# Introduction to family violence

**Karen Bentley:** So welcome. Before I get going, I would like to acknowledge the traditional custodians on the land in which we meet today, and pay my respects to Elders past, present, and emerging. Okay. So Louise has basically just introduced WESNET. Who's heard of WESNET? One person, yeah. We sort of operate in the background. We've been around for about 20 years. We are the national peak body for domestic and family violence frontline services across the country. We've got about 350 members across all of Australia, and they vary from refuges to DV crisis services to women's information and referral services. And we work with mainly the Commonwealth Government, but also with our State counterparts, around trying to advocate on behalf of the women and children that our frontline services support when they're escaping or dealing with domestic and family violence. We've got two main projects. One is the Australian Women Against Violence Alliance, which any organisation who's interested in prevention or elimination of violence against women can join. It's a national coalition of many, many different women's organisations who all come together to try and harness and share information. And the second one is, as Louise mentioned, the Safety Net Project, which actually examines the intersection between technology abuse and violence against women.

So what is family violence? All of you have heard of it. Experienced. I think it's pretty hard in Victoria at the moment to have not had some kind of crossover with the Royal Commission into Family Violence. So we know in the world that one in three women will have experienced violence at some point in their lifetime. We also know that one in five women have experienced sexual violence from the age of 15 in Australia, and we are also seeing alarming rates of homicide. So in Australia at the moment, nearly one woman a week is murdered. That continues. We've had horrifying murders again in the last few days. We also need to understand that violence against women intersects with a whole range of other socio, political, gender, economic issues, which is around how that actually happens with different groups. So we want to try and focus a bit on that as well today.

In Victoria, family violence is actually defined in legislation, the Family Violence Protection Act. So it's behaviour that is physically, sexually, emotionally, psychologically, or economically abusive, threatening or coercive, controls or dominates the family member and causes that family member to fear for the safety or wellbeing of that family member or another person. And secondly, it's behaviour that causes a child to hear, witness or otherwise be exposed to the effect of any behaviour referred to above. Are you all familiar with that definition? It's not, yes, you're all. So domestic and family violence, we've moved a long way in Victoria beyond domestic or family violence being considered as just physical violence. It is a pattern of behaviour which is usually used to control or coerce. So it can include sexual abuse, emotional or psychological abuse, verbal abuse, spiritual abuse, could be constraining religious freedom or preventing access to families, so things like isolation. Stalking, intimidation. Financial abuse, so holding and controlling all access to all money. Cruelty to pets, damage to property. It's a range of behaviours that the abuser uses.

Often the term 'family violence' and 'domestic violence' are used interchangeably. And in Victoria we tend to use the term 'family violence', which also covers intimate partner relationships, as well as family and other relationships of mutual obligation and respect. Family violence is a pattern of behaviour that's experienced. It's not generally a one-off occurrence, it's a pattern of behaviour that proceeds over time. So that's one of the ways that you can understand the controlling behaviour that goes through. Most domestic violence is perpetrated by men against women and children. However, women can also be perpetrators of violence, and domestic violence or family violence also occurs in same-sex relationships. And women are at much greater risk of violence from intimate partners during pregnancy, and after separation. So we are starting to hear much more around, the time that a woman is most at risk of family violence or severe physical violence or homicide is when she's planning to leave or just after she's left. And a safety survey conducted by the ABS in 2005 found that 17% of women who'd experienced violence from a partner during the relationship experienced it for the first time when they were pregnant. So pregnancy can be a real trigger for family violence starting, or starting to emerge. So it's something to be aware of. How many of you are familiar with the power and control wheel? Question from the back?

**Seminar participant:** Is there any, what are the thoughts around that, about pregnancy being a trigger? Because the woman's changing or?

**Karen Bentley:** I haven't got any evidence. My sense is that when women are pregnant, they tend to be put on a pedestal, and they tend to gain more respect from their community and family and start to, sort of, garner that respect, and that sort of may challenge his power and control over her. So that can upset the balance. Yeah, so that's very common. Anybody familiar with the power and control wheel? Yeah. One. Okay. So this is work that's come out of Minnesota in Duluth. This particular wheel I've actually adapted for technology, but you can adapt them for all different types of circumstances. But basically what it shows is that there's a range of behaviours that happen by the abuser to the survivor or the victim. So here we've got coercion and threats, intimidating, monitoring and stalking. Emotional abuse, so ridiculing or putting down somebody, calling them names.

Isolating, so isolating a survivor, not letting her go out, not let her see a family, not let her leave the house, we've seen cases where that happened. Minimising, denying and blaming, so pushing the reason for his violence on to the victim, usually, or to something else. 'It was the alcohol that caused it.' Using others, so getting other people to pile on, we see that quite a lot in the technology abuse, but perhaps also using children. Using privilege and oppression, so taking over, making all the decisions for the family unit, making all the decisions about the household. And economic abuse, so tracking expenditure or completely controlling the finances. So all of these are types of things that you might see, and they're often used in concert and continuum as a sort of range of behaviours that happen when you're seeing family violence. And it's an ongoing pattern. And perpetrators are quite clever, they use different tactics at different times. They might use some sometimes and others sometimes, and they start to potentially escalate.

So we're going to do a little group exercise. I hope you've all got your phones. I'm going to get you to turn back over your slides, don't look at those. If you've got your phone, can you go to menti.com, menti.com. Hopefully you've got internet access. And when you're there, type in that code. 178766. So let's go through some of these myths. Some of the really common myths that we hear around family violence is that it's caused by drugs and alcohol, so that if you control the alcohol content in the community, for example Aboriginal communities, that you're going to control the violence. Often it can be seen as just an anger management issue. 'He just needs to control his anger.' And you will find me today completely and utterly 100% talking about males as perpetrators and females as survivors or victims. And that's just because I'm a women's services network.

We do acknowledge that it can be the reverse and that there are sometimes male victims and sometimes female perpetrators. But for the purpose of today, the overwhelming statistics show that 95% of perpetrators are male. Both men and women can be victims. Male children are particularly high being victims of family violence as well. Anger management. 'If he could just learn how to control his anger, it wouldn't be an issue.' We often hear that he's got a personality disorder, or he's a malignant psychopath, or something like that, and this is what the reason is, this is the reason that explains what is the underpinning cause of the domestic violence. Poverty, stress. Growing up with violence is really strongly thought in the community to be a cause of family violence. So if he didn't grow up in a violent situation, or if she didn't grow up in a violent situation, she wouldn't have married a violent man.

And if he hadn't have grown up in a violent home, he wouldn't have become a violent man. And many, many victims and survivors of childhood family violence would really strongly object to being characterised in that way. Biology. 'It's just a man thing.' Men, inherently more violent. 'She drove him to it, she provoked him.' 'She grew up with violence.' 'She should leave'. So one of the really, really big things that we find, and we find in all communities is, why doesn't she just leave? What is it that's keeping her there? If she really was, it was really that dangerous, she would leave. And really is quite a complex issue for women because, and they know that the most, it is so dangerous to leave. 'If I leave, I'm going to really tip him off and then I'm going to be dead,' is a really real fact for many women who are in that violent situation.

'She's making it up.' Many women are not believed because the tactics are around making the victim feel like it's her fault. Her self-esteem and her emotional wellbeing is severely eroded, particularly in long-term family violence. 'It's a private matter. This is something between a man and his wife in the privacy of their own home, nothing to do with us.' And that it only occurs in lower socioeconomic groups and communities. And we patently know now that it doesn't, it occurs across all levels of society in all communities. It's just that women who may be a bit more financially secure have got more options in terms of escaping or getting out.

I'll just quickly go on to sexual violence, and some of what you put up on the screen before, we're sort of doing that. So sexual violence, it isn't about sex, it's actually about power. It's about control and having power over a victim. We know, again, that many rapists are actually serial rapists. Not all men are violent, not all men are rapists, but there are many serial perpetrators who repeatedly offend. We know that sexual report is vastly under-reported, and we know it's even more under-reported when it occurs as part of family violence. So you will actually find that sexual assault occurs quite often in family violence, you just never hear about it. They'll focus on some of those other issues and not necessarily the sexual violence. Often victims are assumed to be lying or they're blamed. So very much a culture of 'she was asking for it, she shouldn't have worn that short skirt and those red high heels when she was out.' And we are also seeing that rape culture is really pervasive. So we can see how our female media are completely and utterly dogpiled on when they're in the media, and they're constantly receiving rape threats. So there is a large rape culture happening. Any questions before we move on? Yes.

**Seminar participant:** With the sexual assault [inaudible], I was wondering if it's under-reported, if it's also to do with sibling abuse, with sexual assault?

**Karen Bentley:** So sibling-on-sibling sexual assault? Could well be, yeah, we just know that generally the statistics are going up. So about 1.9% of women in Australia will report sexual violence in 2017 for the last 12 months, and it's gone up slightly from 1.5%, so at any one time. But I mean there's very alarming statistics around how many women in Australia. So one in five women from the age of 15 have experienced sexual assault of some form. And the most common age groups are 15 to 19, but also 11to 15-year-olds is the most common demographic.

So you are all working with clients coming into your consultation rooms. I haven't probably got the language right, in terms of your, you're regularly in touch with your settlement patients or clients that are coming in. And so I wanted to talk to you a little bit about some of the indicators that you might need to be aware of when you are working with your patients or clients. What do you call them, patients or clients? Clients, okay. All the way through, this is going to say patients, but... So most presentations of family violence are probably going to be hidden, and they're not going to be the obvious 'black eye'. The other thing that you'll find is that within your groups and communities, they don't call it family violence, they call it a family dispute or an argument or something else. So you've just, let's look at the behaviours and the characteristics rather than the names of what might be coming to you. So these are all in this GP kit, which I'll give you the link to at the end of the presentation. So you don't need to madly scramble these down, you've got them in your presentation.

So things like unexplained bruising or other injuries. We've all seen television series where we've got the woman who's a victim of family violence and she's got a massive black eye or bruise or something like that, and she's 'run into the door', and there's all sorts of excuses about how she got that. So things like accidents or injuries where the injuries sustained don't fit the history of, the history given. So bruises of various ages might be a sign. So it's not just one bruise, it's bruises and they're of different ages. Head, neck, facial injuries, particularly looking around neck, like if strangulation is there, that's something you really need to take strong notice of. Accidents during pregnancy, things like chronic abdominal pain, miscarriages, ulcers, dizziness. Sexually transmitted diseases, why might that be something? Coercion and force, could be something that's indicated with sexual assault as well. Other gynaecological problems. And you've just had a session on something, I hope that was, might've been relevant.

Okay, moving on to psychological and behavioural. So anxiety, indecisiveness, confusion, maybe even hostility, like, 'Don't ask me that question.' Sleeping and eating disorders, anxiety, depression, post/prenatal depression, psychosomatic and other emotional complaints, drug abuse. Are these types of things that you see in clients? Sometimes these might be indicators that there's family violence occurring. It doesn't mean that if you have these, there is family violence, but just to sort of be aware that when these types of behaviours show up and your little radar goes up, maybe there's something going on. Social isolation, no access to transport and no way to actually get anywhere.

Missing appointments repeatedly, like just can't get to the appointments, might be a really an interesting sign. And where the partner remains and will not let her have a consultation with you or a session with you without being present. And usually some good excuse like, 'She's got no English, so I've got to be here as her interpreter or as her translator.' So he won't let her out of his sight. With kids, difficulty eating and sleeping, slow weight gain, physical complaints, eating disorders, psychosocial, behavioural. This is not in any particular order but in younger children, regressive behaviour in toddlers, but it might be something different in slightly older children like fighting with peers. Acting out, sexually abusive behaviour, abusive of siblings or parents. There can be a whole range of other types of indicators that are happening in the children. And it's important to think about the children, because mum might be keeping it together, but the kids might not. So she might have a mask and be able to be in control, but the kids might actually be the flag that lets you know. So if you see some of these indicators and your antenna have gone up, how comfortable are you in asking? Do you feel like you've got the tools to ask the questions? Some do. That's great, we're going to be calling on you. And some don't.

**Seminar participant:** It depends on if it's the first or second visit.

**Karen Bentley:** Yes.

**Seminar participant:** Like if it's the first time you've met them, I wouldn't feel comfortable in that first visit, whereas second or third and we've developed a bit more of a rapport, then maybe.

**Karen Bentley:** That's right. So that is part of why the health services are so important, because you may very well form an ongoing relationship, and you can create that sense of trust. So it's really important to understand that you might be the only person that she's going to tell. A study In 2000 by Kelsey Hegarty, I don’t know if any of you have come across her, she's down at the University of Melbourne. She found that, unlike the TV episode where the victim goes to incredible lengths to hide what's happening, women actually want to be asked. So, and a 2016 article in the Journal of Clinical Nursing about New South Wales student nurses said that clinician inquiry is one of the strongest determinant of abuse disclosure. Whereas ineffective responses can discourage future help, seeking behaviour can lead, and help-seeking behaviour can lead to greater endangerment. Women who receive an initial positive response to disclosures of domestic or family violence are more likely to escape violence. And nurses have an important role in identifying people who are victims of family violence through screening and facilitating their access to assistance and support. So you'll pay a very crucial role in helping, identifying and also being there to disclose to. So as family and friends, victims are most likely to tell a health professional about violence after anybody else. And what we see with refugee and settlement communities is that they don't necessarily have those family and friends around them anymore. So your role can be even greater.

So let's look at how you could ask your patients. So the way to think about this is to start with broad questions that are perhaps not necessarily too invasive. You can ask broad question about whether your patient's relationships are affecting her health and wellbeing. And then you might go into slightly more direct questions, so you can ask those direct questions, but only if it's appropriate. We'll talk about that as we keep going. And if you do see some of these clinical indicators, maybe you can ask some specific questions around that. So we're going to do a little exercise now, maybe in your tables.

So the thing to remember is that if you suspect there are problems you can start asking indirectly, and then move towards direct questions. So let's do a little case study. This is Yasmina. So she's been settled in town for about six months and she's got two children and is pregnant with her third child. Her husband always generally attends the service with her and he tends to do all the talking. You can't seem to get her away from him. She's got limited English and the settlement team have been encouraging her to come to a local sewing group and English conversation classes being held on Tuesday afternoons, but she always refuses and so does the husband. She seems quite anxious about her pregnancy and she's complaining of spotting, abdominal cramping and has come to the clinic today with her sister-in-law. And just before you called Yasmina into the consult room, you noticed that she was constantly checking her phone and replying to her text messages. So if you'd like to just work in your groups, I'm going to give you about, maybe eight minutes or so, just to work in your groups and try and work out, what are you going to ask? How are you going to ask Yasmina? And also think about what you are not going to do. So what are you going to ask Yasmina and what might be some of those things that you wouldn't do? Okay, so who would like to just come back with, what's a broad question that you could ask in this? Did you have one?

**Seminar participant:** Do you feel safe in your relationship?

**Karen Bentley:** Do you feel safe in your relationship? Yeah. Others?

**Seminar participant:** We start with the physical health things, so the—

**Karen Bentley:** So start with physical health. Yeah. How is she going? Yeah.

**Seminar participant:** Are you excited for the baby? And then leading on from that.

**Karen Bentley:** So looking for a way in. So, are you excited for the, I'm having to repeat, but so, are you excited for the baby? So maybe starting to sense what kind of reaction you get from her.

**Seminar participant:** Were you anxious with your other pregnancies?

**Karen Bentley:** Right. Were you anxious with your other pregnancies.

**Seminar participant:** [inaudible] interpreters make or break?

**Karen Bentley:** Yes. Let's just stop for a minute and talk about interpreters. So interpreters can be tricky because you can't necessarily, if you're not fluent in the language, you can run into some problems. Who is the interpreter? Is she comfortable with the interpreter? Is the interpreter somebody that she knows in the community? Especially in rural/regional, it's very tricky. So yes, it can be quite interesting. Do you ever get family members offering to be interpreters?

**Seminar participant:** All the time.

**Karen Bentley:** So that could be very awkward and tricky, couldn't it? So having strategies, and I mean I think there are probably issues that you have to deal with in your services anyway, and hopefully you've got policies and procedures around not, and making sure that you've got the appropriate interpreters. We have had cases with phone interpreters where, terrible cases where she's been trying to do something and the interpreter's gone off piece, basically, and just decided to ring up the abuser and give him a piece of his mind. So it's really very, you do need to work with the interpreters quite carefully from time to time. So it is an issue and it is very difficult when you have got language barriers. So just to acknowledge that is a big issue.

How about just asking is how's everything going at home? So just ways in. So some of the ways might be, 'How are things at home?' 'How are you and your partner getting on?' might be a way in. 'Is there anything else that might be happening that's affecting your health?' So to just give her the opening to potentially come back. Then moving on to sort of the more direct questions, and again, you've sort of got to use your judgment here, and you'll have that judgment in terms of where you're going and how you're working with your clients. So if perhaps you get a positive to this broader question, then you might go into a slightly more direct question. So did you think about any of those in your groups? A slightly more direct question? I think the one that you had before is everything. 'Are you scared?', or, you had one before.

**Seminar participant:** And, 'What particular things that make you anxious about this particular pregnancy?'

**Karen Bentley:** So, 'What's making you anxious about this particular pregnancy?' Did you have one?

**Seminar participant:** Is there something specific that happened that she thinks might have caused the cramping?

**Karen Bentley:** Yes. So if you've got something like a lever to get in, that's it's really good. Yep. So you might then lead onto questions which are a bit more direct, which are things like, 'Are there ever times when you're frightened of your partner?' Or, 'Are you concerned about your safety or the safety of your children?' 'Does the way your partner treat you make you feel unhappy or depressed?' Might, it sort of, you're going to have to use your judgment in the way that you do that.

**Seminar participant:** Are we able to get a copy of some of those?

**Karen Bentley:** Yes, absolutely. Yes. They're all in the GP kit and it's all at the end, and the link is there. 'Has your partner ever physically threatened or hurt you?' Or, 'Violence is really common in the home and I ask a lot of my patients about abuse because no-one should have to live in fear.' So again, do that general thing. I ask this of all my patients, or all my clients, because... Yeah.

**Seminar participant:** I also think, I often have to tell my patients, look there's an out. If you say that you are suffering from violence, there are options for you. Because often our clients don't know, you know, if they say yes, what's going to happen next?

**Karen Bentley:** That's right, yeah, it's really can be quite challenging. They may not know that there's services and support available or they may be really, really scared about what happens if that is the next step. So with specific clinical symptoms, say you see some bruising or something like that, and you see a particular injury, say, 'When I see injuries like this, I wonder if someone could have hurt you.' So you're just sort of putting it back into the 'I', but you can actually get to quite a direct question. 'Is there anything that we haven't talked about that might be contributing to your condition?' 'You seem very anxious and nervous. Is everything all right at home?' So again, you can start to get to those very specific questions. And I think it's really important that you would never have the abuser or the potential abuser in the room. So you do have to go to quite a lot of work to try and get her alone and away from him or any of his proxies, for want of a better word. And you'll get a sense of that from the client herself. Did anybody else have any other gems of ideas for?

**Seminar participant:** I know when we had some training at the hospital, just briefly, what I remember in emergency, some of the stuff we would learn, ask the partner, 'Can you go and get us a drink of water?' and why they're quickly out, or, 'Can you take this form and drop it off?' or, 'Fill out this form, but could you take it to the ward clerk?' and why they're quickly out, it gives you kind of 30 seconds or a minute to get—

**Karen Bentley:** Yeah, and I think you were talking at your table here about the idea of maybe doing some kind of clinical assessment, which might be an opportunity to say, 'Oh no, this is women's business, out you go, we're going to do a—' yeah, and just see whether or not that, yeah. Okay, so what do you do? So you've just been soliciting a disclosure, but sometimes you might get a disclosure just randomly because you are a trusted professional and you've built a relationship with your client. So the key steps after the disclosure is basically this. Listen, communicate belief, validate the decision to disclose, emphasise the unacceptability of violence and be clear that she's not to blame. So they're sort of the five golden rules.

So just being listened to can be a very empowering experience for the woman who's being abused, particularly if it's been going on for quite some time and you are the first person that she's disclosed it to, and you are the first person to listen. So your reaction to it will be really key to whether or not she then goes on to get any more help. So being able to just listen is great. Communicating that you believe her. So, 'That must've been very frightening for you,' or somehow just saying, 'That must've been hard for you to tell me.' 'I understand it would be very difficult for you to talk about this,' particularly if she's severely isolated. So just validating her decision to actually disclose, you haven't done the wrong thing, you're not going to set off a whole pipeline of activities here, you're just with me, we're in a confidential situation and you've disclosed for me, you've taken your first step.

Emphasising that violence is never acceptable. So just being very aware of how you respond and not inadvertently pulling through some of those myths. Like, you wouldn't do things like ask, 'What did you do? or, 'Why did it happen?' Just talk about the unacceptability of violence. Also just always avoiding that idea that she's somehow to blame for this. So just trying to lift that whole blame. It is one of the barriers, the shame around disclosing. Obviously don't ask, 'Why don't you leave?' straight up, because she may not be in a position, or ready, or it may not, she may not feel that it's actually safe to leave because that might escalate things. 'What could you have done to avoid the situation?' Again implies that she has to moderate her behaviour to avoid it, doesn't help her. Or ask, 'Why did he hit you?' because that again applies, she did something and he retaliated. So just watching your language around some of those things.

So let's keep going with Yasmina a little bit. So you have asked the right questions, you've got a really good relationship with her. The questions that you've just asked her have actually meant that she has disclosed. And she's basically saying that her husband's controlling her every move. She cannot go out without him. She has to get his permission to do everything. She's feeling a bit like a slave at home, stuck at home looking after the kids and pregnant with a third child, and she's got no other family here who would normally help to defend her against her husband. He has given her a mobile phone and if she's away from him, he constantly texts her and demands that she immediately responds, which is why, when she's in the waiting room, she is responding all the texts. So if she's away from him, he will basically just text, 'What are you doing? What are you doing?' and she's got to respond. And he's also monitoring where she's going using location services on the phone. So what is your response to Yasmina? So just work again in your groups for a couple of minutes about what are you going to do now.

So client-centred practice, what does she want to do? Working around what it is that she wants to do, what does she feel that she wants to do? What are her next steps? She may just say she just wants the violence to stop, and she may have a particular view about what's causing her husband or the abuser to actually be violent, and she might want some help. And there could be some community things or other things that you do that might help there. But yes, so working with her and what she wants to do is really important. Other things at the back?

**Seminar participant:** Would you have to ask though about safety for children?

**Karen Bentley:** Yeah, so safety is the most important issue that you're going to have to deal with, which is the risk and safety, and we'll move on to that in a second. But yes, you do need to do that, all in the context of safety. Yeah. Other feedback or comments?

**Seminar participant:** Could you talk a little bit about the authorities in Australia and how you hope that they have a good experience but that they can trust the police here and they're there to help, rather than perhaps where they've come to where it may not be.

**Karen Bentley:** So we see that a lot, which is particularly for some communities where there have been lots of issues with police and authorities in their country of origin, and they have a deep seated fear of police and authorities. Yes, that can be quite a hard barrier to overcome. There's another comment?

**Seminar participant:** Just some emergency phone numbers she might have to memorise or something.

**Karen Bentley:** Yeah, a bit of a plan. Yes, having a plan or trying to work with her so that she's got a plan. Now you're going to have to work with what you've got because you may not have her separately. So we're going to talk a bit about safety planning now.

So you've listened to her, you've validated what's going on and hopefully you're going to get the opportunity to do what's called an 'initial safety assessment'. And that's about trying to help her assess her risks for escalating violence. So you are going to have some evidence that you've potentially gathered. So there would be potentially, you're going to be listening to her story and hearing what she tells you. You may not get the whole story, but there might be some things that start to be quite red flags to you. Certainly things like the presence of weapons, if there's been any strangulation, any disclosure of sexual violence, harm of pets, harm to children, threats to harm, those are the types of things that you really need to take quite seriously because they are proven indicators that they may lead to very severe physical violence or death. So take those ones really seriously.

Sometimes it's not as severe and the escalation is not happening and it's just an ongoing pattern of abuse, psychological, verbal, emotional, isolation. So you have to work with her to help assess what's happening now, and just bring her own perceptions of the risk into it. So what does she think is happening? What does she think is going to happen next? And you have to just, we always, when we're working in with domestic violence and family violence clients, she's with the abuser. She knows the abuser best. So always trust her instincts on that. And she's also going to, she's been working for years probably on how to keep him, like, she's walking on eggshells. She tries not to tip him off. She'll have all sorts of strategies not to set him off, or she'll know his patterns. So she will have a very good sense, potentially, of her own risk and whether things are escalating.

That said, sometimes it's a 'frog in boiling water'. She doesn't actually perceive that the threat is increasing, because it's just very slow and very gradual. So you do also need to bring that professional judgment in to bear. So things like checking for immediate concerns. If she has disclosed to you, is it actually safe for her to go home now or not? Do you actually need to have an exit strategy right now? Some other way of getting out of the building. Are her children safe? Does she need an immediate place of safety? Do you actually need to get her into some kind of refuge? If immediate safety is not an issue, check her future safety. So does he have weapons at home? Does she need a referral to the police or a legal service? Does she have the emergency telephone numbers? Does she need a referral to a domestic violence agency who could help her make an emergency plan? And it's a good idea to try and help document those plans. And depending on the circumstance, you may not send that home with her. Yeah. Any other comments?

**Seminar participant:** I'd just like to say with, does she need a referral to a domestic violence service? Does she want one?

**Karen Bentley:** Yes, can be a really huge issue. And there's been studies done which show that many CALD and other refugee and settlement clients do not want to be referred into mainstream domestic and family violence services. And so you have to respect that that's the case, and maybe try to work with her on how else, maybe you get some support and advice from the domestic and family violence service, but she doesn't necessarily get referred into there, or you go through to other services. Okay, so hopefully she's going to have formed a relationship of trust with you and she's coming back. So you really do need to just constantly keep an eye on that safety issue and just be aware that things can change really rapidly. So things might be going along okay and then all of a sudden things might really escalate, and the violence could get really triggered, and you can be all sorts of troubles, particularly when he starts to feel that his power and control over her is being eroded.

So once that dynamic is upset and he doesn't have as much power over her, that's when things can start to really escalate. Really work with her to help her try and make her own decisions. Sometimes for victims of really extended abuse and violence, that's very hard because they've been just so down trodden and eroded that self-esteem and those kind of behaviours are very, very difficult. Respect the knowledge and the coping skills that she has got and try to work with those. And I think you're probably working with that generally in terms of health and wellbeing anyway. So that won't be unfamiliar to her. Providing her with emotional support, just reaffirming that it is confidential and that you are there to help her. Making sure that you don't inadvertently advise somebody else or that it gets back to him, so that you just keep that confidentiality really secure. And that might be also with things like text messages and things like that, just communicating with the client, just being very careful, And just working in your own areas, with referral services, actually making the connections with the services in your area that you can refer to.

**Seminar participant:** So Karen, can I just ask you on that, if you've had an interpreter involved and they've heard all of this, and then, so do you wait for the client to leave and then have a chat with the interpreter before—

**Karen Bentley:** I think I probably would in terms of just, particularly if it's quite serious, just to try and make sure that they understand what the situation is.

**Seminar participant:** And that they're not to say anything and that you'll be the one that'll ensure she's safe and that they have to keep it confidential?

**Karen Bentley:** I think it's probably a good idea. I mean it's going to vary from time to time, but I mean, they've also probably, I don't know, I haven't worked—

**Seminar participant:** [inaudible]

**Karen Bentley:** Yeah, yes.

**Seminar participant:** That's their job, to keep [inaudible].

**Karen Bentley:** Yeah. I'm presuming that most of you working as nurses are already looking after your own safety. So you've got, all of you have policies and procedures around making sure that you are safe when you're doing, do you do outreach visits, and you're telling everybody that you're going to such-and-such place, you don't park in the driveway so you can get blocked in. So all of those types of things. Particularly if you do come across quite a violent perpetrator, and you really do need to think about your escape routes out of places and things like that, don't get, so that, I was thinking that's pretty common sense for—

**Seminar participant:** I would not have thought not to park in the driveway.

**Karen Bentley:** Yeah, well you can be blocked in. Yeah, so if you, do park on the curb so that hopefully you haven't got a car behind you and a car in front of you, it's much harder to block somebody in when you're parked on the street or around the corner than it is if you're blocking the driveway and they can just put a car behind you, you're stuck, you can't get out then. So when family violence workers are actually taught to make sure that they sit between the client and, or perpetrator, and the door so that they've always got a clear line. I mean it's those basic types of things that you will have, you should have, most of you would have safety procedures for things like that. Yeah.

Okay. So I just want to spend a bit of time talking about some of the issues in particular with the intersection of family violence and refugees. So we've started to touch upon it, but there really are some enormous barriers for all women or victims of family violence to disclose. But when we're working with culturally and linguistically, or NESB communities, or non-English speaking background communities, there are some additional barriers. So things like languag. We've already come across that with Yasmina's case. Language can be a severe barrier to disclosing. And also when something else is going on, which is that she's been deliberately isolated, so perhaps is not even getting access to language classes or any way to actually improve her capacity around the language. Financial insecurity. So that really comes down to what she does next or what she's planning on doing, which is that she may lose, her financial situation is going to get worse if she tries to leave or if she's got to sort of try and navigate that system.

One that's not on here is immigration concerns. So what happens if you're working with clients with uncertainty around their immigration status? Oh, it is there. Fear of police. We touched on that before. So that can be a really big issue around just not working, I mean, I used to work at Bendigo Community Health Service and I was next door to the settlement services team who spend quite a lot of time each session when they've got their new Karen and Afghan communities coming in talking about how police are not going to shoot you here, so that they can be trusted. So that is a very real issue for some women who just have fear of police and state authority. I think probably one of the biggest one is fear of isolation from the community, or reprisal. That we are going against the culture or that if you do speak out, it's a cultural betrayal. And so those three, isolation, cultural betrayal and language skills, can be one of the major barriers to actually disclosing. The threat. So quite often we'll see perpetrators say, 'If you leave me, you're going to be deported.' Yeah. Religious beliefs.

**Seminar participant:** I was talking to one of my colleagues and she is working with a client who's had five years of abuse and just recently he's become quite loving and nice to her. And my colleague has read some research and she's like, this is bad, this is a big risk factor. I wasn't aware of that, so I was just, because [inaudible] start to leave because she's saying she's fine, he's lovely, and...

**Karen Bentley:** Yeah, I'm too cynical and biased, but I would also, my radar would sort of go up. Scared of being isolated. It's stigma attitudes, the community. Parenting payments. So interaction with Centrelink. Yeah.

**Seminar participant:** They're sponsored for two years, they can have no access to—

**Karen Bentley:** Centrelink. Another thing that we're trying to work on with Commonwealth Government at the moment, yes.

**Seminar participant:** We have a colleague who went to, fronted up to Centrelink with a client that was on the spousal visa, and they wanted to separate the payments, and they rang the perpetrator. To say she was at Centrelink. Centrelink rang to say, and they had to leave.

**Karen Bentley:** So when you're working with other services, that's a really important point. So one of the things that we do find happens from time to time is that you are trying to work with your client, with another service, and the other service then doesn't have any safety or risk assessment around contacting the perpetrator. So Centrelink then contacts the perpetrator. Perpetrator is alerted to the fact that they're trying to separate the payments and the violence escalates.

**Seminar participant:** Do they have, does Centrelink [inaudible] processes?

**Karen Bentley:** Again, there's a consultation process happening at the moment around, what are some of the main things that we could do to try and help survivors of this kind of thing. And Centrelink payments being, not having them for two years, which leaves women in refuge for up to two years with no income whatsoever, has been identified as a really big barrier for accessing and moving on.

**Seminar participant:** And even just the process of trying to get those funds is impossible, that your family violence has to have occurred within seven days. That you need proof from a doctor, you need a police report. That implies a level of literacy that many of our clients don't have. Exactly. And it's like, oh, you can only, and the payment itself is, dodgy as, but there's so many barriers. And I sort of thought that the Royal Commission would've highlighted it.

**Karen Bentley:** Hopefully. Yeah, okay. So we've got lots of those. Have we got things like gender roles? You've mentioned those before, which is around just very defined, tightly defined gender roles. And that can be, so, that 'This is the way that it should be because he's the head of the family. I'm subordinate to that.' Losing children. So men and women who try to call for help are seen as betrayals of their own culture. And conversely, there's also some evidence that once here, some women do feel that there are laws and that the government will help them. So they will actually lever that and leverage that to try and do that. But yeah, there's a whole range of issues going on there.

**Seminar participant:** Can I just add as well, before we said about the police being safe here, that's not always the experience as well.

**Karen Bentley:** No.

**Seminar participant:** And they know that from community as well, so they don't feel safe going to the police here and rightly so.

**Karen Bentley:** Again, that's really true. And we see the community attitudes that we see generally around the myths are also in every sector. So we do tend to see that. So again, they have to deal with racism and other issues around that. So yes, that's a very, that's true as well. Again, strongly encourage you to work with your local police, which I imagine many of you are. I know that there's often quite a lot of work between settlement teams and local police to try and break down some of those barriers. Okay, I'm not going to be able to, thank you.

So some of the research that we've also found, and a lot of this is from InTouch, which is a great organisation. I'm not sure if you work with InTouch down here. But the majority of refugee women and children, particularly coming out of war-torn or strife areas in conflict have actually experienced sexual violence. And so that actually can have quite a trauma load and is one of the leading potential contributors to women having post-traumatic stress disorder. In fact, they've, I think 43%, they've done some surveys in the US and the UK around leading indicators and determinants of developing PTSD and sexual violence is 43%. And so that is actually one of the things that can be very devastating and also being carried. So violation by state or enemy soldier is not more devastating than violation by an intimate partner, because of the levels of betrayal and trust around that. Domestic violence is often hidden or minimised. It could be disguised in other things that are going on as part of settlement or just the alienation and isolation that people often experience when they're settling.

And domestic violence causes as much, if not more, grievous bodily psychological harm to women and children as armed conflict. And you've probably heard around all the stats about, family violence is actually the leading contributor to women's health issues in Victoria. So I just wanted to also talk a little bit about some of these other notions and issues. So one is around the 'cultural pressure cooker', which is that women's gender roles and the traditional notions of masculinity can be rigorously defended when cultures are threatened by strong external pressures. So what happens or can happen, and I've got this, where is this, managed to lose my piece of paper.

As women become more independent, and the Australian way of life, which is associated with being individualist, rushed and anti-social, sort of comes up, then potentially the traditional masculine roles start to decline. And so that can actually be a trigger or a pressure that might escalate or have the family violence. But it's, again, this very tricky sort of balance, which is, the research shows that there's not actually more family violence in refugee communities than any other kind of community. This is not a cultural thing that occurs in those communities. But what happens is that the pressures of settlement and upset and all of those other types of things can help the perpetrator keep her isolated and keep her from disclosing. So it's not, it's a complex web of issues that are going on there, but it's not something, and so we do sometimes see in the Australian community, 'That particular community is very violent and they're violent by nature.' What the research shows is that there's no more levels of family violence in those communities than other communities. It's just that may be masked and some of that is tactics that the perpetrator may use to keep her in the situation longer. Does that make sense? Yeah.

**Seminar participant:** But that's with the reported cases.

**Karen Bentley:** That's with the reported cases, but it's also in working with refugee communities and is what's, I don't know if you've seen this particular report, and that's got lots of really fabulous research about, so it's called Refugee Settlement Safety and Wellbeing, Exploring Domestic and Family Violence in Refugee Communities. Great document put out by Vic Health in 2006. And because I'm a specialist in technology abuse, I had to just do a little bit of a plug around this. So in some recent studies that they've done around technology-facilitated abuse and Domestic Violence Resource Victoria did this in association with WESNET and Women's Legal Services New South Wales. They asked 549 frontline practitioners in domestic violence and women's legal services about how many of their clients were experiencing some form of technology abuse. And about 98% of those practitioners said that they saw technology-facilitated abuse happening as part of domestic violence.

And they actually dug into that a little bit more. And so the group that was most commonly identified by those practitioners as facing particular risks in relation to tech-facilitated abuse was women from non-English speaking countries. So the types of technology-facilitated abuse we see are constant harassing text messages, location monitoring, potential abuse through things like social media, and taking tech away. So this might be her only way of communicating with family and getting support from home, and he controls her access to technology. So abusers often exploit social isolation, and they often exploit the language barriers faced by those women. So one of the things that a mobile phone can give you is a translation app so that she can actually start to communicate. The other thing that happens is that women from CALD backgrounds often receive threats through third parties. So proxies are used, so he may humiliate or threaten to humiliate her through social media, and do those kinds of things, and technology can make that really easy. So it's not necessarily the technology that's causing that, but technology is one of those tools that is used quite often in family violence. So Australian men who sponsor their partners will often take away their phone and internet access, causing them social isolation. Do you experience that?

**Seminar participant:** I do find that a lot of, well people that we see, they don't have, the woman doesn't have the phone, that whenever you try to call it, the husband has it. It doesn't mean that there's anything going on, but [inaudible].

Or they'll have a [inaudible] that we can't use, [inaudible] that they'll use.

**Karen Bentley:** Yes.

**Seminar participant:** I have different experiences, I work with mostly Iraqis womens, they're more communicative and they're more proactive than the man. Only when you call them, the womens are the one who's responding to. It's maybe different—

**Karen Bentley:** Different for different, but we do also see that women often use technology really well to stay connected. So it's really important for women to sort of stay on technology if they can. We've got a program which we have with Telstra where Telstra has donated 20,000 smartphones to WESNET, and we've got 289 agencies around Australia who have got the phones ready to go. I know, Sharon, Bendigo Community Health is an agency, but there are other agencies all around Victoria that do. So if you do ever have a woman who needs a new smartphone and it's safe to give her one, don't give Yasmina a phone and tell her to go home, because her husband will go off his brain, but yes, there are phones available and they come with $30 prepaid credit.

**Seminar participant:** Do they come with a plan?

**Karen Bentley:** It's a prepaid mobile. It comes with just a $30 in 28 days, but then they can change that to something else. So it could just be a 90-day plan or a 365-day plan.

**Seminar participant:** I might just mention, just around the tech stuff as well, that it can be useful, obviously there's, if the woman is tech literate and savvy and has a smartphone, that there's lots of great apps out there for collecting data. So Daisy's one of them I used with clients, and if they've got desktop access, so you can get information off it which is in Arabic, and then the app will often not look like, it won't say, it'll look like a news, so it'll just have 'news updates' or the weather. So the perpetrator can't identify what the app is on the phone. There's so many different ones.

**Karen Bentley:** There's many apps now that are available and often they're in different languages as well. They can be used to send alarms or duress alerts, or they could be to collect evidence, or they could just be to sort of get information about where to go for help, so that she could look up specific services that might be culturally appropriate for her.

**Seminar participant:** Are there some recommended ones?

**Karen Bentley:** There's not necessarily a big list. I mean I think the one that domestic Violence Resource Victoria is developing now, which is currently called SmartSafe+, but will be relaunched later this year or early next year as Arc is a good one. Ask Izzy is a great app, and I think 1800RESPECT is also doing a couple of apps as well. When your patient or client is the perpetrator and when you are working with both. So consider the safety of her above everything else.

Be aware that abusers often will play the victim. So just need to be quite careful around working out whether or not your male client, who says he's a victim of the female client, just use a bit of extra caution around that. May very well be the case, but quite often what we see is a presentation of the perpetrator as the victim. He turns everything around in his mind and will work for him. So again, if violence is suspected, start with broad question. If it's disclosed, or he discloses that he's using violence, try then to ask more specific questions, and be very careful to acknowledge it but not collude. So again, it's like, well, 'I can understand why you hit her,' or, you're not going to do that, but just making sure that you don't inadvertently collude with him, and also try to refer on to specialist services.

You might also need to think, when you're working with both or the family together, again, primary duty is to her, to the victim and her children, refer that perpetrator out if you can. And you need to establish protocols. So if you've got some team members working with a perpetrator and some working with her, that you're very careful around confidentiality of records, like if it's all on your one system and they can all read the case notes for everything else you may have a, you've got to do that sort of case management across your team. The other thing to note is that marital and couples counselling, generally not recommended. Why not?

So they're couples, they're in counselling, everything's lovely, sort of all working through. Once they're out, it's a power and control dynamic. So she's not going to feel necessarily able to disclose. She may think that that's going to be, so there is evidence that shows that couple counselling and marriage counselling in the situation where there's family violence and that power and control balance is really out of whack, that actually it can be escalating and can actually do more harm. So just think very carefully before referring in. Mandatory reporting. Just going to touch on that very briefly. You're all aware of, I'm sure, all of the mandatory reporting requirements. Do I need to spend any time on that?

**Seminar participant:** If you want to go briefly.

**Karen Bentley:** Okay. So you are mandated to report with children. So if you have the belief on reasonable ground that a child is in need of protection, which is due to physical injury or sexual abuse, then you do have mandatory reporting requirements under the Sections and the legal Act. It doesn't cover psychological abuse, emotional abuse, financial abuse, in Victoria it just covers physical injury, sexual abuse, and it can be past, present, and future. So if you've got significance concerns, just be aware that you do have that mandatory reporting issue. And I think that's fair enough because if you do suspect those kids are at risk of physical harm, then you probably need to.

**Seminar participant:** I just had a case of a pregnant lady a few weeks ago, my management [inaudible] required to report and she did. So she's 18 months pregnant and there was no children involved. Pregnancy.

**Karen Bentley:** Pregnancy as well. Yeah. Okay. Any adult in Victoria. Also, if there's a reasonable belief that there's a sexual offense that's been committed, they're also required to disclose as well under the Crimes Act. Alright, I've got about five minutes left. Safe Steps. So if you do want to refer, you're probably all familiar with Safe Steps, that is your central referral spot in Victoria. And I'm not sure, have you referred clients in through that? No. So that to try and get somebody out and into the crisis accommodation or counselling. I really strongly urge, where you possibly can, to actually make links with your local specialist family violence service in your area. How many are you from region? I know we've got one from, yeah, so just to try and work with them.

Like all services, things are variable and organisations are at different levels, but I think the work that the Royal Commission has done in Victoria means that more and more of these specialist services are providing and increasing their knowledge and awareness around intersectional issues and some of those barriers which are the mainstream 'white feminist' model of domestic and family violence, and broadening that, and really starting to look at some of those other issues so that we do cater for diverse clients. 1800RESPECT, the national sexual assault and domestic violence counselling service. They do have interpreters. They are a point where perhaps clients could turn. The other thing to remember is that they have a professional arm, so if you need support and you don't have a local domestic family violence or sexual assault service that you, but you need some clinical supervision around that, you can ring that and actually get through to the professional arm of that so that they can advise you as well. They've got trained trauma counselling, domestic violence, and other sexual assault for really amazing organisations across the country. Sexual Assault Crisis Line, the Men's Referral Service and the InTouch Multicultural Centre Against Family Violence. They do all sorts of amazing work, so I strongly recommend that you look them up and make a connection with them if you haven't already.

The thing that I've been using today is the GP Toolkit for Women by the Women's Legal Services New South Wales. It's very lovely. It's very short, and it's something that you can just have on your shelf, and it sort of walks through much of what we've done today and a little bit more. That's designed for New South Wales. There is also a version, which is on their website, which is done for national, so it not so New South Wales centric, but the principles do apply. Again, that paper 4, I find that is a really valuable paper, because it is specifically about refugees. So reason Rees and Pease. Domestic Violence Resource Centre, again, has got all sorts of training If you haven't done it yet. The CRAF training is also very useful around the risk and assessment framework. And DV Vic, also, good sources of information here in Victoria. Two minutes to go. Thank you.

End of transcript

Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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