Institute for Urban Indigenous Health (IUIH) Network Submission

Women's Safety and Justice Taskforce consultation

16 July 2021

The Institute for Urban Indigenous Health (IUIH) was established in 2009 as a regional strategic response to the significant growth and geographic dispersal of Indigenous people within South East Queensland (SEQ). As Australia's largest Community Controlled Health Service (CCHS), the IUIH represents a network of five CCHSs in SEQ, Australia's largest and fastest-growing Indigenous region and home to 40% of Queensland's and 11% of Australia's Indigenous population. Since 2011, it is estimated that the IUIH Network population footprint more than doubled, from 50,672 people in 2011 to an estimated population of 110,776 Indigenous people in 2021.

The IUIH regional network provides care to around 32,000 Indigenous people through 20 community controlled clinics operated by IUIH Network Members in SEQ. IUIH aims to achieve family wellness through a one-stop-shop model of integrated health and social support services for Aboriginal and Torres Strait Islander families. IUIH is the first CCHS in Queensland to directly own and operate a legal education, advocacy and referral service as an integrated component of its comprehensive primary health care system. IUIH recognises the important intersection between legal matters and health, and that early, intensive and integrated legal education, advocacy, prevention and support was not readily accessible to many Indigenous people, especially those who experience social and financial hardship. For these reasons in July 2017, IUIH pioneered the ground-breaking and unique IUIH System of Care Integrated Health Justice Partnership (Partnership).

The Partnership is the first of its kind in Australia whereby both legal services and health services are owned and governed by a single community controlled entity, with the provision of legal services embedded within a fully integrated model of primary healthcare that values and affirms cultural identity and asserts the link between rights, responsibilities, self-determination and well-being. Through the Partnership, IUIH operates a Legal Service providing free, high quality, timely legal advice for families and individuals, fully integrated within a regional primary healthcare model. Led by an experienced Indigenous lawyer, this service is underpinned by culturally appropriate and culturally safe services, a culturally aware and trained workforce, trauma-informed approaches, holistic service delivery and community control.

Discussion paper 1

(Question 1)

What other types of behaviours or risk factors used by perpetrators in domestic relationships might amount to coercive control?

Intimidation, particularly in the form of:

- threatening the parent-child relationship. In these instances, Child Safety are notified/involved.
- threatening secure housing with complaints to housing providers.
- threatening the safety of the children or pets.
- threatening client's access to health services, medical services, medication, financial resources for transport or access to car.
- threatening to damage connections in community using social media or rumours through local connections/support networks.

(Question 2)

What aspects of women's attempts to survive and resist abuse should be taken into account when considering the issue of coercive control?

It is important to consider how fears impact or present for different people, and the resulting impacts.

- Fight: physical violence, arguments, raised voices, behaving demonstratively with large, expressive gestures, using objects to make a point (throw, break, damage items), challenge or confront others. Police and service providers may view women and children as engaging in risky behaviours and limit service provision, without addressing reasons for a fear-based response.
- Flight: excessive or unusual sleepiness, lethargy, fatigue, sudden absence in daily routine, "leaving with the kids". Service providers could perceive this fear-based response as laziness, lack of participation/engagement, or mental health challenges which negatively impact woman's ability to parent thereby putting the custody of children at risk.
- Fawn: sexualised behaviour, excessive or unusual compliance with those who pose risk/those in power/service providers; perceived as high-risk behaviour, personality vulnerabilities, and therefore unstable.

It is also important to recognise how coercive control could impact a person's engagement with services. For example, people may frequently miss appointments,"lose their phone" or "run out of credit", request food vouchers, or assistance with transport. Substance use, especially alcohol consumption, can be a means of coping with distress, and perpetrators may also coerce women into substance use.

Resisting coercive control usually involves concessions in numerous areas of the relationship in order to safeguard independence or control in other areas. These can be intelligent, risk-assessments based on the woman's experience and knowledge of the perpetrator. For example:

- Drinking heavily with friends and then "staying over because I can't drive" to avoid the perpetrator at a time of day when they are most harmful. The risk to the woman is that she can be perceived by service providers as a substance user, addict, or exhibiting "risk-taking behaviour".
- "Playing the pokies" or "wandering in the shops" for hours so the woman and children are away from the perpetrator. The risks to the woman is that she can be perceived by service providers as "neglectful towards the child" or in the worst case scenario, she is not "willing and able to care for children" and Child Safety is notified.
- Sleeping rough so woman and children are physically removed from the perpetrator. The risk to the woman is she can be perceived by service providers as compromising the wellbeing of the children, worst case scenario parent is not "willing and able to care for children" and Child Safety is notified.
- Lack of food using money assigned for groceries to pay for car registration and fuel so the woman has access to a car at all times for independence, crisis accommodation and connection to others. The risks to the woman is she can be perceived by service providers as irresponsible and restrict services because "she's asked too many times".
- Uncontrolled debt using money assigned for household bills to purchase favour with perpetrator e.g.: alcohol, "a nice dinner just the way he likes it". The risks to woman is she can lose access to credit, secure housing due to rent arrears, and increase her own distress.

It is important to consider that clients who require the assistance of specialist services, but who do not identify the coercive control in relationships nor the associated risks to their safety, may find open discussions about domestic violence challenging enough to dis-engage.

(Question 9) What could be done to improve the capacity and capability of the service system to respond to coercive control (this includes services to victims and perpetrators)?

- Specialised DV training via DVConnect / BVDS or another DV service that could help support staff to work with both victims and perpetrators of coercive control to provide information and training / alongside these services. This includes training for frontline service providers to invite client conversations about the nature of their important relationships, curiosity and humility.
- Training embedded within service delivery across all sectors (health, justice, education, housing etc), to build the capacity of staff to identify the indicators and signs of coercive control. This is critical given coersive control can often go undetected or be unreported.
- Risk assessment tools specific to coersive control.
- Once clients are ready to discuss the coercive relationship and engage in safety planning and risk assessment, then specific services/referrals should be offered. This incudes collaboration with external and specialist services to provide wrap-around and culturally appropriate supports.
- Provide healthy relationships education as part of service delivery, delivered by frontline staff. As a generic part of service delivery, this may reduce the client and perpetrator's perceived threats to their safety and increases the likelihood the client will be able to participate freely.

(Question 12) What could be done to better ensure that perpetrators, have access to services and culturally appropriate programs with the capability to respond to coercive control whilst they are on remand or after sentencing in a correctional facility?

There is a critical gap in the availability of specialist services and programs for perpetrators of coercive control, particularly for those on remand. An approach to addressing this access gap must also consider:

- Delivery through culturally appropriate service providers, such as community-controlled health services.
- Specialist male / female employees with specific training and qualifications (specialised DV) to work with perpetrators
- Specialist family / couples counselling when required
- Stronger integration across service providers

(Question 16) What are the opportunities to improve integrated responses to victims and/or perpetrators of coercive control to achieve better outcomes?

Coercive control and domestic violence requires a multifaceted response. This includes embedding a focus on coersive control into prevention programs and iniatives, including within the school curriculum. Patterns of coersive control are developed over time

Dedicated funding for community-controlled services, to ensure culturally appropriate and integrated service delivery across the domains of health, justice, child safety and housing. This will also help to address waiting lists, capacity and engagement issues with current providers. Staff from other specialist services should also be embedded within community controlled organisations so they are co-located and provide immediate responses to staff with experience and understanding of each organisation's model of care, culture, values, and staff capabilities.

Specialist services funded to prevent and address coercive control in relationships need to:

- Train, advise, and collaborate with frontline service providers who have an ongoing, trusting relationship with clients experiencing coercive control. Staff assigned a caseload of region/type of community organisations e.g. Indigenous, community-controlled service providers or LGBTIQ+ client service providers.
- Specialist services must build reliable, informed, site-specific, collegial working relationships as the context for their input into frontline services, which best supports frontline staff.

- Familiarise staff with the unique complexities of each population as well as refer to a few expert staff e.g. populations in resettlement, Indigenous mothers, young women with a lived history of child protection involvement, etc.

(Question 17) Have you had any experience with the existing integrated service responses or co-responder models operating in the Brisbane, Ipswich, Logan/Beenleigh, and Moreton regions? a. What worked well? b. What could be done better? c. What outcomes have been achieved?

The Institute for Urban Indigenous Health (IUIH) Network has engaged with a range of existing service responses and co-responder models across South East Queensland.

What worked well?

Timeliness and quick action of some specialist services

One particular specialist service has provided timely responses to referrals for home security systems, and responded to requests for professional advice on the phone. Staff provide timely responses to referrals, and respectful and useful advice by phone which includes alternative/additional referral options and professional advice. Referrals are effective largely because the service communicates directly with clients and actions referrals quickly. While they provide information and advice by phone, their timeliness and clear provision of information about the services and products ensures each referral is secure.

Outcomes:

As a result of referrals to this service, and the professional advice provided by phone, clients have received home security technology and a technology audit which then identified technological abuse. Another client received a home security system, thereby enabling her to live in her home safely without surrendering her lease and possibly risking homelessness/transience with her children.

What could be done better?

- Dedicated funding for community-controlled services, to ensure culturally appropriate and integrated service delivery across the domains of health, justice, child safety and housing. This will also help to address waiting lists, capacity and engagement issues with current providers.
- Specialist service organisations need to offer services which strengthen the capacity and abilities of frontline staff and their relationship with clients, as well as specialist services for clients.
- Dedicated and accessible training and education for frontline staff on coersive control.
- Better integrated support and referral pathways.

What outcomes have been achieved?

- People, Community, services and government services are listening and discussing what is needed to support people being safe and understanding that coercive control is a part or domestic violence with levels of risk that if we can educate at an early age and at all stages and interactions we will have better outcomes.

(Question 19) What parts of the civil protection order system under the DFVP Act could be improved to better protect women and children from coercive control?

Family violence must be defined in family violence law to reflect the nature and dynamics of family violence – including coercive control as a defining feature. It should articulate the responsibilities of all justice system stakeholders. This also requires a shared understanding of coercive control as family violence. Coercive control needs to be reflected in a material way in the civil and domestic violence jurisdictions, so that victims may rely upon it when they are seeking protective court orders.

Making coercive control offences effective, whether through civil or criminal proceedings depends on a women's willingness to engage with police and service providers. This is challenging for women who are already socially isolated and are experiencing trauma through coersive control. This highlights the importance of integrated service delivery and risk assessment approaches to identify coersive control, as discussed earlier.

(Question 21) What could be done to help the civil protection system under the DFVP Act be more effective in protecting women and children from perpetrators who coercively control them?

As highlighted earlier, there is a need for improving non-legal prevention responses, including those that increase financial independence and security to achieve safe and effective early intervention. Prevention and early intervention must happen outside the court room. The focus must be beyond the justice sector to include health, education, employment, and housing, through cross-sector collaboration.

Contact

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