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

Abstract

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

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

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

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

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

Key words

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

1. Introduction

Aboriginal and Torres Strait Islander[i] women are experiencing violence at disproportionate rates compared to non-Aboriginal and Torres Strait Islander women in Australia. In 2014-15, Aboriginal and Torres Strait Islander women were 32 times more likely to be hospitalised for non-fatal family violence[1] and two times more likely to be killed by a current or previous partner from 2012-13 to 2013-14[2] than non-Aboriginal and Torres Strait Islander women. Violence experienced by Aboriginal and Torres Strait Islander women includes any act or threat of gender-based, and domestic or family violence experienced by an Aboriginal and/or Torres Strait Islander woman that results in physical, sexual or psychological harm or suffering[3] and also includes social, spiritual, cultural and economic harm or suffering,[4,5] while domestic violence encompasses acts of violence perpetrated by a current or former intimate partner,[6] family violence further encompasses violence perpetrated within families, extended families, kinship networks and communities.[5]

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

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

multiple barriers to accessing mainstream services, which is compounded by barriers to disclosing violence.[12]

Thereby, PHC health policy frameworks that are explicitly designed for Aboriginal and Torres Strait Islander women are important as they establish the steps necessary to achieve sustainable and meaningful health care responses. Additionally, health policy plays a role in informing the general public and health care workers on the priorities of an issue, and the standard that is to be expected. Robust and appropriate health policy addressing Aboriginal and Torres Strait Islander women who experience violence must consider Aboriginal and Torres Strait Islander women's unique and disproportionate experience of violence and encourage interaction between health care workers and workers from other sectors.[8] Additionally, policymakers must be aware of ongoing colonisation manifesting as systemic inequalities and structural violence, which is reinforced through discriminatory policies and inequitable laws.[13] The impacts of this are well regarded as the root cause of contemporary health disparities between Aboriginal and Torres Strait Islanders and mainstream Australia.[7,14–16] This analysis will be conducted from a decolonising perspective, which requires reflecting on current and past actions, policies and ideologies to understand current circumstances and relationships.[17]

1.1.Background to colonial and contemporary policy

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

The framing of Aboriginal and Torres Strait Islander women in contemporary policy is rooted in the 1788 British invasion,[25,26] and subsequent dispossession and detachment of Aboriginal and Torres Strait Islander peoples from their lands and cultures with the myth of *terra nullius*.[27–30] In the early 1900s under the guise of 'protection', legislation was introduced effectively granting punitive control of Aboriginal and Torres Strait Islander people to state and territory governments.[31] These policies were a continuation of invasion colonial strategy aimed at forcing disconnection from identity, land and kin [32]; destroying traditional family and community co-operation laws;[33] and creating dependency.

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

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

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

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

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

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

1.2 Objectives

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

(Insert Table 1 here)

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

2. Methods

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

(Insert Figure 1 here)

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

2.1.Identifying the research question

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

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

2.2.Study selection

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

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

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

2.3.Charting the data

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

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

2.4.Synthesising, summarising and reporting the results

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

3. Results

Ninety-seven policies were selected for possible inclusion following a title scan. Sixty-six policies were selected following a summary scan (see Figure 2). Policies were included in the final review if they contained actions or strategies relating to PHC providers or services for Aboriginal and Torres Strait Islander women experiencing violence. Seven policies were selected for review based on the inclusion criteria (Table 2), of these, four were National,[4,51–53] two were from WA[54,55] and one was from NSW[56]. The two clinical guidelines that were included were not identified through the search strategy but identified through recommendations from the steering committee[52] and the peer review process[53].

(Insert Figure 2 here)

(Insert Table 2 here)

3.1.Target Population

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

The target population of the National Plan[4] and the Third Action Plan[51] are all women living in Australia and their children.[4,51] The specific needs of Aboriginal and Torres Strait Islander women are recognised in the National Plan but not within the national outcomes and the

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

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

The target population of the NSW AFHW Operational Guidelines[56], the WA Reference Manual[54] and the White Book[52] are patients accessing health services. Chapter 11 of The White Book refers to Aboriginal and Torres Strait Islander violence in communities but does not specifically focus on women.[52] Aboriginal and Torres Strait Islander women are indirectly referred to in a case study[52] and a recommended DVD on family violence.[52] GPs with Aboriginal and Torres Strait Islander patients are directed to chapters designed for all women for ‘ways of asking about violence and ways of responding to disclosure’(p.86).[52] The role of AFHWs in the NSW AFHW Operational Guidelines is to focus on ‘family violence within Aboriginal communities’ (p.2) and provide support groups for women to share experiences.[56] In the WA Reference Manual[1] ‘Aboriginal People and Families’ are a specialist area (p.51-53).[54] ‘Aboriginal women’ are specifically mentioned regarding fear of reprisal, the removal of children and the importance of discharge planning (p.53).[54] In the WA Guideline, health professionals are directed to refer to the ‘Aboriginal People and Families’ practice points in the WA Reference Manual (p.8).[55]

3.2.Drafting process

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

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

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

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

3.3.Evaluation and Implementation Mechanisms

The National Plan's[4] Outcome 3 (Indigenous communities are strengthened) will use data from the National Aboriginal and Torres Strait Islander Social Survey to measure:

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

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

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

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

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

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

3.4.Key Concepts

All policies defined and embedded the concept *'Family Violence'* and all policies, except for one [56], defined and embedded the concept *'Violence Against Aboriginal and Torres Strait islander Women'*. Comparably the concepts *'Social Determinants of Health'*[4,56] and *'Cultural Safety'*[54,55] were only defined and embedded in two and three policies respectively. The concept *'Holistic Health'* was defined in three policies,[54–56] however it was not mentioned in two policies.[4,52] Similarly, *'Trauma'* was not mentioned in two policies,[52,56] *'Patient Centred Care'* was not mentioned in four policies[4,51,52,56] and *'TVIC'* was not mentioned in five policies.[4,52,54–56] These three concepts were only mentioned and not defined in the remaining policies. See Table 3 for an assessment of all key concepts in each policy.

(Insert Table 3 here)

4. Discussion

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

4.1.Mainstream policies

The National Plan[4] and Third Action plan[51] recognised that Aboriginal and Torres Strait Islander women have specific needs but did not provide a specific policy addressing those needs. When women's health concerns are referred to in general terms it minimises the urgency to address the different health needs of specific groups.[16] In the context of Aboriginal and Torres Strait Islander women it fails to recognise the overt and systematic colonial structures and views present in mainstream contemporary policies,[13,20,21] which in effect reproduces and reinforces the effects of historical and cumulative trauma experienced by Aboriginal and Torres Strait Islander women.[14,15] Effective and equitable PHC responses must be contextually specific in order to address the complex and nuanced intersectional issues Aboriginal and Torres Strait Islander women experience.[57]

4.2.Narrow conception of violence

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

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

4.3.Language used in the policies

4.3.1. Deficit Discourse

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

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

for Aboriginal and Torres Strait Islander women experiencing violence relies on addressing the social determinants of Indigenous health[50]. The WHO's measures such as stress, early life experiences, social exclusion, unemployment and transport, are based on Western cultural norms that ignore the effects of colonisation and the importance of land and family relationships on good health outcomes for Aboriginal and Torres Strait Islander people.[62]

4.3.2. Definition of Family Violence

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

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

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

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

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

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

4.5.Drafting

When drafting policy, it is important to involve the population it will affect. Excluding Aboriginal and Torres Strait Islander women in the drafting process replicates colonial silencing.[57] As stated in the NAHS, Aboriginal and Torres Strait Islander women should be in control of issues that fall within women's domains[39] and in consulting, designing and developing their health services.[46,63] Except for the White Book and Minymaku Kutju Tjukurpa, there is little indication that the included policies were drafted with or by Aboriginal and Torres Strait Islander people. It is Aboriginal and Torres Strait Islander women's right to have ownership of initiatives to improve their health and wellbeing.[46,57] As a starting point, policies should refer to the National Aboriginal and Torres Strait Islander Women's Health Strategy, which is built on Aboriginal and Torres Strait Islander women's work and words and states what is required to make a difference.[51,54–56] When policy does not include the voices of the population it will affect, knowledge about health and health care tends to be constructed to serve the needs and perceptions of others.[7]

4.6.Evaluation and Implementation Mechanisms

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

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

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

4.7.Missing Definitions

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

Cultural safety is the foundation of many key components (see Table 1) as culturally safe environments are integral to supporting Aboriginal and Torres Strait Islander women experiencing violence who will not disclose in unfamiliar and unsafe environments. Culturally safe PHC embodies holistic health and includes patient centred care. Although largely missing, when holistic health was defined, the NAHS definition was drawn from but not referenced.[39] Concepts defined by Aboriginal and Torres Strait Islander people must be included in Aboriginal and Torres Strait Islander policy. Patient centred care was only defined in the WA Reference Manual, which should be used as a starting point for discussions about cultural safety and patient centred care in PHC policy.

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

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

4.8.Strengths and limitations of the review

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

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

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

4.9.Implications for future direction

4.9.1. Policy

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

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

4.9.2. Practice

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

4.9.3. Research

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

5. Conclusion

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

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