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Abuse and violence

Working with our patients in general practice (4th edition)

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Abuse and violence: Working with our patients in general practice (4th edition)

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The Royal Australian College of General Practitioners
RACGP House
100 Wellington Parade
East Melbourne VIC 3002 Australia
Tel 1800 626 901
Fax 03 9696 7511
www.racgp.org.au

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Clinical editors

Dr Elizabeth Hindmarsh, MBBS, FRACGP, RACGP Co-Chair of the RACGP Faculty of Specific Interests – Abuse and Violence Network

Professor Kelsey Hegarty, MBBS, FRACGP, DRANZCOG, PhD, General Practice and Primary Health Care Academic Centre, University of Melbourne, Victoria; RACGP Co-Chair of the RACGP Faculty of Specific Interests – Abuse and Violence Network

Contributors

Dr Jill Benson MBBS, DCH, FACPsychMed (Chapter 14), Medical Director, Kakarrara Wilurrara Health Alliance, South Australia

Associate Professor Jan Coles PhD, MMed (Women's Health), MBBS, DCH, GCHPE (Chapter 6), Department of General Practice, Monash University, Victoria

Dr Kyllie Cripps BA (Hons), PhD (Chapter 11), Indigenous Law Centre, The University of New South Wales, New South Wales

Dr Gillian Eastgate MBBS, FRACGP, Grad Cert Health Studies (Chapter 10), School of Medicine, The University of Queensland

Ms Kirsty Forsdike BA (Hons), PgDipLaw, PgDipLegalPractice (Chapters 10, 13 and administrative coordination), General Practice and Primary Health Care Academic Centre, University of Melbourne, Victoria

Ms Kerry Haarsma BBSc, BA (Hons) (Chapter 4), Department of General Practice, Flinders University, South Australia

Professor Kelsey Hegarty, MBBS, FRACGP, DRANZCOG, PhD (Chapters 1–5, 13), General Practice and Primary Health Care Academic Centre, University of Melbourne, Victoria; RACGP Co-Chair of the RACGP Faculty of Specific Interests – Abuse and Violence Network

Dr Elizabeth Hindmarsh, MBBS, FRACGP (Chapters 6, 8, 10, 13), RACGP Co-Chair of the RACGP Faculty of Specific Interests – Abuse and Violence Network

Associate Professor John Litt MBBS, PhD, FRACGP, FAFPHM, MSc (Epid), DipRACOG (Chapters 4, 7), Discipline of General Practice, Flinders University, South Australia

Dr Ronald McCoy MBBS (Chapter 9), Central Clinical School, University of Sydney, New South Wales

A/Prof Ruth McNair MBBS, DRANZCOG, DA (UK), FRACGP, FACRRM (Chapter 2), General Practice and Primary Health Care Academic Centre, University of Melbourne, Victoria

A/Prof Vanita Parekh MBChB, FAChSHM, FACLM, DipVen, GradCertHE, DFSRH, DFFP (Chapter 9), ANU Medical School, Australia National University, Canberra

Dr Gwenneth Roberts PhD, Bbus (HealthAdmin) (Chapter 10), School of Medicine, University of Queensland, Queensland

Professor Phillip Slee BA (Hons), DipEd, PhD (Chapter 7), School of Education, Flinders University, South Australia

Professor Angela Taft MPH, PhD (Chapters 5, 12), Judith Lumley Centre, La Trobe University, Victoria

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The RACGP National Standing Committee – Quality Care

The RACGP National Faculty of Aboriginal and Torres Strait Islander Health

Dr Evan Ackermann

Dr Christine Boyce

Dr Graham Cato

Associate Professor Jan Coles

Dr John Crimmins

Ms Jill Duncan

Dr Michael Fasher

Ms Virginia Geddes

Dr Mark Harris

Dr Rosemary Isaacs

Dr Deepthi Iyer

Dr Caroline Johnson

Dr Margaret Kay

Dr Cathy Kezelman

Dr Sheila Knowlden

Ms Anita Morris

Professor Kim Oates

Professor Dimity Pond

Mr Rodney Vlais

Dr Hester Wilson

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Development of the White book

Abuse and violence: working with our patients in general practice, 4th edition, (the White book) was developed by general practitioners (GPs) and experts to ensure that the content is the most valuable and useful for health practitioners.

The manual provides an easy and practical resource and was based on the best available evidence in February 2014. This included 2014 Cochrane systematic reviews on advocacy;[1] 2013 Cochrane systematic reviews on screening[2] for intimate partner violence; 2013 World Health Organization (WHO) guidelines for health professionals based on systematic reviews and international consensus on intimate partner and sexual violence;[3] international consensus intimate partner violence guidelines;[4] 2013 randomised controlled trial evidence from general practice;[5] a 2006 meta-synthesis of qualitative studies of what women experiencing intimate partner violence expect from health practitioners[6] and a 2009 systematic review on child abuse interventions.[7]

For clinical interventions, the Grades of Recommendation, Assessment, Development and Evaluation (GRADE) methodology was used to assess the quality of the supporting evidence. For some recommendations, existing guidelines were relied on, in part, and the quality of the evidence in those guidelines was assessed. Recommendations on healthcare provision, and on mandatory reporting, were considered to be best practice by consensus or to address human rights.

How to use the White book

The manual offers health practitioners evidence-based guidance on appropriate identification and response in clinical practice to patients experiencing abuse and violence. In particular, it focuses on intimate partner and sexual violence and children experiencing abuse, as these are often the main victims of abuse.

Although men are also survivors of intimate partner abuse and sexual violence, this manual focuses on women, because they experience more severe physical and sexual violence, and more coercive control from male partners.[3] However, much of the advice given will be relevant in respect of violence by family members and others, and may be relevant for intimate partner abuse against men.

This edition of the White book adopts the most recent National Health and Medical Research Council (NHMRC) levels of evidence and grades of recommendations.[8] Recommendations at the start of each chapter are graded according to levels of evidence and the strength of recommendation. The levels of evidence are coded by the Roman numerals I–IV, while the strength of recommendation is coded by the letters A–D. Practice points are employed where no good evidence is available (refer to *Table 1*).

Table 1. Coding scheme used for levels of evidence and grades of recommendation

Levels of evidence	
Level	**Explanation**
I	Evidence obtained from a systematic review of level II studies
II	Evidence obtained from a randomised controlled trial (RCT)
III–1	Evidence obtained from a pseudo-RCT (ie alternate allocation or some other method)
III–2	Evidence obtained from a comparative study with concurrent controls: • non-randomised, experimental trial • cohort study • case-control study • interrupted time series with a control group.

Table 1. Coding scheme used for levels of evidence and grades of recommendation	
Levels of evidence	
III–3	Evidence obtained from a comparative study without concurrent controls: • historical control study • two or more single arm study • interrupted time series without a parallel control group.
IV	Case series with either post-test or pre-test/post-test outcomes
Practice point	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees
Grades of recommendations	
Grade	**Explanation**
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

What's new in the 4th edition of the White book

Much of the content in this edition is similar to the 3rd edition, however it has been extensively updated and reformatted to align with other RACGP publications. Two new chapters have been added regarding Aboriginal and Torres Strait Islander peoples and migrant and refugee communities. Particular attention is paid to rural communities throughout the manual. Levels of evidence and recommendation grades are now provided alongside each recommendation at the start of each chapter.

Resources have now been combined into *Appendix 7* to allow ease of reference. A link to *Appendix 7* is included at the end of each chapter to allow you to select resources relevant to your state, territory or nationally.

Acronyms

ADVO	apprehended domestic violence order
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
APVO	apprehended personal violence order
ASCA	adults surviving child abuse
ASP	autism spectrum disorder
CBT	cognitive behavioural therapy
FVO	family violence order
GBD	global burden of disease
GLBT	gay, lesbian, bisexual, transgender
GP	general practitioner
GRADE	Grades of Recommendation, Assessment, Development and Evaluation
IMG	international medical graduate
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
MBS	Medicare Benefits Schedule
MI	motivational interviewing
PTSD	post-traumatic stress disorder
RACF	residential aged care facility
RACGP	Royal Australian College of General Practitioners
STI	sexually transmitted infection
TTM	transtheoretical model of behaviour change
WHO	World Health Organization

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Chapter 1.What is interpersonal abuse and violence?

Key messages

- Interpersonal abuse and violence includes intimate partner abuse, adult survivors of child abuse, sexual assault, child abuse, bullying and elder abuse. Violence is not just physical; it includes emotional, sexual, economic and social abuse[9]
- Interpersonal abuse and violence is very common, with the main perpetrators of such violence being men, but women can also be perpetrators[10]
- 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 (refer to *Appendix 1. Nine steps to intervention – the 9 Rs*)[3]

Recommendations

- Safety is a concept that should be foremost when working with patients experiencing abuse and violence[3] **Practice point**
- Health practitioners should have a system in place that includes the whole of practice and referral pathways to safety and healing[3] **Practice point**
- It is important to receive training that includes our own attitudes and assumptions about abuse and violence as they can affect the way we respond to patients experiencing abuse and violence[3] **Practice point**

Introduction

In this manual, abuse and violence encompasses:

- **Intimate partner abuse (often known as domestic violence)** – any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship.[9] An intimate relationship may refer to a survivor's current or previous partner or living companion, including same sex relationships
- **Perpetrators of intimate partner abuse** – a person who commits, or knowingly allows, acts of abuse, neglect or exploitation to occur
- **Children in violent families** – children who are members of a family in which abuse and violence occurs, whether or not they themselves are abused
- **Child abuse** – any type of abuse that involves physical, emotional, sexual, or economic abuse or neglect of a child under 18 years of age (16 years of age in New South Wales, 17 years of age in Victoria)
- **Adult survivors of child abuse** – adults who experienced physical, sexual, or emotional abuse or neglect during their childhood or adolescence
- **Sexual violence** – 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, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object[3]

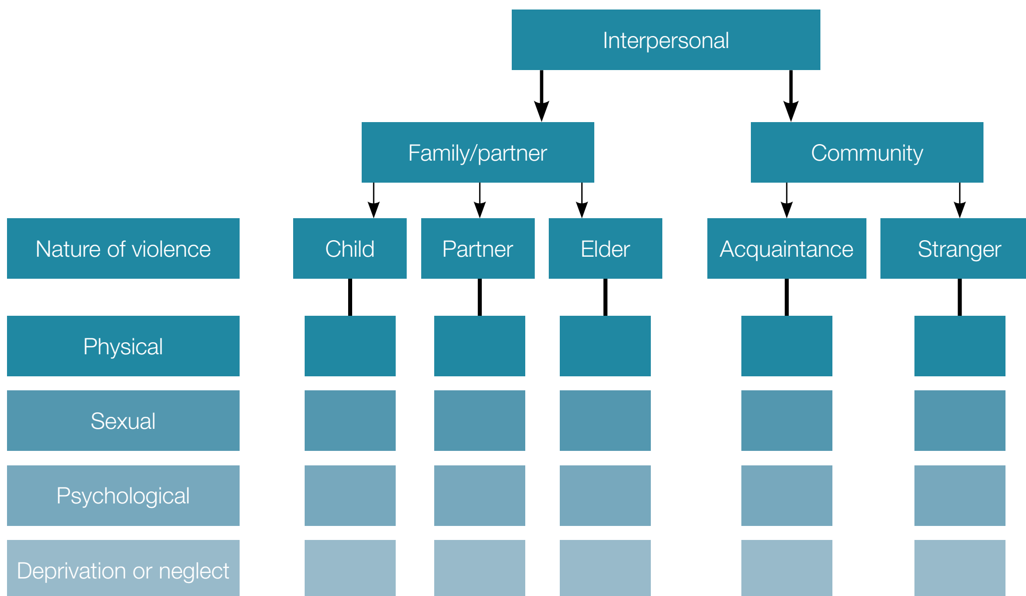
- **Elder abuse** – any type of abuse (physical, emotional, sexual, economic) or neglect of a person 65 years of age or over, either in a residential aged care facility (RACF), in private care, or living independently. It can be a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.[11]

Family violence is broader than intimate partner abuse or domestic violence and child abuse as it includes any violence or abuse that is occurring within a family – between, for example, siblings, uncles, aunts, cousins, grandparents and in-laws.

While it is acknowledged that not all survivors of abuse are women and not all perpetrators are men, research supports that men are the perpetrators in the majority of cases for child abuse, sexual assault and intimate partner abuse. Intimate partner abuse incidents that are reported show that the majority of those affected are women.[12]

The WHO categorises all of the above forms of violence within interpersonal violence (refer to *Figure 1*). This manual does not address acquaintance violence (apart from child and young person bullying) or stranger violence (apart from sexual assaults by strangers). It also does not cover the large burden of abuse and violence that occurs in global conflict zones, refugee camps and asylum detention centres.

Figure 1. Typology of interpersonal violence[13]



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This manual includes guidance on intimate partner abuse (*Chapters 2–5*), child abuse (*Chapter 6*) young people and bullying (*Chapter 7*), adult survivors of child sexual abuse (*Chapter 8*), sexual assault (*Chapter 9*). It also addresses specific populations such as the elderly and disabled (*Chapter 10*), Aboriginal and Torres Strait Islander peoples (*Chapter 11*), and migrant and refugee communities (*Chapter 12*). It concludes with reference to legal issues (*Chapter 13*) and, importantly, doctor self-care (*Chapter 14*). There is an emphasis on particular issues for rural populations and same-sex populations throughout the manual.

Prevalence

The Australian Bureau of Statistics found that young people aged 18–24 are the most likely group to have experienced some form of violence over the past year.[10] More than one in 10 young women, and nearly one in four young men had experienced some form of violence during 2012.

Both men and women were more likely to have experienced physical violence than sexual violence. However, sexual violence was four times more common for women than men: 19% of women had experienced sexual violence since the age of 15 compared to 4.5% of men.[10]

Since the age of 15, women were more likely to have experienced violence from someone they knew than by a stranger, while the reverse was true for men.[10]

This manual concentrates on the more prevalent form – violence against women by someone they know. The prevalence of different types of violence and abuse are detailed in individual sections of this manual.

Types of abuse and violence

Abuse and violence can take many forms. Violence can be severe and leave obvious injuries, but some victims may be subject to more subtle abuse that may not leave physical injuries. Abuse and violence 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, head injuries and injuries to internal organs. For many victims, 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, or killing or hurting family pets.
- **Emotional abuse** – may include subtle or overt verbal abuse, humiliation, threats or any behaviour aimed at scaring or terrorising the person experiencing the abuse. The victim 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.
- **Child sexual abuse** – for children, sexual abuse may involve forcing or enticing them to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. The abuse may include non-contact activities such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.
- **Adult sexual assault** – involves any type of sexual activity to which there is no consent. This may or may not involve penetration or physical contact with the victim (for example, exposure). It is important to note that people with a disability or the elderly may not have consented, or they may have lost their ability to consent (for example, those with dementia).
- **Economic abuse** – restricting access to money and essential needs, fraudulently using another's money for personal gain, or stealing from the victim; the illegal taking, misuse, or concealment of funds, property or assets.
- **Social abuse** – isolating the victim from family and friends, and other contacts in the community.
- **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.

Types of abuse are across populations and ages, however, all of them involve an abuse of power. The next section illustrates how a partner uses power.

Abuse and violence can take many forms in intimate relationships, and is often not recognised as such by the victim. 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.*

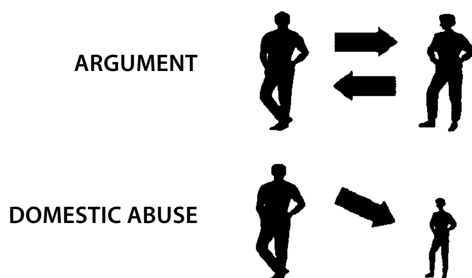
Intimate partner abuse – not just an argument

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, intimate partner abuse occurs where one partner is being abused by the other partner and lives in fear of being exposed to that abuse again (*Figure 2*). Fear experienced by the abused partner may be constant or episodic. Regardless of the frequency with which abuse occurs, it is still abuse.

Many intimate partner abuse survivors say that arguments did not precede the violent episodes or that the perpetrator often provoked the confrontation deliberately.

Figure 2. Intimate partner abuse: power imbalance in an abusive relationship



The role of GPs

The role of GPs includes all of the following to address family violence across the lifecycle (refer to *Appendix 1. Nine steps to intervention – the 9 Rs*):[14]

- identifying predisposing risk factors
- noting early signs and symptoms
- 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.

What part does the community play?

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

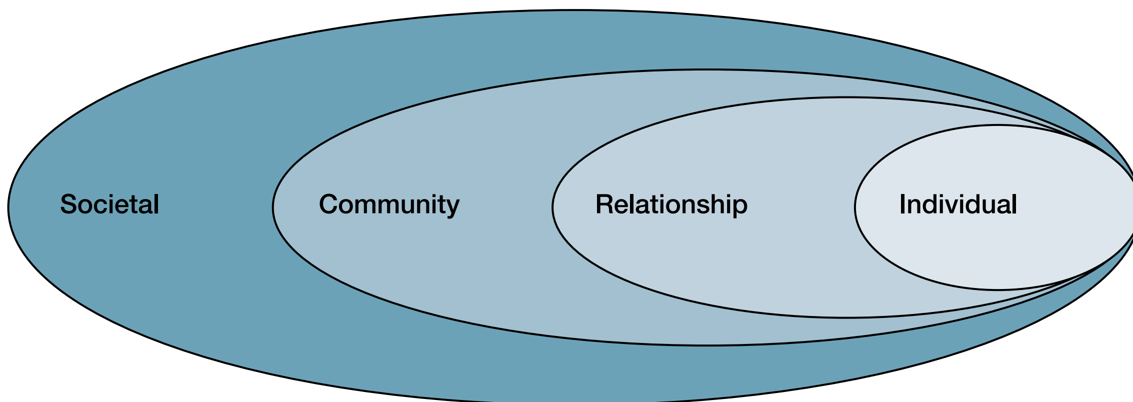
Other factors influence community responses:

- 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 some, the greatest danger lies in the home itself.
- As a community, we believe that the family is the basis of a good community and a strong 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 (refer to *Figure 3*). 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.[15]

Figure 3. Factors associated with violence[13]



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This manual particularly addresses vulnerable populations, including disabled women, women from culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander women, all of whom may be subjected to a higher prevalence of abuse and violence. Rural populations, which may have less access to services and information, are also highlighted.

Attitudes in society

Attitudes within the Australian community regarding family violence have been improving over time, although there are some gender differences. A 2009 survey[16] by the Victorian Health Promotion Foundation explored attitudes towards violence in Australia. The strongest predictors for holding violence-supportive attitudes were being male and having low levels of support for gender equity or equality. There is a developing awareness that interpersonal abuse and violence is a crime and is not acceptable.

Attitudes regarding rape[16]

- 93% of people agree that forced sex is a crime.
- 1 in 20 people believe that 'women who are raped ask for it'.
- 34% believe 'rape results from men being unable to control need for sex'.
- 1 in 4 agree that 'women make false claims of being raped'.
- 13% agree women 'often say no when they mean yes'.
- 1 in 6 agree that a woman 'is partly responsible if she is raped when drunk or drug-affected'.

Attitudes regarding intimate partner violence[16]

- 1 in 5 people (22%) believe that domestic violence can be excused if the perpetrator later regrets what they have done.
- 22% of people believe that domestic violence is perpetrated equally by both men and women.
- 14% of Australians regard domestic violence as a private matter.
- 4% of Australians condone the use of physical force by a man against his wife.

In this community survey,[16] women are more likely than men to be aware that intimate partner abuse can consist of both psychological and physical abuse. Women also tend to attach a greater degree of seriousness to such abuse. Both men and women identify men as more likely to be perpetrators.

Many myths (refer to *Box 1* and *2*) however, are still held as beliefs by health practitioners, despite more training on family violence being available to clinicians in the last decade.

Box 1. Myth 1 – Alcohol misuse causes violence

In reality …

Alcohol appears to be involved in about 45% of incidents of intimate partner violence.[17]

However, 55% of cases involve sober perpetrators. Abuse of alcohol is a risk factor that contributes to intimate partner abuse by lowering inhibitions, but alcohol does not cause intimate partner abuse, sexual assault, child abuse or elder abuse, nor is it an excuse for these behaviours.

Box 2. Myth 2 – Abuse and violence only occurs in certain groups, for example only poor women are abused

In reality …

Numerous studies, in Australia and internationally, show that both victims and perpetrators are found in all social classes and across all ethnic groups.[18] The abuse may be more hidden in higher socioeconomic groups, even among GPs themselves.

These myths and GPs' own experience of abuse (refer to *Chapter 14*) may impact on their work with patients experiencing family violence.

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.[19]

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.[20,21]

GPs need to understand the nature of violence and abuse so that they can help break this intergenerational cycle of abuse.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

The further reading and information listed below will assist GPs in this role.

- Refer to *Appendix 1. Nine steps to intervention – the 9 Rs*
- 1800RESPECT is a phone line and website (www.1800respect.org.au) providing information, advice and connection to resources in your area
- Australia's National Research Organisation for Women's Safety (ANROWS) is an independent, not-for-profit company. ANROWS delivers research evidence to drive policy and practice aimed at reducing violence against women and children. More information is available at www.anrows.org.au
- *The National Survey on Community Attitudes to Violence Against Women 2009* – this report presents findings from a community survey conducted by VicHealth. It provides an interesting insight into community attitudes towards violence and how this has changed over the past decade. Visit www.vichealth.vic.gov.au/Publications/Freedom-from-violence/National-Community-Attitudes-towards-Violence-Against-Women-Survey-2009.aspx

Chapter 2. Intimate partner abuse: identification and initial validation

Key messages

- The majority of intimate partner abuse victims are women in heterosexual relationships; however, intimate partner abuse also occurs in same-sex relationships[22]
- Intimate partner abuse is common. It is one of the leading contributors to death and disability for women of child-bearing age[23] and has major effects on the health of children[24]
- Most women are open to enquiry about intimate partner abuse[25] and the gender of a patient's health practitioner does not affect disclosure of intimate partner abuse[26]

Recommendations

- Health practitioners should ask patients who are showing clinical indicators of the mental and physical effects of intimate partner abuse about their experiences of abuse[3] **Level II B**
- Health practitioners should provide first line support – listening, inquiring about needs, validating women's disclosure, enhancing safety and providing support – to women who disclose abuse[3] **Practice point**

Introduction

Intimate partner abuse (or domestic violence) is the most common form of assault perpetrated against adult women in Australia today.[10] Globally, one in three women experience physical or sexual violence at the hands of their partners.[3] Because it occurs in the privacy of the home, and those involved are often reluctant to talk about it, intimate partner abuse remains a hidden problem in all strata of society. Intimate partner abuse occurs in heterosexual and homosexual relationships for men and women. However, as intimate partner abuse is perpetrated more often against women, this chapter focuses on women (and their children) as victims of abuse. That said, the overarching statements and recommendations in this chapter relate to both genders.

This chapter outlines an appropriate initial response by GPs and their practices to survivors of intimate partner abuse. *Chapter 4* outlines the ongoing management and response for survivors. *Chapter 3* provides an overview of documentation, risk assessment and mandatory reporting and *Chapter 5*, the response to perpetrators. In particular, doctors working in the Northern Territory need to be aware of the mandatory reporting requirements for domestic and family violence. Visit www.1800respect.org.au/workers/fact-sheets/mandatory-reporting-requirements for further details.

Understanding and naming intimate partner abuse is the first important step in breaking the silence. This manual employs a broad definition that includes abuse of a physical, sexual or emotional nature (*Figure 4*).

Forms of violence

Violence used by partners can take many forms:

- punching, hitting, slapping, shoving, throwing objects, pulling hair, twisting limbs, choking and other forms of physical assault including use of weapons and homicide, threats to injure or otherwise harm adults, children or pets
- sexual abuse or assault
- harassment by telephone, email or at the workplace
- deprivation of finances and basic human needs (access to food, sleep, medical care)
- erosion of self-esteem through humiliation and verbal abuse
- social isolation through denial of outside contact with friends or relatives
- use of technology to abuse, for example, sexting.

Although many victims of intimate partner abuse experience physical abuse, most victims say that the constant fear of the next episode is as bad as the actual violence:

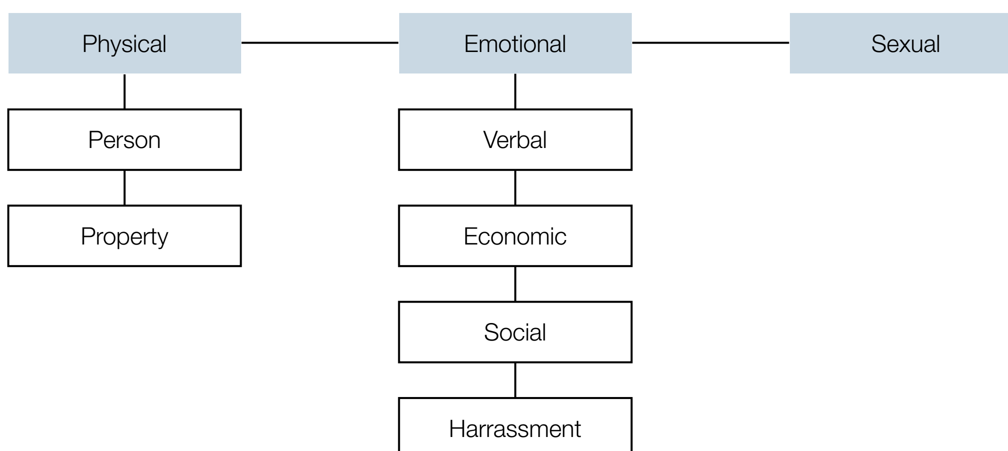
- *You don't know what the limit is when he's attacking you. It is very frightening.*
- *Each time you think: This will be the last. He's going to kill me.*

Physical injuries heal. Emotional abuse, if not dealt with, can cause long-term suffering for the survivor:

- *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.*
- *If you leave, I will kill myself.*

Many intimate partner abuse survivors also undergo forced sexual contact, but sexual abuse is rarely an isolated form of abuse. In most cases, it takes place within relationships where physical assaults and emotional abuse are occurring.

Figure 4. Types of abuse



When does it start?

People don't enter relationships expecting that the relationship will become violent.

> *I'll never forget when he hit me for the first time ... the pain of split lips and blackened eyes was outdone by the shock I felt. I just couldn't believe it had happened.*

Violence erupts in many relationships in the first year of that relationship, sometimes involving a pregnancy, and setting off a cycle of abuse that may last years.

Who are the victims of intimate partner abuse?

Survivors of intimate partner abuse (and their children) come from all social, cultural, economic and religious backgrounds. We know this from telephone and household surveys, as well as research conducted in hospital accident and emergency departments and general practice consulting rooms.[3]

One survivor of intimate partner abuse 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.*

Prevalence

The Australian Bureau of Statistics 2012 Personal Safety Survey[10] collected information about the nature and extent of violence experienced by men and women since the age of 15. It includes men's and women's experience of current and previous partner violence, lifetime experience of stalking, physical and sexual abuse before the age of 15 and general feelings of safety. The report shows that:

- women were more likely than men to experience violence by a partner:
  - 17% of all women aged 18 years and over (1,479,900 women)
  - 5.3% of all men aged 18 years and over (448,000 men)
- women were more likely than men to have experienced violence by a partner in the previous 12 months:
  - 1.5% of all women aged 18 years and over (132,500 women)
  - 0.6% of all men aged 18 years and over (51,800 men)
- 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
  - men was at a place of entertainment or recreation
  - the majority of male and female physical assaults are not reported to the police
- women were more likely than men to have experienced emotional abuse by a partner: 25% of women compared to 14% of men
- children frequently experience (hear or witness) the violence between their parents.

What is happening in general practice?

GPs often say we do not see many patients who have experienced violence.[27] It is true that violence doesn't necessarily present in an obvious way, and it may not be identified by our patient as their reason for presenting.

Despite this, it has been estimated that full-time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse – physical, emotional, sexual – in the past 12 months.[22] One or two of these women will have experienced severe intimate partner abuse – for example, being raped, attacked with a weapon, locked in their home or not allowed to work. These figures are from a survey of 1836 consecutive women attending 20 randomly chosen Brisbane general practices (with a response rate of 78.5%). One in three women in current relationships attending routine general practice

clinics had experienced partner abuse in their lifetime. Abused women were more likely to be younger, separated or divorced, have experienced child abuse and come from a violent family.[28]

It is important that we have an idea of the level of abuse and violence in general practice populations and the intergenerational transmission of abuse in families. This heightened awareness may help to identify health issues related to abusive episodes.

The role of GPs

GPs have a role in prevention, early identification, responding to disclosures of intimate partner abuse, and follow-up and support of patients and their children experiencing the health effects of violence and abuse.

Prevention

Preventing intimate partner abuse requires culturally safe strategies involving community institutions and opinion leaders, including primary care.[29] However, there is very limited evidence to guide healthcare organisations in primary prevention activities.[30] Some examples of workplace-based strategies[31] that a primary care organisation may choose include:

- training of staff in respectful relationships or bystander education to gain the skills and confidence required to identify, speak out about or seek to engage others in responding to specific incidents of violence, attitudes, practices or policies that contribute to violence[32]
- appointing practice or hospital champions who will assist with instituting prevention awareness activities across the workplace[33]
- acknowledging, as an organisation, significant days relating to the elimination of violence against women
- improving the workplace climate and peer support to work with this sensitive issue.

Identification of intimate partner abuse

Types of presentation

Studies show abuse is associated with depression, anxiety, other psychological disorders, drug and alcohol abuse, sexual dysfunction, functional gastrointestinal disorders, headaches, chronic pain and multiple somatic symptoms (*Table 2*).[34] Sexual abuse has also been linked with chronic pelvic pain.[3,34]

Table 2. Potential presentations of intimate partner abuse[35]

Psychological	Physical
• Insomnia	• Obvious injuries (especially to the head and neck)
• Depression	• Bruises in various stages of healing
• Suicidal ideation	• Sexual assault
• Anxiety symptoms and panic disorder	• Sexually transmitted infections
• Somatiform disorder	• Chronic pelvic pain
• Post-traumatic stress disorder	• Chronic abdominal pain
• Eating disorders	• Chronic headaches
• Drug and alcohol abuse	• Chronic back pain
	• Numbness and tingling from injuries
	• Lethargy

Depression appears to be one of the strongest clinical predictors of intimate partner abuse. One in five currently depressed women attending Victorian general practices has experienced severe physical, emotional and sexual abuse by a partner or ex-partner in the past 12 months.[36] Multiple physical symptoms are also a key indicator of abuse.[28]

Long-term consequences of intimate partner abuse include post-traumatic stress disorder (PTSD, refer to DSM-V criteria for PTSD, available at www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf), which is recognised as being likely to manifest itself following a 'psychologically distressing event that is outside the range of usual human experience'. Intimate partner abuse and sexual assault are recognised as being events that can result in PTSD due to the abuse being experienced with feelings of terror, fear for one's life, loss of control and a sense of helplessness. Abuse is also associated with other symptoms such as phobic avoidance of similar situations to where the abuse happened, anxiety, fear, withdrawal, isolation, depression, appetite and sleep disturbances, as well as problems with intimate and sexual relationships.

More general clinical indicators include a delay in seeking treatment or inconsistent explanation of injuries, frequent presentations to general practice, noncompliance with treatment or attendances, an accompanying partner who is over-attentive or identifiable social isolation.

What is the effect on children?

Child indicators[24] include effects on school and home behaviour including:

- bedwetting, sleeping disorders, anxiety, stress, depression, withdrawal
- aggressive behaviour and language, problems at school
- chronic somatic problems and frequent presentations
- drug and alcohol abuse
- suicidal ideation in adolescence.

Inquiry and disclosure of abuse

Although the majority of female patients attending general practices state that they would not object to being asked about abuse, it is only a minority who are asked.[25]

Women do disclose abuse to their GPs in significant numbers, particularly if they are directly asked. In a Brisbane study, one-third of abused women had told a GP about the abuse, while only 13.2% had been asked by a doctor.[27] GPs from this study said they did not inquire about abuse because of lack of time and appropriate skills, and a perception that they were unable to help abused women. The GP may communicate attitudes, directly or indirectly, that discourage disclosure – for example, 'it's the woman's fault', 'it's unlikely', 'it's not my role to ask', 'women don't want to be referred', 'most will stay with the abuser anyway'. The GP may worry about invading the woman's privacy despite women wanting to be asked.

Women are significantly more likely to disclose if they are asked by their doctor about the abuse. The gender of the GP does not affect disclosure if communications skills are good.[26] Barriers to disclosing sexual and physical violence include women not identifying the act as sexual violence or a crime, not thinking that they will be believed, fearing how they will be treated by the doctor or criminal justice system, and fearing reprisals from the partner. They may consider that they can handle it themselves and don't want family and friends to know because of the humiliation and shame. They often tend to minimise or normalise the violence and, if the abuse is mostly emotional, they may see it as not serious enough.[37]

This failure to identify an act as abuse at the time may also be a 'survival strategy' for some women, particularly those who have been sexually assaulted by an intimate partner.

One interview study revealed:

> *Women told us that it was not until they were no longer in the relationship and sometimes not until many years later that they had the perspective to recognise they were being raped within their relationship. While they were in the relationship, they struggled to make sense of what was*

happening to them, and were caught in our society's demand to make the marriage work. While in the relationship, they minimised the rapes, they blamed themselves or they feared even worse consequences if they didn't comply.[38]

Thus, there are many reasons why disclosure is not immediate and is often sporadic. It has been called the 'dance of disclosure', where women reveal only partially, often get frightened after they disclose and disappear for some time and then disclose at another time and place.

In relation to same-sex relationships, additional barriers to disclosure of intimate partner abuse include:[39]

- internalised homophobia – the internalisation of negative attitudes and assumptions about homosexuality
- declaration – the fear of being 'outed' to friends, family and/or work colleagues
- emasculation – men declaring abuse at the hands of another man may be disempowering
- police heterosexism – a number of studies indicate that homophobic behaviours and violence are both permitted and committed by the police
- societal homophobia – society tends not to promote disclosure, whether this be due to homophobia or a tendency to view the world in terms of heterosexuality.

Studies show that there is a need for patients to be encouraged to discuss abuse and to see it as affecting their health. We need to have a high level of suspicion and to be able to ask direct questions in a sensitive way. There is insufficient evidence for screening in clinical settings,[3,2] with the possible exception of antenatal care. However, there should be a low threshold for asking about abuse, particularly when underlying psychosocial problems are suspected. Possible questions to ask and statements to make are listed in *Table 3*.

Table 3. Questions and statements to make if you suspect intimate partner abuse
• Has your partner ever 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?
• 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.

Why don't women report the abuse?

Most people do not report their partner to the authorities for intimate partner abuse because of fear of reprisals or counter charges from their partner. Abused women are often:

- too terrorised to be able to always protect their children, and too worn down by repeated violence to seek help
- living in fear of violence with the use of weapons
- in real fear of losing their children to authorities whom they fear will disapprove of their home life and take the children into care
- at greater risk themselves of abusing their children
- unable or reluctant to recognise the cycle. The patient continues to see each episode as a discrete event 'caused' by another specific event.

Box 3. Myth – abused women can always leave if they wish

Abused women are usually constrained from leaving home by a number of factors. These include:

- fear of reprisals – many women are subjected to threats of injury and violence to themselves or their children if they leave. Approximately 40–45% of women killed by their spouse are separated or in the process of separating[40,41]
- social isolation – a number of social factors contribute to why women feel they cannot leave; having dependent children, being deliberately isolated from friends and family by the perpetrator, and shame relating to injuries. Abused women often have no-one to turn to and are unaware of available services
- financial dependence – women generally do not have equivalent earning capacity to men. To leave their partner condemns many women, and their children, to a substantial decline in their standard of living[42]
- emotional dependence and fear – many abused women are committed to their relationship, love their partner and are hoping for a change in the relationship. Some abused women are fearful that their partner will not cope with a separation and/or the partner may be threatening to suicide if she leaves
- poor self-esteem – after years of physical violence and verbal abuse, many victims lose their self-confidence and doubt their ability to cope on their own.

Management

In a meta-analysis of 25 interview studies of women's expectations and experiences when they encounter clinicians, there were consistent messages about how GPs can respond appropriately to the issue of partner violence (*Table 4*).[43]

Table 4. What abused women say they want from GPs
Before disclosure or questioning
• Understand the issue, including knowing about community services and appropriate referrals • Ensure that the clinical environment is supportive, welcoming, and non-threatening • Place brochures and posters in the clinical setting • Try to ensure continuity of care • Be alert to the signs of abuse and raise the issue • Use verbal and non-verbal communication skills to develop trust • Assure abused women about privacy, safety and confidentiality issues • Be compassionate, supportive and respectful towards abused women
When the issue of intimate partner abuse is raised
• Be non-judgemental, compassionate and caring when questioning about abuse • Be confident and comfortable asking about intimate partner abuse • Do not pressure women to disclose; simply raising the issue can help them • Consider asking about abuse at later consultations because patients may disclose at another time • Ensure that the environment is private and confidential, and provide sufficient time

Table 4. What abused women say they want from GPs
Immediate response to disclosure
• Take time to listen • Respond in a non-judgemental way, with compassion, support and belief of experiences • Validate experiences, challenge assumptions and provide encouragement (*Table 5*) • Acknowledge the complexity of the issue, respect the patient's unique concerns and decisions • Put patient-identified needs first, making sure social and psychological needs are addressed • Address safety concerns • Provide information and where appropriate offer referral for more specialised help • Assist patients to make their own decisions
Response in later interactions
• Be patient and supportive; allow the patient to progress at their own pace • Understand the chronicity of the problem and provide follow-up and continued support • Respect the patient's wishes and do not pressure them into making any decisions • Be non-judgemental if patients do not take up referrals immediately

Even if a woman does not choose referral to specialist intimate partner abuse services, our validation of her experience (*Table 5*) and the offer of support is an act that may contribute to her being able to change her situation. These questions and responses are applicable for both male and female victims. The readiness to action model can be very helpful in understanding a patient's current position within the journey of change (refer to *Chapter 4*).

Table 5. Possible validation statements if a patient discloses intimate partner abuse
• Everyone deserves to feel safe at home • You don't deserve to be hit or hurt and it is not your fault • I am concerned about your safety and wellbeing • You are not alone; I will be with you through this, whatever you decide. Help is available • You are not to blame; abuse is common and happens in all types of relationships • Abuse can affect your health (and that of your children).

In addition to offering support, we need to make an initial assessment of the patient's safety (*Table 6*). This may be as simple as checking if it is safe for her (and her children) to return home. A more detailed risk assessment (refer to *Chapter 3*) will include questions about escalation of abuse, the content of threats, and direct and indirect abuse of any children.

Table 6. Assessing the safety of patients experiencing intimate partner abuse
• What does the patient need in order to feel safe?
• Has frequency and severity increased?
• Is the perpetrator obsessive about the patient?
• How safe does she feel?
• How safe does she feel her children are?
• Has the patient been threatened with a weapon?
• Does the perpetrator have a weapon in the house?
• Has the violence been escalating?

Specific populations

Pregnant women

GPs involved in obstetric or shared antenatal care need to be aware that pregnancy is a risk factor for intimate partner abuse. Evidence suggests that four to nine women in every 100 pregnant women are abused.[44]

We ask pregnant patients about smoking, alcohol and breastfeeding, and we also need to screen for intimate partner abuse.[3,2]

For many women, pregnancy and the post partum period exacerbates the violence and threats within their relationship.[45] For some, pregnancy may even provoke it. A violent and jealous partner may resent the pregnancy because he is not prepared to 'share' her. There may be financial or sexual pressures, which are compounded by the pregnancy.

Abused pregnant women are twice as likely to miscarry than non-abused pregnant women. An abusive partner will often target the breasts, stomach and genitals of their pregnant partner.[3] Often the abuse will start with the first pregnancy, and as a result the woman may avoid prenatal check-ups. Women who do not seek antenatal care until the third trimester should raise suspicion.

Consider asking about intimate partner abuse in the antenatal period.[3]

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander victims of violence include men, women and children, but women are the predominant victims of intimate partner abuse.[46] The most vulnerable age group is 15–24 years followed by 25–34 years and 35–44 years – the risk for being a victim of Aboriginal and Torres Strait Islander family violence decreases after the age of 45.[46] One factor alone cannot be singled out as the 'cause' of family violence, but research has found that the strongest risk factor for being a victim of violence as an Aboriginal and Torres Strait Islander person is alcohol use. Other factors include being removed from one's family, single parent families and financial stress (refer to *Chapter 11*).[47]

Gay, lesbian, bisexual and transgender people

Diverse sexual orientations and gender identities require specific knowledge and skills of the GP.[48] It is particularly important for us to understand the impact of societal homophobia, biphobia and transphobia (prejudice against gays and lesbians, bisexual, and transgender people respectively) on this group of people. Homophobia, biphobia and transphobia commonly manifest in abuse and violent outbursts towards gay, lesbian, bisexual and transgender (GLBT) people. This ranges from victimisation of same-sex-attracted young people at school, to harassment in the workplace and violence in public places. In an Australian population-based sample, 63% of lesbian and bisexual women reported lifetime abuse as compared with 37% of heterosexual women.[49] Experiences of such violence, and the pervasive fear of assault, have a negative impact on the mental and physical health of GLBT people. It can lead to the need to conceal their sexual orientation or gender identity to reduce the risk of violence. It can also lead to non-disclosure within consultations, as the patient cannot predict the attitude of the health practitioner.

There is a predominant assumption in society that violence within same-sex relationships does not exist, or that it is not as confronting as violence within heterosexual relationships. Also present is the assumption of 'mutual combat', implying that violence is reciprocated or, at the very least, the victims are able to defend themselves because they are of the same gender. These statements are sometimes true, but if so, victims may question their victim status if they responded with violence, and may feel guilty for having participated in a violent way. Conversely, they may berate themselves for not defending themselves.

Emerging evidence from population-based studies indicates that there are no differences in the prevalence, type or severity of abuse between same-sex and opposite-sex couples; and in one study women survivors of same-sex domestic violence were twice as likely than those with male perpetrators to have poor self-perceived health status.[50] This poor health status may be due, in part, to a reluctance to report the violence due to fears of triggering a negative response from services.[51] The result of the relative invisibility of same-sex intimate partner abuse is that GPs do not consider it, and do not ask about it.

Cultural sensitivity can encourage disclosure of sexual orientation and gender identity, and therefore related experiences of violence. This can be communicated to GLBT people within the general practice setting in the following ways:[52,53]

- waiting areas – displaying materials specific to GLBT people including a rainbow flag sticker and specific information pamphlets on local services and support groups
- staff training – ensuring that all staff are trained not to make assumptions about the gender of patients and their partners, and to be aware of other forms of heterosexism
- practice policy – including anti-discrimination statements specific to sexual orientation and gender identity
- communication within the consultation – the use of gender-neutral language when discussing partners, being openly non-judgemental about different lifestyles, and being willing to ask direct questions about the possibility of abuse and discrimination.

Culturally and linguistically diverse women

The problems for women from a non-English speaking background are often compounded by social isolation, language barriers, the migration experience, cultural differences and for some, their religious beliefs. They may be less aware of the resources that exist within the community and how to access them. They may also need help in their own language and support that is culturally appropriate. Migrant women often feel economically and socially marginalised and need support to seek services and to understand the Australian legal system (refer to *Chapter 12*).

Conclusion

In 2013, the WHO released clinical and policy guidelines for GPs responding to intimate partner violence and sexual violence.[3]

The guidelines recommend that GPs ask women about intimate partner abuse as a part of assessing the conditions that may be caused or complicated by intimate partner abuse. These include mental health symptoms, alcohol and other substance use, chronic pain or chronic digestive or reproductive symptoms.

Minimum requirements for GPs to ask women about violence include that it is safe to do so – that the abusive partner is not present, for example – and that they have training and systems in place. Domestic violence posters and pamphlets should also be available in women's bathrooms within the practice or service.

GPs should provide immediate first-line support to women who disclose violence including:

- being non-judgemental and supportive, and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk
- helping her to access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children
- providing or mobilising social support.

GPs are often the only health practitioners seeing the victim, the perpetrator and the children, which can create difficulties for doctors. The major principles of management are safety and confidentiality within legal limits. *Chapter 3* outlines documentation, safety and risk assessment issues, *Chapter 4* ongoing follow-up and management of patients and *Chapter 5* management of perpetrators.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Available at http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf
- When she talks to you about the violence – a tool kit for GPs on domestic violence that was developed in NSW. Available at www.itstimetotalk.net.au/gp-toolkit/
- *Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians* – this guide outlines information relating to management of the whole family. Developed by an international group, it explores the evidence surrounding identification and management of patients experiencing intimate partner abuse. Available at www.latrobe.edu.au/jlc/research/reducing-violence-against-women-and-children
- For more information on implementing change at a practice level, refer to the RACGP's *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (the Green Book). Available at www.racgp.org.au/your-practice/guidelines/greenbook

Chapter 3. Safety and risk assessment

Key messages

- Health practitioners should express their concern about a patient's safety and likelihood of risk but it is a woman's right to decide on her own pathway to safety[3]
- Mandatory reporting of child abuse is required throughout Australia (refer to *Chapter 6*)
- In the context of intimate partner abuse, where the child or young person does not appear to have directly experienced any violence, you may consider a referral to a vulnerable children's organisation (see *Resources*)

Recommendations

- Health practitioners should work closely with specialist services including police, to enhance safety for women and children[3] **Practice point**
- Safety assessments need to be undertaken by health practitioners when seeing any patient experiencing abuse and violence[3] **Practice point**
- Documenting carefully what a patient has said about the abuse and violence in the record is important for communication with others and potentially for legal processes (refer to *Chapter 9* and *Chapter 13*)[3] **Practice point**

Introduction

Chapter 2 outlines issues around identification of intimate partner abuse including how to ask and provide an initial response. This chapter outlines how GPs can provide an initial assessment of risk and safety for women and children. This does not preclude consulting and referring to specialist services including police, women's and domestic violence services for a more detailed assessment of risk and safety.

The role of the GP

Many doctors feel very concerned about women's welfare and want to stop women returning to an abusive environment, however, women are often the best judge of whether it is safe to go home.[54] A series of questions, outlined below, enable us to assess risk and assist women to reflect on their own safety and their children's safety. In addition, it is important for us to assess directly the level of fear and safety of children if they are old enough to understand.

We need to inform women that whatever they tell us is confidential subject to the legal requirements around child abuse. Doctors working in the Northern Territory need to be aware of the mandatory reporting requirements for domestic and family violence. It is important to inform women that the greatest risk to their lives may be at the time they are leaving or thinking about leaving.[55] Documentation may assist with communication with other health practitioners, services and in legal processes.[56]

Assessing the safety of women experiencing intimate partner abuse

Some questions to consider when assessing a woman's immediate safety include:

- Does the woman feel safe to go home today?
- What does she need in order to feel safe?
- Has the frequency and severity of violence increased?
- Is he obsessive about her?
- Has she been threatened with a weapon?
- Does he have a weapon in the house?
- Has she been to hospital because of the violence?
- How safe does she feel?
- How safe are her children?

Risk assessment

Any assessment of risk to victims of intimate partner abuse must be structured and informed by:

- the woman's own assessment of her safety and risk assessment
- the presence of risk indicators outlined below
- your own professional judgement.[54,57]

There are several factors consistently associated with perpetrators of intimate partner abuse. These include age, severity (for example, strangulation) and duration of previous violence, history of arrest and incarceration, violence in the family of origin, drug and alcohol abuse, hostility levels and unemployment.

Risk indicators

Risk indicators of ongoing family violence include:

- perpetrator history of violent behaviour both within and outside of the household
- perpetrator access to lethal weapons
- perpetrator use of alcohol and drugs
- recent separation or divorce
- perpetrator stressors such as unemployment or recent loss
- perpetrator history of witnessing or being the victim of family violence as a child
- evidence of mental health problems or personality disorder in perpetrator
- perpetrator resistance to change and lack of motivation for treatment
- attitude of perpetrator that supports violence towards women.[58]

Some researchers have developed risk assessment tools,[54] for example, the Danger Assessment Scale (www.dangerassessment.org/DA.aspx)[59] was developed for use by GPs in consultation with women to enhance women's reflection on safety and self-care.

Women might be feeling unsafe to go home and may need urgent crisis referral (refer to *Resources*) and an urgent safety plan. Many women feel safe to go home after the consultation that day. For these women further discussion of ongoing detailed safety planning may be delayed until the next follow-up visit.

Safety planning

Safety planning is the development of a plan to achieve and maintain safety of women and their children. It includes:

- compiling a list of emergency numbers
- helping to identify a safe place for the woman to go to and how she will get there
- identifying family and friends who can provide support
- ensuring cash is available
- providing a safe place to store valuables and important documents.

Devising a safety plan with a patient in case of an emergency may be as simple as identifying where she would go, where to leave a packed bag and where to hide keys and money.

Below is a list of safety behaviours that women might include in their emergency safety plan.

Table 7. Safety behaviours
Hide money, an extra set of house and car keys
Ask neighbours to call the police if violence begins
Establish a code with family or friends that signals you need help
Remove weapons
Ensure quick access to the following materials: • Medicare and tax file numbers • rent and utility receipts • birth certificates (woman and children) • ID and driver's licence (woman and children) • bank account and insurance policy numbers • marriage licence, valuable jewellery • important phone numbers, hidden bag with extra clothing

Documenting intimate partner abuse

It is important to document intimate partner abuse in the health record as follows:

- Enter in the medical record any health complaints, symptoms, and signs, as you would for any other woman, including a history of who injured her.
- Describe physical injuries, including type, extent, location and age.
- If you are sure the records will be kept confidential, it may be helpful to note the cause or suspected cause of these injuries or other conditions. This is important for follow-up purposes, to remind yourself or alert another provider at later visits.
- Some practices use a code, located either on the medical record or an electronic medical system or special coloured sticker, to indicate cases of abuse or suspected abuse.
- If the confidentiality of records cannot be guaranteed or a woman requests that you not keep notes, it is better not to overtly document actions or interventions, for example, risk, any discussion about onsite or external services, secondary consultation or referral.
- At the end of the medical record entry, document the plan for the woman, for example, follow-up or referral to services.

It is important to document two things: information the woman has given you in a factually accurate way, and your own observations of injuries, affect, any other health conditions and anything else that is relevant. The notes should be detailed, and include what the patient said using quotation marks. Record any relevant behaviour you observed, for example, 'patient cried when she spoke about …' (refer to www.itstimetotalk.net.au/gp-toolkit). Documentation is critical for adequate care for the woman, as well as for follow-up should there be a legal process, which is often unknown at the time of medical intervention (refer to *Chapter 9* and *Chapter 13*).

To ensure confidentiality of records in the health setting, it is important that neither patients nor their visitors or support persons are able to gain access to the medical records unless this has been formally requested and in adherence to the relevant confidentiality protocol.

What to do if the patient is at high risk

Where you reasonably believe a patient is in imminent threat of danger, you should seek their consent to report the matter to the police. If the patient is not capable of giving the consent for any reason, which may include intimidation, the GP is relieved of any obligation to adhere to privacy principles to the extent that disclosure is necessary to safeguard the patient's immediate wellbeing. You may want to seek legal advice if you are in doubt, but common sense should be applied if the patient is manifestly in danger or threat of physical harm, and the police contacted.

Privacy and imminent threat

Sometimes the patient does not fall under mandatory reporting laws and does not want to go to the police, but you may perceive an imminent threat. This might be a situation such as a patient who is cognitively impaired, or where there has been a life-threatening risk, such as when a gun or knife is involved. The NSW Department of Health recommends in its Domestic Violence Policy discussion paper that health workers notify the police where the victim has serious injuries such as broken bones, stab wounds, lacerations or gunshot wounds (refer to *Chapter 13*). It is wise to get advice from appropriate authorities in these instances, including your medical defence organisation.

Safety of children and mandatory reporting

Children are particularly vulnerable to the impact of intimate partner abuse (refer to *Chapter 6*). In the context of intimate partner abuse, where the child or young person does not appear to have directly experienced any violence, you may consider a referral to a vulnerable children's organisation (refer to *Resources*) or a report to Child Protection. The overlap with child abuse and intimate partner abuse is strong.[60] Interventions that assist children to realise that their parent's violence is not their fault and to safety plan for the next episode of violence, are key features of a response for safety.[61,62]

Referring children to vulnerable children's or family services may be appropriate where there is a low-to-moderate impact on the child and their immediate safety is not compromised. As an example, the Department of Human Services in Victoria provides useful information for professionals working with vulnerable children, suggesting factors that may trigger a referral to a vulnerable children's service. This service, upon assessment, may then make a report to Child Protection.

The Victorian Department of Human Services also summarises the circumstances in which a report to Child Protection should be made, together with factors to consider when deciding whether to make such a report. To view this information, visit www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/about-child-abuse/how-to-make-a-report-to-child-protection

The Victorian Government has also developed a comprehensive framework for family violence risk assessment. To view this information, visit www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/family-violence-risk-assessment-risk-management-framework-manual

These principles and guidelines apply to any vulnerable families across Australia and local resources can be found in each state and territory (refer to *Appendix 7*).

Dealing with the perpetrator

Chapter 5 outlines how you should approach patients who are using violence against their partners, including how to ask and respond, and referral to services. When both partners are patients, you need to be extra careful with confidentiality and safety issues.[63] This includes considering referring the perpetrator to another practitioner or another practice and not communicating about the issue with the perpetrator unless the woman agrees. Ensuring safety protocols are in place in the practice and developing safety plans with the woman are essential.[64]

Conclusion

Within your practice there are a number of steps you can take to assist with dealing with abuse and violence issues. It is important to discuss issues surrounding abuse with all staff and to decide upon a practice policy related to reporting. This will give you a clearer framework within which to operate. Each state and territory police force now has trained domestic and sexual assault teams, including trained domestic violence officers who may be a helpful resource for managing these issues in general practice.

If you suspect that an adult patient is being repeatedly assaulted, and that patient is not willing to approach the police, you should still provide the patient with the appropriate information on, for example, family and domestic violence or sexual assault services (refer to *Resources*, *Chapter 9* and *Chapter 13*). Also consider approaching the police yourself. Remember, if there is a serious and imminent threat to the life and health of an individual, it may be appropriate to provide a report to the police on the basis that there is an overriding duty to disclose information in the public interest. These are often difficult and complex cases and you are encouraged to seek advice from colleagues and/or your medical indemnity insurer if faced with this situation.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- 1800RESPECT is a 24-hour telephone line that provides online and telephone crisis and trauma counselling. More information is available at www.1800respect.org.au

Chapter 4. Intimate partner abuse: responding and counselling strategies

Key messages

- Intimate partner abuse is strongly associated with mental health issues, which should be treated by health practitioners with a good understanding of violence against women[3]
- Women and their children are at increased risk at the time of separation. This process needs to be carefully planned to maintain safety[65]
- Intimate partner abuse is an issue for the whole community. Health practitioners have a role to play[3] and need to see themselves as part of the wider intervention – domestic violence services, legal, police, housing – that needs to occur to support survivors

Recommendations

- A range of counselling approaches, including motivational interviewing strategies, provide support and are effective in assisting women to discuss safety and reduce depressive symptoms in general practice[2] **Level II B**
- Health practitioners should offer to refer women who have post-traumatic stress disorder (PTSD) and who are no longer experiencing violence for trauma-informed cognitive behavioural therapy (CBT)[3] **Level I B**
- Pregnant women who disclose intimate partner abuse should be offered empowerment counselling and advocacy support by trained health practitioners[3] **Level I B**
- Health practitioners should offer children who have been exposed to intimate partner abuse a referral for psychotherapeutic counselling or small group therapy[3] **Level I B**

Introduction

Once we have overcome the many barriers to identification (*Chapter 2*), there is a role for ongoing follow-up, support and referral. GPs working in the Northern Territory need to be aware of the mandatory reporting requirements for domestic and family violence (visit www.1800respect.org.au/workers/fact-sheets/mandatory-reporting-requirements).

Key ingredients to effective engagement, counselling and support include:

- continuity of care
- a sensitive, non-judgemental approach to enquiry
- a good understanding of available community resources and barriers that these women face
- ongoing support (refer to *Chapter 2*).

In a consultation with a victim of intimate partner abuse, you should:

- demonstrate that you believe the patient
- provide a strong statement that violence is never okay
- make an assessment of their risk and safety (including any children) (refer to *Chapter 3*)
- provide information about possible referral and support services
- make an offer of ongoing support.

There are a number of challenges for GPs responding to intimate partner abuse, including feeling

overwhelmed and managing personal experiences of abuse (refer to *Chapter 14*).

A range of responding and counselling strategies may assist patients experiencing intimate partner abuse. GPs 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, and 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 (www.1800respect.org.au). They could consider offering access to this at their practice if the patient had no other opportunity to make a call or would be at risk if they tried to do this from home. This service can also offer help and information about services to the GP and practice.

This chapter outlines how we can respond to, follow-up and counsel our patients in a time-efficient manner. It also includes how to work appropriately with other services and refer to other practitioners to enable pathways to safety and healing.

The counselling strategies we use need to be:

- effective
- appropriate and possible in a GP setting
- acceptable to patients and GPs
- cognisant of the issues of disclosure and engagement.

Counselling approaches

In addition to safety assessment and planning (*Chapter 3*), effective counselling strategies that can assist survivors include CBT, motivational interviewing[66–69] and an understanding of the behaviour change process.[70–79]

Motivational interviewing

Motivational interviewing (MI) is a patient-centred clinical intervention intended to assist in strengthening motivation and readiness for action.[67] With intimate partner abuse, a woman's ability to change her situation may be very limited. It is important that MI is done with safety as the foremost concern for women and their children.

One goal of MI is to elicit and reinforce 'change talk' from the patient.[67,69,80] 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 help to 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 skilful counselling style blended with a clear patient-centred approach. Key elements of the MI spirit include:[69]

- 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 using 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 both 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.

MI is different to the transtheoretical model of behaviour change. The latter is intended to provide a comprehensive conceptual model of how and why changes occur, whereas MI is a specific clinical method to enhance personal motivation for change.[81]

The transtheoretical model of behaviour change (TTM) is commonly referred to as the 'stages of change' model and has been used in many clinical settings to determine patient readiness for action, including intimate partner abuse and other types of abuse and violence.[2,82–84] 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 of intimate partner abuse.[2,83,85] It is preferable to maintain a degree of flexibility rather than adopting a rigid approach when choosing intervention strategies.[86]

The stages of change, as applied to intimate partner abuse, can be categorised into five components outlined below. It is important to keep in mind the limitations outlined above.

- **Pre-contemplative** – the woman is not aware that she has a problem or holds a strong belief that it is her fault. Awareness is a key issue that you will wish to work on with your patient.
  - Suggest the possibility of a connection between symptoms and feelings of fear using the woman's terms.
- **Contemplation** – she 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 she 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 her decision about what she wants to do – for example, talk to family/friends/counsellor, leave the relationship, 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, having limited or no access to children or resources.
  - Support her 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.

Getting started – raising the issue

Raising the issue can be challenging (refer to *Chapter 2*). Women are not likely to disclose abuse unless directly asked[87] and many GPs don't ask.[88] Understanding the factors that contribute to disclosure and engagement in discussion is the first step in the process. It is also important to have an index of suspicion, especially with some typical presentations. For example, it may be a patient you have seen for years for depression, persistent headaches or vague somatic complaints. Begin to explore the possibility that they are experiencing violence or have experienced violence in the past with general and then specific questions (refer to *Chapter 3*).

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.

> *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?*

It is useful at this, and any, time to signal your support and acknowledgement that any violence is not acceptable. 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.[2,72,85,87] 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.

There are a number of barriers (refer to *Chapter 2*) to disclosure, particularly in small or rural communities – for example, not wanting the GP to think badly of the perpetrator, particularly if there is a family doctor who also sees other family members. There is often also a fear of repercussions and consequences, particularly in small, interconnected and isolated communities where anonymity cannot be maintained. Women in rural and remote areas may also find it more difficult to seek help or end a violent relationship. A range of factors may compound the isolation that survivors already experience as part of the abuse, such as:

- access to services
- concerns about maintaining confidentiality and anonymity
- the stigma attached to the (public) disclosure of violence
- lack of transport and telecommunications.[89,90]

Table 8 outlines some of the contributors to both disclosure and engagement.

Table 8. Strategies to increase disclosure, engagement and readiness for action in women who experience intimate partner abuse

Issue	What is needed	Description and comments	References
Healthcare worker characteristics	Clinician attitudes, judgements and behaviours	• Clinicians need to be non-judgemental, empathetic, active listeners, respectful, and compassionate. There must be development of trust • Importance of recognising/supporting patient autonomy	43, 91
Raising the issue	Setting the agenda communication and counselling skills	Open questions, reflection and active listening, sensitivity non-judgemental enquiry, expressing empathy	2, 43, 92
Enquiry	Ask about emotions and safety	• Ask about the woman's fears and concerns – anxiety, shame, self-blame, loneliness, humiliation and embarrassment are commonly associated with a reluctance to disclose • Assessment of safety (victim and any children) is important – *What does she need in order to feel safe? How safe does she feel? Has the violence been escalating?*	43, 91
Reluctance to disclose	Linkage to the presenting complaint	Increasing awareness of how intimate partner abuse is a contributor to the woman's presenting complaint – have a suspicion of intimate partner abuse when women present with anxiety, depression, substance abuse and chronic pain	2, 95

Table 8. Strategies to increase disclosure, engagement and readiness for action in women who experience intimate partner abuse

Issue	What is needed	Description and comments	References
Complexity	Insight	Women want GPs to have a deeper understanding of the complexities of their situation and circumstances. GPs need to gain an understanding of how the woman views intimate partner abuse and what are their identified supports	43, 71, 96
Validation	Legitimisation of experiences	Affirmation of experiences – address misconceptions eg *it's my fault, I deserve it* GP: *You do not deserve this and it is not your fault*	43
Vulnerability	Asking about and acknowledging vulnerability	• Cognitive behavioural strategies and motivational interviewing techniques • Promotion of patient autonomy, empowerment	2, 68, 93, 97, 98 92, 93, 99
Time	Sufficient time to discuss	Even brief interventions are valued, allowing the woman to progress at her own pace	43, 91
Decision making	Collaborative approach	Shared decision making, identifying turning points: • protecting others from the abuse/abuser • increased severity or humiliation with abuse • increased awareness of options/access to support and resources • fatigue/recognition that the abuser is not going to change • partner betrayal or infidelity	78, 85, 100
Ambivalence	Exploration of the value of changing and eliciting change talk	• Enquiring about ambivalence and motivation to do something • Change talk includes: – desire to change *(I wish ... I would like to …)* – ability *(I could, I can, I might ...)* – reasons (specific arguments for change), need (statements about the need to change) – commitment *(I will, I am going to …)* – taking steps *(this week I started …)*	69
Privacy and confidentiality	Secure environment	Reassurance of privacy and confidentiality, ensuring continuity of care	43, 71, 100

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.[100]

> *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 and motivational interviewing tool. 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. A decision-balance matrix is also a constructive tool to explore a patient's ambivalence about her partner and the relationship.[80] Emphasise that the reasons entered in the boxes should be her own reasons, not what someone else has told her.

The GP needs to consider both dimensions of exploring a 'decision balance' – the emotional as well as the cognitive. 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 intimate partner abuse can be a prevailing deterrent for survivors trying to move forward and away from abusive partners. Often regaining confidence and emotional strength can be a gradual process, so that even small advances are initially viewed as real hurdles. GPs need to be aware that moving out of an abusive relationship may take quite some time; sometimes years. The GP can be an important source of ongoing support and strength if they are non-judgemental of the rate of change and supportive of the decisions and choices the 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 and 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 take legal action, leave or change?

Most victims 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.

Turning points

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:[85]

- 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 they 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 of physical abuse has occurred 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 …*).

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 – for example, documenting injury and impact and referrals to intimate partner abuse 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 *Appendix 5. Non-directive problem-solving/goal-setting tool*).

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 believes they cannot leave. Making judgements about the merit of the decision is rarely useful and may alienate the victim. It is useful for GPs to understand the circumstances why this has occurred 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 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 – for example, 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.*

Warm 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 – for example, if she doesn't have a phone or a safe place to make a call.
- Provide her with the written information she needs – 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 make a decision using non-directive problem-solving techniques. Barriers may include childcare, transport, fear that the partner may find out. Always check to see if she has questions or concerns, and to be sure she has understood.

Conclusion

If GPs want to undertake supportive counselling, there are specific techniques that are helpful, including MI and non-directive problem solving. Not all GPs will feel comfortable providing this. Active listening is a simple supportive intervention in itself. Warm referrals to other professionals can also assist women on a pathway to safety, healing and recovery.

Case study: Mary

Mary is a professionally employed woman in her late 40s who experienced significant intimate partner abuse during her (now-ended) 23-year marriage. Before leaving her abusive partner, the violence escalated and she reached a crisis where her physical safety was seriously threatened. She identified a turning point when she recognised her domestic situation was abusive.

> A turning point for me in my journey out of my abusive marriage was gaining access to domestic violence literature. I remember sitting with a small publication in my hands and reading through a list of different types of abuse: emotional, psychological, social, financial, physical, and a list of common behaviours in these categories. I was in a state of shock because I could tick most of the categories and behaviours on the list as 'my life'. The book also discussed the 'cycle of violence' and I could identify closely with the patterns it described. I had always considered myself an intelligent, well educated person but the 'cycle of violence' occurring in my life had created so much confusion that I was unable to put it all together and understand that this was systematic cyclic abuse being used to control me and that living with the stress was making me increasingly physically sick. I could not deny it to myself any longer.

Mary confiding in her GP and friends and their ongoing support was pivotal in changing her internal dialogue, providing the reality check she needed to confront the pattern of violence and become more confident and decisive about changing her circumstances.

> It took a long, long time for me to give up the hope, the dream that things were going to change. I had adopted a strategy of forgetting abusive events as quickly as possible as a means of coping and surviving. It often came as an enormous shock when my GP or friends reminded me of an event or how I had felt at the time because I was editing my consciousness, trying desperately to dwell on the good things and kindnesses that always followed the abusive episodes that left me incredibly emotionally vulnerable and usually quite unwell physically.
>
> During a particularly bad period in my marriage, my GP suggested that I see a psychiatrist. This was helpful because he affirmed that it was my domestic situation that was making me ill and that it was my husband who needed therapy. This was very empowering for me to hear. The medication [given to me by the psychiatrist] helped to stabilise my mood, and my personal strength and ability to think more clearly began to grow. My husband had repeatedly refused to seek any counselling or therapy during the 23 years we were together.
>
> Later on, I confided in one of my university lecturers that my home situation was affecting me very badly and I was having problems coping with my course. She suggested I speak to a professional and referred me to a therapist she knew. The therapist worked intensively with me with a focus on the future. She helped me to explore ways that I could make changes and gain some control over my life. She helped me to set goals and identify tasks that needed to be done. She recommended a change in medication and encouraged me to open my own bank account and make extra keys and arrange somewhere I could go in an emergency. I suppose this is when I finally decided I would leave because I now believed I had the strength and support to do it.
>
> Following the first incident of serious physical violence I saw my GP who documented my injuries and counselled me at length. She, better than anyone, knew my history and she was as frightened for me as I was for myself and told me that I must leave him now – she had never articulated her fears for me so strongly before. We discussed my options and explored my available supports and I left the appointment feeling completely numb and paralysed. However, I was now determined to leave and my thoughts were preoccupied with putting as much in place as possible in the 2 months leading up to the night the death threats occurred.
>
> I can't even remember what the trigger was on that Saturday night but he was very drunk and he had just lost the job he had recently started. I sat frozen with fear on my bed for hours while he screamed at me that he wanted to kill us both. I could not get out of the house but I managed to lock myself in a bedroom and waited till he left the house the next day before leaving the room. That day I went to see my mother to see if I could stay with her for a while but she was frightened. I went home and locked myself in my room again overnight. On Monday I went to work and spoke to a friend who is a GP and academic and he listened and counselled me at length. He advised me to contact the police to seek assistance, however, I was told there was nothing they could do while I was living in my home with my husband. I never went home again. I had nothing with me except my handbag and the clothes I was wearing.
>
> In the first few weeks after leaving I was very ill, both physically and emotionally. The sense of loss and grief for the life I had known for the past 23 years was immense; my home, my garden, my pets and everything I had created was in that house. I could barely function, bursting into tears constantly night and day – I just couldn't control it. I was extremely anxious. I couldn't eat … I couldn't sleep without drinking alcohol. I felt like there was an electric current vibrating through my whole body and I just wanted it all to stop. I found myself thinking that if I could get home again, this violent emotional upheaval and the painful physical symptoms would go away. This is not what I wanted, or how I wanted my life to go. It was the most awful, distressing time of my life. I felt like I would have accepted comfort from almost anywhere. I was incredibly vulnerable and frightened that my husband would follow through with his threats to suicide. I was terrified for my own personal safety and was very concerned that I was putting my mother's safety at risk by staying with her.

This time I did not go back even though I considered it many times … I knew I would not survive if I did and the many small steps I had made towards independence with the help of a number of people, including my GP, meant that I now had the strength, health and support to leave.

Mary's story: 7 years on

It is now 7 years since I left my abusive marriage. A couple of months after I left and had resettled into a new home, my husband broke into my house and attacked me. I honestly thought I was going to die that night. A friend arrived shortly after he had left and saw I was injured and badly shaken and insisted we call the police. They arrived quickly and this time they responded very differently because we were no longer living together. I laid charges against my husband and arranged a restraining order. While I had some sense of support from the police, I certainly did not feel safe as he had again threatened to kill us both. The following 6 months was the loneliest time in my life, being in that empty house alone and terrified he would come back again. Friends and family didn't feel safe to visit me. I started to drink alcohol to cope and to numb my feelings. I drank too much for quite a long time.

Friends and family became aware that I was drinking too much too regularly and confronted me about it and I did see a psychologist a few times. I just didn't care that much about myself at the time to take health warnings seriously. I was so desperately upset and anxious most of the time. I felt awful so I self-medicated with alcohol. It was really my secret life. I never drank when I went out or when I was with company. But once I was inside my front door I would pour myself a glass of wine and often I couldn't stop until I fell into bed after cleaning the house for hours almost obsessively.

I left my marriage and survived, but while the high risk period just after leaving is far behind me, I have ongoing health and psychological problems to this day. Recurring traumatic nightmares have been a persistent problem for me. It is not unusual for me to wake up screaming and incredibly distressed two to three times a week. I am acutely sensitive to aggression even on TV. Just witnessing aggression will trigger a traumatic nightmare. I have had persistent sleep problems also. I frequently wake up at night and cannot get back to sleep. Work and financial pressures can trigger episodes of anxiety that I feel totally incapable of getting under control. These episodes can last for weeks at a time when I live with an internal tremor, a fluttering feeling in my chest and pounding in my temples and enormous tension despite being on antidepressant medication. During such episodes my blood pressure rises considerably, I feel very very unwell, cannot sleep and my work and relationships suffer. I just start to hide and avoid anything that further exacerbates the tension and anxiety. I have had three serious episodes of ulcerative colitis over the past 7 years.

The impact on my professional life has been considerable, due to my health and sleep problems. I have needed to take quite a lot of sick leave at times.

Unfortunately my GP stopped practising a couple of years after my marriage ended, so for a long time I did not have a GP at all and did not see a doctor. I couldn't face the prospect of starting over with a new GP and having to tell my story and make someone else understand the background to my health problems. I think it would have made a huge difference if I had had the ongoing support and care of my GP over the past 7 years.

I have recently found a new GP who has helped me to understand that I have a type of PTSD that needs to be treated and managed with medication and therapy. It was a relief really to have someone identify it as PTSD and start to explore options for treatment with me. I am beginning to gain more of a sense of control, that things are not so hopeless, and that in time I will not feel so exhausted and overwhelmed. I have been somewhat immobilised by the tiredness. I felt I couldn't plan for the future because I just didn't have any energy. I really can't say I have been happy or that I have enjoyed life for a very long time. All I have been able to manage is to keep putting one foot in front of the other to keep life together.

My advice to anyone going through post separation after living in an abusive domestic environment is to maintain those precious relationships that will be your lifeline – including your GP. Keep regular contact with your doctor so you get the support you need to manage the inevitable health issues you will more than likely experience. I feel incredibly fortunate to have had the support of my mother and a wonderful group of female friends and some special work colleagues who have stood by me but looking back, I should have sought out more professional help along the way. It could possibly have reduced the health impacts of intimate partner abuse a great deal for me.

Looking back now I realise what a pivotal role my GP had in my journey out of my abusive marriage. One of the most powerful techniques she used with me was reminding me of why I had come to see her the last time and asking how things had gone over the following week or two. It forced me to remember and face the considerable distress and effect on my health being caused by my husband and to relate it to the current situation and state of my mental and physical health.

I also think that is it was really helpful to imagine that someone else, someone I love, was experiencing the same treatment that I was and to be asked how I would feel about that. I seemed to have a far greater ability to put behaviour into acceptable versus non acceptable categories when it was associated with someone else. Perhaps my GP's greatest gift to me apart from managing my health problems was helping me to achieve coherence with regard to my current situation and a possible alternative future. I know she was instrumental in saving my life and I cannot emphasise enough the importance of the role she played.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- When she talks to you about the violence – a tool kit for GPs on domestic violence that was developed in NSW. Available at http://itstimetotalk.net.au/gp-toolkit

Chapter 5. Dealing with perpetrators in clinical practice

Key messages

- Mainly perpetrators are men and victims are women, although men may be victims as well[101]
- Perpetrators are not a homogenous group; they come from all socioeconomic, cultural and social groups[102]
- It is not recommended for one health practitioner to counsel both the victim and the perpetrator[4]

Recommendations

- Health practitioners need to have an index of suspicion of the possibility of men using violence when they are also experiencing substance abuse issues[103] **Practice point**
- Men's behaviour change programs are the referral options of choice for men who perpetrate domestic violence **Practice point**

Introduction

While it is important to focus on the survivors of abuse and violence, it is equally important to acknowledge the entire family when considering care. General practice, unlike other health services, may come into contact with the victim, the perpetrator and/or the children. Intimate partner abuse affects all members of the family. Most perpetrators of intimate partner abuse will be men, but it is also possible for a woman to be the abuser.[3]

Perpetrators of intimate partner abuse come from all social, cultural and religious backgrounds. One of the main problems in acknowledging the extent of abuse and violence is the fact that there is no distinguishing characteristic of a man who will be violent towards his partner.

We need to be aware that perpetrators of intimate partner abuse tend to minimise responsibility for their use of violence, blame the victim or other issues and greatly under-report their use of violence. They generally have developed ways of convincing themselves and others that they aren't responsible for their violence, and can invite GPs and other practitioners to collude with those attitudes and beliefs that minimise responsibility.

Prevalence

In research conducted with perpetrators, self-reporting mechanisms are often used. This has led to fundamental issues of under-reporting,[104] with the most consistent evidence coming from reports by survivors. These figures place prevalence rates of perpetration of violence at 20–25% of the general population.[9]

In order to understand why particular men become perpetrators, it is important to understand that there are larger community and societal issues – norms, expectations – that create a complex framework in which perpetrators operate. Perpetrators use physical, sexual, emotional, social, financial and other forms of violence to maintain their power and control in the relationship. This is often based on societal acceptance of male dominance, stereotyping of gender roles, linking masculinity to dominance and acceptance of violence as a way to resolve conflict. These are all attitudes that are associated with intimate partner abuse.[105]

While gender-based power and control is an underlying factor in men's perpetration of intimate partner abuse, other factors are involved. Perpetrators are more likely to come from families where intimate partner abuse occurred, where they experienced child abuse or an absent or rejecting father. However, some perpetrators report well-adjusted childhoods and peaceful family-of-origin environments. Other factors that have been linked to intimate partner abuse are mental disorders[15] and substance abuse[106,107] and these have also been correlated with more significant risk of injury to the victim.[108,109] Poverty, unemployment and associating with delinquent peers in the community are also risk factors for perpetration of intimate partner abuse. However, perpetration occurs across the socioeconomic spectrum.

Personal, situational and sociocultural factors all play a part in shaping perpetrators, 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 violence.[110]

It is extremely important to qualify here that while some of the factors outlined above may be risk factors for intimate partner abuse, they are not causal. It cannot be assumed that perpetrators are mentally ill and/or substance abusers. Profiling the characteristics of perpetrators is a new field of research.

The role of GPs

Research shows that perpetrators present to general practice for healthcare needs and may be presenting more often than non-abusive men. This can include a range of issues from injuries to anxiety and depression. They can also have low self-esteem as an outcome of the abuse and violence.[111]

It is not recommended for one GP to counsel both the victim and the perpetrator.[4] This may be managed by referral within the practice of one of the partners or by referral to another agency. Doctors in rural areas may find this particularly difficult. Doctors in small rural towns may need to refer patients to services in neighbouring towns where available. This can help to protect your patient's safety and/or confidentiality.

Separate GPs are recommended because:

- it is not possible for one person, however skilled, to counsel both parties in this sort of conflict
- of the danger of a GP inadvertently revealing some of the information provided by the victim to the perpetrator. Many perpetrators are very alert and extremely sensitive to what they think the victim might be telling others, and can feel threatened or 'less in control' if they believe that the victim is disclosing about the violence. If the GP 'lets something slip', even subtly, about what the victim has disclosed to the perpetrator, in some situations this can lead to the perpetrator retaliating against the victim
- perpetrators can appear very persuasive in minimising, denying, excusing and justifying their use of violence. They can appear quite convincing in blaming their partner, pathologising their partner – 'she is so hysterical, you know what women are like …' – or blaming their use of violence on the relationship or communication problems. Many perpetrators have quite intricate violence-supporting narratives and other methods that they use to absolve themselves of responsibility for their use of violence
- many perpetrators try to directly or indirectly invite professionals and others to collude with these responsibility minimising narratives. It is therefore important for a different GP to hear the victim's stories, so as not to be influenced by the perpetrator's violence-supporting narratives.

Types of presentations in general practice

GPs need to be aware that any patient may be a perpetrator. However, many of these patients are reluctant, unwilling or unable to identify themselves as being perpetrators of intimate partner abuse.[112]

While not all those who have mental health issues or substance abuse problems will display abusive tendencies, we need an index of suspicion of the possibility of abuse among this cohort. While there are links with mental illness and substance abuse, it is important for us to not over pathologise the perpetrator. Abandoning generalisations and negative attitudes, along with being open to providing support to perpetrators, is important in providing successful treatment.[113]

Management

Immediate safety of abuse survivors – the partner and any children – should be the predominant concern when a perpetrator is identified. Management objectives also include:

- taking a history – especially suicidality, substance abuse, mental health and weapon ownership
- reinforcing that abuse and violence are not okay – condemn the actions, not the person
- encouraging ownership – help the perpetrator take responsibility and encourage active change.

Broaching the subject of violence with perpetrators may be difficult for a number of reasons including:

- trouble viewing the patient as violent
- damaging the patient–doctor relationship for ongoing care
- being at risk from added stress[114]
- invading the patient's privacy
- managing confidentiality and privacy issues when managing the entire family.

Remember, addressing the issue may help reduce risk for other members of the family. Broaching the subject of abuse with perpetrators is possible with the use of funnelling questions.[112,115] 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:[112]

- 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?
- 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?

Anger

Perpetrators do not use violence only when they are angry. The perpetrator might be feeling a range of emotions when they use violence. Furthermore, many perpetrators use forms of violence when they are fairly calm – controlling tactics used to restrict their partner's life and to instill fear. Most perpetrators choose not to use violence in other settings when they feel anger, such as in the workplace. Many perpetrators 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 perpetrator to rehearse his violence-supporting narratives like this for too long, and to assertively yet calmly bring the attention back to him. For these reasons, anger management programs are not recommended for perpetrators of intimate partner abuse.

Men's behaviour change programs are not anger management programs, though they might include components of anger management. Community-based intimate partner abuse perpetrator programs by and large come from a gender-based perspective that conceptualise men's use of intimate partner abuse as a choice based on gender-based power and privilege, entitlement and sexist attitudes towards women, intentional choices towards coercively controlling women and restricting their lives for men's benefit. The types of violence are seen as an intentional interlocking of tactics to control women's lives. The programs often are based on a combination of this power model and approaches such as CBT or narrative. A CBT approach involves pointing out the pros and cons of violence, social skill training, and anger management techniques to promote alternatives to violence.[116] In a systematic review that focused on CBT for men who use physical violence against their partners, there were very few evaluation studies.[117]

Keep in mind the stages of change model (refer to *Chapter 4*) and try to identify the most appropriate time to refer to an adequate program. This may be a specific behaviour change program for perpetrators run by an accredited agency (also providing support for the victim), drug/alcohol rehabilitation or a mental health specialist. Men's behaviour change programs are the referral option of choice, even with men who have substance abuse or mental health issues. Men's behaviour change programs include a thorough assessment and can work with, or refer men to, accompanying substance abuse or mental health services. If the substance abuse or mental health issues are urgent, or if the man is not ready to accept a referral to a men's behaviour change program, then a referral to a drug/alcohol rehabilitation or mental health service is certainly better than no referral at all.

In most states (refer to *Resources*) there is a statewide telephone information, referral and counselling service for men who perpetrate family violence. These can assist you to locate men's behaviour change program options. Men who do not appear ready to attend a men's behaviour change program might be more comfortable taking the initial step of calling such a service. The service will then attempt to motivate them to attend a men's behaviour change program. As the GP, you can also phone any of these services to find out information about local men's behaviour change referral options, or you can encourage the perpetrator to phone this service direct. Check your local area for counselling and accredited groups available to perpetrators.

Note that providing the perpetrator with a referral is not the end of our involvement. Supporting the perpetrator's change and monitoring the safety of the family is an important and ongoing task. If you are seeing the victim and the perpetrator for medical care (not counselling), it is important to check with the victim as to how they perceive the perpetrator is progressing. It is also very important to do the best possible to ensure that the victim is receiving counselling and support from a specialist family violence service. Indeed, this should be the first priority – that the victim is receiving specialist services.

The importance of this ongoing care is underscored by the fact that men's behaviour change programs are not successful with all perpetrators. For some perpetrators, these programs work to drastically reduce or even stop their use of violence. For some others, the programs produce mixed results, such as benefits that do not sustain over time, the man stopping some forms or tactics of violence and not others. For other men, these programs produce little discernable benefit, or they drop out after the first few sessions.[118]

Finally, as a note of caution, many experts suggest that couple or family counselling is not appropriate until the abusive behaviour has ceased[112] as it is not possible to provide couple or family counselling where there is such a power imbalance.

A resource for GPs managing these issues, *Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians*, is available at at www.latrobe.edu.au/jlc/research/reducing-violence-against-women-and-children

Conclusion

This chapter has provided an overview of the prevalence, identification and management of perpetrators in general practice. There is a lack of research in this area and GPs need to keep the safety of women and children at the forefront of their minds when discussing issues with perpetrators.

Case study: Gabby

Gabby married her husband Nick after a long relationship and shortly thereafter moved to her husband's family farm. The couple were happy at the farm and soon had their first child. During the pregnancy Nick's behaviour began to change and by the time their daughter was born the relationship did not 'feel' as it had before. Nick seemed withdrawn and spent long periods of time by himself. He began to remind Gabby of Nick's father who had always been a stern presence in his life.

Nick's behaviour became threatening and controlling, especially in relation to money and social contact. He was increasingly aggressive in arguments and would often shout and throw objects around the room. Gabby thought that because he wasn't physically hurting her, his behaviour did not constitute abuse. Nick did not show much interest in their daughter, Jane, except when in public, where he would appear to be a doting and loving father.

Jane was generally a well-behaved child, however, Gabby found that she was unable to leave her with anyone else. Jane would cry and become visibly distressed when Gabby handed her to someone else to be nursed. This was stressful for Gabby and also meant that her social activities were further limited.

Jane took a long time to crawl, walk and begin talking. Her sleeping patterns were interrupted and Gabby did not often sleep through the night, even when Jane was over 12 months of age. When Jane did begin to talk, she developed a stutter and this further impeded her speech development. Gabby worried about Jane a lot. Their family doctor told her that this was normal for some children and if the speech problems persisted, that she could always send Jane to a specialist at a later date.

After a number of years, Nick's behaviour became unacceptable to Gabby. During arguments he had taken to holding the rifle that he had for farming purposes, and Gabby found this very threatening. On a number of occasions, items that Nick threw hit Gabby and she was increasingly afraid for their daughter. Gabby decided to leave and consulted the local women's service, who assisted her to get an intervention order against Nick.

Once Gabby had taken Jane away from Nick her behaviour changed. Jane's development seemed to speed up and Gabby couldn't understand why. As part of her counselling at a local women's service, she discussed this issue and her counsellor recognised the developmental delay, stutter, irritation and separation anxiety as effects of Jane's having lived in an abusive situation.

This could be seen as a missed opportunity for identifying family violence. If the family doctor could have asked Gabby or Nick (who had presented with chronic back pain) about their relationship then what was happening to the family, and specifically to Jane, could have been identified much earlier.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- *Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians* – outlines information relating to management of the entire family. Developed by an international group, this document explores the evidence surrounding identification and management of IPV. Available at www.latrobe.edu.au/jlc/research/reducing-violence-against-women-and-children
- Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London. Churchill Livingstone Elsevier, 2006 – provides an overview of the literature on abuse and violence in primary healthcare. Explores the prevalence and barriers faced by GPs addressing abuse and violence.

Chapter 6. Child abuse

Key messages

- Child abuse is common, and most commonly perpetrated by someone within the family, or by a person known to the child.[119] Children less than one year of age are particularly vulnerable especially to physical abuse and poor attachment to parents[120]
- 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[121]
- 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 10*)

Recommendations

- Health practitioners have a role in prevention of child abuse by identifying families at risk (eg where domestic violence is co-occurring) and referring to parent training programs and nurse home visitation programs[122–124] **Level I A**
- Harmful alcohol and drug use has a strong link with child abuse. Alcohol screening and brief interventions in health settings have proved effective in reducing alcohol use. The WHO recommends working to reduce alcohol consumption in adults with children in their care[125] **Practice point**

Introduction

Child abuse is often called child maltreatment or non-accidental injury in the literature. In this guide, the term child abuse is used as defined by the WHO as:

> *physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.*

In addition, child abuse includes exposure to domestic violence, due to the long-term damage on children of experiencing or witnessing parental intimate partner abuse.[60]

Child abuse includes a wide range of behaviours:[7,127]

- **physical abuse** – intentional use of physical force or objects against a child that results in, or has the potential to result in, physical injury which includes hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, shaking, strangling, smothering, burning, scalding, and poisoning
- **emotional/psychological abuse** – intentional behaviour that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs which can include 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. This includes threatening, yelling, taunting, debasing (eg 'you're worthless', 'you're dumb', 'no-one likes you'). Witnessing intimate partner abuse can also be classified as exposure to emotional/psychological abuse
- **sexual abuse** – any completed or attempted sexual act, sexual contact, or non-contact sexual interaction which includes penetration, touching a child inappropriately and exposure to sexual activity, filming or prostitution

- **neglect** – failure to meet a child's basic physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene, or shelter; or 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; and failure to protect a child from violence in the home or neighbourhood or from avoidable hazards
- **exposure to intimate partner abuse** – children living in families where intimate partner abuse (any incident of threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults who are, or have been, intimate partners or family members) occurs are considered to be victims of child abuse, whether directly or indirectly abused. Therefore you need to ensure, where possible, that the child or children and the non-abusive parent are in a safe environment. Mandatory reporting may be required in this situation if safety cannot be ensured.

All these above behaviours occur across all socioeconomic strata in society.[127]

Individual and community costs of child abuse

The Australian Institute of Family Studies reported in 2013 that the individual and community costs of child abuse in Australia were estimated to be $4 billion in 2007, with a further lifetime cost of the burden of disease being $6.7 billion. These costs were based on the adverse effects of child abuse, such as future drug and alcohol use, mental and physical illness, increased health service usage, homelessness and involvement with the legal system.[128,129]

Rights of the child

Child abuse is an international issue that has serious life-long consequences. There are a number of treaties and agreements that attempt to set the world standard for managing this difficult topic (refer to *Further information* for more information on the Convention on the Rights of the Child).

Prevalence

Internationally 20% of women and 5–10% men report childhood sexual abuse, while 25–50% children report being physically abused.[126]

In Australia from 2011 to 2012 there were 37,781 substantiated reports of child abuse and neglect made to Australian state and territory community services departments. These figures are the substantiated reports and are an underestimate of the prevalence of child abuse in Australia. These reports involved children aged <1 year to 17 years of age. Very young children aged <1 year had the highest rates of substantiation with children aged 15–17 years the least likely. During 2011–12, Aboriginal and Torres Strait Islander children had nearly eight times the substantiation rates of child abuse and neglect compared with non-Indigenous children.[120]

The most common form of substantiated childhood abuse is emotional abuse (36%), followed by neglect (31%), physical abuse, which varied across states and territories (13–29%) and sexual abuse (12% with a range 13–29%). Girls were more than twice as likely to experience substantiated sexual abuse while boys were more likely to experience neglect. Physical and emotional abuse was more likely to be substantiated for boys in most states and territories.[120]

Deaths from child abuse

In 2006, 27 Australian children died of assault related injuries; it was the third most common type of injury after transport related deaths (66 deaths) and drowning (46 deaths). Infants less than 12 months of age were most at risk. The Australian Institute of Criminology (2003) estimated that, on average, 25 Australian children are killed by their parents each year.[130] This figure is likely to be an underestimate. Recent evidence suggests GPs are often consulted prior to the child's death and that parental depression and the finalisation of a parental separation (often related to domestic violence) are possible red flags to improve the identification of children most at risk.[131]

The role of GPs

GPs can work on managing issues related to child abuse at three levels:

- to prevent the problem from occurring
- to detect the problem and respond when it does occur
- to minimise its long-term negative impacts.[121]

Prevention

Preventive measures and identifying families at risk

Family situations change over time and GPs are often aware of these changes and the potential stress that it places on families. Because of this awareness, GPs are well placed to monitor families for a potential situation that may give rise to child abuse. These situations may include family break up, work stress, additions to the family, or moving location.

However, children in families where there is parental substance abuse, mental illness and/or domestic violence are at greater risk of child abuse.[132] As the highest incidence of abuse and neglect happens in the first year of life, families with infants and toddlers may require specific attention and support.[120] Children in the first 4 years of life are particularly vulnerable to the impact of child abuse on brain development.[133]

Other established risk factors for child abuse include:

- inadequate parenting, including the failure of any infant–parent attachment
- unrealistic expectations of child development
- a belief in the effectiveness and social acceptability of harsh physical punishment
- an inability to provide for high-quality childcare when the parent is absent.

Conversely, various strategies that promote early and secure infant–parent attachment and non-violent modes of discipline, and create the conditions within the family for the positive mental health development of the child, have been proved effective in preventing child abuse.

The evidence that programs focusing on parenting improvement and support are effective in preventing child abuse is strong. The two most widely evaluated and widely applied models for delivering these strategies are training in parenting programs and home visitation programs.[122]

The Triple-P program of training in parenting, as developed by the University of Queensland, is one example (www.pfsc.uq.edu.au).[123] A number of independent outcome evaluations of Triple-P have shown it to be effective in improving family management techniques, parental confidence in effective child rearing, and behavioural outcomes, including health behaviour and aggression.[123] Resources for parents can be found at www.families.nsw.gov.au/resources/resources-index.htm

A meta-analysis of 40 family support prevention programs for those with children at risk of physical abuse and/or neglect returned similar positive, yet modest results.[134] This analysis suggested reduction in manifestation of abuse, along with an increase of positive risk reducing behaviours such as parent–child interaction.

The Cochrane Report exploring school-based programs to prevent child sexual abuse (teaching school children about child sexual abuse and how to protect themselves) found some enhancement of children's knowledge of abuse and their protective behaviours.[135] The applicability of these studies to the Australian context needs further investigation – most of the studies were conducted in North America, there was no long-term follow-up, and several studies reported harm such as increased anxiety.

Refer to the adults surviving child abuse (ASCA) factsheet for GPs in the *Further information* section at the end of this chapter. It is useful to identify local services and have their details on hand to refer patients – in particular, parenting and home visit programs in your local area. It is also beneficial to work collaboratively with the local maternal and child health nurse.

Identification

Identifying suspected child abuse involves detection and response.

This is a very sensitive issue in general practice consultations for a number of reasons:

- children do have accidents, and frequently have bruising on their bodies
- children usually attend with other family members, for example, parents
- children may present for a reason unrelated to abuse, but the GP may suspect abuse for other reasons.

Types of presentations in general practice

GPs are often the first point of contact for families under stress and for children at risk of abuse. It is important for us to remain aware of the possibility of abuse when caring for children, particularly children with emotional or behavioural issues or unexplained injuries, or when you have identified a woman is experiencing intimate partner abuse.

Within a consultation it can be very difficult to know definitively that the root cause of the presentation is abuse or neglect. The family may also be actively trying to hide the abuse or neglect.

Child abuse can present in myriad ways and these effects vary from child to child. While some children may present with bruising or injuries that raise suspicion, most won't. In the majority of children, direct physical injuries cause less morbidity than the long-term effects of violence on the child's neurological, cognitive and emotional development and health.[136]

Children in families where one or both parents are abusing alcohol or other drugs will have a high incidence of neglect and of other forms of abuse.[125,137]

Possible presentations in children and presentations in young adults

A recent meta-analysis of the health consequences of non-sexual child abuse provides the evidence for the health effects[136] (*Table 9*).

Table 9. Summary of the strength of the evidence for related health outcomes[136]

Robust evidence	Weak/inconsistent evidence	Limited evidence
Physical abuse		
Depressive disorders	Cardiovascular diseases	Allergies
Anxiety disorders	Type 2 diabetes	Cancer
Eating disorders	Obesity	Neurological disorders
Childhood behavioural/conduct disorders	Hypertension	Underweight/malnutrition
Suicide attempt	Smoking	Uterine leiomyoma
Drug use	Ulcers	Chronic spinal pain
Sexually transmitted infection (STI)/risky sexual behaviour	Headache/migraine	Schizophrenia
	Arthritis	Bronchitis/emphysema
	Alcohol problems	Asthma
Emotional abuse		
Depressive disorders	Eating disorders	Cardiovascular diseases
Anxiety disorders	Type 2 diabetes	Schizophrenia

Table 9. Summary of the strength of the evidence for related health outcomes[136]		
Robust evidence	**Weak/inconsistent evidence**	**Limited evidence**
Suicide attempt	Obesity	Headache/migraine
Drug use	Smoking	
STIs/risky sexual behaviour	Alcohol problems	
Neglect		
Depressive disorders	Eating disorders	Arthritis
Anxiety disorders	Childhood behavioural/conduct disorders	Headache/migraine
Suicide attempt	Cardiovascular diseases	Chronic spinal pain
Drug use	Type 2 diabetes	Smoking
STIs/risky sexual behaviour	Alcohol problems	
	Obesity	

For more information, view this short presentation by Dr Vince Felitti MD, which provides a summary of the important links between childhood adversity and poor adult health:
www.youtube.com/watch?v=GQwJCWPG478

Barriers to disclosure

There are many barriers to disclosure of child abuse, including:

- the child fearing that they will not be believed[138]
- the child assuming abuse is a normal life event[139]
- wishing to protect the perpetrator as they may enjoy certain aspects of the relationship with them[138,139]
- being threatened not to tell[138,139]
- fearing negative consequences for themselves and their families, particularly their mother
- experiencing disbelief, confusion, and unreality as they try to understand the trauma they have experienced in a context where their lives continue as if nothing has happened[139]
- a lack of linguistic abilities to express the abuse or the cognitive ability to understand completely what has happened[119,139]
- the perpetrator deliberately provoking confusion, where children may dismiss early incidents as 'a dream', 'a nightmare', or just their imagination[139]
- the relationship between child and perpetrator[119,140]
- the gender and ethnicity of the child – for example boys may be less likely to disclose sexual assault[119,139]
- a perceived lack of opportunity to bring up abuse[138]
- a feeling of being responsible for the abuse or feeling guilty for not telling sooner.[139]

All abuse is difficult for children to disclose, in particular sexual abuse.[139]

In relation to sexual abuse, the perpetrator is likely to have 'groomed' or threatened the child, which makes it difficult for them to reveal the abuse. Younger children may not be able to identify what is happening to them as abuse. Some older children think that what is happening to them happens to everyone, as they may have little contact with other families in order to make a comparison.

In identifying sexual abuse, GPs must remember the underlying thread of 'lack of consent'. The child or young person may be forced to participate or cannot properly judge what their participation means. The display of pornography, or an adult exposing themselves to a child is considered abuse, despite the fact that this act may not contain any physical contact with the perpetrator.

Safe ways to ask families

Where you are unsure whether abuse is taking place, but concerned about a child or their family, you may need to seek external assistance from an appropriate service that safeguards GPs or assists GPs troubled by doubts whether the relevant circumstances call for mandatory reporting. In some Australian states there are resources that may be accessed by the person abused, or by a GP (refer to *Resources*).

Children need to be asked questions that are age appropriate and asked in a safe environment. Children often try to please adults and may give GPs the answer that the child thinks the GP wants. It is important to have the confidence to explore the possibility of child abuse but also to know the limitations and not to ask too many questions. An in-depth history should be left to forensic medical officers and trained social workers. Questions phrased in the third person can be very valuable in exploring the possibility of child abuse.

It is also important to remember that many of these children's mothers will be victims of intimate partner abuse, although at times they may also be the perpetrator. In a case where mother and child are both being abused, both need to be supported, believed, not blamed and their safety ensured. Recommendations vary on the subject of what age a child can be so that it is safe to discuss abuse issues in front of them with another adult. Many experts think that the child needs to be pre-verbal to ensure safety from the perpetrator. On occasion it may be necessary for us to ask the child about abuse without the primary carer present.

Where the child is at risk, mandatory reporting is required as a matter of law.

Examining children

When you examine children, it is important to talk to them. Explain that you are only examining them because you are a doctor and to help them to understand why they are sick; other adults are not allowed to do the same things.

Questions you can ask during the examination include:

- *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 another child 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 lots of things, like when they have a fight with their friend, or they feel their teacher was mean to them. Kids also worry about things in their homes, 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 you can ask older children:

- *How good are the good days? What makes them so good?*
- *How bad are the bad days? What makes them bad?*

Advice from an experienced colleague or child abuse service can also be helpful and this sharing of information may resolve the dilemma in circumstances of doubt.

Provided there is no disclosure of patient identity, there is no impediment to seeking assistance, in confidence, without patient consent.

In rural and remote areas there may be fewer services available and issues of confidentiality are very important and need to be meticulously implemented. However there is the opportunity for the community to come together and devise ways of dealing with child abuse issues. This takes leadership and commitment but also provides the chance for community empowerment.

Mandatory reporting

GPs have a responsibility to report child abuse or neglect. The laws are different in every state and territory. If you need advice you can ring your local reporting number and discuss your concerns without revealing personal details. Your medical defence organisation may provide other help and advice. Refer to *Table 10* for the key features of 'state of mind' that activate the duty to report and the extent of harm.

The family, or the child's needs, may require services additional to medical assistance, such as counselling or family services, or they might be managed appropriately in another way. Mandatory reporting does not affect a GP's continuing professional obligation to the patient.

Management

GPs have a role in prevention, identification, mandatory reporting and helping to minimise the long-term effects of abuse.

Minimising the long-term effects of child abuse

The evidence-based 'team approach' across disciplines to the prevention and management of child abuse has improved care over the last 30 years.[7]

Preliminary studies suggest that for abused children, foster care may be more beneficial than home-based care.[7] Kinship care is another option for children unable to remain at home.

In all societies there are many children affected by sexual abuse. The long-term effects will vary and can result in ongoing behavioural and psychological problems which can still be an issue in adulthood. There has been a Cochrane Review: *Cognitive behavioural interventions for children who have been sexually abused*.[141] The studies show that CBT can be helpful to these children but the results were generally modest. Some of the issues experienced by these children were depression, post-traumatic stress and anxiety. Children who have been abused need to have these issues addressed in a relational intervention where they can be believed, supported and helped in a safe environment.

In order to manage child abuse it is important to work with the practice to identify:

- early childhood services doing home visits
- parenting programs using Triple-P
- drug and alcohol services for parents in need of these services
- allied health providers who provide CBT for children who have been sexually abused
- domestic violence workers who can work with both the mother and the children.

A further way to source services is to ask your local primary healthcare organisation for a list of services in your area.

In rural and remote areas these services may not be readily available. You may need a response from the local community, or to ask for services to be provided or for local health professionals to receive further training.

Conclusion

This chapter has described the prevalence and major health effects of child abuse. GPs have a role in prevention, detection, mandatory reporting and minimisation of the long-term impacts of child abuse. GPs are ideally placed, as they see children frequently. There is good evidence that prevention through parenting training programs and nurse home visitation is effective.

Table 10. Key features of legislative reporting duties: 'state of mind' that activates reporting duty and extent of harm[142]

Jurisdiction	State of mind	Extent of harm
ACT	Belief on reasonable grounds	Not specified: 'sexual abuse ... or non-accidental physical injury'
NSW	Suspects on reasonable grounds that a child is at risk of significant harm	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'
NT	Belief on reasonable grounds	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child
QLD	Becomes aware, or reasonably suspects	Significant detrimental effect on the child's physical, psychological or emotional wellbeing
SA	Suspects on reasonable grounds	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"
TAS	Believes, or suspects, on reasonable grounds, or knows	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
VIC	Belief on reasonable grounds	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
WA	Belief on reasonable grounds	Not specified: any sexual abuse
Australia	Suspects on reasonable grounds	Not specified: any assault or sexual assault; serious psychological harm; serious neglect

Source: Adapted from relevant state and territory legislation.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- Oates, RK. Role of the medical community in detecting and managing child abuse. Med J Aust 2014, 200:7–8.
- *Ampe akelyernemane meke mekarle – Little children are sacred.* Available at www.inquirysaac.nt.gov.au/pdf/bipacsa_report_summary.pdf
- McCutcheon LK, Chanen AM, Fraser RJ, Dew L, Brewer W. Tips and techniques for engaging and managing the reluctant, resistant or hostile young person. Med J Aust 2007;187:S64 –7.
- *Never shake a baby* – the Children, Youth and Women's Health Service has produced this guide that explains why you shouldn't shake a child and gives alternative methods to quieten a child. Available at www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=305&id=1913
- *Everyone's got a bottom* by Tess Rowley and illustrated by Jodi Edwards is a good book to consider having in the practice waiting room. It is available from Family Planning Queensland at www.fpq.com.au/publications/teachingAids/everyones_got_a_bottom.php.
- Specific information for children of Aboriginal and Torres Strait Islander descent and their communities is available: *Through young black eyes: A handbook to protect children from the impact of family violence and child abuse* can be obtained from the Secretariat of National Aboriginal and Islander Child Care at www.snaicc.org.au/tools-resources/dsp-shop.cfm?loadref=141&id=55933BE0-2219-A8B0-B6948391962AFAC3
- The Convention on the Rights of the Child is an interesting example of international responses to child abuse. Available at www.unicef.org/crc/files/Implementation%20Handbook%203rd%20ed.pdf
- *Benefits of programs: A detailed description* by Professor Louise Newman and Peta Murcutt, available at www.abc.net.au/radionational/programs/lifematters/trauma-and-kids/4896956
- *ASCA factsheet for general practitioners: Understanding complex trauma*, available at www.asca.org.au/Portals/2/ASCA Fact Sheet_GPs.pdf

Chapter 7. Young people and bullying

Key messages

- Bullying is a common factor in the life of many Australian children and young people. Bullying is physically harmful, socially isolating and psychologically damaging[143]
- Young people with special needs, eg autism spectrum disorder (ASD) or other disability, are particularly at risk[144]

Recommendations

- Health practitioners should ask young patients with chronic physical, social or mental health indicators about their experience of bullying[143] **Level III-2 C**
- Health practitioners should understand that school programs can be very effective to deter and deal with bullying if supported across the whole school[145] **Level I A**

Introduction

Bullying can be broadly defined as:

> *acts intended or perceived as intended to cause harm. It is unwanted, aggressive behaviour among children that involves a real or perceived power imbalance. The behaviour is often but not always repeated, or has the potential to be repeated, over time*[146–149]

Cyberbullying is defined as:

> *repeated, harmful interactions which are deliberately offensive, humiliating, threatening and power-assertive*[148, 149]

Cyberbullying interactions are enacted using electronic equipment, such as mobile phones or the internet, by one or more individuals towards another. Cyberbullying can take the form of instant or email messages, images, videos, calls and also the exclusion or prevention of someone being a part of a group or an online community.[150]

Sexting is the act of:

> *creating, sharing, sending or posting of sexually explicit messages or images via the internet, mobile phones or other electronic devices by people, especially young people*[151,152]

Intimate images taken with consent during a relationship may, when that relationship falters, be distributed to others for the purposes of humiliation and denigration of reputation, which raises moral, ethical, legal and parenting concerns. This is particularly worrisome because the behaviour occurs at a significant period in young people's lives, just as they are developing their sexual identity and engaging in early romantic relationships.

It is important to understand that there may be legal implications and that there are laws in place that address the issue of sexting. As Butler et al have noted, 'Schools should be aware of the potential for cyberbullying to amount to criminal behaviour, so they may better gauge when it may be appropriate to contact police.'[153] For example, under the *Criminal Code Act 1995* (Commonwealth) the misuse of telecommunications to menace, threaten or hoax other persons is potentially a criminal act.

Bullying can be characterised by its mode (for example – online, in person), type (verbal, relational), and the environment (school, home). The relationship context can be either explicit – sibling, dating partner, friend or acquaintance – or implicit, due to differences in popularity, economic status, academic status that may not be clearly apparent.[154]

It is worth noting that bullying behaviour doesn't have to be repeated to have an impact; some isolated violent bullying situations can have a lasting impact. A further challenge is that there is usually an imbalance of power between the victim and the bully. On occasions, the power differential can be difficult to define or identify.[146–149]

Social norms also influence whether the behaviour is classified as bullying – for example, until fairly recently, many regarded sibling bullying as the normal 'rough and tumble' of growing up. This is despite the emerging evidence of both the extent and negative impact of sibling bullying which has been shown to compound school and other forms of bullying.[155–157] Other social norms may make it difficult to distinguish between 'healthy competition' and physicality and bullying. In these situations, the repetition of such actions would tend to skew them towards bullying.

Prevalence

Bullying is a significant children's health issue for GPs and the community. It has a high annual prevalence with up to 56% of young people involved either as victim, perpetrator or both.[156,158–162] These figures may be underestimates as there is often a reluctance to disclose.[163–165]

The pattern of bullying varies, with verbal bullying occurring more frequently than physical or cyberbullying. Typically, there are repeated incidents over a period of time.

Cyberbullying is emerging as a significant new form as bullies move from 'behind the scenes to behind the screens'. The recent emergence of the phenomenon of 'sexting', involving the sending and/or exchange of sexually explicit images by electronic means, is of concern to educators, healthcare providers, lawmakers and police.

The prevalence of cyberbullying and sexting has been hard to quantify given the variability in the definition. A national survey in 2010 revealed 59% of teenagers have sent sexually suggestive emails or messages.[151] A government study found 7–10% of Year 4 to 9 students reported they were bullied by means of technology over the school term.[162]

The probability of any one child being victimised is directly related to the number of risk factors she or he experiences.[166] Children with special needs are particularly vulnerable to bullying with, in one study, over 60% of children diagnosed with ASD reporting they had been bullied.[167,168]

It is unclear whether the prevalence of bullying is higher in rural areas although the consequences may be worse due to:[169]

- greater difficulties in accessing support services
- issues surrounding confidentiality, especially if there is a mental health component
- bullying and harassment potentially compounding other forms of discrimination.

The role of GPs

Prevention

GPs can be advocates in the school environment by voicing support for school anti-bullying programs and encouraging the parents of both bullies and victims to contact the school regarding support and additional counselling. GPs can also advocate through professional associations using policy, position statements, professional education or within local communities as opinion leaders and local champions.

The ability to cope with bullying is enhanced by involving caring adults, teaching appropriate cognitive and social skills and providing strong social support systems such as whole-of-school programs to deter and deal with bullying.

School programs can be very effective if supported across the whole school.[145,170,171] Some have had good evidence of impact – for example, the KiVa school-based anti-bullying program (www.kivaprogram.net/program).[173–175]

Research is now identifying factors that may be associated with the increased likelihood that children will engage in bullying others. For example, parental anger with their children is associated with the increased likelihood of children engaging in bullying behaviour, while parental communication with their children and meeting their child's friends is associated with a lower likelihood of children bullying others.[166] In relation to young people who are victimised, recent research suggests that interventions are more likely to be successful if they focus on both the psychosocial skills of adolescents and their relationships with their family.[173]

Identification

Adverse health impact of bullying

There is a considerable burden of illness in both the short and long-term for both victims and bullies.[155,176–182]

The impact of cyberbullying on mental health and emotional response is only just beginning to be understood.[183–185] It has been suggested that it will be significant due to the 24 hour nature of it, the anonymity aspects and the broader audience that can be targeted through the visual electronic media.

Bullying has a consistent, strong and graded association with a large number of physical and psychological symptoms.[143,158,178,179,186–190] In the short-term, it is associated with:

- physical health/symptoms
  - injury, headaches, abdominal pain, repeated sore throats, recurrent colds, breathing problems
- social health issues
  - loneliness and isolation though a more limited ability to make friends
  - lack of assertiveness, social immaturity
  - decline in school performance/functioning, absenteeism from school/ home, withdrawal/avoidance
- mental health problems
  - psychosomatic symptoms, eg bedwetting, sleeping problems, abdominal pain, difficulty concentrating, dizziness, poor appetite, and feelings of tension or tiredness
  - anxiety, depression, increased suicide ideation and suicide
  - eating disorders, smoking, drug and alcohol problems
  - low self-esteem/withdrawal
  - behavioural symptoms, eg aggressiveness, self-harming.

In the longer term, children who are bullied have:

- poorer quality of life[191,192]
- higher rates of anxiety and depression[178,193]
- increased smoking and substance abuse[194]
- increased likelihood of psychotic symptoms.[195]

Bullies also experience negative long-term impacts including:

- elevated rates of health-risk behaviours such as smoking and excessive drinking[194]
- increased risk of later offending[196]
- increased anxiety, depression, and among males, increased suicidality[178]
- increased perpetration of intimate partner abuse as an adult.[197]

Box 4. Some myths about bullying

Myth	Reality
Bullying only happens at school	• Bullying is a broader social problem that often happens outside of schools[148,198] and in homes[156] • Physical aggression/bullying between siblings has been reported to be the most common form of family violence and is experienced by up to half of all children in the course of a year[157]
Most bullying is physical	Other forms of bullying are collectively more common: • cyberbullying: email, mobile phone, texting and social networking • psychological bullying: threatening, manipulation and stalking • social/covert/relational: lying, deliberately excluding, spreading rumours
People who bully are insecure and have low self-esteem	• Many people who bully are popular and have average or better-than-average self-esteem.[199] They often take pride in their aggressive behaviour and control over the people they bully • People who bully may be part of a group that thinks bullying is okay. Some people who bully may also have poor social skills and experience anxiety or depression. For them, bullying can be a way to gain social status[200] or power over others[201]
Nothing can be done at schools to reduce bullying	• School initiatives to prevent and stop bullying have reduced bullying by 15–50%.[145,170,171,175,202] The most successful initiatives involve the entire school community of teachers, staff, parents, students and community members
Kids grow out of it	• For some (up to 50%), bullying continues as they become older.[203] Unless someone intervenes, the bullying is likely to continue and, in some cases, grow into violence and other serious behavioural problems. Children who consistently bully others often continue their aggressive behaviour through adolescence and into adulthood[178,196] • While bully/victim numbers appear to decrease during adolescence; sibling bullying remains relatively stable over time, at least between 10 and 15 years of age[204]
Parents always know when their child is being bullied	Adults (including teachers) often do not witness bullying despite their good intentions[164,205]

For more information about myths refer to www.stopbullying.gov/resources-files/myths-about-bullying-tipsheet.pdf and www.prevnet.ca/bullying/bullying-facts

GPs can identify cases, or ‘case-find’ by thinking about whether bullying is occurring in typical presentations as outlined above.[164,165,206–208]

You have the opportunity to identify and support children who have been bullied through a careful history taking (refer to *Box 5*) followed up by counselling and support. It is important to listen and believe.

Box 5. Questions to consider

General

Many people experience bullying at school or via the net or phone or at home. Has this ever happened to you? How often? How long has this being going on for? What happens? How do you feel? Have you told anyone about it? Who can you go to for help if you are being bullied?

School

How is school going? What do you like about school? What are you good/not good at?

How many good friends do you have in school? How do you get along with others at the school and the teachers? Do you ever feel afraid to go to school?[209]

Up to 60% of victims of bullying have seen a GP in the last 12 months with a range of somatic or other symptoms. GPs should ask about bullying when children and adolescents present with unexplained psychosomatic and behaviour symptoms; when they experience problems at school or with friends; if they begin to use tobacco, alcohol, and other drugs; and if they express thoughts of self-harm or suicide.

Management

Support includes acknowledging that:[165,207]

- they have shown courage in coming forward and talking about it and that they don't have to face it on their own
- it's not their fault
- all students have a right to learn in a safe environment
- they should not tackle the bully by themselves
- they should tell an adult or someone in authority.

GPs can be advocates for the child who is bullied.[165,206–208,210] This can be done within the consultation by getting the family involved and encouraging them to take an active role in monitoring their children and engaging them in positive school and community activities.

Conclusion

In summary, the issue of school bullying in all its forms is now on the national and international research and policy agenda for all those concerned with the health, wellbeing and education of young people (refer to www.caper.com.au and/or www.flinders.edu.au/ehl/swapv/swapv_home.cfm).

As noted in this chapter, the matter of school bullying has been identified as a significant public health issue. GPs who are interested in treating the child and family unit as a whole are at the forefront in advocating for the wellbeing of young people. The following case study highlights the significant role of GPs in addressing and treating bullying.

Case study: Kristy

Kristy is 11 years old. She attends with her mother, Liz, holding out her arms and complaining of painful wrists that hurt when she moves them. The doctor does not know the family particularly well. Kristy has attended the practice intermittently for several years. It is only after the consultation that the doctor discovers that there has been a prior consultation where anxiety has been an issue. She is clearly perfectly well today – a bright young person who, while a little subdued, is easy to get on with. She allows the doctor to move her wrists passively through the full range of movements without wincing.

The doctor then asks about any stress in the background. Her mother discloses a torrent of troubles caused by the out-of-control behaviour of Kristy's teenage brother Sam. The aggression, the opposition and the teasing of Kristy has escalated to an intolerable level.

The doctor has not seen Sam – a situation that appears likely to change.

In answer to a direct question, her mother says there has been recent bullying at school but that this has been attended to.

Given Kristy's early adolescent stage of development and the 'concrete thinking' she displays that is typical of early adolescence, the doctor concludes this 10-minute consultation with some concrete declarations in conversation with Kristy.

- Your body is very healthy (Kristy smiles).
- The pain in your wrists is caused by the stress your brother is causing you and your family. The brain makes stress chemicals that can cause pain. Your mum is going to look after you and your mum and I are going to have a meeting to plan how to get help.

Kristy and her mother leave with an apparent sense of purpose and relief. A further – and long – consultation is planned with Kristy's mother alone. This consultation will brainstorm ways of improving family functioning and ways of minimising the impact of the current state of affairs on Kristy. The doctor needs to explore Kristy's social and academic functioning and understand the nature of the bullying at school and at home, mentioned but not closely examined today. This will also involve planning an assessment of Sam's issues with a view to intervention.

Skimming the notes afterwards the doctor discovers that she has seen Kristy a year earlier with weekday morning headaches but no school absence. Factors that emerged at the time included the mother's own history of anxiety and the fact that Kristy had been excluded from socialising with a particular group of girls in the playground. It is also evident that Kristy had not been presenting recurrently with unexplained physical symptoms – a red flag for social or emotional distress. So that was promising.

Reflections

The risk of medicalising this presentation was avoided.

The consultation satisfies the important principle 'to consider and address biomedical and psychosocial issues concurrently'.[211]

This is all done in just under 10 minutes.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- National Safe Schools Framework – http://education.gov.au/national-safe-schools-framework-0
- Bullying. No way! – http://bullyingnoway.gov.au
- Child and Adolescent Psychological and Educational Resources – www.caper.com.au
- Promoting relationships and eliminating violence network (PREVnet) – www.prevnet.ca
- Stop Bullying – www.stopbullying.gov
- National Centre against Bullying – www.ncab.org.au
- Kidsmatter: a nationally recognised resource for addressing the mental health of young people – www.kidsmatter.edu.au
- Australian Medical Association (AMA) Guidance for Doctors on Childhood Bullying – https://ama.com.au/ama-guidance-doctors-childhood-bullying
- Student Wellbeing and the Prevention of Violence (SWAPv), Flinders University Research Centre – www.flinders.edu.au/ehl/swapv/swapv_home.cfm

Chapter 8. Adult survivors of child abuse

Key messages

- Patients abused as children often experience a diverse range of ongoing health problems, including mental and physical health problems, which increases their healthcare utilisation rate compared with those who have not been abused[136]
- Many patients have never told anyone about their abuse, or if they have, have not been believed. Many also have not made a link between their current health issues and their childhood abuse[212]

Recommendations

- Health practitioners need to recognise that child abuse is associated with a higher incidence of comorbidity: mental health issues, suicidality, drug and alcohol problems and chronic disease in adults[136] **Level 1 A**
- A trauma-informed approach to care across all human and health sectors services, as well as trauma specific services, may assist patients who have experienced abuse as children[3] **Practice point**

Introduction

Child abuse has been outlined in detail in *Chapter 6*, including definitions, health consequences, and identification and management including mandatory reporting. Although the majority of child abuse is by someone known to the child, a number of state investigations into institutional child abuse and the National Royal Commission into Institutional Responses to Child Sexual Abuse have established that these issues have stayed hidden for long periods of time. It is apparent that many survivors have been unable to disclose, and if they have were often not believed either as a child or an adult. It is also clear that child abuse often occurs in multiple forms concurrently and frequently has long-term effects on survivors.

This chapter explores the possible presentations of adults in general practice who were abused as children, including physical, emotional and sexual abuse, neglect and growing up in situations of domestic violence. Research suggests that adults abused as children are at increased risk of further victimisation as adults.[213]

Experiences of sexual abuse as a child can affect later adult offending or victimisation. One study that examined the relationship between child sexual abuse and subsequent criminal offending and victimisation found that both male and female child sexual abuse victims were significantly more likely than non-abused people to be charged for all types of offences, in particular violence and sexual offences.[213]

Prevalence

There has been no national, methodologically rigorous study of the prevalence or incidence of child abuse and neglect in Australia as there is currently no consistency in data collection. There are, however, a number of recent studies that consider one or two abuse types in detail, or have superficially measured all individual abuse types.

Prevalence estimates for physical child abuse range from 5% to 18%, with the majority of studies finding rates between 5% and 10%. Studies that comprehensively measured the prevalence of child sexual abuse found that:[214–224]

- women had rates of 4.0–12.0% for penetrative abuse and 13.9–36.0% for non-penetrative abuse
- men had rates of 1.4–8.0% for penetrative abuse and 5.7–16.0% for non-penetrative abuse.

Rates of neglect of both genders, along with physical and emotional abuse in general practice populations, are less researched.

The Australian Institute of Health and Welfare indicates that, in 2011–12, there were 252,962 notifications involving 173,502 children in Australia, a rate of 34.0 per 1,000 children. Of the notifications, there where 48,420 substantiated notifications of child abuse in Australia.[120] 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 after-effects of their abuse.

Children are most likely to be abused within the family or by people known to them. The ASCA support line has documented 4376 cases over 3.5 years, with 1686 of these recording the relationship of the perpetrator to the survivor. It was found that 64% of callers were abused by their immediate family, 19% by extended family, 10% by a family friend, 21% by perpetrators in institutions (for example religious, educational, in care and health institutions), 2% by strangers and some by multiple perpetrators.[225]

The way in which an adult may perceive their childhood abuse experiences will vary greatly depending on a range of factors. The needs of each patient will therefore also differ. Anecdotally, it has been suggested that some adult survivors appear to have experienced little or, at times no effect, although many will experience a profound effect on many aspects of their lives, without the right treatment, throughout their lifespan. Many elements influence how well a survivor copes, including the type/s of abuse experienced, frequency, duration, family life, response to disclosure, and adult experiences of abuse and violence.

The role of GPs

Child abuse in all its forms often has long-term sequelae and health implications. It is important to consider the possibility of prior trauma or abuse in a diversity of presentations in general practice. Most patients will be unlikely to disclose their traumatic experience to GPs unless they know how to ask. To optimise patient care, GPs 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.[212]

In an effort to establish the prevalence of adverse health outcomes in relation to childhood abuse, a 2012 systematic review identified 124 studies that investigated the relationship between child physical abuse, emotional abuse, or neglect and various health outcomes. The meta-analysis provides suggestive evidence that child physical abuse, emotional abuse, and neglect are causally linked to mental and physical health outcomes.[136]

For example, emotionally abused individuals are three times more likely to develop a depressive disorder than non-abused individuals. Physically abused and neglected individuals also had a higher risk of developing a depressive disorder than non-abused individuals. Other mental health disorders associated with child physical abuse, emotional abuse or neglect included anxiety disorders, drug abuse and suicidal behaviour. This group of adult survivors also had a higher risk of sexually transmitted diseases and/or risky sexual behaviour.[136]

Some survivors who have been abused as a child may adopt strategies to enable them to cope. Some of these – for example, smoking, alcohol and drug abuse, physical inactivity and overeating become risk factors for adult health issues. Other strategies can include psychological mechanisms such as dissociation (a defence mechansim which allows the survivor to compartmentalise their lives), or behavioural disturbances such as self-harm. In the long-term, these strategies are often not constructive and contribute to long-term morbidity and mortality. When GPs are not educated about these strategies, they often perceive the patients as being manipulative or attention seeking. A trauma-informed lens enables GPs to understand patients' presentations in the context of their lived experience and respond appropriately.

Child abuse has also been correlated with a diverse range of ongoing health problems.[136,226] Patients who are survivors of child abuse may present to general practice in some of the following ways, illnesses which have been found to have a much higher incidence:[136,226,227]

- 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.

Major illnesses, including cancer, chronic lung disease, fibromyalgia, irritable bowel syndrome, ischaemic heart disease and liver disease have also been linked to childhood abuse. The increased incidence of smoking is a confounding factor for these diseases.[136] Women with a history of child sexual abuse are also more likely to utilise medical care at a greater frequency than women who have not been abused.[226] They may have complicated presentations and not respond easily to treatment.

Research shows that survivors of child abuse may experience flashbacks of prior traumatic events at any time during their adult life. Trigger factors may include:

- marriage
- the birth of a child
- themselves or their child reaching a certain age
- the death of the perpetrator (eg family member)
- watching a television program relating to incest
- a particular place or smell.

Flashbacks may present associated with:

- sleep disturbances
- depression
- nightmares
- perceptual disturbances, and
- anxiety at times of sexual activity.

Experiences of physical, sexual, emotional abuse or neglect can result in low self-esteem and difficulties with trust, and impinge on the ability to form close relationships. Survivors may fear for their safety and have difficulties caring for themselves. Asking about family relationships when they were children and the abuse of alcohol by their parents may provide clues.

Disclosure only occurs in a relationship of trust.[228] However, trust may take some time to develop as adult survivors of child abuse have been previously abused rather than cared for in prior relationships of 'trust'. Patients who have been abused tend to have a very negative sense of self. This makes it more difficult for them to care for themselves, seek help and to follow advice. GPs may be able to help by providing a safe space in which they can discuss their needs and which over time, can help establish trusting relationships.

It is of course crucial to always treat these patients with dignity and respect, provide them with a sense of hope and optimism and help them improve their capacity for self-care by helping them to achieve a healthy and safe lifestyle. Sometimes this will additionally entail referral to a health professional with specialist skills in supporting adult survivors.

To assist with this education, the RACGP has produced a DVD, The hidden factor: *the effects of child abuse on adults. A resource for GPs and other health professionals*. In this DVD, three women tell their stories of abuse in order for doctors and other health professionals to have a better understanding of the factors that helped with the healing process. The DVD is available from the RACGP (refer to *Further information*) and can be downloaded from www.racgp.org.au/guidelines/abuseandviolence/hiddenfactor

Management

ASCA has produced *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*,[230] which will assist you to understand the presentations of patients who have experienced child abuse and respond appropriately. The *Practice Guidelines* contain two sets of guidelines, which have been officially recognised as an accepted clinical resource by the RACGP. Available at www.asca.org.au/guidelines

The first presents the principles of trauma-informed care, which work from a premise of 'do no harm', focusing on what happened to the person rather than what is wrong with the person. Implementing trauma-informed care involves working in the domains of:

- **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 second presents the principles of clinical treatment of ASCA, stressing the importance of establishing safety as a core part of any therapeutic work.

There are also the *Australian Guidelines for the Treatment of Acute Stress Disorder and Post Traumatic Stress Disorder* (refer to *Further information)*.

Helpful ways of working with survivors of sexual abuse

In the report, *It's still not my shame: Adult survivors of child sexual abuse* (visit www.whs.sa.gov.au/pub/Its_still_not_my_shame_report.pdf), semi-structured interviews were conducted with five target groups including survivors (28 individuals), service providers (67 individuals) and service managers (17 individuals).[229] These were conducted in metropolitan and country areas in South Australia. A significant number of survivors spoke about the usefulness and importance of survivor groups in addressing some of the effects of the abuse. They suggested that these groups helped to reduce the sense of isolation, promote a shared understanding and challenge self-blame.

Other helpful practices included:

- being believed
- not being judged
- working from a narrative approach
- availability of services outside of office hours (eg groups in the evenings)
- assurance of confidentiality
- complementary therapies – for example, music and art therapies.

Unhelpful ways of working with survivors

It was not uncommon for survivors to have negative experiences in accessing assistance. Commonly reported issues were:

- not being believed or listened to
- lack of trained counsellors
- time constraints
- the worker presenting as the only expert
- being only medicated for the presenting issue – for example, depression
- being blamed for the abuse
- gender/age barriers imposed by agencies for accessing a service
- sexuality barriers, particularly for gay and lesbian survivors
- lack of continuity of workers.

GP ongoing care

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. Appropriate treatment options to consider with the patient may include individual counselling/therapy, referral to specialist service, therapeutic groups and self-help groups.

It is important to note that certain procedures and investigations – for example, Pap smears in some women who have been sexually abused – may be especially challenging for these 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 symptoms of possible prior abuse need to be kept in mind, as does the need to minimise any potential for re-traumatising patients with particular sensitivities.

Boundary issues

Patients abused as children have often had their boundaries violated. All workers and practitioners engaging with survivors, including GPs, need to model clear boundaries. They need to do what they can to make their patients feel and be safe and this means being very respectful of the patient's physical and emotional space. Should they inadvertently intrude on their patient's boundaries, they may replicate aspects of prior abuse and this can be re-traumatising for survivors. Maintaining the role as a GP while the patient seeks help from the counsellor, psychologist or psychiatrist further models good boundaries and helps provide the comprehensive model of care many survivors need.

GPs can make an important contribution, but may not always be able to provide everything the patient needs. Sometimes they will see patients who are in counselling or who are in need of 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.

Keep in mind that resources will vary from one area to another and it is often difficult to find sufficient, adequate or appropriate resources. Information from the ASCA website (www.asca.org.au) or ASCA professional support line on 1300 675 380 may be of assistance.

Referrals could be to:

- another GP with training and experience in supporting adult survivors
- a psychologist or psychotherapist with experience and training in working with adult 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 survivors.

The ASCA professional support line has a referral database of practitioners and agencies with expertise and experience for working with adult survivors of child abuse.

It is important to 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.

The following are two case studies that illustrate these principles

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 is aware that the boss 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 he is not sleeping well and he agrees, saying that he is having difficulties getting off 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 4–5 months ago.

John's father had a problem with alcohol and was violent towards John's mother. He left the family home when John was 9 years old. 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 he was sexually assaulted as a child 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 does not treat the underlying issue and 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 for the symptoms, which, at the time was not identified. John is ultimately helped over a period of time through 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, 21 years of age and living in a country town, presents to your practice requesting a Pap test. While taking a history, Susan reveals that she is dissatisfied with her sexual relationship; 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 Pap test 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.

On examination, Susan is extremely tense and performing the Pap test is difficult. You stop the examination, coming to the conclusion that to proceed would be detrimental to Susan. Susan is upset and once she is dressed you reflect back 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 Pap test. 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 that the memories are unclear. She is obviously distressed.

Most likely diagnosis:

- sexual dysfunction
- child sexual abuse.

Management

Together you explore the options – for example, counselling/therapy (individual or group) and whether she wants to see a counsellor at the sexual assault centre or an allied health practitioner with expertise and experience in supporting patients with past abuse. Should she not be able to see a counsellor/therapist immediately, it would be important to see her regularly in the interim. You could 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. If you were concerned that she was deeply depressed and/or suicidal, you could consider contacting the local crisis team or psychiatric help.

Outcome

Susan opts to go and see a counsellor at the local sexual assault service. As the waiting period is 3 months you offer to see Susan on a weekly basis for support. She agrees to this arrangement and you are able to work with her to help her feel safe and improve her capacity for self-care. Nine months later she comes to see you for a Pap test. 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 Pap smear is indicative of her progress as well. She thanks you for your involvement.

Conclusion

This chapter has outlined the long-term impacts of childhood abuse as they present in general practice, and issues in management. Louis Cozolino has said, 'It stands to reason that the most devastating types of trauma are those that occur at the hands of caretakers'.[230] GPs need to be aware that early trauma in childhood may underlie a diverse number of physical and mental health presentations.
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 survivors.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- ASCA *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. Dr Cathy Kezelman and Dr Pam Stravopoulos. Available at www.asca.org.au/guidelines
- *Australian Guidelines for the Treatment of Acute Stress Disorder and Post Traumatic Stress Disorder*. Available at http://guidelines.acpmh.unimelb.edu.au/adults
- *After Abuse* – this book, written by Victorian psychiatrist Dr Gita Mammen, outlines types of treatment and may be helpful to GPs trying to find an appropriate referral or seeing patients in a counselling role
- Better Access Initiative – the MBS item relating to the GP Mental Health Care Plans may be useful for patients wanting to initiate ongoing mental healthcare. See the RACGP information relating to the scheme, available at www.racgp.org.au/your-practice/mh/better-outcomes
- *The hidden factor* DVD is available to RACGP members for loan, from the RACGP library: email library@racgp.org.au, phone 03 8699 0519 or download from www.racgp.org.au/guidelines/abuseandviolence/hiddenfactor
- Living well – a website for men who were sexually abused as children or who have been sexually assaulted as adults, available at www.livingwell.org.au

Chapter 9. Sexual assault

Key messages

- Sexual assault is very common, with one in five women and one in twenty men having experienced an assault in their adult lives[231]
- Many victims do not report sexual assault; therefore the effects, both physical and psychological, may go untreated[231]
- Particular groups are at greater risk of sexual assault, including young people, those with a disability, and those who have previously experienced abuse[231]

Recommendations

- Offer first-line support to women and men who are survivors of sexual assault by any perpetrator[3] **Practice point**
- Consider and ask about post trauma responses by assessing for mental health problems – acute stress, PTSD depression, alcohol and drug use problems, suicidality or self-harm and offering appropriate support and treatment[3] **Practice point**
- Offer emergency contraception if within 72 hours of assault and offer all women sexually transmitted infection investigation, prophylaxis and treatment as appropriate[3] **Practice point**

Introduction

Sexual assault is any behaviour of a sexual nature that makes a person feel intimidated, threatened or frightened. It is behaviour that is unwanted and uninvited where another person uses physical, emotional or psychological forms of coercion. It is committed more frequently than many people realise and can include any activity from sexual harassment through to life-threatening rape. The latter is defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, and may also include oral penetration.[3]

Every person 16 years and over has the right to choose about participating in sexual activity and must be afforded the opportunity to form free agreement (consent). Free agreement may be negated by many factors, including age, intellectual ability, use of force, threats or fraud, and the effects of drugs and/or alcohol. In some states, including NSW, it is specifically recognised that a person who is substantially intoxicated cannot consent to sex. Sexual assault is always violence – never a legitimate expression of a person's sexuality, love or affection.

Sexual assault is a distressing experience and people who have been sexually assaulted report higher rates of adverse health outcomes.[232–234] It is important to make it clear that sexual assault is never the fault of the victim. Above all sexual assault takes away the person's control over what happens to their body so an understanding of this and a non-judgemental approach is essential. Many survivors access specialist sexual assault counselling when they are ready to do so, and find this helpful. The provision of high quality forensic and medical care is critical to successful patient outcomes following a recent sexual assault. GPs not familiar with forensic care should consult an appropriate sexual assault centre (refer to *Resources*).

GPs may not see many acute sexual assault presentations and may more often be involved in follow-up or other health issues, such as patients asking for emergency contraception or STI checks. The most frequent presentation of sexual-assault-related health issues to GPs will be for physical and other health conditions that are the long-term impacts of child sexual abuse. Commonly, patients may also be experiencing sexual harassment and intimate partner sexual assault.

Prevalence

In 2011, there were 17,238 reports of sexual assault in Australia or 76 reports per 100,000 people.[231] This is likely to be lower than the true prevalence, due to under-reporting.

The age patterns for reports of sexual assault victims in Australia are similar for both sexes, peaking in the 10–14 year age group and then declining, but with rates of assaults against females being consistently higher in all age groups than in males.[231]

For females aged 10–14 years, the rate of sexual assault was 494 per 100,000 population, compared with 96 per 100,000 for males.[3]

The Australian Bureau of Statistics 2012 Personal Safety Survey[10] showed that 17% of women (1,494,000) aged 18 years and over and 4% of men (336,000) aged 18 years and over have experienced at least one episode of sexual assault since the age of 15.

Relationship to perpetrator

Both men and women who had experienced sexual assault since the age of 15 were more likely to have been sexually assaulted by someone they knew, for example a friend or family member, than by a stranger. Specifically, in 2011, almost half of all victims were sexually assaulted by a 'known other' and 31% by a family member. Strangers accounted for only 15% of sexual assaults in 2011.[231]

Using a broad and inclusive definition of sexual coercion, an Australian survey found that 2.8% of men and 10.3% of women reported sexual coercion under the age of 16 years.[214] Only 31.5% of men and 37.9% of women had ever talked to someone about the assault, with the majority talking solely to a friend.[214] A low 2.6% of men and 8.4% of women reported the incident to police. These data provide a small insight into how common sexual coercion is in our society, and how infrequently disclosure is made or legal action instigated.[214]

People who have an increased risk of sexual assault

Certain groups of people appear to experience sexual assault more frequently and sexual assault can be part of intimate partner or family violence:

- Socio demographic risk
  - women[214]
  - young people, aged 10–14 years[231]
  - Aboriginal or Torres Strait Islander peoples.
- Associated health issue
  - alcohol users (either consumed by choice or via spiked drinks)[235]
  - illicit drug users (taken by choice or consumed via spiked drinks), including those injecting[236]
  - mental health issues
  - a disability (including learning difficulties).[237]
- Past history of abuse
  - previous experiences of sexual assault[238]
  - a history of childhood sexual assault (up to one in three women who were sexually assaulted as a child report sexual assault as an adult).[239]
- Living or working in circumstances such as:
  - poverty[239]
  - homelessness or threat of homelessness[240]
  - the sex industry[241]

- custody and incarceration[242]
- travelling or being an international student
- an area of war and civil crisis.[243]

The majority of victims who have been sexually assaulted do not report the incident to the police. They may fear that they will not be believed, or are reluctant to enter a system that they fear will treat them as being responsible for the assault. Reporting of sexual assault is also dependent on the person's previous experience with authority figures. They may also not recognise the incident as an assault or may blame themselves – this may also be influenced by cultural issues (refer to *Chapter 10*).

The role of GPs

GPs need to maintain a high level of awareness that a history of sexual assault can be part of a patient's history. The GP's role includes identification and response to acute assault as needed and management of long-term consequences of sexual assault.

The most prevalent forms of sexual violence are child sexual abuse, sexual harassment and intimate partner sexual assault. Gender attitudes towards women are thought to underlie both intimate partner abuse and sexual violence[3] (refer to *Chapter 2*).

Identification

Types of presentations in general practice

A patient may disclose a sexual assault immediately, or years after the event.

GPs working in casualties and within sexual assault services will be seeing patients presenting immediately or very soon after the sexual assault. They will be trained to provide forensic assessment and to arrange follow-up.

Other presentations to general practice following a recent sexual assault may be for emergency contraception or STI checks. The patient may report that her behaviour was atypical – 'not like me'. If patients present for these reasons, it is important to consider asking gently whether this was consensual sex. Later presentations may be for mental health and other health problems.

Sexual assault is extremely damaging to the victim's sense of safety and self-esteem. It can result in a range of physical, mental and emotional disturbances.

Medical consequences of sexual assault can include:

- immediate effects
  - physical injuries
  - unintended pregnancy, terminations and STIs
  - psychological affects
- long-term effects
  - recovering from sexual assault can take many years. There are many ways of dealing with the experience. Some of the more common presentations are listed in *Table 11*.

Table 11. Common presentations of sexual assault	
• Fear	• Disrupted menstrual cycle
• Self-blame/self-harm	• Exhaustion
• Guilt	• Gastrointestinal problems
• Anger	• Severe sleep disturbances
• Concern about relationships	• Urinary, genital and pelvic pain
• Shame	• Joint stiffness
• Flashbacks	• Other chronic pain states
• Substance abuse	• Eating disorders, anxiety or depression
• Sexual dysfunction	• Ambivalence regarding legal prosecution
• Suicide or suicidal ideation	• A sense of being damaged or contaminated
• Lack of energy	

Any post-assault reactions such as those outlined are important to note – nearly one-third of victims will develop rape-related PTSD. Victims are also three times more likely to experience a major depressive disorder compared to those who have not been sexually assaulted.[245]

Disclosure of sexual assault

Disclosure of sexual assault will rarely be direct and most likely will be couched in vague stories, clues or terms. The disclosure may take the GP by surprise. However, there are a number of strategies that can be used in dealing with a disclosure. Taking victim concerns into account helps to set the scene for the consultation.

In 2013, the WHO released clinical and policy guidelines for GPs responding to intimate partner abuse and sexual violence.[3]

The guidelines recommend that GPs ask women about sexual violence as part of assessing conditions that may be caused or complicated by such violence. These include mental health symptoms, alcohol and other substance use, chronic pain or chronic digestive or reproductive symptoms.

Before asking about violence you need to ensure that it is safe to do so — for example that the abusive partner is not present — and that you have systems in place that promote safety and a referral network. GPs should provide immediate first-line support to women and men who disclose violence, including:

- being non-judgemental and supportive, and validating what the woman/man is saying
- providing practical care and support that responds to her/his concerns, but does not intrude
- asking about their history of violence, listening carefully, but not pressuring the patient to talk
- helping them access information about resources, including legal and other services that the patient might think helpful
- assisting the patient to increase safety for themselves
- providing or mobilising social support.

Survivors' concerns can revolve around issues of confidentiality (especially relatives and friends finding out), issues of blame, shame and medical issues – for example, pregnancy and STIs. The issue of confidentiality can present ethical dilemmas. The GP cannot maintain confidentiality when the safety of the patient, especially a child, is at risk. GPs are mandated to report child sexual abuse (refer to *Chapter 6*). Discussion with a colleague, sexual assault service and/or medical defence organisation may help clarify any dilemmas the GP may have in making such a report.

Management

Management will vary depending on when the assault occurred. It is important to listen to the patient, believe their story, and be non-judgemental and supportive. Management includes:

- being aware of treatment options
- allowing the patient to accept or decline treatment options using shared decision making
- being aware of local resources – for example, sexual assault counsellors, group support
- contraception, STIs and what needs to be offered now
- forensic examination if a recent assault – this needs to be performed by an appropriately trained doctor or nurse as soon as possible after the assault, preferably within 72 hours[246]
- follow-up – patients may need to return for follow-up at 2, 6, and 12 weeks following STI checks
- continuing your involvement as the patient's GP.

Any investigations performed depend on the nature of the assault and prevalence of the STI in the geographic area. Screening recommendations following a recent sexual assault, suggested prophylaxis, and a review program are outlined in *Tables 12–14*.

Information is also available from the *National Management Guidelines for Sexually Transmissible Infections*, www.mshc.org.au/Portals/6/NMGFSTI.pdf

Also check with your local health department or centre for disease control, as there are some variations in treatments in different parts of Australia.

Table 12. Baseline screening recommendations to be considered for STIs

Infection	Test	Site (take according to history)
HIV	HIV antibody	Blood
Hepatitis B	Hepatitis B surface antigen (HbsAg), core antibody	Blood
Syphilis	Rapid plasma regain (RPR) + treponema pallidum Treponema pallidum EIA (TPEIA)	Blood
Chlamydia	Polymerase chain reaction	Endocervical swab, first void urine or high vaginal swab
Gonorrhoea	Polymerase chain reaction or microscopy, culture and sensitivity (MC&S)	Endocervical swab, first void urine, rectal swab* or throat swab*
Trichomonas	Microscopy, culture and sensitivity (MC&S) PCR may be available in some jurisdictions	High vaginal swab

* MC&S only as PCR is not validated for these sites

Source: Mein JK, Palmer CM, et al. Management of acute adult sexual assault. Med J Aust 2003; 178(5):226-230
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Table 13. Suggested prophylaxis to be considered for STIs	
STI	**Treatment**
Chlamydia	Azithromycin (1g orally)
Hepatitis B	Hepatitis B vaccine (1mL intramuscularly [IM])
Gonorrhoea (only if considered high risk)	Ceftriaxone (250 mg IM) **OR** Where local gonococcal sensitivities permit: Ciprofloxacin (500 mg orally) **OR** Amoxycillin (3g orally) and probenecid (1g orally)
Syphilis (if high risk)	Benzathine penicillin (1.8g IM)
HIV (if high risk)	Telephone local infectious diseases or sexual health physician urgently; initial dose must be given within 72 hours, sooner is better
Other STIs	Consult local infectious diseases or sexual health physician

Source: Mein JK, Palmer CM, et al. Management of acute adult sexual assault. Med J Aust 2003; 178(5):226-230
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Table 14. Review program
2–3 days Assess injury healing if relevant
2 weeks Test results, pregnancy testing, healing, coping Follow-up testing: HIV chlamydia, gonorrhoea, trichomonas (depending on local prevalence and practice)
3 months Follow-up serological tests for HIV, hepatitis B virus, syphilis
6 months (if hepatitis C was considered a risk) Follow-up serological test for hepatitis C virus if a test was performed initially Examine and swab, as appropriate, all sites that as a result of the assault are at risk of infection

Source: Mein JK, Palmer CM, et al. Management of acute adult sexual assault. Med J Aust 2003; 178(5):226-230
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Male sexual assault

Apart from the specific gynecological and reproductive health issues for women, men experience many similar emotional and psychological impacts of sexual assault. The principles outlined above are equally appropriate for men.

A common issue for men who have been sexually assaulted is concern about their sexuality. Sexual acts that 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. It is good to take the time with your patient to ensure that they understand the difference.

Male sexual assault may involve more force and violence, and physical injuries may be more severe. Societal and other values may prevent men from disclosing sexual assault; again the strategies discussed earlier can be applied – for example, involvement of police and sexual assault teams.

The decision whether to report an assault to the police is ultimately the victim's. They may want to access help in making their decision through rape crisis and sexual assault centres. A nationwide list can be found at Forensic and Medical Sexual Assault Clinicians Australia (refer to *Resources*). The most important exception to this rule is mandatory reporting for children, in which case GPs are mandated to report child sexual abuse (refer to *Chapters 6* and *13*).

There may be other circumstances where a GP may consider reporting. In cases where the person has an intellectual disability or dementia you may involve the legal guardian, provided they are not the abuser. This may also be a consideration where an ongoing risk is present for the victim. In these circumstances, discussion with a medical defence association and colleagues may be of use before deciding whether to disclose to the police.

Conclusion

Sexual assault requires a multidimensional team of providers to assist survivors on a pathway of healing and recovery. A GP who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night at a district level.

Clinical care of survivors of sexual assault,[3] in addition to first line support – listening, practical care and support, offering comfort – includes using shared decision making by:

- offering emergency contraception – levonorgestrel within 72 hours or IUD within 5 days
- considering offering HIV post-exposure prophylaxis within 3 days for sexual exposure – get advice from an on-call immunologist about the level of risk as soon as possible
- exploring legal and other community services referral
- documentation
- encouraging support within the victim's community.

Watchful waiting in the first 3 months, using regular follow-up and offers of ongoing support, allows the GP to identify the women who become incapacitated during this time by post-rape symptoms. In this case psychological therapies specific to women who have been traumatised may be helpful. GPs should also treat any mental health issues in accordance with best evidence guidelines for depression, alcohol or drug use problems. For women after 3 months, GPs need to assess for a diagnosis of PTSD.

Case study: Sarah

Sarah, 26 years of age, presents to the GP with worries about 'the possibility of vaginal infection'. On careful history taking the story begins to take shape. Sarah worked part time in a club while studying. She reveals that she had gone home with one of the local patrons for a cup of coffee and he had sexually assaulted her. She has been unable to tell anyone since it happened 2 weeks ago.

Diagnosis

Sarah has been sexually assaulted and now has concerns about pregnancy and STI. She appears to have continued to function for the last 2 weeks and wishes to address her feelings and seek help now.

Management

You need to acknowledge that Sarah has been sexually assaulted and then help her deal with the consequences. Is she pregnant? Does she have an STI? All these issues need to be addressed in this and subsequent consultations.

Emotionally, Sarah needs to talk about what has happened to her so that she can perhaps understand and be aware of how this may be affecting her. You should explore the options with Sarah of reporting the incident to the police, being referred to a sexual assault service for counselling, and considering if she could share this with a member of her family or with a friend. Sarah is also given the option of seeing the GP once a week for 4–5 sessions to begin to work through these issues. Consider using a mental health plan and using a mental health referral to someone with appropriate training in this area if this is needed.

Outcome

Sarah is not pregnant nor has she contracted any STIs. She opted to see you for four sessions and was able to discuss this with her family who were very supportive. She may need further help. Other victims may feel more comfortable talking with a counsellor or attending a sexual assault centre.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- *Adult sexual assault* – this article discusses forensic care for those who have experienced adult sexual abuse. Available at www.australiandoctor.com.au/cmspages/getfile.aspx?guid=effc01e4-be26-4703-9145-127f7fed3ca1
- Better Access Initiative – the MBS item relating to GP Mental Health Care Plans may be useful for survivors wanting to initiate ongoing mental healthcare. Available at www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat
- RACGP information relating to GP Mental Health Care Plans. Available at www.racgp.org.au/education/gpmhsc/gps/mhtp

Chapter 10. Specific vulnerable populations: the elderly and disabled

Section 10.1 Elder abuse

Key messages

- Abuse may be physical, emotional, sexual or financial and may include neglect. It can occur in an aged care facility or in the community[11]
- Risk factors for elder abuse can be related to the individual, the perpetrator, relationships and the wider environment[248, 249]

Recommendations

- Elder abuse needs to be considered by any health practitioner seeing elderly patients, as they have a pivotal role in the recognition, assessment, understanding and management of elder abuse and neglect[250] **Practice point**
- If confronted with elder abuse, establish the patient's capacity to make decisions. Help may need to be sought from the person legally responsible for giving consent for their healthcare. If this person is the abuser, then seek help from the appropriate advocacy source in your state or territory[251] **Practice point**

Introduction

Elder abuse is defined as any type of abuse – physical, emotional, sexual, economic – or neglect of people aged 65 years or over, either in an residential aged care facility (RACF), 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.[11] Elder abuse occurs in all cultural and socioeconomic strata whenever there is an imbalance of power[252] and is linked to increased mortality and disability.[253]

Abuse may occur to an elderly person being cared for by family or other community carers, or in an RACF and hospital when the frailty of elderly residents renders them unable to defend themselves. An abuser may be a family member or carer, and 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.

Elder abuse may occur for many reasons, covering individual, relationship, community and sociocultural causative factors.[252] For example, caring for a family member means there may be a change in role where the carer becomes the 'parent' and the 'parent' becomes the 'child'. This increasing dependency can be frustrating and act as a catalyst for abusive behaviour by the carer, particularly if the carer is insufficiently supported.

The ongoing safety of the patient is paramount. Safety may only be achieved by transferring the patient from home or from the RACF. For elderly people the fear of retribution is strong and may be contributing to their unwillingness to disclose.[11]

Prevalence

There are no recent national statistics in relation to elder abuse[254] and few worldwide. A NSW study of clients referred to an Aged Care Assessment Service showed that 4.6% of older people living in the community and referred to the Aged Care Assessment Service had experienced elder abuse.[255] A study of four Aged Care Assessment Teams in QLD, WA and NSW showed a prevalence rate of 2.3%[256] and a study in a large regional aged care service in NSW found 5.4% of clients referred had also experienced elder abuse.[257] In studies in the United States (where participants aged 60 and over are included), the prevalence of elder abuse ranged from 11.4% to 14.1%.[248,258] Apart from the age of those participants included in the studies, discrepancies in prevalence rates may be due to issues of definition as some types of elder abuse were not included.[254]

In addition, there may be five unreported instances of abuse to every one reported.[259] The real prevalence of elder abuse is obscured due to a number of factors, including fear of retribution when reporting a complaint. The ageing of Australia's population and the increasing numbers of adults with dementia contribute to the anticipated growth in the prevalence of elder abuse.[260]

The role of GPs

The Australian Medical Association (AMA) stipulates in its position statement on the care of older people that GPs have a 'pivotal role in the recognition, assessment, understanding and management of elder abuse and neglect'.[250]

GPs are often the first independent professional to see an elderly victim of abuse. There are a number of reasons why medical practitioners may not have been more involved in managing cases of abuse. These include lack of awareness, insufficient knowledge regarding identification or follow-up of a potential case, ethical issues, time constraints, and the victim's potential reluctance to report the abuse.[11]

Identification

Understanding the risk factors for people who abuse vulnerable elders can provide information for intervention and preventive strategies.[260]

Risk factors can include:[248,249]

- individual
  - cognitive impairment
  - behavioural problems
  - psychiatric illness or psychological problems
  - functional dependency
  - poor physical health or frailty
  - low income or wealth
  - trauma or past abuse
  - ethnicity
- perpetrator
  - caregiver burden or stress
  - psychiatric illness or psychological problems
- relationship
  - problems within the family
  - relationship conflicts

- environment
  - low social support
  - living with others (except for financial abuse).

Types of presentations in general practice

A US study found that community-dwelling middle-aged and older women who reported physical abuse in the preceding year, verbal abuse or both types of abuse had significantly higher adjusted mortality risk than non-abused peers.[261]

A predisposing factor to elder abuse is dependency caused by physical impairment, dementia, mental illness, stroke, sensory impairment, or intellectual impairment.[252] This risk factor occurs regardless of whether the older person is being cared for in the home or in an RACF. However, as the majority of RACF residents have some form of dependency, such as physical or cognitive impairment, the GP and RACF staff should be alert to the possible occurrence of elder abuse.[248] Refer to *Table 15* for a list of possible signs and symptoms of elder abuse.

Table 15. Possible signs and symptoms of elder abuse[262]
General behaviour
• Being afraid of one or many person/s • Irritable or easily upset • Worried or anxious for no obvious reason • Depressed, apathetic or withdrawn • Change in sleep patterns and/or eating habits • Rigid posture and avoiding contact • Avoiding eye contact or eyes darting continuously • Contradictory statements not from mental confusion • Reluctance to talk openly
Physical abuse
• A history of physical abuse, accidents or injuries • Injuries such as skin trauma, including bruising, skin tears, burns, welts, bed sores, ulcers or unexplained fractures and sprains • Signs of restraint (eg at the wrists or waist) • Unexplained behaviour changes suggesting under-medication or over-medication • Unusual patterns of injury
Sexual abuse
• Bruising around the breasts or genital area • Unexplained genital or urinary tract infections • Damaged or bloody underclothing • Unexplained vaginal bleeding • Bruising on the inner thighs • Difficulty in walking or sitting
Emotional abuse

Table 15. Possible signs and symptoms of elder abuse[262]
• A history of psychological abuse • Reluctance to talk, fear, anxiety, nervousness, apathy, resignation, withdrawal, avoidance of eye contact • Rocking or huddling up • Loss of interest in self or environment • Insomnia/sleep deprivation • Unusual behaviour or confusion not associated with illness
Economic abuse
• History of fraudulent behaviour or stealing perpetrated on the patient • Lack of money to purchase medication or food • Lack of money to purchase personal items • Defaulting on payment of rent or RACF fees • Stripping of assets from the family home or use of assets for free
Neglect
• A history of neglect • Poor hygiene, bad odour, urine rash • Malnourishment, weight loss, dehydration (dark urine, dry tongue, lax skin) • Bed sores (sacrum, hips, heels, elbows) • Being over-sedated or under-sedated • Inappropriate or soiled clothing, overgrown nails, decaying teeth • Broken or missing aids such as spectacles, dentures, hearing aids or walking frame

If the possibility of abuse is suspected or concern is raised, you can use the consultation time to observe the emotional reactions and body language of the older person and the suspected abuser. Also, you can observe face-to-face interactions between the two. If the patient is in an RACF, remember that an abuser may be another resident (sometimes with dementia), a staff member (including volunteers), visitors or family members.

Management

If the patient has the capacity to give a history, it should be taken without others present. If this history differs from that given by carers or other family members, suspicions should be raised.[251] Ask the patient direct questions (refer to *Appendix 6. Elder Abuse Suspicion Index*), and if suspicion of abuse is confirmed, you can request permission from the patient to report the information to the appropriate parties (*Table 16*). However, although there is no legal compulsion requiring GPs to report elder abuse, any abuse affects the health and wellbeing of the patient and therefore the GP needs to have a response that ensures safety for the patient (refer to *Chapter 13*).

Management of sexual or physical assault

If you are given permission by the patient, or you are satisfied that there are grounds to believe that the patient has been abused sexually or physically (eg the patient's guardian has told you of the abuse) you may want to notify the police. Once it is established by the police that abuse has occurred, they will conduct any further notification or questioning.

In criminal cases you should document all injuries and consider photographing injuries before initiating treatment. You will need to gain consent from the patient to photograph injuries. In the case of sexual assault, evidence may need to be collected by forensic examination. Refer to *Chapter 9* and *Resources* for details about consulting forensic specialists or referring patients to them.

Table 16. Reporting and documenting
Reporting elder abuse – there is a range of reporting mechanisms that may be appropriate, depending upon the specific circumstances – particularly the type of abuse, the location and the suspected abuser
• Cases of a criminal nature – if there is suspicion that a crime has occurred or if protection is required for the survivor or others, the police should be notified • Cases relating to professional malpractice – the Australian Health Practitioners Regulation Agency (AHPRA) 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 the RACF (www.ahpra.gov.au). The Australian Government Department of Health Office of Aged Care Quality and Compliance addresses standards of care in RACFs and can be contacted regarding cases of known or suspected abuse occurring within an RACF (www.health.gov.au/oacqc) • Cases requiring guardianship intervention – if the case relates to an older adult who has lost capacity to make decisions (for example, due to dementia) the matter should be referred to the Public Guardian (or your state equivalent) for investigation or advocacy. Refer to *Table 19* in *Chapter 13*, and *Resources*)
Documentation – any report or suspicion of abuse should be clearly documented, including quotes from the patient, and others, and photographs of injuries. Documentation in RACF progress notes may be inappropriate if the doctor knows of, or suspects, the abuse is being perpetrated by an RACF employee. In this instance, progress notes should be kept off premises in the GP's patient files

A rural perspective

Rural and remote communities present another set of challenges associated with the lack of RACFs and access to other services.[263] In some rural communities people living in an RACF will be some distance from their families and will be more isolated. There is also the understated issue of maintaining confidentiality within small community groups. Below is a case study from a rural area that illustrates some of the issues.

Case study: 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 make house calls to 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. Another alternative is to seek the help of an aged care assessment team if available. Respite care or admission to an RACF are other options, depending on what is available.

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 with weekly house calls.

Section 10.2 People with disabilities

Key messages

- Health practitioners have a role in preventing, detecting and managing abuse in their patients with disabilities[3,264]
- People with disabilities need appropriate education, care and protection to ensure that violence and abuse are minimised and that responses are adequate when they do occur[265]

Recommendations

- Health practitioners should be aware that people with disabilities, particularly those with a mental illness, are at a much greater risk of violence – physical, sexual, or intimate partner – than those without a disability[266] **Level I C**

Introduction

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.[3]

Prevalence of disability

The Australian Bureau of Statistics research in 2009 identified 18.5% of the community as having a disability. Of these, 2.9% of people had a 'profound core limitation', indicating the need for assistance with daily tasks such as self-care, mobility or communication. About 1.86% of the population has an intellectual disability.[267]

Abuse and people with disabilities

People with disabilities, especially those with intellectual disability or mental illness, are at high risk of violence perpetrated against them,[266] especially sexual exploitation. Children with disabilities are more likely to be victims of violence than are their peers who are not disabled.[144] Research suggests that 50–99% have been sexually exploited by the time they reach adulthood.[267,268,269] Abuse may include intimate partner abuse, violence and sexual, emotional and financial exploitation.

People with intellectual disability (especially men) are also at risk of being accused of abuse due to their sometimes-poor understanding of appropriate behaviour and poor social and relationship skills.

Abuse of people with disabilities is most likely to be perpetrated by family members, support workers or co-clients of support services. It can be difficult to differentiate between 'passive' abuse such as rough handling, inattention and withholding of care information, and more purposive abuse, such as sexual and physical assault. Poor screening of support workers and drug and alcohol abuse by family members or support workers increase the risk of abuse.

Research has been undertaken to explore the issue of sexual abuse in women with intellectual disabilities and ways of helping family members and support workers develop skills to help in the prevention of abuse of people with intellectual disability.[264,265]

Other research has demonstrated that it is possible to teach people with intellectual disability skills in decision making and identifying the difference between healthy and abusive interactions. People have also been assisted to use these skills in their own life situations.[270–272]

The role of GPs

GPs and other health practitioners have a duty of care to patients with disabilities, as to all patients. However, access to and provision of appropriate healthcare for people with disabilities may be difficult due to physical access problems, communication difficulty or lack of awareness of the need for care on the part of patients and their carers.[269] Research has shown that people with disabilities have greater health needs and less access to healthcare. Good general practice care has the potential to greatly improve the health and welfare of people with intellectual disability. GPs need to be mindful of the possibility of abuse.

Identification

A person with a disability may:

- lack support to deal with violence and abuse
- live in a group home or other supported living situation with little privacy
- experience abuse from those responsible for his or her care
- not understand his or her rights
- need appropriate support to communicate effectively
- be 'not believed' or told it is their fault
- believe it is their fault even if not directly told this
- fear that if they speak up the abuse will escalate.

People with disabilities can experience the same effects of family violence and sexual assault as the elderly (refer to *Table 15*) or people without disabilities (refer to *Chapters 2, 6, 7* and *9*). Patients with intellectual disability in particular may have limited or no verbal communication, and may present with changes in behaviour such as sudden excitability or withdrawal, challenging behaviour and/or mental illness as a result of abuse.

Management

GPs can assist by:

- listening in a non-judgemental manner
- seeing the patient alone for some of the time if they are able to communicate independently (keeping in mind that the accompanying person may be the perpetrator of abuse)
- giving permission to speak about sensitive issues, especially sexual abuse
- helping the patient understand the effects of abuse on their health and welfare
- helping the patient to find ways to be safe
- reassuring the patient that they are not to blame
- reinforcing that everyone has the right to live without violence
- being aware of services in the community such as counselling, advocacy, police and legal services
- allowing time for the patient to make their own decisions.

Changes in the disability system: The NDIS

In 2013 there was major shift in the structure of disability funding. The Australian Government passed legislation to replace the current separate state-controlled systems with the National Disability Insurance Scheme (NDIS, also referred to as DisabilityCare Australia). The NDIS aims to individualise funding and allow more choice of service provider and use of available funds. Disability advocates have hailed it as a breakthrough in fairness, choice and control for people with disabilities. However, as with any system, care will need to be taken to ensure that as the system is rolled out, it meets its potential to reduce harm, abuse and neglect.[273]

Conclusion

The elderly and those with disabilities are at increased risk of experiencing abuse and violence. However, these particular patient groups may find it difficult to disclose such abuse because of their situation or even an inability to verbally communicate. Some patients may not understand that what they are experiencing is abuse or what their rights are because of potentially limited intellectual capacity. GPs should consider the possibility of abuse and identify and appropriately care for patients to ensure their safety.

Where the patient has lost the capacity to make decisions, help may need to be sought from the person legally responsible for giving consent for their healthcare. If this person is the abuser, then seek help from the appropriate advocacy source in your state or territory (refer to *Resources*).

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Chapter 11. Aboriginal and Torres Strait Islander violence

Key messages

- Aboriginal and Torres Strait Islander victims of violence include men, women and children. However, women are the predominant victims of intimate partner abuse[46]
- The most vulnerable age group is 15–24 years followed by 25–34 years and 35–44 years. Your risk for being a victim of Aboriginal and Torres Strait Islander family violence decreases after age 45[46]
- One factor alone cannot be singled out as the 'cause' of family violence, however, research has found that the strongest risk factor for being a victim of violence as an Aboriginal and Torres Strait Islander person is alcohol use. Other factors are being removed from one's family, single parent families and financial stress[47]

Recommendations

- Health practitioners should raise the issue with any Aboriginal or Torres Strait Islander patient, no matter where they live, who is presenting with indications of being a victim of violence[3] **Level III A**
- At a community level, health practitioners need to show leadership through local organisations by advocating for provision of services that meet the needs of Aboriginal and Torres Strait Islander peoples experiencing family violence **Practice point**

Introduction

Abuse and violence in Aboriginal and Torres Strait Islander communities across Australia has been the subject of intense media coverage over the past decade. These are not new issues. However, to address the health needs of patients, they need to be part of the care they will receive wherever they present to an Aboriginal and Torres Strait Islander medical service or general practice.

Prevalence

State-commissioned inquiries and government reports since 1999 have consistently reported that the occurrence of family violence in Aboriginal and Torres Strait Islander communities across Australia is disproportionately high in comparison to the Australian population as a whole. They have also highlighted that the main victims of family violence are women and children. However, men are also equally the victims of violence perpetrated often by other men.[274–280] The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS)[46] confirms that:

- of the 23.4% of Indigenous people reporting to be victims of physical or threatened violence in the 12 months prior to the survey, men and women had similar levels of victimisation[47]
- a further, more in-depth study of the data, however, reveals that assaults by an intimate partner represented 41.7% of the most recent incidents reported. The largest proportion of incidents were against women[46]
- 2.6% of Indigenous men reported being assaulted by a current or former partner, or date.[46] This figure needs to be treated with some caution because the small numbers involved increase the risk of sampling error

- men were most likely to be assaulted by someone outside of the family, either a person they knew by sight only or other known person (35.0%), friend, work colleague, fellow student or neighbour (22.8%).[46]

Children experiencing family violence

It should be recognised that family violence continues to be a significant risk factor for Aboriginal and Torres Strait Islander child abuse notifications to be substantiated in most states and territories. The data however is difficult to disaggregate and to obtain. In Victoria, for example, the police have reported that in Aboriginal and Torres Strait Islander family violence matters attended in 2005–06, children were present in 65% of the cases.[281] These children are likely to have experienced and/or witnessed various forms of abuse and are intimately aware of its visible consequences for themselves and for their caregivers.[282,283] Research evidence is widely available asserting that children living in homes in which violence occurs are vulnerable to physical, emotional and psychological abuse.[282,283]

Outcomes of this violence

As has been outlined in other chapters, exposure to violence puts children and adults at a greater risk of anxiety, depression and behavioural disorders. In addition, the experience of violence in childhood is a significant risk factor for being both a victim and a perpetrator of violence in adulthood.[282,283] Thus, it is through children that a cycle of violence may take root and become intergenerational. This has been a significant concern for Aboriginal and Torres Strait Islander communities across the country and certainly in the many state inquiries that have been conducted over the past decade. There is copious evidence to illustrate the intergenerational transmission of violence. This is entrenched by the fact that many families have had little support in addressing the problems that led to the violence or indeed any assistance in healing from the violence.

Defining Aboriginal and Torres Strait Islander violence

In most states and territories there is a general acceptance that Aboriginal and Torres Strait Islander violence encompasses:

> *A wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.*[279]

The term 'lateral violence' has also grown in prominence in Aboriginal and Torres Strait Islander communities in recent years. It describes the way people in positions of powerlessness, covertly or overtly, direct their dissatisfaction inward towards each other, toward themselves, and towards those less powerful than themselves. Langton explains that those most at risk of lateral violence in its raw physical form are family members and, mainly 'the most vulnerable members of the family: old people, women and children. Especially the children'.[284]

Lateral violence occurs worldwide in all minorities, but particularly among Aboriginal and Torres Strait Islander peoples where its roots lie in colonisation, oppression, intergenerational trauma and ongoing experiences of racism and discrimination. Lateral violence is the expression of rage and anger, fear and terror that can only be safely vented upon those closest to us when we are being oppressed. It has been argued that those who do the oppression do not adequately bear witness to or respond appropriately to Indigenous experiences of oppression and as a consequence oppressed peoples feel unsafe in seeking supports from them.[285]

Behaviours included under the spectrum of lateral violence range from gossiping, jealousy, bullying, shaming of others, backstabbing, family feuding, organisational conflict, attempts at socially isolating others and in extreme situations, physical violence.[284,286] By recognising these actions as violence, you can better appreciate that this kind of assault can be just as damaging as the other forms of violence. You also need to appreciate that this type of violence can take place alongside the other forms of violence and as a consequence make the context of individual, familial and community experiences with violence all the more complex. It also can inhibit individuals' choices and options when making decisions about responding to the violence being inflicted upon them.[285]

Aboriginal and Torres Strait Islander violence in specific contexts

The violence occurring in Aboriginal and Torres Strait Islander communities happens across the country regardless of locality in proportions consistent with the disbursement of the population. For example, in the 2008 NATSISS, 26% of Aboriginal and Torres Strait Islander people living in major cities had experienced physical violence during the 12 months prior to interview, compared to 22% of Aboriginal and Torres Strait Islander people living in remote areas.[46] While there has been a large focus in the media and by government on the occurrence of violence in the Northern Territory, the available evidence tells us that the violence occurs in all states and territories. *Figure 5* provides data from the 2008 NATSISS that demonstrate this. The table also illustrates the significance of age in the reporting of Aboriginal and Torres Strait Islander violence – those under the age of 35 are more likely to report being survivors of physical or threatened violence than those who are older.

Figure 5. Reporting of physical and threatened violence by location and age in 2008 NATSISS (expressed as percentages)

	15–24 years			25–34 years			35–44 years			≥45 years			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Major cities of Australia	30.7	30.3	30.5	24.3	23.4	23.9	30.0	24.8	27.2	15.7	14.5	15.1	25.3	23.7	24.5
Regional Australia	26.1	30.9	28.4	28.8	29.7	29.3	23.3	23.5	23.4	14.5	13.1	13.7	22.9	23.8	23.4
Total non remote	27.9	30.6	29.3	26.4	27.0	26.7	26.4	24.1	25.1	15.0	13.6	14.3	23.9	23.8	23.8
Remote/ very remote Australia	30.7	30.8	30.7	25.6	22.7	24.1	22.2	18.9	20.5	9.1	10.6	9.9	21.8	20.9	21.3

Source: Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey 2008. Canberra: AGPS; 2010.

The proportion of victimisation decreased with age and this finding is consistent with other population groups.[46] Older members of the community experience other forms of violence, including economic abuse.

It is also significant to note that, of the Aboriginal and Torres Strait women who reported in the 2008 NATSISS that they had experienced physical assault during the 12 months prior to the interview, almost all (94%) knew the perpetrator of their most recent incident of physical assault, with the categories most frequently recorded being a current or previous partner (32%), or a family member (28%). Aboriginal and Torres Strait Islander men on the other hand were significantly less likely to identify a current or previous partner as the perpetrator of their most recent incident of physical assault (2%). They were more likely to report being assaulted by a family member (20%), friend (16%), known person by sight (20%), or other known person (25%).[46]

Factors contributing to the violence

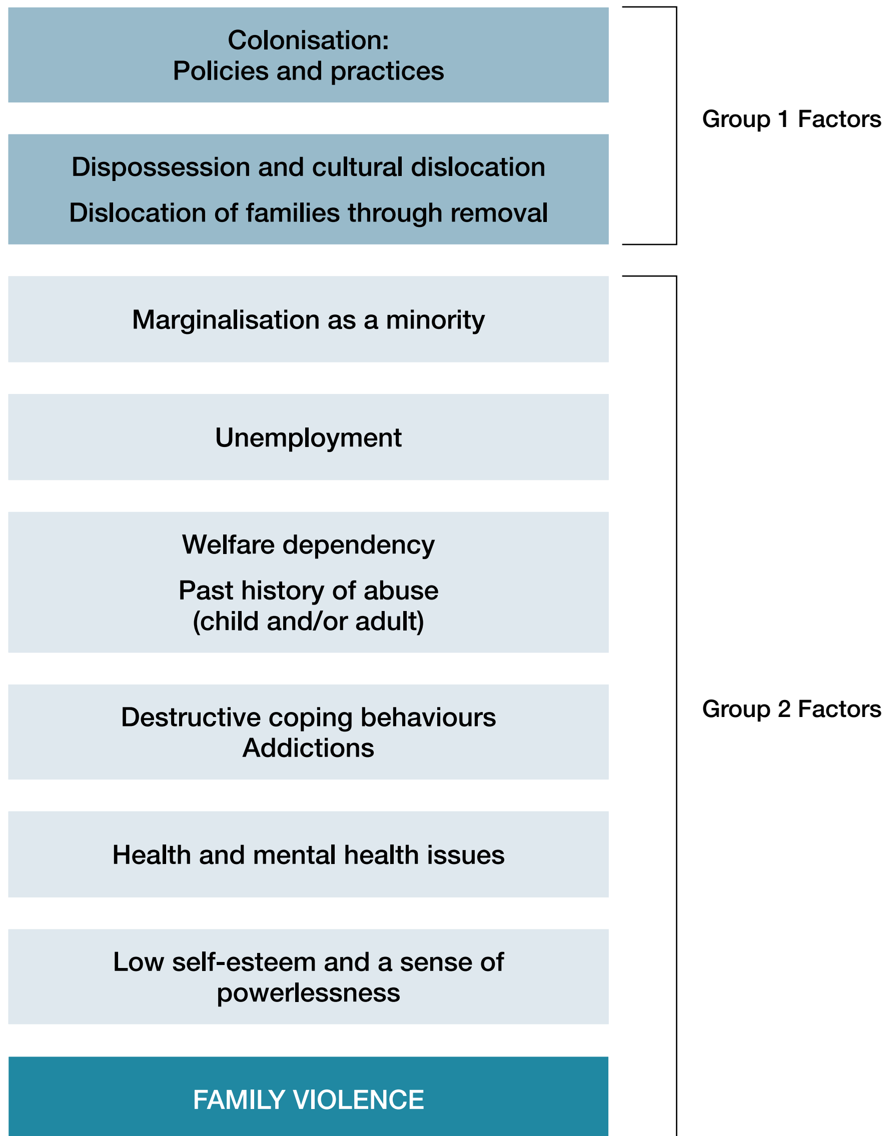
One factor alone cannot be singled out as the cause of violence. Often a multitude of interrelated factors are responsible. A useful way of understanding the multitude of factors is by categorising them into two groups, as demonstrated in *Figure 6*.

Group 1 factors have been experienced specifically by Aboriginal and Torres Strait Islander peoples and their communities. It should be noted that for many Aboriginal and Torres Strait Islander peoples, 'our lived' experiences would dictate that any or all of the factors in Group 1 could also be identified as contributing to current experiences of violence.

Group 2 factors are seen as contributing to high levels of distress and can occur separately or in multiples in any population impacting on one's experience of violence. Sufficient research evidence is now widely available to support this contention.[287–293]

The NATSISS conducted in 2002 and 2008 have also demonstrated that there is a strong relationship between reported victimisation and being removed from one's natural family.[47,294] For Group 2 factors, Weatherburn and Snowball found that the strongest risk factor for being a victim of physical violence was alcohol use.[47] In addition, they demonstrated that significant predicators of victimisation included substance use, lone-parent families and financial stress.

Figure 6. Factors contributing to Aboriginal and Torres Strait Islander family violence



Sources: Cripps K. Enough family fighting: Indigenous community responses to addressing family violence in Australia and the United States. Melbourne: Monash University; 2004.
Cripps K, Adams M. Family Violence: Pathways Forward. In: Dudgeon P, Milroy H, Walker R, editors. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: Commonwealth of Australia; 2014:399–416.

The role of GPs

The issues around identifying family violence are covered in *Chapter 2*. *Intimate partner abuse: identification and initial validation*.

Management

If your patient identifies as being Aboriginal or Torres Strait Islander, is under the age of 45, lives in any location in Australia and is presenting with indications of being a victim of violence, you should attempt to raise the issue with the patient. For ways of asking about violence and ways of responding to disclosure refer to *Chapter 2*, *Chapter 3*, and *Chapter 4*.

At a community level, GPs need to show leadership, for example through local primary healthcare organisations and other local organisations, by advocating for provision of services that meet the needs of Aboriginal and Torres Strait Islander peoples. The case study below provides an insight into the experience of family violence in an Aboriginal and Torres Strait Islander context and identifies some key issues to be mindful of in your interaction with an Aboriginal or Torres Strait Islander survivor of abuse.

Case study: Lisa

Lisa, a 24-year-old Aboriginal woman with three children aged 6 months, 20 months and 3 and a half years, presents to the emergency department of a regional hospital at the weekend. This is the fourth time in 18 months. She has injuries related to family violence. You have a follow-up visit with her at your clinic in your small regional town of 2000 people, 30% of whom are of Aboriginal or Torres Strait Islander descent. As you review her file you note that this is not her first presentation at the emergency department, or indeed at the practice, for injuries consistent with family violence. The first was about 2 years ago and included a broken nose and facial bruising. Other presentations have included:

- a broken wrist
- facial bruising
- broken ribs
- bruising.

On this occasion she has had more broken ribs, and extensive bruising down one side of her body from being repeatedly kicked. She has come in today because the hospital told her she needed to see her GP on Monday to follow-up on the tests they did in the hospital last Friday night.

The context

As you are reviewing Lisa's notes you are thinking about what you know about Lisa, her partner, her broader family and the community in which she lives. This is a community that has had a significant history of dispossession and cultural dislocation and many of the families, including Lisa's, have had aunts, uncles, brothers and sisters forcibly removed both as a policy of the Stolen Generation but also as a consequence of recent Child Protection involvement.

This is a community and family who have not had opportunities to heal from the hurts they have suffered and they struggle with day-to-day living. You know this because you have seen the high incidence of chronic illness, alcoholism and mental health issues in some sectors of the community and it is not unusual for you to be patching up patients who have borne the brunt of violence.

There are also many related issues that confound the problems faced by these community members. These include the high unemployment in the area, because of seasonal work, and the low educational attainment levels related to the racism experienced at the local school. Further, the high turnover of staff at schools and community centres, and more broadly the high levels of both financial and personal stress experienced by most community members, also confound the problems.

It is not unusual for members to be attending funerals at least once a month and this can have a great effect on individuals' feelings of unresolved grief and powerlessness over their own circumstances.

Ongoing care

As you reflect on this context, you think about how you can draw on available resources to support Lisa and her children, to provide them with safety and then to begin the road to healing.

Lisa comes in with her sister Ella, whom she is staying with at the moment. Ella is well known in the community and works as an Aboriginal GP. She will be a great asset to you as you work with Lisa in developing both a safety and care plan for her.

Lisa's children also attend the appointment. They have no obvious injuries and Lisa says that Rob has never hit them. The children, however, appear withdrawn – they are very quiet, appear scared, and are clingy to both their mum and their aunty.

Lisa says she hasn't seen Rob since he got angry in the emergency department and they called security on him.

Rob will also need help. This should be provided by another GP, to assist with maintaining confidentiality. At this time the GPs responsibility is to Lisa and the children (refer to *Chapter 3. Safety and risk assessment*, and *Chapter 5. Dealing with perpetrators in clinical practice*).

Lisa's safety

You may wish to discuss with Lisa and her sister what options are available to ensure her immediate safety. These might include:

- staying with a family member or in a refuge – if available, a refuge specifically for Aboriginal and Torres Strait Islander women. Finding a refuge that has space can be challenging. Call the domestic violence line in your state
- police assistance through the domestic violence liaison – remembering that many Aboriginal and Torres Strait Islander peoples have had bad experiences with the police
- an Aboriginal Family Violence Prevention Legal Centre to obtain help or assistance with an intervention order.

If you are referring Lisa to the women's refuge, or shelter, it is worth noting that they are in high demand, may not be able to cater for the number of children and can have quite strict rules that may be unsettling for Aboriginal and Torres Strait Islander clients. So the 'fit' may not always be the best option. It is, however, still worth trying.

Services for men

In terms of Lisa's partner Rob, the number of Aboriginal and Torres Strait Islander men's programs has grown significantly over the past decade, but there are still considerably fewer services available to address men's needs than are available for women. GPs need to understand the context of Aboriginal and Torres Strait Islander men's use of violence. Many men speak of their anger being related to colonisation. Colonisation, through its policies and practices, including dispossession and dislocation – for example, through the period of the Stolen Generations – often 'constrain the control which people experience in their lives, and limit their personal choices under stress'.

Men's ways of managing their trauma are too often, as Maggie White explains, seen as 'bad' or sometimes 'mad', but rarely as 'sad'.[296] Men are quickly seen as perpetrators but rarely as victims. Rex Wild and Pat Anderson's Little Children are Sacred report of 2007 sheds more light on this underlying issue of men's trauma and the intergenerational abuse that takes place in some communities as a consequence of little or no intervention for abused children.[280] They provide the example of HG, reproduced here to exemplify Maggie White's comments:

> HG was born in a remote Barkly community in 1960. In 1972, he was twice anally raped by an older Aboriginal man. He didn't report it because of shame and embarrassment. He never told anyone about it until 2006 when he was seeking release from prison where he had been confined for many years as a dangerous sex offender. In 1980 and 1990, he had attempted to have sex with young girls. In 1993, he anally raped a 10-year-old girl and, in 1997, an 8-year-old boy (ZH). In 2004, ZH anally raped a 5 year-old boy in the same community. Who will ensure that in years to come that little boy will not himself become an offender?

The above example clearly illustrates that Aboriginal men's ways of coping tend to bring them into contact with the justice system and it is here that they may get their first court-ordered behavioural change type program, whether this occurs while incarcerated or on some form of bail or community-based order. In the event that no such program is ordered or offered through the criminal justice process, the GP may be in a unique position to offer other referrals to Rob should he visit your practice and this can be broached without confidentiality being breached (refer to Chapter 5). This will require some research in terms of what is available locally within Aboriginal and Torres Strait Islander medical services, via men's groups or, again, via the Aboriginal Family Violence Prevention Legal Centres which may be able to refer you to legal service providers engaged in this work.

Addressing the needs of children

It would be worth keeping a watchful eye on Lisa's children. In this chapter, the significant concern of the intergenerational transmission of violence and the need to break this cycle in these communities was discussed. Lisa's children are very young but have potentially already witnessed a lot in their short lives. They will need to be monitored to ensure that their development is appropriate and that they do not continue to be exposed to violence. In the event that the latter occurs, as a GP you would need to carefully consider your mandatory reporting requirements and how you were going to communicate them to Lisa (refer to *Chapter 6*).

If available in your area, specific services for children experiencing family violence can be very helpful. A discussion with the family and a referral for Lisa and the children may help to deal with what has happened and contribute to their safety.

Conclusion

The consequences of violence within Aboriginal and Torres Strait Islander communities continue to be felt long after the bruises fade. A therapeutic response to the problem means thinking about the complexities that are often inherent in these contexts, as the above case study highlights. A decade of reports and research clearly articulates that any response or intervention must fundamentally engage with the multilayered factors that are contributing to the violence. These interventions need to take place and engage with the factors on an individual, familial and community basis for healing to be successful.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- *Our Family Business* – Spirit Dreaming DVD. Spirit Dreaming has produced a series of DVDs exploring family violence from the perspective of Aboriginal women. These DVDs provide moving personal accounts of family violence experienced by Aboriginal women and the impact it has had on their lives. The resource is divided into four parts, with each section documenting real-life stories of what family violence looks like (The Face), what family violence feels like (The Heart), what it takes to change (The Spirit) and the wisdom gained (The Soul). The resource has also produced booklets for women, elders and children, available at www.spiritdreaming.com.au/resources/our-family-business
- Transgenerational trauma, available at http://whatsupwithmymob.com.au
- Prevention messages: *Strong families, strong culture: Use your strength wisely* commercials
  - www.youtube.com/watch?v=JlyKwh9yOyY
  - www.youtube.com/watch?v=okoLytSmOZU
  - www.youtube.com/watch?v=bM8A7BMEScE
  - www.youtube.com/watch?v=ehDxwdeD7LQ

Chapter 12. Migrant and refugee communities

Key messages

- Avoid making assumptions about a patient's cultural beliefs. Speak to the patient as an individual while still acknowledging that their cultural background may inform their personal beliefs and expectations
- Health practitioners need to reflect upon their personal belief systems so that they can recognise how these beliefs impact upon their consultations with others
- Patients from migrant and refugee backgrounds who are experiencing violence may be disadvantaged by a lack of knowledge about their rights, lack of good support systems, and their social isolation.[297] Patients may be experiencing abuse by multiple people, including in-laws and intimate partners[298,299]

Recommendations

- In working with patients from migrant and refugee backgrounds, remember that they are likely to have similar symptoms to other victims of family violence.[300] However consider that this may be in addition to trauma experienced in their country of origin, refugee camps and in transit **Practice point**
- Practices need to put systems in place to ensure care is delivered in a culturally sensitive manner[300] **Practice point**
- Assistance and support offered in a culturally sensitive manner to migrant and refugee women helps to empower women to make positive changes in their lives. Ideally these services should be language concordant[301] **Practice point**

Introduction

In Australia, a country rich in cultural diversity, approximately one in four people is a first generation migrant, and 60% of Australian migrants come from non-English speaking backgrounds.[302] Many medical practitioners, including GPs, have a migrant or refugee background.

The measure of cultural identity may not be a spoken language, religion and/or place of birth. Cultural identity is complex and is often entangled with gender, class, socioeconomic status and other factors. The indefinable nature of culture means it is important to be aware of the potential for cultural misunderstanding in every day practice. Yet it is also important to avoid making assumptions about the individual. A person's health beliefs and values are informed by a mix of cultural understandings, personal experiences and knowledge. Because of this, different individuals from the same culture may have very different expectations and understandings when seeking care from a GP.

Not all members of a gender, family or culture will hold the same values. The individual patient who is presenting to the doctor may be able to assist the doctor with how their cultural beliefs influence their gender roles, family roles and what constitutes abuse and violence, as well as how willing they are to disclose their concerns. However, the shame and stigma of the issue, wider family pressures, fears of ostracism or deportation[297] and ignorance of the law and supports in the Australian system are powerful barriers to disclosure. GPs should be mindful of these issues.

Importantly, not only do patients bring culturally influenced values, beliefs and behaviours to clinical practice, so do GPs.[114] It is necessary for GPs to identify and confront their own belief systems and values to understand how these impact upon their clinical decision making. Just as GPs develop clinical skills, they must also develop their cultural competence and sensitivity. GPs must examine their own attitudes about abuse and violence in their own and other cultures.

Prevalence

The 2011 census[302] found, within the Australian population, that:

- 27% were first generation migrants
- 33% of migrants came from South-East Asia
- 49% of longer-standing migrants and 67% of recent arrivals spoke a language other than English at home
- religious affiliations were: 68% Christian, 2.5% Buddhist, 2.2% Muslim, 1.3% Hindu, 0.5% Jewish and 22.3% no religion.

Family, especially intimate partner, violence is prevalent in the home countries of migrant and refugee communities seeking a new life in Australia.[303] In the Asia-Pacific region, estimates of the prevalence of women assaulted by a partner in the previous 12 months vary from 3% or less among women in Australia to 19% of currently married Bangladeshi women.[9] The global estimate for intimate partner violence using the Global Burden of Disease (GBD) shows that the lifetime prevalence rate in South Asia is 41.7%.[3] Intimate partner violence is more common in countries where war or other conflict or social upheaval has recently taken place. Population studies in their own countries have estimated that approximately one in three Vietnamese or Indian women report ever experiencing physical or sexual violence,[304,305] and 8.5% of Vietnamese women reported abuse in the previous 12 months.

The few studies that exist in diaspora countries have found similar rates to those in the home country.[298,306,307] Newer migrant communities often represent significant proportions of families with young children, and this can be a time of greater risk of violence. Women from migrant backgrounds can be over-represented in crisis services and murder statistics.[40] Drug abuse, gambling and alcohol misuse are also associated with violence perpetration in migrant and refugee communities, as they are in other communities.[308,105]

The role of GPs

Cultural sensitivity

It is important to remember that the health effects of violence are very consistent across countries and cultures.[309] However cultural taboos may surround the issue of violence in families and this may make it difficult for patients to disclose without additional encouragement, support and sensitivity. The building of a trusting therapeutic relationship is essential to facilitate this disclosure. Cultural sensitivity, but more importantly, non-judgemental and supportive practice (refer to *Chapter 2*) will make it 'culturally safe' for victims to find the appropriate moment to speak about their concerns with a GP. Consider training reception, nurse or other clinic staff so that they are culturally sensitive and act as a bridge to the community. Some practices in particular locations may employ bilingual reception and clinical staff.

Ensuring culturally sensitive care may also include:[300]

- booking and using an interpreter that is not a family member (refer to *Resources*)
- allowing time to establish rapport and trust
- explaining and emphasising doctor–patient confidentiality, patient consent, choice and control
- understanding that confidentiality and consent issues vary dramatically in different cultures, with some cultures understanding consent as a community issue not an individual issue
- explaining procedures and being prepared to repeat information
- providing opportunities for the patient to ask questions or seek clarification – some will have come from other cultures in which this was not encouraged
- explaining why you are asking certain questions
- considering gender issues – for example, male GPs may consider referring female patients to a female GP

- establishing if there are any cultural or religious factors that need to be accommodated
- taking into account a patient's cultural or religious practices – for example, considering the need for halal medications for patients of Muslim faiths and issues related to times of fasting.

Assistance and support offered to migrant and refugee women that is culturally appropriate and if possible, in their own language, is extremely important in empowering women to feel that they can make changes in their lives.[301] Many larger states have services specifically for migrant and refugee women that offer direct service support to women experiencing violence. Some also have links with ethno-specific men's behaviour change programs (refer to *Resources*).

The ethnicity of a GP and its congruence with the practice population may impact upon the clinical consultation. GPs of a similar culture and/or ethnic background may be more aware of health disparities experienced by the community – for example, access to services. A GP who belongs to the same cultural group may understand how to address the issues of abuse more effectively within a culture, offering helpful and relevant advice, often with significant cultural authority. Conversely, a GP of a similar background to the patient may overlook the possible presence of abuse or violence or may minimise its significance or accept it as a cultural normal, rather than engage with the definition accepted by mainstream society.

Presentations in general practice

Victim presentation or symptoms and health effects do not differ across cultures. These issues have been presented in *Chapter 2* and *Chapter 6*. WHO guidelines for GPs should guide your approach in the identification of intimate partner abuse.[3]

Because of the possible normalisation of abusive behaviours and cultural taboos in many migrant and refugee communities, GPs need to modify their language to speak about it. For example, the most common symptoms related to abuse, such as depression, trauma or anxiety[310] are often associated with significant stigma in different communities. In some countries, there is no word equivalent to depression in the language. Symptoms are often somaticised and this can lead to over-investigation of the patient who is experiencing the effects of abuse. Careful discussion, description and recognition of the patient's attribution of the symptoms is essential when disentangling these concepts where there is a cultural divide.

Some patients from culturally and linguistically diverse backgrounds may have their experience of abuse complicated by other issues that may add further complexity to their experience:

- Victims may be experiencing abuse from other family members – for example, their in-laws (mother, father or brother-in-law).[298,299] Questioning should elicit the full spectrum of abuse being perpetrated in the family and not only focus on intimate partner abuse.
- Children from refugee backgrounds may have witnessed or experienced serious violence prior to their arrival, and continuing violence within the home can add to the pre-migration trauma experiences and the acculturative stress issues.
- For younger women, especially students and migrant workers on limited visas, fears about immigration status may affect their comfort to disclose.
- If the patient is in an abusive gay or lesbian relationship, fears about confidentiality and stigma may be very strong.
- In all cases, reassure patients about their confidentiality within limits of legal requirements (refer to *Chapter 13*), explore safety and express support and offer ongoing help. If you share the same language and culture as the patient, this reassurance at the outset will be very important.

Refer to *Chapter 2* for examples of how to ask patients about experiences of violence.

Alcohol and drug abuse are potential signals for perpetration in migrant communities as they are elsewhere,[308] so you should be alert to asking about the effect of such substance misuse on other family members, especially children. The safety of the survivor and children needs to be paramount.

Management

Many GPs can think that their gender or ethnicity is perceived as a barrier to disclosure by a victimised patient from a migrant or refugee background. But if a patient is reassured empathically, and if they perceive their GP to be listening, trustworthy and understanding, then empathy within the therapeutic relationship can overcome stereotypes of gender and culture. Feder et al[6] found near unanimity among over 800 victimised women's views about the need for GPs to be empathic and non-judgemental in their care. When developing healing relationships with our patients, Scott et al [228] established that trust, hope and a sense of being known were the important things identified by patients.

In order to address the cultural diversity of patients who present, the GP needs to:

- be mindful of their own personal beliefs and assumptions
- respect and appreciate the values and beliefs of all patients
- be informed of cultural issues relevant to their patient, including their migrant and refugee patients.

In many migrant communities, doctors are highly regarded authoritative figures. It is therefore a very powerful message for a GP to suggest that the survivor's symptoms are related to their partner's or other family members' abuse. A clear message from the GP stating that the abusive behaviour is not acceptable is valuable for the patient, especially when pathways to help and support the survivors and their families are identified. Ensuring the patient understands the connection between the violence and health, including the health of their children and other family members, is important.

Assure confidentiality

It is good practice to reassure any abused patient that the consultation – subject to legal and mandatory reporting requirements – is strictly confidential, but for migrant and refugee patients it is vital to convey clearly that you will NOT reveal information gathered during the consultation to anyone else. This may be very important if you are a member of the same community and language community. It is also important to assure the patient that trained interpreters are also bound by these rules of confidentiality. Even where this information has been provided, confidentiality can be a difficult concept to relay within a cross-cultural environment and it may take some time for the patient to engage with this understanding.

The importance of culturally appropriate language

Members of many communities find that language barriers pose a significant problem in their efforts to access healthcare. When the GP and patient do not speak the same language it can lead to a loss of important information – for example, misunderstandings can occur regarding the presentation of illness and instructions for the use of medications. Abuse and violence identification and intervention can be especially difficult without proper linguistic tools. In many states, there are specific domestic violence services for migrant and refugee communities and they can provide secondary consultations and sometimes interpreting services if organised ahead of time (refer to *Resources*). It is important that any interpreter has been vetted for sensitivity to family or partner violence, as domestic violence services report anecdotally that interpreters from mainstream interpreting agencies may not always be confidential.

Professionally trained interpreters from mainstream agencies should always be used (refer to *Resources*). It is inappropriate to place children, family members or friends in the role of interpreter, particularly when abuse and violence is an issue. *Table 17* outlines recommended guidelines for working with interpreters.

Table 17. Guidelines for interpreters [311]

- Use professionally trained interpreters
- Try to talk to the interpreter before the visit, to share the agenda
- Talk directly to the patient, not the interpreter
- Use words, not gestures, and avoid technical terms
- Speak slowly, and only ask one question at a time
- Check frequently with the patient to ensure the patient is understanding
- Ask the patient to repeat back important information to ensure that it has been understood correctly
- Maintain eye contact with the patient by sitting in a triangular arrangement
- Allow the interpreter to interrupt if needed
- Repeat the phrases using different words if the message is not understood
- Be alert to any discomfort the patient or interpreter may have with each other or the topic under discussion
- Meet with the interpreter afterward to get their impressions of the visit and to debrief

Take a careful history

If a patient has disclosed, you need to take a careful history (refer to *Chapter 2*) and ask questions about:

- all those who are abusing the patient
- the safety and situation of the patient and any children or young people, including access to weapons. This may be more likely if the family is living in a rural area – regardless, it should always be explored (refer to *Chapter 2* for questions relating to safety)
- any pressure to maintain family harmony, irrespective of the safety of the victim and any children
- any financial dependence, visa or migration status issues that complicate the relationship with the abuser and vulnerability of the abuser
- other financial abuse – for example, gambling or drug abuse funding
- religious or spiritual abuse
- if you have the patient's trust, consider asking about sexual abuse and coercion.

Safety planning and referral

After informing a patient that abusive behaviour is unacceptable and damaging to their health and that they are not to blame, it is appropriate to discuss:

- what their perspective and preferences are and whether they wish to take any action
- discuss their comfort to be referred for support – for example, to a mainstream or ethno-specific agency
- assess their risk and safety and make a safety plan (refer to *Chapter 3*) that may include hiding copies of all important papers and documents, including passports, visas, birth and marriage certificates if appropriate
- the law and rights and support services in Australia (refer to *Chapter 13*). For example, women from overseas who have married Australian men need to know that their visa application will be given special consideration if there has been domestic violence. The GP may be able to provide documentation that can assist this process
- the role of police, intervention orders and courts in Australia. This may be very different to the individual's country of origin. This can be especially important if the individual is in a rural community and the perpetrator has access to weapons.

Services for men

If the abusive partner is seen separately and will accept help, you could suggest referral or access to Mensline (www.mensline.org.au) or No to Violence (http://ntv.org.au/). As outlined in *Chapter 5*, it is important that the abusive male partner be seen by another GP to maintain confidentiality and safety for the victim.

Conclusion

While the health effects of violence are consistent across countries and cultures, there are a number of specific issues that GPs need to be aware of when caring for people of migrant or refugee background. Access to healthcare and specifically access to culturally sensitive services can be difficult. GPs need to understand these issues to be able to identify and support patients from migrant and refugee communities who are experiencing family violence. This chapter has detailed several ways to provide culturally sensitive care, and the *Resources* section provides details of additional assistance – for example, interpreters.

GPs need to be able to reflect upon how their gender, ethnicity and cultural background might impact upon a consultation with patients of migrant or refugee background. Reassuring patients by developing trust and providing an empathic culturally sensitive consultation can help to overcome many of the barriers to care.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- The Centre for Ethnicity and Health (Vic) is a useful organisation and provides papers that explore the impact of migration law, screening by the maternal and child health service, increasing service access for women, and dispute resolution strategies for men. Available at www.ceh.org.au/dih/dih-program/dih-daily-program-guides/7-june/practitioner-perspectives

Chapter 13. Violence and the law

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[246]
- Assault occurring between family members is a criminal offence[246]
- 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[246]

Recommendations

- Health practitioners can assist their patients experiencing abuse and violence by providing information on legal options and access to legal services[3,312] **Practice point**
- 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[246] **Practice point**

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 of sexual assault. The information in this section is not legal advice. This information may be useful as a resource to guide and to empower our patients in considering realistic options of legal protection for their own safety. If a patient expresses an interest, the contact references may be passed on to them. They need to take responsibility for their own legal issues.

Introduction

When a patient discloses family violence, including sexual assault and sexual assault between intimate partners, it is valuable for the GP to have a basic understanding of the legal framework.[246] This could include an understanding of family violence orders, the role of the police, and knowledge of referral options to community legal services.[3,312,313] In cases of assault 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 potential criminal court proceedings.[246]

This chapter outlines responses to family violence and sexual assault involving legal intervention. However, Australian states and territories have differing legislation that may apply to one or all of these types of abuse. Legal responses to violence are not the domain of general practice.

The role of GPs

GPs should encourage their patients to approach the police directly and report an assault. The police may be able to provide more information about the patient's legal options. In many cases the patient, having reported to the police, will be able to activate or withdraw from criminal proceedings at a later stage. GPs should also offer to report the incident to the appropriate authorities, including the police, if the patient wants this.[3] However, it is important to respect their wishes and not pressure them into making any decisions.[312]

In sexual assault, for adults there may be 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. Further to this, a number of counselling services can be made available to a victim of assault via victim of crime support agencies. These differ in each state and contact can be made via the police (refer to *Table 18*).

There may be a range of reasons that patients may not wish to involve the police, such as fear of retribution, the event having occurred sometime in the past, or embarrassment. In particular, barriers to disclosing sexual violence include women not having identified the act as sexual violence or a crime, thinking that they will not be believed, fearing how they will be treated by the criminal justice system, and considering that they may be able to handle it themselves.

Delay in reporting an offence to the police can be for a number of other reasons including:[27]

- fear of reprisals from the partner
- not wanting family and friends to know because of the humiliation and shame
- fear of coping with police, the justice system and legal procedures
- shame and prevalent social attitudes, which blame the victim
- denial and disbelief
- hope for change.

Thus, there are many reasons, outlined above, why disclosure is not immediate and is often sporadic or non linear. It has been called the 'dance of disclosure' – where women reveal only partially, become frightened after they disclose and disappear for some time, then disclose at another time and place. Sometimes they disclose major incidents – for example, rapes first then, with time, other incidents.

Most state and territory police forces have specially trained units that can still assist patients in referring them to appropriate services if they do not wish to seek a protection order or pursue charges against the perpetrator. Alternatively, local community services may liaise with the police on the patients' behalf.

The NSW Department of Health recommends in its Domestic Violence Policy discussion paper that health workers notify the police where the survivor has serious injuries such as broken bones, stab wounds, lacerations or gunshot wounds. Wherever possible, the victim should be informed when a decision is made to inform the police.[314]

Table 18. Police assault and family violence investigation teams/units in each state or territory	
ACT	www.police.act.gov.au/crime-and-safety/abuse-and-family-violence.aspx
New South Wales	www.police.nsw.gov.au/community_issues
Northern Territory	www.pfes.nt.gov.au/Police/Community-safety.aspx
Queensland	www.police.qld.gov.au/programs/adultassault www.police.qld.gov.au/programs/cscp/dv/Response.htm
South Australia	www.police.sa.gov.au/sapol/safety_security.jsp
Tasmania	www.police.tas.gov.au/programs/safe-at-home
Western Australia	www.police.wa.gov.au/Yoursafety/tabid/1080/Default.aspx
Victoria	www.police.vic.gov.au/content.asp?Document_ID=36237

Family violence

Generally the law can address family violence in two ways: family violence orders that are legislated under civil law, and criminal charges. The term 'family violence order' is used in this chapter as a generic term for those orders specifically for family violence, though some states may have different names for these. Some states may use one form of order to cover both instances of family violence and assault. These can be called 'intervention orders', 'protection orders' or 'restraining orders'. See below for more detail on what such orders can do.

If your patient is a victim of 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 services assisting in family violence orders.

Specially trained police officers can assist victims 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 – patients may be helped by meeting with a trained police officer directly (refer to *Resources*).

Family violence and protection orders

These orders, which are made by the court and in some emergency cases the police, attempt to restrict or prohibit certain behaviours by the perpetrator. Orders may, for example, include prohibiting a person from harassing or threatening the survivor and/or approaching the victim'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 (*Table 19)*. However, restraining orders may relate to:

- recent assaults, threats and/or harassment by a partner, family member, friend or stranger where the person is fearful of it happening in the future – especially death threats
- actual or threatened damage to property.

It is preferable that a person obtaining a restraining 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).

It is beyond the scope of this manual to advise GPs in relation to the law in each state and territory. At the same time a complaint about criminal conduct is made to the police, their assistance should be sought and, if necessary, further legal advice obtained.

Court support services can be very helpful for women who have experienced family violence. Availability of these services can vary, and are offered by local community agencies. They may also be accessed at the magistrates' court and the police may be able to provide further information.

Please note that in the Northern Territory, **mandatory reporting** provisions in the *Domestic and Family Violence Act* 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.

Table 19. Family violence and protection orders	
State	**Type of intervention**
Australian Capital Territory	In the ACT, 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 is available at: • www.victimsupport.act.gov.au • www.legalaidact.org.au
New South Wales	The patient or the police on their behalf can apply for either an ADVO or an apprehended personal violence order (APVO), where the people involved are not related and do not have a domestic relationship, for example, they are neighbours or work together. Further information is available under the topic 'domestic violence' at: • www.legalaid.nsw.gov.au/publications/factsheets-and-resources
Northern Territory	The *Domestic and Family Violence Act* 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. Further information is available at: • www.childrenandfamilies.nt.gov.au/Domestic_and_Family_Violence/index.aspx
Queensland	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). Further information is available at: • www.legalaid.qld.gov.au/legalinformation • www.courts.qld.gov.au/courts/magistrates-court/domestic-and-family-violence
South Australia	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. An interim intervention order may initially be issued, after which it may be confirmed by the magistrates' court. Further information is available at: • www.sa.gov.au/topics/emergency-safety-and-infrastructure/safety-at-home-and-in-the-community • www.dontcrosstheline.com.au

Table 19. Family violence and protection orders	
State	**Type of intervention**
Tasmania	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. More information is available at: • www.dpac.tas.gov.au/divisions/cdd/information_and_resources/family_and_community_violence • www.magistratescourt.tas.gov.au/divisions/criminal__and__general/restraint_orders/
Western Australia	For cases of both 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. Further information is available at: • www.police.wa.gov.au/YOURSAFETY/FamilyViolence/tabid/895/Default.aspx • www.wa.gov.au/information-about/community-safety/domestic-violence
Victoria	There are two types of intervention order 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 Magistrates' Court of Victoria provides useful information about taking out these intervention orders at: • www.magistratescourt.vic.gov.au/jurisdictions/intervention-orders Victoria Legal Aid has booklets available for download regarding the law and sexual assault or family violence on its website. There is also further information about both types of intervention orders, available at: • www.legalaid.vic.gov.au/find-legal-answers

Sexual assault

It is useful for GPs to become aware of other services and service providers in the 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.[246]

No matter how long ago the sexual assault happened, a victim can, and may wish to, contact the police. There is no 'statute of limitations' for sexual assault. In the event that they do, they can contact any police station, which will, in turn, arrange for a trained officer to contact the victim. Most Australian states 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 – for example, provision of emergency contraception
- changes to the physical evidence – for example, healing of injuries
- loss of forensic material – for example, evidence of contact with the assailant, including blood and semen.[246]

However, victims of sexual assault may not present for treatment for some considerable time after the assault.[246] *Chapter 9* provides greater detail of the management of patients who have experienced sexual assault and the WHO has produced guidelines for health workers managing cases of sexual assault (refer to http://whqlibdoc.who.int/publications/2004/924154628X.pdf).

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 *Resources* and *Chapter 9*). 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.[246] 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 from the crime scene, from clothing or sheets, or for example from CCTV, which would otherwise be lost. In most cases the victim will later be able to withdraw if she does not wish to continue with criminal proceedings. Many victims 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, even if they themselves choose not to proceed with the court process.

In many Australian states 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 *Resources*). 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, relevant local community or legal services to get 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 other states and territories, all 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 10*, *Chapter 6*). 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.

Elder abuse and other vulnerable population groups (other than children)

There is no mandatory framework requiring GPs to report adult abuse, except in the Northern Territory. However, it may be the case that a patient is exposed to abuse or violence threatening his or her safety. If a patient has lost capacity, and is unable to make decisions in his or her own best interests, the assistance of a substitute decision maker may be required.

In the case of suspected abuse where the patient has lost capacity, the first step is to check the patient's record to identify if a substitute decision maker has already been appointed. If there is no clear indication of the existence of a substitute decision maker, 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 – for example, if they are elderly – the more important it may be for the doctor to inform the police or seek medico-legal advice.

Table 20 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. For more information about guardians and advance care directives, visit www.racgp.org.au/guidelines/advancecareplans

Table 20. Advocacy groups in each state	
Victoria	www.publicadvocate.vic.gov.au
New South Wales	www.publicguardian.lawlink.nsw.gov.au
Western Australia	www.publicadvocate.wa.gov.au
South Australia	www.opa.sa.gov.au
Queensland	www.justice.qld.gov.au/justice-services/guardianship/public-advocate
Australian Capital Territory	www.publicadvocate.act.gov.au
Northern Territory	www.health.nt.gov.au/Aged_and_Disability/Adult_Guardianship
Tasmania	www.publicguardian.tas.gov.au
National	www.agac.org.au www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-stpgb.htm

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 in order 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, RACF and the public advocate or your state or territory equivalent (refer to *Tables 18* and *20*). Protection orders and sexual assault services may be considered, if appropriate.

Conclusion

The service most frequently identified as the first point of contact for victims of assault is a doctor or hospital. This initial contact is important in a patient's decision to address the violence. It is important for GPs to understand the legal frameworks of abuse. Remember that GPs do not need to, and should not, provide advice to patients in these legal matters. That said, providing patients with information and links to appropriate services is important, as this provides them with the avenues they require to make an informed choice.

It is helpful to be able to provide patients with appropriate medical care, accurate information and referrals. But most importantly, to provide the message that their safety is paramount and that what is happening to them is:

- not their fault
- not okay
- is a crime.

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 to seek legal action (refer to *Chapter 4*).

Case study

This is a true story of a patient's journey through the legal processes of dealing with intimate partner abuse. 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 6 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 2 to 3 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.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- *When she talks to you about the violence* is a tool kit for GPs on domestic violence that was developed in NSW. Available at http://itstimetotalk.net.au/gp-toolkit

Chapter 14. The doctor and the importance of self-care

Key messages

- Working with those who are experiencing family violence can be emotionally challenging and result in the experience of vicarious trauma[315]
- It is important to maintain an environment, both individually and in practice, where there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence[315–317]

Recommendations

- Health practitioners cannot give to others if they are experiencing compassion fatigue, so it is advised that self-care and a whole of practice approach be addressed so that patients receive the best care[318] **Practice Point**
- Working as a team within the practice by using a system that provides peer support and the ability to discuss distressing cases may help protect against stress[315] **Practice Point**

Introduction

Managing the effects of abuse and violence on our patients can be a rewarding aspect of general practice, however, it can be stressful. If GPs feel empowered, then that empowerment can positively enhance the doctor–patient interaction. Factors that may contribute to this enhancement are ongoing training, clearly delineated practice policies, case management supervision, peer support, clear doctor–patient boundaries and a developed network of resources and referrals.

As well as the usual stresses associated with difficult and time-consuming clinical encounters, there are factors that are important for GPs to address when working with patients who have experienced abuse or are currently being abused. The trauma that these patients have experienced constantly challenges our individual limits and drains personal resources.[319] GPs often face professional isolation, ambiguous success, unreciprocated giving and failure to live up to our own expectations for ensuring positive change.[320] Dealing with these issues is important, not just for the health of the GP, but also so that we can maintain as objective a stance as possible to facilitate a successful outcome for the patient, and maintain good relationships with the patient's family, friends and community.

Vicarious traumatisation is the inner transformation of the care givers experience as 'a result of empathic engagement with victims, clients and their trauma material'.[321] It can 'encompass changes in frame of reference, identity, sense of safety, ability to trust, self-esteem, intimacy and a sense of control'.[322] This is a particular danger when dealing with those who are, or have, experienced abuse and violence. GPs who have a similar background to the community they serve are at a higher risk of vicarious trauma. This may include GPs of Aboriginal and Torres Strait Islander descent, those who were refugees and many international medical graduates (IMGs). These situations will be particularly difficult for GPs who have personally experienced abuse or have experience abuse in their families.

It is important to maintain an environment in which there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence. The medical profession has a 'long and admirable, but often unhealthy, tradition of self-sacrifice to work'.[316] Those who work in this field need to be vigilant about ways to overcome compassion fatigue, renew the joy in practice, create life balance,[317] and adequately care for their own physical, mental, emotional and spiritual health.

A rural perspective

GPs who work in rural areas are at a higher risk of problems with stress, burnout and vicarious trauma. They are highly likely to find it difficult to access locums, peer support and ongoing training, and usually have more after-hours work, are more isolated and find it more difficult to maintain clear boundaries between themselves and their patients.[316]

Many rural GPs are IMGs who have the added burden of having to negotiate different cultures, ethnicities, language, religion and the difference between rural and urban environments in Australia. They will also have to learn about the expectations Australian patients have of their doctor and about a new health system and 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.[323]

The role of GPs and their practice in self-management

'You cannot give to others out of emptiness in yourself' (Quote from a GP)

Saakvitne and Pearlman[321] developed a model that allows GPs to explore their situation and think about solutions. This occurs by identifying issues of awareness, balance and connection in each of the GP's 'realms':

- personal
- professional
- organisational.

Using this model (*Table 21*) may help set the stage for good self-care[319,321]

Table 21. Example of awareness, balance and connection strategies

	Personal	Organisational
Awareness	• Proactively instigate self-care strategies • Understand and improve your awareness of when you are stressed, tired, overwhelmed	• Ensure your practice has a mentor or supervisor to support your professional development • Consider using debriefing strategies (formal or informal) in your practice • Cultivate open and supportive dialogue with your practice team • Ensure organisational boundaries are known and understood by patients (eg home visits, consultation length)
Balance	• Review your lifestyle and consider healthy options • Seek balance in all spheres of your life: physical, psychological and social	• Review workload regularly to ensure that all members of the practice team are adequately supported • Take care in scheduling complex care needs patients
Connection	• Consider joining a social action group where you have a passion for change • Talk to others about work, debrief safely • Nurture positive relationships with family and friends	• Join a peer support or Balint group or informal network • Undertake regular continuing professional development with your colleagues

The following explores this model in relation to the management of patients who are experiencing or have experienced abuse or violence.

Awareness

Personal

- When the GP has a similar background to the patient, the possibility of family violence may be more difficult for to consider[115] as the GP may actually have 'normalised' the abuse and disregarded it.[322]
- Others may feel more personally vulnerable when abuse is disclosed.
- The GP can be drawn into the deceit; the unwillingness to openly discuss or report the violence.[115]
- The GP may feel powerless and fearful for the patient's safety when that patient chooses a path the GP considers dangerous.[115]
- The patient could remain at risk and the GP has to learn to live with that concern.[115]
- It is a difficult and stressful path supporting and empowering the patient while resisting the temptation to be directive.[115]
- Hearing about abuse and violence confronts the GP's own beliefs about the family and the world. It can make them feel uncomfortable and challenge their own sense of security.
- Dealing with complex and seemingly hopeless situations over and over again can erode the GP's optimism and self-confidence, and diminish their sense of purpose and enjoyment of their career.[324]
- It is important for GPs to stay connected with their core reasons for choosing to work in a challenging area and to maintain a respect for the patients themselves.[325]
- GPs need to recognise their personal signals of distress and find ways to articulate the feelings and act to redress the distress.[326]
- The lack of safety and security in the lives of patients involved in abuse and violence repeatedly confirms the physical and emotional perception of alarm, danger and its impact. The GP may also be left with the same feelings of a personal sense of vulnerability and intolerance of violence.
- Courage involves stepping outside their comfort zone but not so far that they lose their own sense of safety.

Professional

- Dealing with the perpetrator of abuse or violence is even more difficult than dealing with the victim, especially in rural practices where the entire family is likely to be well known to the GP.[115]
- The GP is likely to also feel at risk, especially if they are drawn into the power dynamics of the violence or if they are dealing with the perpetrator.[115]
- Maintaining an 'intellectual engagement' with difficult work can assist as a protective strategy.[325]

Organisational

- GPs have been trained to deal with individuals and to take personal responsibility but are now moving towards working in teams.[326] This brings challenges around sharing information and maintaining confidentiality.
- Dealing with abuse and violence requires using a whole-of-practice approach and working with other services in the community.

Balance

Personal

- Lifestyle choices that promote 'wellness' include relationships, religion or spirituality, focusing on success, maintaining a balance in life and a positive outlook,[317] as well as simple measures such as getting enough sleep, exercise, nutrition and laughter.
- There is a need for purposeful physical, intellectual, spiritual and relationship sustenance.[317]
- Without a positive countervailing exposure to human good and world order, a GP may experience the same loss of a sense of personal control, freedom and trust.

Professional

- Appropriate support for the doctor in training and clinical practice needs to be readily available, especially considering that 14% of male doctors and 31% of female doctors have a personal history of child abuse or physical violence with an intimate partner.[115]
- GPs with less perceived control, greater stress from uncertainty, higher job demands and fewer social supports are at greater risk of burnout.[327]
- One of the difficult balances in abuse and violence is the stress of maintaining confidentiality and still getting added support from other health professionals.
- Learn to celebrate small achievements rather than feel overwhelmed by the big picture.[322]
- As with other complex and time-consuming occupations, it is important to have clear boundaries between work and home, attend peer support groups and maintain professional development and training activities.[324]
- As a defence against the sometimes intense feelings of helplessness, a GP 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.

Organisational

- Organisational balance involves a sense of control over the practice environment, social support from colleagues and satisfaction with work demands and resources.[327]
- Many organisations may become caught in a struggle between promoting the wellbeing of their patients and trying to cope with the policies and structures in a system that tends to stifle the empowerment and wellbeing of their staff.[328]
- 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 organisations' requirements for performance.[322]
- GPs need physical security and a safe, confidential workplace, support for continuing education, and adequate vacation and sick leave.
- Problem-solving rather than blaming helps the patient and the GP be more objective and balanced.[323]
- 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.
- Control working hours in the challenging area and, if possible, balance this with other less challenging jobs.[325]

Connection

Personal

- Working in teams is associated with being better able to cope with stress.[315,326]
- If a GP is becoming burnt out, there may be increased substance use, pessimism and suspiciousness of patients and colleagues.[324]

- If a GP is experiencing compassion fatigue or burnout, they need to ask for help and find activities that connect with mind, body and support networks.[324]
- Social support systems can provide understanding and renew emotional reserves.[324]

Professional

- Confidentially debriefing with colleagues can reduce stress levels by sharing the experience.
- Normalise emotional reactions, develop more understanding of reactions and learn stress management strategies.
- Peer support groups, professional development and training activities can be replenishing and reinforce the value and meaning of work.

Organisational

- Working and communicating well as a team with the GPs, practice nurses and receptionists within the practice, and with public health nurses, teachers, police and other agencies, is very important in the identification and management of abuse and violence.[115]

Conclusion

This chapter has highlighted the importance of self-care for the GP when working with families experiencing violence and abuse. It encourages self-reflection, peer support and working as a whole of practice approach to these families.

Resources

Please refer to *Appendix 7* for resources nationally and in your area.

Further information

- *Keeping the doctor alive* – this guidebook provides information and resources on strategies for self-care as an essential element of professional life. It aims to encourage medical practitioners to recognise and discuss the challenges facing them, promote self-care as an integral and accepted part of the professional life of medical practitioners, and assists medical practitioners to develop useful strategies for self-care. It is available to purchase from the RACGP website at www.racgp.org.au/publications/ordering/tools
- *General practice – a safe place: tips and tools* – available free of charge at www.racgp.org.au/your-practice/business/tools/safetyprivacy/gpsafeplace
- Rowe L, Kidd M. *First do no harm: being a resilient doctor in the 21st century*. North Ryde: McGraw Hill Australia, 2009.
- *Understanding and addressing vicarious trauma*. Headington Institute. Self-study available at http://headington-institute.org/Default.aspx?tabid=2647
- Vicarious Trauma, available at www.headington-institute.org/topic-areas/125/trauma-and-critical-incidents/246/vicarious-trauma
- RACGP GP Support Program – a free service offered by the RACGP to foster a culture of self-care. It is available to all Australian RACGP members who are registered medical practitioners, regardless of where you live or work. Members can access professional advice to help cope with life's stressors which may include personal and work related issues that can impact on their wellbeing, work performance, safety, workplace morale and psychological health. The GP Support Program can provide help to RACGP members with a range of issues, including: handling work pressures, managing conflict, grief and loss, relationship issues, concerns about children, anxiety and depression, alcohol and drug issues, traumatic incidents. More information is available at www.racgp.org.au/yourracgp/membership/exclusiveoffers/wellbeing/

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Appendices

Appendix 1. Nine steps to intervention – the 9 Rs

All GPs need to understand the nine steps to intervention:

- **Role** with patients who are experiencing abuse and violence
- **Readiness** to be open to
- **Recognise** symptoms of abuse and violence, ask directly and sensitively and
- **Respond** to disclosures of violence with empathic listening and explore
- **Risk** and safety issues
- **Review** the patient for follow-up and support
- **Refer** appropriately and also
- **Reflect** on our own attitudes and management of abuse and violence
- **Respect** for our patients, our colleagues and ourselves is an overarching principle of this sensitive work.

Role

Abuse and violence, as defined in the manual, is very common in our communities, affecting all age groups and socioeconomic strata. It occurs more commonly against women and children than men. Abuse and violence has major mental and physical health effects on our patients. As a result they use health services more frequently, although GPs often fail to identify the underlying abuse and violence. GPs are likely to be the first professional contact for survivors of any abuse and violence, as outlined in the manual. Unless this role is recognised and embraced, we will fail to address this major public health problem.[3]

Readiness

The practice can be enhanced if all members of the clinic and clinic protocols are appropriately prepared with safety, confidentiality, choice, collaboration and empowerment as priority principles.[329]

Readiness to work in this area may be enhanced by undertaking training for doctors and all staff in recognition and management of patients experiencing abuse and violence, including the management of all family members. Placing posters and leaflets in clinic waiting areas offering support and referral to patients may allow patients to self-refer or realise that we are interested in this sensitive area.

GPs need to pay attention to confidentiality in our quality assurance and accreditation processes – including ensuring that the patient file is confidential and not accessible to other family members.

Practice protocols need to address the needs of these patients and the safety of staff.[4]

Recognise

You need to ask patients who present with typical symptoms of abuse and violence and those with symptoms of abusive behaviour about violence and safety (case-finding).

Respond

WHO recommends the following for all GPs:

- non-judgemental support and validation including expressing the unacceptability of any abusive behaviour but not of the patient
- practical care and support that responds to concerns but does not intrude
- asking about history of violence, listening carefully, but not pressuring the patient to talk
- provide information about resources, including legal and other services that the patient might think helpful
- assisting the patient to increase safety for themselves and their children, where needed
- providing or mobilising social support
- providers should ensure that the consultation is conducted in private and emphasise confidentiality within limits of harm to herself/himself or others.

Risk and safety

GPs need to assess the patient's safety, risk of harm to themselves and others and discuss a basic safety plan with ongoing monitoring of the woman, her partner and children for safety and progress. You also need to assess the risk to children of abuse and violence and children's and adult perception of the impact on children. It is important to document comprehensively and carefully, and to offer to report the incident to the appropriate authorities if the patient wants this. However, you need to report children at risk as well as women according to mandatory laws in the Northern Territory. When seeing couples, consider referring one partner to another colleague. Use a clinic protocol for monitoring danger to the patient and other family members in your practice.[4]

Review

Responses during later interactions need to be informed by an understanding of the chronicity of the abuse and violence problem and to provide follow-up and continued support, which respects patient's wishes. This will include an assessment of the patient's and family's level of social support and consider children's access to significant supportive others. Do not offer couple counselling where there is abuse and violence in the couple's relationship.

Refer

Offer options for referrals for women and children to safety, advocacy and therapeutic support services. Offer men who abuse referral to accredited behaviour change programs when available. We need to involve ourselves in inter-agency collaboration for the benefit of our patients.

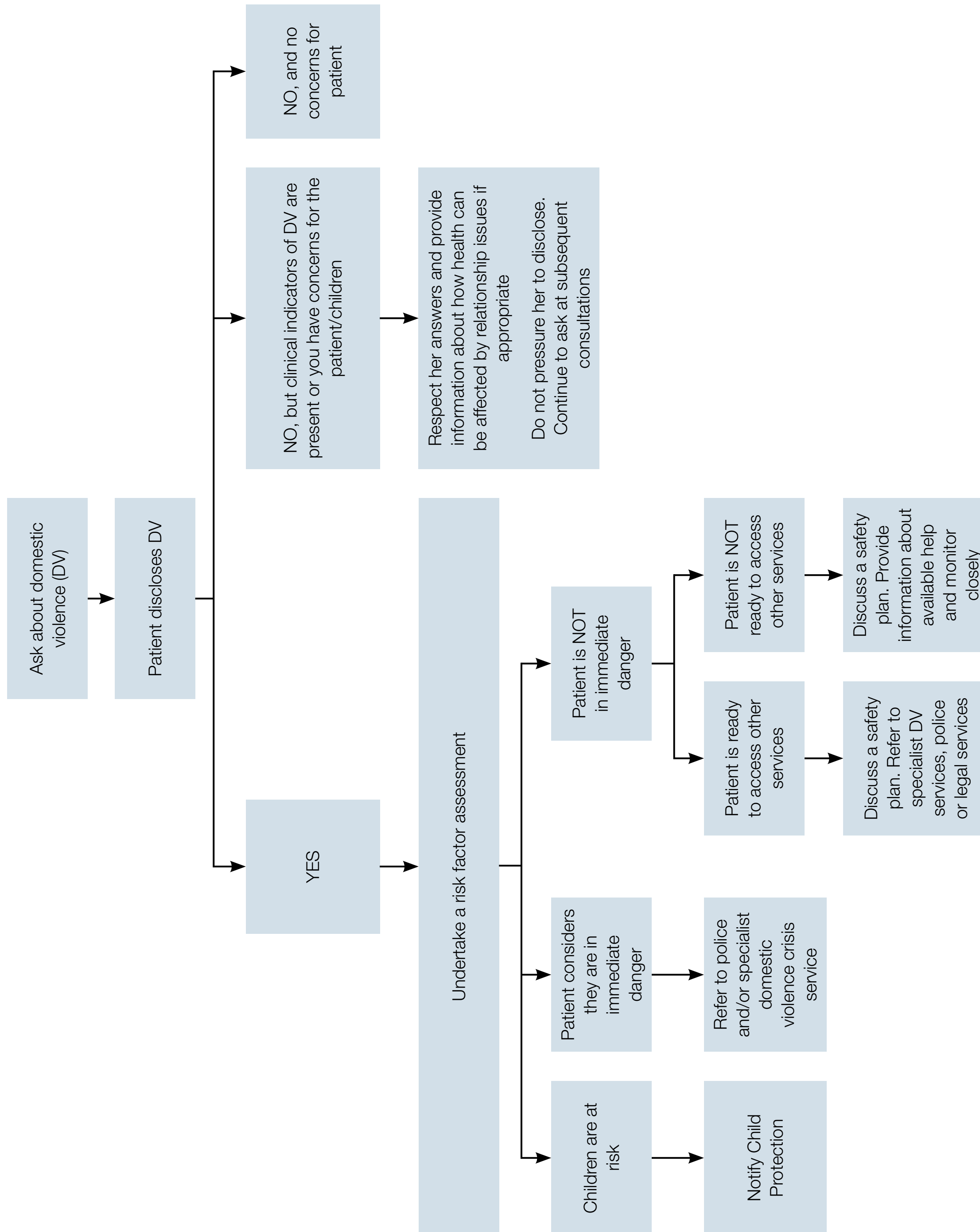
Reflect

Monitor personal and professional attitudes about abuse and violence for management bias and set up processes and policies that support the doctor and other staff in managing what can be complex issues.[4] Ensure that you take time to reflect and take care of your own health and wellbeing.

Respect

Respect is an overarching principle when dealing with issues of abuse and violence. This involves respecting patient's wishes, respecting our own limits and abilities to undertake abuse and violence work and, finally, modelling respectful relationships with our colleagues and in the community.

Appendix 2. Risk assessment flow chart[330]



Appendix 3. 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.

Appendix 4. Readiness to change – 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.*

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

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

	Like	**Dislike**
Relationship		
Action (specify)		

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?

Appendix 5. Non-directive problem-solving/goal-setting tool

Non-directive problem solving assists individuals to use their own skills and resources to function better.[331] 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
1.	1. 2. 3		
2.	1. 2. 3		

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. ______________________________

Appendix 6. Elder Abuse Suspicion Index (EASI)

EASI questions Q.1–Q.5 asked of 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 aides or medical care, or from being with people you wanted 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 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

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Appendix 7. Resources

Resources are listed here by location. Click on the state or territory, or scroll down the page, to find resources in that state or territory.

- National
- Australian Capital Territory
- New South Wales
- Northern Territory
- Queensland
- South Australia
- Tasmania
- Victoria
- Western Australia

National	
General	
Lifeline	13 11 14 www.lifeline.org.au
Sexual assault and family violence services	
1800RESPECT - National Sexual Assault, Domestic and Family Violence Counselling Line	1800 737 732 www.1800respect.org.au
The Australian Domestic and Family Violence Clearinghouse	www.austdvclearinghouse.unsw.edu.au
Forensic and Medical Sexual Assault Clinicians Australia	www.famsacaustralia.org.au
The Foundation to Prevent Violence Against Women and their Children	www.preventviolence.org.au
Men's services	
Relationships Australia	1300 364 277 www.relationships.com.au
Mensline Australia	www.menslineaus.org.au
Children related services and reporting	
Kids Helpline	1800 55 1800 www.kidshelpline.com.au
Australian Institute of Family Studies – provides contact telephone numbers for each state and territory to report incidences of child abuse	www.aifs.gov.au
Australian Childhood Foundation	1800 176 453 www.childhood.org.au
The Child Abuse Prevention Service	1800 688 009 www.childabuseprevention.com.au
Adult survivors of child abuse	
ASCA	1300 657 380 www.asca.org.au

National	
Living well – offers services to assist men who have experienced childhood sexual abuse or sexual assault abuse or sexual assault	1300 114 397 www.livingwell.org.au
Vulnerable populations	
National disability abuse and neglect hotline	1800 880 052 www.disabilityhotline.net.au
Office of Aged Care Quality and Compliance	www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-about-professional.htm
Rights of Older People – website of advocacy services for older people	www.agedrights.asn.au/rights/home.html
Elder Abuse Prevention Unit	1300 651 192 (helpline) (07) 3867 2525 www.eapu.com.au
Intellectual Disability Rights Service	1800 666 611 (free call)
Migrant and refugee communities	
FASSTT: Forum of Australian Survivors of Torture and Trauma (provides refugee centres around the country)	(03) 9389 8932 www.fasstt.org.au
Translating and Interpreting Service (TIS)	131 450 www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/index.htm 1300 131 450 (Doctors' priority line) www.tisnational.gov.au/Help-using-TIS-National-services/Contact-TIS-National
Aboriginal and Torres Strait Islander violence	
Indigenous health services – lists services across all states	www.healthinfonet.ecu.edu.au/key-resources/organisations
Legal support services	
Forensic and Medical Sexual Assault Clinicians Australia	www.famsacaustralia.org.au

ACT	
Sexual assault and family violence services	
Service Assisting Male Survivors of Sexual Assault (SAMSSA)	(02) 6287 3935 www.samssa.org.au
Canberra Rape Crisis Centre	(02) 6247 2525 www.crcc.org.au
Domestic Violence Crisis Service	(02) 6280 0900 www.dvcs.org.au
Men's services	
Men's Centre	(02) 6230 6999 www.menscentre.org.au
Domestic Violence Crisis Service	(02) 6280 0900 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 www.communityservices.act.gov.au/ocyfs
Child, Youth and Family Gateway	1800 647 831 www.thegateway.org.au
Adult survivors of child abuse	
Service Assisting Male Survivors of Sexual Assault (SAMSSA)	(02) 6287 3935 www.samssa.org.au
Canberra Rape Crisis Centre	(02) 6247 2525 www.crcc.org.au
Vulnerable populations	
ACT Disability, Aged and Carer Advocacy Service	(02) 6242 5060 www.adacas.org.au
Migrant and refugee communities	
Multicultural Women's Advocacy	www.multiculturalwomensadvocacy.org
Companion House (assisting survivors of torture and trauma)	(02) 6251 4550 www.companionhouse.org.au
Legal support services	
Legal Aid ACT	1300 654 314 www.legalaidact.org.au
Magistrates' Court	(02) 6207 1709: Civil (02) 6207 1728: Criminal www.courts.act.gov.au/magistrates
Doctors' support	
Doctor's Health Advisory Service: 'Colleague of First Contact' – 24 hour phone service	0407 265 414

New South Wales	
Sexual assault and family violence services	
NSW Rape Crisis Centre	1800 424 017 www.nswrapecrisis.com.au
DoCS Domestic Violence Line	1800 656 463
Another Closet: ACON Anti-violence (Lesbian, Gay and Intersex Domestic Violence Support)	1800 063 060
Men's services	
Relationships Australia	(02) 9635 9311 www.relationships.com.au
Children related services and reporting abuse	
Department of Community Services	132 111 (24 hours) (02) 9716 2222 www.community.nsw.gov.au
Adult survivors of child abuse	
NSW Rape Crisis Centre	1800 424 017 www.nswrapecrisis.com.au
Vulnerable populations	
Elder Abuse Helpline	1800 628 221 www.elderabusehelpline.com.au
Office of the Public Guardian	1800 451 510 www.publicguardian.lawlink.nsw.gov.au
Migrant and refugee communities	
Multicultural Health Communication Service	(02) 9816 0347 www.mhcs.health.nsw.gov.au
Immigrant Women's Speakout	(02) 9635 8022 www.speakout.org.au
STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)	(02) 9794 1900 www.startts.org.au
Legal support services	
Legal Aid NSW	1300 888 529 www.legalaid.nsw.gov.au
Law Access NSW	1300 888 529 www.lawaccess.nsw.gov.au
Local courts (listing of courts in NSW)	www.localcourt.lawlink.nsw.gov.au/localcourts/index.html
Aboriginal Legal Service (NSW/ACT)	www.alsnswact.org.au
Doctors' support	
Doctors' Health Advisory Service – 24 hour phone service	(02) 9437 6552

Northern Territory	
Sexual assault and family violence services	
Crisis Line	1800 019 116
Sexual Assault Referral Centre	Darwin – (08) 8922 6472 Katherine – (08) 8973 8524 Tennant Creek – (08) 8962 4100 Alice Springs – (08) 8955 4500 www.health.nt.gov.au/Sexual_Assault_Services/index.aspx
Women's Information Centre Alice Springs	(08) 8951 5880
Dawn House – women's shelter and domestic violence counselling	(08) 8945 1388 www.dawnhouse.org.au
Ruby Gaea – support for women and children survivors of sexual assault	(08) 8945 0155 www.rubygaea.net.au
Men's services	
Crisis Line	1800 019 116
Children related services and reporting abuse	
Department of Health and Community Services – Child abuse/child protection hotline	1800 700 250 (24 hours) www.health.nt.gov.au/
Ruby Gaea – support for women and children survivors of sexual assault	(08) 8945 0155 www.rubygaea.net.au
Vulnerable populations	
Executive Office of Adult Guardianship	08) 8922 7343 (Darwin) (08) 8951 6028 (Alice Springs) (08) 8951 6741 (Office of Public Guardian)
Migrant and refugee communities	
Multicultural Council of the Northern Territory	(08) 8945 9122 www.mcnt.org.au
Melaleuca Refugee Centre (Torture and Trauma Survivors Service of the Northern Territory)	(08) 8985 3311 www.melaleuca.org.au
Legal support services	
Northern Territory Legal Aid Commission	1800 019 343 www.ntlac.nt.gov.au
Magistrates' Court	www.nt.gov.au/justice/ntmc
North Australian Aboriginal Family Violence Legal Service	1800 041 998 – Darwin 1800 184 868 – Katherine www.naafvls.com.au
Doctors' support	
Doctors' Health Advisory Service – 24 hour phone service	(02) 9437 6552 – helpline 0409 446 489 – office

Queensland	
Sexual assault and family violence services	
Brisbane Rape and Incest Survivors Support Service	1800 010 120 (07) 3391 0004 www.brissc.org.au
Statewide Sexual Assault Helpline	1800 010 120 www.health.qld.gov.au/sexualassault/
Zig Zag Young Women's Resource	(07) 3843 1823 www.zigzag.org.au
DV Connect	1800 811 811
Men's services	
dvconnect mensline	1800 600 636 www.dvconnect.org.au
Men's Domestic Violence Helpline	(08) 9223 1199 1800 000 599 www.dcp.wa.gov.au/crisisandemergency/pages/domesticviolencehelplines
Children related services and reporting abuse	
Department of Communities, Child Safety and Disability Services – Child safety after hours service Child safety services enquiries unit	 1800 177 135 / (07) 3235 9999 1800 811 810 www.communities.qld.gov.au/childsafety
Adult survivors of child abuse	
Brisbane Rape and Incest Survivors Support Service	1800 010 120 (07) 3391 0004 www.brissc.org.au
Living Well – offers services to assist men who have experienced childhood sexual abuse or sexual assault	1300 114 397 (07) 3028 4648 www.livingwell.org.au
Vulnerable populations	
Elder Abuse Prevention Unit	1300 651 192 www.eapu.com.au
Office of Adult Guardian	1300 653 187 www.justice.qld.gov.au/justice-services/guardianship/adult-guardian
Queensland Government: Department of Communities, Child Safety and Disability Services – What to do if you suspect someone is being abused	www.communities.qld.gov.au/communityservices/violence-prevention/elder-abuse/for-health-practitioners/what-to-do-if-you-suspect-someone-is-being-abused
Migrant and refugee communities	
Migrant Women's Advice Service (Nambour)	1800 451 183 www.qlddomesticviolencelink.org.au/the-migrant-womens-advice-service/
Immigrant Women's Support Service	www.iwss.org.au
QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)	(07) 3391 6677 www.qpastt.org.au/
Legal support services	
Legal Aid QLD	1300 651 188 www.legalaid.qld.gov.au

Queensland	
Magistrates' Court: Domestic and Family Violence	1800 811 811 www.courts.qld.gov.au/courts/magistrates-court/domestic-and-family-violence
Magistrates' Court (listings of magistrates' courts in QLD)	www.courts.qld.gov.au/contact-us/courthouses
DV Connect	1800 811 811 – Dvconnect womensline 1800 600 636 – Dvconnect mensline www.communities.qld.gov.au/communityservices/women/contact-us/emergency-assistance
Department of Communities, Child Safety and Disability Services	13 74 68 www.communities.qld.gov.au/communityservices/violence-prevention www.justice.qld.gov.au/courts/contacting/add_mag.htm
Aboriginal and Torres Strait Islander Legal Service (QLD) Ltd	1800 012 255 www.atsils.com.au
Doctors' support	
Doctors' Health Advisory Service – 24 hour phone service	(07) 3833 4352 – helpline (07) 3872 2222 – office

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 www.wis.sa.gov.au
Yarrow Place Rape and Sexual Assault Service	1800 817 421 (08) 8226 8777 www.yarrowplace.sa.gov.au
Domestic Violence Gateway Helpline	1800 800 098
Children related services and reporting abuse	
Department for Communities and Social Inclusion – child abuse support line	131 478 www.dcsi.sa.gov.au
Adult survivors of child abuse	
Relationship Australia (SA)	1800 188118 or 1800 161 109 www.respondsa.org.au
Vulnerable populations	
Office of the Public Advocate	08) 8342 8200 1800 066 969 (Country SA toll free) www.opa.sa.gov.au
Migrant and refugee communities	
Migrant Women's Support Service, Adelaide	www.migrantwomensservices.com.au
STTARS (Survivors of Torture and Trauma Assistance and Rehabilitation Service)	(08) 8206 8900 www.sttars.org.au
Legal support services	
Legal Services Commission SA	1300 366 424 www.lsc.sa.gov.au
Magistrates' Court	(08) 8204 2444 www.courts.sa.gov.au/OurCourts/MagistratesCourt
Aboriginal Legal Rights Movement Inc	1800 643 222 www.alrm.org.au
South Australian Council of Community Legal Centres	(08) 8342 1800 www.saccls.org.au
Doctors' support	
Doctors' Health Advisory Service – 24 hour phone service	(08) 8366 0250 – helpline (08) 8232 1250 – office
Dr DOC (Duty of Care) program for rural doctors in SA	(08) 8234 8277 drdoc@ruraldoc.com.au

Tasmania	
Sexual assault and family violence services	
Sexual assault support service	(03) 6231 1817 www.sass.org.au
Laurel House – North and North-West Tasmania Sexual Assault Support Services	(03) 6334 2740 (North) (03) 6431 9711 (North-West) www.laurelhouse.org.au
Family Violence Counselling and Support	1800 608 122
Men's services	
Centacare	(03) 6278 1660 www.centacaretas.org.au
Children related services and reporting abuse	
Department of Health and Human Services – Child Protection Services	1300 737 639 www.dhhs.tas.gov.au/children
Commissioner for Children	(03) 6233 4520 www.childcomm.tas.gov.au
Adult survivors of child abuse	
Sexual Assault Support Service	(03) 6231 1817 www.sass.org.au
Laurel House – North and North-West Tasmania Sexual Assault Support Services	(03) 6334 2740 (North) (03) 6431 9711 (North-West) www.laurelhouse.org.au
Vulnerable populations	
Office of the Public Guardian	(03) 6233 7608 www.publicguardian.tas.gov.au
Migrant and refugee communities	
Multicultural Women's Council of Tasmania	www.nirwa.org.au/pages/the-multicultural-womens-council-of-tasmania.html
Phoenix Centre (Support for Survivors of Torture and Trauma)	(03) 6221 0999 www.mrchobart.org.au/content/phoenix-centre
Legal support services	
Legal Aid Commission of Tasmania	1300 366 611 www.legalaid.tas.gov.au
Magistrates' Court	www.magistratescourt.tas.gov.au
Tasmanian Aboriginal Centre	www.tacinc.com.au
Doctors' support	
AMA Tasmania Peer Support Service Confidential and anonymous peer support for doctors by doctors – 365 days of the year from 8am to 11pm	1300 853 338

Victoria	
Sexual assault and family violence services	
Centre against sexual assault (CASA) – Sexual Assault Crisis Line	1800 806 292 www.casa.org.au
Women's Information and Referral Exchange (WIRE)	1300 134 130 www.wire.org.au
Domestic Violence Resource Centre Victoria	(03) 9486 9866 www.dvrcv.org.au
Women's Domestic Violence Crisis Service	1800 015 188 www.wdvcs.org.au
Men's services	
Men's Referral Service	1300 766 491 www.mrs.org.au
Children related services and reporting abuse	
Department of Human Services – Child Protection Crisis Service; Children, Families and Young People	13 12 78 www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people
Royal Children's Hospital – Gatehouse	(03) 9345 6391
Adult survivors of child abuse	
Centre against sexual assault (CASA) – Sexual Assault Crisis Line	1800 806 292 www.casa.org.au
Vulnerable populations	
Office of the Public Advocate	1300 309 337 www.publicadvocate.vic.gov.au
Seniors Rights Victoria	1300 368 821 www.seniorsrights.org.au
Migrant and refugee communities	
In Touch Multicultural Centre Against Family Violence (Victoria)	1800 755 988 www.intouch.asn.au/
Refugee and Immigration Legal Centre	(03) 9413 0101
Victorian Immigrant and Refugee Women's Coalition	03 9654 1243
Centre for Ethnicity and Health	www.ceh.org.au
Foundation House (Victorian Foundation for Survivors of Torture)	03 9388 0022 www.foundationhouse.org.au
Legal support services	
Victoria Legal Aid	1300 792 387 www.legalaid.vic.gov.au
Magistrates' Court of Victoria	03 9628 7991 www.magistratescourt.vic.gov.au
Aboriginal Family Violence Prevention and Legal Service Victoria	1800 105 303 www.fvpls.org
Women's Legal Service	1800 133 302
Doctors' support	
AMA Victoria Peer Support Service – phone advice service 8am–11pm	1300 853 338 – helpline (03) 9280 8722 – office
Victorian Doctors' Health Program Clinical services with some phone support	(03) 9495 6011

Western Australia	
Sexual assault and family violence services	
Crisis Care Helpline	(08) 9325 1111
Sexual Assault Resource Centre	1800 199 888 (08) 9340 1828 www.kemh.health.wa.gov.au/services/sarc
Women's Domestic Violence Helpline	1800 007 339
Men's services	
Men's Domestic Violence Helpline	08) 9223 1199 1800 000 599
Menstime	www.menstime.com.au
Children related services and reporting abuse	
Department for Child Protection and Family Support	(08) 9222 2555 www.dcp.wa.gov.au
Adult survivors of child abuse	
Incest Survivors' Association	(08) 9443 1910 www.isa.asn.au
Vulnerable populations	
Office of the Public Advocate	1300 858 455 www.publicadvocate.wa.gov.au
Migrant and refugee communities	
Multicultural Women's Advocacy Service	08) 9328 1200 (08) 9336 8282 – Fremantle (08) 9490 4988 – Gosnells (08) 9344 8988 – Mirrabooka (08) 9227 8122 – Northbridge www.whfs.org.au/services/fdvs/mwas
ASeTTS (Association for Services to Torture and Trauma Survivors)	(08) 9227 2700 www.asetts.org.au
Legal support services	
Legal Aid WA	1300 650 579 www.legalaid.wa.gov.au
Magistrates' Court	www.magistratescourt.wa.gov.au
Aboriginal Legal Service of Western Australia	1800 019 900 www.als.org.au
Doctors' support	
Doctors' Health Advisory Service	(08) 9321 3098

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