB, et al. Childhood maltreatment, borderline personality features, and coping as predictors of intimate partner violence. *J Interpers Violence* 2021 Jul;36(13-14):6693–721. [Accessed 10 May 2021].
17. [Campo M. Children's exposure to domestic and family violence: Key issues and responses \(CFCA Paper No. 36\). Melbourne: Child Family Community Australia information exchange, Australian Institute of Family Studies; 2015 \(<http://aifs.gov.au/cfca/publications/childrens-exposure-domestic-and-family-violence>\)](#) [Accessed 27 October 2021].
18. Alaggia R, Donohue M. Take these broken wings and learn to fly: Applying resilience concepts to practice with children and youth exposed to intimate partner violence. *Smith College Studies in Social Work* 2018;88(1):20–38. [Accessed 27 October 2021].
19. Anderson R, Edwards L, Silver K, Johnson D. Intergenerational transmission of child abuse: Predictors of child abuse potential among racially diverse women residing in domestic violence shelters. *Child Abuse Negl* 2018;85:80–90. [Accessed 27 October 2021].
20. Skodol AE, Bender DS, Pagano ME, et al. Positive childhood experiences: Resilience and recovery from personality disorder in early adulthood. *J Clin Psychiatry* 2007 Jul;68(7):1102–8. [Accessed 27 October 2021].
21. Miller JR, Cheung A, Novilla LK, Crandall A. Childhood experiences and adult health: The moderating effects of temperament. *Heliyon* 2020;6(5):e03927-e. [Accessed 27 October 2021].
22. Atzl VM, Grande LA, Davis EP, Narayan AJ. Perinatal promotive and protective factors for women with histories of childhood abuse and neglect. *Child Abuse Negl* 2019 May;91:63–77. [Accessed 27 October 2021].
23. [Australian Bureau of Statistics. Characteristics and outcomes of childhood abuse. Canberra: AIHW, 2019 \(<http://www.abs.gov.au/articles/characteristics-and-outcomes-childhood-abuse>\)](#) [Accessed 23 July 2021].
24. [World Health Organization. Child Maltreatment. Geneva: WHO, 2020 \(<http://www.who.int/news-room/fact-sheets/detail/child-maltreatment>\)](#) [Accessed 10 May 2021].
25. Chartier MJ, Walker JR, Naimark B. Childhood abuse, adult health, and health care utilization: Results from a representative community sample. *Am J Epidemiol* 2007 May 1;165(9):1031–38. [Accessed 10 May 2021].
26. Cloitre M, Garvert DW, Weiss B, Carlson EB, Bryant RA. Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European J Psychotraumatology* 2014;5:10.3402/ejpt.v5.25097. [Accessed 10 May 2021].
27. Goldstein E, Athale N, Sciolla AF, Catz SL. Patient preferences for discussing childhood trauma in primary care. *Permanente* 2017;21:16–55. [Accessed 10 May 2021].
28. Kezelman C, Stavropoulos P. 'The Last Frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. Sydney: Adults Surviving Child Abuse, 2012. [Accessed 10 May 2021].
29. Scott JG, Cohen D, DiCicco Bloom B, et al. Understanding healing relationships in primary care. *Annals Fam Med* 2008;6(4):315–22. [Accessed 10 May 2021].

- 
30. Cutajar MC, Mullen PE, Ogloff JR, Thomas SD, Wells DL, Spataro J. Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse Negl* 2010 Nov;34(11):813-22. [Accessed 10 May 2021].
31. World Health Organization. International Statistical Classification of Diseases and Related Health Problems (ICD-11). Geneva: WHO, 2020. [Accessed 10 May 2021].
32. Chamberlain C, Gee G, Harfield S, et al. Parenting after a history of childhood maltreatment: A scoping review and map of evidence in the perinatal period. *PLoS One* 2019;14(3):e0213460. [Accessed 10 May 2021].
33. McLaughlin KA, Conron KJ, Koenen KC, Gilman SE. Childhood adversity, adult stressful life events, and risk of past-year psychiatric disorder: A test of the stress sensitization hypothesis in a population-based sample of adults. *Psychol Med* 2010 Oct;40(10):1647-58. [Accessed 10 May 2021].
34. Cortese BM, Leslie K, Uhde TW. Differential odor sensitivity in PTSD: Implications for treatment and future research. *J Affect Disord* 2015 Jul 1;179:23-30. [Accessed 10 May 2021].
35. Chung JY, Frank L, Subramanian A, Galen S, Leonhard S, Green BL. A qualitative evaluation of barriers to care for trauma-related mental health problems among low-income minorities in primary care. *J Nerv Ment Dis* 2012 May;200(5):438-43. [Accessed 10 May 2021].
36. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Women & Health* 2012;52(6):587-605. [Accessed 10 May 2021].
37. Department of Health. The Fifth National Suicide Prevention Plan: Commonwealth of Australia. Canberra: DoH,2017. [Accessed 10 May 2021].
38. Plener PL, Kaess M, Schmahl C, et al. Nonsuicidal self-injury in adolescents. *Dtsch Arztebl Int* 2018;115(3):23-30. [Accessed 10 May 2021].
39. Augsburger M, Basler K, Maercker A. Is there a female cycle of violence after exposure to childhood maltreatment? A meta-analysis. *Psychol Med* 2019 Aug;49(11):1776-86. [Accessed 10 May 2021].
40. Abdallah CG, Averill LA, Akiki TJ, et al. The neurobiology and pharmacotherapy of posttraumatic stress disorder. *Annu Rev Pharmacol Toxicol* 2019;59:171-89. [Accessed 10 May 2021].
41. Phoenix Australia. The Australian guidelines for the prevention and treatment of acute stress disorder, posttraumatic stress disorder and complex PTSD. Melbourne: Phoenix Australia, 2020. [Accessed 10 May 2021].
42. Kezelman C, Stavropoulos P. Practice guidelines for treatment of complex trauma. Sydney: Blue Knot Foundation, 2019. [Accessed 10 May 2021].

# Adult sexual assault

'I am passionate in my work, and my experiences don't make me weak. My best work experience was done escaping and rebuilding my life, I can achieve anything.' **Kelly, victim/survivor, The WEAVERs Group (<https://www.saferfamilies.org.au/weavers>)**

## Key messages

- Sexual violence is very common<sup>1,2</sup> and associated with serious physical, emotional and reproductive harm.<sup>3</sup> For women, sexual violence is most commonly perpetrated by male intimate partners or other acquaintances.<sup>4</sup>
- Many people do not disclose sexual violence;<sup>5</sup> therefore, the effects may go unrecognised and untreated.
- GPs can provide support to patients who have experienced sexual violence, in the short, medium and long term. Sensitive, trauma-focused inquiry is generally well received by people who have experienced sexual assault.

## Recommendations

Offer first-line support to people who have experienced sexual violence by any perpetrator. This may include assessing and managing physical and mental health concerns, and suicide, safety and risk assessments.

**(Practice point: Consensus of experts)**

Consider and sensitively inquire specifically about a history of sexual violence (in addition to other traumatic experiences) when seeing patients with otherwise unexplained mental or physical health problems, alcohol or substance abuse issues, suicidality or self-harm.

**(Practice point: Consensus of experts)**

Assess need for emergency contraception and offer as required. Offer sexually transmitted infection (STI) investigations, prophylaxis and treatment as appropriate.

**(Practice point: Consensus of experts)**

## Clinical context

Sexual violence is broadly defined as any sexual act (or attempted act) perpetrated against someone's will.<sup>3</sup> It includes rape and physical forms of sexual assault, as well as a range of more subtle behaviours such as sexual coercion, forced consumption of pornography, non-consensual condom removal ('stealthing') and unauthorised sharing of intimate images online.<sup>3</sup>

Sexual violence is prevalent in Australia. National surveys have demonstrated one in every five women and one in every 20 men have experienced sexual violence since the age of 15.<sup>1</sup> Rates of sexual violence perpetrated against non-binary and transgender people have also been reported as high.<sup>6</sup> It is important to remember these estimates provide some idea of prevalence but are unlikely to represent the true scope of the problem. Sexual violence is underreported and many behaviours are not included in national surveys.<sup>7-10</sup> Thus, it can be reasonably assumed the true prevalence of sexual violence is much higher.

Sexual violence is consistently associated with poor mental and physical health outcomes for victims/survivors.<sup>3</sup> These impacts can occur in the short, medium or long term following an assault. In the immediate aftermath, there can be obvious physical injuries or trauma to the genital or anal area,<sup>11</sup> which may require treatment (although for many types of sexual violence there may be no outward signs of injury at all). In the medium term, victims/survivors may find they have contracted an STI<sup>12</sup> or experience an unwanted pregnancy.<sup>3</sup> Longer-term impacts can include post-traumatic stress disorder (PTSD), depression and anxiety, alcohol and substance misuse, eating disorders, gynaecological problems, suicidality and self-harm.<sup>3,13,14</sup> Long-lasting mental health problems are particularly common, with sexual violence often going unrecognised as an underlying cause.

Given the strong associations between sexual violence and poor health, victim/survivors tend to access health services, including general practice, more frequently than those who have not experienced sexual violence.<sup>15,16</sup> Australian studies have found almost half of women attending general practices had experienced at least one incident of sexual violence during their adult lives.<sup>17,18</sup> Attendance at general practices presents a critical opportunity for GPs to identify and respond to sexual violence in their patient populations.<sup>16</sup> It is important to note many victims/survivors are reluctant to disclose what has happened to them.<sup>14</sup> The reasons can be complex and varied, but may include shame and embarrassment,<sup>19</sup> self-blame<sup>8</sup> or unwillingness to accept that what they experienced was a form of sexual violence.<sup>8</sup> These barriers may be particularly pronounced when the perpetrator is an intimate partner<sup>19,20</sup> or when the sexual violence is more 'subtle'. On the other hand, research suggests many victims/survivors may feel comfortable disclosing experiences of violence to their GP<sup>4,16,21,22</sup> if they receive a competent, non-judgemental and trauma-focused response.<sup>21-23</sup>

## In practice

### The role of general practice

GPs can play a vital role in responding to adult sexual violence in the short, medium or long term. As there is often silence on the issue, GPs need to be proactive and maintain a high level of awareness that a history of sexual violence can be part of a patient's past experiences.

GPs need to be:

- prepared for a disclosure and create an environment in which patients feel safe and able to be heard
- mindful when ordering or conducting medical procedures such as cervical screening tests, which may potentially trigger distress, and work with patients to reduce this distress
- mindful that people who have been sexually assaulted may be fearful and anxious when booking or attending an appointment.

### Environment

It is important the individual GP and the entire practice team create a trauma-sensitive atmosphere and environment. Given the prevalence of sexual violence among the general practice patient population, it is highly likely multiple patients with a history of sexual violence will attend a clinic on any given day. It is essential every patient is provided with a warm and welcoming response from all the staff, beginning at the front desk; there is an option for patients to speak quietly and confidentially with reception staff; and a private space is available for patients who may need to use it. Posters outlining a short grounding exercise that patients can do unobtrusively in the waiting room may also help give the impression that the clinic has a trauma-informed focus.

### Referrals

Patients who have experienced sexual violence may feel particularly anxious when referrals need to be made for specific medical and mental health issues. The GP can allay this anxiety in several ways. This might include:

- ensuring practitioners joining the patient's care team are trained to be trauma-sensitive and understand the dynamics of sexual violence
- providing warm referrals to specialist care providers
- for some patients, the GP explaining their history directly to other specialist practitioners to avoid the patient having to repeat their story – this should only be done with the patient's consent
- seeing the GP after attending the referral service to check their needs are being met.<sup>24</sup>

## Identification

Identification is straightforward if a victim/survivor presents at the practice because of sexual violence. In most cases a patient will likely present with vague, unexplained mental or physical health complaints. In these situations, identifying a patient's sexual violence history can be challenging. It is not necessary for the GP to identify every patient in their practice who has experienced sexual violence; however, the GP does need to be aware of the possibility that sexual violence may underlie some common presentations.

GPs should be mindful of particular groups who appear to be at increased risk of sexual violence, including women with disabilities, women working in the sex industry, women experiencing other types of intimate partner abuse/violence (IPAV), women who are homeless, [LGBTIQ+ people \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence) and people who have previously experienced sexual abuse.<sup>2,20</sup>

Table 14.1 shows some possible presentations of sexual violence in the general practice setting.

**Table 14.1. Possible presentations of sexual violence in general practice**

- |   |   |
|---|---|
| • Fear or anger                                 | • Disrupted menstrual cycle                             |
| • Self-blame                                    | • Exhaustion  |
| • Concern about relationships                   | • Gastrointestinal problems                             |
| • Disclosure of physical or psychological abuse | • Severe sleep disturbances                             |
| • Shame or embarrassment                        | • Urinary, genital and pelvic pain                      |
| • Flashbacks                                    | • Other chronic pain (eg headaches)                     |
| • Substance abuse                               | • Eating disorders, anxiety or depression               |
| • Sexual dysfunction                            | • A sense of being dirty or contaminated                |
| • Self-harm or suicidal ideation                | • Difficulty with cervical screening                    |
| • Lack of energy                                | • Sexually transmitted infections                       |
| • Unintended pregnancy                          | • Concerns about sexuality (for male victims/survivors) |

The World Health Organization (WHO) recommends that GPs ask about sexual violence when assessing conditions that may be caused or complicated by such violence, such as those noted above.<sup>5</sup> If the patient is presenting alone, the GP can gently say:

'Sometimes things that happened in the past can affect how you feel now. For example, I often see patients who have had an unwanted sexual experience in the past, who feel stressed, anxious or down. It is really common to feel this way. Do you think that might be the case for you?'

This may help reduce some of the stigma associated with being a 'victim' of sexual violence and help the patient feel more comfortable disclosing their experience. Initially refer to 'unwanted sexual experiences' rather than 'sexual violence' or 'rape' given that many people do not relate to these more confronting terms.

## Disclosure

A patient may disclose sexual violence immediately, or years after the event. Disclosure may be unexpected or made in response to gentle questioning in the context of the assessment of other health problems. GPs need to be prepared in advance for a disclosure. If a GP is planning to ask about violence, a longer appointment may be required. They need to be aware of local protocols, legal obligations and reporting requirements, useful resources and referrals. It is important to consider issues of confidentiality and to ask about violence when the person is alone and to be aware that a patient may not be ready to disclose when asked.

The WHO [clinical handbook on healthcare for women subjected to IPAV or sexual violence \(https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/\)](https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/)<sup>25</sup> recommends that women should be provided with immediate first-line support on disclosure through the LIVES (Listen, Inquire, Validate, Enhance safety, Support) approach (refer to Box 14.1). Although it was developed for women, the same principles apply to patients of any gender who disclose sexual violence.

### Box 14.1. The WHO LIVES approach<sup>25</sup>

- Listen closely, with empathy, and without judgement.
- Inquire about needs and concerns.
- **Validate** and show you understand and believe the patient. Assure them they are not to blame.
- **Enhance safety**. Discuss a plan to protect from further harm.
- **Support** with referrals if needed and follow-up.

Refer to [Chapter 2 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) for more detail about LIVES.



When responding to a disclosure, it is vital that you ensure the patient is central and in control of any decisions about further care. People who have experienced sexual violence often say they value the support of health professionals who inquire about their needs, rather than telling them what to do.<sup>26</sup>

## Response

Most sexual violence-related health concerns can be readily managed in general practice.

### Managing immediate health concerns

These include concerns related to a disclosure of recent sexual violence, particularly in the case of rape or sexual assault. Table 14.2 outlines aspects of medical care. Some of the options available after recent sexual violence are time limited, but other options can be provided at any time a patient discloses they have been sexually assaulted.

Patients may at times present with vague memories of an assault, for example, if the assault was drug or alcohol facilitated. Others may have no memory of an assault, but have been in situations that raise real concerns that they have been assaulted. In general, it is prudent to provide the same care as you would for a patient who has a clearer memory of the assault.

The RACGP has [detailed information about managing immediate medical concerns \(https://www1.racgp.org.au/getattachment/24bbbe3b-99e9-40f1-97ec-e91f025e2fed/Clinical-management-of-patients-presenting-followi.aspx\)](https://www1.racgp.org.au/getattachment/24bbbe3b-99e9-40f1-97ec-e91f025e2fed/Clinical-management-of-patients-presenting-followi.aspx).

**Table 14.2. Considerations for healthcare following recent sexual violence**

Health concerns	Information	Time frames
<ul style="list-style-type: none"> <li>Assess and treat serious injuries, including inquiry about and assessment for strangulation</li> <li>Assess and manage common post-assault injuries</li> </ul>	<ul style="list-style-type: none"> <li>Refer the patient to hospital if serious injuries</li> <li>For further information on strangulation assessment refer to '<a href="https://www.rcpa.edu.au/getattachment/59a67b0e-ca6b-4686-a81f-14a1a15e70fe/Clinical-Forensic-Assessment-and-Management-of-Non.aspx">Clinical forensic assessment and management of non-fatal strangulation (https://www.rcpa.edu.au/getattachment/59a67b0e-ca6b-4686-a81f-14a1a15e70fe/Clinical-Forensic-Assessment-and-Management-of-Non.aspx)</a>'</li> <li>Document injuries carefully</li> <li>Provide information about treatment of minor injuries such as bruises and abrasions</li> <li>Determine if tetanus prophylaxis is required</li> </ul>	<ul style="list-style-type: none"> <li>On disclosure of recent assault</li> <li>For long-term concerns about physical damage, any time after disclosure</li> </ul>

Health concerns	Information	Time frames
<ul style="list-style-type: none"> <li>Assess need for emergency contraception and offer as required</li> </ul>	<ul style="list-style-type: none"> <li>Options available:               <ul style="list-style-type: none"> <li>Copper intrauterine contraceptive device: most effective form of emergency contraception; must be inserted up to 120 hours post unprotected sexual intercourse</li> <li>Ulipristal acetate 30 mg: most effective oral emergency contraception; effective up to 120 hours post unprotected sexual intercourse</li> <li>Levonorgestrel 1.5 mg: marketed for use within 72 hours but some efficacy up to 96 hours post unprotected sexual intercourse</li> </ul> </li> <li>For further information on emergency contraception refer to <a href="https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017">Royal College of Obstetricians and Gynaecologists emergency contraception guideline (https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017)</a></li> <li>Note: Trans men may also require emergency contraception</li> </ul>	<ul style="list-style-type: none"> <li>Pregnancy test three weeks post assault</li> <li>If pregnant from an assault, provide usual pregnancy option information and consider collection of evidence from the pregnancy: seek permission to speak to detective investigating the case</li> </ul>

Health concerns	Information	Time frames
<ul style="list-style-type: none"> <li>• Assess and manage the risk of sexually transmissible infection</li> <li>• Ensure local referral information is available for advice and referral for post-exposure prophylaxis against STIs. Contact the local sexual health clinic, specialist sexual assault service or infectious disease specialist</li> </ul>	<ul style="list-style-type: none"> <li>• Offer risk assessment, and baseline and follow-up testing for STIs. Refer to the <a href="http://www.sti.guidelines.org.au">Australian STI management guidelines for use in primary care (http://www.sti.guidelines.org.au)</a> for testing and treatment advice</li> <li>• Consider providing post-exposure prophylaxis for HIV and hepatitis B for patients presenting immediately after an assault. Refer to the guidelines and offer as recommended:               <ul style="list-style-type: none"> <li>◦ <a href="http://www.pep.guidelines.org.au">Post-exposure prophylaxis for HIV: Australian national guidelines (http://www.pep.guidelines.org.au)</a></li> <li>◦ <a href="https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/hepatitis-b">Australian Immunisation Handbook (https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/hepatitis-b)</a> (for hepatitis B)</li> </ul> </li> <li>• There are no specific Australian guidelines for prophylaxis against other STIs and testing and treatment as required is the usual practice. Prophylaxis should be considered when the risk assessment indicates a high risk for a particular STI/s and follow-up is unlikely. Refer to: <a href="https://www.rcpa.edu.au/getattachment/e03f7e44-c5bd-4b86-ad98-f63910f2ba27/Sexually-Transmitted-Infection-Management.aspx">RCPA guideline: Sexually transmitted infection management in patients who have experienced sexual violence (https://www.rcpa.edu.au/getattachment/e03f7e44-c5bd-4b86-ad98-f63910f2ba27/Sexually-Transmitted-Infection-Management.aspx)</a>.</li> <li>• Offer (a course of) hepatitis B vaccination according to guidelines for susceptible patients who have not been vaccinated, are incompletely vaccinated or are not immune. Refer to the <a href="#">Australian Immunisation</a></li> </ul>	<ul style="list-style-type: none"> <li>• Baseline testing on presentation</li> <li>• Follow-up testing at two, six and 12 weeks post assault</li> <li>• HIV post-exposure prophylaxis to start within 72 hours of assault</li> <li>• Hepatitis B post-exposure prophylaxis requires hepatitis B immunoglobulin to be started within 72 hours of assault (but may be given up to 14 days post-exposure) and a course of hepatitis B immunisation to be started within 14 days post-assault</li> </ul>

Health concerns	Information	Time frames
<ul style="list-style-type: none"> <li>Assess and manage suicide risk and other mental health concerns</li> </ul>	<p><a href="https://immunisationhandbook.health.gov.au/">Handbook (https://immunisationhandbook.health.gov.au/)</a>.</p> <ul style="list-style-type: none"> <li>Assess risk and develop safety plan</li> <li>Offer resources including 24-hour numbers</li> <li>Refer when further assistance is required</li> </ul>	<ul style="list-style-type: none"> <li>Repeat on each review</li> <li>Plan for support for times of increased stress (eg giving evidence in court)</li> </ul>
<ul style="list-style-type: none"> <li>Provide legal options and refer for forensic medical examination for collection of forensic evidence if patient requesting police investigation</li> <li>Ensure local referral information is available</li> </ul>	<p>Advise re: preserving forensic evidence if the conduct of the forensic medical examination will be delayed – if possible no shower, take clothes to forensic medical examination in separate bags</p> <ul style="list-style-type: none"> <li>Note: many victims/survivors will have already showered prior to a forensic medical examination and should still be offered this option despite having showered</li> <li>Wear gloves while conducting any examination</li> <li>Some sexual assault services provide evidence storage and time to decide on legal action</li> <li>Document consultation carefully as GP may be required to provide a report and/or give evidence in court</li> </ul>	<ul style="list-style-type: none"> <li>Forensic medical examination: within 72 hours, or up to seven days (and rarely to 10 days) post-assault depending on the jurisdiction and sexual assault service</li> <li>Patient can seek legal action at any time post-assault whether or not forensic medical examination is conducted</li> </ul>

Health concerns	Information	Time frames
<ul style="list-style-type: none"> <li>Assess for safety and consider legal obligations</li> </ul>	<ul style="list-style-type: none"> <li>Conduct risk assessment when intimate partner violence is identified, including safety of children</li> <li>Provide information and refer as required</li> <li>Conduct safety assessment following sexual assault</li> <li>Complete any mandatory requirements (eg child abuse reporting)</li> </ul>	<ul style="list-style-type: none"> <li>On disclosure and review</li> </ul>
<ul style="list-style-type: none"> <li>Develop and confirm plan for care with patient</li> <li>Provide written information</li> </ul>	<ul style="list-style-type: none"> <li>Develop plan for care with patient and follow-up depending on time frame of disclosure and issues to be addressed</li> <li>Add follow-up to recall</li> <li>Provide written information and resources</li> </ul>	<ul style="list-style-type: none"> <li>As per plan</li> </ul>

*STI, sexually transmitted infection*

**Managing medium- and long-term health impacts**

GPs are ideally placed as a consistent care provider to address a range of physical and mental health concerns caused by sexual violence. Some patients recover with minimal support from the GP. But for others, even though many years may have passed since an experience of sexual violence, ongoing issues continue to cause a significant impact on their quality of life. It is not possible to accurately predict which patient will experience prolonged distress, although compounding risk factors such as a history of childhood sexual abuse, concurrent IPAV, or alcohol or substance misuse may make recovery more challenging.<sup>26-28</sup> GPs need to be aware that individual responses and impacts of sexual violence are variable<sup>29</sup> and may change with time. It is important to ask the patient about their current concerns and needs and work with them to determine how they would like to address these. Scheduling regular appointments to review progress<sup>24</sup> can help to identify when the patient may need a change in the care plan.

Mental health impacts of sexual violence predominate in the medium and long term, although some patients will also experience ongoing physical impacts such as chronic pelvic pain and other conditions as noted in Table 14.1. The range of mental health concerns includes depression, PTSD, generalised anxiety disorder, substance abuse and panic disorder.<sup>3,14</sup> These can impact interpersonal relationships and their view of the world.<sup>29</sup> Many of these issues can be helped by trauma-informed counselling, although talk-based therapies are not useful for all patients<sup>30</sup> (mindfulness or trauma-informed yoga

can be suggested as an alternative). There is limited evidence to suggest that trauma-based cognitive behavioural therapy can assist in the management of PTSD symptoms<sup>31</sup> for patients who are not currently experiencing violence.

Antidepressant medication (if appropriate) can be considered if the patient is receptive. This can help stabilise their mood so they can more effectively work on the underlying trauma.

Suicidal ideation and self-harm are common experiences of people with sexual violence histories<sup>28,32</sup> and are of particular concern. A risk assessment can help identify patients who need more support and management to improve safety. This should be repeated at each review as changes may occur during the recovery process.

### **Women experiencing IPAV or reproductive coercion**

GPs should be alert to the possibility of sexual violence when a woman discloses other types of IPAV.<sup>19,33</sup> Sexual violence against women in the context of intimate relationships is very common. Women may not voluntarily disclose that sexual violence is happening in their relationship, even after disclosing physical or psychological abuse.<sup>19</sup> GPs should sensitively inquire about whether a woman has felt pressured, forced or blackmailed into unwanted sex if she mentions physical or psychological violence or indicators of coercive control. Women who have experienced intimate partner sexual violence may feel an acute sense of betrayal and damage to their self-esteem, which differs from women assaulted by a stranger.<sup>34</sup>

Similarly, sexual violence may be a mechanism through which a partner seeks to control a woman's reproductive choices.<sup>35,36</sup> Questioning how a woman feels about a pregnancy/contraception, and how her partner has responded to it, may elicit a disclosure of reproductive coercion.<sup>24</sup> Safety should always be reviewed when IPAV, including reproductive coercion, are identified and at any follow-up appointments. Refer to [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety).

### **Male, non-binary or gender-diverse victims/survivors**

Male, non-binary and gender-diverse people experience many similar emotional and psychological responses to women after sexual violence. The principles outlined above are equally appropriate for these patients.

In addition, a common issue for men who have been sexually assaulted is concern about their sexuality. Sexual acts they may have been forced to perform (or have performed on them) may challenge their perception of their sexuality. For example, getting an erection or ejaculating during the assault are physiological processes, but may be interpreted by the victim as an emotional response. GPs may need to take more time with male patients to ensure they understand the difference.

For non-binary and gender-diverse patients, sexual violence can be experienced in the context of discrimination or transphobia. Trans patients may be more likely to self-blame, fearing their gender presentation 'caused' the sexual violence. They may be particularly reluctant to disclose for fear of judgement or an insensitive response. Ensuring the practice and the GP's response is supportive and

welcoming to people of all genders is critical to being able to gain the trust of patients who are gender-diverse or non-binary. Refer to '[LGBTIQA+](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence)' chapter (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence>).

### **Boundaries and self-care**

Responding to sexual violence can be challenging for the GP. Good self-care is essential, including ensuring there are opportunities to debrief with colleagues or supervisors. GPs should be alert to the possibility of vicarious trauma and take steps to manage this (refer to [self-care chapter \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care).) It is also important to acknowledge many GPs will themselves have a history of sexual violence or other traumas.

GPs should set clear boundaries with patients around their role. This helps to keep expectations realistic and avoid distress to the patient.

## **Case study: Sarah**

Sarah, age 25 years, is an occasional patient of your practice. She comes to see you because she has been having trouble sleeping and is feeling really low. She is not managing at work, and thinks she needs some time to 'sort herself out'. You talk with her about her concerns and ask her how things have been at home. She tells you she split up with her partner three months ago and that she rented a room in a share house after this. She moved out of there recently and is now staying with a friend. On further discussion, she tells you that she moved out five weeks ago because one of her flatmates raped her.

You provide a supportive response to this disclosure and talk with Sarah about her concerns. She says she is most worried about her mental health because she had been having a hard time with the breakdown of her relationship before she was raped and is now feeling much worse.

You conduct a mental health assessment, and as part of this ask her whether she has had any thoughts of suicide and self-harm. She nods and starts to cry. You acknowledge her distress and let her know that people often feel this way after an assault. The thoughts are frightening but are very likely to settle with time and support.

Sarah agrees to have a suicide risk assessment. You determine that she is having passive suicidal thoughts, with no actual plans about how or when she would harm herself. You develop a safety plan with her and give her numbers she could call, including a 24-hour service should she need this. You normalise the reactions she is having and talk with her about treatment options.

Sarah says she is feeling much better having spoken to you and will get back into exercise again, as this always elevates her mood. You establish that she is safe with her friend and can stay there until she finds new accommodation. Her friend is supportive and is aware of how she has been feeling.

Sarah is not worried about pregnancy as she took the emergency pill and has done a pregnancy test since then. She is concerned about STIs and would like to come back for a check-up. She hasn't thought about legal action in relation to the assault as yet.

You give her a work certificate and make an appointment for review and STI check.

You see Sarah again the following week. She says she has been up and down, but is sleeping better and is generally more like her normal self. She says that the suicidal thoughts have decreased significantly and that she talks with her friend when she is feeling low. Sarah says she is now able to go back to work.

You conduct the STI check-up and her first cervical screening test (CST). This is done with her consent and a careful explanation of each step in the process.

Her STI tests and CST are negative. At a follow-up appointment, Sarah tells you that she would like to talk to someone to help her decide about legal action. She agrees to a warm referral to the Sexual Assault Service and they make an appointment to see her.

You also make an appointment to see Sarah in two weeks. At this time, she tells you she is doing well, is feeling more positive and able to move on with her life. She attended her appointment at the Sexual Assault Service and decided that she would provide information to the police, but not go through with the legal process. The counsellors helped her to find an appropriate person to talk to about unresolved issues from her relationship breakdown and this counselling has really helped. She was offered counselling at the Sexual Assault Service to help with the reactions to the assault, but she feels that she is recovering well with the support of her family and friends.

You suggest that she make an appointment with you if she is having problems, otherwise you will see her when her 12-week post-assault blood test for STIs is due.

At the 12 weeks post-assault test appointment, Sarah says she is not feeling much better, but is managing to get to work each day and catch up with a small group of friends socially. She has constant feelings of self-blame and intrusive thoughts of the assault when she is not occupied with her work. She agrees to go back to the sexual assault service for some trauma-focused cognitive behavioural therapy.

The role of the GP in identifying, responding, and supporting patients who have experienced sexual violence is vitally important. GPs should feel confident that with some simple strategies and a patient and trauma-focused mindset, they can provide effective support in the short, medium and long term.

## Resources

- [Clinical management of patients presenting following a sexual assault \(https://www1.racgp.org.au/getattachment/24bbbe3b-99e9-40f1-97ec-e91f025e2fed/Clinical-management-of-patients-presenting-followi.aspx\)](https://www1.racgp.org.au/getattachment/24bbbe3b-99e9-40f1-97ec-e91f025e2fed/Clinical-management-of-patients-presenting-followi.aspx)
- [Survivor video stories \(https://www.saferfamilies.org.au/survivor-stories\)](https://www.saferfamilies.org.au/survivor-stories)
- [Care package for adults who have experienced sexual trauma \(https://www.kemh.health.wa.gov.au/~/\\_/media/Files/Hospitals/WNHS/Our-Services/State-wide-Services/SARC/696-Care-Package-for-Sexual-Violence-Survivors--Screen.pdf\)](https://www.kemh.health.wa.gov.au/~/_/media/Files/Hospitals/WNHS/Our-Services/State-wide-Services/SARC/696-Care-Package-for-Sexual-Violence-Survivors--Screen.pdf)
- [Trans and gender-diverse health care \(Equinox\) \(https://equinox.org.au/\)](https://equinox.org.au/)
- [Management of PTSD \(https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/\)](https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/)
- [Survivor resource \(https://www.kemh.health.wa.gov.au/our-services/service-directory/sarc\)](https://www.kemh.health.wa.gov.au/our-services/service-directory/sarc)



---

**Sexual assault services**

---

National                    1800-RESPECT, 1800 737 732, [www.1800respect.org.au](http://www.1800respect.org.au)

---

Victoria                    • [SASVic \(http://www.sasvic.org.au\)](http://www.sasvic.org.au), 1800 896 292 (Crisis Line), to locate local Centres Against Sexual Assault

---

New South Wales                    • [NSW Rape Crisis \(http://www.rape-dvservices.org.au\)](http://www.rape-dvservices.org.au), 1800 424 017  
• [Sexual Assault Counselling Australia \(http://www.rape-dvservices.org.au\)](http://www.rape-dvservices.org.au), 1800 211 028

---

Queensland                    • [Statewide Sexual Assault Helpline \(http://www.health.qld.gov.au/sexualassault\)](http://www.health.qld.gov.au/sexualassault), 1800 010 210

---

South Australia                    • [Yarrow Place \(http://www.sahealth.sa.gov.au/yarrowplace\)](http://www.sahealth.sa.gov.au/yarrowplace), 1800 817 421 (toll-free in SA)

---

Northern Territory                    • [Sexual Assault Referral Centres \(https://nt.gov.au/wellbeing/hospitals-health-services/sexual-assault-referral-centres\)](https://nt.gov.au/wellbeing/hospitals-health-services/sexual-assault-referral-centres)

- Darwin: (08) 8922 6472
- Katherine: (08) 8973 8524
- Tennant Creek: (08) 8962 4361
- Alice Springs: from 8.00 am to 4.21 pm, Monday to Friday: (08) 8955 4500 or after hours 0401 114 181

---

Tasmania                    • [Sexual Assault Support Centre \(http://www.sass.org.au\)](http://www.sass.org.au), 1800 697 877

---

Australian Capital Territory                    • [Canberra Rape Crisis Centre \(http://www.crcc.org.au\)](http://www.crcc.org.au), (02) 6247 2525

---

Western Australia                    • Sexual Assault Resource Centre, (08) 6458 1828, 1800 199 888 (free call from landlines)

---

## References

1. Australian Bureau of Statistics. Personal Safety Survey. Canberra: ABS, 2017.
2. [Australian Institute of Health and Welfare. Sexual assault in Australia 2020. Canberra: AIHW, 2020 \(http://www.aihw.gov.au/getmedia/0375553f-0395-46cc-9574-d54c74fa601a/aihw-fdv-5.pdf.aspx?inline=true\)](http://www.aihw.gov.au/getmedia/0375553f-0395-46cc-9574-d54c74fa601a/aihw-fdv-5.pdf.aspx?inline=true) [Accessed 6 August 2021].
3. World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO, 2013. [Accessed 6 August 2021].
4. Cox P. Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012. Sydney: Australia's National Research Organisation for Women's Safety, 2015. [Accessed 6 August 2021].
5. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013. [Accessed 6 August 2021].
6. Callander D, Wiggins J, Rosenberg S, et al. The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of findings. Sydney: The Kirby Institute, 2019. [Accessed 6 August 2021].
7. Cook B, David F, Grant A. Sexual violence in Australia. Australian Institute of Criminology Research and Public Policy Series. Canberra: Australian Institute of Criminology, 2001. [Accessed 6 August 2021].
8. Lievore D. Non-reporting and hidden reporting of sexual assault: An international literature review. Canberra: Australian Institute of Criminology, 2003. [Accessed 6 August 2021].
9. Tarczon C, Quadara A. The nature and extent of sexual assault and abuse in Australia. Melbourne: Australian Institute of Family Studies, 2012. [Accessed 6 August 2021].
10. Australian Bureau of Statistics. Defining the data challenge for family, domestic and sexual violence: Summary 2013. Canberra: ABS, 2013. [Accessed 6 August 2021].
11. Zilkens RR, Smith DA, Phillips MA, et al. Genital and anal injuries: A cross-sectional Australian study of 1266 women alleging recent sexual assault. *Forensic Sci Int* 2017;275:195–202. [Accessed 6 August 2021].
12. Allsworth JE, Anand M, Redding CA, et al. Physical and sexual violence and incident sexually transmitted infections. *J Womens Health* 2009;18:529–34. [Accessed 6 August 2021].
13. Mark H, Bitzker K, Klapp BF, et al. Gynaecological symptoms associated with physical and sexual violence. *J Psychosom Obstet Gynaecol* 2008;29:164–72. [Accessed 6 August 2021].
14. Chen LP, Murad MH, Paras ML, et al. Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clin Proc* 2010;85:618–29. [Accessed 6 August 2021].
15. Plichta SB, Falik M. Prevalence of violence and its implications for women's health. *Womens Health Issues* 2001;11:244–58. [Accessed 6 August 2021].
16. García-Moreno C, Hegarty K, d'Oliveira AFL, et al. The health-systems response to violence against women. *Lancet* 2015;385:1567–79. [Accessed 6 August 2021].
17. Tarzia L, Maxwell S, Valpied J, et al. Sexual violence associated with poor mental health in women attending Australian general practices. *Aust N Z J Public Health* 2017;41:518–23. [Accessed 6 August 2021].
18. Tarzia L, Thuraisingam S, Novy K, et al. Exploring the relationships between sexual violence, mental health and perpetrator identity: A cross-sectional Australian primary care study. *BMC Public Health* 2018;18:1410. [Accessed 6 August 2021].
19. Wall L. Research Report: The many facets of shame in intimate partner sexual violence. Melbourne: Australian Institute of Family Studies, 2012. [Accessed 6 August 2021].
20. Logan TK, Walker R, Cole J. Silenced suffering: The need for a better understanding of partner sexual violence. *Trauma Violence Abuse* 2015;16:111–35. [Accessed 6 August 2021].
21. Feder G, Hutson M, Ramsay J, et al. Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Arch Intern Med* 2006;166:22–37. [Accessed 6 August 2021].
22. Tarzia L, Bohren M, Cameron J, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339. [Accessed 6 August 2021].

- 
23. Martsolf DS, Draucker CB, Cook CB, et al. A meta-summary of qualitative findings about professional [Accessed 6 August 2021].
24. Tarzia L. Identifying and responding to adult sexual violence. Medical Republic. 25 October 2017. [Accessed 6 August 2021].
25. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: WHO, 2014. [Accessed 6 August 2021].
26. Ranjbar V, Speer SA. Revictimization and recovery from sexual assault: Implications for health professionals. *Violence Vict* 2013;28:274–87. [Accessed 6 August 2021].
27. Campbell R, Dworkin E, Cabral G. An ecological model of the impact of sexual assault on women's mental health. *Trauma Violence Abuse* 2009;10:225–46. [Accessed 6 August 2021].
28. Dworkin ER, Menon SV, Bystrynski J, et al. Sexual assault victimization and psychopathology: A review and meta-analysis. *Clin Psychol Rev* 2017;56:65–81. [Accessed 6 August 2021].
29. Boyd C. The impacts of sexual assault on women. Melbourne: Australian Centre for the Study of Sexual Assault, 2011. [Accessed 6 August 2021].
30. Schintler T, Taylor G, Watson J. Trauma-Informed body based therapies in sexual assault program evaluation. Melbourne: Western Region Centre Against Sexual Assault, 2020. [Accessed 6 August 2021].
31. Regehr C, Alaggia R, Dennis J, et al. Interventions to reduce distress in adult victims of rape and sexual violence: A systematic review. *Research on Social Work Practice* 2013;23:257–65. [Accessed 6 August 2021].
32. Self-blame, psychological distress, and suicidality among African American female sexual assault survivors. Press release. Educational Publishing Foundation, 2020. [Accessed 6 August 2021].
33. Tarzia L. Toward an ecological understanding of intimate partner sexual violence. *J Interpers Violence* 2020. doi: 10.1177/0886260519900298 [Accessed 6 August 2021].
34. Tarzia L. 'It went to the very heart of who I was as a woman': The invisible impacts of intimate partner sexual violence. *Qual Health Res* 2021;31:287–97. [Accessed 6 August 2021].
35. Basile KC, Smith SG, Liu Y, et al. Rape-related pregnancy and association with reproductive coercion in the U.S. *Am J Prev Med* 2018;55:770–6. [Accessed 6 August 2021].
36. Tarzia L, Hegarty K. A conceptual re-evaluation of reproductive coercion: Centring intent, fear and control. *Reprod Health* 2021;18:87. [Accessed 6 August 2021].

# Abuse of older people

'Ageing eventually comes to all Australians, and ensuring that all older people live dignified and autonomous lives free from the pain and degradation of elder abuse must be a priority.' **Australian Law Reform Commission 2017**<sup>6</sup>

## Key messages

- Abuse of older people may be physical, emotional, sexual or financial, and may include neglect. It can occur in any setting, including aged care facilities or in the community. Caring for older people who are being abused is critical to the health of these patients <sup>1</sup>
- Risk factors for the abuse of older people can be related to the individual, the perpetrator, relationships, the facility and the wider community. There are many barriers to the older person being able to disclose the abuse. <sup>1</sup>

## Recommendations

Abuse of older people needs to be considered by any health practitioner, family member or aged care staff member who is caring for older patients, as they have a pivotal role in the recognition, assessment, understanding and management of the abuse and neglect of older people.

**(Practice point: Consensus of experts)**

Consider working with carers and families to prevent 'carer stress', which can contribute to the abuse of older people.

**(Practice point: Consensus of experts)**

## Clinical context

The abuse of older people is a significant public health problem, and is linked to increased mortality and disability.<sup>1</sup>

This is made clear by the recent Royal Commission into Aged Care, which investigated neglect and abuse of older people in Australia. The summary report states that ‘substandard care and abuse pervades the Australian aged care system’, and that the abuse carried out in these settings ‘should be a source of national shame.’<sup>2</sup> In addition, the interim report suggests ‘a shocking tale of neglect of older people’ in Australia, stating, ‘At the heart of these problems lies the fundamental fact that our aged care system essentially depersonalises older people’.<sup>3</sup>

In 2018, there were an estimated 3.9 million older Australians (aged 65 years or older), equivalent to 16% of the population (Figure 15.1). This was an increase from 2.9 million people (13% of the population) in 2009. Very old Australians (aged 85 and over) accounted for 2.0% of the population in 2018, and this proportion is projected to increase to 4.4% by 2057.<sup>4</sup>

The increasing number of older people and the changing characteristics of the ageing population are associated with a range of issues. These include:

- implications for high-level aged care
- a need for policies and services that respond to the needs of this population and support healthy, positive ageing
- the potential for social isolation and abuse of older people.<sup>5</sup>

In the words of the Australian Law Reform Commission report: ‘Ageing eventually comes to all Australians, and ensuring that all older people live dignified and autonomous lives free from the pain and degradation of elder abuse must be a priority’.<sup>6</sup>

Furthermore, the concept of healthy ageing should inspire a new focus for healthcare in older people. This involves optimising people’s intrinsic capacity and functional ability as they age.<sup>7</sup>

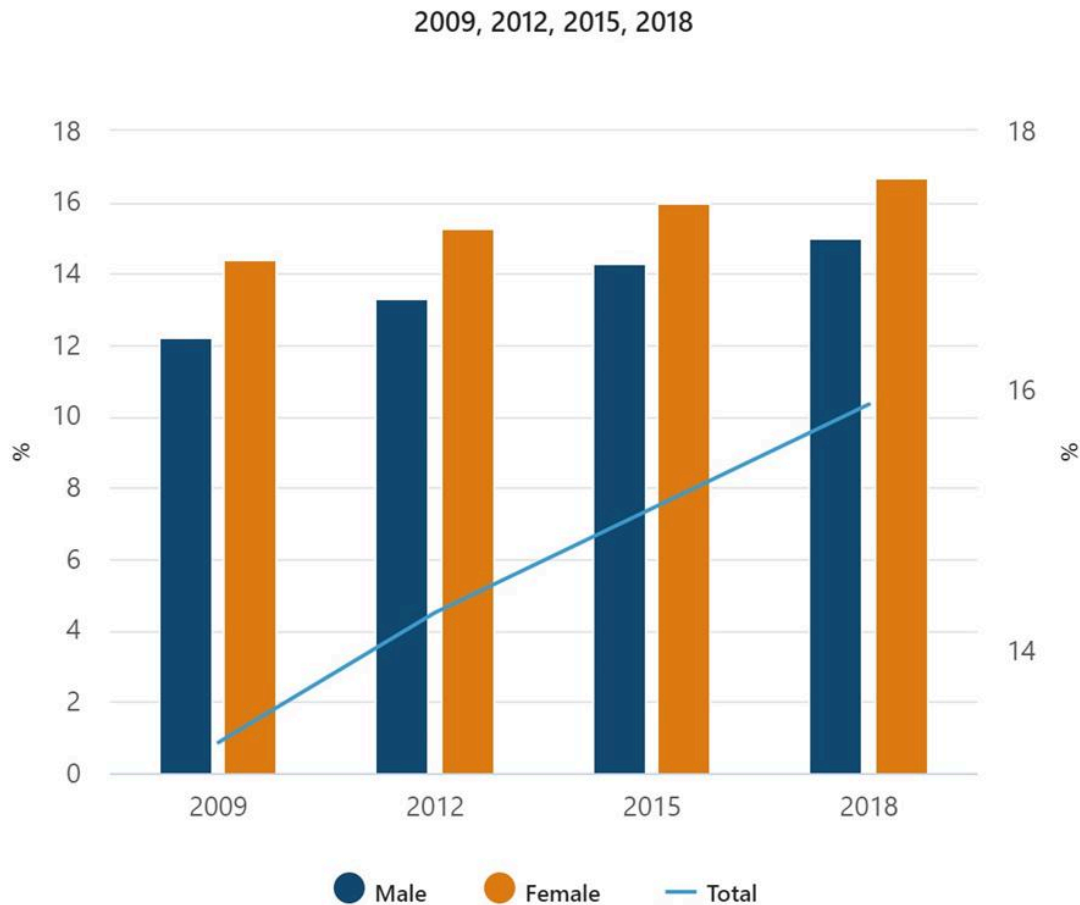


Figure 15.1. Proportion of Australians aged 65 years and over<sup>4</sup>

Source: Australian Institute of Health and Welfare.

## Definitions

Note that the term 'abuse of older people' has been chosen over 'elder abuse' in this chapter in deference to Aboriginal and Torres Strait Islander peoples, for whom the title of 'elder' has such cultural significance. However, the term 'elder abuse' is used widely in the published literature on this topic.

Abuse of older people is defined as any type of abuse or neglect of people aged 65 years or over. Types of abuse include:<sup>8</sup>

- physical
- emotional and psychological
- sexual
- financial
- neglect

The abuse or neglect can be a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.<sup>1</sup>

## Prevalence

The World Health Organization (WHO) estimates the incidence of abuse of older people to be about one in six, and suggests that it is generally a hidden problem.<sup>1</sup>

A 2017 meta-analysis of studies from 28 countries estimated that 15.7% of people aged 60 years and older were subjected to some form of abuse over the past year.<sup>9</sup> There is some evidence that rates of abuse are higher in institutional settings compared with community settings.<sup>1</sup>

Older women experience violence and abuse at two and a half times the rates of older men; 20–25% of these incidents are intimate partner abuse/violence (IPAV), with women particularly vulnerable if their partner has a duty of care relationship with them.<sup>10</sup> IPAV in older people is often a continuation of ongoing abuse; violence against older women exists in the margins between domestic violence and abuse of older people, with neither field adequately capturing the experiences of older women who are victims/survivors of IPAV.<sup>10</sup>

In Australia, the prevalence of abuse in the older population is estimated to be between 2% and 14%, with neglect possibly occurring at a higher rate.<sup>4</sup> However, there has been a lack of research in the areas of prevalence and management. Australia's first national prevalence study of abuse of older people commenced in 2019 and is expected to provide data to guide the [national response to abuse of older people \(https://www.ag.gov.au/sites/default/files/2020-03/National-plan-to-respond-to-the-abuse-of-older-australians-elder.pdf\)](https://www.ag.gov.au/sites/default/files/2020-03/National-plan-to-respond-to-the-abuse-of-older-australians-elder.pdf).

In 2018 there were an estimated 219,000 Australians with dementia, which is a risk factor for abuse.<sup>8</sup> Females, with a prevalence of 1.0%, were more likely than males to have the condition (0.8%).<sup>11</sup>

## Where does abuse happen?

Abuse of older people occurs in all cultural and socioeconomic strata whenever there is an imbalance of power.<sup>1</sup>

Abuse may occur to an elderly person being cared for by family or community services, or in a residential aged care facility or hospital.

Perpetrators can be family members or carers; in the case of older persons in residential care, the abuser may be another resident (sometimes with dementia), a staff member (including volunteers), visitors or family members.

Abuse of older people may occur for many reasons, including individual, relationship, community and sociocultural factors (see below). For example, where a child is caring for a parent, there might be a change in roles where the carer becomes the 'parent' and the 'parent' becomes the 'child'. This increasing dependency, sometimes accompanied by responsive behaviour in people living with dementia, can be frustrating and act as a catalyst for abusive behaviour by the carer, particularly if the carer is insufficiently supported. Relationships Australia provides a [factsheet \(https://www.relationships.nsw.org.au/what-is-elder-abuse-how-to-spot-the-warning-signs/\)](https://www.relationships.nsw.org.au/what-is-elder-abuse-how-to-spot-the-warning-signs/) on how to identify warning signs of abuse of older people.

## Abuse of older people in specific populations

There is a lot of variation in how different cultural groups respond to the abuse of older people. In Australia there is limited research about the abuse and neglect of older people among culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander communities, but there is some evidence to suggest that they are particularly vulnerable to financial abuse.<sup>4</sup>

Aboriginal and Torres Strait Islander people make up 3% of the total population, and about 3% of this population were over 65 in 2017. Aboriginal and Torres Strait Islander people are entitled to aged care services from the age of 50, due to their shorter life expectancy.<sup>4</sup> One in five older Aboriginal or Torres Strait Islander people live in rural and remote Australia with limited services.<sup>12</sup> Much of their care is carried out by family members.<sup>13</sup>

Refer to Case study 15.2 and the chapters on [migrant and refugee communities \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities) and [Aboriginal and Torres Strait Islander peoples \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/aboriginal-and-torres-strait-islander-communities).

## Risk factors

A number of risk factors, associated with both the older person and with their carer/s or other people of trust, can increase the potential for abuse of an older person. These risk factors relate to the individual, relationship, community and society level. Figure 15.1 shows how these risk factors fit into an 'ecological' approach to identifying, managing and preventing abuse of older people.



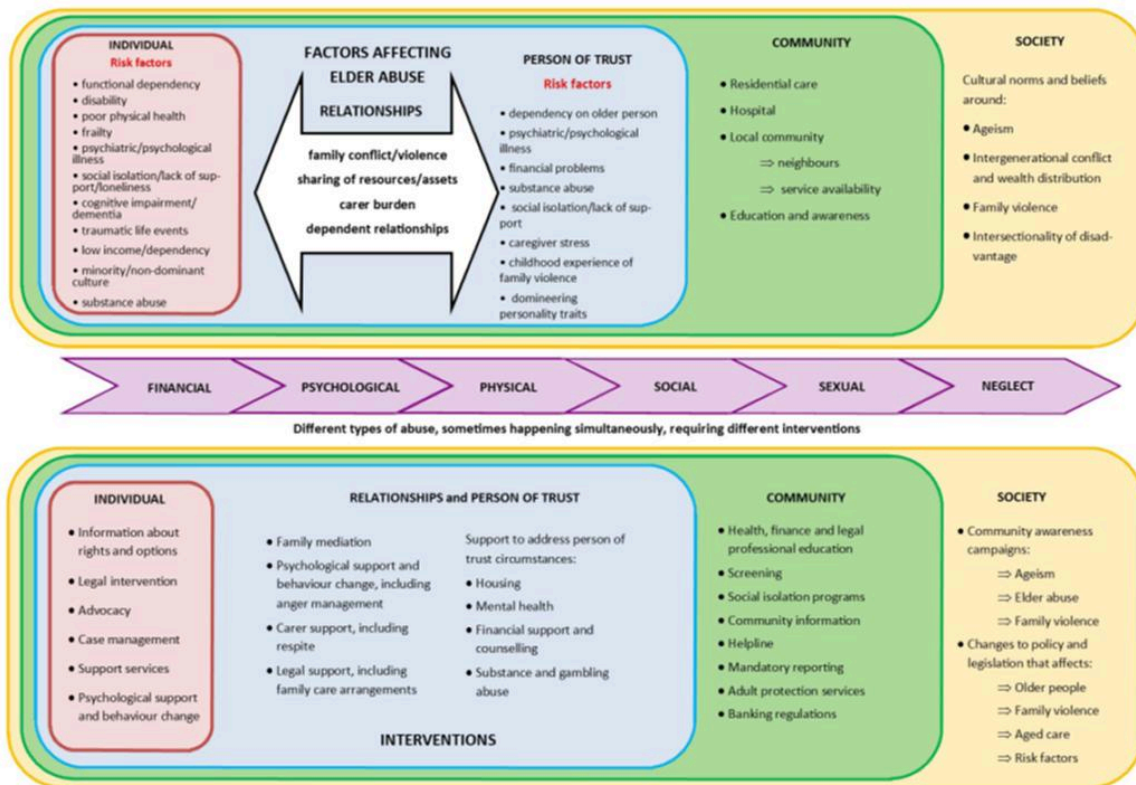


Figure 15.2. Applied ecological approach to abuse of older people<sup>14</sup>

Source: Joosten M, Vratsides F, Dow B. Understanding elder abuse. A scoping study. Melbourne: Melbourne University and National Ageing Research Institute, 2017:1092–110.

An ecological approach can be applied to abuse of older people, where factors at the individual, close relationships, community and societal level all are considered.

### Risk factors associated with the older person

Risks factors at the individual level include:<sup>8,14</sup>

- poor physical health or frailty
- cognitive impairment and dementia
- poor mental health, including psychiatric illness
- being in a shared living situation
- behaviour problems
- functional dependency (needing assistance with activities of daily living)
- low income or wealth
- trauma or past abuse
- ethnicity
- social isolation or loneliness
- lack of social support
- gender<sup>14</sup>

### Risk factors associated with carers and people of trust

There are a number of factors to be aware of in the people who care for an older person or who are in positions of trust that increase the risk of their perpetrating abuse.

Risk factors related to the carer or care relationship include:<sup>8,14</sup>

- caregiver burden or stress
- mental health problems
- alcohol or substance use
- financial dependency on the older person
- a history of trauma or abuse.

### Relationship and community factors

Relationship risk factors include:

- a history of poor family relationships
- unrealistic expectations of caring.

Being in a shared living situation is a risk factor for abuse of older people. However, it is not clear whether spouses or adult children of older people are more likely to be the perpetrators of abuse.<sup>1</sup>

### Institutional risk factors

Within institutions, abuse is more likely to occur where:<sup>1</sup>

- standards for healthcare, welfare services and care facilities for elder persons are low
- staff are poorly trained, poorly remunerated and overworked
- the physical environment is deficient
- policies operate in the interests of the institution rather than the residents.

## In practice

### The role of general practice

GPs, practice nurses and Aboriginal health workers deliver much of the medical aged care in Australia. As such they have a role to play in advocating for prevention of abuse as well as identifying and acting when an older person is involved in abuse and neglect.

Given the prevalence of abuse of older people, how should general practice and Aboriginal health services respond?

First it involves being aware of the possibility of some form of abuse happening to our older patients. A lack of understanding about abuse and neglect of older people by health professionals is one of the key barriers to abuse being identified in older patients. Other barriers include:

- the cost of implementing systems that help protect older people
- inadequate training on the signs of abuse of older people, particularly financial abuse
- limited access to standard screening and assessment tools
- inadequate organisational support to delineate pathways of care and aid the reporting of identified cases of abuse and neglect of older people.

GPs and practices therefore need to address these barriers at an individual and systems level. This might include:

- working out ways of identifying and assessing these patients (refer to 'Identification and assessment' below)
- when a problem is identified, having systems to manage the situation and keep the patient safe
- making the most of the opportunities in general practice where the GP has an ongoing relationship with the patient, and often the carer
- involving practice nurses and/or Aboriginal health workers when developing care plans, diabetic assessments and 75-plus health assessments, to identify possible abuse or neglect of the person being seen; it is important to ensure that everyone who does these plans and assessments understands what to do if abuse is uncovered
- looking for opportunities for ongoing education for GPs, practice nurses and Aboriginal health workers, as this has been shown to improve identification<sup>15</sup>
- helping patients who have cognitive capacity to make plans with supportive family or friends, such as appointing an enduring guardian (or equivalent in each state) and an enduring powers of attorney and writing an advance care directive. These plans can help with the care of older people, especially if they lose capacity to make their own decisions.

## Identification and assessment

Identification of abuse begins with GPs being aware that the older patients we care for could be living in a situation where abuse or neglect is occurring.

It is important to be aware of the risk factors for abuse – in both the patient and their carer or other people of trust (refer to 'Risk factors', earlier in this chapter) – and the signs and symptoms of abuse in older patients (refer to Table 15.1).

**Table 15.1. Possible signs and symptoms of abuse in older people<sup>16</sup>**

General behaviour	<ul style="list-style-type: none"> <li>• Being afraid of one or many person/s</li> <li>• Irritable or easily upset</li> <li>• Worried or anxious for no obvious reason</li> <li>• Depressed, apathetic or withdrawn</li> <li>• Change in sleep patterns and/or eating habits</li> <li>• Rigid posture and avoiding contact</li> <li>• Avoiding eye contact or eyes darting continuously</li> <li>• Contradictory statements not from mental confusion</li> <li>• Reluctance to talk openly</li> </ul>
-------------------	---

**Table 15.1. Possible signs and symptoms of abuse in older people<sup>16</sup>**

Physical abuse	<ul style="list-style-type: none"> <li>• A history of physical abuse, accidents or injuries</li> <li>• Injuries such as skin trauma, including bruising, skin tears, burns, welts, bed sores, ulcers or unexplained fractures and sprains</li> <li>• Signs of restraint (eg at the wrists or waist)</li> <li>• Unexplained behaviour changes suggesting under-medication or over-medication</li> <li>• Unusual patterns of injury</li> </ul>
Sexual abuse	<ul style="list-style-type: none"> <li>• Bruising around the breasts or genital area</li> <li>• Unexplained genital or urinary tract infections</li> <li>• Damaged or bloody underclothing</li> <li>• Unexplained vaginal bleeding</li> <li>• Bruising on the inner thighs</li> <li>• Difficulty in walking or sitting</li> </ul>
Emotional abuse	<ul style="list-style-type: none"> <li>• A history of psychological abuse</li> <li>• Reluctance to talk, fear, anxiety, nervousness, apathy, resignation, withdrawal, avoidance of eye contact</li> <li>• Rocking or huddling up</li> <li>• Loss of interest in self or environment</li> <li>• Insomnia/sleep deprivation</li> <li>• Unusual behaviour or confusion not associated with illness</li> </ul>
Economic abuse	<ul style="list-style-type: none"> <li>• History of fraudulent behaviour or stealing perpetrated on the patient</li> <li>• Lack of money to purchase medication or food</li> <li>• Lack of money to purchase personal items</li> <li>• Defaulting on payment of rent or residential aged care facility fees</li> <li>• Stripping of assets from the family home or use of assets for free</li> </ul>
Neglect	<ul style="list-style-type: none"> <li>• A history of neglect</li> <li>• Poor hygiene, bad odour, urine rash</li> <li>• Malnourishment, weight loss, dehydration (dark urine, dry tongue, lax skin)</li> <li>• Bed sores (sacrum, hips, heels, elbows)</li> <li>• Being over-sedated or under-sedated</li> <li>• Inappropriate or soiled clothing, overgrown nails, decaying teeth</li> <li>• Broken or missing aids such as spectacles, dentures, hearing aids or walking frame</li> </ul>

When assessing a patient for possible abuse or neglect:

- establish the patient’s capacity to make decisions and try only to ask about abuse when the competent patient is alone
- if the person has lost capacity, help may need to be sought from the person legally responsible for giving consent for their healthcare – if this person is the potential abuser, then seek help from the appropriate advocacy source in your state or territory (refer to Resources)
- consider using the [Elder Abuse Suspicion Index \(EASI\) questionnaire \(https://www.ageingdisabilitycommission.nsw.gov.au/download?file=666421\)](https://www.ageingdisabilitycommission.nsw.gov.au/download?file=666421) if the patient is competent
- talk to the carer, unless this person is thought to be the perpetrator – identify someone else if possible
- be aware that the older person may be reluctant to disclose and even more reluctant to seek help because of the perceived impact on the relationship with the family
- take a detailed medical history, geriatric assessment and documentation of injuries and other issues.

<b>Tool 15.1 EASI questions</b>			
Q.1-Q.5 asked patient; Q.6 answered by doctor within the last 12 months			
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?	YES	NO	Did not answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you want to be with?	YES	NO	Did not answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5. Has anyone made you feel afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

**Table 15.2. Elder Abuse Suspicion Index (EASI) questions** When asking patients about possible abuse, be aware that older adults may not disclose or may be reluctant to disclose abuse because of a number of barriers, including:

- a lack of understanding about what constitutes abusive behaviour and therefore an inability to recognise when it is occurring
- fear of retaliation from the perpetrator
- feelings of guilt if the perpetrator is a child
- a desire to protect the perpetrator from negative consequences that may result if the abuse was reported.

## Management

More evidence is needed to know what works to prevent or stop the abuse of older people.<sup>14</sup> However, family mediation, as well as multidisciplinary approaches (involving counselling, legal interventions, medical care and financial controls, or restrictions on how an older person's money can be used by those who have power of attorney) show promise.<sup>14</sup>

Regardless, the ongoing safety of the patient is paramount. This is important whether the abuse is a form of IPAV or abuse in other circumstances.

If it is decided that a patient is at risk of abuse and/or neglect, a decision needs to be made about the patient's safety.

### **If the patient is assessed as at immediate risk:**

- the person needs to be transferred to a hospital or aged care facility, after discussions with the patient and any supportive family
- where the patient has been assaulted or sexually abused, the police will need to be notified.

### **If the patient is not assessed as at immediate risk – consider the following options:**

- discuss with a carer who is not involved in the abuse and work out how to keep the older person safe and cared for without repercussions from the perpetrator (in cases where there is a non-abusive carer)
- discuss the situation with the relevant helpline in your state or territory
- discuss the case with another GP or a geriatrician
- make a referral to a geriatrician or organise a telehealth consultation
- consider respite care while the situation is being investigated and resolved
- if the patient is in an aged care facility, speak with the facility manager.

## Reporting and documenting abuse of older people

### Reporting abuse

A range of reporting mechanisms may be appropriate for reporting abuse, depending upon circumstances, particularly, the type of abuse, the location and the suspected abuser.

### In cases of a criminal nature

If there is suspicion that a crime has occurred, or if protection is required for the victim/survivor or others, notify the police.

### In cases relating to professional malpractice

The [Australian Health Practitioners Regulation Agency \(http://www.ahpra.gov.au\)](http://www.ahpra.gov.au) has the power to investigate complaints relating to providers of health services, such as GPs, nurses and allied health professionals, and should be contacted in professional malpractice cases relating to residential aged care facilities. The [Australian Government Department of Health Office of Aged Care Quality and Compliance \(http://www.health.gov.au/oacqc\)](http://www.health.gov.au/oacqc) addresses standards of care in residential aged care facilities and can be contacted regarding cases of known or suspected abuse occurring within a residential aged care facility.

### Cases requiring guardianship intervention

If a case relates to an older adult where financial abuse is happening or the person has lost capacity to make decisions (eg due to dementia) the matter should be referred to the Public Guardian (or your state or territory equivalent) for investigation or advocacy. (Refer to Table 20.4 in [Chapter 20: Violence and the law \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/system-issues/violence-and-the-law).)

## Documentation

Any report or suspicion of abuse should be clearly documented, and include quotes from the patient, and others, and photographs of injuries. Documentation in residential aged care facility progress notes may be inappropriate if you know, or suspect, the abuse is being perpetrated by an employee. In this instance, progress notes should be kept off premises in the GP's patient files.

## Case study 1: Mr White

Mr White is an 81-year-old man whose son, Gary, has moved in to live with him after his divorce some months ago.

Mr White's GP notices that he is losing weight and has some bruising. Mr White says that he has stopped going to bowls and helping with Meals on Wheels, and he appears to be becoming depressed. This alerts the GP to the fact that something may be happening at home.

The GP uses [Elder Abuse Suspicion Index \(EASI\) questions \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/appendices/appendix-6-elder-abuse-suspicion-index-easi\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/appendices/appendix-6-elder-abuse-suspicion-index-easi) (refer to earlier in this chapter) and Mr White answers 'yes' to Question 4, which includes financial abuse. However, Mr White is reluctant to talk in much detail about what was happening with his son.

The GP calls the elder abuse helpline (refer to Resources for specific information for each state and territory) to discuss the situation and what options are available, and finds that very supportive and helps to work out a plan. After further discussions with Mr White, the GP refers him for an aged care assessment. She also refers him to the Guardianship Tribunal in her state, who interview Mr White and his son. They help direct Mr White to obtain financial management and to understand his financial rights while making very clear to Gary that he is not entitled to use Mr White's money or to harass him about money.

Once Gary lost access to money, he moved out and Mr White, with ongoing help and support, resumed many of his previous activities and was no longer depressed.

## Case study 2: Stephanie

Stephanie is an older Aboriginal woman with chronic obstructive airways disease. She lives on a Homeland, where she is cared for by her granddaughter. There is some concern about the care she is receiving, as she has needed to be brought into the main centre in town on a number of occasions. She receives good medical care in the main centre and lives with her daughter as her carer when in town.

After she is brought to the main centre again, it becomes clear that she is not receiving her medication on the Homeland. However, Stephanie does not want to remain in town, and wants to return to the Homeland to live and to receive care.

While she is in town, a family conference is arranged, including the Aboriginal health worker, to discuss the situation and to try to resolve what appears to be a lack of care and a carer's pension being received without the care being given.

The family agreed to discuss this with the granddaughter and after the family conference there will need to be follow-up by the medical team that visits the Homeland.

## Case study 3: Winnie

Winnie, aged 69 years, is fiercely independent and lives by herself in a small country town. She has been a patient of yours for a number of years. She has severe arthritis and requires more and more help with the activities of daily living. Even with regular visits from community services, she finds it difficult to cope, but she is adamant that she doesn't want to go to the regional hospital. Eventually she moves in with her daughter and husband and their young sons. The neighbours begin to complain about the noise. Since Winnie has moved in, there is not much space in the house and the children are fighting more often, shouting and generally playing up. Winnie's daughter receives no help from her other sisters and is expected to cope with the increased washing, cooking and other duties without complaint.

When you see Winnie, you notice that she has marks and bruises on her arms and upper torso. These are explained away by her daughter, who says that she is becoming clumsier and keeps knocking into things. Winnie just shakes her head and says nothing, even when you speak to her in private. You are worried about pressing the issue because your clinic is the only one in town and you do not want to upset anybody.



**Diagnosis:** GPs need to acknowledge that abuse may be happening in this situation. The Elder Abuse Suspicion Index can help with an assessment.

**Management:** You may involve the home nursing service, home help, day centre, carer support groups or other local services to relieve the pressure on this family. The GPs can ring the elder abuse helpline (or equivalent) in the state. Another alternative is to seek the help of an aged care assessment team if available. Respite care or admission to a residential aged care facility are other options, depending on what is available and what Winnie is willing to accept.

**Outcome:** Winnie remains in her daughter's house with some extra aids – for example, a toilet raise, home help for bathing, respite care – which allows her daughter time out of the house, and Winnie attends the day centre once a week. It is unclear that this will alleviate the situation, so it is important to maintain a close watch on Winnie and her daughter, if possible weekly, for a time.

## References

- World Health Organization. Elder abuse 2020. Geneva: WHO, 2020.
- Royal Commission into Aged Care Quality and Safety. Final report: care, dignity and respect. Volume 1. Summary and recommendations. Canberra: Commonwealth of Australia, 2021.
- Royal Commission into Aged Care Quality and Safety. Interim report: Neglect. Canberra: Commonwealth of Australia, 2019.
- [Australian Institute of Health and Welfare. Australia's welfare 2019 data insights. Australia's welfare series no. 14, cat. no. AUS 226. Canberra: AIHW, 2019: \(http://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2019-data-insights/contents/summary\)](http://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2019-data-insights/contents/summary) [Accessed 24 August 2021].
- [Australian Institute of Health and Welfare. Australia's welfare 2017: 5.1 Ageing and aged care. Australia's welfare series no. 13, cat. no. AUS 214. Canberra: AIHW, 2017 \(http://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2019-data-insights/contents/summary\)](http://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2019-data-insights/contents/summary) [Accessed 24 August 2021].
- Australian Law Reform Commission. Elder abuse—A national legal response. ALRC Report 131. Canberra: Commonwealth of Australia, 2017. [Accessed 24 August 2021].
- World Health Organization. WHO guidelines on integrated care for older people. Geneva: WHO, 2017. [Accessed 24 August 2021].
- Johannesen M, LoGiudice D. Elder abuse: A systematic review of risk factors in community-dwelling elders. *Age Ageing* 2013 May;42:292–98. [Accessed 24 August 2021].
- Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Elder abuse prevalence in community settings: A systematic review and meta-analysis. *Lancet Glob Health* 2017;5:e147–56. [Accessed 24 August 2021].
- Crockett C, Brandl B, Dabby FC. Survivors in the margins: The invisibility of violence against older women. *J Elder Abuse Negl* 2015;27:291–302. [Accessed 24 August 2021].
- [Australian Bureau of Statistics. Dementia in Australia. Canberra: ABS, 2020: \(http://www.abs.gov.au/articles/dementia-australia\)](http://www.abs.gov.au/articles/dementia-australia) [Accessed 19 April 2021].
- [Australian Bureau of Statistics. Estimates and projections, Aboriginal and Torres Strait Islander Australians. Canberra: ABS, 2019: \(http://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/la-test-release\)](http://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/la-test-release) [Accessed 24 August 2021].
- Australian Institute of Health and Welfare. Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over: 2019—In brief. Cat. no. IHW 207. Canberra: AIHW, 2019. [Accessed 24 August 2021].
- Joosten M, Vrantides F, Dow B. Understanding elder abuse. A scoping study. Melbourne: Melbourne University and National Ageing Research Institute, 2017:1092–110. [Accessed 24 August 2021].
- Mohd Mydin FH, Wan Yuen C, Othman S, et al. Evaluating the effectiveness of I-NEED Program: Improving nurses' detection and management of elder abuse and neglect – A 6-month prospective study. *J Interpers Violence* 2020. doi: 10.1177/0886260520918580 [Accessed 24 August 2021].

16. Yaffe MJ, Tazkarji B. Understanding elder abuse in family practice. *Can Fam Physician* 2012;58:1336–40. [Accessed 24 August 2021].

## ***Specific populations***

# Aboriginal and Torres Strait Islander communities

'Dadirri (deep listening) –recognises the deep spirit within us' **Miriam-Rose Ungunmerr-Bauman Northern Territory Elder and Older Australian of the Year**

## Key messages

- Health professionals are responsible for ensuring they are aware of the impact colonisation has on creating mistrust in health services. The aim of care is for a culturally safe approach (ask the patient what feels like safety for them), which includes the development of rapport and a respectful relationship.<sup>1,2</sup>
- Addressing family abuse and violence in Aboriginal and Torres Strait Islander communities involves deep listening (known as Dadirri [*da-did-ee*], from the Ngan'gikurunggurr and Ngen'giwumirri languages of the Daly River region in the Northern Territory), ensuring safety and helping patients contemplate how they will begin their healing process and find support.<sup>2-4</sup>
- The management of family abuse and violence needs to address the family as a whole and whenever safe to try and keep the family together. This will involve the recognition of trauma and loss as contributing to family abuse and violence (FAV). Recognising that culture is a protective factor and involvement of Elders in healing when appropriate can be very helpful in finding meaningful community solutions.<sup>2,5-7</sup>
- There is an expectation that healthcare professionals will offer safety from racist attitudes, institutional control and from issues with confidentiality in tight-knit communities.<sup>2</sup>
- There is a need to understand the ideas and beliefs each worker brings to FAV response. For many health workers addressing FAV in Aboriginal and Torres Strait Islander communities, it is a cross-cultural experience. Preconceived ideas may be a facilitator or a barrier to understanding and empathy, and may ultimately impact the health worker's ability to facilitate healing in Aboriginal and Torres Strait Islander peoples.<sup>2</sup>

## Recommendations

Healthcare professionals need to demonstrate cultural awareness and a commitment to understanding the historical context that influences family abuse and violence.

**(Practice point: consensus of experts)**

Practices should provide a safe environment that addresses the barriers faced by Aboriginal and Torres Strait Islander people who require support for family abuse and violence.

**(Practice point: consensus of experts).**

## Clinical context

### Aboriginal and Torres Strait Islander family abuse and violence in context

This chapter discusses Aboriginal and Torres Strait Islander FAV. In this chapter we refer to the commonly used Australian Human Rights Equality Commission definition of family violence because it is inclusive of cultural and spiritual abuse:<sup>8</sup>

‘Family violence involves any use of force, be it physical or non-physical, which is aimed at controlling another family or community member and which undermines that person’s well-being. It can be directed towards an individual, family, community or particular group. Family violence is not limited to physical forms of abuse, and also includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous families and communities.’

It is important to recognise that FAV is not part of Aboriginal and Torres Strait Islander culture.<sup>5,9</sup> Aboriginal and Torres Strait Islander FAV is complex, and is influenced by historical factors inherent with European settlement.<sup>5</sup> (Figure 16.1).



Figure 16.1. Elements contributing to higher rates of family abuse and violence in Aboriginal and Torres Strait Islander communities

It is accepted that high levels of FAV in Aboriginal and Torres Strait Islander communities are attributable to the many interrelated elements that are associated with colonisation, kinship disruption, disconnection from land and culture, and constant trauma.<sup>5</sup>

Factors such as unemployment, poverty and over-incarceration of Aboriginal and Torres Strait Islander peoples also contribute to higher rates of violence.<sup>9</sup> Furthermore, trauma is complex for Australia’s Indigenous populations, particularly when they have been denied the ability to grieve and heal for a long time.<sup>10</sup>

To learn more about intergenerational trauma, watch this [short video from the Healing Foundation \(http://healingfoundation.org.au/intergenerational-trauma/\)](http://healingfoundation.org.au/intergenerational-trauma/).

One form of violence stemming from colonisation is lateral violence. The term ‘lateral violence’ describes the way people in positions of powerlessness, covertly or overtly, direct their dissatisfaction ‘inward’: towards each other, towards themselves, and towards less-powerful family members – older people, women and especially children.<sup>11</sup> Lateral violence occurs worldwide in all minority communities. It has grown in prominence in Aboriginal and Torres Strait Islander communities in recent years.

Healthcare providers such as GPs and practice nurses need to understand that the removal of children and many subsequent policies have created mistrust of governments, policy-makers and the healthcare profession.<sup>5,9</sup> Although all FAV victims/survivors have reasons for avoiding help-seeking, Aboriginal and

Torres Strait Islander peoples have additional reasons than non-Indigenous Australians.<sup>4,12</sup> Barriers specific to Aboriginal and Torres Strait Islander peoples include shame, fear and culturally inappropriate service provision.

Recent evidence suggests that Indigenous peoples (globally) report poor experiences with healthcare providers when accessing care for FAV.<sup>2</sup> A lack of cultural awareness, problems with communication, mistrust and perceiving the environment to be unsafe contribute to the poor experiences and expectations reported.<sup>2</sup>

GPs, primary healthcare teams and Aboriginal health services have a role in changing this outcome.

## Prevalence

FAV in Aboriginal and Torres Strait Islander communities across Australia is disproportionately high in comparison to the non-Indigenous Australian population.<sup>13,14</sup> Additionally, Aboriginal and Torres Strait Islander women are more likely to experience serious forms of violence such as physical assault.<sup>14</sup> FAV is the biggest single factor contributing to the disparities in health outcomes between Aboriginal and Torres Strait Islander women and non-Indigenous women.<sup>13</sup> An example of this is higher rates of hospitalisation: in some parts of Australia, 73% of mothers admitted to hospital because of FAV were identified as Aboriginal.<sup>15</sup>

Despite the higher rates of violence, the 2014–15 National Aboriginal and Torres Strait Islander Social Survey found that only one in four women who are physically injured seek help from a healthcare professional.

FAV is also responsible for 34% of the total fatal burden observed in Aboriginal and Torres Strait Islander women, a rate that is 10% higher than women who do not identify as Indigenous.<sup>16</sup>

Although the main victims/survivors of FAV are women and children, Aboriginal and Torres Strait Islander men are also at increased risk of being victims of family violence, and are nine times more likely than non-Indigenous counterparts to be hospitalised from family-violence related assault (refer to Table 16.1).<sup>17</sup>

**Table 16.1. Male hospitalisation rates for family violence-related assaults, by Indigenous status, 2014–15<sup>17</sup>**

Age group (years)	Rate of assaults (per 100 000 population)	
	Indigenous	Non-Indigenous
0–14	42.1	5.1
15–24	166.8	11.4

**Table 16.1. Male hospitalisation rates for family violence-related assaults, by Indigenous status, 2014–15<sup>17</sup>**

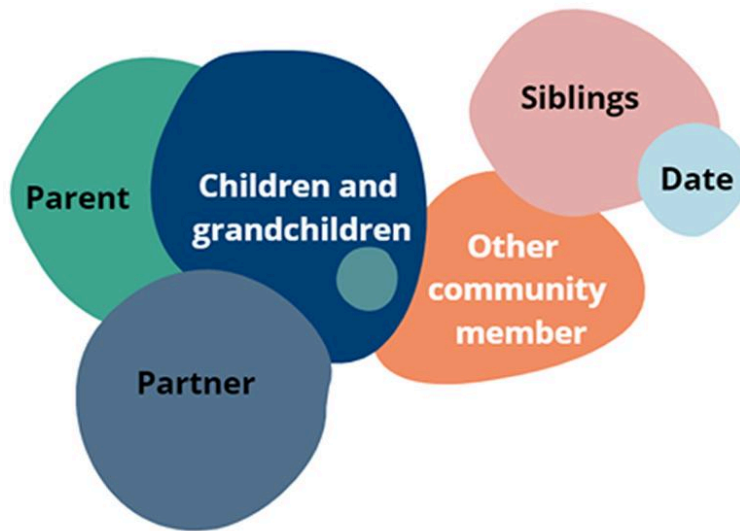
25–34	415.7	13.6
35–44	431.8	12.7
45–54	285.2	10.4
55–64	106.2	7.5
65+	47.4	6.0

Source: based on Steering Committee for the Review of Government Service Provision data, *Overcoming Indigenous Disadvantage 2016*

Much of the violence perpetrated against Aboriginal and Torres Strait Islander women comes from men from a broad range of backgrounds; it is not always perpetrated by Aboriginal and Torres Strait Islander men.

The relationships of the people who are perpetrating the abuse and violence in Aboriginal and Torres Strait Islander families can be complex. As shown in Figure 16.2, people who use or experience FAV can be family members of all sorts, other community members, or even a date.





*Figure 16.2. Perpetrators and victims/survivors of Aboriginal and Torres Strait Islander family abuse and violence*

## In practice

### Concepts of health

When working with Aboriginal and Torres Strait Islander people, the issues of family abuse and violence are important because their view of health is holistic; it is inclusive of the body and the mind, as well as cultural, spiritual, country (land), environmental and community connection and wellness (Figure 16.3).<sup>18</sup> All these factors, in turn, can impact a person's health outcomes and, more immediately, impinge on their presentations in primary care settings.

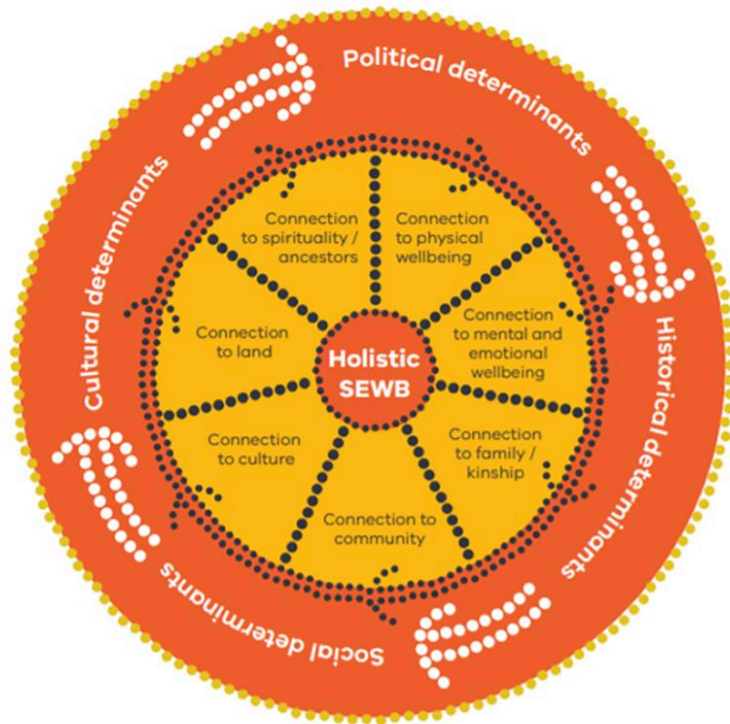


Figure 16.3. Determinants of social and emotional wellbeing<sup>18</sup>

Awaiting permission from: Gee G, Dudgeon P, Schultz C, et al. Aboriginal and Torres Strait Islander social and emotional wellbeing. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice 2014;2:55–68.

The next section looks at some of the important elements to consider in GPs' approach to caring for someone who is experiencing FAV.

## The CATCH model

The CATCH (commitment, advocacy, trust, collaboration, health system) model (Figure 16.4) provides a framework for approaching FAV in practice.

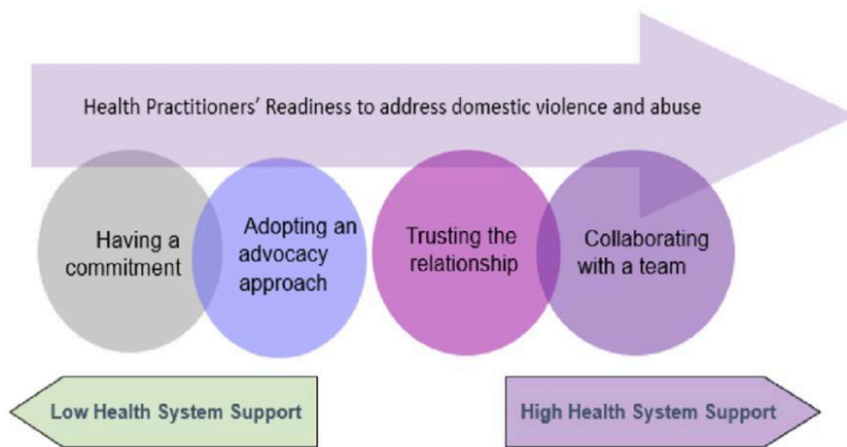


Figure 16.4. The CATCH model

In practice, it is important to consider how you can apply the CATCH principles while also meeting the expectations that Aboriginal and Torres Strait Islander peoples have of their healthcare professionals when seeking support for FAV. Three Indigenous-identified expectations include that practitioners:

1. demonstrate cultural awareness
2. work to establish a trusting relationship
3. provide strength though safety.<sup>19</sup>

The CATCH principles fit into these expectations as follows:<sup>2</sup>

- Having a **commitment** aligns with expectations that practitioners demonstrate cultural awareness, which is gained from a commitment to training and understanding the historical context of Aboriginal and Torres Strait Islander FAV.
- Adopting an **advocacy** approach is clearly linked with Aboriginal and Torres Strait Islander people’s expectations that practitioners will keep them safe from inappropriate care and institutional control, which can be done by advocating among colleagues and more broadly in society.
- **Trust** is something that Aboriginal and Torres Strait Islander peoples would like to experience in the relationship and comes from developing a rapport, slowly demonstrating an investment in the relationship, and the ability to have a yarn with the practitioner.
- **Collaborating** with a team is closely associated with safety because collaborating with team members will offer practitioners a chance to share their new knowledge with others, advocate for better care outcomes, and contribute to policy and practice guidelines that will impact Aboriginal and Torres Strait Islander peoples.
- **Health system** support recognises that organisations need to support practitioners in the work

they do with Aboriginal and Torres Strait Islander peoples by creating learning opportunities, encouraging professional development in the cultural space, and involving Aboriginal and Torres Strait Islander input into workplace policies and procedures.

Refer also to Figure 16.5.

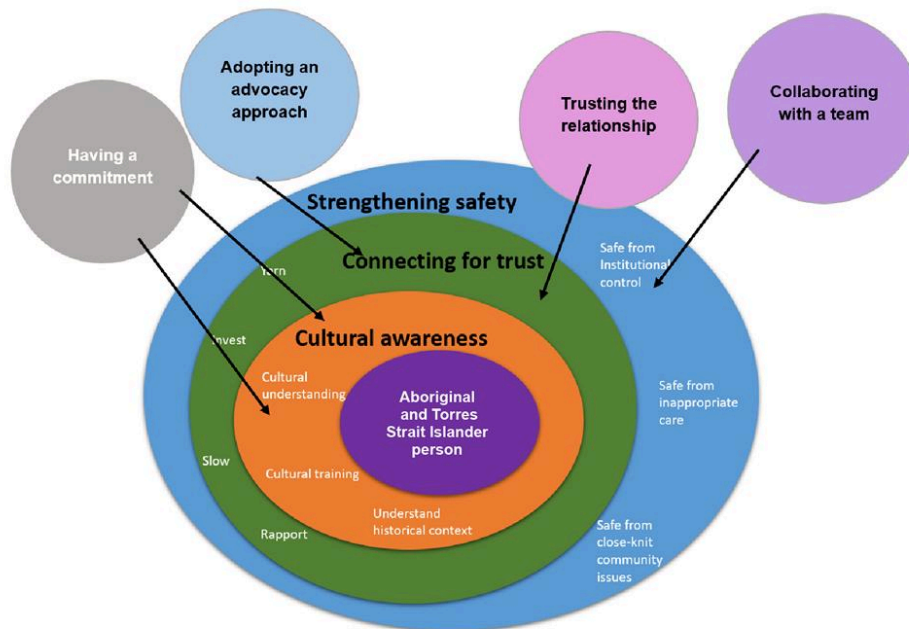


Figure 16.5. Applying the CATCH model to Aboriginal and Torres Strait Islander people's expectations of care

## Responding to Aboriginal and Torres Strait Islander family violence as a practice

As a practice, it is important to ensure that all team members are sensitive to the issue of FAV. Everyone working in the practice team needs to feel confident in their knowledge about how they can support patients and each other if FAV is identified. Following are some whole-of-practice initiatives that may improve awareness and confidence within the practice team.

- Bring the entire team together to discuss FAV to demonstrate its importance to everyone.
- Organise training so that all team members feel equipped to respond to FAV and expand their cultural awareness.
- Identify roles and clearly outline what every staff member is safe to do and the response that falls within their scope of practice.
- Identify strategies the team can implement to support each other and nominate 'champions' who will be responsible for maintaining a focus on the area.
- Display posters and provide resources that promote keeping families together and support for FAV so patients know they can discuss these issues.

- Demonstrate that the practice embraces culture by celebrating Aboriginal and Torres Strait Islander peoples. This can be done through clearly displaying Aboriginal and Torres Strait Islander flags, investing in local Aboriginal art for the waiting rooms, and promoting partnerships with Aboriginal organisations.
- Let patients know if the team has Aboriginal or Torres Strait Islander staff members so there is an option to speak to someone who has cultural knowledge.

## Working with individual patients and their families

Healthcare workers and non-clinical team members can benefit from incorporating the following elements into their practice when responding to Aboriginal and Torres Strait Islander patients experiencing FAV.

- Demonstrate cultural awareness through an understanding of the history of the Aboriginal Country you practise on and familiarise yourself with their values, beliefs and traditions.
- Establish a rapport with individuals and their families. Work on gaining trust through having a 'yarn' and getting to know the individual. It is acceptable to let Aboriginal and Torres Strait Islander people know that you have limited knowledge about their cultures but are willing to learn.
- Establish a safe space for the individual to slowly learn to trust you. Reassure the client that their needs will be prioritised and that you intend on taking an approach that values their connection to family, culture, and country.
- Engage in *dadirri* – a process of deep listening – in an attempt to build the relationship and enhance feelings of trust. Aboriginal and Torres Strait Islander people often prefer to be heard than to see that a healthcare practitioner is taking notes.
- Ask about fears or barriers to help-seeking that may deter the individual from pursuing support.
- As with any other client, allow the individual to determine their own needs to demonstrate person-centred care. Encourage self-determination by encouraging the individual to contemplate their priorities for the future.
- Following the establishment of trust, when working with women during antenatal period, it is important to ask all patients about FAV because of the elevated risk during this time.
- Link and liaise with Aboriginal health workers, Aboriginal health organisations and specialist FAV services where the client permits you to do so (refer to Box 16.1).
- Encourage healing by working with the individual to identify their strengths, their preferences for healing, and to determine who could help them in their healing journey.
- Advocate for resources for Aboriginal and Torres Strait Islander patients and investments in developing the Aboriginal health workforce.

### **Box 16.1. Involving Aboriginal and Torres Strait Islander health workers and practitioners**

Renee Owen (Chair, AHPRA Aboriginal and Torres Strait Islander Health Practice Board of Australia and Director, Aboriginal Health Services, Barwon Health) has some advice to share for those who are unsure about whether to involve Aboriginal and Torres Strait Islander health workers and practitioners in care:

‘Aboriginal and Torres Strait Islander health workers and practitioners are a culturally safe ready workforce with the skills and knowledge to apply a cultural lens in servicing and supporting Aboriginal and Torres Strait Islander people who experience family violence. The Aboriginal and Torres Strait Islander health worker and practitioner is well-positioned to strengthen relationships between Aboriginal and Torres Strait Islanders and non-Indigenous service providers and organisations during this time.’

## **Working with communities**

Healthcare workers and non-clinical team members can also assist individuals, families and communities experiencing FAV by engaging in the following activities.

- Encourage community control and determination by supporting Aboriginal community-controlled health organisations and communities.
- Provide culturally safe, respectful services to the community but also recognise when Aboriginal organisations may be better positioned to provide the care/share the care with your practice.
- Enable the embedding of healing and protective factors into practice by acknowledging the role that culture, spirituality and connection has in recovery and healing.
- Work on Aboriginal and Torres Strait Islander community engagement, and learn more about the country your practice occupies. Develop partnerships with Aboriginal and Torres Strait Islander service providers, organisations and communities.

To learn more about how you can make healthcare accessible, acceptable and respectful for Aboriginal and Torres Strait Islander peoples, you may wish to view the [short video from SA Health on a cultural respect framework](https://www.youtube.com/watch?app=desktop&v=D6TcM9ETfsY&feature=emb_logo). ([https://www.youtube.com/watch?app=desktop&v=D6TcM9ETfsY&feature=emb\\_logo](https://www.youtube.com/watch?app=desktop&v=D6TcM9ETfsY&feature=emb_logo))

## **Services for men**

Aboriginal and Torres Strait Islander people recognise that it is the entire family who is impacted by FAV. Aboriginal and Torres Strait Islander men experience FAV at much higher rates than non-Indigenous Australian men. In addition, some Aboriginal and Torres Strait Islander men have witnessed or used violence behaviours in their lifetime. Regardless of the type of exposure men have had to FAV, there is a need for FAV responses to include men. To ensure that you are meeting the needs of Aboriginal and Torres Strait Islander men, consider the following inclusive practices:

- Provide a whole-of-family response that considers the needs of each family member, regardless of their role in FAV. This will involve planning so that one practitioner is not responsible for looking after all members of the family. There should be a plan whereby all staff are able to support each other to support the family.
- Encourage men to seek out Aboriginal men's groups, including men's sheds and (if required) Indigenous-specific behavioural change programs.
- Encourage men to identify their strengths and the strength they receive from culture and identity.
- Acknowledge that perpetrators of abusive behaviours need to heal also; it is not just those who experience or witness violence who require a journey towards healing.
- Consider some of the factors that may have contributed to the use of violence when responding to perpetrators. Be accepting and supportive of the person but clear that the abusive behaviour is not acceptable. Helping them deal with those factors instead of using abusive behaviours is an important aspect of care.
- Consider referral or encourage self-referral to [Dardi Munwurro \(https://www.dardimunwurro.com.au/\)](https://www.dardimunwurro.com.au/), which delivers a range of family violence, healing and behaviour change programs and services to Aboriginal families and communities. This organisation now has a 24-hour Aboriginal men's crisis line 1800 435 799.
- Provide ongoing assessment of the entire family with a focus on healing, strengthening family capacity, keeping family together and encouraging engagement of all family members in promoting family cohesion.

## Case studies: Lisa, Trevor and Angus

Contemplate the following situations and reflect on whether FAV could be an underlying contributor for presentation. Refer to Figure 16.4. Remember that all members of the practice team can work towards creating an environment that facilitates an appropriate response to the scenarios.

**Lisa**, an Aboriginal woman aged 27 years, attends your practice. She is experienced sleeping difficulties and has recently been diagnosed with depression.

**Trevor**, an Aboriginal man aged 61 years, presents with poor liver function related to longstanding drug and alcohol issues.

**Angus**, a Torres Strait Islander boy aged 12 years, is brought to your clinic because of poor behaviour at school.

- What prompts you to explore the possibility that FAV is occurring in each of these situations?
- How would you respond?
- What actions could you take to initiate discussions?

**Lisa** is experiencing FAV. She has been with her non-Indigenous partner since they were teenagers, and the first five years of their relationship were wonderful. In the last few – particularly since the birth of their first child – Lisa's partner has been verbally abusive, intolerant of her lack of sex drive, and is reluctant for Lisa to spend time with her family.

**Trevor** is not currently experiencing FAV or using abusive behaviours, but admits to experiencing it over many years as a child who was removed from his parents. Spending two years on a mission and then three years with a non-Indigenous family, he had a troubled upbringing and never saw his father again after being removed.

**Angus** has been having a hard time at school since one of his teachers stated in front of the class that he must only be 'part Aboriginal' because he is not dark skinned. Since that day, Angus has also been getting angry at home, especially towards his sisters, who seem to be comfortable with their own identity and connection to culture.

Contemplate the following. How will it inform your practice at the individual and family level?

- The story about Lisa helps us to see how FAV can start in pregnancy and can present in many ways. It reminds us that depression is a frequent presentation of FAV. Lisa may not share this information unless she is asked at a time when she feels safe and comfortable to talk. She may not recognise verbal abuse, sexual coercion and isolation from family as forms of FAV – she may say there is no violence. However, there is abuse and this is likely to be contributing to her depression.
- Trevor's story is about being an adult survivor of child abuse. He is likely to have had adverse childhood experiences that will have impinged on his health and wellbeing and his relationships as an adult. Reconnection to family and culture may help with his healing. He may or may not wish to talk about what happened as a child.
- Angus's story is about racism and the abuse of power and its effects. Angus is having difficulty knowing how to manage this situation and how he feels, which is completely understandable. He is angry and dealing with this by becoming involved in lateral violence. It may help Angus to have the racism identified by the healthcare provider, who can also encourage his sense of self and cultural connections.



### Box 16.2. Focus on Lisa

Lisa's long-term partner is perpetrating verbal, sexual, social and psychological abuse. Lisa tells you that every second Wednesday (payday) tends to be a day where drinking occurs and her partner becomes verbally abusive. He has never hit Lisa or their child, but Lisa has been verbally abused in front of the child during these times and is worried about the violence escalating.

She acknowledges that taking the child to Grandma's on a Wednesday for a sleepover is an effective tool for minimising exposure to her child, but she has not thought about strategies for keeping herself safe.

She is not interested in separation from or removal of her partner because she loves him, they have been together for a long time and because of their child.

Lisa is reluctant to speak to the Indigenous FAV worker, who is her cousin.

- How could you make sure that Lisa keeps communicating with you about her concerns?
- How can you encourage Lisa to begin to prioritise her own safety needs?
- What resources could you offer/referrals could you make safely for Lisa at this time?
- How will you prioritise your own self-care while caring for Lisa?

## Summary

Colonisation and ongoing racism contribute to the higher incidence of FAV seen in Aboriginal and Torres Strait Islander communities. All practitioners are encouraged to increase their understanding about the influence colonisation continues to have on generating mistrust in healthcare practitioners and organisations. Doing so creates an opportunity to provide culturally appropriate and safe care.

In attempting to provide appropriate and culturally safe care, the practitioner needs to demonstrate a willingness to invest in the relationship, have a yarn and display deep listening. Aboriginal and Torres Strait Islanders prioritise keeping the family together and they also recognise that FAV has an impact on the whole family. Therefore, it is essential that a whole-of-family response is included in care provision, and that all family members are encouraged to begin a healing journey from their experiences with FAV. To facilitate this journey, the practice team can work in partnership with Aboriginal and Torres Strait Islander health workers and practitioners to improve the likelihood that cultural connection is used as a strength for healing.

## Resources

- [WELLMOB: healing our way \(https://wellmob.org.au/\)](https://wellmob.org.au/) – brings together online resources made

by and for Aboriginal peoples with a focus on social and emotional wellbeing.

- [NATSILS \(http://www.natsils.org.au/Home.html\)](http://www.natsils.org.au/Home.html) – the national peak body for Aboriginal and Torres Strait Islander legal services.
- *The little red yellow black book: An introduction to Indigenous Australia* (<https://aiatsis.gov.au/publication/34972>), Bruce Pascoe, Aboriginal Studies Press, 2012.
- *Dark emu* (<https://www.magabala.com/products/dark-emu>), Bruce Pascoe, Magabala Books, 2014.

## Aboriginal and Torres Strait Islander resources by state/territory

### New South Wales

- [The Redfern foundation \(http://www.redfernfoundation.org.au/index.html\)](http://www.redfernfoundation.org.au/index.html) – offers women and men's programs to develop strong communities.
- [Wirringa Baiya \(https://www.wirringabaiya.org.au/\)](https://www.wirringabaiya.org.au/) – a statewide community legal centre for Aboriginal peoples.

### Northern Territory

- [Tangentyere Family Violence Prevention Program \(https://www.tangfamilyviolenceprevention.com.au/\)](https://www.tangfamilyviolenceprevention.com.au/) – offers support, referrals, resources group and individual sessions for men, women and young people impacted by family violence.
- See NPY Women's Council (South Australia)

### Queensland

- [Queensland Indigenous Family Violence Legal Service \(http://www.qifvls.com.au/\)](http://www.qifvls.com.au/) – provides culturally appropriate legal support for 50 Aboriginal communities.
- [DV Connect \(https://www.dvconnect.org/\)](https://www.dvconnect.org/) – provides services for women and men and relevant printed resources.

### South Australia

- [Ninko Kurtangga Patpangga \(https://www.womenssafetyervices.com.au/index.php/about/services/32-ninko-kurtangga-patpangga-ninko-the-southern-regional-aboriginal-family-violence-service\)](https://www.womenssafetyervices.com.au/index.php/about/services/32-ninko-kurtangga-patpangga-ninko-the-southern-regional-aboriginal-family-violence-service) – a women's safety service for the southern regional areas.
- [Kornar Winmil Yunti Aboriginal Corporation \(https://www.kwy.org.au/\)](https://www.kwy.org.au/) – a culturally appropriate service supporting Aboriginal families in South Australia, providing programs for families, women and men.
- [NPY Women's Council \(https://www.npywc.org.au/about/\)](https://www.npywc.org.au/about/) – provides domestic and family violence services as well as social and emotional wellbeing support to all on the Ngaanyatjarra Pitjantjatjara Yankunytjatjara region of central Australia (includes Western Australia and Northern Territory).

### Tasmania

- [Tasmanian Aboriginal Centre \(http://tacinc.com.au/about-us/\)](http://tacinc.com.au/about-us/) – offers health, family, community and cultural services.

### Victoria

- [Dijira \(https://dijira.org.au/\)](https://dijira.org.au/) – provides support and legal advice for Aboriginal women and children experiencing family violence.
- [Dardi Munwurro \(https://www.dardimunwurro.com.au/\)](https://www.dardimunwurro.com.au/) – delivers a range of family violence, healing and behaviour change programs mainly focused towards men, youth and family connections. [Victorian Aboriginal Health Service \(https://www.vaahs.org.au/\)](https://www.vaahs.org.au/) – provides a range of family services and social and emotional wellbeing services
- [Burndawan \(https://burndawan.com.au/\)](https://burndawan.com.au/) – a resource created with the Aboriginal and Torres Strait Islander people living on Wadawurrung Country. ‘Burndawan’ means safe and the website looks to help families involved in family abuse and violence.

#### Western Australia

- [Aboriginal Family Law services \(https://www.afls.org.au/about/\)](https://www.afls.org.au/about/) – offers legal services as well as community education, prevention and early intervention programs.
- [Relationships Australia WA – Aboriginal Community Support \(https://www.relationshipswa.org.au/services/aboriginal-community-support\)](https://www.relationshipswa.org.au/services/aboriginal-community-support) – offers a variety of programs to Aboriginal and Torres Strait Islander families and communities.

## References

1. Downing A, Kowal E, Paradies Y. Indigenous cultural training for health workers in Australia. *Int J Qual Health Care* 2011;23:247–57.
2. Fiolet R, Cameron J, Tarzia L, et al. Indigenous people’s experiences and expectations of health care professionals when accessing care for family violence: A qualitative evidence synthesis. *Trauma Violence Abuse* 2020. doi: 10.1177/1524838020961879.
3. Atkinson J. *Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia*. North Geelong, Vic: Spinifex Press, 2002.
4. Fiolet R, Tarzia L, Hameed M, et al. Indigenous peoples’ help-seeking behaviors for family violence: A scoping review. *Trauma Violence Abuse* 2019. doi: 10.1177/1524838019852638.
5. [Blagg H, Bluett-Boyd N, Williams E. Innovative models in addressing violence against Indigenous women. Sydney: Australia’s National Research Organisation for Women’s Safety, 2015 \(http://anrows.org.au/publications/landscapes/innovative-models-in-addressing-violence-against-indigenous-women-state\)](http://anrows.org.au/publications/landscapes/innovative-models-in-addressing-violence-against-indigenous-women-state) [Accessed 11 May 2021].
6. [Blagg H, Williams E, Cummings E, et al. Innovative models in addressing violence against Indigenous women: Key findings and future directions. Sydney: Australia’s National Research Organisation for Women’s Safety, 2018 \(http://www.anrows.org.au/publication/innovative-models-in-addressing-violence-against-indigenous-women-key-findings-and-future-directions/\)](http://www.anrows.org.au/publication/innovative-models-in-addressing-violence-against-indigenous-women-key-findings-and-future-directions) [Accessed 11 May 2021].
7. Burnett C. Family and cultural protective factors as the bedrock of resilience and growth for Indigenous women who have experienced violence. *J Fam Soc Work* 2018;21:45–62. [Accessed 11 May 2021].
8. Australian Human Rights Equal Opportunity Commission. *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities—key issues: an overview paper of research and findings by the HREOC, 2001–2006*. Sydney: HREOC, 2006. [Accessed 11 May 2021].
9. [Olsen A, Lovett R. Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: Key findings and future directions 2016. Sydney: Australia’s National Research Organisation for Women’s Safety, 2016 \(http://www.anrows.org.au/publication/existing-knowledge-practice-and-responses-to-violence-against-women-in-australian-indigenous-communities-state-of-knowledge-paper/\)](http://www.anrows.org.au/publication/existing-knowledge-practice-and-responses-to-violence-against-women-in-australian-indigenous-communities-state-of-knowledge-paper/) [Accessed 11 May 21].

- 
10. Menzies K. Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma. *International Social Work* 2019;62:1522–34. [Accessed 11 May 21].
11. Langton M. The end of 'big men' politics. *Griffith Review* 2008;22:48. [Accessed 11 May 21].
12. Fiolet R, Tarzia L, Owen R, et al. Indigenous perspectives on help-seeking for family violence: Voices from an Australian community. *J Interpers Violence* 2019. doi: 10.1177/0886260519883861. [Accessed 11 May 21].
13. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia 2018. Canberra: AIHW, 2018. [Accessed 11 May 21].
14. [Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey, 2014–15. Canberra: ABS, 2016 \(http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0\)](http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0) [Accessed 7 June 2021].
15. Orr C, Fisher C, Glauert R, et al. A demographic profile of mothers and their children who are victims of family and domestic violence: using linked police and hospital admissions data. *J Interpers Violence* 2020. doi: 10.1177/0886260520916272. [Accessed 7 June 2021].
16. [Ayre J, On M, Webster K, et al. Examination of the burden of disease of intimate partner violence against women in 2011: Final report. Sydney: Australia's National Research Organisation for Women's Safety, 2016 \(http://www.anrows.org.au/publication/examination-of-the-burden-of-disease-of-intimate-partner-violence-against-women-in-2011-final-report/\)](http://www.anrows.org.au/publication/examination-of-the-burden-of-disease-of-intimate-partner-violence-against-women-in-2011-final-report/) [Accessed 7 June 2021].
17. [Steering Committee for the Review of Government Service Provision. Overcoming Indigenous disadvantage: Key indicators 2016. Canberra: Productivity Commission, 2016 \(http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016\)](http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016) [Accessed 11 May 2021].
18. Gee G, Dudgeon P, Schultz C, et al. Aboriginal and Torres Strait Islander social and emotional wellbeing. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice 2014;2:55–68. [Accessed 11 May 2021].
19. Fiolet R, Cameron J, Tarzia L, et al. Indigenous people's experiences and expectations of health care professionals when accessing care for family violence: A qualitative evidence synthesis. *Trauma Violence Abuse* 2020. doi:1524838020961879. [Accessed 11 May 2021].

# Working with migrant and refugee communities

'Planning a safe pathway for migrant individuals requires additional care, as social and community isolation can be extreme. The caseworker or a GP may be their only safe contact.'

## Key messages

- Nearly half the Australian population were born overseas or have at least one parent born overseas, and 21% of Australians speak a language other than English at home.<sup>1</sup>
- Some people of migrant and refugee backgrounds may be hesitant to disclose their experiences of family abuse and violence (FAV).<sup>2,3</sup>
- Language, level of health literacy and marginalisation impose barriers to accessing welfare, employment and health services. Many non-permanent residents have limited, or no access, to education, support services, income or Medicare.
- Planning a safe pathway for migrant individuals requires careful inquiry and culturally sensitive care. As social isolation can be extreme, a caseworker or a GP may be someone's only safe contact.

## Clinical context

### Background and prevalence

Australia is a culturally diverse nation – almost half of its population were either born overseas (6.2 million, or 26%) or have at least one parent who was born in countries other than Australia (4.5 million, or 21%).<sup>1</sup> More than 300 identified languages are spoken in Australia, and 21% of Australians speak a language other than English at home.<sup>1</sup>

Intimate partner abuse/violence (IPAV) is prevalent around the world,<sup>4</sup> and the prevalence of IPAV among women of immigrant and refugee backgrounds residing in various host countries ranges from 17% to 70.5%.<sup>5</sup> IPAV is more common in countries where war or social upheaval has recently taken place.<sup>6, 7</sup> The few studies of diasporas in various countries have found similar rates of FAV to those in the home country.<sup>8-10</sup>

General practices play an important role in screening for vulnerability and early identification, providing first-line support and facilitating referral to specialised services.

However, people of migrant and refugee backgrounds may have limited access to primary care services, due to racial discrimination, cultural and language differences, low income, transportation challenges, social isolation or difficulty in navigating the primary care system.<sup>11,12</sup>

Furthermore, some people of migrant and refugee backgrounds may be hesitant to disclose their experiences and request support.<sup>2,3</sup> Reluctance to disclose could be due to personal factors such as shame, fear or self-blame. There may also be wider, societal-level factors, such as being on a dependent visa, fear of deportation, cultural values and beliefs, normalisation of violence in countries of origin, and religious or community influences.<sup>13</sup>

Immigration policies that reinforce women's economic dependence on their families and restrict their access to government benefits such as Centrelink and childcare support could pose additional barriers to service access.<sup>14</sup>

Therefore, culturally attuned and accessible healthcare, conscious of the challenges faced by individuals of migrant backgrounds, is critical to their wellbeing and safety. This chapter outlines how general practices can create a culturally safe environment for people of migrant and refugee backgrounds who are experiencing family or domestic violence.

## **Instituting culturally competent family violence care in your practice**

Culturally competent care requires a combination of actions and efforts at the whole-of-practice and individual levels, as shown in Figure 17.1.<sup>15</sup>

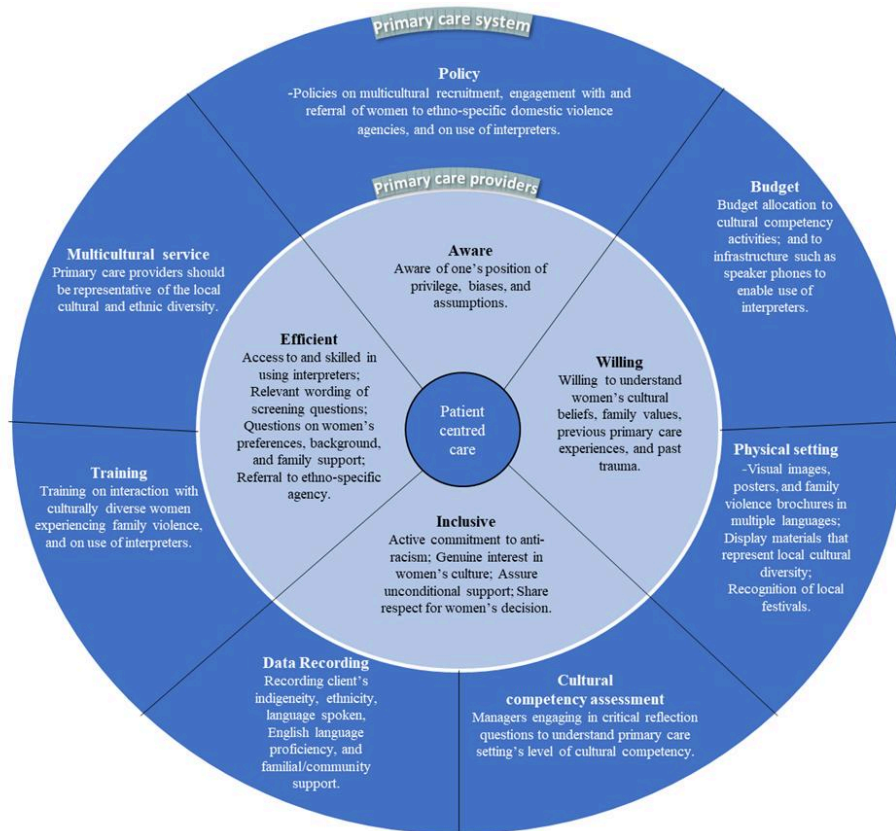


Figure 17.1. Culturally competent primary care response to family violence<sup>15</sup>

Reproduced with permission from: Pokharel B, Yelland J, Hooker L, et al. A systematic review of culturally competent family violence responses to women in primary care. *Trauma, Violence and Abuse*, 2021. Copyright SAGE Publications.

The outer rim shows whole-of-practice policies and actions that can facilitate culturally competent care. The inner part of the wheel shows individual clinician traits and actions that are enabled by the outer rim and allow a safe space for people from migrant or refugee backgrounds. At the centre, patient-centred care respects each individual's decisions regarding their own situation.

### Actions at the whole-of-practice level

As shown in Figure 17.1, actions that can be taken at the whole-of-practice level to facilitate culturally competent care include:

- implementing policies that
- enable efficient access to and use of interpreters
- facilitate pathways for referral of patients of migrant backgrounds to FAV support services
- encourage recruitment of clinical and non-clinical staff that reflect the local cultural diversity – staff from diverse backgrounds may provide insight into how patients express themselves; their expectations and preferences; and what rituals or traditions they may engage in
- allocating budget to resources that improve efficiency and access to migrant specific healthcare, such as speaker phones for telephone interpreting, additional space for consultations that include interpreters or bi-cultural workers, and extended consultation times
- using images or objects in the practice building that represent the cultural diversity of the local

community to create a culturally inclusive physical setting

- making resources, such as FAV brochures, available in multiple languages relevant for patients who attend the practice
- implementing practice systems to support recording of patients' language, ethnicity, need for an interpreter, country of origin, year of arrival in Australia and visa status. This can help determine the diversity of the patient population that the clinic usually serves. It also enables staff to pre-arrange interpreters specific to gender or ethno-culture and to allocate extended consultation times
- training clinical as well as non-clinical staff (such as receptionists) on how to respond to FAV and how to best communicate with culturally and linguistically diverse (CALD) clients, including how to work with interpreters
- assessing the cultural competence of the practice to determine how equipped it is to accommodate patients of migrant and refugee backgrounds who present in the highly sensitive context of FAV. Practices can use the questions in Box 17.1 to assess their level of cultural competency.<sup>15,16</sup>

#### Box 17.1. Questions to assess organisational cultural competency<sup>15,16</sup>

- Does the practice promote and foster a culturally friendly environment?
- Is it located in an area where people of migrant and refugee backgrounds live?
- What countries and ethno-cultural groups do those people originate from?
- Do staff display attitudes and behaviours that demonstrate respect for all cultural groups?
- Does the practice involve or collaborate with migrant and refugee community groups or individuals when planning events, programs, service delivery and organisational development activities?
- Does the practice have policies and procedures that take cultural matters into consideration (eg systems to collect and record data about cultural and linguistic diversity)?
- Does the practice provide programs that encourage participation by people of migrant and refugee backgrounds?
- Do the practice systems enable easy access to interpreter services?
- Does the practice have knowledge of local migrant and refugee groups, their protocols, and methods for communicating with, or referring to local ethnic groups?
- Does the practice develop and/or implement a collaborative service delivery model with specific multicultural FAV support groups, such as [inTouch \(https://intouch.org.au/\)](https://intouch.org.au/), that provide culturally diverse FAV services?

#### Actions at the GP level

The inner part of the wheel in Figure 17.1 shows how GPs can enable a culturally competent environment for people from migrant and refugee backgrounds, as explained below.



- Efficient delivery of service is an important aspect of culturally competent FAV care. The window for disclosure or intervention may be small and every opportunity to engage with patients should be taken. For example, if a person who does not speak English attends the clinic, staff should not feel unprepared. Telephone interpreting can be immediately arranged, and a staff member may take extra time to determine what type of appointment the patient needs. Readiness for these types of interactions needs to occur at the whole-of-practice and individual levels.<sup>15</sup>
- All practice staff can and should assess their own cultural competency to become aware of their biases and assumptions (Box 17.2).<sup>15,16</sup>
- Staff should endeavour to understand the unique ethno-cultural context of their individual patients. People come from not only different countries and cultural groups, but they also follow different religions, hold a broad set of values, and may differ in their response to FAV – these differences exist even between people from the same country or ethnic group. Therefore, staff should aim to understand an individual’s experiences and personal narrative, while avoiding stereotypes and oversimplified schema.<sup>15</sup>

‘Case study: Sylvia’ demonstrates why it is so important that GPs frequently assess their own cultural competency.

#### Box 17.2. Questions to assess own cultural competency<sup>15,16</sup>

- Are my actions and attitudes culturally appropriate when I am with patients from migrant and refugee backgrounds? Am I being sufficiently careful not to reflect prejudice, bias or stereotypical attitudes?
- What practical experience do I have of FAV?
- Do I have knowledge of cultural practices, protocols and beliefs related to FAV? Have I undertaken any cultural development program that prepares me to best support FAV experiences of patients of migrant and refugee backgrounds?
- Do I interact with people of migrant and refugee backgrounds experiencing FAV? Have I worked alongside people of migrant and refugee backgrounds experiencing FAV? Have I consulted with people of culturally and linguistically diverse groups?
- What is my motivation to become culturally competent?

## In practice

This section outlines specific clinical considerations for caring for patients of migrant and refugee backgrounds experiencing FAV. Figure 17.2 shows how these can be put into practice. These points complement the recommendations in [Chapter 2: Intimate partner abuse and violence: Identification and initial response](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse>), [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse>).

er-abuse-safety) and [Chapter 4: Intimate partner abuse and violence: Ongoing support and counselling](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel>). Box 17.4 includes a summary of practice tips.

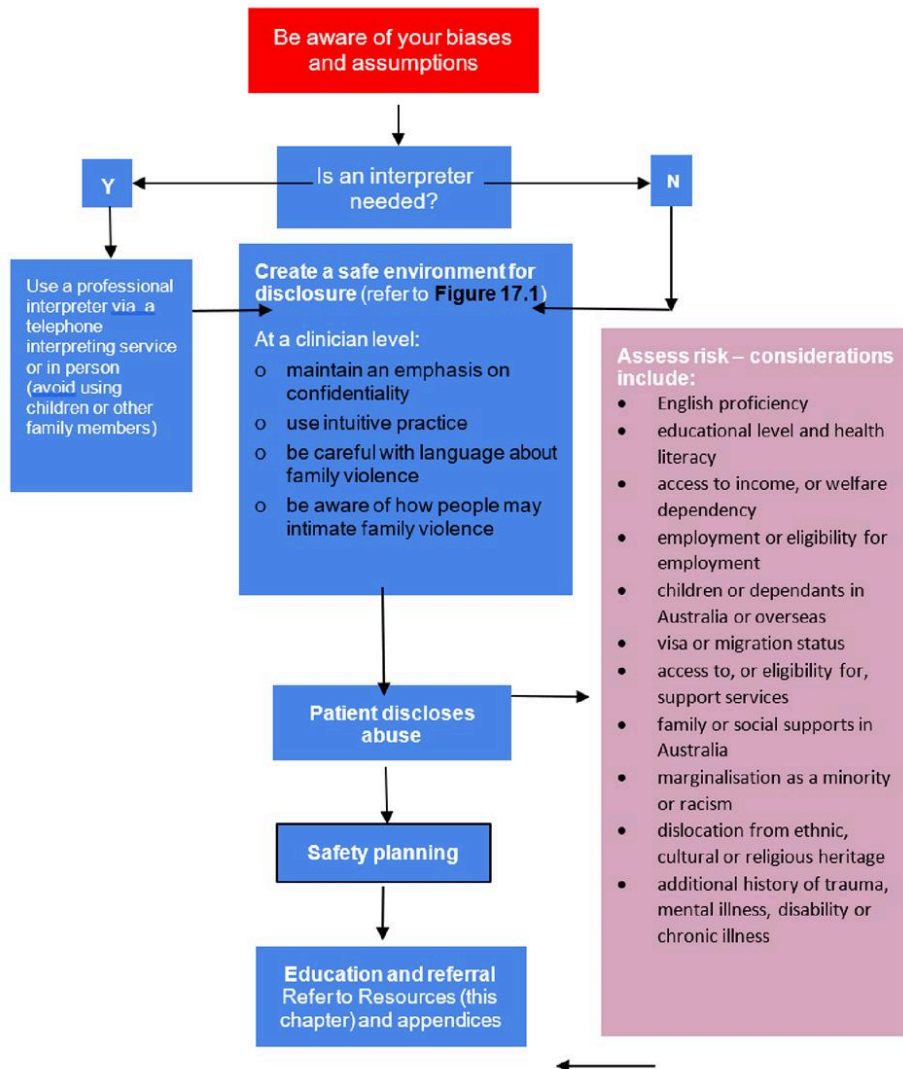


Figure 17.2. Considerations for assessing and managing patients from migrant and refugee backgrounds who might be or are experiencing intimate partner abuse

## Creating a safe environment for disclosure

### Confidentiality and consent

Migrant, asylum seeker and refugee patients are often hesitant to disclose experiences of abuse because of fear of confidentiality breaches, particularly when working with interpreters.<sup>17–19</sup> Individuals who are navigating temporary visas, student visas or awaiting refugee determinations may have fears regarding how disclosing abuse will affect them legally, or whether their clinical information will be

shared with government authorities. Particularly within small communities, it may be prudent to avoid culturally congruent referrals (refer to section titled 'Education and referral') in case family or social networks intersect.

It is important to understand that consent is understood differently by different cultures. Some cultures understand consent as a community issue, not an individual issue – for example, a patient may be reluctant to disclose issues that they feel could bring shame to their community. Therefore, clarifying the patient's view on consent may be prudent.<sup>15,20</sup>

### **Intuitive practice**

GPs' suspicion of FAV is often triggered by patient behaviour or physical evidence of violence (eg traumatic injury) (refer to [Chapter 2: Intimate partner abuse and violence: Identification and initial response \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse)).<sup>19,21</sup> Suspicion of abuse should prompt an inquiry about abuse; if denied, ask again in subsequent visits. GPs may need to apportion extra time to their consultations, as patients may not readily disclose their experiences.

### **Careful use of language about family violence**

GPs may need to modify their language when discussing FAV with migrant and refugee people. For example, common comorbid conditions such as depression, trauma or anxiety may be associated with stigma or shame.<sup>22-24</sup> In some countries, there is no direct translation or word equivalent for 'depression'.

In some communities, FAV might be normalised, or it might be taboo, meaning some individuals will not acknowledge abuse. This requires the GP to prompt or ask directly about abuse, for example: 'Has your partner ever beaten you, ever forced you to have sex with them, ever threatened to get you deported, or violently or constantly been jealous of you?'

### **Considerations when assessing patients of migrant and refugee backgrounds**

Victims may be experiencing abuse from multiple family members, including their in-laws (mother, father or brother-in-law).<sup>9,25,26</sup> Ask if anyone else is abusing them.

Some people, especially refugees, may have witnessed or experienced serious violence before their arrival, and continuing violence within the home can add to the pre-migration trauma experiences and the acculturative stress issues.<sup>14</sup>

For younger people, especially students and migrant workers on temporary visas, fears about immigration status may affect their comfort to disclose. Women, those on spousal visas and those with dependants or children may also feel particularly apprehensive about the repercussions of disclosure.

If the patient is in an abusive LGBTIQA+ relationship, fears about confidentiality and stigma may be stronger, especially if they are from countries where same-sex relationships are illegal.

### **Visa considerations**

Individuals may be reluctant to leave an abusive situation for fear of the impact on their immigration status.<sup>13</sup> Navigating the migration and legal pathways creates a high degree of stress; mental illness improves once a visa is obtained.<sup>27</sup>

It is valuable for GPs to have a basic understanding of migration pathways. This includes the variable eligibility for support services, healthcare (Medicare or state hospital services), income support and working rights.

Individuals on skilled migrant visas have conditional access to health services and limited work rights.<sup>14</sup>

Asylum-seekers may hold one of many different temporary visa types, including bridging visas, temporary protection visas, or safe haven enterprise visas. Not all temporary visa-holders have the right to work, and access to Medicare may lapse when a visa expires. An individual may be applying for their next visa and experience delays while reapplying for Medicare.

Individuals who arrive on other visas, such as tourist visas or student visas, do not have access to Medicare or income support, and have restricted work rights.

Information about visa types and support services can be found from:

- [visa types for asylum seekers awaiting status resolution \(https://www.kaldorcentre.unsw.edu.au/publication/australias-refugee-policy-overview\)](https://www.kaldorcentre.unsw.edu.au/publication/australias-refugee-policy-overview)
- [checking visa details and conditions \(https://immi.homeaffairs.gov.au/visas/already-have-a-visa/check-visa-details-and-conditions/see-your-visa-conditions\)](https://immi.homeaffairs.gov.au/visas/already-have-a-visa/check-visa-details-and-conditions/see-your-visa-conditions) .

### **Awareness of how patients may disclose family abuse and violence**

Patients from migrant and refugee backgrounds could disclose less explicit experiences of abuse, such as forced termination of pregnancy, or family members prohibiting the use of contraception.<sup>21,28</sup>

GPs may uncover neglect of a patient by the family members or caregivers.<sup>21</sup>

Some patients may express feeling lonely or being controlled.<sup>29</sup> Therefore, GPs can prompt responses by questioning patients about their family situations or situations at home.

Patients may describe their distress through somatic symptoms or use physical terms to describe emotional distress.

## **Working with interpreters**

Using interpreters needs to be foundational to practice policy and part of the work done by front desk staff in their interactions with patients. Practice points for using interpreters in clinical practice, developed by the Migrant and Refugee Women's Health Partnership, are shown in Box 17.3.

Professionally trained interpreters should always be used – it is inappropriate to place children, family or friends in the role of interpreter, particularly when FAV is an issue. Practices should institute speaker phones, have readily available access codes for telephone interpreting services and have translated instructions to explain to patients how to access telephone interpreting services.

Improper use of interpreters, such as dialect mismatches, using a non-professionally accredited interpreter, or disregarding a patient's gender preference for the interpreter, can result in communication failures that may impair safety planning or inadvertently expose confidential information and risk potential retribution.

Specific recommendations for interpreter use in the context of FAV include:

- use interpreters who are trained in FAV, if available
- consider using a pseudonym to ensure confidentiality (in smaller communities there is a risk of interpreters being socially connected to the patient)
- monitor non-verbal cues to determine if the patient is comfortable with the interpreter (be conscious that there may be a discriminatory interaction between interpreter and patient)
- implement a code-word in cases where the patient wants to terminate the consultation abruptly
- if there is a risk of interpreters being socially connected to the patient, consider using an interstate interpreter, or if the patient is multi-lingual, a language other than that of their primary community.

**Box 17.3. Practice points for working with interpreters in a healthcare setting<sup>30</sup>**

- Where possible, GP informs interpreters about the nature of the consultation before it begins, recognising the need to assist the interpreter to prepare for the consultation.
- GP introduces the interpreter to the patient and explains that the interpreter is a non-clinical member of the healthcare team who will facilitate effective communication in the consultation through accurate interpretation, is bound by confidentiality and maintains impartiality.
- When working with an onsite interpreter, GP interacts directly with the patient, using direct speech, and maintains appropriate body language and facial expressions.
- When working with a telephone interpreter, GP uses a speakerphone or a hands-free telephone.
- When working with a telephone or video interpreter, GP interacts directly with the patient, ensures they manage turn-taking, and uses adequate descriptive language.
- GP speaks clearly, uses plain English and explains complex concepts and terms to enhance the patient's understanding.
- GP speaks at a reasonable speed, with appropriate pauses, and avoids overlapping speech, to enable the interpreter to interpret.
- In a multidisciplinary team consultation, GP ensures adequate speech rate, pauses and turn-taking for all parties to facilitate good-quality and accurate communication with the patient.
- When possible and appropriate, GP and interpreter may debrief and exchange feedback following a consultation.

Adapted with permission from: Migrant and Refugee Women's Health Partnership. Guide for clinicians working with interpreters in healthcare settings. Canberra: Migrant and Refugee Women's Health Partnership, 2019.

### **Risk assessment**

Following disclosure, assessing risk for a migrant or refugee person experiencing FAV requires consideration of specific factors that may affect their ability to safely stay or leave their situation (refer to 'Assess risk' in Figure 17.2). These factors also influence whether someone has the capacity to navigate wider systems. Language, literacy and marginalisation impose barriers to accessing financial, occupational and health services

### **Safety planning**

Planning a safe pathway for migrant individuals requires additional care, as social and community isolation can be extreme. The caseworker or a GP may be their only safe contact.

Identification documents including passports, immigration paperwork or birth certificates may not be available. Advice from an immigration-specific lawyer may be prudent, to advise on how to manage if these documents are not available.

Access to interpreters is critical to enable people to contact Centrelink, or access legal and medical assistance. Educating patients on how to access telephone interpreting services independently is an essential part of safety planning.

[Daisy app by 1800 RESPECT \(https://www.1800respect.org.au/languages\)](https://www.1800respect.org.au/languages) provides links to local support services for FAV and is available in 28 languages.

Refer to safety and risk assessment in [Chapter 3: First-line response to intimate partner abuse and violence: Safety and risk assessment \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety).

Refer to 'Case study: Josephine' for an example of safety planning.

### Education and referral

GPs are well positioned to educate individuals that what they are experiencing is not acceptable and does not need to be tolerated. Education may also include advising of available services, such as emergency shelters or free legal services. For migrant communities, there is frequently a reliance on welfare and acute crisis response, as there may be no family members to assist.

Choosing the appropriate community service can be challenging, and considering whether to use a culturally congruent community service versus an alternative service may require sensitive inquiry. Individuals may be wary of approaching community elders because they fear that they will advise them according to cultural norms, such as acceptance or submission.

In some cultures, divorce may require public disclosure, or approval from community leaders or extended family. Avoid assumptions about social structures, and actively seek to gain an understanding of what influence family and community leaders have on situations of family separation. The first line of inquiry may be the individual themselves and their perception of those structures. It may also be valuable to meet with community leaders or bicultural workers to inquire in a general way, taking care to protect the confidentiality of the individual patient.

The Status Resolution Support Services program (SRSS) is an Australian Government program for non-citizens awaiting immigration resolution, including those released from detention, those in community detention and some asylum seekers. SRSS providers are appropriate points of first contact for individuals in need of casework and income support (Table 17.1).

In general, people deemed to be managing a crisis, such as domestic violence, would be [eligible for SRSS \(http://refugeehealthnetwork.org.au/wp-content/uploads/Information-sheet\\_2018\\_May\\_SRSS\\_changes.pdf\)](http://refugeehealthnetwork.org.au/wp-content/uploads/Information-sheet_2018_May_SRSS_changes.pdf). However, individuals who have had a negative determination at the Immigration Assessment Authority may no longer be eligible for SRSS, putting them in a potentially precarious situation. In some cases, state or territory governments may provide emergency housing and healthcare access. Multicultural FAV services, such as [inTouch \(https://intouch.org.au/\)](https://intouch.org.au/), include immigration and FAV casework, legal and financial support with<sup>30</sup> FAV-specific interpreting services.

Be aware that many clients will require letters of support from their GPs, as these may be used as evidence through their legal pathway.

You may access a [current summary of who is eligible to access the SRSS \(https://www.rch.org.au/immigranthealth/clinical/Status\\_resolution\\_support\\_services\\_SRSS/\)](https://www.rch.org.au/immigranthealth/clinical/Status_resolution_support_services_SRSS/), and [what services asylum-seekers are eligible for \(https://www.rch.org.au/immigranthealth/clinical/Asylum\\_seekers/\)](https://www.rch.org.au/immigranthealth/clinical/Asylum_seekers/).

**Table 17.1. Status Resolution Support Services program providers in each state or territory**

Australian Capital Territory/New South Wales	<a href="#">Life Without Barriers (about:blank)</a> <a href="#">Settlement Services International (about:blank)</a>
Northern Territory	<a href="#">Life Without Barriers (about:blank)</a>
Queensland	<a href="#">Access Community Services Ltd (Access) (about:blank)</a> <a href="#">Multicultural Australia (about:blank)</a>
South Australia	<a href="#">Australian Migrant Resource Centre (about:blank)</a> <a href="#">Life Without Barriers (about:blank)</a>
Tasmania	<a href="#">CatholicCare Tasmania (about:blank)</a>
Victoria	<a href="#">AMES Australia (AMES) (about:blank)</a> <a href="#">Life Without Barriers (about:blank)</a>
Western Australia	<a href="#">MercyCare (about:blank)</a>

More information about the SRSS can be found [here \(https://immi.homeaffairs.gov.au/what-we-do/status-resolution-service/status-resolution-support-services\)](https://immi.homeaffairs.gov.au/what-we-do/status-resolution-service/status-resolution-support-services).



#### Box 17.4. Practice tips

- A culturally attuned general practice response to FAV for patients of migrant and refugee backgrounds needs to include targeted actions by individuals and the whole of practice. These include policy priorities, budget allocation, training and efficient service provision.
- Primary care providers and practices should frequently self-assess their cultural competency in providing culturally appropriate FAV care.
- GPs need to actively create a safe environment for disclosure of FAV by ensuring confidentiality, engaging intuitive practice and through the careful use of language. They should be aware of the different ways migrant and refugee people may intimate about abuse.
- Professional interpreter services should be routinely used, and practice staff and GPs should be competent with using them in the context of FAV.
- Risk assessment in migrant and refugee people needs to assess language proficiency, immigration status and the individual's eligibility for support services. Many will experience marginalisation from the wider community through racism, as well as dislocation from their ethno-cultural heritage.
- Safety planning should include education about how to independently access telephone interpreting services.
- Ensure individuals understand that abuse does not need to be tolerated and there are alternative pathways available to them. GPs should consider referrals to migrant legal services and SRSS. Consider carefully whether culturally congruent community services are the safest option for the individual, or whether alternative services are required.

## Case study: Sylvia

Sylvia is a 70-year-old Italian-Australian woman. Her family is well known to her GP after Franco, Sylvia's husband, passed away last year following a long struggle with bowel cancer. Sylvia's eldest son, Giorgio, has moved into the family home with his wife. When Franco was alive, he would attend appointments with Sylvia and translate for Sylvia, because her English is limited.

Sylvia comes to her GP with back pain, requesting painkillers. Without Franco there to translate, her GP realises she has never seen Sylvia alone. She uses a telephone interpreter and asks Sylvia how she is coping with Franco's death. Sylvia immediately begins to cry.

Sylvia discloses that throughout their 40 years of marriage, Franco physically abused her. She never said anything, as she believed that these were issues between husband and wife. Now her son and daughter-in-law have begun abusing her, both physically and mentally, since moving in with her. Giorgio is like his father and often shouts at Sylvia, calling her names. Sylvia is depressed, doesn't eat much and has lost weight. She says that she stays in her room most of the time and cries.

Sylvia and Franco left Italy for Melbourne in 1972. Franco worked in a box factory for 40 years and Sylvia stayed home to raise their five children. Franco controlled all their finances and Sylvia doesn't know what her rights are now that he has died. Since Giorgio arrived, he and his wife have taken control of the house and finances. They give Sylvia some money, but they don't like her to leave the house. She has a sister who lives in another state, but Sylvia is ashamed to tell her sister about her problems.

The GP connects Sylvia with an Italian-Australian community organisation that facilitates access to Commonwealth Home Support and coordinates social activities. Building a social network enhances Sylvia's independence and through this, she finds the confidence to seek advice from a social worker to take back control of her finances.

## Key points

This case highlights the importance of culturally competent care (refer to Figure 17.1 and Box 17.2). Rather than using family members to translate, culturally competent care involves engaging a professional interpreter. As part of regular self-assessment of her own cultural competence, the GP might also have reflected on any personal assumptions about marital ideals or conventions and actively facilitated appointments where Sylvia could attend alone.

At a practice level, recording Sylvia's preferred language and educating Sylvia about how to book her own appointments, using telephone interpreting services, would enable reception staff to pre-book interpreters and Sylvia to attend the clinic independently. This may have provided an earlier opportunity for her to disclose IPAV.

- Use professional interpreters and not family members.
- Frequently assess cultural competency at a GP and practice level (Box 17.1, Box 17.2).
- Challenge personal biases and understand the unique ethno-cultural context of the individual.
- Develop a network of local providers who provide culturally specific services and understand how to collaborate with or refer to them.

## Case study: Geetu

Geetu is a 17-year-old high school student. She lives with her parents and one brother. Geetu's parents moved from Nepal for a better life for the children.

Geetu comes to see you at the clinic and tells you that her parents are forcing her to get married and leave her studies. However, Geetu loves school and has dreams of becoming a doctor to help others. She feels trapped and doesn't know what to do.

Geetu already has a boyfriend that her parents are not aware of and who doesn't understand what she's going through. Her friends don't either. They don't understand her culture and think her parents are weird.

The engagement is in a couple of months and a dowry has already been paid. This upsets Geetu. Her parents keep badgering her about the engagement, which angers her. She feels nauseous and headachy.

'I feel sick,' she says. 'I feel nauseous all the time, I'm irritated and lose my temper a lot.'

She doesn't sleep and is anxious about the future.

This is a relatively common situation for people from many cultures and religious backgrounds. What appears to be customary or a socio-cultural norm may be coercive, oppressive and potentially violent activity.

Creating a safe environment for disclosure may take a longer consultation than initially planned (refer to Box 17.3). It may not be clear to Geetu that her situation is type of FAV. Alternatively, she may be acutely aware that refusing the marriage will put her, or her family, at great risk, either financially, or potentially at risk of violent retribution. Listening to and reaffirming Geetu's concerns are paramount. Targeted questions may be required to fully understand Geetu's home situation and the risks for her should she either go against her parents plans or enter a forced marriage.

You arrange a time to speak with the school counsellor, with Geetu's consent. The counsellor works closely with Geetu in managing her symptoms of distress and anxiety. With time, Geetu decides that she will speak to her parents about her concerns.

## Key points

- Create a safe environment for disclosure by apportioning extra time to consultations.
- Use directive questioning to assess risk (refer to 'Creating a safe environment for disclosure' earlier in this chapter).
- Be conscious of how people may intimate abuse, including presenting with somatic symptoms or expressing feelings of being controlled or not being understood (Box 17.3).
- Consider risks that may be specific to your patient's ethno-cultural context. The financial implications of losing a dowry, or the risk of going against the community's norms, or the risk to a woman entering a forced marriage – all need to be explored carefully (refer to 'Risk assessment', earlier in this chapter).

## Case study: Zahara

Zahara is a 35-year-old Somali woman. Her husband, Fahad, arrived in Australia through a United Nations refugee program in 2015, via a refugee camp in Kenya. Zahara and their children arrived only recently. Fahad is completing his professional recognition as a researcher.

You first meet Zahara and Fahad for their son's catch-up immunisations. They ask if there is free childcare available to them, because Zahara is having seizures. When you finish taking a history and examining Zahara, you wonder whether the seizures may have been aggravated by stress. Regardless, you refer Zahara to a neurologist for a second opinion and arrange some tests. A week later, Zahara returns alone to check her test results. She asks you directly if you think the seizures might be caused by stress.

Zahara tells you that Fahad left Somalia soon after she gave birth to their second child. While he was away, Zahara stayed with her parents, completed her studies in history and worked part time in an office. Zahara loved working and was reluctant to leave Somalia, but wanted her children to be reunited with their father. Since arriving in Australia, Fahad has not wanted her to work and he believes that a woman's role is at home. He frequently shouts at her or speaks to her as though she's a servant.

Leaving him is not an option, since Zahara has a temporary partner visa. This means that if they separate, she will need to return to Somalia and may never see her children again. On one occasion, when Zahara tried to leave the house, Fahad threatened to report her to the Department of Immigration so that she would be deported. She also explains to you that leaving a marriage is frowned upon in her culture and that her parents, while relatively open-minded, would never accept her back to their home.

After Zahara's visit, you spend some time reflecting on your personal cultural competency. You have not had many patients from Somalia and have not developed any stereotypes or cultural biases. You do work in a community with a high number of refugee people and have had experience working with women in FAV situations, particularly across linguistically diverse groups. Zahara felt confident to disclose her situation to you, after you established a good rapport during your first meeting.

You consider the factors that contribute to FAV risk in migrant communities. For Fahad, these might include marginalisation, dislocation from his cultural heritage and acculturative stress. For Zahara these also include financial and visa dependency, her children and a lack of social, or family support.

You refer Zahara to the Refugee Council of Australia and the Australian Red Cross, both of which can provide case work and support services regardless of refugee status. You also make a referral to inTouch<<link to <https://intouch.org.au/>>>, a Victorian service that works specifically with FAV and migrant people and offer case work, legal services and financial support. Refer to the [Domestic Violence Resource Centre Victoria website \(https://www.dvrcv.org.au/support-services\)](https://www.dvrcv.org.au/support-services) to find services by state.

## Key management issues

- Assess individual cultural competency and screen for personal bias or assumptions (Box 17.2).
- Build rapport and trust to help create a safe environment for disclosing FAV (Box 17.3).
- Consider the specific risks faced by individuals from migrant and refugee backgrounds (Figure 17.2).
- Be aware of migrant/refugee and FAV-specific services.

## Case study: Josephine

Josephine is a 22-year-old Papua New Guinean woman. She frequently misses her appointments, so you are surprised to see her in your waiting room. She is particularly withdrawn and keeps her eyes lowered. You ask her gently what she needs today. She tells you that she has had stomach pain for the last few weeks.

After a thorough history and examination, you are unable to come to a clear diagnosis. As part of a review of systems, you ask whether she has been sleeping well. Josephine says that she has not slept well for years and that she rarely feels like eating. Stress is overwhelming her, and she frequently has nightmares. Gradually, she discloses the full extent of her worries.

Josephine left Papua New Guinea (PNG) eight months ago, using money that she had been hiding away. She knew that she needed to leave her husband, who had been physically and sexually abusing her. They were married when she was 16 years old and immediately moved from her family's province to Port Moresby. At first, she thought he was a quiet and reserved man, but quickly she realised that he

was cruel and violent. On several occasions, Josephine tried to get help from the police, the pastor at her church and her cousin who also lived in Port Moresby. Nobody believed her. After the first year of marriage, Josephine gave birth to a baby girl. That was when she knew that she had to leave and find a better life for her daughter.

What distresses Josephine the most is being separated from her daughter. She could not afford to bring her to Australia and so she came alone, applying for the visa after arriving in Australia. The lawyer who is helping her with her visa application has told her that it may take years for her determination to be finalised. At present, her daughter is safe and staying with her parents in their home province. However, her husband has sent them threatening messages and she worries that he will try to hurt her family to punish her.

You ask Josephine if she would prefer to speak with PNG-Australian people that run local support groups, but she says she would rather not. With Josephine's consent, you instead contact Access Community Services and speak to an intake worker. They advise you that with Josephine's current visa, she can access SRSS and they will arrange a case worker to help her navigate the visa process and find safe housing. They link her with a local women's sewing group.

Six months later, Josephine's visa conditions have changed: she is no longer eligible for SRSS, and her case worker contacts you asking for assistance. You speak to the local tertiary hospital to see what they can offer. While they have GPs and specialists that can provide medical advice, they have limited allied health services and no case workers. Eventually, you find a non-government community health clinic, World Wellness Group, that can see people pro-bono and they offer psychologist support for Josephine. The local Catholic church group arranges some short-term financial assistance.

A year later, Josephine contacts you for a letter of support for the Department of Immigration to bring her daughter to Australia.

## Key management issues

- Social isolation can be profound, and the GP may be the only support person available.
- It is important to clarify with the individual whether they would prefer to work with a culturally congruent service, or an alternative. Consider whether there may be stigmatisation, judgement or unwanted intrusion by leaders, or other members of the same community.
- Precarious immigration status and visa conditions can create challenges for GPs to find support services that their patients can utilise. Consider non-government, independent and charitable health services, or community groups.

## Resources

- [The Refugee Council's service directory \(https://www.refugeecouncil.org.au/services/\)](https://www.refugeecouncil.org.au/services/) – provides location-based search for settlement services, English classes, case management, legal services, domestic violence support and community support groups.
- [Refugee health guide directory \(http://refugeehealthguide.org.au/referrals/\)](http://refugeehealthguide.org.au/referrals/) – for state-based, refugee-specific contacts including domestic violence counselling and advice service.
- [Ask Izzy \(https://askizzy.org.au/\)](https://askizzy.org.au/) – a national database of location-specific services that enables search for domestic violence organisations specific to the client's individual

circumstances, including LGBTIQ+, CALD, and asylum-seeker groups.

- [Refugee and Immigration Legal Service \(https://www.rails.org.au/\)](https://www.rails.org.au/) – provides free legal advice for disadvantaged, refugee and migrant communities.
- [AMES Australia \(https://www.ames.net.au/\)](https://www.ames.net.au/) – offers support services including English language courses, migration legal agents, youth services, workforce-ready programs, Humanitarian Settlement Program (Victoria, South Australia, Tasmania), immigration Status Resolution Support Services and refugee mentoring program.
- [1800 RESPECT \(https://www.1800respect.org.au/daisy\)](https://www.1800respect.org.au/daisy) – has developed the Daisy app to connect people experiencing violence and abuse to services in their local area. This is available in 28 languages. 1800 RESPECT also has [an app, Sunny, for women with disability who are experiencing violence and abuse \(https://www.1800respect.org.au/sunny\)](https://www.1800respect.org.au/sunny).
- [Australian Red Cross \(https://www.redcross.org.au/get-help/help-for-migrants-in-transition\)](https://www.redcross.org.au/get-help/help-for-migrants-in-transition) – provides support for refugees, asylum seekers and migrants who are vulnerable; visa status does not determine eligibility.
- [InTouch \(https://intouch.org.au/\)](https://intouch.org.au/) – a family and domestic violence specialist organisation that provides financial, legal and other support services to women of immigrant and refugee backgrounds experiencing family violence.

## State/territory support services

### Australian Capital Territory

- [Migrant and Refugee Settlement Services \(https://www.marss.org.au/\)](https://www.marss.org.au/) – provides casework, homelessness services, emergency relief and community development programs including learning to drive and English language classes.

### New South Wales

- [Immigration Advice and Rights Centre \(https://iarc.asn.au/\)](https://iarc.asn.au/) – provides free legal advice for family and humanitarian visa cancellations, with a focus on assisting people who have experienced FAV.
- [Immigrant Women's Speakout Association \(http://www.speakout.org.au/rsrscs.html\)](http://www.speakout.org.au/rsrscs.html) – provides a referral directory, with domestic violence service, general support services, legal services and migrant community services.
- [Settlement Services International \(https://www.ssi.org.au/services/asylum-seeker-assistance\)](https://www.ssi.org.au/services/asylum-seeker-assistance) – manages Status Resolution Support Services and a Building Stronger Families program for Tamil and Arabic-speaking men.

### Northern Territory

- [Anglicare Refugee and Migrant Settlement Services \(https://www.anglicare-nt.org.au/service/refugee-migrant-settlement-services-ramss/\)](https://www.anglicare-nt.org.au/service/refugee-migrant-settlement-services-ramss/)
- [Life without Barriers Refugees and Asylum Seekers \(https://www.lwb.org.au/services/refugees-and-asylum-seekers/\)](https://www.lwb.org.au/services/refugees-and-asylum-seekers/)
- [Multicultural Council of the Northern Territory \(https://www.mcnt.org.au/\)](https://www.mcnt.org.au/)
- [Relationships Australia Northern Territory \(https://nt.relationships.org.au/\)](https://nt.relationships.org.au/)

### Queensland

- [ACCESS \(https://www.accesscommunity.org.au/contact\)](https://www.accesscommunity.org.au/contact)
- [Immigrant Women's Support Services \(http://www.iwss.org.au/\)](http://www.iwss.org.au/)
- [Multicultural Australia Status Resolution Support \(https://www.multiculturalaustralia.org.au/status\\_resolution\\_support\)](https://www.multiculturalaustralia.org.au/status_resolution_support)
- [Queensland Government Support for Victims of Abuse and Family Violence \(https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence/find-local-support#statewide\)](https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence/find-local-support#statewide)
- [Queensland Program of Assistance to Survivors of Torture and Trauma \(https://qpastt.org.au/\)](https://qpastt.org.au/)

### South Australia

- [Australian Migrant Resource Centre \(http://https://amrc.org.au/\)](http://https://amrc.org.au/) – has family violence prevention and community education program, parenting and family support, crèche, financial management education and emergency relief services.
- [Australian Refugee Association \(https://www.australianrefugee.org/\)](https://www.australianrefugee.org/) – offers case-management services for people experiencing FAV and for children at risk.
- [Lutheran Care Community Hubs \(https://www.lccare.org.au/find-help/community-hubs/\)](https://www.lccare.org.au/find-help/community-hubs/)
- [Multicultural Youth South Australia \(https://www.mysa.com.au/\)](https://www.mysa.com.au/)
- [Relationships Australia SA Multicultural Services \(https://www.rasa.org.au/services/couples-families/peace-multicultural-services\)](https://www.rasa.org.au/services/couples-families/peace-multicultural-services)
- [Uniting SA Child, Youth and Family Services \(https://unitingsa.com.au/community-services/children-and-families/\)](https://unitingsa.com.au/community-services/children-and-families/)
- [Welcoming Australia \(https://www.welcometoaustralia.org.au/\)](https://www.welcometoaustralia.org.au/)
- [Womens Safety Services \(https://www.womenssafety.com.au/\)](https://www.womenssafety.com.au/)

### Tasmania

- [Catholic Care Tasmania Status Resolution Support Services \(https://catholicaretas.org.au/programs/status-resolution-support-services\)](https://catholicaretas.org.au/programs/status-resolution-support-services)
- [Migrant Resource Centre Tasmania \(https://mrctas.org.au/\)](https://mrctas.org.au/)

### Victoria

- [Asylum Seeker Resource Centre \(https://www.asrc.org.au/\)](https://www.asrc.org.au/)
- [Australian Vietnamese Women's Association \(https://www.avwa.org.au/en/\)](https://www.avwa.org.au/en/)
- [Cabrini Outreach Asylum Seeker and Refugee Health Hub \(https://www.cabrinioutreach.com.au/heritage-and-strategy/australian-programs/asylum-seekers-and-refugees/asylum-seeker-and-refugee-health-hub\)](https://www.cabrinioutreach.com.au/heritage-and-strategy/australian-programs/asylum-seekers-and-refugees/asylum-seeker-and-refugee-health-hub)
- [Centre for Culture, Ethnicity and Health \(https://www.ceh.org.au/\)](https://www.ceh.org.au/)
- [Foundation House \(https://foundationhouse.org.au/\)](https://foundationhouse.org.au/)
- [in touch Multicultural Centre Against Family Violence \(https://intouch.org.au/\)](https://intouch.org.au/) – provides in language, culture family violence services, co-case management and cultural advice to practitioners. Patients must be over 18.
- [Kildonan Uniting Care South Asian Men's Behaviour Change Program \(https://www.unitingkildonan.org.au/programs-and-services/child-youth-and-family-support/family-violence/south-asian-mens-behaviour-change-program/\)](https://www.unitingkildonan.org.au/programs-and-services/child-youth-and-family-support/family-violence/south-asian-mens-behaviour-change-program/)
- [Multicultural Centre for Women's Health \(https://www.mcwh.com.au/\)](https://www.mcwh.com.au/)
- [No to Violence \(http://https://ntv.org.au/\)](http://https://ntv.org.au/) – a service for perpetrators.

- [Royal Children’s Hospital caseworker resources \(https://www.rch.org.au/immigranthealth/clinical/Caseworker\\_Resources/\)](https://www.rch.org.au/immigranthealth/clinical/Caseworker_Resources/)
- [Royal Children’s Hospital Immigrant Health \(https://www.rch.org.au/immigranthealth/\)](https://www.rch.org.au/immigranthealth/)
- [Victorian Immigrant and Refugee Women’s Coalition \(http://virwc.org.au/\)](http://virwc.org.au/)

### Western Australia

- [Centre for Asylum Seekers and Refugees and Detainees \(https://www.carad.org.au/\)](https://www.carad.org.au/) – provides case work and emergency relief, including food and material aid.
- [Mercy Care Multicultural Support Services \(https://www.mercycare.com.au/youth-family-and-support/multicultural-support-services/status-resolution-support-services\)](https://www.mercycare.com.au/youth-family-and-support/multicultural-support-services/status-resolution-support-services)
- [Women’s Health and Family Services \(https://whfs.org.au/services/multicultural-womens-advocacy-support/\)](https://whfs.org.au/services/multicultural-womens-advocacy-support/)

## References

1. Australian Bureau of Statistics. *Census of Population and Housing: Reflecting Australia – Stories from the census, 2016*. Canberra: ABS 2017 (<http://www.abs.gov.au/ausstats/abs@nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Cultural%20Diversity%20Article~60>) [Accessed 20 October 2020].
2. Bhuyan R, Senturia K. Understanding domestic violence resource utilization and survivor solutions among immigrant and refugee women: Introduction to the special issue. *J Interpers Violence* 2005;20:895–901. [Accessed 20 October 2020].
3. Cross-Sudworth F. Ethnicity and domestic abuse: Issues for midwives. *Br J Midwifery* 2009;17:212–15. [Accessed 20 October 2020].
4. Garcia-Moreno C, Jansen HA, Ellsberg M, et al. Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet* 2006;368:1260–69. [Accessed 20 October 2020].
5. Goncalves M, Matos M. Prevalence of violence against immigrant women: Systematic review of the literature. *J Fam Violence* 2016;31:697–710. [Accessed 20 October 2020].
6. Silverman JG, Decker MR, Saggurti N, et al. Intimate partner violence and HIV infection among married Indian women. *JAMA* 2008;300:703–10. [Accessed 20 October 2020].
7. Vung ND, Ostergren P-O, Krantz G. Intimate partner violence against women in rural Vietnam – Different socio-demographic factors are associated with different forms of violence: Need for new intervention guidelines? *BMC Public Health* 2008;8:55. [Accessed 20 October 2020].
8. Raj A, Silverman JG. Intimate partner violence against South Asian women in greater Boston. *J Am Med Womens Assoc* 2002;57:111–14. [Accessed 20 October 2020].
9. Baba Y, Murray SB. Spousal abuse, Vietnamese children's reports of parental violence. *Journal of Sociology and Social Welfare* 2003;30:97. [Accessed 20 October 2020].
10. Raj A, Liu R, McCleary-Sills J, et al. South Asian victims of intimate partner violence more likely than non-victims to report sexual health concerns. *J Immigr Health* 2005;7:85–91. [Accessed 20 October 2020].
11. Woodgate R, Busolo D, Crockett M, et al. A qualitative study on African immigrant and refugee families' experiences of accessing primary health care services in Manitoba, Canada: It's not easy! *Int J Equal Health* 2017;16:1–13. [Accessed 20 October 2020].
12. Kang C, Tomkow L, Farrington R. Access to primary health care for asylum seekers and refugees: A qualitative study of service user experiences in the UK. *Br J Gen Pract* 2019;69:e537–45. [Accessed 20 October 2020].
13. Pokharel B, Hegadoren K, Papatthanassoglou E. Factors influencing silencing of women who experience intimate partner violence: An integrative review. *Aggression and Violent Behavior* 2020;52:101422. [Accessed 20 October 2020].



14. Vaughan C, Davis E, Murdolo A, et al. Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia. The ASPIRE Project: Key findings and future directions. Sydney: Australia's National Research Organisation for Women's Safety, 2016. [Accessed 20 October 2020].
15. Pokharel B, Yelland J, Hooker L, et al. A systematic review of culturally competent family violence responses to women in primary care. *Trauma, Violence and Abuse*, 2020. [Accessed 20 October 2020].
16. Walker R, Schultz C, Sonn C. Cultural competence – Transforming policy, services, programs and practice. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* 2014:195–220. [Accessed 20 October 2020].
17. Campbell JC, Campbell DW. Cultural competence in the care of abused women. *J Nurse Midwifery* 1996;41:457–62. [Accessed 20 October 2020].
18. Mehra V. Culturally competent responses for identifying and responding to domestic violence in dental care settings. *J Calif Dental Assoc* 2004;32:387–95. [Accessed 20 October 2020].
19. Alvarez C, Debnam K, Clough A, et al. Responding to intimate partner violence: Healthcare providers' current practices and views on integrating a safety decision aid into primary care settings. *Res Nurs Health* 2018;41:145–55. [Accessed 20 October 2020].
20. The Victorian Foundation for Survivors of Torture. *Caring for refugee patients in general practice: A desktop guide*. 4th edition. Brunswick, Vic: The Victorian Foundation for Survivors of Torture, 2012. [Accessed 20 October 2020].
21. Shamu S, Abrahams N, Temmerman M, et al. Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe. *Cult Health Sex* 2013;15:511–24. [Accessed 20 October 2020].
22. Kumar S, Jeyaseelan L, Suresh S, et al. Domestic violence and its mental health correlates in Indian women. *Br J Psychiatry* 2005;187:62–67. [Accessed 20 October 2020].
23. Kahn S, Alessi EJ, Kim H, et al. Facilitating mental health support for LGBT forced migrants: A qualitative inquiry. *Journal of Counseling & Development* 2018;96:316–26. [Accessed 20 October 2020].
24. McCann TV, Renzaho A, Mugavin J, et al. Stigma of mental illness and substance misuse in sub-Saharan African migrants: A qualitative study. *Int J Ment Health Nurs* 2018;27:956–65. [Accessed 20 October 2020].
25. Huria KA, Deepti D, Lajya D, et al. Domestic violence in pregnancy in North Indian women. *Indian J Med Sci* 2005;59:195–9. [Accessed 20 October 2020].
26. Raj A, Sabarwal S, Decker MR, et al. Abuse from in-laws during pregnancy and post-partum: Qualitative and quantitative findings from low-income mothers of infants in Mumbai, India. *Matern Child Health J* 2011;15:700–12. [Accessed 20 October 2020].
27. Nickerson A, Byrow Y, O'Donnell M, et al. The association between visa insecurity and mental health, disability and social engagement in refugees living in Australia. *Eur J Psychotraumatol* 2019;10:1688129. [Accessed 20 October 2020].
28. Chibber KS, Krishnan S, Minkler M. Physician practices in response to intimate partner violence in southern India: Insights from a qualitative study. *Women Health* 2011;51:168–85. [Accessed 20 October 2020].
29. Wrangle J, Fisher JW, Paranjape A. Ha sentido sola? Culturally competent screening for intimate partner violence in Latina women. *J Womens Health (Larchmt)* 2008;17:261–68. [Accessed 20 October 2020].
30. Migrant and Refugee Women's Health Partnership. *Guide for clinicians working with interpreters in healthcare settings*. Canberra: Migrant and Refugee Women's Health Partnership, 2019. [Accessed 20 October 2020].

# Working with violence and abuse in people with disabilities

'Disability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life. Over one billion people – about 15% of the global population – live with some form of disability and this number is increasing.' **World Health Organization 2021**<sup>4</sup>

## Key messages

- Health practitioners have a role in preventing, detecting and managing abuse in their patients with disabilities.<sup>1,2</sup>
- People with disabilities are a vulnerable group within our society and among our patients. They are at increased risk for neglect and for multiple forms of abuse, including verbal, psychological, physical and sexual abuse.<sup>2,3</sup>
- People with intellectual disability in particular are at high risk of physical, psychological and sexual abuse, problems that may present in general practice as mental illness and/or challenging behaviours.<sup>1</sup>

## Recommendations

Be aware that people with disabilities, including those with a mental illness, are at a much greater risk of abuse and violence than those without a disability.

**(Practice point, consensus of experts)**

## Clinical context

### Background and prevalence

People with disabilities are a vulnerable group within our society and among our patients. They are at increased risk for neglect and for multiple forms of abuse, including verbal, psychological, physical and sexual abuse.<sup>2,3</sup>

In this chapter we will look at the risk of abuse and violence happening particularly with patients with more marked physical and intellectual disabilities.

The number of people with disability in Australia increased from 4.3 million in 2015 to 4.4 million in 2018, and the number of people with disability aged over 65 years increased from 1.8 million in 2015 to 1.9 million in 2018. In 2018, 5.7% of all Australians had a profound or severe disability, and 23.2% of all people with disability reported a mental or behavioural disorder as their main condition.<sup>5</sup>

Evidence suggests that up to 25% of children with disability will experience abuse and violence within their lifetime, and children with disability are three to four times more likely to be victims/survivors of violence than their peers without disability.<sup>6</sup> Additionally, the prevalence of sexual abuse may be higher in children with mental or intellectual disability than children with other impairments.<sup>6</sup> Refer also to [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/ke-y-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/ke-y-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect).

Likewise, adults with disability appear to be at increased risk of interpersonal violence, for reasons including exclusion from education and employment, the need for personal assistance with daily living, reduced physical and emotional defences, communication barriers that hamper the reporting of violence, societal stigma and discrimination.<sup>3</sup>

In particular, people with intellectual disability (Box 18.1) are at higher risk of violence and sexual assault.<sup>7</sup> Adults with intellectual impairment or mental illness had the highest population rates of violence compared both with individuals with other disability types, and with adults in the general population.<sup>3</sup> Prevalence estimates of any recent violence – including physical, sexual or intimate partner abuse/violence (IPAV) – were highest in adults with mental illness, and lowest in those with non-specific impairments. The pooled prevalence of violence in people with mental illness was quoted as 21.4%, in intellectual disability 9.9%, and sexual abuse 5.5%.<sup>3</sup> Perpetrators will target this population as they are more vulnerable to manipulation and their cognitive disability makes it harder to bring about a conviction.

The United Nations Committee on the Rights of Persons with Disabilities reported in 2015 that current anti-discrimination laws in Australia fail to adequately recognise and address discrimination against people with disabilities, including its cumulative effects, because of the requirement that each occurrence is dealt with in isolation.<sup>8</sup>

## Violence against women with disabilities

Women with disability experience a range of impairments that impact on their lives in various ways, encompassing medical conditions and/or sensory, physical, cognitive and psychosocial impairments, singly or in combination.<sup>8</sup> In 2015, the United Nations Committee on the Rights of Persons with Disabilities expressed concern that gender equality national policies and plans often lacked a disability perspective, and gender is not mainstreamed in disability policies. A lack of awareness of the rights of children with disability was also reported.<sup>8</sup>

Furthermore, violence against women with disabilities continues to be downplayed, by being described as abuse, neglect, service incidents, administrative infringements or just a workplace issue to be addressed, rather than being described as violence or crimes.<sup>9</sup>

IPAV is considered a major global health issue, affecting women in particular. However, the World Health Organization's (WHO) 2013 guidelines *Responding to intimate partner violence and sexual violence against women* address only patients without a disability,<sup>2</sup> and do not always apply to women with disability.

An estimated 54–80% of women with disabilities have experienced IPAV, which can seriously impact their physical, mental, sexual and reproductive health.<sup>10</sup> A study found a prevalence of IPAV between 26–90% in women with disability, at a disproportionate rate compared with men with disabilities.<sup>3</sup>

### Box 18.1. Intellectual disability definitions<sup>11</sup>

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) defines intellectual disabilities as ‘neurodevelopmental disorders which begin in childhood, characterised by intellectual disabilities and difficulties in conceptual, social and practical areas of living’.<sup>12</sup>

Intellectual difficulties include:

- difficulties with reasoning, problem-solving, planning, abstract thinking, judgement, academic learning and learning from experience
- deficits in adaptive functioning that significantly hamper the ability to conform to developmental sociocultural standards for independence of the individual, and ability to meet social responsibilities.

Onset is within the first two decades of life.

Although the term ‘intellectual disability’ is used throughout this chapter, only people with mild to moderate intellectual disability would have the ability to explain their experiences or respond to questions. If a person has a more severe level of intellectual disability, observation (eg of changes in behaviour and function) and careful history-taking with carers will be important.

The National Disability Insurance Scheme (NDIS) (<http://www.ndis.gov.au/applying-access-ndis/how-apply/information-support-your-request/types-disability-evidence>) details the requirements for the initial (access) application for NDIS funding. For those whose primary disability is autism, intellectual disability, developmental delay, global developmental delay or Down syndrome, evidence in order of preference is:

- DSM-5 (<https://www.psychiatry.org/psychiatrists/practice/dsm>)
- Vineland Adaptive Behaviour Scale (Vineland-II) (<https://pearsonclinical.in/solutions/vineland-ii/>)
- WHO Disability Assessment Schedule (WHODAS 2.0) (<https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule>) (17 years and over)
- PEDI-CAT (<https://www.pedicat.com/>) (16 years and under).

**Mild to moderate intellectual disability** encompasses the majority of people with intellectual disability. People with mild intellectual disability are challenged in all areas of conceptual development, as well as social and daily living skills. They are able to learn practical living skills, allowing them to function in ordinary life with minimal support. However, they require much more training time than for people without disability, and may struggle if something unexpectedly changes, such as a bus route. Patients with moderate

intellectual disability are able to take care of themselves with moderate support, travel to familiar places within their community, and learn basic skills related to safety and health, again with longer training time.

**Severe intellectual disability** is diagnosed in a person who has major delays in development. The person may understand a few basic commands but have limited communication skills. They may also have physical limitations. Engagement in simple daily routines is possible with support, but they may require supervision in social settings. People with severe intellectual disability require close supervision and help with self-care activities, and accommodation is generally either with family or in a supervised setting. People with severe intellectual disability are likely to have associated medical conditions.

## The role of GPs

GPs and other health practitioners have a duty of care to patients with disabilities, as to all patients. However, research has shown that despite having greater health needs, people with disabilities have less access to appropriate healthcare, often due to physical access problems, communication difficulty or lack of awareness of the need for care on the part of patients and their carers.<sup>13</sup> People with intellectual disability in particular have specific needs, but may experience difficulty addressing these needs.<sup>1.14</sup>

Good general practice care therefore has the potential to greatly improve the health and welfare of people with disability, but GPs need to be mindful of the possibility of abuse. All practice staff need to have disability awareness training, including receptionists, who are the first point of contact with a patient with intellectual disability.

## In practice

### Identifying abuse or violence among patients with disability

People with disabilities may find it difficult to disclose abuse because of their situation of being dependent on their care givers or an inability to verbally communicate. Some patients with potentially limited intellectual capacity may not understand that what they are experiencing is abuse or what their rights are. GPs should consider the possibility of abuse and identify and appropriately care for patients to ensure their safety.

Some people with disabilities can display the same presentations of IPAV or sexual assault as seen in older people (Table 18.1) or people without disabilities.

**Table 18.1. Possible signs and symptoms of abuse and violence**

General behaviour	<ul style="list-style-type: none"> <li>• Afraid of one or many person/s</li> <li>• Irritable or easily upset</li> <li>• Worried or anxious for no obvious reason</li> <li>• Depressed, apathetic or withdrawn</li> <li>• Change in sleep patterns and/or eating habits</li> <li>• Rigid posture and avoiding contact</li> <li>• Avoiding eye contact or eyes darting continuously</li> <li>• Contradictory statements not from mental confusion</li> <li>• Reluctance to talk openly</li> </ul>
Physical abuse	<ul style="list-style-type: none"> <li>• A history of physical abuse, accidents or injuries</li> <li>• Injuries such as skin trauma, including bruising, skin tears, burns, welts, bed sores, ulcers or unexplained fractures and sprains</li> <li>• Signs of restraint (eg at the wrists or waist)</li> <li>• Unexplained behaviour changes suggesting under-medication or over-medication</li> <li>• Unusual patterns of injury</li> </ul>
Sexual abuse	<ul style="list-style-type: none"> <li>• Bruising around the breasts or genital area</li> <li>• Unexplained genital or urinary tract infections</li> <li>• Damaged or bloody underclothing</li> <li>• Unexplained vaginal bleeding</li> <li>• Bruising on the inner thighs</li> <li>• Difficulty in walking or sitting</li> </ul>
Emotional abuse	<ul style="list-style-type: none"> <li>• A history of psychological abuse</li> <li>• Reluctance to talk, fear, anxiety, nervousness, apathy, resignation, withdrawal, avoidance of eye contact</li> <li>• Rocking or huddling up</li> <li>• Loss of interest in self or environment</li> <li>• Insomnia/sleep deprivation</li> <li>• Unusual behaviour or confusion not associated with illness</li> </ul>
Economic abuse	<ul style="list-style-type: none"> <li>• History of fraudulent behaviour or stealing perpetrated on the patient</li> <li>• Lack of money to purchase medication or food</li> <li>• Lack of money to purchase personal items</li> <li>• Defaulting on payment of rent</li> </ul>

**Table 18.1. Possible signs and symptoms of abuse and violence**

Neglect	<ul style="list-style-type: none"> <li>• A history of neglect</li> <li>• Poor hygiene, bad odour, urinerash</li> <li>• Malnourishment, weight loss, dehydration (dark urine, dry tongue, lax skin)</li> <li>• Bed sores (sacrum, hips, heels, elbows)</li> <li>• Being over-sedated or under-sedated</li> <li>• Inappropriate or soiled clothing, overgrown nails, decaying teeth</li> <li>• Broken or missing aids such as spectacles, dentures, hearing aids or walking frame</li> </ul>
---------	--

Patients with intellectual disability in particular may have limited or no verbal communication; however, they may present with changes in behaviour as a result of abuse (eg sudden hyper-alertness or withdrawal, challenging behaviour and/or mental illness). If a person with intellectual disability presents with very sudden onset of mental illness or challenging behaviour, abuse needs to be excluded, particularly sexual abuse.

Likewise, if a family member or service manager reports a marked behavioural change in a person with disability, this could be due to illness, but may be an indicator that something has happened to the person with disability. Another sign could be the refusal to attend a support service, participate in a particular activity or become agitated in the company of a particular person.

Patients with severe or profound intellectual disability may be even more vulnerable to abuse, either in a family environment, an accommodation service, or day service; abuse will only be recognised if it is observed by another person, change in behaviour or there are physical signs of abuse, including bruising or other visible evidence.

### **Risk factors**

People with disabilities may experience a number of factors that contribute to abuse being perpetrated against them, or that can stop them speaking out or disclosing abuse. These include:

- lack of support to deal with violence and abuse, especially if they are being abused by those responsible for their care – they may fear an escalation of abuse if they speak up
- worry they would 'not be believed' or told it is their fault if they disclose the abuse – they may also believe the abuse is their fault
- poverty and dependence (economic, physical or social) on others, exclusion from the labour market
- inappropriate places of residence or service settings (eg living in a group home or other supported living situation with little privacy, or lack of access to crisis accommodation and support)
- service system issues, including difficulties in negotiating support systems, or lack of appropriate support to communicate effectively
- lack of participation and access to decision making and representation
- lack of access to the criminal justice system, and no understanding of their rights



- poor screening of support workers; drug and alcohol abuse by family members or support workers increases the risk of abuse
- vulnerability to perpetrators who will target them because of difficulty in making a successful conviction.

Compounding vulnerabilities are childhood abuse or adversity, previous experience of IPAV, victim or perpetrator alcohol or drug abuse, social isolation and lack of mobility.

Research examining the motivation for sexual offending self-described by autistic offenders found five main themes: social skills difficulties, lack of perspective, misunderstanding the seriousness of their behaviours, lack of appropriate relationships and a period of disequilibrium before committing the sexual offence.<sup>15</sup> Other research suggests an individual with autism is at risk of sexually abusing if they have a history of being physically abused (10.8 times more likely) or a history of being sexually abused (8.6 times more likely).<sup>16</sup> A study found lack of professional support before offending, which might be due to the later diagnosis of autism spectrum (mean age 13.13 years, compared with most children diagnosed between 3.17 to 10 years).<sup>17</sup>

Box 18.2 shows further vulnerabilities observed by parents in their adult children with intellectual disability.

Stress in caregivers, whether family, friends or paid carers, is associated with increased rates of depression, anxiety, substance abuse and anger, for both carers and the person receiving care.<sup>18</sup> These problems can escalate over time, becoming risk factors for IPAV. This may lead to deterioration of self-care, including reductions in exercise, social isolation and poor sleep. Lack of self-care and increasing stress may result in maladaptive emotion-regulation strategies such as avoidance, rumination and alcohol abuse, with increased susceptibility to mental health problems.

### **Box 18.2. Vulnerabilities to abuse of women with intellectual disability**

Parents of women with intellectual disability participating in a research focus group revealed how vulnerable their daughters with mild to moderate intellectual disability were, with sexual relationships particularly challenging.<sup>14</sup> Observations included that their children:

- are lonely, disempowered and vulnerable to abuse, desperately craving intimate caring relationships like those seen on television
- lack sex knowledge ('babies come out of the belly-button'), relationship skills and self-protection skills, which may increase their risk of abuse
- may not recognise their experience to be abusive
- lack employment, meaningful activities and close relationships
- may have unrecognised health problems, plus mental illness with challenging behaviours, for which they are prescribed psychotropics
- access unhealthy and possibly exploitative sexual activity in bars and with prostitutes and are exposed to pornography
- want intimate relationships, but have limited opportunities and difficulty negotiating the relationships
- have difficulty interpreting social cues and lack interpersonal skills and assertiveness.

Some noted that vulnerability to exploitation for young females with intellectual disability is exacerbated by new technologies, including the internet, mobile phones, chat rooms, online dating and the sex industry.

It was also reported that women who had been sexually abused were frightened of getting into trouble if reporting the abuse. Additionally, they lacked the verbal skills to describe it. When a girl is young, some parents use euphemisms rather than correct anatomical terms for sexual parts. This adds to difficulty reporting abuse as an adult, as parents may no longer be around to interpret the euphemisms.

The issues around appropriate sexuality education, support and protection from abuse are highly complex. Innovative programs such as Johnson and Frawley's, Living Safer Sexual Lives program have demonstrated that people with intellectual disability are not only able to learn new skills, but can actively participate in developing programs. However, the process is slow and painstaking and effective learning and support requires ongoing funding and significant attitudinal change.<sup>1,19</sup>

## **Working with patients with intellectual disability**

As with all patients, it is important to establish rapport and trust with your patients who have intellectual disability. Opportunities within regular consultations can be used to discuss their sexuality and relationships in a non-threatening way, which could allow you to ask more specific questions should the

situation require it. This might be during an annual health assessment, during a Pap smear or breast examination for females or testicular examination for males. It is important that you have a second person within the room during these examinations.

If you suspect that a patient with intellectual disability is being abused or vulnerable to abuse, first consider the patient's level of verbal communication in order to make an assessment (Box 18.3). If they are able to communicate independently, try to see the patient alone for some of the time – keep in mind that an accompanying person or carer may be the perpetrator of abuse; if the patient is living in an accommodation service, it is possible that the abuser is another client of the service or a member of staff.

While people with mild to moderate intellectual disability may have adequate communication skills, it can be difficult to obtain a consistent history from that person. Particular care should be taken not to make leading statements when taking a history. If there is a suspicion, early referral to an appropriately skilled counsellor is advised. Some individuals may have a history of what has been shown to be false accusations directed at carers. However, each situation should be judged on its merits with the safety of the individual the main priority.

Reduce the patient's anxiety by asking non-threatening general questions first, selecting the ones that seem to be more appropriate for them. Ask permission to speak about sensitive issues, especially if sexual abuse is suspected.

- Initial example questions can include: 'Where do you live?', 'What type of accommodation is it?', 'Do others live there too?', 'Do you need help from anyone else?', 'What do you do during the day?', 'Do you go out at night?', 'What things do you enjoy doing?', 'What don't you like doing?'
- It may then be appropriate to ask about relationships, including: 'Do you have friends?', 'Do you have family?', 'Do you have a partner?'
- Finally, you might ask: 'Has anyone ever hurt you badly?' From there, it may be appropriate to lead into asking questions relating to abuse, including IPAV.

While they can be vulnerable to abuse, people with mild to moderate intellectual disability are capable of having meaningful intimate relationships.

### **Box 18.3. Establishing clear communication with people with intellectual disability**

People with intellectual disability can have varying levels of ability to communicate verbally, and an individual's ability level may not be apparent on first meeting them. It is important to establish their level of communication and understanding to ensure clear communication throughout an appointment.

It is important to listen to the story presented by the carer, who is likely to have come with the patient. It is also important to see the patient on their own. Begin with short questions and use simple words as you listen to their account.

Tips for communication include:

- when greeting a patient, the words they use to respond will indicate their ability to communicate
- listen in a non-judgemental manner
- look at the patient when speaking
- speak slowly and clearly
- allow more time for the patient to respond to questions.

It may be useful to have a clinical record indicator (eg a note in electronic records, or blank coloured sticker on paper records) to indicate that a patient has an intellectual disability and that they should have a contact person to whom appointment reminders and other correspondence should be sent.

Some patients with intellectual disability become distressed and noisy if there are a number of people in the waiting room, and may leave the premises without waiting for the appointment. A note in the patient's clinical record could be useful to indicate the patient could be allowed to wait in a quieter area, outside, or in the car.

In assessing whether sexual abuse has occurred, it is important to assess whether the person is able to understand what they are consenting to and whether their intellectual disability makes them vulnerable to coercion. This can be a particular issue if there is a marked difference in the intellectual capacity of the individuals involved. This may require review by an experienced counsellor. Where abuse is suspected and is affecting the quality of life of the individual, psychological counselling could be beneficial. This could be through a mental health plan or through the person's NDIS plan. Sexual assault and family planning services may have [specialist services for people with disabilities \(https://www.rap-e-dvservices.org.au/resources/people-living-with-disabilities\)](https://www.rap-e-dvservices.org.au/resources/people-living-with-disabilities); this will vary depending on the state/territory.

Referral to or other involvement of a speech and language pathologist may be of use, particularly when the patient with disability has had an unexpected deterioration in communication.<sup>10</sup>

This may represent a non-threatening option for disclosure if the victim of abuse is accompanied by the abuser. The patient may also feel less intimidated disclosing abuse to a speech and language pathologist.

Patients with limited communication skills are more vulnerable to abuse and less likely to have this discovered. This abuse can be from a co-client, staff or even family. It is important to be aware that changes in behaviour or deterioration in mood could be a sign of abuse (eg if an individual becomes distressed in the presence of a particular person or refuses to travel in a bus or attend a particular activity). There can also be bruising and scratching or other physical signs of abuse. If a person with intellectual disability presents with very sudden onset of mental illness or challenging behaviour, abuse needs to be excluded, particularly sexual abuse.

## Intimate partner abuse

Although there is literature on disability and IPAV, there are limited guidelines for managing IPAV experienced by a person with disability. Factors that need to be considered include:

- the comprehension ability of the abused person
- the insight of that person, and any partner
- whether the partner is providing personal care to the abused person, and how dependent the person is on them (eg for home or economic support).<sup>18</sup>

Adults with intellectual disability may require education to help their understanding of healthy relationships.<sup>20</sup> This will only be relevant for those with mild intellectual disability, and perhaps some with moderate intellectual disability.

Some practical ways to help people with disability who are experiencing IPAV are:

- help the patient understand the effects of abuse on their health and welfare
- help the patient to find ways to be safe, especially if they are being abused in an accommodation service
- reassure the patient that they are not to blame
- reinforce that everyone has the right to be safe and live without abuse and violence
- help with financial needs to access treatment (eg National Disability Insurance Scheme [NDIS] funding could be used for a psychologist to help decide what to do, or patients may be eligible for Chronic Disease Management plans (eg Enhanced Primary Care plan or GP Mental Health Treatment Plan).

Allow time for patients to make their own decisions as to the next steps. Offering another appointment later on can give them time to think through decisions, providing they are not immediately at risk.

GPs and other practice staff should make themselves aware of services in the community that can assist people with disabilities in this situation, such as counselling, advocacy, shelters, police and legal services.

A list of state and territory disability rights services can be found [here \(https://humanrights.gov.au/our-work/disability-rights/disability-rights-disability-legal-services\)](https://humanrights.gov.au/our-work/disability-rights/disability-rights-disability-legal-services).

## Working with the National Disability Insurance Scheme

Since 2013, disability funding has been distributed through the NDIS. The NDIS aims to individualise funding and allow people more choice of service provider and use of available funds.

GPs are ideally situated to support patients with disabilities and their carers in applying for NDIS support and reviewing their plans, by:

- helping with the application
- drafting a letter of support about a particular issue faced by the patient
- referring to appropriate specialists or services to investigate or identify a problem
- identifying how a particular health issue or vulnerability might impact need for support.

It is useful to keep a copy of patients' NDIS plans on file – this requires permission from the patient or their medical treatment decision maker.

## Case study: Kayla

Kayla, a 22-year-old woman with mild intellectual disability and type 1 diabetes, has been your patient for two years. She is usually likeable, and her speech can be difficult to understand, particularly when she is anxious. Kayla lives with her elderly parents and younger sister, Sarah.

When Kayla's father recently needed major surgery, her parents arranged for Kayla to go into a respite house, which she had been to before.

Kayla comes to see you for a regular check-up, accompanied by Sarah. During the appointment, Sarah says that Kayla has not been her usual bubbly self, being irritable and argumentative. This has adversely affected the health of their parents, to the extent that Sarah has rented a unit and moved out with Kayla.

Sarah is worried about her sister's diabetes management, saying that Kayla has been irregularly taking her blood glucose levels (BGL). When you take a BGL, her reading is 18.5 mmol/L. As Kayla is hyperglycaemic, you arrange for her to be taken immediately to a nearby emergency department.

Kayla's insulin dose is increased in the hospital, and she is sent home with orders to return if her BGL goes up again. A few days later, Kayla again develops hyperglycaemia, so she returns to the emergency department and is admitted. The hospital staff run investigations for sources of infection, but find none and discharge Kayla after several days.

A few days later, a nurse notices that Kayla's hospital notes mention that Kayla mentioned someone coming 'into my bedroom with his pants off' during her stay at the respite house. Kayla's urine is checked for sexually transmitted infections (STIs), and returns positive results for chlamydia and gonorrhoea. Kayla is treated for those conditions and referred to a social worker, who tells her to carry condoms in her handbag in future.

When the hospital nurse informs you of this, you contact Kayla to arrange to see her immediately.

Kayla comes in with Sarah, but clearly feels embarrassed about the STIs. You reassure her that it is not her fault, and that she has done nothing wrong. You offer to tell Kayla's parents about the abuse on her behalf, or with her, but Sarah says that she would prefer to tell them.

Sarah and their mother accompany Kayla to the police station, where she makes her report.

On Kayla's next visit, Sarah tells you that she and Kayla have moved back into the family home, and Kayla is partially back to her bubbly self, managing her diabetes well again. You discuss the possibility of counselling, including support and advocacy for Kayla as she goes through the legal processes of making her police report. They agree that it could be helpful, so you make a referral to a local sexual assault support service that has counsellors trained in supporting people with disability.

Kayla continues to attend her regular appointments and seems back to her usual self. Her diabetes remains well-controlled.

## Key points

The person who abused Kayla could have been a disability support worker or another client staying in the respite house. Therefore, the accommodation support organisation will need to undergo its own investigation. If a co-resident potentially has an STI this needs to be investigated. All residents should be reviewed by their GP. If the abuser is identified as a co-resident, the service should investigate how he contracted the STIs, including whether he was himself abused. If the abuser is a paid carer, then other people in the service are at risk. While it is not your role as a GP to carry out this investigation, you should ensure that it takes place.

It is difficult to know how much Kayla understood about the significance of the abuse, as her intellectual disability may have protected her from full realisation. However, a person with mild intellectual disability is likely to be able to identify the person who abused them. In the past, getting consistent evidence that would stand up in court might have been difficult, but current procedures allow evidence in-camera. Genomic sequencing could identify the gonorrhoea and STIs and be used as evidence, if these were identified in the perpetrator.

Kayla will need regular Pap smears. Kayla is still capable of having a relationship, and should be given sex education (with care taken not to trigger memories of the abuse) and contraception, if she wants to be sexually active.

## Case study: Josh

Josh is a 10-year-old boy who has autism and intellectual disability. He is not toilet-trained and is currently non-verbal. He is brought to see you by his mother, Jasmine, at the urging of his special school staff. Josh's father, Cameron, is an interstate truck driver who is away alternate weeks.

You ask a number of questions to clarify the situation.

- 'What kind of behaviour are you or the school concerned about?'
- 'How long have they been occurring?'
- 'Do they occur all the time, or now and then?'
- 'If now and then, when do they tend to occur?'

Jasmine says that the behaviours are worse when Cameron is home. When you ask if she has noticed any other changes in Josh, she tells you that Josh is now a very restless sleeper and has nightmares all the time. He is also getting a lot of bruises, and she is worried he might have something wrong with his blood.

On examination you note the following:

- left ear lobe swollen and painful
- adult-sized bruises on upper arms
- adult-sized fingerprints on his lower abdomen, of varying ages, which indicated he had been grabbed from behind by an adult
- reddening around Josh's anus.

You explain to Jasmine that it is possible Josh is being abused by an adult. This means that you have to report it to the Child Abuse Report Line. Jasmine agrees.

Following the report, Cameron is arrested and charged with the sexual and physical abuse of Josh. He is eventually sentenced to prison.

When Josh and his mother are safe, you consider how to support them, which is a challenge because of Josh's disability and the potential cost of therapy. You have heard about victim support and ring to see if Josh would qualify and if they could pay for this service. You find that Jasmine also qualifies for a support service and there is funding available to help them in other ways (Box 18.4). The other option is to try to access services through funding from NDIS.

A therapist is found through Autism Spectrum Australia<<link to <https://www.autismspectrum.org.au/>>>. Josh starts to see a therapist who has training in working with children with his disabilities.

You arrange to see Jasmine without Josh, to see if she will accept a referral to help her cope with the after-effects of the domestic violence and Josh's child abuse. Her financial situation needs to be explored, as well as her current living arrangements. She declines a therapist referral for now, but commits to seeing you regularly.

Six months later, Josh is looking happier, has put weight on, is taller, and has begun to talk again. Josh's mother is also looking more relaxed, and reveals that she had been physically abused by her partner. Again, the option of a referral is discussed but declined because she does not feel ready to go to an unknown person. You continue to see her regularly to build up her confidence to accept a referral to a domestic violence service or a psychologist with experience working with people exposed to domestic violence.

Inability to communicate is not a barrier to perpetrators being identified, charged with sexual abuse and gaoled.



**Box 18.4. Victim Support Services in each state and territory**

Australian Capital Territory	<p><u><a href="http://www.victimsupport.act.gov.au/">Victims Support ACT (http://www.victimsupport.act.gov.au/)</a></u></p> <p>1800 8222 72</p>
New South Wales	<p><u><a href="http://vs@dcj.nsw.gov.au">Victims Services (http://vs@dcj.nsw.gov.au)</a></u></p> <p>1800 633 063 <u><a href="mailto:vs@dcj.nsw.gov.au">vs@dcj.nsw.gov.au</a></u> (mailto:vs@dcj.nsw.gov.au)</p>
Northern Territory	<p><u><a href="https://justice.nt.gov.au/justice-services/crime-victims-services-unit">Crime Victims Services Unit (https://justice.nt.gov.au/justice-services/crime-victims-services-unit)</a></u></p> <p>1800 460 363 or (08) 8924 4080 <u><a href="mailto:cvsu.doj@nt.gov.au">cvsu.doj@nt.gov.au</a></u> (mailto:cvsu.doj@nt.gov.au)</p>
Queensland	<p><u><a href="http://www.qld.gov.au/victims">Victims Assist Queensland (http://www.qld.gov.au/victims)</a></u></p> <p>1300 546 587</p> <p><u><a href="mailto:VictimAssist@justice.qld.gov.au">VictimAssist@justice.qld.gov.au</a></u> (mailto:VictimAssist@justice.qld.gov.au)</p>
South Australia	<p><u><a href="http://www.voc.sa.gov.au/">Commissioner for Victims' Rights (http://www.voc.sa.gov.au/)</a></u> &lt;&lt;link to www.voc.sa.gov.au/&gt;&gt;</p> <p>(08) 8204 9635</p> <p><u><a href="mailto:victimsofcrime@sa.gov.au">victimsofcrime@sa.gov.au</a></u> (mailto:victimsofcrime@sa.gov.au)</p>

Tasmania	<p><a href="http://www.justice.tas.gov.au/victims">Victims Support Services Tasmania (http://www.justice.tas.gov.au/victims)</a></p> <p>1300 663 773 or (03) 6165 7524</p>
Victoria	<p><a href="http://www.victimsofcrime.vic.gov.au/">Victims of Crime Victoria (http://www.victimsofcrime.vic.gov.au/)</a></p> <p>1800 819 817</p> <p>Text: 0427 767 891</p> <p><a href="mailto:vsa@justice.vic.gov.au">vsa@justice.vic.gov.au (mailto:vsa@justice.vic.gov.au)</a></p>
Western Australia	<p>Victims of Crime Western Australia&lt;&lt;link to <a href="http://www.victimsofcrime.wa.gov.au/">www.victimsofcrime.wa.gov.au/</a></p> <p>1800 818 988 or (08) 9264 1600</p> <p>or (08) 9425 2850</p> <p><a href="mailto:cvoc@justice.wa.gov.au">cvoc@justice.wa.gov.au (mailto:cvoc@justice.wa.gov.au)</a></p>

---

## Resources

- [Developmental disability \(https://tgldcdp.tg.org.au/index\)](https://tgldcdp.tg.org.au/index) – refer to the chapter on ‘Abuse, trauma and supporting people with developmental disabilities’. Therapeutic Guidelines, 2021.
- [Rape and Domestic Violence Services Australia \(https://www.rape-dvservices.org.au/resources/people-living-with-disabilities\)](https://www.rape-dvservices.org.au/resources/people-living-with-disabilities) – information for people with disabilities and their carers and families.

## References

1. Eastgate G, Van Driel M, Lennox N, et al. Women with intellectual disabilities – Study of sexuality, sexual abuse and protection skills. *Aust Fam Physician* 2012;40:226–30.
2. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
3. Hughes K, Bellis M, Jones L, et al. Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *Lancet* 2012;379:1621–29.
4. World Health Organization. Disability. Geneva: WHO, 2021.
5. [Australian Bureau of Statistics. Disability, ageing and carers, Australia: Summary of findings. Canberra: ABS, 2019 \(http://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release\)](http://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release) [Accessed 19 April 2021].
6. Jones L, Bellis M, Wood S, et al. Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *Lancet* 2012;380:899–907. [Accessed 19 April 2021].
7. Nixon M, Thomas S, Daffern M, et al. Estimating the risk of crime and victimisation in people with intellectual disability: A data-linkage study. *Soc Psychiatry Psychiatr Epidemiol* 2017;52:617–26. [Accessed 19 April 2021].
8. UN Human Rights Office of the High Commissioner. Committee on the Rights of Persons with Disabilities. General comment on Article 6: Women with disabilities. Geneva: United Nations, 2015. [Accessed 19 April 2021].
9. Frohmader C, Dowse L, Didi A. Preventing violence against women and girls with disabilities: Integrating a human rights perspective. *Human Rights Defender* 2015;24:11–15. [Accessed 19 April 2021].
10. Ballan M, Freyer M. Intimate partner violence and women with disabilities: The role of speech-language pathologists. *Am J Speech-Lang Pathol* 2019;28:1692–97. [Accessed 19 April 2021].
11. Patel DR, Cabral MD, Ho A, et al. A clinical primer on intellectual disability. *Transl Pediatr* 2020;9:S23–S35. [Accessed 19 April 2021].
12. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Fifth edition. Arlington, VA: American Psychiatric Association, 2013. [Accessed 19 April 2021].
13. Jenkins R, Davies R. Neglect of people with intellectual disabilities. *J Intellect Disabil* 2006;10:35–45. [Accessed 19 April 2021].
14. Eastgate G, Scheermeyer E, Van Driel M, et al. Intellectual disability, sexuality and sexual abuse prevention – A study of family members and support workers. *Aust Fam Physician* 2011;41:135–39. [Accessed 19 April 2021].
15. Payne KL, Maras K, Russell AJ, et al. Self-reported motivations for offending by autistic sexual offenders. *Autism* 2020;24:307–20. [Accessed 19 April 2021].
16. Mandell DS, Walrath CM, Manteuffel B, et al. The prevalence and correlates of abuse among children with autism served in comprehensive community-based mental health settings. *Child Abuse Negl* 2005;29:1359–72. [Accessed 19 April 2021].
17. Daniels AM, Mandell DS. Explaining differences in age at autism spectrum disorder diagnosis: A critical review. *Autism* 2014;18:583–97. [Accessed 19 April 2021].
18. Salwen J, Gray A, Mona L. Personal assistance, disability, and intimate partner violence: A guide for healthcare providers. *Rehab Psychol* 2016;61:417–29. [Accessed 19 April 2021].
19. Johnson K, Frawley P, Hillier L, et al. Living safer sexual lives: Research and action. *Tizard Learning Disability Review* 2002;7:4–9. [Accessed 19 April 2021].
20. Bowen E, Swift C. The prevalence and correlates of partner violence used and experienced by adults with intellectual disabilities: A systematic review and call to action. *Trauma Violence Abuse* 2019;20:693–705. [Accessed 19 April 2021].

# LGBTIQA+ Family abuse and violence

'My abuser and I were both raised in a homophobic world where violence against gay men was normalised. My abuser made a choice to control and abuse me. But without homophobia ... perhaps he wouldn't have had so many tools on hand to hurt me and to control me.' **Russell Vickery, LGBTIQA+ Representative, Victim Survivor Advisory Council**

## Key messages

- LGBTIQA+ people experience family violence at higher rates than non-LGBTIQA+ Australians, in the form of intimate partner abuse/violence (IPAV) and violence within families of origin.
- LGBTIQA+ Australians with other diverse identities – such as being multicultural or multifaith, having a disability, or Aboriginal or Torres Strait Islander people – may be at higher risk of family violence due to cultural sensitivities and marginalisation.
- Health professionals need to understand that the experiences of discrimination, violence and abuse of LGBTIQA+ people in Australian society are associated with significant disparities in physical and mental health.<sup>1-5</sup>
- Risk of suicide amongst LGBTIQA+ people in Australia is higher for those lacking family acceptance, and with histories of physical and sexual abuse.<sup>6</sup> This needs to be understood, considered and addressed by the treating health professional where appropriate.
- Significant barriers to help-seeking include fears of discrimination within service systems, and family violence care often being focused on heterosexual relationships, female victims/survivors and male perpetrators.
- Primary care is an important location for identification of LGBTIQA+ family violence, support and referral to LGBTIQA+ inclusive services.
- Primary violence prevention strategies can be incorporated into routine primary care for LGBTIQA+ people.

## Introduction

Lesbian, gay, bisexual, trans and gender diverse, intersex, queer, asexual (LGBTIQA+) represents a collection of diverse communities, and distinct and overlapping identities. In discussing these issues, it is particularly important to avoid common pitfalls in confusing or conflating sexual and gender diversity, or gender diversity (ie experiences of trans or non-binary people) and sex characteristics (ie the experiences of people with intersex variations).

Many LGBTIQA+ people enjoy happy and healthy lives, including positive and loving relationships. However, dominant social norms regarding sex, gender and sexuality in Australia have a significant influence on LGBTIQA+ people's lives, resulting in experiences of inequality, stigma and discrimination.

LGBTIQA+ people are often made to feel there is something wrong with their bodies, identities and relationships because they do not fit normative ideas of 'male' and 'female', 'masculine' and 'feminine' or monogamous heterosexuality. Despite increasing recognition and legal protection of human rights, LGBTIQA+ people continue to report high levels of harassment, violence and abuse in many different areas of their lives.<sup>5, 7-9</sup>

A Victorian population-based study conducted in 2017 found that LGBTIQA+ people were more likely to experience discrimination in the past year than non-LGBTIQA+ people, including 56.1% of trans or gender-diverse adults, 39.9% gay or lesbian, and 31.5% bisexual, queer or pansexual respondents compared with 15.6% in non-LGBTIQA+ adults.<sup>10</sup> Some LGBTIQA+ people underutilise health services and delay seeking treatment due to actual or anticipated experiences of stigma and discrimination from service providers.<sup>11, 12</sup>

These experiences of discrimination, violence and abuse are associated with significant disparities in general health<sup>4, 5</sup> and mental health.<sup>1-3</sup> Risk of suicide among LGBTIQA+ people in Australia is higher for those lacking family acceptance, and with histories of physical and sexual abuse.<sup>6</sup> It is important to understand this social context for LGBTIQA+ people, which also frames their experiences of family violence.

For a glossary of terms, refer to [A Language Guide: Trans and Gender Diverse Inclusion \(https://www.ac.on.org.au/wp-content/uploads/2019/11/TGD-Language-Guide\\_2019\\_updated.pdf\)](https://www.ac.on.org.au/wp-content/uploads/2019/11/TGD-Language-Guide_2019_updated.pdf) and [LGBTIQ+ Inclusive Language Guide \(https://www.vic.gov.au/inclusive-language-guide\)](https://www.vic.gov.au/inclusive-language-guide).

## Clinical context

### Prevalence of LGBTIQA+ intimate partner and family violence

There is a lack of population-level data on violence and abuse experienced by LGBTIQA+ people. This is a result of population-level surveys, including those conducted by the Australian Bureau of Statistics not including adequate questions around sex characteristics, gender identity and sexuality. This limits both an understanding of the size of the LGBTIQA+ population, and the potential for disaggregated analyses of experiences of violence and abuse. Similar issues exist in the collection of health service data.<sup>13-15</sup>

---

Research focus on LGBTIQA+ people is a relatively recent, reflecting the social marginalisation of these communities. A growing body of research shows higher levels of intimate partner abuse/violence (IPAV), sexual violence, and violence within biological families among LGBTIQA+ people.

- IPAV is experienced at similar or higher rates in same-gender relationships compared to heterosexual relationships.<sup>16-19</sup>
- The Victorian Population Health Survey 2017 data showed that 13.4% of LGBTIQA+ adults had experienced family violence in the past two years compared with 5.1% of non LGBTIQA+ adults.<sup>10</sup> All types of family violence listed were significantly higher, with emotional/psychological abuse being most prevalent (Figure 19.1).
- There are indications of higher rates for bisexual women compared to lesbian or heterosexual-identified women<sup>17, 20, 21</sup> and for trans and gender-diverse people compared to cisgender people.<sup>22, 23</sup> For a glossary of terms, refer to [A Language Guide: Trans and Gender Diverse Inclusion \(https://www.acon.org.au/wp-content/uploads/2019/11/TGD-Language-Guide\\_2019\\_updated.pdf\)](https://www.acon.org.au/wp-content/uploads/2019/11/TGD-Language-Guide_2019_updated.pdf) and [LGBTIQA+ Inclusive Language Guide \(https://www.vic.gov.au/inclusive-language-guide\)](https://www.vic.gov.au/inclusive-language-guide).
- There is limited research into the violence experiences of people with intersex variations;<sup>24</sup> however, there is some evidence for violence within families, peers and schools including [body shaming \(https://ihra.org.au/familyviolence/\)](https://ihra.org.au/familyviolence/).
- Sexual violence is much higher for LGBTIQA+ than non-LGBTIQA+ people, with the Victorian Population Health study showing seven times the rate of sexual abuse (Figure 19.1).<sup>10</sup> Reported experiences by Australian trans and gender-diverse people are even higher, with 53.2% of the 1434 trans and gender-diverse respondents reporting sexual violence and coercion.<sup>25</sup>
- Many LGBTIQA+ people experience violence and abuse within their biological family or 'family of origin', although this is often not defined as family violence. A number of studies have focused on the impact of negative relationships between parents and LGBTIQA+ young people, particularly relating to 'coming out' and experiences of violence or abuse arising out of familial rejection.<sup>26-28</sup> While there is less research focus on experiences of abuse in childhood, some studies have found that lesbian, gay and bisexual young people are more likely than heterosexual siblings to experience verbal, physical and sexual abuse.<sup>29</sup>

'I became ashamed about being gay, about being sexually attractive and about having sexual desires. It was like going back into the closet.' **David, age 27 years**

'She had a drug, gambling and mental illness problem and would steal my money, threaten to self-harm, actually self-harm, and yell abuse at me.' **Sarah, age 37 years**

Source: Another Closet 2014

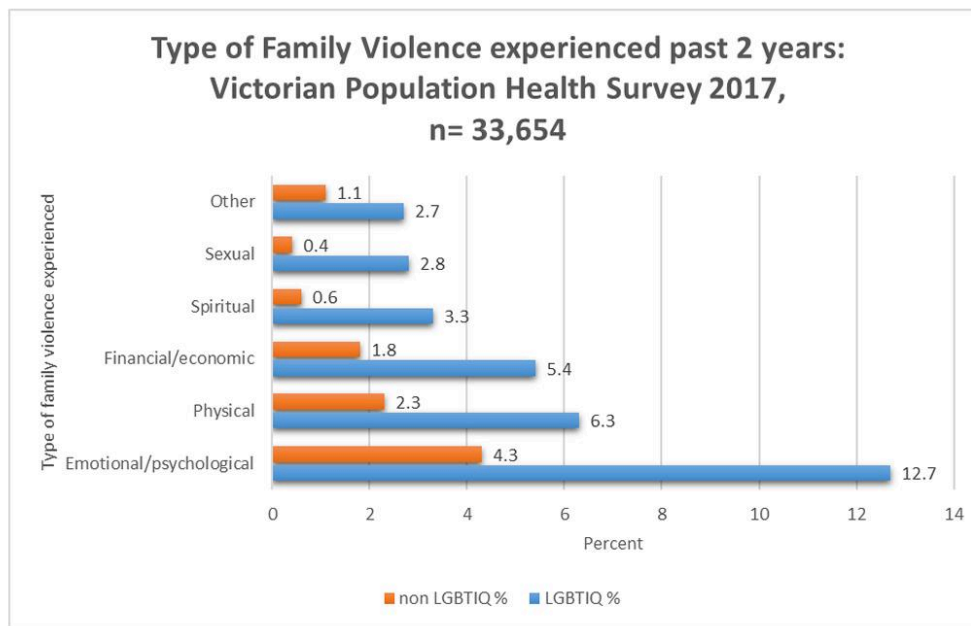


Figure 19.1. Types of family violence comparing LGBTIQA+ and non-LGBTIQA+ Victorians<sup>10</sup>

Reproduced with permission from: Victorian Agency for Health Information. *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria. Findings from the Victorian Population Health Survey 2017. Melbourne: VAHI, 2020.*

## Risk factors for family violence specific to LGBTIQA+ people

As well as the usual risk factors for family violence, additional risks have been identified for LGBTIQA+ people who are victims/survivors and/or perpetrators.<sup>30, 31</sup> These can be summarised as minority stress experiences<sup>32</sup> and include:

- internalised homophobia
- being HIV positive
- experiences of LGBTIQA+ based discrimination
- higher rates of complex trauma experiences.

## Intersectional influences on LGBTIQA+ family violence

LGBTIQA+ people who experience marginalisation or minority status in other areas of their life can be more at risk of family violence. This includes people from conservative religious backgrounds, or some multicultural communities, including recent arrivals, refugees and people seeking asylum.<sup>33, 34</sup> Cultural sensitivities can lead to unique forms of family violence for LGBTIQA+ people, including:

- family exile
- forced marriage
- honour abuse

- corrective rape
- conversion therapy.

For example, research conducted in New South Wales with Arabic-speaking communities suggest that LGBTIQA+ people have reported family assault, confiscation of mobile phones, banned access to sympathetic family members and other forms of intimidation due to their stigmatised LGBTIQA+ status.<sup>33, 34</sup>

'I have been bashed by a family member for shaming the family [...] Talks at family gatherings that being GLQ [gay, lesbian, queer] is due to corruption of the WEST. The Imam and sheikh claiming that the death penalty is the punishment for GLQ.' **A lesbian woman, age 30 years**<sup>35</sup>

Community, organisational, religious, cultural and extended family connections can also be important sources of support for LGBTIQA+ people.<sup>35</sup>

LGBTIQA+ people with disability are at higher risk of family violence, due to reliance on family as carers and policing of their diverse sexual or gender identities.<sup>36</sup> Older LGBTIQA+ people often have a history of rejection by families of origin, and of concealing their intimate relationships from others.<sup>37</sup> This can create a situation in which IPAV is not revealed and is potentially tolerated for long periods. Living in rural or regional areas of Australia can exacerbate issues of isolation, and fear of negative responses to disclosure of same-gender relationships from family, communities or healthcare providers. Disclosure of violence in those relationships can be even more difficult.

Unfortunately, there is little research that investigates the experiences of LGBTIQA+ Aboriginal and Torres Strait Islander people, but this intersection is likely to be important both in understanding experiences of abuse and violence, along with ways of responding and engaging communities.

Finally, LGBTIQA+ people who form their own families can have particular risks for family violence. These have been outlined in a forthcoming study in Victoria.<sup>38</sup> These risks include specific experiences around parenting in LGBTIQA+ parented families, such as family formation stress, isolation from family and friends, and gendered norms around parenting.

## Recognising and responding to LGBTIQA+ family violence

GPs play a significant role in supporting LGBTIQA+ patients, their partners and families, to recognise and respond to abuse and violence, and its aftermath. GPs can also play a role in the primary prevention of abuse and violence experienced by LGBTIQA+ communities, by demonstrating awareness and recognition, and promoting pride in LGBTIQA+ bodies, identities and relationships.

Existing models for responding to family violence have focused on the significant problem of men's violence against women. While this is valid and necessary, there are some indications this can perpetuate silence around LGBTIQA+ experiences of family violence, making it harder for LGBTIQA+ people to recognise and label their experiences as family violence.<sup>39, 40</sup> For example, men's experiences



as victims/survivors of family violence are rarely considered, and likewise women's experiences as perpetrators. Trans and non-binary people may have very diverse experiences too. Accessing inclusive and knowledgeable services for each of these groups is difficult.

There are also specific barriers to help-seeking, including a lack of understanding of the unique forms that abuse and violence can take for LGBTIQA+ people, fear of stigma and a lack of faith in institutions such as police, the judicial system or the family violence service system, which has historically focused on men's violence against women.<sup>41</sup> Other barriers include the perpetuation of myths that violence does not occur in lesbian relationships or that violence in gay male relationships is less serious as both partners are men.<sup>42</sup>

'But I think where I've seen or experienced violence in an intimate partner relationship because if you're both queer or you're both trans, you're both trying to survive in a world that wants to kill you, basically. And by exposing your partner, even if they're being abusive or violent towards you, by exposing them to interactions with police or the criminal legal system, or prison, it could, could basically ... be the death of them. And it's far worse than the sort of abuse or violence that is being done within that relationship.' **A queer, transgender woman, age 30 years**<sup>6</sup>

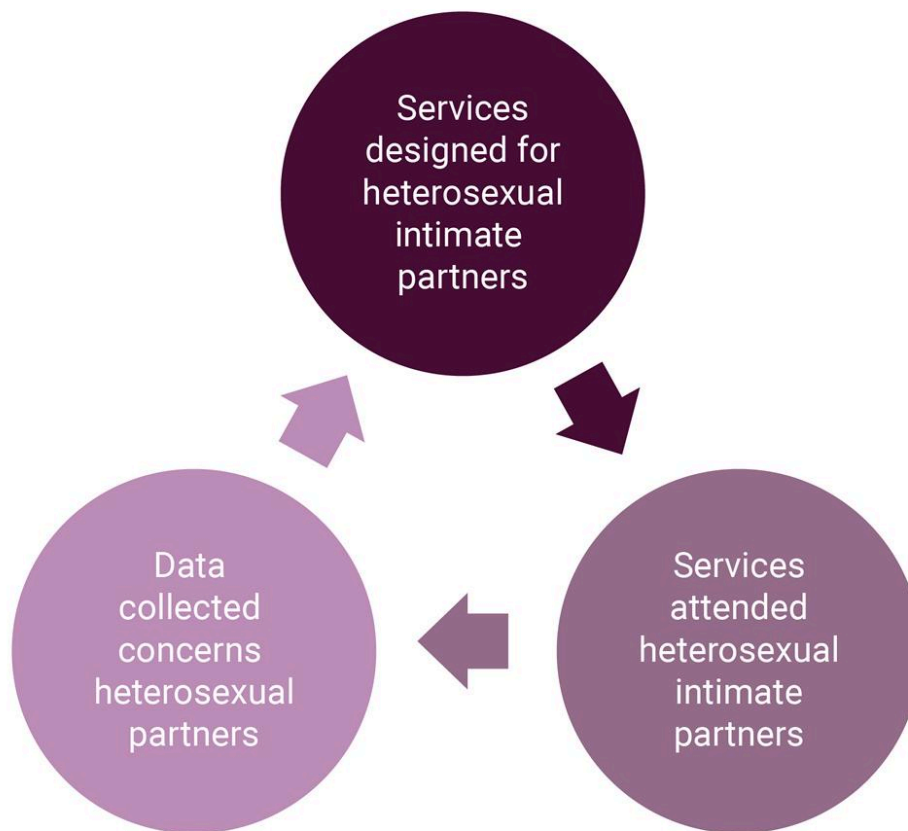


Figure 19.2. Barriers to identification of LGBTIQA+ family violence

© Copyright State Government of Victoria

Recent work analysing the drivers of family violence for LGBTIQA+ communities, and drawing on feminist theories and models, suggests that perpetration of abuse and violence are linked to violence-supporting attitudes, including views that LGBTIQA+ bodies, people and relationships are less valid, healthy or worthy (Figure 19.3).<sup>44</sup> These attitudes increase the likelihood that abuse and violence is condoned or accepted by both LGBTIQA+ people and the health and social care system.

'I guess it's partly systemic; that the system doesn't accommodate for diversity. There's also that workers or professionals aren't aware of the different kind of issues that might arise in a LGBTIQA+ family.'

**Lesbian parent**<sup>38</sup>

	Societal	System & institutional	Organisational & community	Individual & relationship
Drivers	<ul style="list-style-type: none"> <li>▶ Rigid gender norms</li> <li>▶ Cisnormativity</li> <li>▶ Hetero-normativity</li> </ul>	<ul style="list-style-type: none"> <li>▶ Inequality in recognition of bodies, identities and relationships</li> </ul>	<ul style="list-style-type: none"> <li>▶ Devaluation of bodies, identities and relationships</li> <li>▶ Reproduction of norms and stereotypes</li> </ul>	<ul style="list-style-type: none"> <li>▶ Homophobic, biphobic, transphobic and intersexphobic behaviour</li> <li>▶ Normalisation of violence and abuse</li> </ul>
What do these lead to?	<ul style="list-style-type: none"> <li>▶ Homophobia, biphobia, transphobia and intersexphobia</li> <li>▶ Gendered cultures of violence</li> </ul>	<ul style="list-style-type: none"> <li>▶ Invalidation of identities and relationships</li> <li>▶ Loss of bodily autonomy</li> <li>▶ Discrimination</li> <li>▶ Failure of responses to violence</li> </ul>	<ul style="list-style-type: none"> <li>▶ Stigma and discrimination</li> <li>▶ Normalisation of inequality</li> <li>▶ Failure to recognise violence</li> </ul>	<ul style="list-style-type: none"> <li>▶ Negative self-worth</li> <li>▶ Perpetration of violence and abuse</li> <li>▶ Poorer health outcomes</li> </ul>

Figure 19.3. Socio-ecological drivers of LGBTIQA+ family violence<sup>44</sup>

Reproduced with permission from: Carman M, Fairchild J, Farrugia C, et al. *Pride in prevention: A guide to primary prevention of family violence experienced by LGBTIQ communities*. Melbourne: Rainbow Health Victoria, La Trobe University, 2020.

## In practice

The general practice response to abuse and violence experienced by LGBTIQA+ communities needs to be comprehensive across the whole practice. This starts with an inclusive practice approach and moves to specific upskilling of all staff regarding safety and confidentiality in the context of family violence. It involves all practice staff in primary care:

- understanding the full range of families of LGBTIQA+ people, including families of origin, families with biological and non-biological or non-birth parents, and families of choice
- recognising there are specific experiences and triggers of family violence for LGBTIQA+ people
- encouraging disclosure of LGBTIQA+ identities and expressions to clinical staff
- ensuring the practice record systems allow documentation of the full range of LGBTIQA+ identities
- supporting LGBTIQA+ clients to recognise abuse and violence within their relationships.

The LGBTIQA+ patient's journey through the clinic must be inclusive at all stages (Figure 19.4).

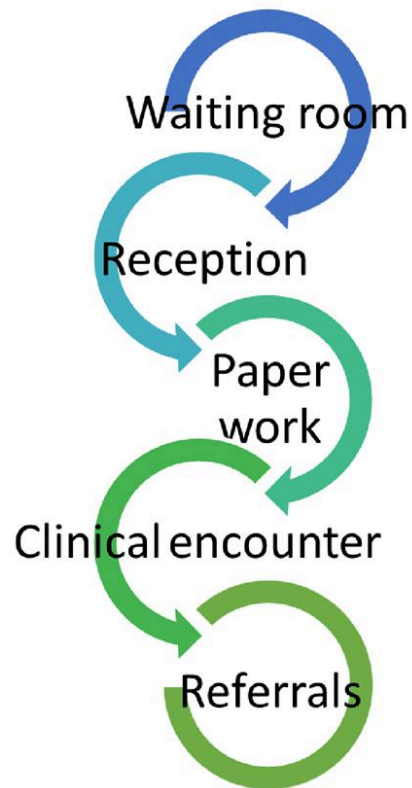


Figure 19.4. Stages of the patient journey in general practice

## Waiting room and reception – creating an LGBTIQA+ inclusive environment

Encouraging disclosure of family violence for any patient starts at the front door, as they need to feel they will be believed, acknowledged and supported. This is even more important for LGBTIQA+ patients who may have experienced negative attitudes from healthcare providers in the past.<sup>45</sup>

There are readily available Australian tools to assist practices become LGBTIQA+ inclusive. One example is the [Rainbow Tick \(https://www.rainbowhealthvic.org.au/rainbow-tick\)](https://www.rainbowhealthvic.org.au/rainbow-tick), an accreditation program and framework.

Key areas for general practices to consider include:

- helping reception staff understand how to greet LGBTIQA+ patients
  - using appropriate language
  - making no assumptions about sex, gender or sexual identities

- ensuring that new patient intake forms include LGBTIQA+ lives, for example:
  - gender identity markers: female, male, transgender, non-binary, agender, prefer not to say, other
  - relationship status rather than marital status
  - sexual identity markers lesbian, gay, bisexual, heterosexual
  - including an option to declare intersex status
- displaying materials and images in the waiting room that represent and welcome LGBTIQA+ people are important signs that the practice is safe and inclusive.

## LGBTIQA+ data collection for medical records

The Victorian Government Family Violence Data Collection Framework (2019) provides a comprehensive guide to the data that should be included in medical records.<sup>43</sup> Currently, many medical software programs do not yet uphold these standards. Practices need to use work-around solutions to include LGBTIQA+ identities in their records.

### Pronouns and titles

- These should be clarified with all patients and documented. This might be on intake forms and/or in the consultation.
- Individuals may use she/her, he/his, they/them or another set of pronouns.
- Titles such as Mr, Ms and Mrs are generally not necessary on letters or referrals and software can be modified so that these are left blank. Where a title is required on documentation it is best to provide the option of Mx, which is used by some non-binary people.

### Gender identity

- The Australian Bureau of Statistics Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables<sup>46</sup> has been developed to standardise collection of data relating to sex, gender, variations of sex characteristics and sexual orientation. Gender is a socially constructed concept.
- Recommended categories are:
  - male
  - female
  - non-binary
  - agender
  - prefer not to say
  - other (please describe).

A two-step approach to data collection about gender is encouraged. This is to allow identification of more trans people, as some binary transgender people refer to themselves as trans male or trans female, and others just use male or female.

- In addition to a gender question, the second step could be either:
  - 'What gender was assigned to you at birth?' with options male, female, prefer not to say, or
  - 'Do you identify as transgender?' with options yes, no, prefer not to say.

### Sexual identity

- Suggested question: 'How do you describe your sexual orientation?'
  - straight or heterosexual
  - gay, lesbian or homosexual
  - bisexual or pansexual
  - asexual
  - another – please describe
  - don't know
  - prefer not to say

### Sex

- Suggested question: 'Do you have an intersex variation?'
  - yes
  - no
  - prefer not to say

### Sex characteristics

This refers to chromosomal, hormonal and reproductive characteristics, including secondary characteristics arising from puberty. Innate variations of sex characteristics, also termed 'intersex variations' or 'differences/disorders of sex development' refer to traits that are perceived to vary from medical or social norms for female or male bodies.

## Identification and assessment of LGBTIQA+ family violence

An important first step in the clinical encounter is to encourage disclosure of diverse sex, gender and sexual identities. Even if clinic paperwork offers these options, individuals may choose not to disclose until they are talking with a clinician. Facilitation of disclosure includes:

- using inclusive language for gender, sexual orientation and sex status
- asking about pronouns and name, which may differ from the Medicare-listed name
  - making no assumptions
  - using the patient's terms for their own body and identities
  - asking directly about relationships and family
  - number of intimate partners
  - genders of intimate partners
  - living arrangements
  - family definitions – biological and/or chosen family
  - children – both biological and non-biological.

Picking up cues for possible family violence related to both victims/survivors and perpetrators and then exploring the issue sensitively can involve:

- defining various behaviours as violence including emotional abuse, financial abuse, sexual

- coercion, cyber bullying and online abuse, spiritual abuse
- asking about current and past experiences of violence in relationships and/or in family or origin
- inquiring whether LGBTIQA+ status is used as an abuse strategy, for example:
  - deliberately disclosing a partner's LGBTIQA+ status or HIV status publicly against their will
  - not acknowledging, or invalidating, a partner's sex, gender or sexual identity
  - isolating the person from LGBTIQA+ community or friends
- understanding the role, if any, of alcohol or drugs in fuelling violence
- asking about general experiences of homophobia, biphobia, transphobia or stigma related to intersex variations and how these may be affecting the family violence
- asking about other marginalising issues that may be involved
  - disability (eg is a carer abusive in relation to LGBTIQA+ status?)
  - culture and/or faith
  - Aboriginal and Torres Strait Islander identity
- asking about the physical and emotional effects of violence and trauma – both past and current
  - self-esteem
  - isolation from community or friends
  - mental health issues
  - direct and indirect physical health issues
  - any children in the family who may have witnessed or been victims
  - using violence as perpetrators due to experiences of trauma
- clarify preferred community connections and whether these are LGBTIQA+ or not
- understanding help-seeking already used and preferred, in the context that a very small proportion of LGBTIQA+ people who experience family violence seek professional support or report the violence to police.

'I was using forms of violence in a recent relationship, like I was getting angry because they were triggering past traumas for me ... and I had to go to counselling to understand what the f... was going on.' **Axel, queer, non-binary, community member, age 30s**<sup>47</sup>

## Management of LGBTIQA+ family violence

It is important to have a framework for understanding the specific issues related to LGBTIQA+ family violence. A socio-ecological model is commonly used to understand the drivers of violence.<sup>48</sup> GPs can act at each level of this model to prevent and respond to violence:

- Societal level
  - Advocacy for change for society to be more inclusive
  - Challenging social norms, particularly around gender stereotypes, that marginalise and drive violence
- System and institutional level
  - Supporting LGBTIQA+ inclusion in systems such as data collection, police and family

- violence support systems
- Understanding legislative supports such as anti-discrimination laws in your state or territory
- Organisational and community level
  - Ensuring practice policies are visibly inclusive of LGBTIQA+ people
  - Promoting pride and cultural change within the workplace to be a safe and inclusive environment for LGBTIQA+ staff, including acknowledging LGBTIQA+ days of significance such as IDAHOBIT (International day against homophobia, biphobia, intersex and transphobia) or Transgender Day of Visibility
  - Supporting patients' schools and workplaces to be LGBTIQA+ inclusive (eg supporting the Safe Schools initiative)
  - Engaging with local police LGBTIQA+ liaison officers
  - Assisting with primary prevention through education of families of origin – parents, siblings, grandparents about LGBTIQA+ lives and relationships
- Individual level
  - Affirming patients' LGBTIQA+ identities
  - Helping patients to label their experiences as family violence
  - Supporting and encouraging police involvement as needed (and directed by the patient), such as obtaining intervention orders
  - Referring to LGBTIQA+ specific and/or inclusive family violence services including shelters, counselling services

## Resources

### For services

- [1800 Respect \(https://www.1800respect.org.au/inclusive-practice/supporting-people-who-identify-as-lgbti/understanding\\_the\\_issues\)](https://www.1800respect.org.au/inclusive-practice/supporting-people-who-identify-as-lgbti/understanding_the_issues) – a national counselling service for victims/survivors of sexual assault and family violence.
- [Auspath trans-inclusive professionals list \(https://auspath.org/providers/\)](https://auspath.org/providers/)
- [Data collection standards for LGBTIQA+ people \(https://www.vic.gov.au/victorian-family-violence-data-collection-framework/data-collection-standards-lesbian-gay-bisexual\)](https://www.vic.gov.au/victorian-family-violence-data-collection-framework/data-collection-standards-lesbian-gay-bisexual)
- LGBTIQA+ [best practice workplace standard \(http://www.prideinhealth.com.au/wp-content/uploads/2020/05/DFV\\_Guide2018\\_min-2.pdf\)](http://www.prideinhealth.com.au/wp-content/uploads/2020/05/DFV_Guide2018_min-2.pdf) in relation to IPAV and family violence
- [Resources for community health services \(https://www2.health.vic.gov.au/primary-and-community-health/community-health/pride-lgbtqi-inclusive-practice-resources\)](https://www2.health.vic.gov.au/primary-and-community-health/community-health/pride-lgbtqi-inclusive-practice-resources)

### Training

- [Introduction to LGBTIQ-inclusive practice \(https://www.rainbowhealthvic.org.au/training-programs/online-and-remote-training-options\)](https://www.rainbowhealthvic.org.au/training-programs/online-and-remote-training-options)
- [Introduction to LGBTIQ-inclusive practice for family violence services \(https://www.rainbowhealthvic.org.au/training-programs/lgbti-inclusive-practice-for-family-violence-services-training\)](https://www.rainbowhealthvic.org.au/training-programs/lgbti-inclusive-practice-for-family-violence-services-training)
- [Medicare Australia eLearning on family and domestic violence \(http://medicareaust.com/MISC/MISCP02/fdv.html\)](http://medicareaust.com/MISC/MISCP02/fdv.html)
- [Health and Wellbeing Equality Index \(http://www.prideinhealth.com.au/index-benchmarking/\)](http://www.prideinhealth.com.au/index-benchmarking/) for health services



## For LGBTIQA+ people

- [Another Closet \(http://ssdv.acon.org.au/\)](http://ssdv.acon.org.au/)
- [Q Life \(https://qlife.org.au/\)](https://qlife.org.au/) – 1800 184 527 – a national counselling and referral service for LGBTIQA+ people.
- AIDS Councils in each state and territory provide LGBTIQA+ counselling for mental health and alcohol and drugs accessible via [LGBTIQ+ Health Australia \(https://www.lgbtiqhealth.org.au/\)](https://www.lgbtiqhealth.org.au/)
- [Australian Federal Police Gay and Lesbian Liaison Officers \(https://www.police.act.gov.au/about-us/programs-and-partners/gay-and-lesbian-liaison-officers\)](https://www.police.act.gov.au/about-us/programs-and-partners/gay-and-lesbian-liaison-officers)
- [TransHub \(https://www.transhub.org.au/\)](https://www.transhub.org.au/) – a digital information and resource platform for all trans and gender-diverse people in New South Wales.
- [Intersex Human Rights Australia \(https://ihra.org.au/\)](https://ihra.org.au/) (formerly OII Australia) – promotes human rights and bodily autonomy for intersex people and provides information, education and peer support.

## References

1. King M, Semlyen J, Tai S, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008;8(1):70.
2. Ploderl M, Tremblay P. Mental health of sexual minorities. A systematic review. *Int Rev Psychiatry* 2015;27(5):367–85.
3. Reisner SL, Poteat T, Keatley J, et al. Global health burden and needs of transgender populations: a review. *The Lancet* 2016;388(10042):412–36.
4. Perales F. The health and wellbeing of Australian lesbian, gay and bisexual people: A systematic assessment using a longitudinal national sample. *Aust N Z J Public Health* 2019;43(3):281–7.
5. Hill A, Bourne A, McNair R, Carman M, Lyons A. *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, 2020.
6. Skerrett DM, Kolves K, De Leo D. Factors Related to Suicide in LGBT Populations. *Crisis* 2016;37(5):361–69.
7. Our Watch. Summary report: Primary prevention of family violence against people from LGBTI communities: An analysis of existing research. Melbourne: Our Watch, 2017.
8. Strauss P, Cook A, Winter S, Watson V, Wright Toussaint D, Lin A. *Trans Pathways: The mental health experiences and care pathways of trans young people. Summary of results*. Perth: Telethon Kids Institute, 2017.
9. Hill A, Jones J, Lyons A, Carman M, McGowan I, Parsons M. In: *The health and wellbeing of LGBTQA+ young people in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, 2020.
10. Victorian Agency for Health Information. *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria. Findings from the Victorian Population Health Survey 2017*. Melbourne: State of Victoria, 2020.
11. Pennant ME, Bayliss SE, Meads CA. Improving lesbian, gay and bisexual healthcare: A systematic review of qualitative literature from the UK. *Diversity in Health & Care* 2009;6(3):193–203.
12. Waling A, Lim G, Dhalla S, Lyons A, Bourne A. *Understanding LGBTI+ Lives in Crisis*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University and Lifeline Australia, 2019.
13. Cahill S, Makadon H. Sexual Orientation and Gender Identity Data Collection in Clinical Settings and in Electronic Health Records: A Key to Ending LGBT Health Disparities. *LGBT Health* 2013 2014/03/01;1(1):34–41.
14. German D, Kodadek L, Shields R, et al. Implementing Sexual Orientation and Gender Identity Data Collection in Emergency Departments: Patient and Staff Perspectives. *LGBT Health* 2016 Dec;3(6):416–23.

- 
15. Dunne MJ, Raynor LA, Cottrell EK, Pinnock WJA. Interviews with Patients and Providers on Transgender and Gender Nonconforming Health Data Collection in the Electronic Health Record. *Transgend Health* 2017;2(1):1-7.
16. Messinger AM. Invisible victims: same-sex IPV in the National Violence Against Women Survey. *J Interpers Violence* 2011 Jul;26(11):2228-43.
17. Walters M, Chen J, Breiding M. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2013.
18. Brown T, Herman J. Intimate partner violence and sexual abuse among LGBT people: A review of existing research. Los Angeles: Williams Institute, UCLA School of Law.2015.
19. Rolle L, Giardina G, Calderera AM, Gerino E, Brustia P. When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. *Front Psychol* 2018;9:1506.
20. Barrett B, St.Pierre M. Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: An exploration of within-group variations. *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice* 2013;25(1):1-23.
21. Coston BM. Power and Inequality: Intimate Partner Violence Against Bisexual and Non-Monosexual Women in the United States. *J Interpers Violence* 2017 Aug 1:886260517726415.
22. Yerke A, DeFeo J. Redefining intimate partner violence beyond the binary to include transgender people. *Journal of Family Violence* 2016;31(8):975-9.
23. Peitzmeier SM, Malik M, Kattari SK, et al. Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. *Am J Public Health* 2020 Sep;110(9):e1-e14.
24. Organisation Intersex International (OII) Australia. Submission: OII Australia's response to NSW discussion paper on domestic and family violence. . Sydney: Organisation Intersex International Australia and ACON, 2009.
25. Callander D, Wiggins J, Rosenberg S, Cornelisse V, Duck-Chong E, Holt M. The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings. Sydney: The Kirby Institute, 2019.
26. Stotzer RL. Violence against transgender people: A review of United States data. *Aggression and Violent Behavior* 2009;14(3):170-9.
27. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs* 2010 Nov;23(4):205-13.
28. Asquith N, Fox C. No place like home: Intrafamilial hate crime against gay men and lesbians. In: Dwyer A, Ball M, Crofts T, editors. *Queering Criminology* London: Palgrave Macmillan; 2016. p. 163-82.
29. McKay T, Lindquist CH, Misra S. Understanding (and Acting On) 20 Years of Research on Violence and LGBTQ + Communities. *Trauma Violence Abuse* 2019;20(5):665-78.
30. Badenes-Ribera L, Sanchez-Meca J, Longobardi C. The Relationship Between Internalized Homophobia and Intimate Partner Violence in Same-Sex Relationships: A Meta-Analysis. *Trauma Violence Abuse* 2019;20(3):331-43.
31. Kimmes JG, Mallory AB, Spencer C, Beck AR, Cafferky B, Stith SM. A Meta-Analysis of Risk Markers for Intimate Partner Violence in Same-Sex Relationships. *Trauma Violence Abuse* 2019 Jul;20(3):374-84.
32. Edwards KM, Sylaska KM. The perpetration of intimate partner violence among LGBTQ college youth: the role of minority stress. *J Youth Adolesc* 2013 Nov;42(11):1721-31.
33. ACON. We're family too': The effects of homophobia in Arabic-speaking communities in New South Wales. Sydney: ACON, 2011.
34. Hopkinson RA, Keatley E, Glaeser E, Erickson-Schroth L, Fattal O, Nicholson Sullivan M. Persecution Experiences and Mental Health of LGBT Asylum Seekers. *J Homosex* 2017;64(12):1650-66.
35. Asquith N, Collison A, Lewis L, Noonan K, Layard E, Kaur G. Home is where our story begins: CALD LGBTIQ+ people's relationships to family. . *Current Issues in Criminal Justice* 2019;31(3):311-32.
36. Leonard W, Mann R. The everyday experience of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability. Melbourne: La Trobe University2018 Report No 111.
37. Westwood S. Abuse and older lesbian, gay bisexual, and trans (LGBT) people: A commentary and research agenda. *J Elder Abuse Negl* 2019 Mar-May;31(2):97-114.
38. Poyner E, McCann B, Wilson C, Gibson M. New parents, new possibilities: family violence prevention for LGBTIQ+ parented families. Melbourne, Victoria: Centre for Family Research and Evaluation2021.
-

39. 39. Bornstein DR, Fawcett J, Sullivan M, Senturia KD, Shiu-Thornton S. Understanding the experiences of lesbian, bisexual and trans survivors of domestic violence: a qualitative study. *J Homosex* 2006;51(1):159–81.
40. 40. Turell SC, Herrmann MM, Hollander GA, Galletly C. Lesbian, gay, bisexual, and transgender communities' readiness for intimate partner violence prevention. *Journal of Gay & Lesbian Social Services* 2012;24(3):289-310.
41. 41. Calton JM, Cattaneo LB, Gebhard KT. Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. *Trauma Violence Abuse* 2016 Dec;17(5):585–600.
42. 42. Duke A, Davidson M. Same-sex intimate partner violence: Lesbian, gay, and bisexual affirmative outreach and advocacy. *Journal of Aggression, Maltreatment & Trauma* 2009;18(8):795–816.
43. 43. Victorian State Government. Family Violence Data Collection Framework. Melbourne: Victorian State Government, 2019.
44. 44. Carman M, Fairchild J, Farrugia C, Parsons M, Power J, Bourne A. *Pride in Prevention: A guide to primary prevention of family violence experienced by LGBTIQ communities*. Melbourne: Rainbow Health Victoria, La Trobe University, 2020.
45. 45. Zeeman L, Sherriff N, Browne K, et al. A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. *European Journal of Public Health* 2018;29(5):974–80.
46. 46. Australian Bureau of Statistics. *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables*. Canberra: ABS, 2021.
47. 47. Gray R, Walker T, Hamer J, et al. *Developing LGBTQ programs for perpetrators and victims/ survivors of domestic and family violence (Research report)*. Sydney: ANROWS, 2020.
48. 48. Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS), VicHealth. *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*. Melbourne: Our Watch, 2015.

# *System issues*

# Violence and the law

'When a patient discloses abuse or violence to a health practitioner, including sexual assault and sexual assault between intimate partners, it is valuable for the health practitioner to have a basic understanding of the legal framework.'

## Key messages

- Health practitioners are responsible for medical care, not legal advice, but they need to have an understanding of the legal issues around family violence and sexual assault <sup>1</sup>
- Assault, including sexual assault, occurring between family members is a criminal offence <sup>2</sup>
- Health practitioners should document any physical injuries and specific descriptions of violence, but should leave any interpretation of physical and other observations to a suitably qualified expert <sup>1</sup>

## Recommendations

Health practitioners can assist their patients experiencing abuse and violence by providing information on legal options and referrals to legal services.<sup>3,4</sup>

**(Practice point: Consensus of experts)**

### References

3. Hegarty K, Taft A, Feder G. Violence between intimate partners: Working with the whole family. *BMJ* 2008;337:a839
4. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.

In cases of recent sexual assault, if you are not trained in the collection of forensic evidence, your patient needs to be referred to a sexual assault service.<sup>1</sup>

(Practice point: Consensus of experts)

## Introduction

The service most frequently identified as the first point of contact for victims/survivors of family violence or sexual assault is a doctor or hospital. This initial contact is important in a patient's decision to address the violence. (Refer also to [the chapter on the initial response to intimate partner abuse \(http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse\)](http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse).)

Therefore, when a patient discloses abuse or violence to a health practitioner, including sexual assault and sexual assault between intimate partners, it is valuable for the health practitioner to have a basic understanding of the legal framework.<sup>1</sup> This could include an understanding of protection orders, the role of the police, and knowledge of referral options to community legal services.<sup>3-5</sup>

In cases of intimate partner abuse/violence (IPAV) and sexual violence, it is important for the doctor to document clearly and accurately what the patient has said about the assault and a description of any injuries. The medical notes may become evidence in future court proceedings.<sup>1</sup>

This chapter outlines legal interventions that may be relevant for the patient where there is disclosure or evidence of family violence or sexual violence. Australian states and territories have differing legislation that may apply to one or all of these types of abuse.

It is important to remember that health professionals do not need to, and should not, provide advice to patients in these legal matters. Providing patients with information and links to appropriate services is important to provide them with avenues to make an informed choice.

Most importantly, GPs should provide the message that the patient's safety is paramount, and what is happening to them is:

- not their fault
- not acceptable

Patients may make very different choices to those of their GP. It is very important to respect their choices, stay involved, and consider their readiness and needs in relation to legal action.

**Box 20.1. Limitations of this chapter**

This chapter provides a general overview of the role of the law regarding family violence and issues to consider when a patient presents as the victim/survivor of sexual assault. The information in this chapter is not legal advice. The information may be useful as a resource to guide and to empower patients to consider realistic options of legal protection for their own safety. If a patient expresses an interest, the contact references may be passed on to them.

Legal information may not be the highest need for clients when they present to you; other issues, including housing and financial support, may be more pressing. Patients need to take responsibility for their own legal issues and should be encouraged to seek advice from their lawyer, a community legal centre or legal aid service (Table 20.1) about next steps.

**Table 20.1. Legal aid and community legal centres in each state and territory**

Australian Capital Territory	<a href="http://www.legalaidact.org.au/">Legal Aid ACT (http://www.legalaidact.org.au/)</a>
New South Wales	<a href="http://www.legalaidact.org.au/">Legal Aid New South Wales (http://www.legalaidact.org.au/)</a>
Northern Territory	<a href="https://www.legalaid.nt.gov.au/">Northern Territory Legal Aid Commission (https://www.legalaid.nt.gov.au/)</a>
Queensland	<a href="http://www.legalaid.qld.gov.au/Find-legal-information/Relationships-and-children/Domestic-and-family-violence">Legal Aid Queensland – Domestic and Family Violence (http://www.legalaid.qld.gov.au/Find-legal-information/Relationships-and-children/Domestic-and-family-violence)</a>
South Australia	<a href="https://lsc.sa.gov.au/">Legal Services Commission of South Australia (https://lsc.sa.gov.au/)</a>
Tasmania	<a href="https://www.legalaid.tas.gov.au/factsheets/family-violence/">Legal Aid for Tasmanians – Family violence (https://www.legalaid.tas.gov.au/factsheets/family-violence/)</a>
Western Australia	<a href="https://www.legalaid.wa.gov.au/">Western Australia Legal Aid (https://www.legalaid.wa.gov.au/)</a>

**Table 20.1. Legal aid and community legal centres in each state and territory**

Victoria	<a href="https://www.legalaid.vic.gov.au/find-legal-answers/family-violence-intervention-orders">Victoria Legal Aid – Family Violence Intervention Orders (https://www.legalaid.vic.gov.au/find-legal-answers/family-violence-intervention-orders )</a>
National	<a href="https://clcs.org.au/">Community Legal Centres Australia (https://clcs.org.au/)</a>

## Clinical context

### Facilitating patient reporting of incidents

GPs should encourage their patients to approach the police directly and report an incident of family violence or sexual violence. The police may be able to provide more information about the patient's legal options. Once the patient has reported the matter to the police, the decision to charge an alleged perpetrator with a criminal offence is a matter for the police. However, once the alleged perpetrator is charged, in most cases the patient's views will be very important in relation to the police or public prosecutor's decision to continue or discontinue the criminal proceedings.

GPs should also offer to report the incident to the appropriate authorities, including the police, if the patient wants this.<sup>4</sup> However, it is important to respect patients' wishes and not pressure them into making any decisions.<sup>3</sup>

In sexual assault matters, adults may have an option of reporting an incident but not proceeding with charges. This is important, as they can reinstate the complaint in the future when they feel more confident and able to cope with the situation. It can remain simply as a 'statement'. This can help to re-empower patients by giving them back some sense of control. A range of services can be made available to a victim/survivor of assault via victim of crime support agencies. These differ in each state and contact can be made via the police (Table 20.2).

**Table 20.2. Police assault and family violence investigation teams/units in each state and territory**

Australian Capital Territory	<a href="https://www.police.act.gov.au/safety-and-security/family-violence">ACT Policing – Family violence (https://www.police.act.gov.au/safety-and-security/family-violence)</a>
New South Wales	<a href="https://www.police.nsw.gov.au/safety_and_prevention/your_community">NSW Police (https://www.police.nsw.gov.au/safety_and_prevention/your_community)</a>  <a href="https://www.police.nsw.gov.au/crime/domestic_and_family_violence">NSW Police - Domestic and family violence (https://www.police.nsw.gov.au/crime/domestic_and_family_violence)</a>



**Table 20.2. Police assault and family violence investigation teams/units in each state and territory**

Northern Territory	<a href="https://pfes.nt.gov.au/police/community-safety">NT Police Force – Community safety (https://pfes.nt.gov.au/police/community-safety)</a>
Queensland	<a href="http://www.police.qld.gov.au/programs/adultassault">Queensland Police – Adult sexual assault (http://www.police.qld.gov.au/programs/adultassault)</a>  <a href="http://www.police.qld.gov.au/programs/cscp/dv/Response.htm">Queensland Police – Safety and preventing crime (http://www.police.qld.gov.au/programs/cscp/dv/Response.htm)</a>
South Australia	<a href="https://www.police.sa.gov.au/your-safety">South Australia Police – Your safety (https://www.police.sa.gov.au/your-safety)</a>
Tasmania	<a href="https://www.police.tas.gov.au/what-we-do/family-violence/">Tasmania Police – Family violence (https://www.police.tas.gov.au/what-we-do/family-violence/)</a>
Western Australia	<a href="https://www.police.wa.gov.au/Your-Safety">Western Australia Police Force (https://www.police.wa.gov.au/Your-Safety)</a> – <a href="https://www.police.wa.gov.au/Your-Safety">Your safety (https://www.police.wa.gov.au/Your-Safety)</a>
Victoria	<a href="https://www.police.vic.gov.au/family-violence">Victoria Police – Family violence (https://www.police.vic.gov.au/family-violence)</a>

### Barriers to reporting

Disclosure and formal reporting may not be immediate or may be sporadic or non-linear. Reasons a person will decide to not report or delay reporting family violence or sexual assault to police, services or others include:<sup>6,7</sup>

- prevalent social attitudes that blame the victim/survivor and fear of not being believed
- fear of reprisals from the partner and escalation of the violence
- shame or denial
- not wanting family and friends to know because of the humiliation and shame
- fear of coping with police, the justice system and legal procedures
- economic dependence on the perpetrator
- fear of exposing their own illegal activities (eg visa overstay, social security fraud)
- fear of negatively impacting on the family (eg removal of children, dissolution of the relationship, perceived dangerous family law outcomes)
- not having identified the act as sexual violence or a crime or believing it is not serious
- wanting to protect the offender, or hoping for change

- believing they will handle it by themselves.

Sometimes people only partially disclose, then become frightened after they disclose and disclose again later, at another time and place. Sometimes they disclose major incidents – for example, rapes first, and then, with time, other incidents. Sometimes they disclose less serious incidents first and then, with time, more serious incidents.

## Referral

Most state and territory police forces have specially trained units that can assist patients by referring them to appropriate services if they do not wish to seek legal interventions or pursue charges against the perpetrator. Sometimes community services may be available to liaise with the police on the patients' behalf.

The Northern Territory is the only Australian jurisdiction that has mandatory reporting requirements regarding family violence. The provisions are located in the *Domestic and Family Violence Act 2007* (Northern Territory). These provisions require that any adult must contact the police where they reasonably believe another person has been, is at risk of or is experiencing serious physical harm through domestic or family violence. This requirement overrides issues of confidentiality.

While reporting is not mandatory in New South Wales, the NSW Department of Health recommends in its Domestic Violence Policy discussion paper that health workers notify the police where the victim/survivor has serious injuries such as broken bones, stab wounds, lacerations or gunshot wounds.

Wherever possible, the patient should be informed when a decision is made to inform the police (refer to Table 20.2).

## Intimate partner abuse

The most common legal response to family violence is a protection order. These orders are legislated under civil law in each state and territory and have different names (refer to Table 20.3). In some cases, the patient may wish to pursue criminal charges. If someone shares property or has children with the person using IPAV, they may seek family law orders. Patients who have insecure visa status may have certain options under migration legislation.

If your patient has experienced family violence, recommend, if appropriate, that they go to the police or relevant local community services, obtain legal advice or approach the local magistrates' court for information and referral.

Specially trained police officers can assist victims/survivors to access appropriate services and emergency orders to provide immediate safety. Doctors or patients can seek advice and information from the police on behalf of a patient without disclosing the patient's name. You can also encourage patients to talk to the police themselves, even if they don't identify themselves.

## Protection orders

The term ‘protection order’ is used in this chapter as a generic term for orders specifically designed to provide protection from future family violence. States and territories have different names for these orders. They are variously called ‘intervention orders’, ‘domestic violence orders’, ‘apprehended domestic violence orders’, or ‘restraining orders’ (refer to Table 20.3). Protection orders may be made by the court and in some emergency cases by the police. Protection orders attempt to restrict or prohibit certain behaviours by the perpetrator. Protection orders may, for example, include prohibiting a person from contacting, harassing or threatening the victim/survivor and/or approaching the victim/survivor’s home or place of employment. The court may also have the power to order that the perpetrator be excluded from the family home.

Details of these orders are different for each state and territory (refer to Table 20.3). However, protection orders may be made to protect a person from future acts of family violence, such as assaults, including sexual assaults; threats and/or harassment by a partner or family member; and actual or threatened damage to property.

It is preferable that a person obtaining a protection order asks for advice about the legislation in their state or territory – what orders are available, and what will afford them the most adequate protection (refer to Resources for links to appropriate sources for such advice).

If the patient decides to report the family violence to the police, the police will be able to provide assistance with and information about protection orders.

Patients do not have to report the family violence to the police to obtain a protection order. Court support services can be very helpful for women who have experienced family violence. These services are offered by local community agencies, and their availability can vary. Often community support services have offices at the local or magistrates’ court.

If necessary, further legal advice should be obtained (refer to Table 20.3).

**Table 20.3. Family violence and protection orders**

State/ territory	Type of intervention
Australian Capital Territory	It is necessary to apply for a domestic violence order or personal protection order through the Magistrates’ Court. For assistance, patients can go to the Legal Aid Domestic Violence and Personal Protection Orders Unit located at the Court.  Further information: <a href="http://www.victimsupport.act.gov.au">Victim Support (http://www.victimsupport.act.gov.au)</a> and <a href="http://www.legalaidact.org.au">Legal Aid ACT (http://www.legalaidact.org.au)</a> .

**Table 20.3. Family violence and protection orders**

New South Wales	<p>The patient or the police on their behalf can apply for either an apprehended domestic violence order (ADVO) or an apprehended personal violence order (APVO), where the people involved are not related and do not have a domestic relationship (eg they are neighbours or work together).</p> <p>Further information: refer to the topic 'domestic violence' at <a href="http://www.legalaid.nsw.gov.au/publications/factsheets-and-resources">Legal Aid New South Wales (http://www.legalaid.nsw.gov.au/publications/factsheets-and-resources)</a>.</p>
Northern Territory	<p>The <i>Domestic and Family Violence Act 2007</i> enforces mandatory reporting to police by all adults who reasonably believe someone has been, is at risk of or is experiencing serious physical harm through family or domestic violence. The patient, someone on their behalf with their consent, or the police can apply to the court for a domestic violence order. If the violence is being committed by someone who is not in a family or domestic relationship with the patient, the patient can apply for a personal violence restraining order.</p> <p>Further information: <a href="https://tfhc.nt.gov.au/domestic-family-and-sexual-violence-reduction/informationsharing">Children and Families NT (https://tfhc.nt.gov.au/domestic-family-and-sexual-violence-reduction/informationsharing)</a></p>
Queensland	<p>The patient or the police or an authorised person such as a friend, relative or community work (on the patient's behalf) can apply for a domestic violence order (protection order). This covers intimate personal relationships, family relationships and informal care relationship (where one person relies on another for daily living).</p> <p>Further information: <a href="http://www.legalaid.qld.gov.au/legalinformation">Legal Aid Queensland (http://www.legalaid.qld.gov.au/legalinformation)</a> (<a href="https://www.legalaid.qld.gov.au/Home">https://www.legalaid.qld.gov.au/Home</a>) and <a href="http://www.courts.qld.gov.au/courts/magistrates-court/domestic-and-family-violence">Queensland Courts (http://www.courts.qld.gov.au/courts/magistrates-court/domestic-and-family-violence)</a>.</p>
South Australia	<p>Police, on behalf of the patient, can either issue an intervention order if grounds to do so and the perpetrator is present or in custody, or they can apply to the courts. A patient, or someone on their behalf, may also apply for an intervention order to the courts directly.</p> <p>An interim intervention order may initially be issued, after which it may be confirmed by the magistrates' court.</p> <p>Further information: <a href="https://www.sa.gov.au/topics/housing/resolving-problems-and-disputes/intervention-orders">South Australia Government (https://www.sa.gov.au/topics/housing/resolving-problems-and-disputes/intervention-orders)</a>.</p>

**Table 20.3. Family violence and protection orders**

Tasmania	<p>Patients can seek a family violence order (FVO) or restraining order with assistance from the police, legal aid commission or court support and liaison service.</p> <p>More information: <a href="http://www.justice.tas.gov.au/national-domestic-violence-order-scheme">Tasmanian Government – Family and Community violence (http://www.justice.tas.gov.au/national-domestic-violence-order-scheme)</a> and <a href="https://www.magistratescourt.tas.gov.au/going_to_court/restraint_orders">Magistrates Court Tasmania – Restraining orders (https://www.magistratescourt.tas.gov.au/going_to_court/restraint_orders)</a></p>
Western Australia	<p>For cases of domestic or family violence and assault, patients can apply for a restraining order at the Magistrates’ Court, or the police may be able to do this on the patient’s behalf. The police can also impose a police order, which is a temporary form of restraining order that can be put in place while the restraining order is applied for through the courts.</p> <p>Further information: <a href="https://www.police.wa.gov.au/Your-Safety/Family-violence">Western Australia Police (https://www.police.wa.gov.au/Your-Safety/Family-violence)</a> and the <a href="http://www.wa.gov.au/information-about/community-safety/domestic-violence">West Australian government (http://www.wa.gov.au/information-about/community-safety/domestic-violence)</a>.</p>
Victoria	<p>There are two types of intervention orders in Victoria. A patient may apply for a family violence intervention order or a personal safety intervention order where the perpetrator is not a family member. The <a href="https://www.mcv.vic.gov.au/intervention-orders">Magistrates’ Court of Victoria provides useful information about taking out these intervention orders (https://www.mcv.vic.gov.au/intervention-orders)</a>.</p> <p>Victoria Legal Aid has booklets available for download regarding the law and sexual assault or family violence on its website. There is also <a href="http://www.legalaid.vic.gov.au/find-legal-answers">further information about both types of intervention orders (http://www.legalaid.vic.gov.au/find-legal-answers)</a></p>

### Do protection orders make a difference?

Study results vary in relation to the effectiveness of protection orders. Most studies have been conducted in the United States, where protection orders have been associated with:

- reduced police incidents and emergency department visits by the victim/survivors, both during and after an order has expired
- victims/survivors’ being more likely to call the police for family violence incidents that did not involve physical assault
- improved police response to incidents of family violence.<sup>8</sup>

## Criminal law responses

When patients decide to report family violence to the police, criminal charges may be laid against the perpetrator of family violence. The police will initially decide whether to charge a perpetrator with a criminal offence, and in making that decision the police will take the patient's views into account. Where the perpetrator is charged with a criminal offence, the patient will be required to provide a statement to the police and may be required to later give evidence in court.

## Family law responses

Patients may have children or share property with the perpetrator. In these circumstances the safety of the patient and children may be strengthened if court orders are made about child contact and property arrangements. Where these issues are relevant, patients should be referred to the [Family Court \(http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/home\)](http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/home) or [Family Relationships Online \(https://www.familyrelationships.gov.au/\)](https://www.familyrelationships.gov.au/), and encouraged to seek legal advice and information from a lawyer (refer to Table 20.1) or community service.

### Immigration law responses

Some patients may have an insecure visa and be concerned that formal reporting of family violence may place them at risk of being deported or not having their visa renewed. Patients who hold partner visas can apply for consideration under the special provisions relating to family violence under the *Migration Regulations 1994 (Cth)*. Under these provisions, the patient may be eligible for a visa.

Where visa issues are relevant, patients should be referred to the [Australian Government Department of Home Affairs \(https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing/partner-onshore/family-violence-and-your-visa\)](https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing/partner-onshore/family-violence-and-your-visa) and encouraged to seek legal advice and information from a lawyer (refer to Table 20.1) or a community service.

Refer also to the [chapter on working with migrant and refugee communities \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/working-with-migrant-and-refugee-communities).

## Legal systems abuse

Perpetrators of family violence might use a range of litigation tactics to gain an advantage over or to harass, intimidate, discredit or otherwise control the other party.<sup>9</sup> This may involve, for example, making false reports to police or other services, commencing litigation simply to harass or intimidate the other person or extending litigation unnecessarily. Increasingly, the misuse of the legal systems in this way is recognised as an extension of family violence.

If a patient reports this experience, they should be encouraged to seek legal advice and information from a lawyer or a community service (refer to Table 20.1).

Further information is available on the [National Domestic and Family Violence Bench Book \(https://dfvb.enchbook.aija.org.au/understanding-domestic-and-family-violence/systems-abuse/\)](https://dfvb.enchbook.aija.org.au/understanding-domestic-and-family-violence/systems-abuse/).

## Sexual assault

It is useful for GPs to be aware of other services and service providers in the local area for both themselves and their patients. These may include counselling services, the police, sexual assault services dealing with the collection of forensic evidence, local hospitals and local courts.<sup>1</sup>

No matter how long ago the sexual assault happened, a victim/survivor can, and may wish to, contact the police. There is no 'statute of limitations' for sexual assault. In the event that a victim/survivor does want to contact police, they can contact any police station, and arrangements will be made for a trained police officer to contact the victim/survivor. Most Australian states and territories have specialised crime units that deal with sexual assault issues.

A physical examination is best performed as soon as possible after the patient presents. Delay may result in:

- lost therapeutic opportunities (eg provision of emergency contraception)
- changes to the physical evidence (eg healing of injuries)
- loss of forensic material (eg evidence of contact with the assailant, including blood and semen).

However, victims of sexual assault may not present for treatment for some considerable time after the assault.<sup>1</sup> The [chapter on adult sexual assault \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-survivors-of-child-abuse) provides greater detail of the management of patients who have experienced sexual assault, and the World Health Organization has produced [guidelines for health workers managing cases of sexual assault \(http://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf?sequence=1\)](http://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf?sequence=1).

If the event occurred recently, forensic evidence is best collected as soon as possible and, in particular, in the first 72 hours after the assault. Forensic evidence will be important if the patient decides to go to court about this matter. If you are not trained in the collection of forensic evidence, your patient needs to be referred to a sexual assault service (refer to the Resources section of this chapter and the [sexual assault chapter \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/adult-sexual-assault)). The implications of, and consent to, the collection of this evidence will need to be discussed with the patient by a professional qualified to do so.<sup>1</sup>

Sensitivity in both the discussion and collection of evidence is required in order not to re-victimise the patient. Forensic and medical sexual assault clinicians are qualified to deal with these issues.

There are other advantages to early reporting to the police. Police may be able to collect evidence – for example, from the crime scene, from clothing or sheets, or from CCTV – which would otherwise be lost. In most cases the victim/survivor will later be able to withdraw if they do not wish to continue with criminal proceedings. Many victims/survivors of sexual assault find some satisfaction or meaning in assisting the police gather evidence that may assist in solving other crimes, or in the protection of other potential victims/survivors, even if they themselves choose not to proceed with the court process.

In many Australian states and territories there are specific sexual assault services, often situated at a hospital. A nationwide list can be found at Forensic and Medical Sexual Assault Clinicians Australia (refer to the Resources section of this chapter). Patients can be referred for forensic examination and for counselling services whether they choose to report, or not to report, the assault to police.

If there is the potential for further sexual assault to occur and the perpetrator is not considered to be related to, or in a domestic relationship with, your patient, they may be able to apply for a form of protection order (the name of these orders vary between states and territories). As in cases of family violence, you may direct your patient to go to the police (refer to Table 20.2), relevant local community or legal services (refer to Table 20.1) for assistance or advice.

## Child abuse

The Northern Territory requires any adult to report to police if they believe on reasonable grounds that a child has been, is, or is likely to be at risk of a sexual offence or to experience harm or exploitation. In all states and territories, medical practitioners are required to report any assault perpetrated against people under the age of 18 years (16 years in New South Wales and 17 in Victoria).

Each Australian state and territory has different legislation regarding what must be reported by whom (refer to Table 9.5, [Chapter 9: Child abuse and neglect \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect)). When in doubt, it is always best to check with your medical defence organisation or with the reporting agency, initially without mentioning the child's name.

## Abuse of older people and other vulnerable population groups (other than children)

The Northern Territory is the only Australian jurisdiction that has mandatory reporting requirements regarding family violence. The provisions are located in the *Domestic and Family Violence Act 2007* (Northern Territory). These provisions require that any adult must contact the police where they reasonably believe another person has been, is at risk of or is experiencing, serious physical harm through domestic or family violence. This requirement overrides issues of confidentiality.

While there is no mandatory framework requiring GPs to report adult abuse, except in the Northern Territory, it may be the case that a patient is exposed to abuse or violence threatening their safety.

In the case of suspected abuse where the patient has lost capacity to make decisions in their own best interests, the first step is to check the patient's record to identify if a substitute decision maker has been appointed. If not, or if that person is the suspected abuser, you need to contact the public guardian, public advocate or appropriate body in your own state or territory – if it is considered necessary or desirable to safeguard the patient's wellbeing.

If a patient has capacity, patient consent may be sought to enlist the support of the public guardian, public advocate or similar person to protect them or to remove them from threatened risk.



In circumstances where you reasonably believe there is an imminent threat of harm to the patient, you can call the police without contravening any privacy principles. The more vulnerable the patient (eg if they are elderly), the more important it may be for the doctor to inform the police or seek medico-legal advice.

Table 20.4 lists government websites that are useful reference points for GPs, or family members of the patient who is incapacitated and qualifies for assistance of the public guardian, public advocate or similar person. The RACGP has more [information about guardians and advance care directives \(http://www.racgp.org.au/guidelines/advancecareplans\)](http://www.racgp.org.au/guidelines/advancecareplans).

If you consider it professionally appropriate to take steps to assist a patient through the appointment of a public advocate or public guardian, it may be desirable first to seek professional advice, without identifying the patient, to ensure that their situation falls within the jurisdiction of the relevant public advocate or public guardian.

If deemed appropriate, you can report abuse to a number of different agencies, including the police (refer to Table 20.1), residential aged care facility, and the public advocate or your state or territory equivalent (refer to Table 20.4). Protection orders and sexual assault services may be considered, if appropriate.

**Table 20.4. Advocacy groups in each state and territory**

Australian Capital Territory	<a href="https://hrc.act.gov.au/public-advocate/">Public Advocate (https://hrc.act.gov.au/public-advocate/)</a>
New South Wales	<a href="https://www.tag.nsw.gov.au/public-guardian">Public Guardian (https://www.tag.nsw.gov.au/public-guardian)</a>
Northern Territory	<a href="https://publicguardian.nt.gov.au/">Public Advocate (https://publicguardian.nt.gov.au/)</a>
Queensland	<a href="http://www.justice.qld.gov.au/justice-services/guardianship/public-advocate">Public Advocate (http://www.justice.qld.gov.au/justice-services/guardianship/public-advocate)</a>
South Australia	<a href="http://www.opa.sa.gov.au">Public Advocate (http://www.opa.sa.gov.au)</a>
Tasmania	<a href="http://www.publicguardian.tas.gov.au">Public Guardian (http://www.publicguardian.tas.gov.au)</a>
Victoria	<a href="http://www.publicadvocate.vic.gov.au">Public Advocate (http://www.publicadvocate.vic.gov.au)</a>
Western Australia	<a href="http://www.publicadvocate.wa.gov.au">Public Advocate (http://www.publicadvocate.wa.gov.au)</a>

---

**Table 20.4. Advocacy groups in each state and territory**

---

National	<a href="http://www.agac.org.au">Australian Guardianship and Administration Council (http://www.agac.org.au)</a>
----------	--

---

## Case study

This is a true story of a patient's journey through the legal processes of dealing with IPAV. It helps us to understand the stress that can be experienced as women negotiate such a journey.

This story started in the mid-1980s as I was preparing to study an arts degree. My husband at first encouraged this, but after marriage he decided it was unnecessary for me to study. The first physical violence occurred within six months of the marriage, around the issue of my studying. I was shocked and confused when he first hit me. I didn't tell anyone. I went to the doctor because I was tired and unwell and he prescribed antidepressants.

My husband was very critical of my using antidepressants and insisted that I cancel my driver's licence and stopped me spending time with family and friends.

We moved away from Sydney and bought an old house, which I was primarily responsible for renovating. My health became worse. I became more isolated. I had arranged a visit to Europe, which my husband did everything in his power to prevent. It was a time when I could reflect on my life, my health improved and I met a family who were very supportive. They recognised that things were not right and encouraged me to talk. Meanwhile, my husband was demanding my return and achieved this by reporting my Visa card stolen. It was cancelled and I had no access to funds.

I arrived home with not a friend anywhere. My husband had turned my family and friends against me. He insisted I write to my friends overseas and cut off contact. They were alerted by this and wrote to my family. My husband continued to abuse me, ranting that I was selfish and ungrateful. He accused me of being lazy and careless and criticised everything I did. He also accused me of having affairs. He kept knives in his bedside table and I was totally intimidated. I couldn't sleep at night – I only slept two to three hours a day when he was out of the house. I lost weight and started smoking.

The letter to my family alerted them and I was able to explain things to my parents and break my husband's hold on them. I began to see a counsellor, Karen, who would prove to be very helpful to me.

Why didn't I leave earlier?

The only way for women to leave domestic violence is to leave the house. When people say: 'Why don't you leave?' I ask them how would they feel if tomorrow morning they were to walk out of their home, leaving everything behind and in the evening they would not come back or the next night or ever again. Just leave everything behind and try to find a new life.

To walk out into the unknown is very hard for someone who has lost all confidence and belief in themselves. It's hard to believe you can manage alone. Also, there is the terrible fear of the husband and what may happen if he catches up with you. Some women not only have to leave, but also have to go far away to be safe. I had to go to Darwin. The logistics can be very daunting.

I was slowly helped, so that I was able to go to a solicitor for advice, make a plan to leave, go to a distant place for safety and arrange for an apprehended domestic violence order (ADVO).

This is only a very small part of the story as it has involved divorce, trying through the Family Court to get a settlement and slowly, very slowly, rebuilding my life. The most difficult times were going to court for the ADVO (I could not have done this without a court support worker), and the meetings at the Family Court where they tried to force me to be in the same room with my husband. The lawyer insisted that we be kept separate as there was an ADVO and it was not possible for any negotiations with my husband. It is as if my husband has been able to continue his abuse through the court system.

Why have I told my story?

I do it in the hope that it will enable you to understand what may be going on behind closed doors; why it is so hard to leave; how intimidated and exhausted one can become; how leaving needs to be planned and carefully done; and how leaving is only the beginning of much more that needs to be organised.

I appreciate the support I have had from my counsellor, family and doctors. I hope to prevent this happening to other women.

## Further information

- [When she talks to you about the violence \(https://www.wlsnsw.org.au/wp-content/uploads/GP-toolkit-updated-Oct2019.pdf\)](https://www.wlsnsw.org.au/wp-content/uploads/GP-toolkit-updated-Oct2019.pdf) – a toolkit for GPs on domestic violence, Women’s Legal Service NSW, 2019.
- [National Domestic and Family Violence Bench Book \(https://dfvbenchbook.aija.org.au/\)](https://dfvbenchbook.aija.org.au/) – a website that includes information about the law and family violence, Australasian Institute of Judicial Administration, 2021.

## References

1. World Health Organization. Strengthening the medico-legal response to sexual violence. Geneva: WHO, 2016.
2. [Australian Institute of Health and Welfare. Sexual assault in Australia. Canberra: AIHW, 2020 \(http://www.aihw.gov.au/getmedia/0375553f-0395-46cc-9574-d54c74fa601a/aihw-fdv-5.pdf.aspx?inline=true\)](http://www.aihw.gov.au/getmedia/0375553f-0395-46cc-9574-d54c74fa601a/aihw-fdv-5.pdf.aspx?inline=true). [Accessed 6 August 2021].
3. Hegarty K, Taft A, Feder G. Violence between intimate partners: Working with the whole family. *BMJ* 2008;337:a839 [Accessed 6 August 2021].
4. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013. [Accessed 6 August 2021].
5. Mezey G, King M, MacClintock T. Victims of violence and the general practitioner. *Br J Gen Pract* 1998;48:906–8. [Accessed 6 August 2021].
6. Hegarty KL, Taft AJ. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Aust N Z J Public Health* 2001;25:433–37. [Accessed 6 August 2021].
7. Voce I, Boxall H. Who reports domestic violence to the police? A review of the evidence. *Trends & Issues in Crime and Criminal Justice* 2018;559. [Accessed 6 August 2021].
8. Kothari C, Karin Rhodes K, Wiley J, et al. Protection orders protect against assault and injury: A longitudinal study of police-involved women victims of intimate partner violence. *J Interpers Violence* 2012;27:2845–68. [Accessed 6 August 2021].

9. Fitch E, Easteal P. Vexatious litigation in family law and coercive control: Ways to improve legal remedies and better protect the victims. *Family Law Review* 2017;7:103–15. [Accessed 6 August 2021].

# Intimate partner abuse and violence: Education and training for healthcare professionals

'A trained and ready health professional is motivated to make a difference, knows how to ask and respond to patients who are experiencing IPAV, feels well supported in their work environment, and has adequate clinical resources to assist and encourage their work'

## Key messages

- Intimate partner abuse and violence (IPAV) education and training can improve healthcare professionals' IPAV knowledge, attitudes and beliefs, as well as their clinical readiness to respond to partner violence.<sup>1</sup>
- It is unclear which IPAV training methods, content and dose produce the best learning and patient outcomes.<sup>1</sup>
- One-off episodes of IPAV education are not enough for consistent or sustained behaviour change.<sup>2</sup> Clinician capacity-building to complete IPAV work is more likely to occur using a comprehensive whole-of-practice, systems approach.<sup>3</sup>
- Experiential learning activities, like interactive simulated role-play and relevant clinical case studies, may produce better learning outcomes than traditional didactic methods.<sup>4,5</sup>
  - IPAV education and training content should include best practice methods regarding:<sup>6,7</sup>
    - when and how to safely ask about IPAV
    - ways to provide an empathic response (eg LIVES – Listen closely, Inquire about needs, Validate her experience, Ensure safety and Support)
    - risk assessment methods
    - safety planning
    - documentation and referral options.
- Impacts on and the safety of children must be covered in IPAV training, along with provider legal obligations. Content inclusive of diverse populations can help encourage an equity informed approach to practice.<sup>6-8</sup>

## Recommendations

All healthcare professionals should be offered IPAV training, as it improves provider knowledge, attitudes and perceived readiness to engage in IPAV inquiry and care with patients.<sup>1</sup>

**(Strong recommendation: low certainty of evidence)**

### Reference

1. Kalra N, Hooker L, Reisenhofer S, et al. Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database Syst Rev* 2021;5:CD012423.

IPAV training content should include routine inquiry about IPAV (for at-risk patients eg antenatal, mental health), including inquiries about children's safety and wellbeing, along with basic first-line response (LIVES) to disclosures. Other content includes case documentation, legal requirements, and referral methods and options.<sup>6,7</sup>

**(Practice point, Consensus of experts)**

### References

6. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: WHO, 2014.
7. World Health Organization. Caring for women subjected to violence: A WHO curriculum for training health-care providers. Geneva: WHO, 2019.

IPAV curricula should be integrated into healthcare provider undergraduate and postgraduate education and delivered to existing, qualified providers as continuing professional development on an ongoing (eg annual) basis.<sup>2</sup>

**(Practice point, Consensus of experts)**

### Reference

2. García-Moreno C, Hegarty K, d'Oliveira AFL, et al. The health-systems response to violence against women. *Lancet* 2015;385:1567–79.

Interactive training methods may include practice of IPAV communication/clinical skills through simulated role-play, supported through clinical resources, supervision and mentorship<sup>1,4,5</sup>

**(Practice point, Consensus of experts)**

### References

1. Kalra N, Hooker L, Reisenhofer S, et al. Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database Syst Rev* 2021;5:CD012423.
4. Kolb DA. *Experiential learning: Experience as the source of learning and development*. 2nd edition. New Jersey: Pearson Education, 2015.
5. Sammut D, Kuruppu J, Hegarty K, et al. Which violence against women educational strategies are effective for prequalifying health-care students? A systematic review. *Trauma Violence Abuse* 2019;22:339–58.

Training content to enhance provider readiness should include methods to foster provider commitment, adopting an advocacy approach, developing trusting relationships and team collaboration.<sup>9</sup>

**(Practice point, Consensus of experts)**

Reference

9. Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067.

## Introduction

This chapter provides an overview of IPAV healthcare provider education and training, and outlines the training content, methods and support required for enhancing knowledge, attitudes and behaviours regarding IPAV. It may be used as a resource to guide continuous professional development and improve educational and skill development for care of patients experiencing IPAV.

IPAV is the largest contributor to morbidity and mortality for young women.<sup>10</sup> It is associated with poor physical/mental health, developmental and behavioural issues in children, child abuse and intergenerational trauma.<sup>11,12</sup>

Healthcare providers have a key role in addressing this public health problem, through early identification and supportive care of all family members exposed to IPAV. Therefore, effectively training healthcare providers is one part of the solution to improving the health system response to IPAV.

However, because the health effects of IPAV are poorly recognised, many healthcare providers have had no or very limited undergraduate/postgraduate or professional development in responding to or managing IPAV.<sup>13,14</sup>

Some providers avoid engaging with patients experiencing IPAV because of lack of time to discuss issues, poor acknowledgement of patient circumstances and/or to avoid complex consultations and disclosures they do not know how to manage.<sup>15</sup> Other individual and environmental barriers, like language/cultural differences, partner presence and lack of privacy and resources, can affect provider behaviour to engage in IPAV work.<sup>16</sup>

Many providers have poor knowledge of IPAV, feel unprepared and lack confidence in asking about IPAV in clinical practice.<sup>17-19</sup> IPAV training and education can overcome some of these barriers and lead to improved care and outcomes for victims/survivors. Embracing a reflective practice approach that includes monitoring of clients experiencing IPAV and using feedback from services can inform and enhance future clinical practice.<sup>2</sup>

Failure to provide adequate healthcare provider IPAV education and training can leave victims/survivors feeling judged, isolated and potentially at further risk of violence.<sup>20</sup> An empathic and supportive response from a well-trained healthcare provider can act as a catalyst for patients, motivating them to make changes in their lives.<sup>21</sup> Inquiry from a provider who is committed and ready to address IPAV is the first step towards helping patients.<sup>9</sup>

A meta-synthesis of 41 qualitative studies exploring healthcare provider views ( $n = 1744$ ) on what enhances their readiness to address domestic violence and abuse found that training embedded within a supportive healthcare system, along with provider commitment, adopting an advocacy approach, trust and team collaboration (the CATCH model, refer to Figure 21.1), all facilitate healthcare provider readiness to practise IPAV work.<sup>9</sup>

## CATCH MODEL

Commitment/Advocacy/Trust/Collaboration/Health system

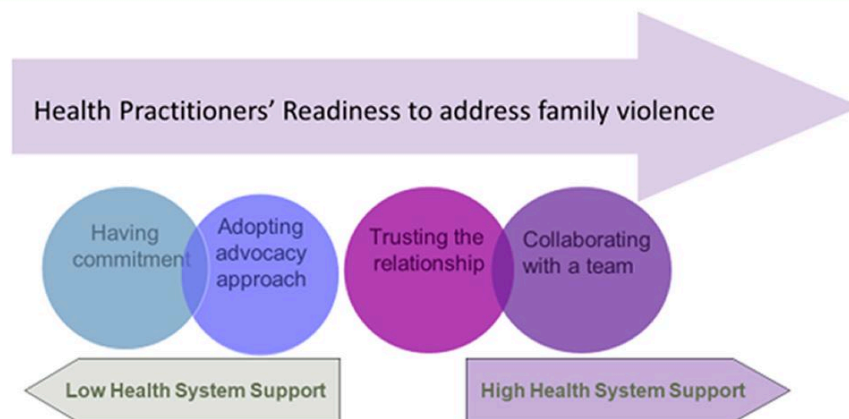


Figure 21.1. The CATCH of model of health practitioner readiness to address intimate partner violence<sup>9</sup>

Source: Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067.



## Does IPAV training work?

Although there is a lack of high-quality evidence regarding the effect of healthcare practitioner training on women's experiences of care, there is some data demonstrating that training and education can have a positive impact on practitioner knowledge, attitudes and readiness to respond to IPAV.

Evidence from several systematic reviews,<sup>1,5,22-24</sup> including a Cochrane review, indicate that healthcare provider IPAV training can enhance IPAV knowledge, attitudes and preparedness to undertake IPAV work. However, the Cochrane review findings show that the evidence quality is low and the sustained effect of these outcomes beyond 12 months post-training is unknown.<sup>1</sup>

Furthermore, training alone has not been clearly shown to change clinician behaviour or clinical practice (eg safety planning, improved documentation of cases or referrals).<sup>1,22</sup> In the Cochrane review, there was no clear improvement for women in outcomes (eg mental health or experience of IPAV) post provider training; however, no studies reported adverse effects from training interventions (for providers or women).<sup>1</sup>

## Effective IPAV training methods

There is inadequate evidence to determine the most effective type of IPAV training method, duration, intensity and content.<sup>1</sup> However, the little existing evidence suggests that educational methods that use problem-based, experiential and interactive approaches can lead to improved practice application.<sup>4,5</sup>

This includes:

- group discussion
- simulated role-play/patients
- online resources such as videos and case studies
- clinical placements
- peer-facilitated training.

There is also some evidence to suggest that longer, more practical training sessions are more effective than short interventions.<sup>5,23</sup>

## World Health Organization curriculum

In 2019, the World Health Organization (WHO) released a 'violence against women' competency-based training curriculum that aims to guide health/practice managers,<sup>25</sup> educators and providers.<sup>7</sup> According to the WHO, successful healthcare provider education and training programs:

- adopt a consistent approach
- have a firm theoretical framework
- ensure interactive and person-centred methods are used
- are programs of longer duration.

WHO training objectives include:

- Demonstrate awareness of violence against women as a public health problem
- Develop helpful responsive behaviours to victims/survivors
- Demonstrate skill development in response to women victims/survivors
- Identify and use resources for victims/survivors and self

The WHO curriculum is flexible and can be delivered over two or more continuous days. It covers 13 topics and 10 core competencies. These competencies are:<sup>7</sup>

- Violence against women as a health issue
- Survivor experiences and how practitioner attitudes impact on care provided
- The health system response to violence against women
- Practitioner–survivor communication skills
- Identification of patients experiencing violence
- LIVES (Listen, Inquire, Validate, Ensure safety, Support ) first-line support
- Local referral pathways and understanding the legal and policy context
- Clinical and forensic care for survivors of sexual violence
- Documentation
- Health professional self-care

This curriculum is delivered using adult learning principles. This approach actively engages the participant learner, rather than relying only on lectures or more traditional, didactic methods. Learning is facilitated through ‘case studies, guided discussions, participatory reflection exercises, videos and readings. This process supports critical reflection, emotional engagement, skills development and the ability to put knowledge into practice’.<sup>7</sup> Regular sessions (eg annually) can help consolidate learning, update provider IPAV knowledge and skills, and sustain best practice.

## Trauma-informed care

A trauma-informed care framework is useful to embed in IPAV training, particularly as it is recommended for responding to IPAV including sexual violence.<sup>8</sup> The framework centralises psychological and physical safety by acknowledging and incorporating the various and complex needs of victims/survivors. To do this, there is attention to discretion, autonomy, connection, partnerships and reconstructing a perception of control.<sup>8</sup>

A trauma-informed care lens suggests that IPAV education and training should include a focus on vicarious trauma, as healthcare providers can be exposed to traumatic storytelling when responding to IPAV.<sup>8</sup> Refer to the chapters [on trauma informed care \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/trauma-informed-care-in-general-practice) and on [health professional self-care \(http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care\)](http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/trauma-and-violence-informed-care/clinician-support-and-self-care).

## Being aware of participants who have experienced IPAV

Educators must be sensitive to the possibility that health professionals may themselves have experienced IPAV. Recent Australian evidence indicates that one in <sup>10</sup> hospital-based practitioners have lived experience of IPAV,<sup>26</sup> are more likely to attend IPAV education, and provide a more comprehensive

and sensitive response to patients.<sup>27</sup> During education sessions, opportunities for reflection and emotional support should be made available to participants, with an emphasis on management of personal experiences, supportive resources and self-care.

## Activities and reflection

- What are the potential individual and structural barriers you experience in relation to your ongoing IPAV professional development?
- What can you do to address these barriers?
- List your own learning needs for best practice identification and response to patients experiencing IPAV.
- What self-care activities can you undertake to prevent vicarious/cumulative trauma?

A trained and ready health professional is motivated to make a difference, knows how to ask and respond to patients who are experiencing IPAV, feels well supported in their work environment, and has adequate clinical resources to assist and encourage their work.<sup>9</sup>

## Resources

### IPAV education and training suppliers

- [RACGP Professional Development Program on Family Violence \(https://www.racgp.org.au/familyviolence/\)](https://www.racgp.org.au/familyviolence/)
- [DV Alert \(http://www.dvalert.org.au/\)](http://www.dvalert.org.au/) – free national training-domestic and family violence response for universal services.
- Specific state/territory IPAV training services (eg in Victoria, [Domestic Violence Resource Centre \(https://training.dvrcv.org.au/\)](https://training.dvrcv.org.au/)).
- [Safer Families resources \(https://www.saferfamilies.org.au/\)](https://www.saferfamilies.org.au/)

### Clinical resources

- [RACGP family violence resources \(https://www.racgp.org.au/familyviolence/resources.htm\)](https://www.racgp.org.au/familyviolence/resources.htm)
- [Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook \(http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/\)](http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/), WHO, 2014.
- [Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers \(https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/\)](https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/), WHO, 2017.
- [Responding to children and adolescents who have been sexually abused: WHO clinical guidelines \(https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/\)](https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/), WHO, 2017. Retrieved from

### Curricula

- [Caring for women subjected to violence: A WHO curriculum for training health-care providers \(https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/\)](https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/), WHO, 2019.

## Evidence

- [Training healthcare providers to respond to intimate partner violence against women \(https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012423/full\)](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012423/full), N Kalra, GL Di Tanna, C García-Moreno, The Cochrane Library, 2017.
- [Training healthcare providers to respond to intimate partner violence against women \(https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012423.pub2/full\)](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012423.pub2/full). N Kalra, L Hooker, S Reisenhofer, GL Di Tanna, C García-Moreno, Cochrane Database of Systematic Reviews, 2021.

## Violence against women research

- [Australia's National Research Organisation for Women's Safety \(ANROWS\) \(https://www.anrows.org.au/\)](https://www.anrows.org.au/) – for up-to-date research on violence against women.
- [Our Watch \(https://www.ourwatch.org.au/\)](https://www.ourwatch.org.au/) – for information on the primary prevention of violence against women.

## References

1. Kalra N, Hooker L, Reisenhofer S, et al. Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database Syst Rev* 2021;5:CD012423.
2. García-Moreno C, Hegarty K, d'Oliveira AFL, et al. The health-systems response to violence against women. *Lancet* 2015;385:1567–79.
3. McCaw B, Berman WH, Syme SL, et al. Beyond screening for domestic violence: A systems model approach in a managed care setting. *Am J Prev Med* 2001;21:170–76.
4. Kolb DA. *Experiential learning: Experience as the source of learning and development*. 2nd edition. New Jersey: Pearson Education, 2015.
5. Sammut D, Kuruppu J, Hegarty K, et al. Which violence against women educational strategies are effective for prequalifying health-care students? A systematic review. *Trauma Violence Abuse* 2019;22:339–58.
6. World Health Organization. *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Geneva: WHO, 2014.
7. World Health Organization. *Caring for women subjected to violence: A WHO curriculum for training health-care providers*. Geneva: WHO, 2019.
8. Browne AJ, Varcoe C, Ford-Gilboe M, et al. EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *Int J Equity Health* 2015;14:152.
9. Hegarty K, McKibbin G, Hameed M, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS One* 2020;15:e0234067.
10. Webster K. *A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions*. Sydney: Australia's National Research Organisation for Women's Safety, 2016.
11. Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse Negl* 2008;32:797–810.
12. Vu NL, Jouriles EN, McDonald R, et al. Children's exposure to intimate partner violence: A meta-analysis of longitudinal associations with child adjustment problems. *Clin Psychol Rev* 2016;46:25–33.
13. Valpied J, Aprico K, Clewett J, et al. Are future doctors taught to respond to intimate partner violence? A study of Australian medical schools. *J Interpers Violence* 2017;32:2419–32.
14. Hooker L, Nicholson J, Hegarty K, et al. Maternal and child health nurse domestic violence training and preparedness to respond to women and children experiencing domestic abuse: A cross sectional study. *Nurse Education Today* 2020;96:104625.
15. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Women Health* 2012;52:587–605.

16. Beynon CE, Gutmanis IA, Tutty LM, et al. Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health* 2012;12:473.
17. Ramsay J, Rutterford C, Gregory A, et al. Domestic violence: Knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *Br J Gen Pract* 2012;62:e647–e55.
18. Po-Yan Leung T, Phillips L, Bryant C, et al. How family doctors perceived their 'readiness' and 'preparedness' to identify and respond to intimate partner abuse: A qualitative study. *Fam Pract* 2018;35:1517–23.
19. Forsdike K, O'Connor M, Castle D, et al. Exploring Australian psychiatrists' and psychiatric trainees' knowledge, attitudes and preparedness in responding to adults experiencing domestic violence. *Australas Psychiatry* 2019;27:64–68.
20. Tarzia L, Bohren M, Cameron J, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open* 2020;10:e041339.
21. Chang JC, Dado D, Hawker L, et al. Understanding turning points in intimate partner violence: Factors and circumstances leading women victims toward change. *J Womens Health* 2010;19:251–59.
22. Zaher E, Keogh K, Ratnapalan S. Effect of domestic violence training: Systematic review of randomized controlled trials. *Can Fam Physician* 2014;60:618–24.
23. Sawyer S, Coles J, Williams A, et al. A systematic review of intimate partner violence educational interventions delivered to allied health care practitioners. *Medical Education* 2016;50:1107–21.
24. Crombie N, Hooker L, Reisenhofer S. Nurse and midwifery education and intimate partner violence: A scoping review. *J Clin Nurs* 2017;26:2100–25.
25. World Health Organization. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. Geneva: WHO, 2017.
26. McLindon E, Humphreys C, Hegarty K. "It happens to clinicians too": An Australian prevalence study of intimate partner and family violence against health professionals. *BMC Womens Health* 2018;18:113.
27. McLindon E, Humphreys C, Hegarty K. Is a clinician's personal history of domestic violence associated with their clinical care of patients: A cross-sectional study. *BMJ Open* 2019;9:e029276.

# ***Supplementary materials***

# Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. It is no substitute for individual inquiry. Compliance with any recommendations does not guarantee discharge of the duty of care owed to patients. The RACGP and its employees and agents have no liability (including for negligence) to any users of the information contained in this publication.

© The Royal Australian College of General Practitioners 2021

This resource is provided under licence by the RACGP. Full terms are available at [www.racgp.org.au/usage/licence](http://www.racgp.org.au/usage/licence) (<https://www.racgp.org.au/usage/licence>)

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

## Recommended citation

The Royal Australian College of General Practitioners. RACGP Abuse and violence: working with our patients in general practice (the White Book). 5th edn. East Melbourne, Vic: RACGP, 2021.

The Royal Australian College of General Practitioners Ltd 100 Wellington Parade East Melbourne, Victoria 3002 Tel 03 8699 0414 Fax 03 8699 0400 [www.racgp.org.au](http://www.racgp.org.au) (<https://www.racgp.org.au/>)

# Acknowledgements

The Royal Australian College of General Practitioners (RACGP) gratefully acknowledges the contributors listed below.

## **White Book Expert Advisory Group**

Professor Kelsey Hegarty MBBS, FRACGP, DRANZCOG, PhD Co-Chair, White Book Expert Advisory Group Professor, Family Violence Prevention, University of Melbourne and Department of General Practice, The Royal Women's Hospital Director, Safer Families Centre of Research Excellence

Dr Elizabeth Hindmarsh MBBS, FRACGP Co-Chair, White Book Expert Advisory Group Chair, RACGP Specific Interests – Abuse and Violence

Associate Professor Ralph Audehm MBBS, DipRACOG

Associate Professor Jill Benson MBBS, DCH, FACPsychMed Medical Director, Kakarrara Wilurrara Health Alliance

Ms Zofia Di Stefano Personal Growth Programs, Workshops, Counselling, Personality and Human Relationships Australia

Professor Gene Feder MD, FRCGP, OBE Professor, Primary Care, Bristol Medical School, University of Bristol

Ms Virginia Geddes Advocate for Women's Rights, Victorian Honour Roll of Women 2016

Dr Mohajer Hameed Master of Psychoanalysis, PhD Research Fellow, Safer Families Centre of Research Excellence, University of Melbourne

Dr Deepthi Iyer MBBS, FRACGP, PhD

Dr Magdalena Simonis MBBS, FRACGP, DRANZCOG, MHHS

Dr May Su BSc (Med), MBBS, MMH (GP), FRACGP

Ms Amanda Lived Experience Survivor Advocate, The WEAVERs Group, University of Melbourne

Ms Alexis Mohay Director, Primary Health Care Governance and Implementation Section, Australian Government Department of Health

## **Contributors**

Associate Professor Jill Benson MBBS, DCH, FACPsychMed Medical Director, Kakarrara Wilurrara Health Alliance (Chapter 8)

Dr Ai-Lene Chan MBBS, FRACGP, DCH, MPH&TM (Chapter 17)



- Ms Marina Carman Director, Rainbow Health Victoria, Chief of Staff, Australian Research Centre in Sex, Health and Society (Chapter 19)
- Ms Zofia Di Stefano Personal Growth Programs, Workshops, Counselling, Personality and Human Relationships Australia (Preface)
- Professor Heather Douglas LLB, BA, LLM, PhD Melbourne Law School, University of Melbourne (Chapter 20)
- Dr Renee Fiolet, RN, PhD Research Fellow, Indigenous Healthy Equity Unit, University of Melbourne (Chapters 16 and 21)
- Dr Bianca Forrester, MBBS, FRACGP GP, Lecturer, University of Melbourne (Chapter 9)
- Dr Mohajer Hameed Master of Psychoanalysis, PhD Research Fellow, Safer Families Centre of Research Excellence, University of Melbourne (Chapters 5 and 6)
- Professor Kelsey Hegarty, MBBS, FRACGP, DRANZCOG, PhD Co-Chair, White Book Expert Advisory Group Professor, Family Violence Prevention, University of Melbourne and Department of General Practice, The Royal Women's Hospital Director, Safer Families Centre of Research Excellence (Chapters 1, 2, 3 and 4)
- Dr Elizabeth Hindmarsh MBBS, FRACGP Co-Chair, White Book Expert Advisory Group Chair, RACGP Specific Interests – Abuse and Violence (Chapters 1, 13 and 15)
- Dr Leesa Hooker RN, RM, MHSc, PhD (Chapter 21)
- Dr Deepthi Iyer MBBS, FRACGP, PhD (Chapters 11 and 12)
- Ms Jacqueline Kuruppu BBmed (Hons), PhD candidate Department of General Practice, University of Melbourne (Chapter 9)
- Dr Margaret Kyrkou MBBS, FRACGP, PhD, OAM (Chapter 18)
- Associate Professor John Litt MBBS, PhD, FRACGP, FAFPHM, MSc (Epid), DipRACOG, Discipline of General Practice, Flinders University (Chapter 10)
- Dr Johanna Lynch MBBS, PhD, FRACGP, Grad Cert (Grief & Loss) (Chapter 7)
- Dr May Su BSc (Med), MBBS, MMH (GP), FRACGP (Chapter 13)
- Ms Amanda Lived Experience Survivor Advocate, The WEAVERs Group, University of Melbourne (Preface)
- Associate Professor Ruth McNair MBBS, DRANZCOG, DA (UK), FRACGP, FACRRM General Practice and Primary Health Care Academic Centre, University of Melbourne (Chapter 19)
- Dr Jennifer Neil MBBS (Hons), FRACGP, GradCert (ClinTeach) Senior Lecturer, Department of General Practice, Monash University (Chapters 2 and 3)
- Ms Bijaya Pokharel RN, PhD scholar (Chapter 17)

Professor Dimity Pond MBBS, FRACGP, PhD Professor, School of Medicine and Public Health, University of Newcastle (Chapter 15)

Dr Lena Sancu MBBS, PhD, FRACGP Department of General Practice, University of Melbourne (Chapter 9)

Dr Ron Schweitzer MBBS, FRACGP Lecturer, Department of General Practice, Monash University (Chapter 5)

Associate Professor Laura Tarzia, PhD Principal Research Fellow, Department of General Practice, University of Melbourne (Chapter 14 )

Dr Lyndall Young MBBS, MForensMed, FFCFM (RCPA) (Chapter 14)

**The RACGP gratefully acknowledges feedback provided by:**

The RACGP Expert Committee – Quality Care

Dr Andrew Baird

Ms Cynthia Brown

Dr Annalyse Crane

Adjunct Associate Professor Robert Davis

Dr Caroline Johnson

Dr Margaret Kay

Dr Cathy Kezelman

Professor James Scott

Dr Sunita Thavarajadeva

Dr Hannah Thomas

Dr Anousha Victoire

Dr Kate Walker

The WEAVERs Group, University of Melbourne

**RACGP staff:**

Ms Sue Gedeon, Senior Project Officer, Quality Care

Ms Sarah Fraser, Senior Project Officer, Quality Care

Mr Roald Versteeg, General Manager, Government Relations, Policy and Practice

Mr Stephan Groombridge, National Manager, eHealth and Quality Care

Ms Su San Mok, Program Manager, Quality Care

Strategic Marketing and Communications and Information Technology team members

---

**Conflicts of interest** This guideline was developed in accordance with the rules and processes outlined in the [RACGP Conflict of Interest Policy \(https://www.racgp.org.au/the-racgp/governance/organisational-policies/conflict-of-interest\)](https://www.racgp.org.au/the-racgp/governance/organisational-policies/conflict-of-interest).

---

---

# Acronyms

---

<b>ABC</b>	awareness, balance and connection
<b>ACE</b>	adverse childhood experience
<b>ADVO</b>	apprehended domestic violence order
<b>AHPRA</b>	Australian Health Practitioner Regulation Agency
<b>AMA</b>	Australian Medical Association
<b>APVO</b>	apprehended personal violence order
<b>ASCA</b>	adults surviving child abuse
<b>ASD</b>	autism spectrum disorder
<b>CATCH</b>	Commitment, Advocacy, Trust, Collaboration, Health system
<b>CBT</b>	cognitive behavioural therapy
<b>CALD</b>	culturally and linguistically diverse
<b>CARE</b>	Consider, Acknowledge, Respond, Empower
<b>FAV</b>	family abuse and violence
<b>GP</b>	general practitioner
<b>GP MHTP</b>	GP Mental Health Treatment Plan
<b>IPAV</b>	intimate partner abuse/violence
<b>LIVES</b>	Listen, Inquire, Validate, Ensure safety, Support
<b>LGBTIQA+</b>	lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning
<b>MBCP</b>	Men's Behaviour Change Program

---

## Acronyms

---

---

**MI** motivational interviewing

---

**NCAS** National Community Attitudes towards Violence against Women Survey

---

**PTSD** post-traumatic stress disorder (PTSD)

---

**PHN** Primary Health Network

---

**RACGP** Royal Australian College of General Practitioners

---

**SRSS** Status Resolution Support Services

---

**STI** sexually transmitted infection

---

**VEGA** Violence, Evidence, Guidance and Action

---

**WHO** World Health Organization


---

# *Resources*

# Useful tools


Useful tools from each chapter are available below.

## Tool 1.1 Eight steps to intervention – the 8 Rs

 [Chapter 1 - What is interpersonal abuse and violence? \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence)

- Be **ready** to identify and respond to intimate partner abuse
- **Recognise** symptoms of abuse and violence, ask directly and sensitively
- **Respond** to disclosures of violence with empathetic listening
- Explore **risk** and safety issues
- **Review** the patient for follow-up and support
- **Refer** appropriately
- **Reflect** on your own attitude, management and limitations to addressing abuse and violence
- **Respect** your patients, your colleagues and yourself. This is an overarching principle of this sensitive work.

## Tool 4.1 Healthy relationships tool

 [Chapter 4 - Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel)

The health of an adult relationship encompasses a spectrum ranging from positive to negative.

Positive relationship health involves mutual trust, support, investment, commitment and honesty. It involves the exchange of words and actions in which there is shared power and open communication.

Negative relationship health involves unhealthy and abusive interactions with varying exchanges of emotional, physical and sexual violence. It involves words and actions that misuse power and authority, hurt people, and cause pain, fear or harm.

**How healthy is your relationship with your current/ex partner?**


Place an X on the point on the line that most closely reflects how you feel. (The X can slide along the scale)

Negative  
abuse

Positive  
healthy

Unhealthy

## Tool 4.2 Motivational interviewing tool

 [Chapter 4 - Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel) Women may be anywhere along a spectrum of how they feel about their partner or ex-partner. Some may have left the relationship, with or without recognising that their partner's behaviour was abusive. Other women may continue in relationships that are unhealthy or abusive. It is most likely that fear of their partner will have affected their emotional health, although some will not see that connection.

### Example of written tool for motivational interviewing

This is a tool you can use with your patient.



**GP:** Taking action is often challenging for people. Below is a set of steps for examining your current situation to decide on what action you might like to take and then how motivated and confident you feel at the moment about carrying out that action.

<b>Step 1</b>	What do you like about your relationship or current situation?
<b>Step 2</b>	What are the things you don't like about your relationship or current situation?
<b>Step 3</b>	[Summarise – GPs understanding of the woman's pros and cons]
<b>Step 4</b>	Where does this leave you now?
<b>For women who are ready to change to some extent:</b>	
<b>Step 5</b>	

For Steps 1 and 2, you may like to ask your patient to use the box below to write down her responses.

	Like	Dislike
<b>Relationship</b>		
<b>Action (Specify)</b>		

For step 5, women may choose a whole range of actions and we have listed some likely options below:

- Feel better about themselves e.g. do more exercise, take up yoga
- Manage finances better
- Become less isolated e.g. go to social group activity
- Have better parenting strategies with their children
- Improve their physical health e.g. cut down on alcohol
- Leave their partner
- Get more understanding/affection from their partner
- Get their partner to go to anger management classes
- Get their partner to stop drinking/get a job/stop gambling.

These last three are obviously out of the woman's control as it involves influencing their partner's behaviour. Acknowledging this difficulty is important. Next, you may ask your patient how motivated they are to carry out the actions they have suggested and what they feel they need in order to carry them out. How motivated do you feel to carry out .....?

You can ask your patient to place an X on the point on the line that most closely reflects how you feel.

Not at all motivated 100% motivated


What would have to happen for your motivation score to increase? How confident do you feel that you would succeed in carrying out...? Place an X on the point on the line that most closely reflects how you feel.

Not at all  
confident

100%  
confident

How can I help to increase your confidence?

## Tool 4.3 Non-directive problem-solving/goal-setting tool

 [Chapter 4 - Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel)

Non-directive problem solving assists individuals to use their own skills and resources to function better. For women who have decided that the abuse is damaging to their health and wellbeing, but whose intentions are not translated into action due to perceived external barriers, then problem-solving techniques may be helpful.

Remembering of course that as GPs we should not problem-solve for the patient.

Goal setting occurs in the following stages:

- clarification and definition of problems
- choice of achievable goals
- generation of solutions
- implementation of preferred solutions
- evaluation.

When used by GPs, this technique engages the patient as an active partner in their care. It creates a framework for individuals to re-focus on practical approaches to perceived problems and learn new cognitive skills.

Whether the solution chosen by the patient is successful is not as important as what the patient learns during the process to apply in other situations. A written example of how a structured approach to problem solving can be applied with an individual is detailed on the next page.

#### **Example of written plan for goal setting**

Non-directive problem solving aims to help you:

- recognise the difficulties that contribute to you feeling overwhelmed
- become aware of the support you have, your personal strengths and how you coped with similar problems in the past
- learn an approach to deal with current difficulties and feel more in control
- deal more effectively with problems in the future.

You are asked to follow six steps:

#### **Step 1**

Identify the issues/problems that are worrying or distressing you.

#### **Step 2**

Work out what options are available to deal with the problem.

#### **Step 3**

List the advantages and disadvantages of each option, taking into account the resources available to you.

**Problem**

**Options**

**Advantages**

**Disadvantages**

**Step 4**

Identify the best option(s) to deal with the problem.

**Step 5**

List the steps required for this option(s) to be carried out.

**Step 6**

Carry out the best option and check its effectiveness.

Best option = -----


What steps are required to do this?

1.-----

2.-----

3.-----

## Tool 4.4. Practitioner reflective questions

 [Chapter 4 - Intimate partner abuse and violence: Ongoing support and counselling \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-ongoing-support-and-counsel)

'What kinds of power and privilege do I have? How do these shape my life and world view?'

'Have I considered how experiencing trauma and violence may have contributed to the development of the presenting complaint or reason for referral?'

'How do his coercive and controlling behaviours constrict her and her children's lives and her ability to do what she wants to do, including ability to engage in any mental healthcare plans?'

'What do I know about what safety strategies she previously tried, how these worked, if services were helpful, her partner's reactions, and what, if any, access she has to financial, family, social and cultural supports?'

'Are she and her family experiencing systemic barriers (eg lack of stable housing, limited access to money and transport, poverty, language barriers and dismissive racist responses from services)? How is this impacting her, her children and family's safety and wellbeing?'


'Who is working with her partner? What strategies are in place to support him and address his use of violence?'

'Comprehending all of this, what actions can I take as a 'safety ally', as part of my treatment plan?'

'How and with whom will I review whether what we are doing is supporting safety for her, the children and her family?'

Adapted from: Short J, Cram F, Roguski M, et al. Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context. *Int J Mental Health Nurs* 2019;28:1209–19.


## Tool 10.1 The HEEADSSS psychosocial interview for adolescents

 [Chapter 10 - Sibling and peer bullying \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/sibling-and-peer-bullying)

[A resource from the Royal Children's Hospital \(https://www.rch.org.au/clinicalguide/guideline\\_index/Engaging\\_with\\_and\\_assessing\\_the\\_adolescent\\_patient\)](https://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient)

Home:	who, where, recent changes (moves or new people), relationships, stress or <a href="https://www.rch.org.au/clinicalguide/guideline_index/Family_Violence/">violence (https://www.rch.org.au/clinicalguide/guideline_index/Family_Violence/)</a> , smartphone or computer use (in home versus room)
Education and employment:	where, year, attendance, performance, relationships and bullying, supports, recent moves, disciplinary actions, future plans, work details
Eating and exercise:	weight and body shape (and relationship to these), recent changes, eating habits and dieting, exercise and menstrual history
Activities:	extra-curricular activities for fun: sport, organised groups, clubs, parties, TV/computer use (how much screen time and what for)
Drugs and alcohol:	cigarettes, alcohol and illicit drug use by friends, family and patient. Frequency, intensity, patterns of use, payment for, regrets and negative consequences
Sexuality and gender:	gender identity, romantic relationships, sexuality and sexual experiences, uncomfortable situations/sexual abuse, previous pregnancies and risk of pregnancy, contraception and STIs
Suicide, depression and self-harm:	presence and frequency of feeling stressed, sad, down, 'bored', trouble sleeping, online bullying, current feelings (eg on scale of 1 to 10), thoughts or actions of self-harm/ hurting others, suicide risk: thoughts, attempts, plans, means and hopes for future
Safety:	serious injuries, online safety (eg meeting people from online), riding with intoxicated driver, exposure to violence (school and community), if high risk – carrying weapons, criminal behaviours, justice system

## Tool 15.1 Elder Abuse Suspicion Index (EASI) questions

 [Chapter 15 - Abuse of older people \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-abuse-issues-for-adults-and-older-people/abuse-of-older-people)

Q.1-Q.5 asked patient; Q.6 answered by doctor within the last 12 months			
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?	YES	NO	Did not answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you want to be with?	YES	NO	Did not answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5. Has anyone made you feel afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

---

# Resources

Resources are listed here by location. Click on the state or territory to find resources in that state or territory.

## National

---

### General

---

Lifeline

 13 11 14


 [Website \(http://www.lifeline.org.au\)](http://www.lifeline.org.au)

---

### Sexual assault and family violence services

---


1800RESPECT - National Sexual Assault, Domestic and Family Violence Counselling Line

 1800 737 732

 [Website \(http://www.1800respect.org.au\)](http://www.1800respect.org.au)

---

Forensic and Medical Sexual Assault Clinicians Australia


 [Website \(http://www.famsacaustalia.org.au\)](http://www.famsacaustalia.org.au)

---

### Men's services


---


Relationships Australia

 [Website \(http://www.famsacaustalia.org.au\)](http://www.famsacaustalia.org.au)

---

Mensline Australia

 1300 364 277

 [Website \(https://www.relationships.org.au/\)](https://www.relationships.org.au/)

---

### Children related services and reporting abuse

---



Kids Helpline

☎ 1800 55 1800

🌐 [Website \(http://www.kidshelpline.com.au\)](http://www.kidshelpline.com.au)

---

Australian Institute of Family Studies – provides contact telephone numbers for each state and territory to report incidences of child abuse

🌐 [Website \(https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect\)](https://aifs.gov.au/cfca/publications/cfca-resource-sheet/reporting-child-abuse-and-neglect)

---

Australian Childhood Foundation

☎ 1300 381 581

🌐 [Website \(http://www.childhood.org.au\)](http://www.childhood.org.au)

---

The Child Abuse Prevention Service

☎ (02) 8080 4600

🌐 [Website \(https://www.capsau.org/\)](https://www.capsau.org/)

---

### Adult survivors of child abuse

---

Blue Knot Redress and Support Service

☎ 1300 657 380

🌐 [Website \(https://blueknot.org.au/survivors/blue-knot-helpline-redress-support-service/\)](https://blueknot.org.au/survivors/blue-knot-helpline-redress-support-service/)

---

Living well – offers services to assist men who have experienced childhood sexual abuse or sexual assault abuse or sexual assault

☎ 1300 114 397

🌐 [Website \(http://www.livingwell.org.au\)](http://www.livingwell.org.au)

---

### Vulnerable populations

---

National disability abuse and neglect hotline

☎ 1800 880 052

🌐 [Website \(https://www.jobaccses.gov.au/complaints/hotline\)](https://www.jobaccses.gov.au/complaints/hotline)

---

Aged Care Quality and Safety Commission


 [Website \(https://www.agedcarequality.gov.au/\)](https://www.agedcarequality.gov.au/)


Older persons advocacy network (OPAN)

 1800 700 600

 [Website \(https://opan.org.au/\)](https://opan.org.au/)

Elder Abuse Prevention Unit

 Queensland: 1300 651 192


 Other states and territories:(07)3867 2525

 [Website \(https://opan.org.au/\)](https://opan.org.au/)

### Migrant and refugee communities


FASSTT: Forum of Australian Survivors of Torture and Trauma (provides refugee centres around the country)


 (07) 3391 6677


 [Website \(https://www.fasstt.org.au/\)](https://www.fasstt.org.au/)

Translating and Interpreting Service (TIS)

 131 450


 [Website \(https://www.tisnational.gov.au/https://www.dss.gov.au/family-safety-pack\)](https://www.tisnational.gov.au/https://www.dss.gov.au/family-safety-pack)

 1300 131 450 (Doctors' priority line)

 [Website \(https://www.tisnational.gov.au/Non-English-speakers/Help-using-TIS-National-services.aspx\)](https://www.tisnational.gov.au/Non-English-speakers/Help-using-TIS-National-services.aspx)

### Aboriginal and Torres Strait Islander violence


Indigenous health services – lists services across all states

 [Website \(https://healthinfonet.edu.au/key-resources/organisations/\)](https://healthinfonet.edu.au/key-resources/organisations/)

### Legal support services

---

Forensic and Medical Sexual Assault Clinicians  
Australia

 [Website \(http://www.famsacaustalia.org.au\)](http://www.famsacaustalia.org.au)

## ACT

---


### Sexual assault and family violence services

---

Canberra Rape Crisis Centre &  
Service Assisting Male Survivors of Sexual Assault  
(SAMSSA)


 (02) 6247 2525

 [Website \(http://www.crc.org.au/\)](http://www.crc.org.au/)

 [Website \(https://www.crc.org.au/support-services/SAMSSA.aspx\)](https://www.crc.org.au/support-services/SAMSSA.aspx)

---

Domestic Violence Crisis Service

 (02) 6280 0900

 [Website \(http://www.dvcs.org.au/\)](http://www.dvcs.org.au/)


---

### Men's services

---

EveryMan

 (02) 6230 6999

 [Website \(https://www.everyman.org.au/\)](https://www.everyman.org.au/)

---

Domestic Violence Crisis Service

 (02) 6280 0900


 [Website \(http://www.dvcs.org.au/\)](http://www.dvcs.org.au/)

---

### Children related services and reporting abuse


---

Reporting child abuse – mandated reporters

 1300 556 728

---


Reporting child abuse – public

 1300 556 729

---

Office for Children, Youth and Family Support

 132 281

 [Website \(http://www.communityservices.act.gov.au/ocyfs\)](http://www.communityservices.act.gov.au/ocyfs)

---


### Adult survivors of child abuse

---

Canberra Rape Crisis Centre &  
Service Assisting Male Survivors of Sexual Assault  
(SAMSSA)

 (02) 6247 2525

 [Website \(http://www.crc.org.au/\)](http://www.crc.org.au/)

 [Website \(https://www.crc.org.au/support-services/SAMSSA.aspx\)](https://www.crc.org.au/support-services/SAMSSA.aspx)

---

### Vulnerable populations

---

ACT Disability, Aged and Carer Advocacy Service

 (02) 6242 5060

 [Website \(http://www.adacas.org.au/\)](http://www.adacas.org.au/)

---

Elder Abuse Prevention Unit

 (07) 3867 2525

 [Website \(http://www.eapu.com.au/\)](http://www.eapu.com.au/)

---

### Migrant and refugee communities

---

Multicultural Women's Advocacy

 (02) 6230 4632

---

Companion House (assisting survivors of torture and  
trauma)

 (02) 6251 4550

 [Website \(http://www.companionhouse.org.au/\)](http://www.companionhouse.org.au/)


---


---

**Legal support services**

---


Legal Aid ACT

 1300 654 314


 [Website \(http://www.legalaidact.org.au/\)](http://www.legalaidact.org.au/)


---

Magistrates' Court

 1300 654 314

 (02) 6207 1709: Civil

 (02) 6207 1728: Criminal


 [Website \(http://www.courts.act.gov.au/magistrates\)](http://www.courts.act.gov.au/magistrates)

---

**Doctors' support**

---

Doctor's Health Advisory Service: 'Colleague of First Contact' – 24 hour phone service

 1300 654 314

 9437 6552

 [Website \(http://www.dhas.org.au/\)](http://www.dhas.org.au/)

---

## NSW

---

**Sexual assault and family violence services**

---


NSW Rape Crisis Centre

 1800 424 017

 [Website \(http://www.nswrapecrisis.com.au\)](http://www.nswrapecrisis.com.au)

---

DoCS Domestic Violence Line


 (02) 6280 0900

 [Website \(http://www.dvcs.org.au/\)](http://www.dvcs.org.au/)

---

ACON (Lesbian, Gay and Intersex Domestic Violence Support)

 1300 364 277

 [Website \(https://www.relationshipsnsw.org.au/support-services/\)](https://www.relationshipsnsw.org.au/support-services/)


---

### Men's services

---

Relationships Australia

 (02)9206 2000


 [Website \(https://www.acon.org.au/what-we-are-here-for/domestic-family-violence/#domestic-family-violence-support-services\)](https://www.acon.org.au/what-we-are-here-for/domestic-family-violence/#domestic-family-violence-support-services)


---

### Children related services and reporting abuse

---

Department of Community Services

 132 111 (24 hours)


 [Website \(http://www.community.nsw.gov.au\)](http://www.community.nsw.gov.au)

---

### Adult survivors of child abuse

---

NSW Rape Crisis Centre

 132 111 (24 hours)

 [Website \(http://www.nswrapecrisis.com.au\)](http://www.nswrapecrisis.com.au)

---

### Vulnerable populations

---


Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---


NSW Trustee & Guardian


 1300 361 389

 [Website \(https://www.tag.nsw.gov.au/public-guardian\)](https://www.tag.nsw.gov.au/public-guardian)

---

Intellectual Disability Rights Service

 1300 665 908

 [Website \(https://www.tag.nsw.gov.au/public-guardian\)](https://www.tag.nsw.gov.au/public-guardian)


---

### Migrant and refugee communities

---

Multicultural Health Communication Service


 (02) 9332 9710

 [Website \(http://www.mhcs.health.nsw.gov.au\)](http://www.mhcs.health.nsw.gov.au)

---

Immigrant Women's Speakout

 (02) 9635 8022

 [Website \(http://www.speakout.org.au\)](http://www.speakout.org.au)

---

STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)

 (02) 9646 6700


 [Website \(http://www.startts.org.au\)](http://www.startts.org.au)

---

### Legal support services

---


Legal Aid NSW

 1300 888 529

 [Website \(http://www.legalaid.nsw.gov.au\)](http://www.legalaid.nsw.gov.au)

---

Law Access NSW

 1300 888 529

 [Website \(http://www.lawaccess.nsw.gov.au\)](http://www.lawaccess.nsw.gov.au)

---

Local courts (listing of courts in NSW)

[Website \(https://courts.nsw.gov.au/courts-and-tribunals/court-lists.html\)](https://courts.nsw.gov.au/courts-and-tribunals/court-lists.html)

---

Aboriginal Legal Service (NSW/ACT)

☎ 1800 765 767 for police charges and court matters

☎ 1800 733 233 for care and protection and family matters

☎ (02) 9213 4100 for general enquiries

🌐 [Website \(http://www.alsnswact.org.au\)](http://www.alsnswact.org.au)

---

### Doctors' support

---

Doctors' Health Advisory Service – 24 hour phone service

☎ (02) 9437 6552

🌐 [Website \(http://www.dhas.org.au/\)](http://www.dhas.org.au/)

---

## Northern Territory

---

### Sexual assault and family violence services

---

Sexual Assault Referral Centre

☎ Darwin – (08) 8922 6472

☎ Katherine – (08) 8973 8524

☎ Tennant Creek – (08) 8962 4361

☎ Alice Springs – (08) 8955 4500

🌐 [Website \(https://nt.gov.au/wellbeing/hospitals-health-services/sexual-assault-referral-centres\)](https://nt.gov.au/wellbeing/hospitals-health-services/sexual-assault-referral-centres)

---

Dawn House – women's shelter and domestic violence counselling

☎ (08) 8945 1388

🌐 [Website \(http://www.dawnhouse.org.au\)](http://www.dawnhouse.org.au)

---

Ruby Gaea – support for women and children survivors of sexual assault

☎ (08) 8945 0155

---





---

### Men's services

---

MensLine

 1300 789 978


 [Website \(http://www.mensline.org.au/\)](http://www.mensline.org.au/)

---

### Children related services and reporting abuse

---

Department of Health and Community Services – Child abuse/child protection hotline

 132 111 (24 hours)


 [Website \(http://www.community.nsw.gov.au/\)](http://www.community.nsw.gov.au/)


---

### Adult survivors of child abuse

---

NSW Rape Crisis Centre

 1800 700 250 (24 hours)

 [Website \(https://tfhc.nt.gov.au/contacts\)](https://tfhc.nt.gov.au/contacts)

---

Ruby Gaea – support for women and children survivors of sexual assault

 (08) 8945 0155

---

### Vulnerable populations

---


Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---

Executive Office of Adult Guardianship

 1800 810 979

 [Website \(https://publicguardian.nt.gov.au/\)](https://publicguardian.nt.gov.au/)

---

---

**Migrant and refugee communities**

---

Multicultural Council of the Northern Territory


 (08) 8985 3311

 [Website \(http://www.mcnt.org.au\)](http://www.mcnt.org.au)

---

Melaleuca Refugee Centre (Torture and Trauma Survivors Service of the Northern Territory)

 (02) 9635 8022


 [Website \(http://www.melaleuca.org.au\)](http://www.melaleuca.org.au)

---

**Legal support services**

---

Northern Territory Legal Aid Commission

 1800 019 343

 [Website \(https://www.legalaid.nt.gov.au/\)](https://www.legalaid.nt.gov.au/)

---

Magistrates' Court

 1300 888 529

 [Website \(http://www.lawaccess.nsw.gov.au\)](http://www.lawaccess.nsw.gov.au)


---

Local courts (listing of courts in NSW)

[Website \(https://localcourt.nt.gov.au/contact-us\)](https://localcourt.nt.gov.au/contact-us)

---

North Australian Aboriginal Family Violence Legal Service

 (08) 8923 8200 – Darwin

 (08) 8972 3200 – Katherine


 [Website \(https://www.naafvs.com.au/\)](https://www.naafvs.com.au/)


---


**Doctors' support**

---

Doctors' Health Advisory Service – 24 hour phone service

 (08) 8366 0250 – helpline

 (08) 8232 1250 – office

 [Website \(http://www.doctorshealthsa.com.au/\)](http://www.doctorshealthsa.com.au/)

## Queensland


---


### Sexual assault and family violence services

---

Brisbane Rape and Incest Survivors Support Service


 Administration line: (07) 3391 2573


 Support line: (07) 3391 0004

 [Website \(http://www.brissc.org.au\)](http://www.brissc.org.au)

---

Statewide Sexual Assault Helpline


 1800 010 120

 [Website \(https://www.dvconnect.org/sexual-assault-helpline/\)](https://www.dvconnect.org/sexual-assault-helpline/)

---


Zig Zag Young Women's Resource

 (07) 3843 1823

 [Website \(http://www.zigzag.org.au\)](http://www.zigzag.org.au)

---

DV Connect


 1800 811 811

---

### Men's services

---

dvconnect mensline

 1800 600 636

 [Website \(http://www.dvconnect.org.au\)](http://www.dvconnect.org.au)

---

---

### Children related services and reporting abuse

---

Queensland Government – Department of Children, Youth Justice and Multicultural Affairs

☎ Child safety after hours service centre: 1800 177 135

🌐 [Local services contact list \(http://www.cyjma.qld.gov.au/contact-us/departments-contacts/child-family-contacts/child-safety-service-centres https://www.cyjma.qld.gov.au/protecting-children\)](http://www.cyjma.qld.gov.au/contact-us/departments-contacts/child-family-contacts/child-safety-service-centres)

---

### Adult survivors of child abuse

---

Brisbane Rape and Incest Survivors Support Service

☎ Administration line: (07) 3391 2573

☎ Support line: (07) 3391 0004

🌐 [Website \(http://www.brissc.org.au\)](http://www.brissc.org.au)

---

Living Well – offers services to assist men who have experienced childhood sexual abuse or sexual assault

☎ New clients & enquiries: 1300 114 397

☎ Existing clients: (07) 3028 4648

🌐 [Website \(http://www.livingwell.org.au\)](http://www.livingwell.org.au)

---

### Vulnerable populations

---

Elder Abuse Prevention Unit

☎ 1300 651 192

🌐 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---


Office of Adult Guardian

☎ 1300 653 187

🌐 [Website \(https://www.publicguardian.qld.gov.au/\)](https://www.publicguardian.qld.gov.au/)

---

Queensland Government


 [Website \(https://www.qld.gov.au/seniors/safety-protection/discrimination-abuse/elder-abuse/info-health-professionals \)](https://www.qld.gov.au/seniors/safety-protection/discrimination-abuse/elder-abuse/info-health-professionals)

---

**Migrant and refugee communities**

Migrant Women’s Advice Service (Nambour)

 1800 451 183

 [Website \(https://qlddomesticviolence.org.au/wynnum/\)](https://qlddomesticviolence.org.au/wynnum/)

Immigrant Women’s Support Service

 (07) 3846 3490

 [Website \(http://www.iwss.org.au\)](http://www.iwss.org.au)

QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)

 (07) 3391 6677

 [Website \(http://www.qpastt.org.au/\)](http://www.qpastt.org.au/)

---


**Legal support services**


Legal Aid QLD

 1300 651 188

 [Website \(http://www.legalaid.qld.gov.au\)](http://www.legalaid.qld.gov.au)

Magistrates’ Court: Domestic and Family Violence


 1800 811 811


 [Website \(https://www.courts.qld.gov.au/going-to-court/domestic-violence\)](https://www.courts.qld.gov.au/going-to-court/domestic-violence)


Magistrates’ Court (listings of magistrates’ courts in QLD)

[Website \(http://www.courts.qld.gov.au/contact-us/courthouses\)](http://www.courts.qld.gov.au/contact-us/courthouses)

DV Connect

 1800 811 811 – Dvconnect  
womensline

 1800 600 636 – Dvconnect  
mensline


 [Website \(https://www.dvconnect.org/\)](https://www.dvconnect.org/)

---

Department of Communities, Child Safety and Disability Services


 13 74 68


Queensland Government – Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

 [Website \(https://www.dsdsatsip.qld.gov.au/contact-us/department-contacts\)](https://www.dsdsatsip.qld.gov.au/contact-us/department-contacts)

---

Aboriginal and Torres Strait Islander Legal Service (QLD) Ltd

 1800 012 255

 [Website \(http://www.atsils.com.au\)](http://www.atsils.com.au)

---

### Doctors' support

---

Doctors' Health Advisory Service – 24 hour phone service

 (07) 3833 4352 – helpline

 (07) 3067 2351 – office

 [Website \(http://dhasq.org.au/\)](http://dhasq.org.au/)

---


## South Australia

---

### Sexual assault and family violence services


---


Crisis Care


 131 611

---

Women's Information Service of South Australia


 1800 188 158

 (08) 8303 0590


 [Website \(http://www.wis.sa.gov.au\)](http://www.wis.sa.gov.au)

---

Yarrow Place Rape and Sexual Assault Service


 1800 817 421

 (08) 8161 2000

 [Website \(http://www.yarrowplace.sa.gov.au\)](http://www.yarrowplace.sa.gov.au)

---

Domestic Violence Crisis Line

 1800 800 098

---

### Children related services and reporting abuse

---

Government of South Australia – child abuse report line  
(24 hours)

 131 478


 [Website \(http://www.dcsi.sa.gov.au\)](http://www.dcsi.sa.gov.au)


---


### Adult survivors of child abuse

---

Relationships Australia (SA)

 1300 364 277

 1800 182 325 (country callers)

 [Website \(https://www.rasa.org.au/\)](https://www.rasa.org.au/)


---

### Vulnerable populations

---


Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(https://www.rasa.org.au/\)](https://www.rasa.org.au/)

---

Office of the Public Advocate

 (08) 8342 8200

 1800 066 969 (Country SA toll free)


 [Website \(http://www.opa.sa.gov.au\)](http://www.opa.sa.gov.au)


---

### Migrant and refugee communities

---


Women's Safety Services SA - Migrant Women's Support Program

 (08) 8152 9260

 [Website \(https://womenssafetyservices.com.au/index.php/information-for-workers/culturally-linguistically-diverse-clients\)](https://womenssafetyservices.com.au/index.php/information-for-workers/culturally-linguistically-diverse-clients)

---

STTARS (Survivors of Torture and Trauma Assistance and Rehabilitation Service)

 (08) 8206 8900


 [Website \(http://www.sttars.org.au\)](http://www.sttars.org.au)


---

### Legal support services

---


Legal Services Commission SA


 1300 366 424

 [Website \(http://www.lsc.sa.gov.au\)](http://www.lsc.sa.gov.au)

---


Magistrates' Court

 (08) 8204 2444

 [Website \(https://www.courts.sa.gov.au/\)](https://www.courts.sa.gov.au/)

---

Aboriginal Legal Rights Movement Inc

 1800 643 222

 [Website \(http://www.alrm.org.au\)](http://www.alrm.org.au)

---

South Australian Council of Community Legal Centres

 (08) 8342 1800

 [Website \(http://www.alrm.org.au\)](http://www.alrm.org.au)


---





## Doctors' support

---

Doctors' Health Advisory Service – 24 hour phone service

 (08) 8366 0250 – helpline

 (08) 8232 1250 – office

 [Website \(http://www.doctorshealthsa.com.au/\)](http://www.doctorshealthsa.com.au/)

---

Rural Doctors Workforce Agency

 (08) 8234 8277

 [Website \(http://www.doctorshealthsa.com.au/\)](http://www.doctorshealthsa.com.au/)

---

## Tasmania

---

### Sexual assault and family violence services

---


Sexual assault support service (24 hours)


 1800 697 877


 [Website \(http://www.sass.org.au\)](http://www.sass.org.au/)

---

Laurel House – North and North-West Tasmania Sexual Assault Support Services


 (03) 6334 2740 (North)


 (03) 6431 9711 (North-West)

 [Website \(http://www.laurelhouse.org.au\)](http://www.laurelhouse.org.au/)

---

Family Violence Counselling and Support Service

 1800 608 122

 [Website \(https://www.communitie.s.tas.gov.au/children/family\\_violence\\_counselling\\_and\\_support\\_services\)](https://www.communitie.s.tas.gov.au/children/family_violence_counselling_and_support_services)

---


---

**Children related services and reporting abuse**

---

Department of Communities Tasmania – Children, Youth and Families


 1800 000 123

 [Website \(http://www.dhhs.tas.gov.au/children\)](http://www.dhhs.tas.gov.au/children)

---

Commissioner for Children and Young People Tasmania

 (03) 6166 1366


 [Website \(http://www.childcomm.tas.gov.au\)](http://www.childcomm.tas.gov.au)

---

**Adult survivors of child abuse**

---

Sexual Assault Support Service (24 hours)


 1800 697 877

 [Website \(http://www.sass.org.au\)](http://www.sass.org.au)

---

Laurel House – North and North-West Tasmania Sexual Assault Support Services

 (03) 6334 2740 (North)

 (03) 6431 9711 (North-West)

 [Website \(http://www.laurelhouse.org.au\)](http://www.laurelhouse.org.au)

---

**Vulnerable populations**

---


Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---

Elder Abuse Tasmania


 1800 441 169

 [Website \(https://www.elderabuse.tas.gov.au/\)](https://www.elderabuse.tas.gov.au/)

---

Office of the Public Guardian

 (03) 6165 3444

 (03) 6165 6767 (emergency after hours number)


 [Website \(http://www.publicguardian.tas.gov.au\)](http://www.publicguardian.tas.gov.au)


---

### Migrant and refugee communities

---

Multicultural Council of Tasmania


 (03) 6170 9196

 [Website \(https://mcot.org.au/home/\)](https://mcot.org.au/home/)

---

Migrant Resource Centre Tasmania - Phoenix Centre  
(Support for Survivors of Torture and Trauma)

 (03) 6221 0999


 [Website \(http://www.mrchobart.org.au/content/phoenix-centre\)](http://www.mrchobart.org.au/content/phoenix-centre)

---

### Legal support services

---

Legal Aid Commission of Tasmania

 1300 366 611

 [Website \(http://www.legalaid.tas.gov.au\)](http://www.legalaid.tas.gov.au)

---

Magistrates' Court Website

 [Website \(http://www.magistratescourt.tas.gov.au\)](http://www.magistratescourt.tas.gov.au)

---

Tasmanian Aboriginal Centre


 [Website \(http://www.tacinc.com.au\)](http://www.tacinc.com.au)

---

### Doctors' support

---

AMA Peer Support Line – phone advice service  
8am–11pm 7 days

 1300 853 338 – helpline

 (03) 9280 8722 – office

---

Victorian Doctors' Health Program

 (03) 9495 6011

Clinical services with some phone support

## Victoria

---

### Sexual assault and family violence services


---

Centre against sexual assault (CASA) – Sexual Assault  
Crisis Line

 1800 806 292

 [Website \(http://www.casa.org.au\)](http://www.casa.org.au)

Women's Information and Referral Exchange (WIRE)

 1300 134 130


 [Website \(http://www.wire.org.au\)](http://www.wire.org.au)

Domestic Violence Resource Centre Victoria


 (03) 8346 5200


 [Website \(http://www.dvrcv.org.au\)](http://www.dvrcv.org.au)

Women's Domestic Violence Crisis Service

 [Website \(http://www.wdvcs.org.a  
u\)](http://www.wdvcs.org.au)

Safe Steps – Family Response Centre – 24 hours


 1800 015 188


 [Website \(https://www.safesteps.or  
g.au/\)](https://www.safesteps.org.au/)

### Men's services

---

Men's Referral Service


 1300 766 491


 [Website \(https://ntv.org.au/get-hel  
p/\)](https://ntv.org.au/get-help/)

### Children related services and reporting abuse

---

Victoria State Government – Families, Fairness and Housing, Child Protection


 13 12 78


 [Website \(https://services.dffh.vic.gov.au/child-protection-contacts\)](https://services.dffh.vic.gov.au/child-protection-contacts)

---

Royal Children’s Hospital – Gatehouse

 (03) 9345 6391

 (03) 9345 5522 (after hours Crisis Care) - ask to page the Gatehouse Centre after hours clinician

 [Website \(https://www.rch.org.au/gatehouse/about/\)](https://www.rch.org.au/gatehouse/about/)

---

### Adult survivors of child abuse

---

Centre against sexual assault (CASA) – Sexual Assault Crisis Line

 1800 806 292

 [Website \(http://www.casa.org.au\)](http://www.casa.org.au)

---

### Vulnerable populations

---

Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---


Office of the Public Advocate

 1300 309 337

 [Website \(http://www.publicadvocate.vic.gov.au\)](http://www.publicadvocate.vic.gov.au)

---

Seniors Rights Victoria

 1300 368 821

 [Website \(http://www.seniorsrights.org.au\)](http://www.seniorsrights.org.au)

---

---

**Migrant and refugee communities**

---

In Touch Multicultural Centre Against Family Violence  
(Victoria)

☎ 1800 755 988

🌐 [Website \(https://intouch.org.au/\)](https://intouch.org.au/)

---

Refugee and Immigration Legal Centre

☎ (03) 9413 0101

🌐 [Website \(https://refugeelegal.org.au/\)](https://refugeelegal.org.au/)

---

Victorian Immigrant and Refugee Women's Coalition

☎ 03 9654 1243

🌐 [Website \(https://virwc.org.au/\)](https://virwc.org.au/)

---

Centre for Culture, Ethnicity and Health

🌐 [Website \(http://www.ceh.org.au\)](http://www.ceh.org.au)

---

Foundation House (Victorian Foundation for Survivors of  
Torture)

☎ 03 9389 8900

🌐 [Website \(http://www.foundationhouse.org.au\)](http://www.foundationhouse.org.au)

---

**Legal support services**

---

Victoria Legal Aid

☎ 1300 792 387

🌐 [Website \(http://www.legalaid.vic.gov.au\)](http://www.legalaid.vic.gov.au)

---

Magistrates' Court of Victoria

🌐 [Website \(http://www.mcv.vic.gov.au\)](http://www.mcv.vic.gov.au)

---

Aboriginal Family Violence Prevention and Legal Service  
Victoria

☎ 1800 105 303

🌐 [Website \(https://djirra.org.au/\)](https://djirra.org.au/)

---

Women's Legal Service Victoria

☎ (03) 8622 0600 (metro callers)

☎ 1800 133 302 (regional callers)

🌐 [Website \(https://www.womenslegal.org.au/\)](https://www.womenslegal.org.au/)

---

### Doctors' support

---

AMA Peer Support Line – phone advice service  
8am–11pm 7 days

☎ 1300 853 338 – helpline

☎ (03) 9280 8722 – office

---

Victorian Doctors' Health Program

☎ (03) 9495 6011

Clinical services with some phone support

---

## Western Australia

---

### Sexual assault and family violence services

---

Crisis Care Helpline

☎ 1800 199 008

---

Sexual Assault Resource Centre

☎ 1800 199 888

☎ (08) 6458 1828

🌐 [Website \(https://www.wnhs.health.wa.gov.au/Our-services/Service-directory/SARC\)](https://www.wnhs.health.wa.gov.au/Our-services/Service-directory/SARC)

---

Women's Domestic Violence Helpline

☎ 1800 007 339

🌐 [Website \(https://www.dcp.wa.gov.au/CrisisAndEmergency/Pages/Women%27s-Domestic-Violence-Helpline.aspx\)](https://www.dcp.wa.gov.au/CrisisAndEmergency/Pages/Women%27s-Domestic-Violence-Helpline.aspx)


---


---

### Men's services

---


Men's Domestic Violence Helpline

 1800 000 599

 [Website \(https://www.dcp.wa.gov.au/CrisisAndEmergency/Pages/Men%27s-Domestic-Violence-Helpline.aspx\)](https://www.dcp.wa.gov.au/CrisisAndEmergency/Pages/Men%27s-Domestic-Violence-Helpline.aspx)

---

Menstime


 [Website \(http://www.menstime.com.au\)](http://www.menstime.com.au)


---

### Children related services and reporting abuse

---

Department of Communities - Child Protection and Family Support

 1800 176 888

 [Website \(http://www.dcp.wa.gov.au\)](http://www.dcp.wa.gov.au)


---

### Adult survivors of child abuse

---

Phoenix Support and Advocacy Service

 (08) 9443 1910

 [Website \(https://www.phoenix.asn.au/\)](https://www.phoenix.asn.au/)

---

### Vulnerable populations

---


Elder Abuse Prevention Unit


 (07) 3867 2525

 [Website \(http://www.eapu.com.au\)](http://www.eapu.com.au)

---

Office of the Public Advocate

 1300 858 455

 (08) 9278 7300

 [Website \(http://www.publicadvocate.wa.gov.au\)](http://www.publicadvocate.wa.gov.au)

---




---

### Migrant and refugee communities

---


Women's Health and Family Services - Multicultural  
Women's Advocacy Service

 (08) 9328 1200

 [Website \(https://whfs.org.au/services/multicultural-womens-advocacy-support/\)](https://whfs.org.au/services/multicultural-womens-advocacy-support/)

---

ASeTTS (Association for Services to Torture and Trauma  
Survivors)

 (08) 9227 2700


 [Website \(http://www.asetts.org.au\)](http://www.asetts.org.au)

---

### Legal support services

---


Legal Aid WA

 1300 650 579

 [Website \(http://www.legalaid.wa.gov.au\)](http://www.legalaid.wa.gov.au)


---

Magistrates' Court

 [Website \(http://www.magistratescourt.wa.gov.au\)](http://www.magistratescourt.wa.gov.au)

---

Aboriginal Legal Service of Western Australia

 1800 019 900


 [Website \(http://www.als.org.au\)](http://www.als.org.au)

---

### Doctors' support

---

Doctors' Health Advisory Service – 24 hours

 (08) 9321 3098

 [Website \(http://www.dhaswa.com.au/\)](http://www.dhaswa.com.au/)

---

***Supplementary chapter for  
primary care providers in Victoria***

# Introduction

This chapter provides an overview of Victorian family violence policy reforms, which aim to:

- increase the safety of adult and child victim survivors of family violence, and hold perpetrators of violence to account
- promote the wellbeing and safety of children.

From 19 April 2021, general practitioners (GPs) and primary care nurses (PNs) working in general practice have been included in two new schemes:

- Family Violence Information Sharing Scheme (FVISS)
- Child Information Sharing Scheme (CISS).

A third reform, the Multi-Agency Risk Assessment and Management (MARAM) Framework, provides a system-wide approach to support services to effectively identify, assess and manage family violence risk.

Mandatory reporting for GPs in relation to child abuse remain unchanged under Victorian law.

## Family violence

Family violence is defined in Section 5 of the *Family Violence Protection Act 2008* (Vic) and includes sexual, physical, emotional, psychological, and economic abuse, as well as coercive control.<sup>1</sup> Under this Act, children are considered victim survivors if they experience family violence directed at them, or they are exposed directly to family violence and/or its effects. Family violence is deeply gendered and is rooted in structural inequalities and an imbalance of power between women and men. While people of all genders can use violence or be victim survivors of family violence, overwhelmingly those who use violence are men who largely perpetrate violence against women (who are their current or former partner) and children.

Around one in 10 women attending general practice have experienced one type of family violence behaviour or a combination of physical, sexual and emotional abuse by a partner within the past 12 months.<sup>2</sup> GPs are a key source of support to victim survivors of family violence and other family members, including children, who might also be victim survivors, and those who use family violence, which is recognised by the MARAM Framework and the two information-sharing schemes. Specific guidance on [identifying, risk assessment and responding to victim survivors of intimate partner violence](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/chapter-1-what-is-interpersonal-abuse-and-violence>) is discussed in Chapters 2–4 of *The White Book* (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble>), and on [child abuse and neglect](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect) (<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/children-and-young-people/child-abuse-and-neglect>) and [men who use intimate partner abuse and violence](https://www.racgp.org.au/clinical-resources/clinical-guideline) (<https://www.racgp.org.au/clinical-resources/clinical-guideline>)

[s/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse](https://www.vic.gov.au/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse)), and will not be discussed here. It is expected that these should be read in conjunction with this chapter.

## **Purpose of the Multi-Agency Risk Assessment and Management (MARAM) Framework and Family Violence Information Sharing Scheme (FVISS)**

After the death of Luke Batty in 2014, a Royal Commission into Family Violence was established in Victoria in 2015.<sup>3</sup> This commission found that information relevant to family violence risk was not being shared adequately between organisations, which could have tragic consequences for victim survivors of family violence. The commission made 227 recommendations, which were all accepted by the Victorian Government, including new legislation resulting in the creation of the MARAM Framework to address the existing gaps identified in the Royal Commission and to ensure services are appropriately assessing and managing family violence risk.<sup>4</sup>

It is useful for GPs and PNs to be across the four pillars of the MARAM Framework, as it helps their information-sharing practice to:

- have a shared understanding of family violence
- participate in consistent and collaborative practice (including risk assessments and information sharing)
- understand their level of responsibilities for risk assessment and management
- undertake systems, outcomes and continuous improvements at an organisational level.

## **Purpose of the Child Information Sharing Scheme**

The CISS was developed in response to numerous independent reviews and inquiries over the past decade. These inquiries have recommended streamlining Victoria's information-sharing arrangements to improve outcomes for children by promoting shared responsibility for their wellbeing and safety, and increasing collaboration across the service system.

New legislation covers the way that information is shared across services and organisations to promote safety for adult and child victim survivors.

## **Information-sharing schemes**

**Family Violence Information Sharing Scheme** (<https://www.vic.gov.au/family-violence-information-sharing-scheme>) This scheme can be used if a patient is experiencing family violence or is perpetrating family violence.

**Child Information Sharing Scheme** (<https://www.vic.gov.au/child-information-sharing-scheme>) This scheme can be used when there are concerns about a child's wellbeing or safety. This scheme is applied at a significantly lower threshold than that to make a report to child protection.

Both these schemes increase collaboration between organisations, with the aim of keeping victim survivors safe and holding perpetrators to account.<sup>5</sup>

Where there is pre-existing legislation, such as the *Mental Health Act 2014* or the *Children, Youth and Families Act 2005*, these obligations still apply. Information sharing or other obligations under these schemes should not impede the information-sharing processes if other legislation applies, such as the need to report child abuse to child protection. For example, an obligation by a GP to make a report to Child Protection under mandatory reporting obligations might occur at the same or similar time to a request under the FVISS and/or CISS. GPs should be clear which legal permissions they are sharing information under and document this as required.

In addition to FVISS and CISS, the *Health Records Act 2001* already states that an organisation can disclose information about an individual if it reasonably believes that the disclosure is necessary to lessen or prevent a serious threat to an individual's life, health, safety or welfare.<sup>6</sup>

## Who can share information under the schemes?

Only services and organisations that are prescribed as information-sharing entities (ISEs) can share information under the FVISS and CISS.

GPs and PNs are prescribed as ISEs under the FVISS and CISS.

Some other examples of ISEs include:

- police, and the Magistrates' Court of Victoria and the Children's Court of Victoria
- public hospitals, maternal child health, community health and mental health services
- specialist family violence services, child protection, sexual assault services and homelessness services
- schools, kindergartens and day care centres.

A full list of organisations and individuals who can share information under the schemes is available [here \(https://www.vic.gov.au/ciss-and-fviss-who-can-share-information\)](https://www.vic.gov.au/ciss-and-fviss-who-can-share-information).

Under the FVISS, some ISEs are also prescribed as risk-assessment entities (RAEs), which is a special type of ISE (Table 1). RAEs can request information for undertaking comprehensive risk assessments, including establishing risk where the presence of violence or the identity of the perpetrator is unknown.

**Table 1. List of prescribed information-sharing entities (ISEs)<sup>7</sup>**

ISEs that are also Risk Assessment Entities (RAEs)	
<ul style="list-style-type: none"> <li>• Child Protection</li> <li>• Child FIRST services (excluding broader family services)</li> <li>• Risk Assessment and Management Panel (RAMP) members (including those services that would not otherwise be prescribed, but only when participating in a RAMP)</li> <li>• State-funded sexual assault services</li> <li>• State-funded specialist family violence services (including refuges, Men's Behaviour Change Program, family violence counselling and therapeutic programs)</li> </ul>	<ul style="list-style-type: none"> <li>• The Orange Door Network</li> <li>• Family Violence Restorative Justice Service</li> <li>• Victim assistance programs</li> <li>• Victims of Crime Helpline</li> <li>• Victoria Police</li> </ul>

Reproduced with permission from Family Safety Victoria. [Family Violence information sharing guidelines: Guidance for information sharing entities \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme). Melbourne: Victorian Government, 2021; p. 328. [Accessed 4 March 2022].

## References

1. [Victorian Government. Part C: Pillars. Victoria: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars\)](http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars) [Accessed 24 October 2021].
2. Hegarty KL, Bush R. Prevalence and associations of partner abuse in women attending general practice: A cross-sectional survey. *Aust N Z J Public Health* 2002;26(5):437–42. [Accessed 24 October 2021].
3. [Victorian Government. About the Royal Commission into Family Violence. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/about-royal-commission-family-violence\)](http://www.vic.gov.au/about-royal-commission-family-violence) [Accessed 7 March 2022].
4. [Victorian Government. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management\)](http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) [Accessed 7 March 2022].
5. [Victorian Government. Family Violence Information Sharing Scheme. Victoria: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 24 October 2021].
6. [Office of the Health Services Commissioner \(Victoria\). Health Records Act 2001 \(Vic\). Proposed statutory guidelines. Issues paper. Victoria: Office of the Health Services Commissioner, 2001 \(http://www.vgls.vic.gov.au/client/en\\_AU/search/asset/1160175/0\)](http://www.vgls.vic.gov.au/client/en_AU/search/asset/1160175/0) [Accessed 24 October 2021].

7. [Family Safety Victoria. Family Violence information sharing guidelines: Guidance for information sharing entities. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 4 March 2022].
8. [Family Safety Victoria. MARAM practice guides: Chapter summaries. Melbourne: Victorian Government, 2020 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
9. [Family Safety Victoria. MARAM practice guides: Foundation knowledge guide – Guidance for professionals working with child or adult victim survivors, and adults using family violence. Melbourne: Victorian Government, 2021; pp. 28–31 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
10. [Family Safety Victoria. Responsibility 3: Intermediate risk assessment – Appendix 5: Brief risk assessment tool. In: MARAM practice guides: Foundation knowledge guide – Guidance for professionals working with child or adult victim survivors, and adults using family violence. Melbourne: Victorian Government, 2021; pp. 153–15 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
11. [Family Safety Victoria. Family violence information sharing guidelines: Guidance for information sharing entities. Melbourne: Victorian Government, 2021; p. 104 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 4 March 2021].

# Implementing Victorian information sharing schemes in primary care

## Sharing Information under the FVISS

If professionals believe a person could be experiencing or using family violence, or a patient discloses experiencing or using family violence, a key part of their professional response is to share information with relevant organisations and services to enhance the safety of adult and child victim survivors. Risk assessments are discussed in detail in [Safety and risk assessment in Chapter 3 \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety) of *The White Book*.



**Figure 1.** Structured Professional Judgement model for undertaking a risk assessment<sup>8</sup> Reproduced with permission from Family Safety Victoria. [MARAM practice guides: Chapter summaries. Melbourne: Victorian Government, 2020; p. 10 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources). [Accessed 4 March 2022].

There are four elements to using the Structured Professional Judgement model in a risk assessment (Figure 1).

- 1. Adult victim survivor's own assessment of their current level of safety.**

A victim survivor is an expert in their own experience, and their assessment forms an important part of a risk assessment.



2. **Evidence-based risk factors.**

These require an understanding of perpetrator behaviour. The brief risk assessment tool could be used to conduct a risk assessment using evidence-based risk factors to assist GPs when determinin the level of risk for their information-sharing obligations. There are some risk factors based on evidence related to higher risk for those who are victim survivors. These evidence-based risk factors are outlined in Figure 2.



**Figure 2.** Evidence-based risk factors<sup>9</sup>

These evidence-based risk factors are formed below as questions that can be asked by health practitioners (see brief risk assessment tool).

**Appendix 1. Brief risk-assessment tool (Multi-Agency Risk Assessment and Management practice guides) based on evidence-based risk factors<sup>10</sup>**

<b>Has the adult victim survivor been asked screening questions?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please indicate if any of the following risk factors were identified in the screening assessment.</i>	
<b>Factors relevant to adult victim survivor</b>	<b>Factors relevant to perpetrator (continued)</b>
<input type="checkbox"/> Self-assessed level of risk	<input type="checkbox"/> Controlling behaviours*
<b>Factors relevant to perpetrator</b>	<input type="checkbox"/> Physical harm
<input type="checkbox"/> Has ever harmed or threatened to harm victim or family members (including child/ren)	<input type="checkbox"/> History of family violence
	<input type="checkbox"/> Emotional abuse
<i>If no, please ask the following questions about the perpetrator, in addition to the set of questions below.</i>	

Question	Yes	No	Comments (or not known)
Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have they physically hurt you in any way? (hit, slapped, kicked or otherwise physically hurt you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question	Yes	No	Comments (or not known)
Is more than one person making you feel afraid? (Are there multiple perpetrators)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following risk related questions refer to the perpetrator:**

<b>RECENTY</b>	Are they currently unemployed?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Have they recently...</b>			
	threatened or attempted suicide or self harm?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	misused alcohol, drugs or other substances?* (specify substance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	followed you, repeatedly harassed or messaged/emailed you? *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	been obsessively jealous towards you?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has any violence increased in severity or frequency?*(what and how)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Question	Yes	No	Comments (or not known)	
<b>Have they ever...</b>				
<b>PERPETRATOR ACTIONS</b>	controlled your access to money, or had a negative impact on your financial situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	seriously harmed you?*(identify type of harm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	assaulted you when you were pregnant?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	threatened to kill you?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	threatened or used a weapon against you?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	tried to choke or strangle you?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	forced you to have sex or participate in sexual acts when you did not wish to do so?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 1. Brief risk-assessment tool (Multi-Agency Risk Assessment and Management practice guides) based on evidence-based risk factors<sup>10</sup>

Reproduced with permission from Family Safety Victoria. Responsibility 3: Intermediate risk assessment – Appendix 5: Brief risk assessment tool. In: [MARAM practice guides: Foundation knowledge guide – Guidance for professionals working with child or adult victim survivors, and adults using family violence \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources). Melbourne: Victorian Government, 2021; pp. 153–15. [Accessed 4 March 2022].

1. **Information sharing.**

The third element of the Structured Professional Judgement model in risk assessment is considering any information received through information sharing. Information that is shared is done to increase the safety of the adult and/or child victim survivors and to keep the perpetrator in view. This information should be used to update and inform risk assessment and management.

2. **Professional judgement intersectional analysis.**

The final aspect of the Structured Professional Judgement model is applying an intersectional analysis when assessing the level of risk. This means understanding that a person might have experienced or is experiencing a range of structural inequalities, barriers and discrimination throughout their life. These experiences will impact on:

- their experience of family violence
- how they manage their risk and safety
- their access to risk management services and responses.

Professionals should consider any additional barriers for the person and make efforts to address these.

Professionals should use each element and the application of their professional experience, skills and knowledge to make an analysis of the level of family violence risk.

A victim survivor could be judged to be at risk, elevated risk or serious risk. If at serious risk, they might require an immediate response. This assessment then informs safety planning (see [Safety and risk assessment in Chapter 3 of The White Book \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety)) and referrals. **At risk:** No high-risk factors present, but other family violence risk factors are present. The victim survivor might already have been referred to family violence services and have supports in place. The victim survivor assesses their safety as high and fear level as low. **Elevated risk:** A number of risk factors are present, including some high-risk factors; however, professional judgement deems that the likelihood of a serious outcome is not high. The victim survivor assesses their safety as moderate and fear level as elevated. **Serious risk:** High-risk factors are present and/or there has been an increase in frequency or severity of violence. There is a high risk of serious outcomes or there might have already been serious outcomes. The victim survivor assesses their safety as low and fear level as high. Victim survivors deemed to be high risk require immediate management to lessen their risk. **Serious risk and requires immediate protection:** In addition to serious risk, as outlined above. Previous strategies for risk management have been unsuccessful. Escalation of severity of violence has occurred/is likely to occur. Formally structured coordination and collaboration of service and agency responses are required. Involvement from statutory and non-statutory crisis response services is required, including possible referral for a Risk Assessment and Management Panel (RAMP) response for risk assessment and management planning and intervention to lessen or remove serious risk that is likely to result in lethality or serious physical or

sexual violence. Victim survivor self-assessed level of fear and risk is high to extremely high and safety is extremely low. As information sharing is all about lessening the risk to adult and child victim survivors, risk level assessment is very important for safety planning and involving the appropriate services. Risk level is also important to information sharing under the FVISS, as it determines whether consent is required or not. See section on consent to share information in this resource.

## Sharing information under the CISS

### Consent under FVISS

Consent from an adult victim survivor or third party is required, unless you believe sharing the information is necessary to lessen or prevent a serious threat to their life, health, safety or welfare, or a child is at risk. However, views of the victim survivor should be sought where appropriate, safe and reasonable to do so.

Consent from a child victim survivor is not required, but their views or the view of their parent, who is not a perpetrator, should generally be sought, where appropriate, safe and reasonable.

Information regarding an individual using violence can be shared on request, without their consent, provided this is relevant to the family violence. GPs and PNs should not share information if doing so would risk a person's life or physical safety.

The CISS allows sharing information to support collaborative service provision to children, and to respond to identified needs and risks, regardless of whether a professional considers the issue related to either wellbeing or safety. Three-part threshold test for CISS ISEs can share confidential information with other ISEs under the CISS if:

- the ISE is requesting or disclosing confidential information about any person for the purpose of promoting the wellbeing or safety of a child or group of children
- the disclosing ISE reasonably believes that sharing the confidential information might assist the receiving ISE to carry out one or more of the following activities:
  - making a decision, an assessment or a plan relating to a child or group of children
  - initiating or conducting an investigation relating to a child or group of children
  - providing a service relating to a child or group of children
  - managing any risk to a child or group of children
- the information being disclosed or requested is not known to be 'excluded information' under Part 6A of the *Child Wellbeing and Safety Act 2005* (and is not restricted from sharing by another law).

## Consent to share information

### Consent under FVISS

Consent from an adult victim survivor or third party is required, unless you believe sharing the information is necessary to lessen or prevent a serious threat to their life, health, safety or welfare, or a child is at risk. However, views of the victim survivor should be sought where appropriate, safe and reasonable to do so.

Consent from a child victim survivor is not required, but their views or the view of their parent, who is not a perpetrator, should generally be sought, where appropriate, safe and reasonable.

Information regarding an individual using violence can be shared on request, without their consent, provided this is relevant to the family violence. GPs and PNs should not share information if doing so would risk a person's life or physical safety.

Consent can be obtained verbally or in writing, and it might be expressly given or implied by the victim survivor. Where obtained verbally, ISEs must make a written record of the verbal consent and the information is shared (eg when providing a tele-based service). When consent is sought, it is important to have regard to their decision-making capacity, including whether the victim survivor is able to understand what they are consenting to, so that they can retain the information for long enough to be able to make a decision (this is especially important in culturally and linguistically diverse communities, and among older people, people with disabilities and Aboriginal and Torres Strait Islander peoples), use the information to make a decision themselves by weighing up the pros and cons, and to communicate their views.<sup>11</sup>

### Consent under the CISS

Under the CISS, if the threshold has been met, ISEs do not require consent from any person to share relevant information with other ISEs. However, ISEs should seek and consider the views of children and family members about information sharing if it is appropriate, safe and reasonable to do so.

## Information-sharing requests

### What information can be shared?

ISEs, including GPs and PNs, might be requested to share information under the FVISS or CISS. For the requirements of the scheme to be met, the request must be from an ISE for family violence risk assessment and management, including about perpetrator behaviour, and/or to promote a child's wellbeing or safety.

Because GPs and PNs are ISEs under the FVISS and CISS, they can:

- make a request for information to other ISEs in the context of family violence risk and for the

wellbeing or safety of children

- disclose information to other ISEs on request if the requirements of the scheme are met
- disclose information voluntarily and proactively to other ISEs if sharing meets requirements under the schemes, including:
  - an adult victim survivor is at serious imminent risk
  - an adult victim survivor gives permission to share information to assess and/or manage family violence risk
  - concern about the behaviour of the individual using family violence – no permission is needed from the individual using violence
  - concern about a child as a victim survivor of family violence or a child’s wellbeing or safety – no permission is needed.

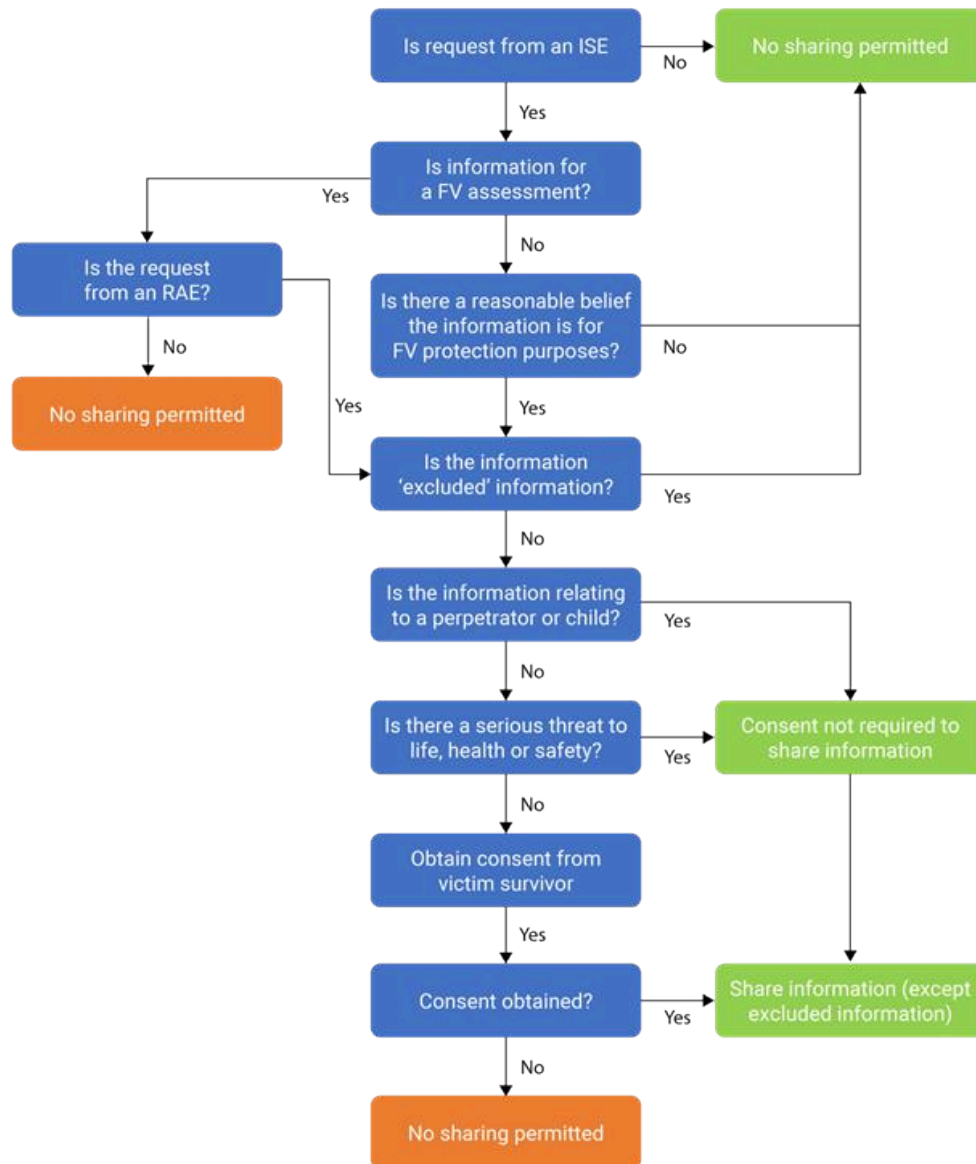
## Responding to information-sharing requests

If a request is received, GPs and PNs must first verify that the request is being received from an ISE or RAE. If the request is by phone, this might involve calling the direct number of the service or organisation that is making the request, and then asking to speak to the practitioner or worker making the request. Alternatively, asking for an email from the requester’s verified work email account will assist in confirming their identity. You should not use a person’s personal email to share information. Requests should be recorded in the patient’s chart, along with what information has been shared. Please note that care needs to be taken with recording information in the perpetrator’s file, to ensure there is no inadvertent alerting to the perpetrator that you are sharing information if there is a request for access to files.

Once confirmation of origin of request has been made, consent requirements should then be considered. When sharing information about family violence under the FVISS, risk consent is not required to share information about perpetrators with other ISEs. As outlined in the section in this resource on consent to share information, consent is also not required to share information about any person when assessing or managing a family violence risk to a child. However, consent is required when sharing information about an adult victim survivor in other circumstances, unless the doctor believes that sharing information is necessary to lessen or prevent a serious threat to an individual’s life, health, safety or welfare. Consent can be verbal or in writing. Verbal consent should be clearly documented in the notes. It is important that, when obtaining consent, the victim survivor fully understands what they are consenting to.

The process that should be followed if a request for information sharing is received is outlined in the flow chart (Figure 3).

This flow chart should be followed if an information request is received under the FVISS.



**Figure 3.** Process if a request for information is made under the Family Violence Information Sharing Scheme

Adapted with permission from Barwon Health information-sharing module.

FV, family violence; ISE, information sharing entity; RAE, risk-assessment entity.

Excluded information includes information that could endanger a person’s life or physical safety, or contravene a court order or law that prohibits the disclosure of the information. You must not share information where, to your knowledge, the information is excluded under the schemes.

Further information can be sought from: Information Sharing and MARAM Enquiry Line 1800 549 646 (available 10.00 am–2.00 pm Monday to Friday) [CISandFVIS@educaton.vic.gov.au](mailto:CISandFVIS@educaton.vic.gov.au) (<mailto:CISandFVIS@educaton.vic.gov.au>)

Remember, information can still be shared with services that are not ISEs under privacy law with consent or where necessary to lessen or prevent a serious threat.

## Proactive sharing information under the FVISS

ISEs might voluntarily share information without a request to an RAE to assist them with establishing and assessing family violence risk. They might also voluntarily share information with another ISE for ongoing risk assessment and management. In both cases, the information must not be information that is excluded under the schemes, and the consent requirements are the same as for information requests (see 'Responding to information-sharing requests').

If a victim survivor is deemed to be at serious and/or immediate risk of harm during an assessment with a GP or PN (see [Safety and risk assessment in Chapter 3 of \*The White Book\* \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/intimate-partner-abuse-safety)), then consent should be sought to discuss the case with a family violence specialist service or organisation and/or police.

If the victim survivor is at serious risk and requires immediate protection, but does not consent, information can be shared with a specialist family violence organisation or the police to keep the victim survivor safe. It is advisable to let the victim survivor know that this information is being shared so they can organise safety planning for themselves and their children, if relevant.

All information shared should be clearly documented in the patient file, along with who the information has been shared with. Again, care needs to be taken with documentation in perpetrator files if the perpetrator is not the source of the information.

## Proactive sharing information under the CISS

Under the CISS, information can be shared proactively if it is believed that the information could assist the service to undertake one of the activities in Part 2 of the CISS threshold test for sharing.

## Requesting information from an ISE

Under the FVISS, GPs and PNs are permitted to request information from other ISEs for family violence protection purposes to assist with assessing or managing the risks within their practice expectations, and under the CISS for child wellbeing and safety purposes. Requests can be made verbally or in writing, and the purpose of your request to the ISE should be made clear.

Requests for information from other ISEs should also include:

- name, title of the person making the request, occupation and organisation
- the level of risk (at risk, elevated risk, serious risk/and requires immediate protection)
- purpose of the request
- identifying details of the person/s subject of the request (eg name, date of birth, address)
- whether the request pertains to adult or child victim survivors or the individual using violence.



It is important to confirm you are speaking to someone who is authorised to provide information under the FVISS or CISS, and clearly document the name of the person providing the information and the service for which they work. All information gained through this conversation should also be documented. Be careful to ensure that all information discussed relates to reducing the risk of victim survivors, and do not overshare information.

## Practical tips

### Pivoting to the perpetrator

One of the key aims of the MARAM Framework is to keep family violence risk of perpetrators in view and to support the service system to work together to hold perpetrators to account for their use of violence. When working with a victim survivor, GPs and PNs can request information about an individual using family violence to better understand their behaviour and to inform the risk assessment and assist with managing that risk for their patients. Information about the person using violence can also be shared with other ISEs, which could include specialist family violence services or the police. Their consent is not required, although you might require consent, as previously specified, if sharing information about the victim survivor.

As a treating GP, managing both the perpetrator and the victim survivor it is not recommended, where possible. When working with an individual who has used violence, it is vital that you never disclose anything about the victim survivor that could increase their risk. You should also not directly discuss the person's use of violence with the perpetrator (if the victim survivor has disclosed), as this is a complex practice that requires specialist skills, and if done incorrectly, could increase risk to the victim survivor.

If you are working with a person who discloses they are using violence, you should:

- ask the patient if they think they need any help with the issues in their life or their relationship issues they have disclosed to you (if safe to do so)
- inquire about their mental health, alcohol intake, drug use and employment status
- seek secondary consultation with other professionals in your service who have a role in working with people who have used violence or specialist services, and share information with other services working with the person using violence or an adult or child victim survivor
- proactively share information, particularly if there is immediate risk

If you deem there is an immediate risk to any person, call 000.

When working with an individual who has used family violence, a GP might receive a request for information from an ISE or might decide to voluntarily share information with an ISE. Consent from the person using the violence is not required; however, if the GP believes that sharing the information will put the victim survivor at risk, they could refuse to do so.

For further information, see [Chapter 5 in \*The White Book – Working with men who use intimate partner abuse and violence\* \(<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse>\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/domestic-or-intimate-partner-abuse-violence/working-with-men-who-use-intimate-partner-abuse).

## How can I be sure I am not breaking the law?

GPs and PNs are protected if information shared under the FVISS and CISS was done so in good faith and using reasonable care. It is always important to take the time to ensure that you are sharing information with an authorised ISE, and that consent has been sought from the victim survivor, unless there is a serious risk or a child at risk. Document every request and conversation carefully in the notes.

## Documentation

It is important to record the following in the notes (Figure 4). Detailed information about this and other resources can be found [here \(https://www.vic.gov.au/guides-templates-tools-for-information-sharing\)](https://www.vic.gov.au/guides-templates-tools-for-information-sharing).

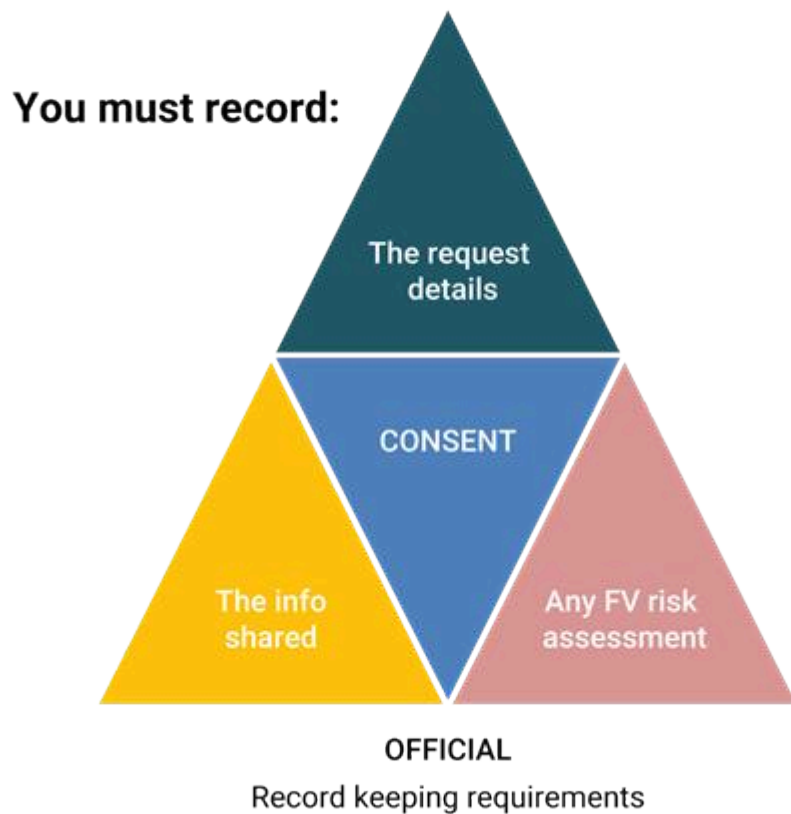


Figure 4: Record-keeping requirements<sup>2</sup>

Reproduced with permission from Family Safety Victoria, PowerPoint presentation to RACGP Victoria, East Melbourne; based on Family Safety Victoria. [Family Violence information sharing guidelines: Guidance for information sharing entities. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme). [Accessed 4 March 2022].

## References

1. [Victorian Government. Part C: Pillars. Victoria: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars\)](http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars) [Accessed 24 October 2021].
2. Hegarty KL, Bush R. Prevalence and associations of partner abuse in women attending general practice: A cross-sectional survey. *Aust N Z J Public Health* 2002;26(5):437–42. [Accessed 24 October 2021].
3. [Victorian Government. About the Royal Commission into Family Violence. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/about-royal-commission-family-violence\)](http://www.vic.gov.au/about-royal-commission-family-violence) [Accessed 7 March 2022].
4. [Victorian Government. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management\)](http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) [Accessed 7 March 2022].
5. [Victorian Government. Family Violence Information Sharing Scheme. Victoria: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 24 October 2021].
6. [Office of the Health Services Commissioner \(Victoria\). Health Records Act 2001 \(Vic\). Proposed statutory guidelines. Issues paper. Victoria: Office of the Health Services Commissioner, 2001 \(http://www.vgls.vic.gov.au/client/en\\_AU/search/asset/1160175/0\)](http://www.vgls.vic.gov.au/client/en_AU/search/asset/1160175/0) [Accessed 24 October 2021].
7. [Family Safety Victoria. Family Violence information sharing guidelines: Guidance for information sharing entities. Melbourne: Victorian Government, 2021 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 4 March 2022].
8. [Family Safety Victoria. MARAM practice guides: Chapter summaries. Melbourne: Victorian Government, 2020 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
9. [Family Safety Victoria. MARAM practice guides: Foundation knowledge guide – Guidance for professionals working with child or adult victim survivors, and adults using family violence. Melbourne: Victorian Government, 2021; pp. 28–31 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
10. [Family Safety Victoria. Responsibility 3: Intermediate risk assessment – Appendix 5: Brief risk assessment tool. In: MARAM practice guides: Foundation knowledge guide – Guidance for professionals working with child or adult victim survivors, and adults using family violence. Melbourne: Victorian Government, 2021; pp. 153–15 \(http://www.vic.gov.au/maram-practice-guides-and-resources\)](http://www.vic.gov.au/maram-practice-guides-and-resources) [Accessed 4 March 2022].
11. [Family Safety Victoria. Family violence information sharing guidelines: Guidance for information sharing entities. Melbourne: Victorian Government, 2021; p. 104 \(http://www.vic.gov.au/family-violence-information-sharing-scheme\)](http://www.vic.gov.au/family-violence-information-sharing-scheme) [Accessed 4 March 2021].

## Referrals and resources

- *The White Book* has an extensive list of [resources and referral pathways \(https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources\)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/resources-1/resources).
- A Royal College of General Practitioners (RACGP) [FAQs resource \(https://www1.racgp.org.au/getmedia/73e5bc82-bcff-467a-abb0-437c4bee6bef/FAQs-for-GPs-Information-Sharing-Schemes.pdf.aspx\)](https://www1.racgp.org.au/getmedia/73e5bc82-bcff-467a-abb0-437c4bee6bef/FAQs-for-GPs-Information-Sharing-Schemes.pdf.aspx) has been developed to assist GPs in their understanding of information-sharing schemes.
- An e-learning module on [supporting primary care to implement family violence information sharing \(https://www.saferfamilies.org.au/info-sharing\)](https://www.saferfamilies.org.au/info-sharing) (60–90 minutes) is available from The Safer Families Centre, University of Melbourne.
- Victorian Government resources and tools can be found [here \(https://www.vic.gov.au/guides-templates-tools-for-information-sharing\)](https://www.vic.gov.au/guides-templates-tools-for-information-sharing).

# Acknowledgement

RACGP Victoria acknowledges the Victorian Government for its support and funding of this resource.

We would also like to acknowledge The Safer Families Centre, University of Melbourne, for developing this resource, in particular Dr Jennifer Neil, Dr Magdalena Simonis and Prof Kelsey Hegarty.

This resource has been developed as part of [The Readiness Program – Primary care’s readiness to address family violence \(https://www.saferfamilies.org.au/readiness-program\)](https://www.saferfamilies.org.au/readiness-program).

# Provided under licence

## Terms and conditions of use

This resource is provided under licence by the RACGP. Full terms are available on the [licence terms page \(https://www.racgp.org.au/licence-terms\)](https://www.racgp.org.au/licence-terms).

In summary, you must not edit or adapt it or use it for any commercial purposes.

You must also acknowledge the RACGP as the owner.