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Responses to the primary health care needs of Aboriginal and Torres Strait Islander women experiencing violence: A scoping review of policy and practice guidelines

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1 **Responses to the primary health care needs of Aboriginal and Torres Strait Islander**
2 **women experiencing violence: A scoping review of policy and practice guidelines**

3

4 **Abstract**

5

6 **Issue Addressed:** It is demonstrated that primary health care (PHC) providers are sought out
7 by women who experience violence. Given the disproportionate burden of violence
8 experienced by Aboriginal and Torres Strait Islander women, it is essential there is equitable
9 access to appropriate PHC services. This review aimed to analyse whether Australian PHC
10 policy accounts for the complex needs of Aboriginal and Torres Strait Islander women
11 experiencing violence and the importance of PHC providers responding to violence in
12 culturally safe ways.

13 **Methods:** Using the Arskey and O'Malley framework, an iterative scoping review
14 determined the policies for analysis. The selected policies were analysed against concepts
15 identified as key components in responding to the needs of Aboriginal and Torres Strait
16 Islander women experiencing violence. The key components are Family Violence, Violence
17 against Aboriginal and Torres Strait Islander Women, Social Determinants of Health,
18 Cultural Safety, Holistic Health, Trauma, Patient Centred Care and Trauma-and-Violence-
19 Informed Care.

20 **Results:** Following a search of Australian government websites, seven policies were selected
21 for analysis. Principally, no policy embedded or described best practice across all key
22 components.

23 **Conclusion:** The review demonstrates the need for a specific National framework supporting
24 Aboriginal and Torres Strait Islander women who seek support from PHC services, as well as
25 further policy analysis and review.

26 **So what:** Aboriginal and Torres Strait Islander women disproportionately experience more
27 severe violence, with complex impact, than other Australian women. PHC policy and practice
28 frameworks must account for this, together with the intersection of contemporary
29 manifestations of colonialism and historical and intergenerational trauma.

30

31 **Key words**

32 Aboriginal and Torres Strait Islanders, public policy, primary health care, interpersonal
33 violence, women's health

34

35 **1. Introduction**

36 Aboriginal and Torres Strait Islander¹ women are experiencing violence at disproportionate
37 rates compared to non-Aboriginal and Torres Strait Islander women in Australia. In 2014-15,
38 Aboriginal and Torres Strait Islander women were 32 times more likely to be hospitalised for
39 non-fatal family violence¹ and two times more likely to be killed by a current or previous
40 partner from 2012-13 to 2013-14² than non-Aboriginal and Torres Strait Islander women.
41 Violence experienced by Aboriginal and Torres Strait Islander women includes any act or
42 threat of gender-based, and domestic or family violence experienced by an Aboriginal and/or
43 Torres Strait Islander woman that results in physical, sexual or psychological harm or
44 suffering³ and also includes social, spiritual, cultural and economic harm or suffering,^{4,5}
45 while domestic violence encompasses acts of violence perpetrated by a current or former
46 intimate partner,⁶ family violence further encompasses violence perpetrated within families,
47 extended families, kinship networks and communities.⁵

48

49 The disproportionate burden of violence reflects a national inability to contribute to the
50 overall health and wellbeing of Aboriginal and Torres Strait Islander women through robust
51 and appropriate policy, notwithstanding the investment in Aboriginal and Torres Strait
52 Islander health.⁷ There is clear evidence that effective and sustainable policy responses to
53 violence involve the health system, in particular primary health care (PHC).⁸ PHC
54 encompasses the frontline (primary) layer of health care services, including health promotion,
55 prevention and screening, early intervention, treatment and management.⁹ PHC providers
56 include general practitioners, nurses, allied health professionals, midwives, pharmacists,
57 dentists and Aboriginal health care workers. Offering frontline health care services, PHC
58 providers are often first responders to women who disclose experiences of violence, and can
59 provide immediate support, referral, medical treatment and follow up care.¹⁰ Aboriginal
60 Community Controlled Health Organisations (ACCHOs) provide holistic and tailored PHC
61 approaches to addressing family violence that have at their core an understanding of
62 Aboriginal culture and family, and the continuing intergenerational impacts of colonisation.

63

64 Often the health system is the first and only point of contact with professionals for women;⁸
65 and evidence suggests women prefer to seek help from PHC providers when experiencing
66 violence.¹¹ However, it is well documented that mainstream PHC and specialist family
67 violence services often do not adequately respond to Aboriginal and Torres Strait Islander
68 women experiencing violence.¹² Aboriginal and Torres Strait Islander women experience

69 multiple barriers to accessing mainstream services, which is compounded by barriers to
70 disclosing violence.¹²

71

72 Thereby, PHC health policy frameworks that are explicitly designed for Aboriginal and
73 Torres Strait Islander women are important as they establish the steps necessary to achieve
74 sustainable and meaningful health care responses. Additionally, health policy plays a role in
75 informing the general public and health care workers on the priorities of an issue, and the
76 standard that is to be expected. Robust and appropriate health policy addressing Aboriginal
77 and Torres Strait Islander women who experience violence must consider Aboriginal and
78 Torres Strait Islander women's unique and disproportionate experience of violence and
79 encourage interaction between health care workers and workers from other sectors.⁸

80 Additionally, policymakers must be aware of ongoing colonisation manifesting as systemic
81 inequalities and structural violence, which is reinforced through discriminatory policies and
82 inequitable laws.¹³ The impacts of this **are** well regarded as the root cause of contemporary
83 health disparities between Aboriginal and Torres Strait Islanders and mainstream
84 Australia.^{7,14-16} This analysis will be conducted from a decolonising perspective, which
85 requires reflecting on current and past actions, policies and ideologies to understand current
86 circumstances and relationships.¹⁷

87

88 **1.1. Background to colonial and contemporary policy**

89 Policies and interventions in Australia generally acknowledge the persisting traumas as a
90 result of colonisation.^{18,19} However, they fail to recognise the overt and systematic colonial
91 structures and views present in contemporary policies.^{13,20,21} Contemporary manifestations of
92 colonisation in policy reproduce and reinforce the effects of historical and cumulative trauma
93 experienced by Aboriginal and Torres Strait Islander women.^{14,15} A review of policy since
94 colonisation demonstrates that, generally speaking, policy relating to Aboriginal and Torres
95 Strait Islander affairs is contradictory and prejudiced, and has largely been reactive and
96 politically contrived.²² Additionally, it is clear that policy that does not acknowledge the
97 continuing effects of colonisation results in ineffective and irrelevant policies and practices
98 that are not implemented or resourced appropriately because the need for unique policy
99 approaches is not made clear.²³ Without well drafted, Aboriginal and Torres Strait Islander
100 specific policies, trauma, dispossession and discrimination will continue to be ignored and/or
101 internalised, serving to maintain the disproportionate levels of violence against Aboriginal
102 and Torres Strait Islander women.²⁴

103

104 The framing of Aboriginal and Torres Strait Islander women in contemporary policy is rooted
105 in the 1788 British invasion,^{25,26} and subsequent dispossession and detachment of Aboriginal
106 and Torres Strait Islander peoples from their lands and cultures with the myth of *terra*
107 *nullius*.²⁷⁻³⁰ In the early 1900s under the guise of ‘protection’, legislation was introduced
108 effectively granting punitive control of Aboriginal and Torres Strait Islander people to state
109 and territory governments.³¹ These policies were a continuation of invasion colonial strategy
110 aimed at forcing disconnection from identity, land and kin³²; destroying traditional family
111 and community co-operation laws;³³ and creating dependency.

112

113 Most notably, the protectionist policies legalised the regular removal of Aboriginal and
114 Torres Strait Islander children, who came to be known as the Stolen Generations.³¹ The
115 trauma and wide-reaching negative impact of the child removals was ignored and denied until
116 the 1997 ‘Bringing them Home’ Report.³¹ In 2019, a majority of the key recommendations
117 made in the Report have still not been implemented¹⁹ and the removal of Aboriginal and
118 Torres Strait Islander children continues. In 2018-19 Aboriginal and Torres Strait Islander
119 children were eight times more likely than non-Aboriginal and Torres Strait Islander children
120 to be involved with child protection services and 1 in 18 were in out of home care.³⁴

121

122 In late 1960s, reflective of the global movement recognising civil rights, Aboriginal and
123 Torres Strait Islander self-determination became a policy focus.³⁵ A group of Aboriginal and
124 Torres Strait Islander activists demanded community control for Aboriginal and Torres Strait
125 Islander people in Australia,³⁶ which saw the establishment of an Aboriginal Legal Service in
126 1970, Aboriginal Community Controlled Health Services in 1971, the Office for Aboriginal
127 Affairs and the erection of the Aboriginal Tent Embassy in Canberra in 1972.

128

129 A Royal Commission was established in 1987 to investigate the disproportionate deaths of
130 Aboriginal and Torres Strait Islander people in custody. The findings, published in the
131 National Report in 1991, highlighted the importance of well resourced Aboriginal and Torres
132 Strait Islander organisations and services in key areas, including health, and opposed the use
133 of mainstream services.^{37,38} A 2015 review found that most of the recommendations were
134 never implemented or partially implemented by governments.³⁸

135

136 In 1989 the Commonwealth Government endorsed the The National Aboriginal Health
137 Strategy (NAHS), the first national policy developed with significant input from Aboriginal
138 and Torres Strait Islander people on Aboriginal and Torres Strait Islander health.³⁹ By 1994
139 the NAHS had still not been implemented effectively and the Commonwealth Department of
140 Human Services and Health assumed responsibility for implementing the NAHS in 1995.

141

142 Post-NAHS policies largely failed to account for the unequal institutional arrangements
143 structuring relationships between Aboriginal and Torres Strait Islander people and the
144 government.⁴⁰ In 2008 the Council of Australian Governments (COAG) developed explicit
145 reforms for health and social outcomes aimed at eliminating the gap in health outcomes for
146 Aboriginal and Torres Strait Islander people. By 2018 only three of the seven targets were on
147 track.⁴¹ In 2009 the Stronger Futures policy (the new Labor Government's name for the
148 Northern Territory Intervention) was maintained despite the United Nations finding it overtly
149 discriminated and stigmatised communities and infringed on self-determination.⁴²

150

151 In 2013 the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP)⁶ and the
152 National Aboriginal and Torres Strait Islander Health Plan Implementation Plan
153 (NATSIHPIP)⁴³ established a ten-year framework for increasing Aboriginal and Torres Strait
154 Islander life expectancy.⁶ The NATSIHP and NATSIHPIP were developed in close
155 consultation with Aboriginal communities and peak bodies, including the National Health
156 Leadership Forum, an independent body established to advocate for the rights of Aboriginal
157 people.⁴⁴ The successful local implementation of the NATSIHP and NATSIHPIP is yet to be
158 established.

159

160 **1.2 Objectives**

161 The aim of the review is to identify where federal, state and territory policy explicitly support
162 Aboriginal and Torres Strait Islander women experiencing violence who access PHC
163 providers, and any policy gaps. The identified policies will be reviewed against concepts
164 identified as key components in best practice policy that addresses the PHC needs of
165 Aboriginal and Torres Strait Islander women experiencing violence. The key concepts
166 include Family Violence, Violence against Aboriginal and Torres Strait Islander Women,
167 Social Determinants of Aboriginal and Torres Strait Islander Health and Wellbeing, Cultural
168 Safety, Holistic Health, Trauma, Patient Centred Care, Trauma and Violence Informed Care.
169 See Table 1 for definitions of the key concepts.

170

171 (Insert Table 1 here)

172

173 The analysis is intended to present an overview of Australian policy and not to provide a
174 quality assessment of individual policies. We hope the review demonstrates the need for
175 contextually based policy that responds to the PHC and cross-sectoral needs of Aboriginal
176 and Torres Strait Islander women experiencing violence, supporting the conclusion reached
177 by the United Nations Special Rapporteur on violence against women and the Special
178 Rapporteur on the rights of Indigenous peoples.^{45,46}

179

180 **2. Methods**

181 The Arksey and O'Malley (2005) six stage framework with Levac et al's recommendations
182 was used as it enabled an iterative approach to scoping expansive data and a broad research
183 topic (see Figure 1).^{46,47} Given the vast and complex nature of the Australian policy
184 landscape it was necessary to flexibly determine and interpret the key policies. This review
185 sits within a larger project, *First Response*,⁴⁷ which aims to provide evidence and critical
186 insight into how PHC providers can be supported to deliver culturally safe, trauma-and-
187 violence-informed care (TVIC) for Aboriginal and Torres Strait Islander women. The First
188 Response steering committee consisting of stakeholders from Aboriginal Community
189 Controlled Organisations and peak bodies, were consulted and provided input into the
190 methods for this review. The consultation process added value as it enabled the research team
191 to consult policy actors at the various stages of the scoping review, in particular the stage of
192 identifying relevant policies and guidelines, and to validate our findings.

193

194 (Insert Figure 1 here)

195

196 The research team comprised a mix of early career, mid-career and senior researchers, of
197 whom five are Aboriginal and Torres Strait Islander researchers. The research team share
198 common experience as public health researchers, and have diverse expertise and experience
199 in Aboriginal and Torres Strait Islander health; Indigenous methodologies; injury and
200 violence; racism; trauma-informed care; culturally safety in health care; primary care; mental
201 health; chronic disease; public health law and policy; nursing; and trauma.

202

203 **2.1. Identifying the research question**

204 The research questions formed part of a larger research project mentioned above. The
205 research team considered the key purposes and intended outcomes of the policy scope in
206 determining the research questions (see Figure 1).⁴⁸

207

208 PHC, distinct from primary care, is the focus of this project as it is aligned with the concept
209 of holistic health. Holistic health is defined as not just the physical well-being of the
210 individual, but the social, emotional and cultural well-being of the whole community;³⁹ and
211 PHC as promotive, preventive, curative and rehabilitative services provided by the health
212 sector and related sectors.⁴⁹

213

214 **2.2.Study selection**

215 A comprehensive search of Australian federal, state and territory government websites was
216 conducted in June 2018. The following terms were searched: Aboriginal and Torres Strait
217 Islander women, primary health and violence. Violence was defined widely; including
218 ‘family violence’, ‘domestic violence’ and ‘violence against women’, to ensure a breadth of
219 policies were captured.

220

221 Policies were included in the final review if they were current. The research team defined
222 policies as policy directives, guidelines, action plans, frameworks and reference manuals;
223 legislation was out of scope. Policies were excluded if they did not expressly apply to
224 Aboriginal and Torres Strait Islander women accessing PHC services. Additionally, policies
225 were excluded if they merely referred to another policy that expressly addressed Aboriginal
226 and Torres Strait Islander women.

227

228 The preliminary search was conducted by two researchers (NW, PC) and later checked by
229 one researcher (NW). The search process was iterative and included input from the research
230 team, *First Response*⁴⁷ steering committee.

231

232 **2.3.Charting the data**

233 Informed by the literature, the research team collectively identified and developed the
234 definitions of key concepts (Table 1) which comprised the data charting categories.⁴⁸ Two
235 researchers (NW, PC) extracted the data to ensure the categories were consistent with the
236 research question and an analysis workshop was conducted by several researchers (NW, TM,

237 ML, JC, KBB, PC) to ensure collective consensus with regard to key concepts and meaning
238 of extracted data.⁴⁸

239

240 **2.4.Synthesising, summarising and reporting the results**

241 The scale used to assess the policies against key concepts was developed by an Aboriginal
242 researcher with experience in policy analysis and refined by the larger research team. This
243 scale rating was as follows: 1 = concept mentioned but not defined; 2 = concept is defined; 3
244 = concept defined and embedded throughout the policy; 4 = concept defined, embedded
245 throughout the policy and best practice explained. Policies were awarded a 0 if the concept
246 was not mentioned in the exact phrasing listed in Table 1 in order to exclude policies that
247 promote a deficit discourse.⁵⁰ For a 3 or 4 rating it was sufficient if the concept was only
248 embedded throughout the section addressing Aboriginal and Torres Strait Islander women
249 experiencing violence.

250

251 **3. Results**

252 Ninety-seven policies were selected for possible inclusion following a title scan. Sixty-six
253 policies were selected following a summary scan (see Figure 2). Policies were included in the
254 final review if they contained actions or strategies relating to PHC providers or services for
255 Aboriginal and Torres Strait Islander women experiencing violence. Seven policies were
256 selected for review based on the inclusion criteria (Table 2), of these, four were National,^{4,51–}
257 ⁵³ two were from WA^{54,55} and one was from NSW⁵⁶. The two clinical guidelines that were
258 included were not identified through the search strategy but identified through
259 recommendations from the steering committee⁵² and the peer review process⁵³.

260

261 (Insert Figure 2 here)

262 (Insert Table 2 here)

263

264 **3.1.Target Population**

265 The Minymaku Kutju Tjukurpa's target population are Aboriginal and Torres Strait Islander
266 women living in remote areas in Australia.⁵³

267

268 The target population of the National Plan⁴ and the Third Action Plan⁵¹ are all women living
269 in Australia and their children.^{4,51} The specific needs of Aboriginal and Torres Strait Islander
270 women are recognised in the National Plan but not within the national outcomes and the

271 policy states ‘Indigenous women and their children must be considered in all elements’ (p.20)
272 of the policy.⁴

273

274 Aboriginal and Torres Strait Islander women and children are a priority area in the Third
275 Action Plan, yet only one of the four key actions refer to them specifically.⁵¹ The remaining
276 key actions focus on violence in Aboriginal and Torres Strait Islander communities and
277 support for Aboriginal and Torres Strait Islander men.⁵¹ Aboriginal and Torres Strait Islander
278 women are referred to in key actions that commit to improving the quality and accessibility
279 of services for women from culturally and linguistically diverse backgrounds, no distinction
280 is made between the groups.⁵¹ The sexual violence service needs of Aboriginal and Torres
281 Strait Islander women are similarly not distinguished from women from culturally and
282 linguistically diverse backgrounds, lesbian, gay and bisexual, transgender, intersex and queer
283 women, older women and women with disability.⁵¹

284

285 The target population of the NSW AFHW Operational Guidelines⁵⁶, the WA Reference
286 Manual⁵⁴ and the White Book⁵² are patients accessing health services. Chapter 11 of The
287 White Book refers to Aboriginal and Torres Strait Islander violence in communities but does
288 not specifically focus on women.⁵² Aboriginal and Torres Strait Islander women are
289 indirectly referred to in a case study⁵² and a recommended DVD on family violence.⁵² GPs
290 with Aboriginal and Torres Strait Islander patients are directed to chapters designed for all
291 women for ‘ways of asking about violence and ways of responding to disclosure’(p.86).⁵²
292 The role of AFHWs in the NSW AFHW Operational Guidelines is to focus on ‘family
293 violence within Aboriginal communities’ (p.2) and provide support groups for women to
294 share experiences.⁵⁶ In the WA Reference Manual¹ ‘Aboriginal People and Families’ are a
295 specialist area (p.51-53).⁵⁴ ‘Aboriginal women’ are specifically mentioned regarding fear of
296 reprisal, the removal of children and the importance of discharge planning (p.53).⁵⁴ In the
297 WA Guideline, health professionals are directed to refer to the ‘Aboriginal People and
298 Families’ practice points in the WA Reference Manual (p.8).⁵⁵

299

300 **3.2.Drafting process**

301 The White Book was authored by GPs and experts based on the ‘best available evidence in
302 February 2014’ (p.v).⁵² From a title scan the evidence referenced does not refer to Aboriginal
303 and Torres Strait Islander women.⁵² Dr Kylie Cripps from the Indigenous Law Centre at the
304 University of New South Wales contributed to writing Chapter 11 (Aboriginal and Torres

305 Strait Islander violence) and the RACGP National Faculty of Aboriginal and Torres Strait
306 Islander Health is acknowledged for providing feedback.⁵²

307

308 The Minymaku Kutju Tjukurpa was drafted by Congress Alukura, an Aboriginal women's
309 health service in Central Australia.⁵³ It is part of the Central Australian Aboriginal Congress,
310 an Aboriginal community controlled health service in the Northern Territory.⁵³ The manual
311 was produced in collaboration with the Central Australian Rural Practitioners Association
312 and the Centre for Remote Health.⁵³

313

314 In the remaining policies it is not clear whether Aboriginal and Torres Strait Islander people
315 or organisations were involved in the drafting process. The National Plan was authored by the
316 National Council to Reduce Violence against Women and their Children (the National
317 Council) lead by Libby Lloyd AM and Heather Nancarrow.⁴ The Third Action Plan was
318 drafted by the Council of Australian Governments (COAG) and informed by 'substantive
319 findings' from 'a number of high profile inquiries' (p.5).⁵¹ The NSW AFHW Operational
320 Guidelines were authored by the Government Relations branch in the NSW Department of
321 Health.⁵⁶ The WA Reference Manual was authored by the Department of Health Western
322 Australia, with advice from the Family and Domestic Violence Advisory Group.⁵⁴

323

324 **3.3.Evaluation and Implementation Mechanisms**

325 The National Plan's⁴ Outcome 3 (Indigenous communities are strengthened) will use data
326 from the National Aboriginal and Torres Strait Islander Social Survey to measure:

327 (the) reduction in the proportion of Indigenous women who consider that family
328 violence, assault and sexual assault are problems for their communities and
329 neighbourhoods; and increase in the proportion of Indigenous women who are able to
330 have their say within their communities on important issues, including violence
331 (p.20).⁴

332

333 The Third Action plan does not state whether Aboriginal and Torres Strait Islander people
334 will be involved in implementation or evaluation.⁵¹ Aboriginal and Torres Strait Islander
335 communities are a focus for working groups led by state and territory government officials
336 and experts from the academic and service sectors monitoring progress and key actions.⁵¹

337

338 The White Book does not provide evaluation or implementation information and resources. A
339 disclaimer in the policy states it is not exhaustive and is only a general guide.⁵²

340

341 The Minymaku Kutju Tjukurpa states it assumes competent general nursing skills and also
342 applies to experienced Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP)
343 but that the guidelines should not replace clinical judgement, expertise or appropriate referral,
344 and that practitioners must only work to their ability.⁵³ The guidelines view women's health
345 from the traditional Aboriginal law perspective and state women's health is women's
346 business and should only be addressed by female clinicians if possible.⁵³ Additionally, the
347 guidelines advocate for a female ATSIHP, Aboriginal community worker (ACW) or Strong
348 Women, Strong Babies, Strong Culture worker (SWSBSC), a senior community woman,
349 grandmother or family woman to be involved in a clinic visit.⁵³ There is no formal evaluation
350 process stated, however users of the guidelines are invited to submit feedback to Remote
351 Primary Health Care Manuals.⁵³

352

353 The NSW AFHW Operational Guidelines emphasise the importance of the role of AFHWs to
354 plan, monitor and evaluate their projects.⁵⁶ Evaluation mechanisms include an annual work
355 plan that is reviewed bi-annually by a culturally appropriate professional supervisor and
356 completion of the Family Violence Data Collection form, which is reviewed and monitored
357 by the Centre for Aboriginal Health.⁵⁶

358

359 The WA Reference Manual is reviewed every three years by the Women and Newborn
360 Health Service to ensure it is up to date with current literature.⁵⁴

361

362 **3.4.Key Concepts**

363 All policies defined and embedded the concept '*Family Violence*' and all policies, except for
364 one⁵⁶, defined and embedded the concept '*Violence Against Aboriginal and Torres Strait*
365 *islander Women*'. Comparably the concepts '*Social Determinants of Health*'^{4,56} and '*Cultural*
366 *Safety*'^{54,55} were only defined and embedded in two and three policies respectively. The
367 concept '*Holistic Health*' was defined in three policies,⁵⁴⁻⁵⁶ however it was not mentioned in
368 two policies.^{4,52} Similarly, '*Trauma*' was not mentioned in two policies,^{52,56} '*Patient Centred*
369 *Care*' was not mentioned in four policies^{4,51,52,56} and '*TVIC*' was not mentioned in five
370 policies.^{4,52,54-56} These three concepts were only mentioned and not defined in the remaining
371 policies. See Table 3 for an assessment of all key concepts in each policy.

372

373 (Insert Table 3 here)

374

375 **4. Discussion**

376 The results demonstrate that Australian government policies do not respond to all the PHC
377 needs of Aboriginal and Torres Strait Islander women who experience violence. Only one
378 policy was drafted to specifically address the needs of Aboriginal and Torres Strait Islander
379 women.⁵³ Subsuming Aboriginal and Torres Strait Islander women in policy addressing all
380 women or in policy addressing a range of groups requiring specialised support fails to
381 acknowledge the intersecting experiences of Aboriginal and Torres Strait Islander women.⁷
382 Most importantly, the lack of tailored support, particularly around disclosure and trauma,
383 ignores the historical, personal and cultural factors that uniquely create vulnerabilities and
384 risk for Aboriginal and Torres Strait Islander women.⁵⁷

385

386 **4.1. Mainstream policies**

387 The National Plan⁴ and Third Action plan⁵¹ recognised that Aboriginal and Torres Strait
388 Islander women have specific needs but did not provide a specific policy addressing those
389 needs. When women's health concerns are referred to in general terms it minimises the
390 urgency to address the different health needs of specific groups.¹⁶ In the context of
391 Aboriginal and Torres Strait Islander women it fails to recognise the overt and systematic
392 colonial structures and views present in mainstream contemporary policies,^{13,20,21} which in
393 effect reproduces and reinforces the effects of historical and cumulative trauma experienced
394 by Aboriginal and Torres Strait Islander women.^{14,15} Effective and equitable PHC responses
395 must be contextually specific in order to address the complex and nuanced intersectional
396 issues Aboriginal and Torres Strait Islander women experience.⁵⁷

397

398 **4.2. Narrow conception of violence**

399 In all policies, there is a focus on supporting women who experience violence in Aboriginal
400 and Torres Strait Islander geographical communities, which assumes that all violence is
401 perpetrated within these communities, and by Aboriginal and Torres Strait Islander men. This
402 is a narrow concept of violence that echoes a colonial legacy of policies that have ignored
403 reports of violence experienced by Aboriginal and Torres Strait Islander women when it is
404 not perpetrated by Aboriginal and Torres Strait Islander men, and demonstrates a general
405 political apathy towards Aboriginal and Torres Strait Islander women.⁵⁷

406

407 Anecdotal evidence suggests non-Aboriginal and Torres Strait Islander men constitute a
408 significant proportion of perpetrators of violence against Aboriginal and Torres Strait
409 Islander women.⁵⁸ Additionally, the policies are silent for Aboriginal and Torres Strait
410 Islander women who live in urban areas and do not live in discrete communities.⁵⁸ Policies
411 that would fill this gap are policies that recognise violence in Aboriginal and Torres Strait
412 Islander communities and violence towards Aboriginal and Torres Strait Islander women
413 constitute related but different policy issues. Policy should promote individualised responses
414 to Aboriginal and Torres Strait Islander women to ensure they are inclusive of all Aboriginal
415 and Torres Strait Islander women's experiences of violence.

416

417 **4.3. Language used in the policies**

418 **4.3.1. Deficit Discourse**

419 All policies that defined violence against Aboriginal and Torres Strait Islander women
420 defined it with a deficit lens by referencing the disproportionate burden of violence
421 experienced by Aboriginal and Torres Strait Islander women whilst providing limited or no
422 best practice solutions. A deficit policy discourse in Aboriginal and Torres Strait Islander
423 affairs focuses issues in poverty, community dysfunction and primitiveness.⁵⁰ Deficit policy
424 discourses can be dated back to the 1900s 'protection legislation', which was founded on the
425 idea that Aboriginal and Torres Strait Islander people were to blame for poverty and health
426 disparities.⁵⁰ The effect of the protection policy discourse granting punitive control of
427 Aboriginal and Torres Strait Islander people to state and territory governments ultimately
428 facilitated the rape and abuse of Aboriginal and Torres Strait Islander women by white
429 men.^{27,59,60} The policy also dispossessed and 'othered' Aboriginal and Torres Strait Islander
430 men, contributing to ongoing lateral violence and the use of violence towards Aboriginal and
431 Torres Strait Islander women. In 2008, the Howard Government publicly promoted a deficit
432 discourse by denying ongoing colonisation when the Prime Minister refused to issue an
433 apology, stating the violence of colonisation was not the responsibility of contemporary
434 Australians.⁶¹

435

436 Comparably, strengths based approaches recognise agency, respect, self-determination and
437 seek to empower Aboriginal and Torres Strait Islander people.⁵⁰ The UN Special Rapporteur
438 on violence against women, critiqued the National Plan for providing no opportunities to
439 empower Aboriginal and Torres Strait Islander women.⁴⁶ A strengths based approach to PHC

440 for Aboriginal and Torres Strait Islander women experiencing violence relies on addressing
441 the social determinants of Indigenous health⁵⁰. The WHO's measures such as stress, early life
442 experiences, social exclusion, unemployment and transport, are based on Western cultural
443 norms that ignore the effects of colonisation and the importance of land and family
444 relationships on good health outcomes for Aboriginal and Torres Strait Islander people.⁶²

445

446 **4.3.2. Definition of Family Violence**

447 In the context of violence experienced by Aboriginal and Torres Strait Islander women, the
448 delineation between family violence and domestic violence was not clear in the policies.
449 Domestic violence is mediated by a current or former intimate partner, whereas family
450 violence can be perpetrated by broader family members and is inclusive of kin relationships.
451 A culturally safe definition of family violence in the Aboriginal and Torres Strait Islander
452 context includes all types of violence and family relationships, and corresponding policy
453 should also support this.

454

455 **4.4. The role of PHC providers to refer patients to cross-sectoral agencies**

456 One of the founding principles of the NAHS that has not been implemented is cross-sectoral
457 collaboration.³⁹ It is well established, the health gap between Aboriginal and Torres Strait
458 Islander people and non-Aboriginal and Torres Strait Islander people reflects a
459 disproportionate burden of socio-economic disadvantage. An important determinant of health
460 inequality is a lack of access to services that address social determinants of Aboriginal and
461 Torres Strait Islander health and wellbeing. PHC services play an important role in referring
462 women who experience violence to cross-sectoral agencies, especially if it is the first time a
463 woman is disclosing.

464

465 An action of the Minymaku Kutju Tjukurpa when seeing a woman who has experienced
466 violence is to 'call in supports'.⁵³ The support services listed include women's shelter, police,
467 domestic/family violence support service, emergency accommodation and emergency travel
468 support but there is no specific emphasis on the importance of referring women to culturally
469 safe services.⁵³ An additional action included as part of the management plan is to ensure the
470 woman have a 'safe place to stay' if they are staying in the community. The NSW AFHW
471 Operational Guidelines similarly emphasised the role of AFHWs as liaisons with other
472 services.⁵⁶ However, the responsibility of PHC providers to provide cross-sectoral referrals
473 and the process of referral was largely missing in the remaining policies.

474

475 Aboriginal and Torres Strait Islander women experiencing violence need referrals to
476 culturally safe agencies and organisations, in particular proper engagement with welfare,
477 education, housing, justice and the police.⁵⁷ Without clearly demarcating referral as a
478 responsibility of PHC providers there is a risk of inconsistent and/or incomplete care. Merely
479 listing social factors that influence violence creates a policy gap as PHC providers can
480 interpret the meaning and required actions of such a list in varying and potentially assumptive
481 ways.

482

483 Specifically, the barriers to housing are acutely experienced by Aboriginal and Torres Strait
484 Islander women yet the policies on a whole did not comprehensively address the need for
485 adequate crisis services, shelters or refuges.⁴⁶ We endorse the recommendation of the UN
486 Special Rapporteur for Violence against Indigenous Women that policy providing access to
487 community infrastructure and housing should be urgently improved.⁴⁶

488

489 **4.5.Drafting**

490 When drafting policy, it is important to involve the population it will affect. Excluding
491 Aboriginal and Torres Strait Islander women in the drafting process replicates colonial
492 silencing.⁵⁷ As stated in the NAHS, Aboriginal and Torres Strait Islander women should be in
493 control of issues that fall within women's domains³⁹ and in consulting, designing and
494 developing their health services.^{46,63} Except for the White Book and Minymaku Kutju
495 Tjukurpa, there is little indication that the included policies were drafted with or by
496 Aboriginal and Torres Strait Islander people. It is Aboriginal and Torres Strait Islander
497 women's right to have ownership of initiatives to improve their health and wellbeing.^{46,57} As
498 a starting point, policies should refer to the National Aboriginal and Torres Strait Islander
499 Women's Health Strategy, which is built on Aboriginal and Torres Strait Islander women's
500 work and words and states what is required to make a difference.^{51,54-56} When policy does not
501 include the voices of the population it will affect, knowledge about health and health care
502 tends to be constructed to serve the needs and perceptions of others.⁷

503

504 **4.6.Evaluation and Implementation Mechanisms**

505 Evaluation priorities for Aboriginal and Torres Strait Islander peoples include connection to
506 Country and community, self-determination and empowerment.⁶⁴ Without consideration of
507 these evaluation priorities, policy relating to Aboriginal and Torres Strait Islander people

508 risks silence in those priority areas. This occurred with the 2009 Stronger Futures policy (the
509 new Labor Government's name for the Northern Territory Intervention), which was
510 maintained despite the United Nations finding it overtly discriminated and stigmatised
511 Aboriginal and Torres Strait Islander communities, and infringed on self-determination.⁴²

512

513 In order to ensure policy is culturally safe and upholds self-determination, Aboriginal and
514 Torres Strait Islander women and community controlled organisations should have a pivotal
515 role in monitoring and evaluating policy, and health services for Aboriginal and Torres Strait
516 Islander women experiencing violence.⁶³ Rigorous evaluation also has the potential to create
517 a robust evidence base that can inform future policy and influence equitable relationships
518 between Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres
519 Strait Islander communities.⁶⁵ There is little indication the policies are being evaluated or
520 implemented with or by Aboriginal and Torres Strait Islander women. Where policies have
521 stated they are consulting Aboriginal and Torres Strait Islander community, people or data, it
522 is not clear to what extent or whether women were/are involved.

523

524 **4.7.Missing Definitions**

525 Language in Aboriginal and Torres Strait Islander policy should always be interpreted with a
526 decolonising lens.¹⁷ Generally, the policies failed to provide definitions of the key concepts,
527 in particular cultural safety, trauma and TVIC, resulting in ambiguous language that can be
528 variably interpreted.

529

530 Cultural safety is the foundation of many key components (see Table 1) as culturally safe
531 environments are integral to supporting Aboriginal and Torres Strait Islander women
532 experiencing violence who will not disclose in unfamiliar and unsafe environments.

533 Culturally safe PHC embodies holistic health and includes patient centred care. Although
534 largely missing, when holistic health was defined, the NAHS definition was drawn from but
535 not referenced.³⁹ Concepts defined by Aboriginal and Torres Strait Islander people must be
536 included in Aboriginal and Torres Strait Islander policy. Patient centred care was only
537 defined in the WA Reference Manual, which should be used as a starting point for
538 discussions about cultural safety and patient centred care in PHC policy.

539

540 Trauma and TVIC were not defined in any of the policies, allowing and facilitating the denial
541 of the depth and extent of trauma. When considering trauma experienced by Aboriginal and

542 Torres Strait Islander women who have experienced violence, a decolonising lens must be
543 used. This ensures trauma is recognised as the impact of historical colonial events and
544 policies, the process of ongoing colonisation manifest in structural violence and systemic
545 inequalities, and the psychological and physical impact of violence.⁶⁶ Additionally, PHC
546 provided in the absence of a TVIC model risks re-traumatising and alienating women who
547 have experienced family violence.

548

549 **4.8.Strengths and limitations of the review**

550 The review is characterised by the following strengths. The methodology allowed for a
551 collaborative and iterative approach throughout all stages of the review, creating
552 opportunities for consensus building and the integration of Aboriginal and Torres Strait
553 Islander perspectives.^{48,67} The multidisciplinary backgrounds of the research team, and
554 Aboriginal and Torres Strait Islander researchers, contributing a variety of perspectives to the
555 research process and findings.⁶⁸

556

557 The scope is limited as it does not consider individual organisational policies, such as the
558 policies of individual ACCHOs, or cross-sectoral policies as they were outside the scope of
559 the review. Cross-sectoral issues and policies should be considered when designing policy
560 supporting the PHC needs of Aboriginal and Torres Strait Islander women experiencing
561 violence as they have a practical effect on health and wellbeing. In particular, there is a
562 growing body of literature on best practice primary prevention and violence reduction policy
563 for Aboriginal and Torres Strait Islander women that acknowledges the historical and
564 intersecting influences on experiences of violence.^{58,69}

565

566 A further limitation is the method of analysis. A content analysis is static and influences such
567 as gender equality, interaction between agencies and data from front line providers on the
568 practical effects of the policy are not taken into account. As there are few evaluative data
569 results publicly available, the evaluation of implementation is beyond the scope of the
570 project, however could form a future research project.

571

572 **4.9.Implications for future direction**

573 **4.9.1. Policy**

574 Future policy should redress the gaps identified by this review. It is essential there are unique
575 policy actions and strategies that respond to the multifaceted and intersectional nature of

576 violence against Aboriginal and Torres Strait Islander women. In particular, policy should
577 focus on developing and supporting culturally safe PHC services and providers who promote
578 holistic health, patient centred care and TVIC. Such policy responses will be sustainable if
579 they exist within a cross-sectoral policy framework, are drafted by or with Aboriginal and
580 Torres Strait Islander women and acknowledge the ongoing process of colonisation.
581 Additionally, as demonstrated historically, targeted, clear and inclusive policy is only
582 effective if it is appropriately resourced; implemented by Aboriginal and Torres Strait
583 Islander people and communities; and evaluated against connection to Country and
584 community, self-determination and empowerment.

585

586 **4.9.2. Practice**

587 PHC providers should recognise the important role they play in providing support for
588 Aboriginal and Torres Strait Islander women who experience violence and as a result should
589 seek to provide culturally safe, patient centred and TVIC. Support should be tailored for
590 Aboriginal and Torres Strait Islander women, especially when providing referrals, as the
591 justice and child welfare systems reflect contemporary manifestations of colonisation.^{40,46}
592 Taking into account the limited scope of the review, the authors recognise the implications
593 suggested may already form organisational policies or established practice within individual
594 PHC services.

595

596 **4.9.3. Research**

597 Future research should consider widening the scope of policies reviewed to include
598 organisational policies and a review of the evaluation, application and implementation of
599 PHC policies, including the interaction of PHC policies with cross-sectoral policies.
600 Additionally, policy actors should be formally consulted to provide insight into the practical
601 application of any policies reviewed and possible hidden gaps. The results of this policy
602 analysis may also be strengthened by a parallel review of health policy in Australia,
603 specifically the evolution of primary health care policy as it may reveal policy gaps where
604 Aboriginal and Torres Strait Islander women seek primary health care for any of the well
605 established health issues that co-occur with experiences of violence.

606

607 **5. Conclusion**

608 The review has demonstrated there are significant gaps in policy responding to the PHC
609 needs of Aboriginal and Torres Strait Islander women experiencing violence. Given the

610 importance of PHC in help seeking behaviours of women who experience violence, it is
611 essential that future PHC policy, practice and research in Australia is accessible to all
612 Aboriginal and Torres Strait Islander women. A specific policy outlining a model of care
613 based on the key concepts in this review, involving Aboriginal and Torres Strait Islander
614 women in the process of drafting, implementation and evaluation and establishing clear links
615 to cross-sectoral policies would fill the policy gaps demonstrated in this review. Unless
616 Aboriginal and Torres Strait Islander women are empowered and affirmed as Aboriginal and
617 Torres Strait Islander women, few gains will be made regarding the disproportionate rates of
618 violence experienced.²⁴

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ⁱ The authors have used Aboriginal and Torres Strait Islander to represent the Aboriginal and Torres Strait Islander peoples of Australia and the Torres Strait Islands, unless it is a direct quotation. However, we acknowledge the diversity of Australia's First peoples, and that they do not represent a homogenous group. Where Indigenous is used, it is representative of indigenous peoples around the world.