Gold Coast Primary Health Network

Needs Assessment 2022

Family and domestic violence

phn GOLD COAST

An Australian Government Initiative

Family and Domestic violence

Local health needs and services issues

- There is a lack of clear health pathways within primary care for domestic and family violence victims and perpetrators.
- Some health professionals do not understand dynamics of domestic violence.
- Family and domestic violence can have severe consequences on child development.
- People who experience domestic violence have higher rates of mental health issues.
- Not many mental health clinicians have a high degree of understanding of domestic violence issues.

Key findings

- General practices are well placed to screen for domestic violence, which would provide opportunity for intervention before escalating to significant harm.
- While the GCPHN region has lower rates of reported domestic violence compared to the total Queensland, the number of reported domestic violence related incidents has increased in recent years.
- General practitioners can screen for domestic violence and assist in referral to domestic violence services however this is not currently happening across most practices.
- Out-of-pocket cost may limit access to services for women experiencing domestic violence.
- Many mental health clinicians do not have specialised knowledge of domestic violence dynamics and services for domestic violence perpetrators are limited.
- Several health issues have been linked to exposure to partner violence, such as:
    - depressive disorder
    - anxiety
    - sufficient self-harm
    - alcohol use disorders
- Women experience violence at much higher rates.
- Some population groups are more vulnerable for experiencing domestic violence including:
    - children
    - young women
    - older people
    - persons with a disability
    - people from a culturally and linguistically diverse backgrounds
    - LGBTIQ+ people
    - people from socioeconomically disadvantaged area

Family, domestic, and sexual violence

Family, domestic, and sexual violence is a major national health and welfare issue that can have lifelong impacts for victims and offenders. It affects people of all ages and from all backgrounds, but primarily women and children who often display including behavioural, emotional, and cognitive-functioning problems as a result. The Australian Bureau of Statistics (ABS) 2016 Personal Safety Survey estimated that 2.2 million Australian adults have been victims of physical behaviour and/or sexual violence from a partner since the age of 15[1].

Family violence refers to violence between family members, typically where the offender uses power and control over another person. The most common and widespread cases occur in intimate (current or previous) partner relationship and are usually referred to as domestic violence.

Sexual violence refers to behaviours of a sexual nature carried out against a person's will. It can be committed by a current or previous partner, other people known to the victim, or strangers.

Some groups of people are more vulnerable:

- children
- young women
- older people
- persons with disability
- people from culturally and linguistically diverse backgrounds
- LGBTIQ+ people
- people in rural and remote Australia
- people from socioeconomically disadvantaged area

Contributing factors

Many factors contribute to and influence family, domestic and sexual violence[2]. These elements relate to victims and offenders and include relationship dynamics, families and communities and geographic and political environments[3]. Contributing factors include:

- Cultural values and beliefs: masculinity linked to dominance and toughness, and strict gender roles.
- Social factors: unemployment, socioeconomic status, social and geographic isolation.
- Situational factors: male dominance in the family, intimate partner conflict, alcohol and other substance use/
- Personal history: witnessing intimate partner violence as a child, being abused during childhood or witnessing domestic violence[4,5].

The underlying drivers of family, domestic and sexual violence can replicate inequalities in the distribution of power, resources and opportunity between females and males[6]. Communities with attitudes reflecting greater levels of gender equality generally have lower rates of domestic, family, and sexual violence[7].

[1] ABS 2017c. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS
[2] EC (European Commission) 2010. Domestic violence against women report. Special Eurobarometer 344. Brussels: EC.
[3] ABS 2013c. Defining the data challenge for family, domestic and sexual violence. ABS cat. no. 4529.0. Canberra: ABS.
[4] Heise L 1998. Violence against women: an integrated, ecological framework. New York: Sage Journals. 2
[5] Edleson, J. L. (2019, August 1). *Children's witnessing of adult domestic violence*. SAGE Journals.
[6] Cox P 2015. Violence against women in Australia: additional analysis of the ABS Personal Safety Survey, 2012. Sydney: ANROWS.
[7] UNIFEM (United Nations Development Fund for Women) 2010. Investing in gender equality: ending violence against women and girls. New York: United Nations Entity for Gender Equality and the Empowerment of Women (UN Women).

A study completed in South Australia interviewed a random sample of 6,000 adults aged 18 years and over. In total, 17.8% of the sample reported some form of domestic violence by a current or an ex-partner[8]. Factors which increased the likelihood of experience with domestic violence included:

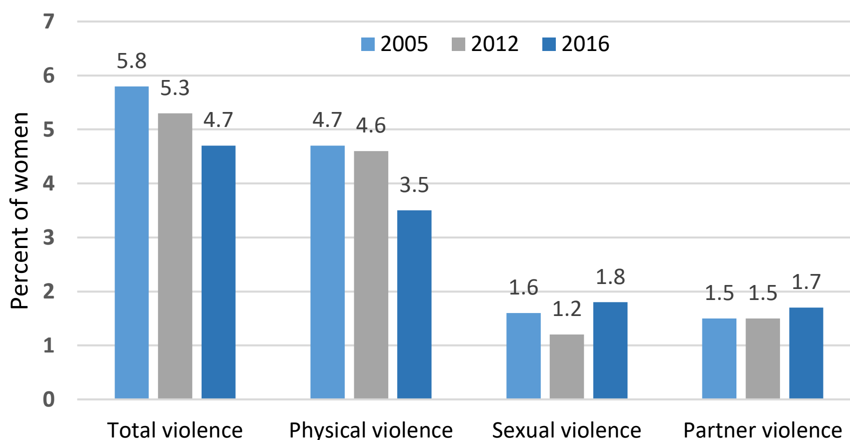
- low household income,
- unemployment or part time employment,
- health variables such as poor self-reported health status and alcohol abuse problems.

Rates of violence over time

Data from a 2016 ABS survey indicates that partner violence (including physical and/or sexual violence from a current or previous partner) have remained steady over the last decade. During the same time, there have been recorded declines in total rates of violence [9,10,11].

Rates of partner violence against women increased from 1.5% in 2005 to 1.7% in 2016. Rates of partner violence against men also increased during this time, from 0.4% in 2005 to 0.8% in 2016.

Figure 1. Proportions of Australian women aged 18 and over who had experienced physical, sexual and partner violence in the 12 months prior, 2005, 2012 and 2016



Source: Family, domestic, and sexual violence in Australia: continuing the national story in 2019. Australian Institute of Health and Welfare

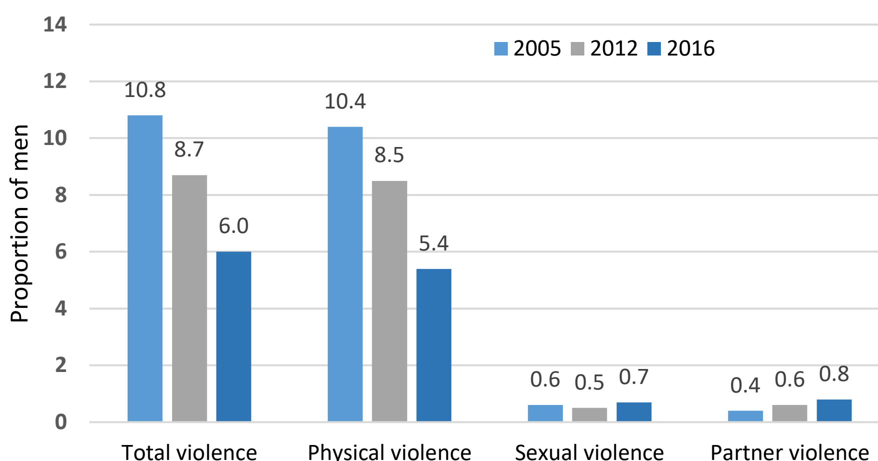
[8] Dal Grande, E., Hickling, J., Taylor, A., & Woollacott, T. (2007, September 25). *Domestic violence in South Australia: a population survey of males and females*. https://onlinelibrary.wiley.com/doi/10.1111/j.1467-842X.1998.tb01496.x

[9] ABS (Australian Bureau of Statistics) 2006. Personal safety, Australia, 2005 (reissue). ABS cat. no. 4906.0. Canberra: ABS.

[10] ABS 2013. Personal safety, Australia, 2012. ABS cat. no. 4906.0. Canberra: ABS

[11] ABS 2017. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS

Figure 2. Proportion of Australian men aged 18 and over who had experienced physical, sexual and partner violence in the 12 months prior, 2005, 2012 and 2016

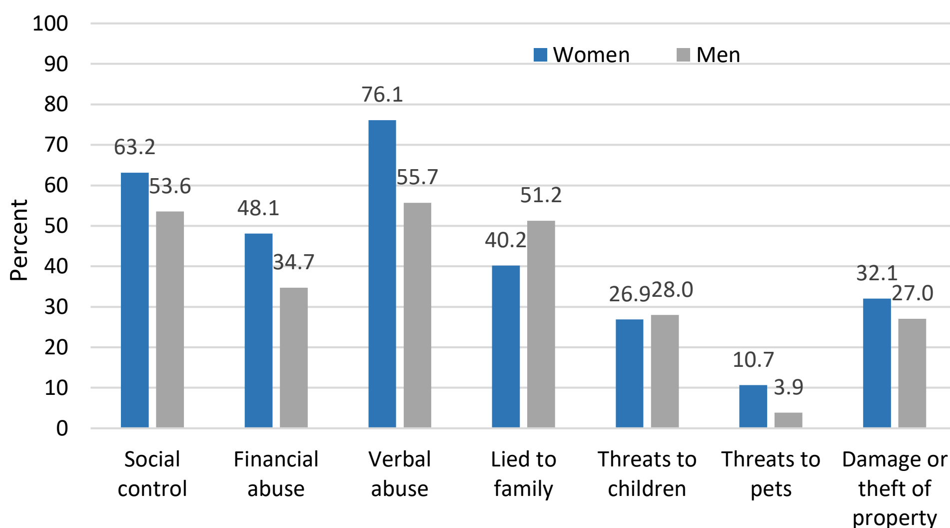


Source: Family, domestic, and sexual violence in Australia: continuing the national story in 2019. Australian Institute of Health and Welfare

Emotional abuse

Almost 23% of women and 16% of men have suffered emotional abuse from a current or previous partner since the age of 15[12]. Verbal abuse was the most common behaviour experienced by both men and women who had been emotionally abused by a previous partner. Threats to children and lies to family were more common behaviours among men.

Figure 3. Emotionally abusive behaviours experienced by Australian adults aged 18 and over from their most recently abusive partner, by sex, 2016



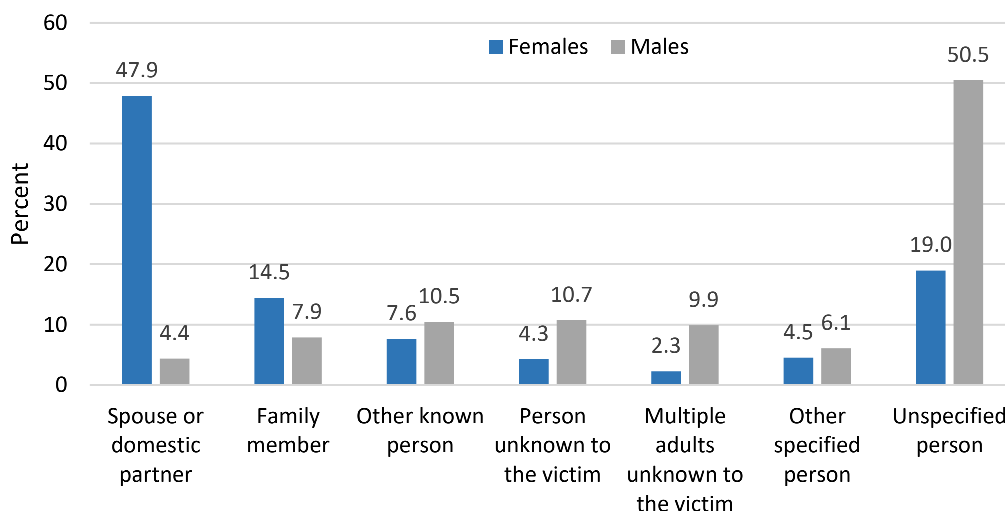
Source: ABS 2018. Personal Safety Survey, 2016, ABS cat. no. 4906.0. Findings based on use of ABS Table Builder data.

[12] ABS 2017. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS

Hospitalisations for assault

In 2016-2017, 29% of the 21,400 hospitalisations for assault injuries in Australia were a result of family and domestic violence. Of the family and domestic violence-related assault hospitalisations, the offender was reported as a spouse or domestic partner in 66% of assaults and as another family member in 33% of assaults[13].

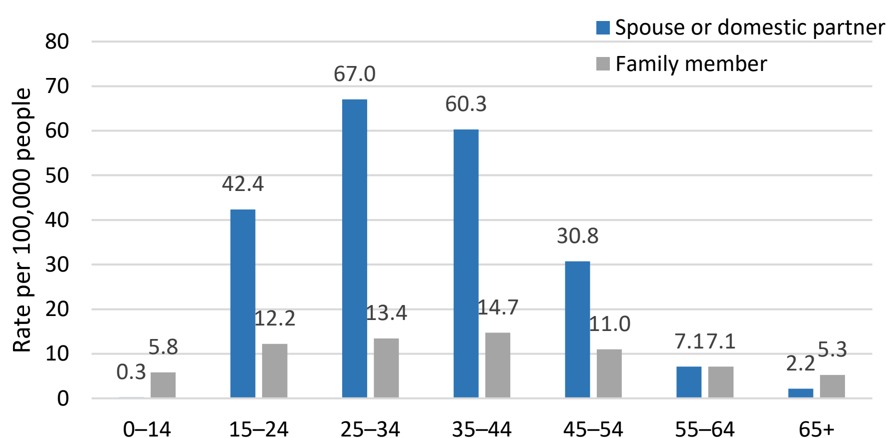
Figure 4. Assault hospitalisations in Australia, adults aged 15 and over, by relationship to perpetrator and sex, 2016-17



Source: AIHW National Hospital Morbidity Database

In 2016-17, Australian women had a significantly higher rate of hospitalisation for assault by a spouse or partner compared to men. Rates were highest for women aged 25-34 (67 per 100,000) and then fell noticeably to 2.2 per 100,000 for women aged 65 and over. Amongst males, hospitalisations were higher for assaults committed by family members compared to spouse or domestic partner.

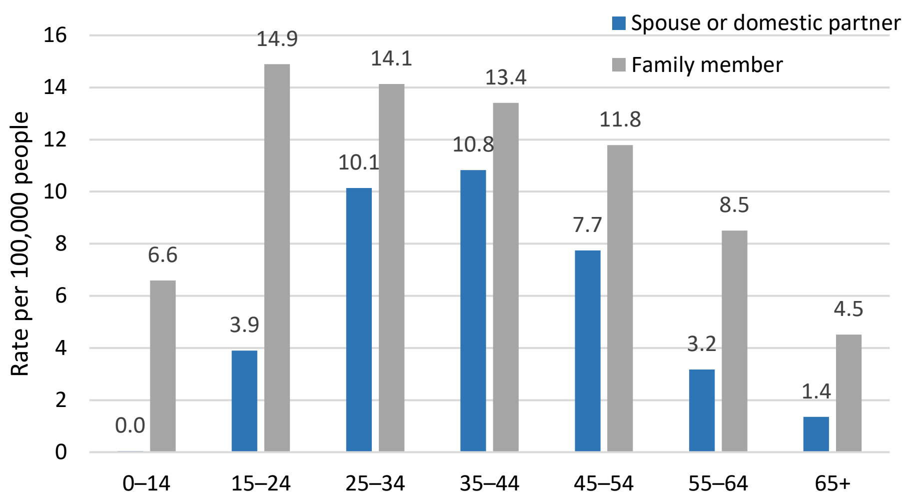
Figure 5. Rate per of Australian female hospitalisations for family or domestic violence assaults, by relationship to perpetrator and age, 2016-17



Source: AIHW National Hospital Morbidity Database

[13] AIHW 2018d. Trends in hospitalised injury, Australia 1999–20000 to 2014–15. Injury research and statistics series no. 110. Cat. no. INJCAT 190. Canberra: AIHW.

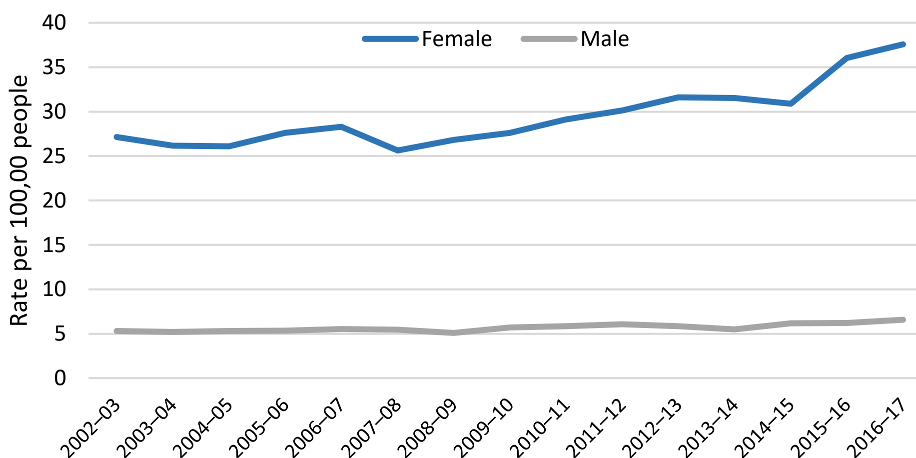
Figure 6. Rate per 100,000 people of Australian male hospitalisation for family or domestic violence assaults, by relationships to perpetrator and age, 2016-2017



Source: AIHW National Hospital Morbidity Database

Hospitalisations of women assaulted by a spouse or partner continue to rise at an average of 2.8% per year between 2002-03 to 2016-17 in Australia, when the rate increased from 27 to 38 hospitalisations per 100,000 population. For males, the rate was relatively stable during this time, increasing from 5.3 to 6.6 hospitalisations per 100,000 population.

Figure 7. Age-standardised rate of assault hospitalisations where the perpetrator was a spouse or partner, by sex, 2002-13 to 2016-17



Source: AIHW National Hospital Morbidity Database

Burden of disease

Burden of disease measures the impact of living with illness and injury and dying prematurely. The 2015 Australian Burden of Disease study projected the amount of disease burden that could be avoided if no female aged 15 and over in Australia were exposed to intimate partner violence. The impact of this risk factor

was estimated only for women, as the evidence in past literature to identify the causally linked diseases and the amount of increased risk was available only for women[14,15].

Six diseases were causally linked to exposure to partner violence:

- depressive disorder
- anxiety conditions
- alcohol use disorders
- early pregnancy loss
- homicide and violence (injuries due to violence)
- suicide & self-inflicted injuries

In 2015, for females aged 15 and over in Australia, partner violence contributed to:

- 223 deaths (0.3% of all deaths) in Australia,
- 1.6% of the burden of disease and injury

Mental health conditions were the largest contributor to the burden, with depressive disorders making up the greatest percentage (43%) followed by anxiety disorders (30%). Partner violence was ranked as the third leading risk factor contributing to total disease burden for women aged 25–44, behind child abuse and neglect during childhood, and illicit drug use[16].

Family violence among Aboriginal and Torres Strait Islander people

Family violence is the preferred term for violence within Aboriginal and Torres Strait Islander communities, as it covers the extended family and relationships in which violence can occur. It remains a critical social policy issue, placing a huge burden on communities, especially on women and children[17]. The removal from land and cultural dispossession over the past 200 years have resulted in social, economic, physical, psychological, and emotional problems for Indigenous Australians. Family violence against Indigenous Australians must be understood as both a cause and effect of social disadvantage and intergenerational trauma.

Aboriginal and Torres Strait Islander Australians experience family violence at higher rates than the non-Indigenous people. Aboriginal and Torres Strait Islander peoples are more likely to be hospitalised due to family violence, more likely to be murdered by a family member, and more likely to have their children removed, compared with non-Indigenous people[18].

Aboriginal and Torres Strait Islander adults are disproportionately affected by family violence:

- In 2016–17, Aboriginal and Torres Strait Islander females aged 15 and over were 34-times as likely to be hospitalised for family violence as non-Indigenous females, with 8 per 1,000 (n=2,200) Aboriginal and Torres Strait Islander females hospitalised, compared to 0.2 in 1,000 (n=2,400) non-Indigenous females.
- Aboriginal and Torres Strait Islander males were 27-times more likely to be hospitalised for family violence as non-Indigenous males, with 3 per 1,000 (n=730) Indigenous males hospitalised, compared with 0.1 per 1,000 (n=990) non-Indigenous males.

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[14] Ayre J, Lum on M, Webster K & Moon L 2016. Examination of the burden of disease of intimate partner violence against women: final report, 2011. Sydney: Australian National Research Organisation for Women's Safety.
[15] GBD 2016 Risk Factors Collaborators 2017. Global, regional, and national comparative risk assessment of 84 behavioural, environmental, and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet 390:1345–422.
[16] AIHW (Australian Institute of Health and Welfare) 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia, 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW.
[17] Closing the Gap Clearinghouse 2016. Family violence prevention programs in Indigenous communities. Resource sheet no. 37 produced by the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies.
[18] AIHW 2018b. Family, domestic and sexual violence in Australia, 2018. Cat. no. FDV 2. Canberra: AIHW.

Domestic violence among lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)

Until recently, intimate partner violence within LGBTIQAP+ relationships was largely unacknowledged until recently and limited research was available on this topic[19]. The Australian Research Centre for Health and Sexuality conducted a national demographic and health and welling survey of 5,476 LGBTIQAP+ people and found significant levels of partner violence[20]. Around 28% of male-identifying respondents and 41% female-identifying respondents reported having been in an abusive relationship.

A smaller study of 390 LGBTIQAP+ respondents in Victoria, also conducted by the Australian Research Centre for Health and Sexuality[21], found that just under a third of respondents had been involved in a same-sex relationship where they were subject to abuse by their partner:

- 78% of the abuse was psychological and 58% involved physical abuse,
- lesbian women were more likely than gay men to report having been in an abusive same sex relationship (41% and 28% respectively),
- 28% had experienced sexual assault within a same sex-sex relationship.

Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, and sexual abuse, and often a combination of these. Like family violence, elder abuse is about one person having power and control over another person.

In 2018, 16.4% of people aged 65 and over in the GCPHN region (n=101,783) reported experiencing elder abuse, which was slightly above the Queensland rate of 15.4%.

In Australia, the available evidence suggest that prevalence varies across abuse types, with psychological and financial abuse being the most common. A population-based study to identify the prevalence of elder abuse (women only) is the Australian Longitudinal Study of Women's Health 2014[22]. This study is based on a random sample of women with the oldest cohort (n = 5,561) being born between 1921 and 1926. When this cohort was surveyed in 2011 (at age 85-90), the findings suggested that 8% had experienced being exposed to abuse, with name calling and put-downs being the most common forms. A similar level of prevalence was evident for this cohort in a preceding wave, conducted in 2008 (age 82-87), and slightly lower prevalence levels were found at younger ages (70-81 years). Measures the researchers used to assess neglect indicate a relatively stable prevalence rate of about 20% across waves, from ages 70-75 and 85-90 years.

In Queensland, calls to the Elder Abuse Prevention Unit (EAPU) have increased in recent years, from just over 200 in 2000-01 to nearly 1,300 in 2014-15[23]. The calls were mostly in relation to female victims (68% female, 31% male and 1% unknown). Perpetrators were males in 50% of calls and females in 45% (unknown 5%). Children were the largest groups of perpetrators reported (31% sons, 29% daughters), with 10% of cases perpetrated by other relatives.

[19] Calton, J., Cattaneo, L. B., Gebhard, K. T. (2015). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. Trauma, Violence and Abuse.

[20] Pitts, M., Smith, A., Mitchell, A., & Patel, S. (2006). Private lives: A report on the health and wellbeing of GLBTI Australians. Melbourne: Australian Research Centre in Sex, Health & Society.

[21] Leonard, W., Mitchell, A., Patel, S. & Fox, C. (2008). Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria. Bundoora, Victoria: Australian Research Centre in Sex, Health and Society.

[22] Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld: University of Newcastle and the University of Queensland.

[23] Spike, C. (2015). The EAPU helpline: Results of an investigation of five years of call data. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015.

In 2014-15, the most reported type of abuse to the EAPU helpline was financial abuse, accounting for 40% of cases. In 2012-13, the most common type of reported abuse was psychological abuse.

Technology

As outlined in the Domestic and Family Violence Protection Act 2012 (Appendix 1), unauthorised surveillance of a person is a form of domestic violence. Studies have indicated this can be assisted with technology including phones, computers, and social networking[24,25]. Technology can create a sense of the perpetrator's presence and aims to isolate, punish and humiliate their victims.

Reported offences

The below tables and figures highlight the number of reported domestic violence cases reported through police officers and private domestic violence orders recorded by Queensland Police. GCPHN acknowledges that the below data tables and figures are a under representation as not all incidents are reported.

In 2019 there was 2,976 reported domestic violence applications, including 2,260 from police and 716 through private applications.

Domestic violence indicator

The rate of reported offences by domestic violence indicator (police officers' perception that the incident was related to domestic violence) has increased for all assault, sexual offences and other offences against the person on the Gold Coast Police District from 2015 to 2019, as seen in Table 1.

Table 1. Number of offences by domestic violence indicator per 100,000 people, Gold Coast, 2015-19

	2015	2016	2017	2018	2019	Change 2015 to 2019 (%)
Assault	31	229	213	238	284	89%
Grievous assault	<5	<5	<5	<5	<5	50%
Serious assault	21	111	104	113	119	82%
Serious assault (other)	<5	18	18	19	24	88%
Common assault	6	99	87	103	138	96%
Sexual offences	<5	8	7	6	11	91%
Rape and attempted rape	<5	<5	<5	<5	7	86%
Other sexual offences	0	<5	<5	<5	<5	100%
Other offences against the person	7	35	44	46	51	86%
Kidnapping and abduction	<5	<5	<5	<5	<5	60%
Stalking	<5	10	6	6	6	67%
Life endangering acts	<5	23	36	35	39	95%

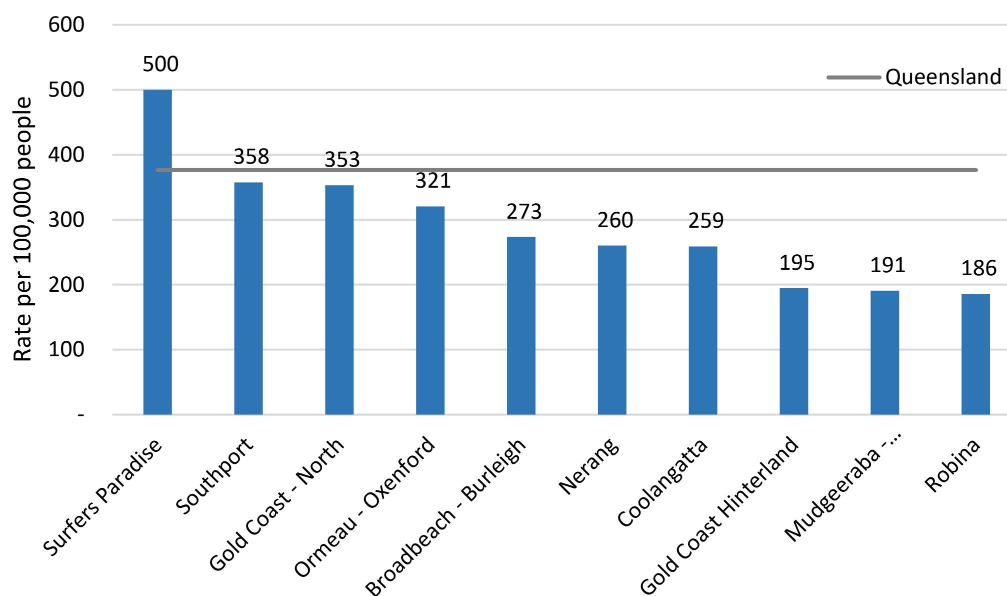
Source: Queensland Police Service

[24] Woodlock, D. (2016, May 12). *The abuse of technology in domestic violence and stalking, 2017*. SAGE Journals.
[25] Briggs, C. (2018, September). *Australian Journal of child and family health nursing - An emerging trend in domestic violence: Technology-facilitated abuse (Health collection) -*

Domestic violence – police applications

Police can apply for a Domestic Violence Order where they reasonably believe that there is sufficient reason to act and there is sufficient evidence to determine that the aggrieved person requires protection.

Figure 8. Rate of Domestic Violence Orders – police applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 2. Number of Domestic Violence Orders – police applications, Gold Coast SA3 regions, 2019-20

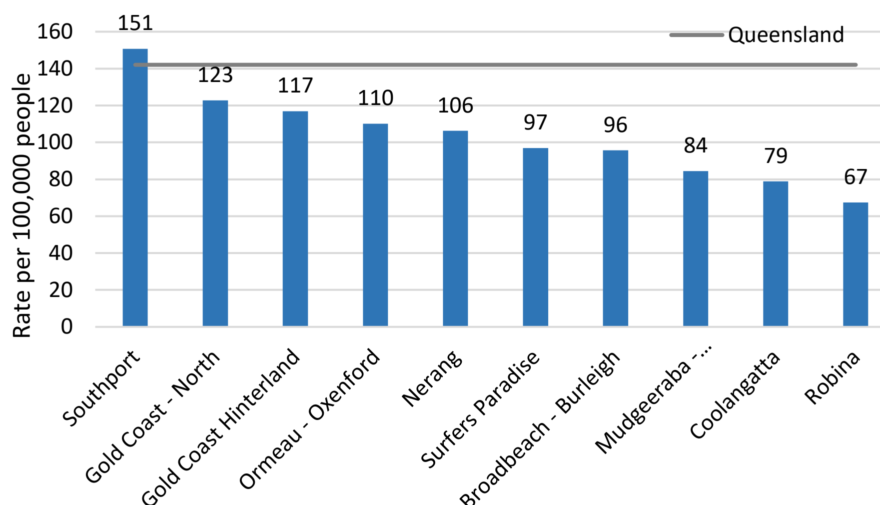
Region	2019	2020	Change from 2019 to 2020 (%)
Queensland	20,479	19,495	-4.8%
Gold Coast SA4	2,261	1,973	-12.7%
Broadbeach - Burleigh	203	183	-9.9%
Coolangatta	170	151	-11.2%
Gold Coast - North	274	253	-7.7%
Gold Coast Hinterland	53	40	-24.5%
Mudgeeraba - Tallebudgera	85	70	-17.6%
Nerang	272	191	-29.8%
Ormeau - Oxenford	564	518	-8.2%
Robina	139	105	-24.5%
Southport	253	230	-9.1%
Surfers Paradise	248	232	-6.5%

Source: Queensland Police Service

Domestic violence – private applications

A private application for a Domestic Violence Order can be made by any member of the public who considers themselves to be at risk within their relationship and feel that their current situation warrants this type of protection.

Figure 9. Rate of Domestic Violence Orders – private applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 3. Number of Domestic Violence Orders – private applications, Gold Coast SA3 regions, 2019-20

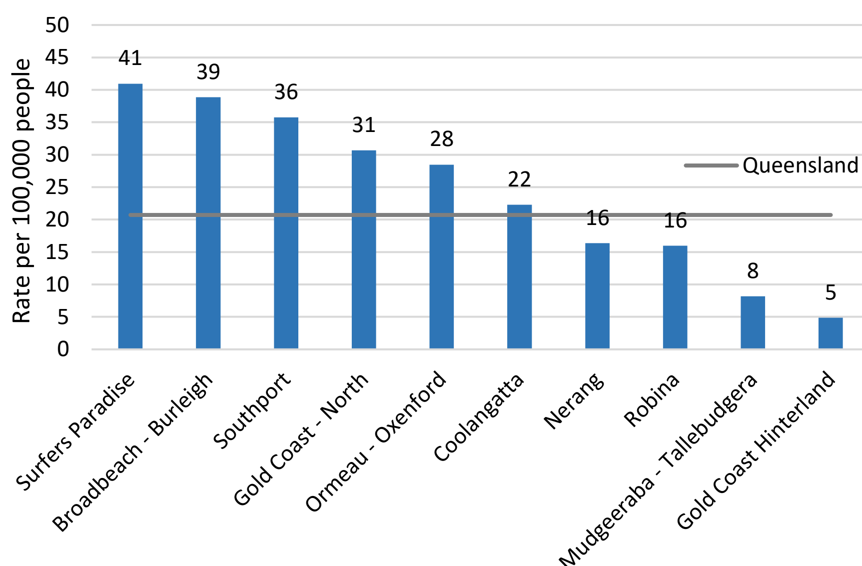
Region	2019	2020	Change from 2019 to 2020 (%)
Queensland	8,239	7,358	-10.7%
Gold Coast SA4	719	689	-4.2%
Broadbeach - Burleigh	53	64	20.8%
Coolangatta	57	46	-19.3%
Gold Coast - North	80	88	10.0%
Gold Coast Hinterland	33	24	-27.3%
Mudgeeraba - Tallebudgera	30	31	3.3%
Nerang	100	78	-22.0%
Ormeau - Oxenford	195	178	-8.7%
Robina	41	38	-7.3%
Southport	95	97	2.1%
Surfers Paradise	35	45	28.6%

Source: Queensland Police Service

Strangulation in a domestic setting

In 2020, the rate of strangulation in the domestic setting in the GCPHN region is above the Queensland rate of 20.7 per 100,000 people. Surfers Paradise had the highest number of strangulations reported to police – 41 per 100,000 people in 2020.

Figure 10. Rate per of strangulation in a domestic setting, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 4. Strangulation in a domestic setting, Queensland and Gold Coast, 2019-20

	2019	2020	Change from 2019 to 2020 (%)
Queensland	1042	1073	3.0%
Gold Coast	190	174	-8.4%

Source: Queensland Police Service

Between 1 July 2010 and 30 June 2014, there were 152 intimate partner homicides in Australia that followed an identifiable history of domestic violence. Most of these homicides involved a man killing his female partner (80%)[26].

[26] Australia's National research organisation for Women's Safety. (2019). Domestic Violence and family violence lethality: The facts about intimate partner homicide. Sydney.NSW: ANROWS

Service system

Services	Number in the GCPHN region	Distribution	Capacity
Domestic Violence Prevention Centre (DVPC) Gold Coast (07 5591 4222 or 07 5532 9000)	1	Gold Coast	The DVPC provides a wide range of programs to support women and their children affected by domestic violence and family violence and work with men who perpetrate domestic and family violence.
Kalwun Family and Domestic Violence Support Program (07 5520 8600)	1	Kalwun Medical Centres	Kalwun family and domestic violence program supports and empowers families escaping and recovering from violence and abuse. Women and children escaping family and domestic violence are eligible.
Gold Coast Centre against sexual violence	1	Gold Coast	Feminist, not for profit, charitable organisation providing free counselling, advocacy, information and practical support, as well as therapeutic and educational groups for women who have experienced sexual violence at any time in their lives.
Support Assessment Referral Advocacy (0405 065 544)	1	Gold Coast	Supports women and their children from culturally and linguistically diverse backgrounds affected by domestic and family violence.
DV Connect Womensline (1800 811 811)	Phone	Australia wide	Telephone hotline for women, their children and pets experiencing domestic violence. Womensline offers emergency transport and accommodation as well as crisis counselling and interventions.
Elder Abuse Helpline- Queensland Only (1300 651 192)	Phone	Australia wide	9am-5pm, Monday to Friday, free and confidential advice for anyone experiencing elder abuse or who suspects someone they know may be experiencing elder abuse.
1800RESPECT (188 737 732)	Phone	Australia wide	24-hour national sexual assault, family and domestic violence counselling line for any Australian who has experienced, or at risk, of family and domestic violence and/or sexual assault.
Men's Referral Service (1300 766 491)	Phone	Australia wide	This service from No to Violence offers assistance, information and counselling to help men who use family violence.
Mensline Australia (1300 789 978)	Phone	Australia wide	Supports men and boys who are dealing with family and relationship difficulties. 24/7 telephone and online support and information service for Australian men
Kids Help Line (1800 551 800)	Phone	Australia wide	Free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25 in Australia.

<table>
<tr><td>Aboriginal Family Domestic Violence Hotline
(1800 019 123)</td><td>Phone</td><td>Australia wide</td><td>Victims Services has a dedicated contact line for victims of crime who would like information on victims’ rights, how to access counselling and financial assistance.</td></tr>
</table>

Consultation

Gold Coast Local Level Alliance

Key issues raised at the Gold Coast Local Level Alliance are listed below:

- Local GPs are advocating for funding in the northern corridor for DV. GPs indicated they have had a large client base that is seeking psychological support for DV given the recent DV tragedies.
- Some GCPHN commissioned providers have indicated they have seen an increase of clients with family and/or domestic violence presentations to services.
- Noticeable increase in crisis calls and walk-ins specifically pertaining to women fleeing DV situations, seeking immediate support.
- Lack of safe accommodation for women, children's and their pets which is often a factor influencing someone to stay in this situation.
- Not often crisis housing will facilitate a pet to stay
- Impact of COVID-19 on increasing DV presentations needs to be considered.

GCPHN Community Advisory Council (July 2020)

What are major health issues that relate to domestic violence that are not currently being addressed on the Gold Coast?

- A lot of DV is from kids to parents, as these kids are under 18 there is no reporting due to parents not wanting to have the family engaged in child protection services. Kids seem to be repeating these behaviours as this is all they have ever known, and it is considered normal. Early intervention with children should be implemented when families visit their local doctor or service for help to:
    - avoid children adopting violent tendencies,
    - avoid children self-harming and development of mental health issues,
    - avoid emergency department admissions.
- Lack of accommodation/safe spaces for women and children.
- The psychosocial support needs of those experiencing domestic and family are currently under-supported due to limitations of GP Mental healthcare plans and similar programs, particularly for those with limited financial capacity to pay for out-of-pocket cost.
- Low-income families experience more domestic violence, and this seems to be a snowball effect from limited earnings, time poor from working for low wages creates fatigue and the feelings of no progression, leading to frustration and aggression.
- More education and early intervention are necessary to avoid ED admissions.
- The impacts of domestic violence on child development and the early onset of chronic disease, mental health issues and self-harming.
- Data show women are the most affected, however men also require safe spaces.

Are there any access issues to services or regions on the Gold Coast that lack services?

- There is a need for more men's behaviour change groups.
- Community attitudes need to change for change to occur on an individual basis and this is something to which more attention should be paid too.
- Adverse childhood experiences and their impacts are still under-acknowledged in the way we design and deliver services and this area requires more attention, due to the multitude of ways in which it impacts children in later life if they're subjected to adversities.
- Women and children need to be moved to safety houses if they suspect men can be dangerous.
- Holistic care to all members of domestic violence.
- Early intervention and empowering men and women at a young age may encourage respect and equality.
- Culturally and linguistically diverse and Aboriginal and Torres Strait Islander people need focus.

Domestic Violence Integrated Response (August 2020)

Domestic Violence Integrated Response (DVIR) which is a collection of about 16 organisations that primarily work in the DFV 'system', these are Police, Queensland Corrective Services, DJAG, Youth Justice, Child Safety, Centrelink, Department of Housing, Refuges, Queensland Health, Department of Education, Legal Aid, Multicultural Families Organisation and domestic violence prevention centre. As a group they meet monthly and largely look at improving the coordination of system responses.

In August 2020, they provided the following feedback:

- Based on evidence and research (Centre for innovative Justice Paper), DVIR is focussed on perpetrator interventions and looks to create doorways for men into services. Healthcare services are one of the limited number of points that could be a door for response required.
- Women tend to use GP and health services more than men. Often health services become aware and get involved in DV situations when there is a crisis. It would be better if DV could be identified earlier or outside of a crisis through proactive response.
- One thing any services who are supporting people in this area need to be aware of is unintended consequences. For example, if a person presents to GCH for DV related injuries would including this information in a discharge summary to GP assist or cause more issues.
- DVIR members noted several issues with private psychologists:
  - Many do not understand the complexity of DV, and many may see it as "marriage counselling" which it is not.
  - If domestic violence is pathologised, it does not make women safer, in fact it can provide "reasons/excuses", important to remember a lot of people drink/take drugs/ have anxiety - not all of them commit DV. They are escalating factors not the whole problem.
  - GPs and private psychologists can become unconscious allies for perpetrators because they focus on treating the individual.
- Also need to consider other general practice staff e.g., nurse and even reception staff. They are often placed to pick up on issues.
- GPs do not always book interpreters when they need to. Some doctors who speak other languages and have patients from those countries will refer women to multicultural support services.
- "Bomb drop training" is not helpful – it should be integrated into the work they do.
- Telehealth consults has provided some insights into family life not otherwise seen. Things going on in the background etc. that flag potential DV situations.

GCPHN Clinical Council (August 2020)

- GPs screen for domestic violence, and it can be a safe place for victims. There are resources available for GP's (White book).
- GPs will ask questions to their patients regarding domestic violence as part of their continued care, it's a longitude relationship with GPs.
- It builds the GP's confidence having conversations with their patient regarding family and domestic violence.
- Unclear health pathways within Primary Care for DV victims and perpetrators, what is the next step to take for a client who is a victim of domestic violence from their GP.
- Some GPs in the group use DV connect as a referral source, challenging to find support and in particular legal support.
- GPs in the group have no preferred psychologists that they would refer victims and perpetrators to. Difficult to search for psychologists with a special interest.
- Gap fee is a barrier for victims to seek psychologists.
- When a patient is referred to a psychologist, the psychologists need to deal with the risk and safety work alongside domestic violence services to focus on safety and not just psychological strategies.

- Pharmacists can give current medications for emergency medications, but unaware on where to refer to next.
- The white book is a great source for information for GPs although not reviewed as often due to time constraints, non-GPs in the group interested in the white book and how it can be of assistance.
- Often an issue can be emergency accommodation if victim of DV moves out with kids, churches can be a safe place although can be difficult for families.

Appendix 1 – Definition of domestic violence

Domestic and Family Violence Protection Act 2012 states that:

(1) *Domestic violence* means behaviour by a person (the *first person*) towards another person (the *second person*) with whom the first person is in a relevant relationship that—

(a) is physically or sexually abusive; or

(b) is emotionally or psychologically abusive; or

(c) is economically abusive; or

(d) is threatening; or

(e) is coercive; or

(f) in any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

(2) Without limiting subsection (1), domestic violence includes the following behaviour—

(a) causing personal injury to a person or threatening to do so;

(b) coercing a person to engage in sexual activity or attempting to do so;

(c) damaging a person's property or threatening to do so;

(d) depriving a person of the person's liberty or threatening to do so;

(e) threatening a person with the death or injury of the person, a child of the person, or someone else;

(f) threatening to commit suicide or self-harm so as to torment, intimidate or frighten the person to whom the behaviour is directed;

(g) causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the person to whom the behaviour is directed, so as to control, dominate or coerce the person;

(h) unauthorised surveillance of a person.

(i) unlawfully stalking a person.

(3) A person who counsels or procures someone else to engage in behaviour that, if engaged in by the person, would be domestic violence is taken to have committed domestic violence.

(4) To remove any doubt, it is declared that, for behaviour mentioned in subsection (2) that may constitute a criminal offence, a court may make an order under this Act on the basis that the behaviour is domestic violence even if the behaviour is not proved beyond a reasonable doubt.

(5) In this section—

Coerce, a person, means compel or force a person to do, or refrain from doing, something.

Unauthorised surveillance, of a person, means the unreasonable monitoring or tracking of the person's movements, activities or interpersonal associations without the person's consent, including, for example, by using technology.

Examples of surveillance by using technology—

- reading a person's SMS messages
- monitoring a person's email account or internet browser history
- monitoring a person's account with a social networking internet site
- using a GPS device to track a person's movements
- checking the recorded history in a person's GPS device

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