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28 May 2015

Commissioner Neave
Royal Commission into Family Violence
PO Box 535
Flinders Lane
MELBOURNE 8009
VICTORIA

Dear Commissioner,

Submission addressing the Terms of Reference for the Royal Commission into Family Violence

Thank you for the opportunity to provide feedback on the important work of the Commission.

Who are we?

Inner East Community Health (*iehealth*) is Australia's oldest surviving community health service, having opened its doors in 1869. Since our inception we have focussed on providing the best possible health outcomes to the most disadvantaged individuals and families in our community.

We have extensive and integrated primary care services at four clinic locations in the cities of Boroondara and Yarra offering medical, nursing, dental, allied health, psychology and alcohol and drug counselling services, for little or no cost to our clients. Complimenting this are a range of community services, childcare and community development and prevention programs. *iehealth* is the lead agency for the **headspace:** Hawthorn Consortium. We are a secular charitable organisation partly funded through government grants.

A Broken System

At *iehealth* we believe that the enduring incidence of family violence within our society is perpetuated – in large part - to a broken prevention and service system. These systemic fractures spread from primary prevention through the acute response to family violence and the long term support of victims.

The prevention and response to family violence extends far beyond the health system. It is complex, multifaceted and multi-sectoral. Our response to the Commission draws on the significant experience of our clinicians and practitioners in managing and responding to family violence while also working hard to prevent it from occurring in the first place.

Children

Children are frequent victims and witnesses of family violence. Our clinicians note that it is often difficult for Child Protection and Child First Services to respond to family violence. Greater resource is needed to support Child Protection and Child First to improve responsiveness, clarify roles and responsibilities and support community services to identify and mandatorily report family violence against children.

CASE ONE:

Four year old "K's" mother and father separated due to family violence. The court decided that he and his brother, with an Autism Spectrum Disorder, are to spend half of their time with their mother and half with their father. This is disruptive for the children and stressful for their mother, who fears for their safety while they are out of her care. It makes scheduling appointments and extracurricular activities for the children difficult, which is particularly important for children with additional needs. Their mother also has to see their father multiple times each week, making recovery from the trauma of the family violence much more difficult.

Young People

At **headspace:** Hawthorn our clinicians note that family violence was almost never the presenting problem for a young person presenting to the service. However, clinicians estimate that 20% of current clients (male and female) have reported past or present family violence that was a key factor in the clinician's formulation of the young person's difficulties. Young people are more likely to disclose a history of family violence in person at Intake or with their ongoing worker than they will on the phone. We are concerned that in some instances young people were not aware that their experiences constituted family violence or abuse.

Family situation can instigate or prolong incidents of family violence due to separated parents who continue to cohabitate in the family home for economic reasons, proximity to schools zones or social stigma. It is our experience that some young people and families disengage with the service when issues relating to family violence are raised by staff.

One of the significant issues that young people and youth services face is the arbitrary separation of child and adult services. This has been improved in some mental health settings, where child and adolescent services now encompass youth clients up to the age of twenty-five. This perspective acknowledges the developmental stage of a young person rather than their chronological age. In our experience, this is particularly significant in the family violence field where young people, too old to be supported by mandated services, are not developmentally competent to manage their own safety in a home environment where family violence is a longstanding problem.

Older Adults

We note that Family Violence is an issue at the end of the life-course also with older adults being the victims or perpetrators of violence from or against familial carers. There is significant underreporting in this demographic and a great deal of shame and lack of self determination for older adults which further confounds this issue. *iehealth* encourages the commission to consider elder abuse within the scope of its report noting the cultural impacts which hamper reporting of family violence perpetrated against or by older adults in our community.

Alcohol and Other Drugs

We note that the Terms of Reference for the Commission view alcohol and other drugs as a contributory factor to family violence. We would also draw the Commission's attention to the fact that substance use can further confuse and fracture the service system for victims and perpetrators.

Individual clients experiencing family violence as either victim or perpetrator are often 'bounced around' between mental health, drug and alcohol, child protection and family violence services with no integrated, co-ordinated response being offered. Clients have been told by a support service to 'come back when you've stopped drinking or using drugs' which demonstrates a lack of understanding about the nature of substance misuse.

Further, victims or perpetrators of Family Violence who are also using substances are often ineligible for services, particular crisis or supported accommodation. Housing services typically forbid substance use which leaves the perpetrator or victim in a situation where they have no other options other than to remain in the family home.

Whilst *iehealth* strongly recommends its clients contact police if they feel unsafe or at risk, clients who are using alcohol or drugs frequently express a strong reluctance to do so. *iehealth* encourages the Commission to be inclusive of alcohol and drugs in its report as both a contributory factor and a confounder to appropriate support systems.

Emerging Risk Cohorts

Our clinicians report that more work is needed to explore the impact of family violence on emerging risk cohorts. We would like to draw the Commissions attention to:

- Exploration of the cultural differences and concepts of family violence in South, East and Southeast Asian communities.
- The special needs of same-sex attracted and gender diverse young people

Preventing Family Violence (Primary Prevention)

We note that the Commission is tasked with investigating the societal response to all forms of family violence. At iehealth, we recognise that victims and perpetrators of violence come from all genders, sexual orientations and cultural groups but the majority of family violence is perpetrated against women and children – by men. For this reason – we are committed to the primary prevention of violence against women.

Gender Equity is a key to prevention. We know that addressing primary determinants of men's violence against women namely gender inequality and adherence to rigid defined gender roles, will help to prevent all forms of violence against women before it occurs, including family violence.

It will take a whole of system and whole of society approach to challenge the norm and eliminate the gender inequalities that are considered 'acceptable' behaviour. Family violence will only stop when community norms and societal structures that perpetuate unequal relations between men and women are changed. Effective prevention requires a range of mutually reinforcing, evidence based strategies reaching out to the whole of the community. We need both structural and cultural change which results in gender equality in our person, community and societal interactions. Increased and
sustained funding and policy emphasis on primary prevention is required. This needs to shift in emphasis and needs to recognise the intersection of different forms of discrimination faced by women.

Along with all Local Governments, Community Health Services, Women's Health, Medicare Locals, Primary Care Partnerships and the Regional Family Violence Partnership in the Eastern Metropolitan Region of Melbourne, *iehealth* has signed up to be a partner of the Together for Equality and Respect (TFER) Project, to improve gender equity and prevent violence against women.

CASE TWO:

TFER is an example of regional integrated effort to prevent violence against women. Led by Women's Health East, the Strategy brings together more than 25 Agencies working on a shared regional priority to prevent violence against women through an evidence-informed approach. The Strategy describes a uniting vision to prevent men's violence against women.

The regional approach promotes the prioritisation, coordination and integration of effort, and supports accountability, efficiency (through shared resources/tools) and consistency in messaging and peer-learning opportunities among Partner organisations.

Examples of local initiatives taking place in the EMR include:

- *Gender Equity training being delivered to TFER Partner Organisations*
- *Organisational Gender Audit Tool being utilised by TFER Partners*
- *Social marketing capacity building and the use of shared messaging to promote gender equity*
- *Consultations with Chinese and Indian communities to build knowledge on effective prevention*
- *Gender equity initiatives focused on specific populations groups eg: early years providers, young women, primary and secondary school children, first time parents, Aboriginal young people and sporting clubs*

More information is available on the TFER website http://whe.org.au/tfer

Supporting Victims

Our clinicians deal on a day to day basis with the aftermath of family violence in the acute phase and to assist victims in moving on from the trauma they have sustained. We note that despite an increased focus and awareness of family violence within the community there is an enduring culture whereby victims are seen as being partly (or wholly) to blame. This victim blaming culture leads to an under-reporting of family violence and sadly is often perpetuated by the services tasked with helping victims as noted below:

CASE THREE:

"M" first came to see the Social Worker due to Child Protection involvement with her 10 month old baby son. The depression she was experiencing impacted on her day-to-day functioning and she was starting to hoard and finding it difficult to go out of the house. "M" told of having lived with domestic violence from her child's father "J" for three years. There was an intervention order in place, but they still had irregular contact mainly so that he could see their child. "M" felt that the child protection workers believed that she was "not a good mum" because they told her that she was not able to protect her baby from her ex's violence ie: "that she was not acting protectively". She felt like the responsibility for the violence was placed on her, rather than on her ex, stating that this "let him off the hook".

We would like to bring to the Commissions attention, what our clinicians see as being the positive and negative structural responses currently in play to support victims of family violence.

There are two stand-out positives which make a noticeable difference to victims:

1. The 72hr Safety Notice that Victorian Police are now able to issue is a recent and effective change to policing that has had a positive impact on women and children's immediate safety.
2. The ability for any party affected by family violence to make a claim through VOCAT (Victims of Crime Assistance Tribunal) for compensation including counselling provides a necessary support to victims although this could be better promoted.

Many of the negatives noted by our clinicians are due to existing cultural norms and a lack of awareness of the impact that family violence has on its victims. In particular we are concerned about:

1. The attitudes of Magistrates and Judges towards women and men which uphold traditional stereo-typical gender roles and further (often) blame the victim and/or excuse the behaviour of the violent party, usually the male.
2. The lack of ongoing support victims or survivors of family violence receive to recommence their lives in safety. Victims are regularly placed in public housing estates where they are exposed to substance use, violence and erratic behaviour, adding to their fear and anxiety and reducing their capacity to recover from the trauma they have suffered.

Recommendations

We make the following recommendations which we encourage the Commission to consider:

- Increased and sustained funding and policy emphasis on primary prevention.
- Improvement of minimum data set to capture the prevalence of family violence.
- The need to adopt gender equity and respectful relationships training in primary schools.
- Increased consideration of elder abuse as a facet of family violence noting the cultural constructs which lead to chronic under-reporting.
- A comprehensive public campaign aimed at identifying all levels of family violence that de-stigmatises families seeking support.
- Training and education for staff around targeted safety planning interventions that are *developmentally appropriate.*
- Integrated partnerships between agencies and professionals though co-location of services, increasing the capacity for joint client assessments and/or secondary consultations between organisations to better share knowledge.
- Greater resourcing of Child Protection and Child First Organisations to improve responsiveness, clarify roles and responsibilities and support community services to identify and mandatorily report family violence against children.
- Training for General Practitioners, who are often the first point of contact, on how to respond to family violence and what services are available.
- Establishing a judicial review process so that victims of family violence can have the judicial decision that continues to put them or the children at risk, reviewed.
- Specific funding provided for drug and alcohol services to provide specialist family services.
- A greater emphasis on integration and up skilling for family violence, mental health and drug and alcohol services (currently all three services are provided by separate, non-integrated agencies).
- Improved child protection training/responses as the victim is often still blamed for staying with the perpetrator of violence and for 'failing to protect the children'.
- More supported accommodation and refuges as well as appropriate post refuge/permanent, affordable and safe accommodation.

Further Information and Clarification

Once again – we thank the Commission for the opportunity to contribute to this Commission.

Should you have any questions please do not hesitate to contact our General Manager: Health Promotion, David Towl - [redacted]

Kind regards,

[redacted]

Dr Harry Majewski
Chief Executive Officer