Government of Western Australia
North Metropolitan Health Service
Women and Newborn Health Service

Working with Diverse Population Groups

There are several vulnerable groups of people that are at heightened risk of experiencing FDV. The list below is not exhaustive and other considerations to keep in mind is young women, people with mental health concerns, socially and economically disadvantaged women, and those living in a rural or remote area.

Aboriginal People

There is a great diversity amongst Aboriginal people in Western Australia and each person's experience within their family and community differs. Not all people experience FDV and it is not part of any traditional Aboriginal cultural practice.

The causes of family violence in Aboriginal communities are complex and must be understood in the context of a long history of racism, dispossession, marginalisation, intergenerational trauma, poverty and separation of children from their parents.

However, Aboriginal women in Australia experience disproportionate rates of a number of forms of violence. Violence against Aboriginal women should be understood in intersectional terms i.e. that they experience multiple forms of oppression of which FDV is one.

Intervention with Aboriginal clients must take into account, and not diminish or threaten, cultural rights, expectations or practices. Aboriginal people have family and kinship responsibilities that are not typical of non-Aboriginal families. Aboriginal people often have strong family networks and Aboriginal people and communities need to be supported to strengthen cultural systems of care. It is important to consider this when discussing intervention options and supports. It is also important to recognise diversity within the Aboriginal population and the differing contexts of remote, rural and urban settings.

When working with Aboriginal people it is important to remember:

- Whole-of-life view of health – social, emotional and cultural wellbeing of not just the individual but the whole community.
- Aboriginal Knowledge – Aboriginal women and men are the principle source of knowledge on Aboriginal family violence.
- Working in partnership – building capacity to recover, re-empower and rebuild family and cultural relationships.
- Recognition of trauma and loss – acknowledgement of historical losses and grief.

Practice points:

Development of trust is important to Aboriginal people. In order to achieve the best outcome, a long-term involvement with the client and/or family is recommended.

- Determine whether the language of the risk assessment appropriate for the client. Consider the use of an interpreter.
- Consult with Aboriginal / Aboriginal liaison staff Officers (?)/ Aboriginal Health Workers where available, and wherever possible offer the choice of an Aboriginal health professional. ALO's and AHW's provide cultural support and guidance to clinicians in their assessment and referral of Aboriginal patients, to help ensure high levels of cultural security. Clinicians should seek approval from both the patient and the ALO / AHW staff member as to whether the referral is appropriate due to potential cultural conflicts amongst Aboriginal communities
- Services and responses provided to Aboriginal people should be culturally responsive and safe, recognising the understanding of family violence, rights to self-determination and self-management, whilst taking into account the experiences of colonisation, systemic violence, discrimination and recognising the ongoing and present day impacts of historical events, policies and practices. Aboriginal people must be offered a clear choice about whether to use a mainstream or Aboriginal service, and this choice must be respected. Where an Aboriginal-specific service response is not available, consultation with an Aboriginal organisation will support culturally respectful service provision.
- For some Aboriginal people, English is not their first language. Always seek permission from patients on whether to utilise the Aboriginal Interpreter Service.
- There may be a preference for group or family approaches rather than individual 'counselling'.
- An Aboriginal woman's situation may be complex and FDV may not be the only issue they are managing.
- Clients may disengage if the subject is raised too early. The health professional must build trust and have a relationship where the client is willing to talk on these matters.
- Aboriginal women may leave a health service before they are medically well. This can relate back to fear of reprisal or concern for their children and the historical circumstances that has created a feeling distrust in some areas and trauma.
- Leaving a violent relationship or going to the police may result in reprisal for an Aboriginal woman by extended family members. Consider whether the client at risk of family retribution or ostracism from the community if legal intervention is initiated?

To view an interview with an Aboriginal Liaison Officer providing culturally competent best practice guidelines when screening an Aboriginal client for family and domestic violence, go to: https://www.youtube.com/embed/C6FRVsv6NbM.

See Appendix 6 of the Guidelines for information on FDV support services available specifically for Aboriginal people.

Migrant and Refugee Women

Women from Culturally and Linguistically Diverse backgrounds, in particular new migrant and refugee women, can be disproportionately affected by family violence more than people of Anglo-Australian background and face unique barriers to accessing support. Barriers may include lack knowledge with services available, or rights under the law, fear of authority, lack of culturally, linguistically and faith-appropriate and safe service delivery.

This is further complicated by the social and economic marginalisation of many people from culturally and linguistically diverse communities, especially those who have recently arrived in Australia.

Women from these communities experience the same forms of family violence as the broader community, as well as cultural or faith specific experiences such as forced/early marriage, dowry-related abuse, and coercion based on visa status, which are not readily recognised as family violence. Women without permanent residency and uncertain visa status, including asylum seekers, also have limited access to services. Some people from multicultural communities may also present with physical and mental health issues exacerbated by displacement and exposure to violence and trauma in their country of origin. The assumption that migrating to a safe country ends the turmoil is false, as often feelings of guilt regarding safety and the onset of family violence occur during this time frame.

The needs of people from a CaLD background are many and diverse as a result of cultural and religious beliefs and practices, race, levels of education, length of residence in Australia, circumstances under which they came to Australia, fluency in English, family and social networks, housing situations and economic circumstances. Given the diversity of people from migrant and refugee backgrounds, a 'one size fits all' approach does not work for multicultural communities.

Practice Points:

Always use an interpreter. When offering the use of Interpreters in cases of family and domestic violence, consider offering a telephone interpreter service (from inter-state) for anonymity. NEVER use relatives or other Aboriginal staff as interpreters. Refer to the WA Health Language Services Policy.

- Some women lack knowledge relating to their rights in Australia, which stops them from accessing support
- Fear of isolation and lack of extended family support
- CaLD women are less likely to leave a violent relationship as there is pressure to remain in a marriage because of their fear of bringing shame and dishonour to the family
- For refugee women, the experience and effects of domestic violence following resettlement in a new country can be particularly devastating, given that many have endured sexual and physical violence prior to their arrival
- Violence can escalate as a result of migration and because of cultural change and the shift of gender roles
- It is important to remember that people perceive domestic violence differently due to their cultural and traditional beliefs
- Always validate someone's experience and do not let a different culture hinder the quality of care delivered
- Respect for individuals culture, including acknowledgement of values and belief systems, while recognising the strengths people from CaLD backgrounds demonstrate is essential

- Women from CaLD backgrounds perceive domestic violence differently. For example, they may fail to recognise violence as criminal behaviour especially non-physical violence.
- Women from CaLD backgrounds do not often seek help as there could be pressure on them to remain in the marriage. Leaving a marriage can often be associated to shameful and dishonourable behaviour

To view a video role-play of a health professional demonstrating culturally competent practice when screening a culturally and linguistically diverse patient for family and domestic violence, go to: https://www.youtube.com/embed/VAG0T_gr7Jg

For further information on this topic, see the *Information Sheet: Working with women from CaLD backgrounds who have experienced family and domestic violence*, located in the FDV Toolbox.

See Appendix 6 of the Guidelines for information on FDV support services available specifically for new migrant and refugee women.

People of diverse sexuality, sex and gender

FDV occurs in diverse sexual gender relationships and there is evidence to suggest that the rates of family and domestic violence in gay, lesbian, bisexual, transgender, transsexual, intersex, queer, and other people of diverse sex, sexuality and/or gender (LGBTIQ) relationships occurs at similar rates as those that identify as heterosexual. The abuse similarly involves the use of power, coercion and control.

Factors that can make people in LGBTIQ relationships more vulnerable to FDV include myths that violence from LGBTIQ people is not family violence, concerns for confidentiality and privacy including being 'outed', lack of awareness regarding rights and entitlements if ending a relationship and internalised homophobia.

When the consequences of gender inequality overlap with the impact of other forms of inequality such as discrimination on the basis of gender orientation or gender identity, the probability of violence against women and men from the LGBTIQ community is higher

In addition to the usual forms of emotional/psychological abuse, abuse experienced by people in LGBTIQ relationships may also involve homophobic control with threats of 'outing' or revealing their sexual identity made by the person responsible. This can result in the client at risk fearing the loss of significant relationships and fearing discrimination in, for instance, the workplace.

Other examples of abusive behaviour include:

- Threats to withhold access to children and pets;
- Explicit threats to pets, home, possessions, posting of personal photographs/images;
- Coercion to engage in risky sexual behaviour;
- Threats to alienate from religious community;
- Threats to self-harm, suicide;
- Heterosexism - a system of attitudes, bias and discrimination in favour of opposite-sex sexuality and relationships;

- Transphobia - is a range of negative attitudes and feelings towards trans-sexualism and transsexual or transgender people, based on the expression of their internal gender identity; and
- Homophobia.

Practice Points:

Use of language and terms. The use of inclusive language is critical and a health professional can confidentially ask how people would like to be referred to. Ask directly how a person wishes to be described. This is important when people do not identify as either a ‘male’ or ‘female’.‘ The term ‘trans’ is sometimes used as an umbrella term for anyone whose gender characteristics are different from societal expectations. It is not appropriate to call someone a ‘trans’, ‘transgender’ or ‘tranny’.

- Intersex and transgender people often describe their bodies in terms that match their gender identity and not in the terms that society may use. There is evidence that when health professionals describe body parts different to what the client may identify with, it creates a barrier to health service provision and can lead to poor health outcomes.
- There is evidence that the prevalence, types and contextual triggers of violence in male same-sex relationships parallel abuse in opposite sex relationships.
  - When talking about people’s relationships, health professionals can use inclusive language such as parent instead of mother/father, or partner instead of boyfriend/girlfriend, husband/wife.
  - Some people may decline gender-affirming medical intervention due to religious, financial, medical or personal reasons.
  - Community isolation may be experienced by people in diverse sexuality and gender relationships.
  - There are limited support services and legal protection available for people who identify as a having diverse gender. Limited availability of suitable crisis accommodation.
  - The focus of intervention should be on enhancing the safety for the client
  - Fear of negative, stereotypical responses from mainstream providers.
  - Lack of appropriate refuges and lack of referral options for both female and male people who have been abusive within mainstream services.

People with disabilities

People with disabilities, both adults and children, are at higher risk of experiencing family violence. Women and girls with disabilities experience even higher rates of abuse and violence than men with disabilities, who are at higher risk than men in the general population.

Practice Points:

- Cognitive impairment may impact a victim survivor’s ability to effectively communicate their experience of risk;
- People with a disability face an additional barrier if the abuser is also their primary carer. It should be noted that disability may increase dependence on the perpetrator;

- Women with children with disabilities may also face additional barriers to services;
- Professionals should believe people with a disability who disclose they are experiencing family violence. Some people with disabilities may doubt they will be believed because they haven't been believed in the past;
- People with disabilities may experience isolation and additional barriers to service access, for reasons such as perpetrators preventing access;
- People with disabilities may experience impairment-based family violence from a family member or carer, including using or withholding aides, medication or other devices that support the day-to-day capacity of people with disability.

Older people

Abuse of older people may take any form of presentation of family violence. There is a higher prevalence of economic or financial abuse, often arising from a sense of entitlement from an adult child or carer, as well as social and service access isolation. Elder abuse can also resemble other forms of family violence, such as intimate partner violence, including sexual abuse, which is experienced predominantly by older women.

The perpetrator is also often the victim survivor's adult child. However, elder abuse can also be

perpetrated by other family members, including extended family members or carers. Older women, who often live longer, experience higher rates of elder abuse than older men. The experience of elder abuse by older men and women may take different forms.

Practice Points:

- Older people may be dependent on the perpetrator and be concerned about the consequences of reporting family violence, such as isolation and a loss of dignity and freedom.
- Older people may believe that family violence is a private matter or may not recognise particular behaviours as violence. Traditional beliefs and values may enhance this view.
- Older people may want to protect and maintain the relationship and not want to get the perpetrator into trouble, particularly if the perpetrator is the older person's adult child. This includes also where an older person is contributing as a carer to grandchildren. This may impact an older person's willingness to engage with legal and justice services.
- Potential barriers to obtaining informed consent, such as access to services due to control of movements and isolation, cognitive capacity or language barriers.

Refer to the WA Health Responding to the Abuse of Older People (Elder Abuse) Policy for further guidance.

Male victims

Men from many backgrounds and identities experience family violence in intimate partner relationships or other forms of family violence, including gay, bisexual, trans, gender diverse and intersex men, Aboriginal men, adolescent males, men with disabilities, and older men.

While perpetrators against female victim survivors are most likely to be male intimate partners, perpetrators against male victims are more likely to be other male family members. Many men who are victims of intimate partner violence in heterosexual relationships also perpetrate family violence, that is, both parties may be using or experiencing violence in the relationship.

Practice points:

There are particular considerations relating to risk, needs and choices for adult males experiencing family violence, which can include:

- fearing that they will not be believed, or that their experiences of violence and abuse will be seen as less important and less urgent than those of women and children
- being the primary carers who may require support for their children.
- The lack of services including safe housing (refuges) for male victims of violence and abuse.

References

Dedeigbo O, Cocodia E. Domestic violence in Australia's CaLD communities: Association between demographics of frontline workers and selected therapeutic approaches. [Internet]. 2016.

El-Murr A. Intimate partner violence in Australian refugee communities. Scoping review of issues and services responses. Australia: Australian Institute of Family Studies and Child Family Communities; 2018.

This document can be made available in alternative formats on request.