Ending family and domestic violence must be a preventative health priority

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Content note: This article discusses family and domestic violence.

One of the priorities I set when I stood for president was a stronger focus on the determinants of health and on prevention. Few issues make that case more clearly than family and domestic violence.

Family and domestic violence is, first and foremost, a violation of a person's safety, dignity and human rights. It is also a major and preventable public health issue. That does not mean medicalising abuse. It means recognising that health policy has an important role in preventing violence, responding safely when it occurs, and supporting recovery – rather than treating only the injuries and illness left behind.

The scale is stark. In 2024, the Australian Bureau of Statistics recorded 47,045 victims of assault in Western Australia. Of those recorded victims, 30,451 (65%) were associated with family and domestic violence. These are police-recorded figures and do not capture all violence or abuse.

Nationally, the 2021-22 Personal Safety Survey found that 21% of Australian adults, approximately 4.2 million people, had experienced violence, emotional abuse or economic abuse by a partner since the age of 15.

Much of this abuse is not visible to others, reported to police, or safely disclosed. That must never allow it to be dismissed as a private matter.

> **"The World Health Organization's LIVES approach – Listen, Inquire, Validate, Enhance Safety, Support – offers a useful foundation for first-line care. Doctors and other health professionals need practical, trauma-informed and culturally responsive training to provide that care confidently.**

Responsibility always lies with the person choosing to use violence, abuse or coercive control. It never lies with the person subjected to it. Our response must not be measured by whether a victim-survivor reports the abuse, leaves a relationship, or discloses before they are ready. It must be measured by safety, choice, recovery and accountability.

Family and domestic violence can affect people of any gender, but its burden is not evenly distributed. Women and children are disproportionately affected. An effective response must acknowledge that gendered reality, while remaining inclusive of every person who needs help. It must also be accessible, culturally safe, and capable of meeting the different needs of metropolitan, regional and remote communities.

The health consequences can be serious and long-lasting, affecting physical and mental health, sexual and reproductive health, housing, education, employment, relationships and financial security. Not every victim-survivor will experience the same effects, and no person should be defined by what has happened to them.

In my work in mental health, I regularly see how experiences of violence can affect a person's wellbeing and recovery. Understanding what is happening at home can be essential to providing appropriate care. Mental illness, alcohol, drugs or life pressures must never be used to explain away or excuse a person's choice to use violence or control.

A health appointment may offer one of the few private opportunities for someone to speak about their safety. But we should not assume that every clinical environment feels safe, or that a person is ready or able to disclose.

When it is clinically appropriate to ask about safety, that conversation must take place privately and sensitively. When someone discloses abuse, our responsibilities are to listen without judgement, take what they say seriously, explain confidentiality and its limits, respect their choices wherever possible, consider immediate safety and, with their consent, help connect them with specialist support.

We must not pressure someone to disclose more than they wish, report the abuse, or leave a relationship. The period

around separation can carry heightened risk, and no one outside the situation can fully understand the choices a victim-survivor must make to remain as safe as possible.

The World Health Organization's LIVES approach – Listen, Inquire, Validate, Enhance Safety, Support – offers a useful foundation for first-line care. Doctors and other health professionals need practical, trauma-informed and culturally responsive training to provide that care confidently.

Policies and screening tools matter, but they must be backed by private consultation spaces, clear referral pathways, specialist social workers, crisis teams and strong relationships with community services. Individual clinicians cannot and should not be expected to navigate this alone.

Safe housing is also health infrastructure.

For some victim-survivors, the safest option may be crisis or transitional accommodation. For others, programs that help them remain safely in their own home, or a home of their choice, may be more appropriate. The central principle must be choice, supported by expert risk assessment and safety planning.

Demand for safe accommodation continues to exceed capacity in parts of Western Australia. An emergency department cannot substitute for a safe home. We need sufficient refuges and transitional housing, alongside outreach services and programs that enable people to stay safely connected to their communities, workplaces, schools and support networks.

Children who live with family violence are not passive witnesses. They experience its fear, control and instability and must be recognised as victim-survivors in their own right, whether or not violence is directed at them personally.

A Western Australian linked-data study found that children whose exposure to family and domestic violence was identified in police records had a 49% higher adjusted risk of contact with mental health services than children in the comparison group.

That is a population-level association, not a prediction for any individual child.

Harm is not inevitable. With safety, stability and timely, culturally appropriate support, children can recover and thrive. Their needs and voices must be incorporated into risk assessment, service design, therapeutic care, and decisions affecting their lives.

We also need to distinguish primary prevention from the essential work of crisis response and recovery.

Primary prevention means acting before violence occurs. It includes age-appropriate, respectful-relationships education; advancing gender equality; challenging attitudes and behaviours that normalise disrespect and coercion; engaging men and boys as active partners in prevention; and supporting culturally informed, community-led programs.

Public education campaigns can help people recognise abuse, challenge harmful behaviour, and find support. But encouraging disclosure must never become an end in itself.

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Prevention is both a moral necessity and sound public health policy. But its value cannot be measured only in hospital presentations avoided or dollars saved. It must also be measured in safety restored, childhoods protected, dignity respected, and lives lived free from fear and control.

No one should be expected to tell their story before they are ready, or in circumstances where doing so may place them at greater risk.

At the same time, prevention must sit alongside early intervention, specialist services and evidence-based programs that hold people using violence accountable and support them to change their behaviour.

I want to place on the record my unreserved appreciation and sincere thanks to the Hon Jessica Stojkovski MLA, Minister for Prevention of Family and Domestic Violence. She deserves unequivocal praise for the urgency, compassion and practical focus she has brought to this portfolio.

Under Minister Stojkovski's leadership, the State has backed awareness with concrete, system-wide action. The 2026-27 State Budget commits an additional $106.3 million over the forward estimates to family and domestic violence prevention and response.

That work includes a $13.7 million investment through WA Health over three years to strengthen the health system's capability, including out-of-hours social workers in emergency departments, service navigation, and stronger specialist counselling.

It also includes additional crisis accommodation; the expansion of Safe at Home from 11 to 19 locations; new tailored support for young people affected by violence; and $6 million for community-led primary-prevention initiatives.

I am deeply grateful to Minister Stojkovski for keeping safety, recovery, choice and perpetrator accountability at the centre of this work. Her leadership deserves the active support of every government portfolio, the health profession, and the wider community.

The annual 16 Days in WA campaign, running from 25 November to 10 December, remains an important opportunity to raise awareness and encourage action. But this work cannot be confined to 16 days. It must be a commitment for every day of the year.

This is not a choice between hospitals and prevention. A capable health system must do both: respond compassionately when harm occurs and invest upstream in preventing violence, safe housing, specialist services, respectful relationships and perpetrator accountability.

Prevention is both a moral necessity and sound public health policy. But its value cannot be measured only in hospital presentations avoided or dollars saved. It must also be measured in safety restored, childhoods protected, dignity respected, and lives lived free from fear and control.

The health system cannot end family and domestic violence alone. But it cannot stand apart from the effort. Ending this violence must be one of our most significant and sustained preventative health priorities. ■

If this article raises concerns for you or someone you know, support is available.

In an emergency, call **000**. For confidential support available 24 hours a day, contact 1800RESPECT on **1800 737 732**, send a text message to **0458 737 732** or visit **1800RESPECT.org.au**.

If your phone or device may be monitored, consider using a safer device or contact method where possible.

More than just a script

Shared care for youth with ADHD

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ADHD is the most common neurodevelopmental condition affecting young people. Australian data shows 7% of children aged four to 17 years of age are affected by ADHD,[1] and rates of diagnosis are continuing to increase in adolescents and adults.[2]

All adolescents navigate psychosocial challenges as they grow towards maturity in adulthood. These include tasks such as achieving independence from parents, managing intimate and peer relationships, and developing a positive self-identity.[3] However, teenagers and young adults with ADHD have a higher risk of negative health, mental health and wellbeing outcomes.[4]

Collaborative shared care for ADHD

Young people with ADHD benefit from regular review with a trusted doctor. In Western Australia, assessment, diagnosis and (in some individuals) initiation of medication treatment remains restricted to Approved Specialists, namely psychiatrists and paediatricians.

More recently, GP Specialists in Western Australia who have completed the RACGP program to become 'Endorsed Prescribers' will be approved to start stimulant medication for eligible youth and adults with a confirmed ADHD diagnosis from the age of 10 years.[5] However, all GP Specialists have a role in collaborating with individuals, families and non-GP Specialists to ensure safe and holistic care for young people with ADHD.

A review appointment with a young person for their ADHD takes time. Beyond medication prescribing, exploration of the impact of their symptoms enables both the GP and the young person to understand where things are going well, and where they can be improved.

Understanding the young person's daily life, their progress at school or in the workplace, their relationships at home, and their participation in social activities, builds a picture for the GP and gives space for the young person's own self-reflection and self-advocacy.

Psychosocial review: ADHD is a lifelong neurodevelopmental condition, with impacts on executive function, mental health and wellbeing. Non-medication supports, such as counselling, ADHD coaching, parent and self-education, and peer support can all act to develop a young person's own suite of management strategies.

Medication review: The most prescribed medications for the management of ADHD symptoms are Schedule 8 psychostimulants, including Methylphenidate, Dexamfetamine and Lis-Dexamfetamine. Non-stimulant medications include Guanfacine and Atomoxetine. Review of medication effectiveness requires enquiry about the onset of effect, the symptoms that improve, the duration of medication effect, and adverse effects such as suppression of appetite and sleep issues.

This is done through interview and the use of symptom rating scales such as the SNAP-IV.[6] Stimulant medication prescribing may uncover underlying mood disorders; it is imperative to monitor the mood and general functioning of adolescents and young adults. Poor compliance, medication misuse and drug diversion should also be considered.

Clinical review: An essential part of clinical review is to assess for adverse effects of the use of medication on health and wellbeing. Young people with ADHD, particularly those treated with stimulant medicines, must have regular monitoring of their growth at least every six months, including weight, height and BMI, with plotting on standardised growth charts. Cardiovascular parameters, such as resting blood pressure and heart rate, should also be recorded.[7]

Provision of a prescription: All GP Specialists must be registered with ScriptCheckWA, Western Australia's real-time prescription monitoring system[8] and be aware of the Monitored Medicines Prescribing Code.[9] A GP Specialist must ensure the prescription being requested is current treatment, consistent with the Approved Specialist's written instructions, and is due for renewal. If these criteria can be satisfied, PBS authority approval can then be requested.

Communication with an Approved Specialist: A key component of safe and successful shared care is communication between professionals.[10] Provision of growth and cardiovascular parameters, as well as an update on progress and wellbeing, can be provided via a standardised proforma, an email to the young person's specialist, or clinical letter.

> **Clear communication and collaboration between specialists, the young person and their family is essential to enable youth with ADHD to thrive.**

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Special considerations for adolescents and young adults

Growth faltering: Growth faltering is defined as inadequate physical growth for age and sex, based on serial measurements.[11] S8 stimulants are commonly associated with appetite suppression and reduced volume of food intake. Executive function difficulties can affect daily living skills such as meal planning, and sensory sensitivities to taste, texture and smell can negatively impact nutritional intake.

If weight or BMI measurements have crossed down one or more major percentile lines, i.e. weight loss or failure to gain expected weight, interventions include dietary recommendations and closer monitoring. Referral back to their Approved Specialist is necessary if these interventions do not result in adequate catch-up growth.

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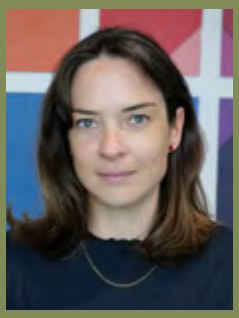
Substance use: A urine drug screen (UDS) should be undertaken by all individuals aged 16 years and older before starting S8 stimulant treatment.[9] However, an interview during a GP review appointment may reveal a young person's current substance use, and UDS can support the identification of any undisclosed substance use.

For a GP Specialist, continued prescribing in this circumstance is *not* appropriate. Review by the young person's Approved Specialist is required, as continuing prescribing requires authorisation from the CEO.[9]

Psychosis: The risk of psychostimulant-induced psychosis in young people is *not* negligible and should be considered by all professionals prescribing medication. In a 2019 study of 13 to 25-year-olds who were prescribed stimulant medicine for the treatment of ADHD, the risk of new-onset psychosis was approximately 1 in 660 (0.15%).[12] A young person with ADHD who presents with hallucinations, delusions and disorganised thinking requires urgent psychiatric assessment. ■

> Recognition, referral and ongoing management of ADHD and its associated co-occurring conditions is a key skill required of all doctors working in primary care. Clear communication and collaboration between specialists, the young person and their family is essential to enable youth with ADHD to thrive.

References available on request.



Cultural safety in mental healthcare for Aboriginal and Torres Strait Islander families

Prof Helen Milroy Honorary Research Fellow and Co-Lead, Embrace
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As we know, the ongoing impacts of colonisation and genocide against Aboriginal and Torres Strait Islander peoples have contributed to substantial inequities in mental health outcomes compared with non-Indigenous Australians.

These disparities emerge early in life. More than 20% of Aboriginal and Torres Strait Islander peoples aged 15-24 years report a long-term mental health condition, and suicide rates among those aged 0-24 years are approximately three times higher than for non-Indigenous Australians.[1,2]

Remedying these inequities requires sustained, multifaceted efforts; and includes making health systems culturally safe for Aboriginal and Torres Strait Islander peoples.

What is cultural safety and why does it matter?

Since the concept of cultural safety was first developed in Aotearoa (New Zealand) in the 1990s,[3] it has been increasingly embedded as a standard of care by regulators and peak bodies (e.g. Ahpra,[4] AMA[5]).

Cultural safety is critical to rebuilding trust in health services. Without an understanding of how culture shapes experience, there is a risk that care may be inappropriate or fail to meet patient needs.

Cultural safety refers to care that actively empowers Aboriginal and Torres Strait Islander peoples by integrating Indigenous understandings of health and wellbeing. It goes beyond cultural awareness (understanding cultural differences) or cultural competence (practitioner knowledge and skills) to address power imbalances, institutional discrimination, and the ongoing impacts of colonisation within health systems.[6]

Historical government policies, such as the forced removal of children, have contributed to deep mistrust of Western services. This mistrust is reinforced by ongoing racism and the continued dominance of Western biomedical models of health and treatment. Indeed, a lack of cultural safety is identified as a key barrier to service engagement.[7]

Cultural safety is critical to rebuilding trust in health services. This is expected to improve service experiences and engagement which, over time, should contribute to more equitable mental health outcomes. It is particularly important in mental healthcare[8] because experiences and expressions of distress can look different across cultures. Without an understanding of how culture shapes experience, there is a risk that care may be inappropriate or fail to meet patient needs.

What can services and practitioners do to support cultural safety?

Our research[9,10] identifies several key principles that support the implementation of cultural safety in mental health services.

At the service level, cultural safety must be embedded in governance, leadership and accountability structures. This includes establishing Aboriginal advisory groups with direct access to executive decision-making. Services should also prioritise the recruitment, retention and development of Aboriginal staff across all levels of the organisation.

Service design should be grounded in culturally informed, strengths-based approaches to care. This includes integrating cultural models of care and healing as recognised clinical options, and ensuring services are trauma-informed and family-centred. Accessibility should be prioritised through welcoming and culturally inclusive environments, and flexible models of care such as walk-in appointments and other low-barrier entry points.

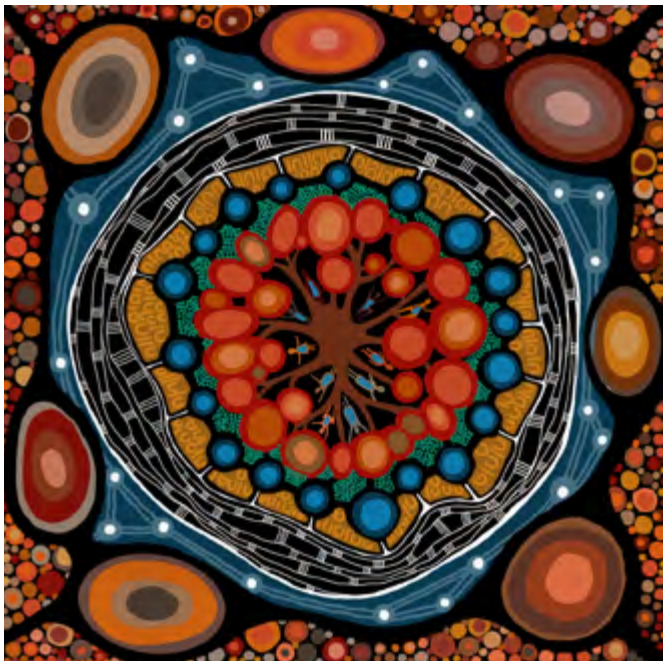
For medical practitioners, Ahpra, the AMC and professional colleges expect cultural safety to be embedded in both clinical practice and the health systems in which doctors often play a critical role. Regardless of where you are starting from, cultural safety is a lifelong learning process that requires ongoing self-reflection, self-education, clinical experience, formal training, and a sustained commitment to improvement.

Doctors also have an important role in fostering culturally safe practice by teaching medical students and junior doctors, role-modelling culturally safe care, and providing mentorship throughout specialist training.[11] For further guidance, see the latest edition of the Good *Medical Practice* guide from the Australian Medical Council.

Cultural safety requires system-wide change

Cultural safety is a critical component of efforts to close the gap in health and wellbeing outcomes for Aboriginal and Torres Strait Islander peoples. It requires sustained, fully resourced, system-wide reform.

Key recommendations will be outlined in our forthcoming guidance framework, to be released later this year.



Dabakan Kooliny: Valerie Ah Chee

Go slowly, walk slowly. A journey that cannot be rushed, that must be done at a steady pace so we can see all the choices and elements that impact on our social and emotional wellbeing and mental health, and take the time to take these into consideration when deciding on what we need to heal and be healthy.

The above quote and illustration give us the process for thinking about cultural safety in clinical services. It is not a quick fix nor a simple addition, but requires careful thought and planning. ■

References available on request.

Researchers using 'big data' to improve the lives of children with autism

A five-year autism research project in WA is mapping the strengths and needs of 3,500 children

Medically trained researcher Mirko Uljarevic cites Hippocrates when explaining the disconnect between making a clinical diagnosis of autism and determining the most effective treatment and support in each case.

"What we know is that the specific diagnostic labels – be it autism, be it ADHD, or any other neurodevelopmental, neuropsychiatric designation – provide very limited information in terms of predicting how well the child will do," Professor Uljarevic explains.

"Just because someone has a diagnosis of autism or ADHD, at the point of diagnosis it's quite difficult to predict the outcomes for the child, what supports they need, and how well they'll respond to specific supports.

"So, it's kind of quite ironic that Hippocrates basically said the point of diagnosis is prognosis. It's been a few years since the ancient Greeks, but as a field we haven't done particularly well!

"Luckily, the research we've done, the research our colleagues have done, and the research from others has shown that, irrespective of the diagnosis, there are specific clinical, cognitive and developmental domains or behaviours or traits that – if captured well – can be very useful in understanding the profile of strengths and areas of need for each child and family, and then be linked to specific support the child should receive."

Professor Mirko Uljarevic

Using international and local 'big data' sets, Prof Uljarevic's project team has developed a computerised adaptive assessment tool to map each autistic child's unique strengths and needs, and match them with the most effective, evidence-based clinical support.

"People who have a diagnosis of autism differ hugely, not only in terms of what we call core autism features – social and communication difficulties, and restricted and repetitive behaviours – but also in terms of other clinical associated features. For example, anxiety, depression, ADHD, and other clinical phenotypes. It's an incredibly heterogeneous condition," Prof Uljarevic explains.

"They also have varied outcomes and crucially different support needs, just given that kind of huge individual differences among them. And what's also really important is they respond differently to the same or identical intervention. You might have two kids with the same diagnosis, receiving specific behavioural intervention; one might respond really well and one might not respond at all. So, it's not only that they have different support needs, but they also respond differently to the same treatments.

Prof Uljarevic, a global leader in autism research, has relocated to Perth to run a $3.4 million project, funded by a Future Health Research and Innovation Fund Distinguished Fellowship grant and more than $1 million from the Stan Perron Charitable Foundation, to improve the accuracy and effectiveness of autism screening, diagnosis and care in WA. He is based at The Kids Research Institute and The University of Western Australia.

"So, to understand what contributes to these individual differences and, most importantly and relatedly, to understand what supports are most suitable to a given person, a given child or a given family, we need large, enriched clinical data sets – information that will be essential for improving both clinical research and practice."

Because of the limitations of a 'one-size-fits-all' diagnostic approach, alternatives have been put forward, including the US National Institute of Mental Health's Research Domain Criteria and Hierarchical Taxonomy of Psychopathology.

"These dimensional frameworks were developed specifically to address the limitations of the current diagnostic systems," Prof Uljarevic explains.

"The assessment protocol that we are currently in the process of validating with 3,500 kids and families was specifically developed to assess and quantify those clinical, cognitive and developmental domains that are essential for understanding the profile of each child.

"The way it works is our tool can help inform the diagnosis – like this child has these particular social difficulties; these particular repetitive behaviours – but it goes beyond that. It captures, for instance, how well this child can recognise someone's emotions; how well they can empathise with someone; how well they can put themselves in someone else's shoes; how good they are at regulating their emotions.

"Those are all the building blocks of healthy functioning and our ability to navigate the complexities of the world, but the current assessments don't really capture those."

Prof Uljarevic says the assessment tool will provide a detailed report for clinicians, with a full profile of a child's clinical cognitive developmental characteristics, and that will support the development of a personalised care program for the child and the family.

"The other feature of the assessment is that it actually enables clinicians to track improvements over time," he says.

"We're developing what we call regression-based change norms, so we can quantify whether the change we are seeing at the level of each child is significant and clinically meaningful or not. It will have a graphic type of output for the clinician so they can see a chart – like now, then in three months and six months, showing how scores of the child change over time. That's quite a unique feature. Most of the instruments don't really provide that.

"You might have two kids with the same autism diagnosis, receiving specific behavioural intervention; one might respond really well and one might not respond at all. So, it's not only that they have different support needs, but they also respond differently to the same treatments.

"Once the instrument is fully developed, fully validated and fully tested, it wouldn't rely on our team at all. It basically will be a clinical decision-support tool. There will be a system where the clinician can just send a survey link to the families for them to complete.

"Based on those norms we're developing, all the statistics, it would calculate the scores from all these different domains. Clinicians would immediately be able to access really detailed reports to say this child most likely has autism, and it would provide clinicians with detailed information in terms of the support needs. And once they start implementing treatment, they will be able to send the assessment link to the family and see whether they're improving, as one is hoping."

The five-year research project is being conducted in consultation and collaboration with a consumer reference group, convened on a regular basis.

"Obviously, the group includes people with lived experience of autism, so family members and kids or adolescents; but it also involves clinicians and policymakers," Prof Uljarevic says. "So, we are getting input from all different stakeholders throughout the lifespan of the project."

Serbian-born Prof Uljarevic, who has worked in the UK, La Trobe University in Melbourne, and most recently at Stanford University's Department of Psychiatry and Behavioural Sciences in California, has brought with him two Australian post-doc research colleagues from the US to work on the Perth project – Dr Lacey Chetcuti and Dr Emily Spackman – whom he knows from his time in Victoria. ■