Queensland Women's Safety and Justice Taskforce

Interim Submission to the Taskforce – June 2021

This *Interim Submission* has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA) in consultation with QNADA member organisations providing treatment services in Queensland. It focuses predominantly on Part 1 of the Taskforce's Terms of Reference, specifically coercive control and the need for a specific offence of domestic violence, and considers:

- the role that non-government alcohol and other drug treatment services can play in responding to domestic and family violence;
- the ongoing importance of enhancing understanding of the inter-relationship between domestic and family violence and alcohol and other drug use; and
- the stigma and discrimination faced by victims of domestic and family violence who may use substances (particularly illicit drugs).

While touching broadly on women's experience within the criminal justice system, our intention is to provide a further submission to the Taskforce in due course. This latter submission will be informed by our *Responsive Systems* project which aims to consider how we can all work together to support more effective system responses to individuals, families and communities affected by alcohol and other drugs.

We commend the important work of the Taskforce and the continued focus on improving responses to domestic and family violence in Queensland. While the consideration of opportunities to strengthen legislation is important, it is equally necessary that changes are appropriately operationalised, and take into account known barriers for victims in seeking help.

For example, one of the ongoing challenges faced by services in responding to domestic and family violence is the capacity of agencies, and in particular frontline services, to recognise nuanced patterns of coercive controlling violence when the system is predominantly incident based, and crisis oriented.

In this respect, legislative amendments are unlikely to be beneficial without ensuring there is a corresponding shift from an incident-based response system to one that supports effective, coordinated, and informed cross-agency responses. This extends to a greater recognition of the role that appropriately resourced alcohol and other drug treatment services can play in supporting both victims and perpetrators of domestic and family violence.

The *Queensland Domestic and Family Violence Death Review and Advisory Board* recognised the important role of these services within their 2016-17 Annual Report when they made specific recommendations about enhancing the responses of treatment services to domestic and family violence by improving screening and assessment, inter-agency collaboration, and service accessibility[1].

While these recommendations were accepted and represent an important step forward, further work is required to fully actualise their intent. This includes by appropriately resourcing treatment services across the state to be able to provide family friendly support to female victims with children, through practical means such as free access to child-care. It can also be achieved through ongoing workforce development activities that aim to ensure services are informed about the intersection between domestic and family violence, trauma, and substance use.

In considering the need to strengthen our legislative responses in this area, it is similarly important that steps are taken to mitigate against the potential for any unintended consequences, particularly

[1] See for example recommendations 6, 7, 8 and 21 of this report, as well as the government response to these recommendations.

where alcohol and other drug use may be part of the presenting issue. The intersection between substance use and domestic and family violence is complex, and while there is no established causal relationship between the two, substance use may heighten the risk of harm in some situations.

In this respect, while it is important that treatment services are appropriately equipped to respond to domestic and family violence, there is also considerable benefit to enhancing other services understanding of how to better respond to people who are affected by alcohol and other drugs.

While the vast majority of people who use substances do not experience problematic use and never come into contact with services around their use, for those that do present because of domestic and family violence there are a number of areas where improved understanding could be beneficial.

For example, some perpetrators may use their partner's substance use as a form of control, especially where this partner uses illicit drugs. This manifests in a number of different ways including a perpetrator seeking to control their victims' access to substances and/or threatening to disclose their use to service providers (such as police or child safety services). These latter behaviours reduce the likelihood of their victim reporting abuse and where they do seek support, acts to diminish their credibility with services if the perpetrator does follow through with their threats. In some instances, this can also lead to a misidentification of the female victim as the respondent, particularly in situations where they may have used violence to protect themselves or their children and/or to resist the abuse they were experiencing. Issues are also encountered when frontline responders attend domestic and family violence incidents where one or both parties are intoxicated due to difficulties in being able to gather sufficient information to accurately understand the relationship dynamics. While it could impact the steps police may take at scene, in these circumstances a more structured process which assists officers to identify the person most in need of protection would be highly beneficial and lead to better outcomes for victims[2].

Two recent case examples have been provided by QNADA members as part of this submission to further demonstrate these points and highlight how treatment services can provide critical support and advocacy to victims of domestic and family violence (Attachments A and B).

More broadly, it is important for all services to have an improved understanding of how stigma and discrimination may impact the experiences of female victims of domestic and family violence who use substances. This includes in both seeking, and receiving, help.

The Queensland Mental Health Commission recently explored issues pertaining to the stigma and discrimination faced by people who use drugs in their report *Changing attitudes, Changing lives* (2018)[3]. This report found that experiences of stigma and discrimination were common among people with a lived experience of problematic alcohol and other drug use and that this created barriers to seeking help, compounded social disadvantage, led to social isolation, and detrimentally affected a persons' mental and physical health.

This report identified a number of options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use, including dedicated training, information, and public

[2] For example, this could occur at an arranged time to gather additional information about the relationship history and support the identification of any underlying patterns of coercive control, which may counteract some of the issues that police face when interviewing intoxicated and distressed persons.

[3] Queensland Mental Health Commission (2018) *Changing attitudes, Changing lives: options to reduce stigma and discrimination for people experiencing alcohol and other drug use*.

awareness strategies; promoting social inclusion and economic participation; and improving justice responses.

The Commission's follow up report, *Don't Judge, Just Listen* (2020) explored the impact of stigma and discrimination related to problematic alcohol and other drug use on Aboriginal and Torres Strait Islander communities, families and individuals living in Queensland[4]. This report found that research participants experienced multiple forms of stigma and discrimination related to race, clan, location and alcohol and other drug use. This acted to intensify their experiences of stigma and discrimination even further, with multiple barriers to accessing services identified.

This report is particularly relevant when considering the barriers faced by female victims of family violence who identify as Aboriginal and Torres Strait Islander including that they do not always wish to deal with family violence through the criminal justice system, they fear the involvement of statutory child protection services, and tend to prefer responses that focus on healing (as opposed to punishment).

More broadly, stigma and discrimination also impacts female victims and offenders who use substances and their engagement with the criminal justice system. In particular, for female victims it may result in a reluctance to report offences because of previous negative experiences with the criminal justice system and/or a fear of harmful consequences (particularly for those who use illicit drugs). Where victims who use substances do report, they are also more likely to encounter (real or perceived) issues with respect to the credibility of their statements which may impede the investigation or successful prosecution of offences.

For female offenders who use substances, there is an increased likelihood of entry into the criminal justice system for low harm, possession offences and greater complexities in negotiating their way through this system.

Accordingly, we commend both of the Queensland Mental Health Commission's reports to you as part of your consideration of the need for attitudinal and cultural change across Government, community entities and other organisations.

We also strongly support the growing momentum for decriminalisation in Queensland, as recommended by the Queensland Productivity Commission in its' *Inquiry into imprisonment and recidivism* (2020)[5]. Such a step would act to swiftly reduce demand across the criminal justice system through the removal of high volume, lower harm offences and ensure that services are better able to prioritise support for female victims and offenders in contact with the system for higher harm offences.

Health-based responses to illicit drug use and possession also reduce the adverse social consequences of contact with the justice system and provide a more efficient and cost-effective opportunity to identify the people most in need of treatment.

In Queensland, people who use illicit drugs are almost nine times more likely than dealers or traffickers to find themselves facing action in the criminal justice system (39,099 and 4,385 respectively in 2016-17).[6] Global research indicates that 88-89% who use illicit drugs do not experience dependence or

[4] https://www.qmhc.qld.gov.au/sites/default/files/qmhc_dont_judge_and_listen_report.pdf
[5] https://www.qpc.qld.gov.au/inquiries/imprisonment/
[6] Australian Criminal Intelligence Commission. Illicit Drug Data Report 2016-17. (2018). https://www.acic.gov.au/sites/default/files/iddr_2016-17_050718.pdf?v=1536906944

require a treatment intervention,[7] which means that for many people who use illicit drugs, the risk of harm to both themselves and community productivity is increased primarily as a consequence of involvement in the justice system, not substance use. The impact of a high rate of sentencing for drug possession offences in Queensland is compounded by a declining rate of police proceedings resulting in non-court action.[8]

The investment required to enforce illicit drug possession offences is significant and growing. Between 2011-12 and 2015-16, the number of people sentenced for drug possession offences (as their most serious offence) has increased by 42.7%, far exceeding population growth in the same period, which was between 1.3% and 2.0%.[9] [10] We note this is consistent with the Productivity Commission's previous findings that *rising imprisonment rates are driven by policy changes, not crime rates*.

For people who would benefit from accessing treatment, research shows that for every dollar invested in alcohol and other drug treatment and harm reduction services, there is a seven dollar return.[11] Comparatively, as stated in the Queensland's Productivity Commission recent inquiry '*there are diminishing returns from the use of imprisonment'*[12]. Therefore, we support the removal of criminal penalties for possession of illicit drugs as a reasonable system recalibration strategy from both an economic and population health perspective.

This position accords strongly with the recent call for action by the Queensland Anti-Discrimination Commission in its' *Women in Prison 2019* consultation report[13] which found that there is a *strong case for sweeping changes to aspects of the criminal justice system. This growing body of evidence and the need for change cannot and should not be ignored. The time for reports is past.*

[7] United Nations Office on Drugs and Crime. World Drug Report 2017. accessed March 1, 2019 https://www.unodc.org/wdr2017/field/Booklet_2_HEALTH.pdf

[8] Arie Frieberg, Jason Payne, Karen Gelb, Anthony Morgan, Toni Makkai, *Queensland Drug and Specialist Courts Review*, Queensland Courts (2016), https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/514714/dc-rpt-dscr-final-full-report.pdf

[9] Queensland Sentencing Advisory Council (2017). Sentencing Spotlight on… possession of dangerous drugs.

[10] Queensland Government Statistician's Office. Population growth highlights and trends, Queensland, accessed March 1, 2019. http://www.qgso.qld.gov.au/products/reports/pop-growth-highlights-trends-qld/index.php

[11] Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," in *Final Report* (Sydney: University of New South Wales, 2014).

[12] Queensland Productivity Commission (2020) *Inquiry into imprisonment and recidivism*, Available here

[13] Available here

Client Journey 1

Queensland Injectors Health Network (QuIHN) Brisbane South Therapeutic Program

Chantel* self-referred to QuIHN in late 2019 by dropping into the Capalaba office. She met with an available Case-Manager to complete the Initial Screen (intake form). Chantel stated that her goal was to maintain abstinence from methamphetamine. To support this, Chantel started with case management support and completed a relapse prevention plan.

As she progressed with working on her plan, Chantel explored additional goals around her mental health, parenting, and came to understand that she was involved in an abusive relationship with her partner. Identification and understanding of her options evolved over time, and Chantel came to realise that preventing relapse of substance use, was linked to her experiences of domestic and family violence and her mental health management.

Chantel opted to participate in the Treehouse Parenting program and was an active and supportive group member. She attended almost every session. A strong component of the Treehouse parenting program is the ability for group members to form informal support networks with individuals in similar situations. Chantel reports that she is still in contact with some members of the group, and they provide reciprocal support to one another. Concurrently with Treehouse, Chantel requested individual counselling from QuIHN, and engaged openly and honestly to work towards her preferred life. Part of the work involved supporting Chantel to contact DV Connect, to refer her to the Queensland Police Service (QPS) Vulnerable Persons Unit to complete an application for a protection order, and transport her to the Cleveland Courthouse to lodge the application. Much of this period involved supporting Chantel with crisis support and safety planning for her and her children regarding her abusive partner.

When Chantel became pregnant and her partner died by suicide, QuIHN was able to appropriately support her through the initial phases of these events, due to the established trust and rapport. The QuIHN Counsellor also worked transparently with Chantel around child protection worries that were arising and worked collaboratively with Chantel towards referrals to other organisations in order to build a team of supporters around Chantel at this very difficult point in her life. Chantel has recently completed her journey with QuIHN and reported that she felt she was in a space where she no longer required this level of support. Chantel has recently given birth to a beautiful young bub.

A referral was made to Family and Child Connect at the Benevolent Society for Chantel to help her access holistic support for the whole family. A warm handover was conducted and upon closing with QuIHN Chantel was engaging weekly with a case manager for family support and reported that this was going well.

Client Journey 2

Youth Empowered Towards Independence (YETI)

Our agency worked with Jane*, a 16-year-old resilient young Aboriginal woman with an intellectual disability (associated with her Fetal Alcohol Syndrome diagnosis) who was engaged in our drug and alcohol related outreach supports. Jane was in state care and had a lengthy history of neglect. Unlike most young people we support she had limited family support. Jane had a youth justice history and faced barriers in complying with the conditions of her orders.

Jane began working with us at age 13. She was the victim of a 65-year-old pedophile who she at times resided with in aged care accommodation. Despite making multiple reports to the QPS about our concerns for Jane as the victim of child sexual abuse, officers advised that no charges could be laid unless Jane was willing to make statements. Her abuse was predicated on the older male supplying Jane with inhalants and cannabis and the relationship was characterised by extreme indicators of coercive control. This included the abuser driving past our agency holding inhalants and cigarettes out of the window of his car in front of practitioners, offering them to Jane to entice her to leave with him. Again, despite our complaints there were reportedly no applicable charges that could be laid against him.

As Jane got older (16 years) she became a victim in a new relationship with a 40-year-old man who had an extensive history of violence, mental health concerns and drug offences. Jane was physically very small (due to an early failure to thrive diagnosis) while the older male was much larger in stature. Again, this male supplied Jane with drugs in exchange for sex. Due to neighbours reporting yelling and fighting at his address, QPS officers attended and instigated a domestic violence order problematically naming Jane as the respondent. Despite our complaints to police regarding this issue, it was not rectified. Jane was reporting to our agency that the male had attacked her with samurai swords (which he collected) and we noted Jane presented with injuries on multiple occasions which we reported to her child protection guardians.

Despite police re-attending this address on other occasions, Jane was not identified as the aggrieved party by any of the officers.

On the second occasion officers attended, Jane was charged with a breach of the domestic violence order listing her as the respondent and was held in the adult watch house for a 13-night period. We contacted the Public Guardian, Legal Aid Queensland Remand Reduction Team in Brisbane and the Youth Advocacy Centre trying to get support for Jane but no assistance was forthcoming. We were advised that as the breach of the protection order had a potential for a 12 month prison sentence no bail application would be made on Jane's behalf.

We explained our concerns that Jane was a victim of predatory relationships and advocated that due to her age, intellectual disability, recent assault-related injuries and the male abusers' known history of violence perpetration/other offending that she should be seen as a victim of sexual abuse and coercion, and not as a respondent.

During the 13 days we visited Jane in the adult watchhouse (due to bed blockage in the juvenile detention system) she was highly distressed, emotionally dysregulated and required multiple suicide assessments. She reported another person providing her with methamphetamine in the watch house which she ingested and was subsequently hospitalised for. When Jane was transferred to a juvenile

detention centre 500 kms away we visited her there where our workers reported she was '*in a ball*' crying about the lengthy watch house experience.

The only charge that had prompted this incarceration was the breach of a domestic violence order that we believed she should never have been subject to due to her age, disability and the very obvious power imbalance in the relationship.

In the months following Janes' release from custody, she was the victim of numerous further episodes of domestic violence by this perpetrator including multiple physical assaults and an episode of non-lethal strangulation. When there was physical evidence of the strangulation, she was referred to the newly established High Risk Domestic Violence Team (HRT).

Even though Jane was supported by the HRT and a protection order was finally established naming her as an aggrieved this order only included standard conditions. Whereas the existing protection order that listed Jane as the respondent included no contact conditions.

This effectively ensured that if Jane were to report any further episodes of abuse to the police, she would also be reporting a contravention of the no contact conditions on the order listing her as the respondent. As there was now a previous history of a contravention of this order, it meant that Jane was likely to receive a custodial sentence if police decided to pursue charges.

At this point Jane was frequently presenting to our service with bite marks and cuts to her lip and sides. We supported Jane to report her injuries to the QPS who took statements and instructed her to contact ATSILS or the Regional Domestic Violence Service (RDVS) to have any orders varied.

Time passed as we worked to link Jane to the RDVS to take her statements.

During this period Jane experienced frequent, recurrent violence but continually reported an unwillingness to make statements due to her fear of being charged (associated with the no contact provisions). It was also left to Jane to make the application to vary the order which was considerably difficult for her due to her young age and intellectual disability, and it took approximately six months for this to occur.

In the week following the variation of this order Jane was hospitalised due to a physical assault which left her with head injuries, bite marks and bruises. It was only at this point that the perpetrator was charged with a breach of a domestic violence order or indeed any offence related to his sustained abuse against Jane.

Within one month there were further reports of domestic violence with Jane at significant and ongoing risk of further harm.

* Names changed to protect privacy. Stories are shared with the agreement of the client.