Ageing and Disability Commission

NSW GOVERNMENT

Reflective practice answer sheet

Identifying, preventing and responding to domestic, family and sexual violence of older women and women with disability

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Acknowledgements

This project is proudly supported by the NSW Women's Safety Commissioner.

We would also like to thank the lived experience advocates and members of the project working group for their valuable contributions and support throughout the project.

Acknowledgement of Country

The Ageing and Disability Commission (ADC) acknowledges Aboriginal People as the First Nations Peoples of NSW, and we pay our respects to Elders past, present and future. We acknowledge the ongoing connection Aboriginal people have to this land and recognise Aboriginal people as the original custodians of this land.

Content warning

The material in this resource may be distressing to some readers and includes information about domestic, family and sexual violence of older women and women with disability.

If you feel upset or affected by the content at any point, please take time for yourself. For example: stop, take a break, talk to your manager or a trusted support person, or seek an Employee Assistance Program (EAP) appointment where possible.

You could also contact one of the following organisations:

- 1800RESPECT - 1800 737 732
- Lifeline - 13 11 14
- 13YARN - 13 92 76

Privacy note: The information in this resource has been de-identified to protect people's privacy. All the names and identifying details have been changed.

Reflective practice answer sheet

You can refer to this answer sheet if you would like some guidance using the reflective practice. This may be helpful if you feel unsure about how to respond to a question, or if you would like to use it after completing your own reflections to compare different perspectives.

The answer sheet offers a collection of responses from frontline workers across various sectors who have also engaged with the lived experience narratives featured in the reflective practice resource.

We have done this so that you can;

- Guide your own responses if you're unsure how to approach a question.
- Compare your reflections with those of other professionals.
- Prompt further discussion and reflection with colleagues or in supervision.

There is no one correct response, and responses may vary depending on a person's role, experiences, and context.

Reflective practice 1: Jean's story

> "I try not to make a noise…my son lives downstairs; he tells me not to make noise…I am afraid of the repercussions of triggering him. I stay awake all night because I am afraid of my son and in the day, I drive to the supermarket and sleep in my car."

Jean is 76 years old and lives in a two-storey house with her adult son, David. David is 48 years old and has only had limited periods of living independently. David has mental health issues but refuses to seek any support. David is verbally abusive to Jean and possibly physically abusive as well as Jean is documented to have unexplained bruises on her arm when she is admitted to hospital for cataract surgery. David lives downstairs and at times has blocked the pathway for Jean to come downstairs and access the front door.

Due to a complication with the surgery, Jean was admitted to hospital for a few days. When it was time to leave, Jean asked to speak with a social worker. Jean disclosed that she was having a "difficult time" at home with her son and that she had a court case coming up. She disclosed that she had a verbal argument with David who called the police. She said she had been drinking at the time and had finally "lost it" with David.

The police had taken out an AVO against Jean, for David's protection. Jean was ashamed of her actions and fearful of what David would do next. She said that every time she raises the issue of David moving out, he becomes abusive, and she spends her days "walking on eggshells". Jean spends her days in her car trying to keep out of the house and away from David, but the eye operation will stop her driving and getting around for a time.

This reflection has been submitted by a caseworker who works in a Disability Legal Support Service.

Consider your role, and where you would fit into Jean's support system.

What steps could you take when you first notice the initial signs and indicators of DFSV?

As a caseworker, my role is to assist Jean in accessing the required supports to ensure that she remains as safe as possible, especially within her own home. The starting point would be to identify what supports Jean already has available to her, both formal and informal, to determine any gaps in her support needs. With Jean's consent, I would facilitate her access to services that can assist with her safety, daily needs, physical and mental health, and other needs as required. While it is apparent that David may benefit from services as well, it is important to remember that Jean is my client, and my role is to support her.

The steps I would take after noticing initial signs and indicators of DFSV would include:

- Speaking to Jean directly to determine whether this is something she is willing to discuss, and if so whether it is an area she is comfortable in receiving support with.
- If so, referrals to specialist domestic violence services would be best placed to support Jean's specific needs.
- Access to such services should be facilitated through warm referrals, to maintain Jean's trust in the new services introduced.
- Safety planning for Jean should also be completed, either by the caseworker or specialist service/s – whichever is more appropriate.
- I would also communicate with the hospital social worker who can also assist with safety planning.
- Providing support in accessing legal assistance / reporting DFSV to the police could also be of assistance in ensuring Jean's safety.
- These options and referral pathways are only to be followed with Jean's consent, and with consideration to her safety and the increased risk this may bring.
- If possible, assist Jean in accessing alternate accommodation while the referrals and legal processes are being followed.
- If Jean is not ready to engage with any further services, I would remain available as a support and reinforce that these options are available at any time should she need support.
- If Jean is comfortable with me as a support but not introducing other services, safety planning can still occur.

How do you think Jean might feel about asking for help from services after a negative experience with the police?

It is likely that Jean feels a lack of trust with the police, and support services more broadly, after her negative experiences. In circumstances where Jean herself is requiring support, the police involvement has failed to evaluate the situation more broadly than what occurred on the evening leading to the AVO. As a victim, having the police take out an AVO against you would likely diminish your trust and willingness to seek support.

Jean might feel helpless, in that if the police cannot assist her, then why would other services be able to intervene? It is important however to not make assumptions on Jeans attitudes towards support, and if attempting to link her with further support services have this be guided by what she says and requests, rather than what you think she might say / want.

Reflective practice 2: Alice's story

> "I have not had time to grieve for my husband and my son has moved in and taken over my life and my house, I just want him to go."

Alice is 78 years old and lives in a small unit with her adult son. Alice's husband died 18 months ago. They had been married for 50 years. Her husband was both physically and verbally abusive. Alice had never sought support for the abuse. It became worse after he developed dementia. Alice was his carer for the years before he died.

Alice's only son, Murray (age 52) moved in soon after Alice's husband died. Alice didn't ask Murray to move in. Murray had recently lost his job and was unable to afford his private rental. Murray did not contribute to any household expenses. He told Centrelink that he was Alice's carer and tried to stop services coming to the house for Alice.

Alice had an ulcer on her leg that needed regular dressings, and she became friendly with the care worker that came to her house. Alice started speaking to the care worker about how Murray had taken over her finances and was verbally abusive to her if she didn't do as he asked. Alice said she was fearful of Murray's temper but also was dependent on him to be able to stay in her own home.

This reflection has been submitted by a disability support worker.

Expectations in society include that women should be caregivers and should keep their family unit together. How do you think this has impacted Alice throughout her life?

Society's expectations that women should be caregivers and keep the family together have likely had a significant negative impact on Alice's life.

Older generations of women were often taught to "put up with" abuse, especially when it involved a husband or family member. There was a strong sense of duty to care for the family and maintain the household. These beliefs may have made it harder for Alice to recognise the abuse she experienced as something she could speak up about or seek help for.

There has also been a lot of stigma around DFSV particularly for older women. Alice may have felt ashamed, afraid of not being believed, or simply unsure where or how to ask for help. It's possible that she did try to reach out in the past and was dismissed, which could have further discouraged her from seeking support.

Financial dependence likely played a big role in Alice's experience too. As a full-time carer for her husband before he passed, Alice may not have had her own income or financial independence. This could have made it difficult and dangerous for her to leave the relationship or access support without risking homelessness or serious financial implications.

The expectation that mothers should always care for their children, even into adulthood, may have made it even harder when her adult son, Murray, moved in without asking. Murray likely felt entitled to living in her home, while Alice still faces societal pressure to be a "good mother" and put his needs before her own.

What might have made Alice feel comfortable to share with her care worker that her son Murray had taken over her finances and was verbally abusive to her?

Alice may have felt comfortable disclosing the abuse to her care worker because of the trust built over time through regular visits and consistent support. The care worker likely showed a genuine interest in Alice and spent time building rapport and a good working relationship. This may have helped Alice feel seen and valued.

The care worker may have also created regular opportunities for private conversations, without Murray present, which allowed Alice to speak freely and safely. Being clear and open about what would happen if Alice disclosed abuse — including how information would be used and who it might be shared with — could have helped Alice feel more in control. Reminding Alice that she has the right to feel safe and be treated with respect may have slowly helped Alice feel comfortable to disclose DFSV to her care worker.

Reflective practice 3: Amie's story[1]

Amie is a woman with a physical disability and speech impairment. She lives with her de-facto partner, Gareth. Gareth would prevent Amie's disability support workers from providing her with basic care. Support staff reported that Gareth would humiliate and degrade Amie. He stopped staff from helping Amie shower, claiming that he did not want them to use all the hot water. Gareth also refused to allow staff to dress a serious pressure wound that required urgent attention.

When the support staff were not present at night, Gareth refused to assist Amie with essential tasks, including food preparation and continence aids. He would also control her access to basic household items and would use Amie's money to buy drugs.

Amie has a good relationship with her disability support worker, who took the time to listen and understand her views and wishes. She expressed that at this stage, she wanted to continue her relationship with Gareth, but was open to receiving other forms of support, such as a referral to a community social group.

[1] Extracted from ADC Annual Report 2023–2024 "Recognising coercive control"

This reflection has been submitted by a Community Supports Manager working in a service for older people and adults with disability.

How can key workers ensure they maintain an environment where Amie feels safe to express her needs or safety as the relationship continues?

- Consult and listen to Amie about what support she wants, or is willing to accept at this time.
- Ensure all discussions do not become focused on DFSV – they should consider a more holistic approach including all her goals and priorities (for example, leisure and health care)
- Where possible, key workers should maintain confidentiality. If confidentiality cannot be maintained, it should be explained why to Amie so she is not surprised or caught off guard.
- Adopt a non-judgemental approach in regard to Amie's decisions for her relationship.
- Pressure wounds can present a critical risk to Amie's physical safety and well-being. Key workers can work with Amie to understand how she would like to manage this risk. For example, a hospital visit, community nursing, GP visit or a private wound specialist.
- Create opportunities for safe disclosure on a regular basis – ensure that Amie has opportunities to speak in private with not only workers but also other friends, family and professionals.

Thinking about Amie's situation, how could a referral to a community social group benefit her? What other referrals or support may help Amie?

Social isolation is a significant risk factor for ongoing abuse and a means by which control can be exerted and amplified. A referral to a community social group would allow the opportunity for social connection, which is critical for building relationships and opportunities for disclosure. It may also help Amie build confidence, especially considering that she is experiencing psychological abuse which can impact a person's feeling of worth and value. Social groups can also provide opportunities to leave the home for a 'legitimate' reason which can then be leveraged to access DFSV services if or when the Amie wants to access these supports.

Other referrals or support that may be of benefit to Amie include;

- A support coordinator could assist in ensuring that her plan is used in accordance with her goals and wishes. They could also help explore other goals that Amie may have such as increasing leisure activities/hobbies or re-establishing control over her finances.
- Amie may also wish to access counselling to speak about her experiences and explore her path forward.

- A disability advocate may be a powerful ally to refocus service delivery on Amie's wishes and not the wishes or direction of her partner.
- Allied health staff may provide advice and support in regard to opportunities to use aides, equipment or funding to further enhance Amie's choice, control and independence.
- This could include opportunities to engage in the community independently of her partner or engage in self-care or domestic tasks, volunteer or paid opportunities that can expand her world and reduce opportunities for her partner to exert control.

> "Being heard is so important when your abuser is silencing you every day, particularly for older women who already feel like we are not as good as we used to be..."[2]

Reflective practice 4: Margaret's story

Margaret is a 72-year-old woman who lives in a remote area with her partner, Rosie (66 years). Margaret has a diagnosis of mild dementia and receives aged care support. Margaret experiences anxiety and has previously told her GP about this.

Margaret's GP referred her to the Ageing and Disability Commission (ADC) after witnessing Rosie display aggressive and controlling behaviour. When Margaret tried to see her GP in private, Rosie refused to leave the room. She then grabbed Margaret by the arm and took her out of the clinic. Margaret later said she had a bruise on her arm from where Rosie grabbed her.

Margaret was able to speak privately with the ADC and initially described Rosie as "protective." However, when asked more about it, she acknowledged that Rosie's behaviour was controlling. Margaret described how Rosie does not like her friends and family and has caused tension and arguments between them. Margaret said that she used to be involved in a local group for older people in the LGBTIQ+ community but stopped attending and has lost contact with many of her friends.

When Margaret most recently went to lunch with her adult daughter and grandson, Rosie questioned her when she returned home. Margaret wants to be able to see her friends and family without worrying about how Rosie will react. Margaret told the ADC that Rosie's verbal abuse worsens when Margaret stands up for herself.

While Margaret receives aged care support, Rosie controls what help she gets. Rosie only allows a nurse to visit once every two weeks and tells service providers that she knows best because she is Margaret's full-time carer.

Community workers visit the home to assist with medication and care. From their perspective, Margaret manages her personal care independently, and the workers reported no concerns about DFSV, the state of the home, or any gaps in services. The workers commented that Rosie is pleasant to them and very involved in Margaret's support.

Right now, Margaret does not want Rosie to be removed from the home, but she does want help to set clear boundaries. Some service providers had withdrawn support because of Rosie's instructions, and Margaret wants this addressed to ensure she continues receiving the care she needs.

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[2] **Quote from lived experience advocate:** ADC consultation for DFSV project. February/March 2025.

This reflection has been submitted by a manager and advocate for the rights of older women.

Why might service providers have missed or dismissed potential signs that Margaret was experiencing DFSV?

As a worker, I can see that there were multiple layers of risk that may have been missed in Margaret's case. Firstly, one of the key factors is that the signs of DFSV were subtle and non-physical - things like controlling behaviour, social isolation, and emotional abuse. These are harder to spot unless we're actively looking for them.

For example, Margaret said Rosie was "protective," and that may have sounded caring on the surface. But if we'd probed more gently, we might have seen that this was actually Margaret minimising the abuse - a common response when someone feels unsafe or dependent.

We relied too heavily on Rosie's version of what support was needed. As Rosie was seen as the full-time carer and presented as pleasant and attentive, we may have unconsciously aligned with her. That meant Margaret's voice - and her autonomy - were sidelined.

Another issue is that staff weren't consistently speaking to Margaret privately. When she tried to talk to the GP alone and Rosie physically intervened, that should have raised a serious red flag. There wasn't a clear system in place to follow up or escalate those concerns.

Ageism has definitely played a role. Margaret is in her 70s and has mild dementia, so it's possible her anxiety, withdrawal from social life, or even her bruise were seen as unrelated to abuse – and attributed to her ageing process. We must not assume older people are "too old" to be abused or "too confused" to disclose it.

Margaret is in a same-sex relationship - these layers of identity may have made her less visible in our systems. If we weren't trained in LGBTQ+ training, we might have hesitated to ask about relationship dynamics, or failed to offer appropriate support.

As of 1 July 2024, coercive control is a criminal offence in New South Wales when it occurs within current or former intimate partner relationships. In Margaret's case, there is clear evidence of the hallmarks of coercive control, including:

Isolation from Support Networks

- Rosie has deliberately severed Margaret's connections with friends, family, and her local LGBTQ+ group.
- Margaret expresses that she wants to see her daughter and grandson without fearing Rosie's reaction.
- This isolation reduces Margaret's access to emotional support and external perspectives.

Monitoring and Surveillance

- Rosie questions Margaret about her whereabouts and who she sees.
- There is a pattern of emotional punishment when Margaret asserts independence - Rosie's verbal abuse increases when Margaret "stands up for herself."

Control of Services and Daily Life

- Rosie controls which aged care services Margaret can access, telling providers that she knows best.
- She allows minimal support (e.g., a nurse only once every two weeks), effectively restricting professional oversight.
- Some providers have withdrawn based on Rosie's instructions, demonstrating her power to override Margaret's needs.

Threats and Intimidation

- Rosie forcibly removed Margaret from a GP consultation when Margaret tried to speak privately - resulting in a physical bruise, which Margaret disclosed.
- This incident suggests intimidation and physical coercion to silence Margaret and prevent her from getting help.

Margaret's situation clearly fits the pattern of coercive control: Rosie exerts sustained control over her movements, relationships, services, and emotional safety. Although the abuse may not always be physically violent, the ongoing psychological domination is deeply harmful and significantly impacts Margaret's autonomy, wellbeing, and access to care.

How can professionals ensure that Margaret feels in control of her choices?

The first step is to prioritise Margaret's autonomy, dignity, and safety. That means making sure she always has opportunities to speak privately, without Rosie present. We need to normalise private check-ins - not as something suspicious, but as part of good, respectful practice.

We also need to recognise that Margaret still has decision-making capacity - even with a mild dementia diagnosis. She has the right to be consulted and to determine what services she receives and how. I'd approach this with supported decision-making, helping her explore her options at her own pace and in ways she understands.

Reinstating the services that were withdrawn without her direct consent is critical. That should involve a care conference or case review where Margaret is at the centre of the conversation. I'd make sure we documented her choices clearly and shared that with all providers so that no one takes instructions solely from Rosie again.

I would also support Margaret to set boundaries. That could involve co-developing a care agreement that outlines who is allowed to attend appointments, what contact Rosie can have with service providers, and how Margaret wants support delivered. This plan should also include safety measures if things escalate.

Reconnecting Margaret with her social network is a priority. Isolation increases risk. I'd work with her to identify friends or family she'd like to see again, and if she wanted, I'd link her with LGBTQ+-inclusive social groups. Lastly, I'd link her with an advocacy service like OPAN to support her long-term.

Overall, it's about giving Margaret consistent opportunities to make decisions for herself, supporting her to rebuild connections, and making sure our services don't replicate the control she's already experiencing.

Reflective practice 5: Linh's story

> "For domestic abuse that does not involve physical violence, it is hard to even accept that it is abuse…I felt ashamed because he had not used physical violence, and I felt that I didn't deserve the help."

Linh, an older woman, experienced coercive control and emotional abuse from her partner throughout their 20-year relationship. Linh had moved to Australia from Vietnam on a partner visa with her partner, speaks English as a second language and had no other friends or family in the country.

After living in Australia for 18 months with her partner and becoming increasingly isolated by and fearful of her partner, Linh gained the courage to reach out for support at a police station. The police officer relied on a standard questionnaire to assess immediate danger, and decided Linh was not in danger. She did not connect Linh to a DFSV worker or offer her any other referrals for support, or provide Linh with information about coercive control and non-physical forms of violence.

A few months later when Linh's partner cancelled her partner visa, she became very frightened that he would also seek revenge in other ways. When she called the same police station for help, the police officer hung up on her because she wasn't speaking "calmly" enough. Linh felt silenced and erased once again.

For Linh, recognising and accepting that she had experienced abuse took time. She initially struggled to label her experience as "abuse" because there had been no physical violence, and she felt undeserving of help.

Linh reflected that if she had been asked specific questions about non-physical forms of abuse (such as whether her ex-partner had monitored her phone, made her feel guilty for certain actions, or denied that events had happened) it would have helped validate her experience and recognise the damage that her partner had caused.

This reflection has been submitted by a specialist domestic violence worker who provides focused support for women from multicultural backgrounds, women with disability, and older women.

Why do you think Linh found it difficult to validate her experience of abuse?

Linh struggled to validate her experience because the abuse she endured did not involve physical violence. She felt ashamed and questioned whether what she was experiencing "counted" as abuse, which led her to believe she wasn't deserving of support.

Many victim-survivors of DFSV are constantly undermined by the perpetrator, who may deny the abuse, shift blame, or make them feel as though they are overreacting. If Linh was experiencing this, it would have eroded her confidence even further, making it harder to recognise the situation as abusive. There was also a significant power imbalance in the relationship. Linh's immigration status was tied to her partner, which may have made her feel dependent on him or that she owed him. This can make it even more difficult to speak out or seek help.

Isolation would have also contributed to Linh's experience. Having migrated to Australia from Vietnam on a partner visa, Linh spoke English as a second language and had no close friends or family nearby. This social isolation increased her vulnerability and meant there was no one around her to help validate her experience or offer support.

There may also have been a lack of culturally and age-appropriate information or resources about DFSV which could have made it harder for Linh to recognise she is not alone.

When Linh sought help from the police, she was not asked appropriate or trauma-informed questions that could have uncovered patterns of coercive control. For example, no one asked whether her partner restricted her movements, controlled her finances, or monitored her communications. If police had explored these areas, it may have helped Linh validate her experience and feel reassured that she was right to seek support.

How could the Police have improved their responses to Linh's disclosures of abuse?

Training and education on non-physical forms of abuse, including coercive control, would help officers better recognise the seriousness of Linh's situation. This includes understanding that victims may be in a heightened emotional state and may require additional time to get their story across.

Instead of dismissing Linh for not speaking "calmly," officers should have acknowledged the distress she was experiencing as a normal response to trauma and provided space and time for her to share her story.

Although the police officer completed a standard risk assessment and determined that Linh was not in immediate danger, they should have taken the time to ask her what she was afraid of and considered her circumstances and level of fear. Professional judgment and

active listening should take priority over ticking boxes on a risk assessment — particularly when someone is describing coercive control. Asking Linh further questions about the DFSV would not only have helped assess the risk more accurately, but also helped Linh feel heard and taken seriously.

As English is not Linh's first language, police should have asked Linh if she would like to use a professional interpreting service. This would have helped police and Linh have clear communication.

Linh should have been offered referrals to culturally appropriate domestic violence services and for legal/immigration support. Providing her with contact information and also offering to help connect her with a support worker could have ensured she received the help she needed.

> "You don't want to cause trouble. If you report [DFSV]...you could end up in a worse situation...like ending up in a home or experiencing more violence."[3]

Reflective practice 6: Marta's story

Marta is 29 years old and has an intellectual disability. Marta attends a disability support service 5 days a week. Marta has a good relationship with one of the disability support workers, and one day during a conversation asked the worker, "is it okay for family to sleep together?".

The worker asked Marta what she meant by this. Marta said, "my cousin will sometimes sleep in bed with me and "she will sometimes tickle me". Marta's worker asked her to expand on what she said. Marta continued that her cousin "will touch me on the 'lower places'" and confirmed that this was under her clothing.

Marta said that the first time this happened was last month when her cousin was visiting from Victoria. Marta told the support worker she was frightened for her parents to find out about this and said her cousin told her she would be in trouble if she told anyone, and that no one would believe her.

The support worker decided to hold a meeting with Marta and her parents to discuss the allegations of sexual assault and try get as much information as possible before discussing with management or making a police report.

During the meeting, the support worker discussed what Marta has disclosed and asked her to provide more information. Marta was visibly distressed and denied that the sexual assault happened. This was the first time Marta's parents had heard about the sexual assault. They denied that Marta's cousin would sexually abuse Marta and threatened to remove Marta from the disability service as a result of the allegation.

[3] **Quote from lived experience advocate:** ADC consultation for DFSV project. February/March 2025.

This reflection has been submitted by a caseworker who works in a domestic violence service.

How could the support worker have helped Marta feel safe after she disclosed sexual abuse?

When Marta told the support worker about the sexual abuse, it was important that the worker made her feel safe, listened to, and believed. This was especially important because Marta said she was scared her parents would find out, and that her cousin told her she would be in trouble if she told anyone, and no one would believe her.

The support worker could have started by thanking Marta for telling her and saying how brave she was to speak up. She could have reminded Marta that she did the right thing, that the abuse was not her fault, and that she is not in trouble, despite what her cousin had threatened.

It may have helped Marta feel safer if the support worker explained what would happen next. For example, she could have said, "I need to tell someone else to help keep you safe, but I'll explain everything and support you through it."

After checking Marta's immediate safety, the support worker could have also asked Marta what would help her feel safer. For example, she could say, "Is there anything you need right now to feel safer or more comfortable?" or "What can I do to support you?" Then they could make a plan together.

Overall, the support worker should stay calm, listen carefully, and show Marta that she is believed and supported.

How would you advise Marta's support worker to respond to her disclosure of abuse in a trauma-informed way? Provide step-by-step examples.

The support worker's first step should be to check if Marta is safe right now. They can gently ask when the abuse occurred and whether her cousin still has any contact with her. This helps determine if Marta is currently at risk. The worker should also ask if Marta feels safe where she is currently staying and whether she has any trusted family members or friends. If Marta wants to report the abuse to the police, the worker should assist her and ensure this happens without delay. Marta should also be offered medical support if appropriate - such as going to hospital, seeing a GP, or visiting a sexual assault support service.

The next step is to provide emotional support. Marta may feel scared, ashamed, or believe the abuse was her fault. The support worker should gently reassure her that it was not her fault, and that sexual violence is never okay. Marta should not be pressured to go into detail or repeat what happened — this should only be done with trained professionals, such as police or staff at a specialist sexual assault service.

The support worker must inform their manager about Marta's disclosure as soon as possible, following the organisation's policies and procedures. They should also document the disclosure clearly and factually, without personal opinions. Using Marta's own words

where appropriate can help with accuracy. It is also important to be honest with Marta about who the information will be shared with, and why — for example, if police or her parents need to be informed.

The support worker can speak to Marta about referrals to specialist sexual violence services. The information should be provided in a format that is accessible and appropriate for Marta's support needs. They should offer warm referrals (such as helping her make a phone call or offering to go with her). If Marta isn't ready to access DFSV services, she should not be pressured or judged. The worker can suggest other options like peer groups, counselling, or community activities that help reduce isolation and support her wellbeing. The worker should remember best practice for communicating with Marta — such as discussing one idea at a time, checking for understanding during conversations, and summarising key points at the end.

The support worker should also be aware of the barriers Marta may face as a woman with intellectual disability who has experienced sexual violence. Marta's wishes and preferences should always be prioritised and respected. These steps should help ensure a trauma-informed response to Marta's disclosure of sexual violence.

Ageing and Disability Commission