The Victorian Royal Commission into Family Violence 2015 – 2016.

We are delighted to have the opportunity to provide a written response to the Royal Commission into Family Violence.

This submission incorporates the experience of two organisations – Drummond Street Services and the Victorian AIDS Council in the providing services to the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning (LGBTIQ) community and more specifically the prevalence, nature and service implications/needs for those who are also experiencing intimate partner violence (IPV). The submission provides an overview of the issues impacting on working with the LGBTIQ community both in a mainstream clinical setting at *drummond street services* who provide specialist LBTIQ services (Queerspace) and the *Victorian AIDS Council* a LGBTIQ specialist service. The submission provides a brief overview of LGBTIQ national and international literature as well as the lived experience of the two services. It will highlight the differential experiences and needs within the LGBTIQ community including highlighting the even greater exclusion experience of transgender and bisexual within the broader LGBTIQ experiences.

The Victorian AIDS Council

The Victorian AIDS Council (VAC) is the largest HIV organisation in Victoria and the oldest HIV organisation in Australia. We are a membership-based, community-controlled not for profit organisation. Our mission is to end HIV by raising awareness of HIV/AIDS, delivering health promotion messages to affected communities, and providing services for people living with HIV. VAC also addresses a broad range of health issues that affect the wellbeing of sexually and gender diverse individuals and communities.

Service Delivery responses to intimate partner and family violence amongst same sex couples and LGBTIQ individuals at VAC

Emergency services for individuals in heterosexual relationships subjected to intimate partner or family violence are part of the suite of services available to address this social problem in our community. Conversely, there are no hot lines, no shelters, no support groups, no advocacy and no public campaigns for individuals in same sex relationships, or who identify as LGBTIQ who are subjected to intimate partner or family violence.

In the Australian context men's behaviour change programs are now recognised by government as a key intervention into men's violence (Oberon 2006). Only one specialised men's behavioural change program exists for gay or bisexual perpetrators of intimate partner or family violence. This program is called *ReVisioning*, a psycho-educational group that has been conducted by the VAC since 2003. No specific funding supports the delivery of this service, as the ReVisioning group has largely been removed from specialised DHS funding for

MBCPs. Having said this, the ReVisioning group meets the minimum standards and quality practice methods set out by *No To Violence*- the governing body which sets the standards for MBCP's in Victoria. This has made it difficult to recruit participants for the group.

The current family violence sector is not sufficiently structured to respond intimate partner and family violence amongst male same-sex couples, let alone to provide referrals to the ReVisioning program. No clear guidelines or protocols appear to exist for victims of intimate partner and family violence amongst male same-sex couples or LGBTIQ individuals either.

Context

The dominant narrative of family violence in Victoria is that violence is something heterosexual men do to heterosexual women and their children. It assumes that only women can be victims of family violence and only men can be perpetrators. This submission contends that this way of understanding violence in intimate relationships is heterosexist and generates gaps in knowledge, policy and practice with respect to violence that occurs in male same-sex relationships. The family violence sector has an obligation to examine the role of heterosexism, homophobia and related biases to understand how these attitudes shape and maintain a climate of invisibility and silence about violence in same-sex male relationships, which ultimately leaves victims at increasing risk of violence or worse. An examination of the role and impact of heterosexism in same-sex male relationships is critical in order for SSRV to be understood and responded to appropriately.

This submission also suggests that the current theoretical frameworks, such as feminism, which are used to understand (heterosexual) men's violence do not always provide an appropriate lens to use in working with male SSRV, such as in men's behaviour change programs. From this perspective men's violence is understood as gendered violence, or a crime against women at the hands of their male partners, taking place in and contributing to a context of gender inequality (Reed et al. 2010; Stark 2010). In this context male aggression is viewed as an expression of male privilege and dominance, whereby a male coerces and controls their partner in order to gain benefits and resources within the relationship (Johnson 2006; Kimmel 2002; Stark 2010). However, this perspective does not include violence in relationships where both partners are male.

Evidence of Need

In 2005 the Australian Domestic and Family Violence Clearinghouse reported that SSRV is an under-researched and under-reported area considering that the rate of intimate partner and family violence (in both male and female same-sex relationships) is as high as the rate of violence committed against women by their male partners in intimate heterosexual relationships (Chan, 2005). The *Coming Forward* report (Leonard, Mitchell, Pitts & Patel, 2008) found that one in three gay and lesbian Australians have experienced some form of intimate partner and family violence. Other Australian reports suggest that intimate partner and family violence between same-sex male couples occurs at an alarmingly high rate and help is rarely sought by victims from community service providers or police. When it is sought the 'help' given is often not particularly useful (Jeffries & Ball, 2008). It has also been noted elsewhere that fear of, or actual experiences of, homophobia and heterosexism by police or service providers prevent same-sex males from seeking help when violence is experienced (Leonard, Mitchell, Pitts & Patel, 2008).

Male same sex Intimate Partner and Family Violence

The following case study provides an example of a male participant in the most recent *ReVisioning* group who perpetrated violence against his female partner in an early relationship and later became the victim of violence in two subsequent same-sex relationships. This study illustrates how well the system worked to protect and support his female partner and conversely, how poorly the system failed him when he was the victim of intimate partner and family violence in a subsequent same sex male relationship.

Case Study: "[redacted]"

[redacted] was married to a woman for almost six years between 1996 and 2001. His wife knew he was gay when they married. They had three children in the first four years of their marriage after which time their sex life died. They also parented a child from his wife's previous marriage. From the first year of their marriage [redacted] and his wife fought constantly about their finances and the child from the first marriage (whom [redacted] accused his wife of "pampering"). During the sixth year of their marriage he became infatuated with a man (although a relationship with him did not subsequently develop) and his wife found a boyfriend. The couple then separated and were divorced six months later. Their conflict escalated after their separation over the issue of managing their children. As well as having arguments with his ex-wife, [redacted] began to be intimidated and threatened by her new male partner. Eventually, all communication between [redacted] and his ex-wife was conducted through their lawyers. In 2001, after they separated, his wife took out an intervention order against him on account of his verbal aggression towards her.

In the same year, [redacted] met [redacted] who was nine years younger than him. Shortly after they met [redacted] moved into [redacted]'s house. At this time [redacted] was on anti-depressants which significantly reduced his sex drive. [redacted] repeatedly harassed [redacted] for sex. Eventually [redacted] sexually assaulted him. [redacted] did not know whether he could call the police about this incident. [redacted] then began to physically assault him as well when [redacted] would refuse to have sex. [redacted]'s violence culminated in an incident at a time when his mother, sister and his children were staying with [redacted] and [redacted]. As a result of [redacted] refusing to have sex with him [redacted] became enraged and locked all of them into a room. His mother managed to ring the police on her mobile phone. When the police arrived at the house "they thought it was a huge joke" according to [redacted].

One of them eventually told him he had talked to [redacted] and that "he had agreed to calm down". The policeman also asked [redacted] why he stayed with [redacted] if he was so afraid of him. So, instead of holding [redacted] responsible for his actions, the policed handed [redacted] the responsibility for leaving the relationship.

Eventually the relationship ended but, throughout the two year period they were together, [redacted] never thought of himself as a victim of intimate partner or family violence.

[redacted]'s next significant relationship did not begin until the middle of 2014 when he met [redacted] and they moved into together shortly after. Within three weeks [redacted] began to physically assault him. The first time this happened [redacted] said it came out of the blue when [redacted] was annoyed with him over a minor matter. [redacted] hit him again later that same day. This violence traumatised [redacted] and it also triggered memories of [redacted] hitting him over a decade ago. Later that night he called the police out of a fear for his own safety and his concern that the violence might happen again in front of his children who were coming to stay in the next few days. [redacted] was escorted out of the house but was not charged. He came back a few days later and there were more assaults. [redacted] was already seeing a counsellor at the VAC. When he told the counsellor about [redacted] coming back and continuing to assault him she suggested he take out an intervention order against him. She sought the advice of a male counsellor experienced in the area of family violence. He accompanied [redacted] to the local police station. The first policeman they saw was reluctant to issue a safety notice or temporary intervention order, saying that [redacted]'s conflict with [redacted] was "a private matter" and that such an order was not warranted. Through the counsellor's persistence they eventually spoke to a Family Violence Liaison Officer there and the safety notice was issued. Eventually the courts issued a two year intervention order against [redacted]. However, since the intervention has been issued, [redacted] has breached it by coming to see [redacted]. [redacted] was then charged and convicted. Once the temporary intervention order was issued [redacted] said that he was well looked after by the relevant family violence support services at the courts. This was in stark contrast to the reaction of the police to the assaults on him by [redacted] in his previous relationship more than ten years before then.

[redacted] joined the ReVisioning group this year as he wanted to address his own propensity for violence in his current and future intimate same-sex relationships. His motivation to avoid perpetrating future relationship violence was enhanced by the fact he was still on an intervention order not to approach his ex-wife.

The dominant paradigm of family violence, where men are the perpetrators and women are the victims, does not sufficiently recognise these issues involving intimate partner and family violence amongst same sex attracted men in relationships. Where male same-sex violence occurs male victims are often dismissed as participating in a mutual fight between equals because of their sex and therefore victim status is not readily available when clear and obvious criminal behaviour is reported. In the above case study there were inadequate protocols and procedures in place to provide an appropriate criminal justice and community service responses to same-sex male relationship violence.

This case study highlights the following issues:

1. violence occurs in same-sex as well as heterosexual relationships;

2. men can be victims of intimate partner and relationship violence, not only perpetrators;

3. the system for addressing intimate partner violence is influenced by, and directed at, heterosexual couples and because of this;

4. there is an absence of structures and services to support the delivery of services to address intimate partner and family violence amongst same sex couples and LGBTIQ individuals;

5. there is a need to look at specific models to address intimate partner and family violence amongst same sex couples and LGBTIQ individuals. ReVisioning presents us with one such model where the situation involves male same sex relationships; and

6. there is a need for specialised services, like ReVisioning to funded by the government as part of a comprehensive suites of services to address intimate partner and family violence across our community.

A Case Study: - Lesbian Intimate Partner and Family Violence - Our Family was Broken.

This case study aims is to educate and make recommendations to the Royal Commission into Family Violence concerning same sex intimate partner and family violence and how existing family violence service systems might better meet the needs of same sex parents and their children.

(The writer has obtained written permission to use partial or full disclosure of the non-violent parent's written account of her and her children's experiences of same-sex intimate partner and family violence. Inclusive of her own and the children's experiences of family violence sector, which struggled at times to provide appropriate responses and care for her and her family. The names of the family have been withheld for reasons of confidentiality and safety.)

Introduction

The following narrative is a case study, a deeply personal narrative about the lived experience of a same - sex parented family comprised of lesbian parents and two young children. This family has now transitioned through the traumatic experiences of same- sex intimate partner and family violence which has concluded with the family living as a separated family.

Vickers (1996) cites Lundy-Bancroft, who states domestic violence whether heterosexual or homosexual, is nothing less than the systemic exercise of illegitimate power and coercive control by one partner over another. Vickers (1996) also cites Hart, who defines lesbian violence as the pattern of violent and coercive behaviours whereby a lesbian seeks to control the thoughts, beliefs, or conduct of her intimate partner or to punish the intimate partner for resisting the perpetrator's control over her.

The case study material will be interspersed within this document with the aim of drawing attention to key themes related to same-sex intimate partner and family violence As is often the case with families who endure and survive such trauma, the longstanding emotional and psychological impacts of intimate partner and family violence are not easily overcome.

> *My long term partner and I were devoted to having children and raising them together; we bought a family home, had a commitment ceremony, underwent years of IVF treatment. We had 2 miracle children, which we both loved. To my horror, whilst on maternity leave with our youngest baby, I witnessed my partner repeatedly psychologically, verbally and, on occasion physically abuse our 5 year old son. As a highly educated, professional woman, raised in a loving family I never imagined that I would find myself in such a terrifying, violent relationship with the woman I loved.*
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> *I was immensely relieved when my partner promised to go to counselling for us to discuss my concerns about her violence, but my hope rapidly turned to despair. My attempts to disclose her violence during these sessions often triggered rage within hours of returning home, where she displayed aggressive violent rages, terrifying*

behaviours directed toward our son coming behind him and hitting him on the back of his head or slapping him across the ear.

Eventually she did admit one of her frequent violent incidents to our family therapist and I was advised to separate to protect my children from being exposed to further violence. Unfortunately my attempts to separate triggered further violence and she eventually injured our son. I carefully waited for her to leave for work on a given day and we escaped to a Women's Refuge and I sought legal advice from that time on.

Linville et al (2012) provide a thorough literature review concerning partner violence in gay and lesbian relationships. They cite Island et al. (2002), who suggest the aetiology of same-sex partner violence and abuse patterns and dynamics are similar to those identified within heterosexual relationships such that the abuse tends to recur, escalate and become increasingly violent overtime. Linville et al, also refers to the risks of using a *blanketing* approach when dealing with same sex partner violence as per the heterosexual models. Taking a blanketing approach can serve to negate distinct casual factors / triggers related to the LGBTIQ target population. Key themes identified include oppression and marginalisation alongside stigma which is a powerful social determinant for LGBTIQ communities.

Australian population health research such as; The Alice Study (2014) and The Swash Report (2014) state that the critical impact upon LGBTIQ communities living with the fear of stigma within the context of a dominant heterosexist and homophobic society as key factors why people from LGBTIQ community do not engage in help seeking behaviours.

Whilst in the Women's refuge, a worker debriefed with me about her struggles related to protecting my male child from a female parent....I found myself pressured to provide the worker with education about same sex violence at a time I needed to focus on my children and prepare for court...clearly the staff were inadequately trained in lesbian intimate partner and family violence.

The Australian Context:

The Australian Institute of Criminology (2014) published a trends and issues paper concerning same –sex intimate partner homicide in Australia. These findings suggest the motivating factors for same – sex intimate partner and family violence, being similar to opposite- sex partners, attributing the greatest causal factor to: domestic arguments leading to same-sex or opposite-sex homicide incidents (n=8; 25% and n=837; 56%)

My initial relief at ending the violence rapidly turned to horror in the weeks following our separation, as it was brought to my attention that my ex-partner was maliciously, calculatedly making false allegations against me and lilting about her violence - I felt powerless to advocate for our children's future safety.

Nevertheless I believe that our young children's welfare was and is paramount, and I persisted in my attempts to protect them from further psychological, verbal and physical abuse. I sought via the support of legal systems to have any future contact with our children and for my ex-partner to be professionally supervised, as I had witnessed her violence in my presence on many occasions.

These requests were countered by the very same legal system designed to protect children due to an application from my ex-partner falsely accusing me of trying to alienate our children against her and being crazy and mentally unstable to the extent that I believed she was capable of perpetrating violence. So effective was my ex-partners behaviours in perpetrating these untruths that my own lawyer advised me to hide the injury my ex-partner had inflicted on our son, to protect me from false allegations that may implicate me as the perpetrator of the violence against our son.

Cherie Chan, a Senior Researcher at the Australian Domestic and Family Violence Clearinghouse (2005); wrote an article focusing on the critical elements of same-sex domestic violence. It highlights Mason's work (2002), which reports that victimisation surveys undertaken during the 1980s and 1990s in the US, UK, Canada, New Zealand and Australia estimated that between 70-80% of lesbians and gay men experienced verbal abuse in public because of their sexuality; 30-40% reported threats of violence; 20% of gay men reported physical violence and 10-20% of lesbians reported physical violence.

The above statistics highlight the prevalence of homophobic attitudes that contribute to the isolation and discrimination of lesbian and gay partners who find themselves victims of intimate partner violence. Homophobia isolates the abused partner and prevents her/him from accessing resources such as family, friends, social services, police and the legal system (Merrill 1996).

Stress amongst members of minority communities is cited in many research studies. This kind of stress is identified as having a profound negative effect upon LGBTIQ communities. It is a critical factor when considering the overall health and wellbeing of LGBTIQ communities and is viewed as an active deterrent for LGBTIQ peoples to engage with services for the purposes of seeking help.

Meyer (2003) describes minority stress theory as:

> *minority stress*—explaining that stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems. The model describes stress processes, including the experience of prejudicial events, expectations of rejection, hiding and concealing, internalized homophobia.

Marshal et al., (2008) proposes minority stress theory as a significant factor which is induced by a hostile, homophobic culture, often resulting in experiences of prejudice, expectations of rejection, and internalised homophobia.

Evidence suggests the minority stress may explain the high prevalence of domestic partner violence in lesbian and gay relationships according to Richard Carroll (2014) associate professor in psychiatry and behavioural sciences at North Western University Feinberg School of Medicine.

Navigating the Court and Legal System:

> *I found the court process traumatising: I had little or no support, was often frantically busy looking after my two young children whilst returning to a demanding job from maternity leave. Throughout the months of the court process, I was often re-traumatised and required to re-tell my story of violence on multiple occasions.*
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> *Witnessing our son being physically abused in our own home, which should have been a safe haven was more traumatising than if I had been abused myself. My lawyer advised me to 'downplay' the violence in anticipation that my ex-partner would allege that I was deluded about her violence, in attempting to follow that advice it made it very difficult to answer some of the questions and give examples.*
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> *I felt powerless to advocate for our children's safety and wellbeing, a position further exacerbated by not being able to speak about the physical injury sustained by our son and subsequent mandatory notification to Child Protection. I had no correct path.*

The above account of this family's experience of the Family Court and legal system is described as contributing to the non-violent parent's experience of a 'double jeopardy' position. As she struggled to withhold relevant witness testimony about the violence she had witnessed her ex-partner direct to their son. She makes the following key point;

> *As family violence often occurs in private, behind closed doors, by default, any adult witnesses are usually in a relationship with the perpetrator. Those of us who choose to act protectively must take on an advocate role. Our children are dependent upon us to advocate for their safety. Instead of being empowered to protect our children from violence, and supported to do so, I have felt utterly traumatised, powerless, financially penalised, and futile in my attempts to be a protective parent. I was unable to find GLBTI family violence support groups, accessible for working parents.*

This case study has been written to voice the *lived experience* of a same-sex couple and their children's experience of intimate partner and family violence. This case study is aimed at highlighting the current systemic gaps in the intimate partner and family violence systems in Victoria.

This case study challenges the courts and our legal system. It highlights how these institutions are inadequately structured to respond to families who experience intimate partner and family violence, in particular LBGTIQ families who require a degree of specialist clinical and sector knowledge to ensure any judicial intervention is sensitive to the needs and cultural characteristics of each case.

VAC greatly appreciates this individual's courage in allowing us to use her testimony to show how the intimate partner and family violence sector and the legal system lack the expertise and structures to respond to same sex intimate partner and family violence.

It is submitted with sincere gratitude to this parent and her family for her courage and wish to make a difference, as a direct result of her and her family's involvement with an imperfect family violence service sector and associated legal systems.

Drummond Street Services – Clinical experiences of IPV in the LGBTIQ community

The following provides additional support to the experiences and issues highlighted by the Vcitoraian AIDS Council review of the literature and client presentations.

drummond street services (formerly the Citizens Welfare Service of Victoria) is a 128 year old not for profit organisation mainstream community and family service agency with a forty year history of providing specialised services for Melbourne's Lesbian, Gay Bisexual, Transgender, Intersex, Queer/Questioning (LGBTIQ/Sex and Gender Diverse) or Gender Queer communities.

drummond street has a solid reputation within the LGBTIQ community for providing specialised queer-affirmative counselling services and programs. With over 40 years of queer service provision experience under our belt, **drummond street** has been at the forefront of service development, building clinical expertise, and researching and evaluating the health and wellbeing of Melbourne's LGBTIQ communities. The vast majority of this work continues to be unfunded and unrecognised. This includes:

Counselling and Case Work Services provided by Queer-Identified specialist clinicians – mental health treatment and general counselling, relationship counselling, Sex and Gender Diverse Child and Youth counselling and support program including support for families, and peer support programs for around 300 LGLBTIQ sex and gender diverse individuals and couples per year. Gender Queer/LGBTIQ clients account for around a third of our total client group, and around 16% of our queer client group are young people aged 15-25. The proportion of GLBTI clients attending our service has risen by 15% each year for the past three years.

Family therapy, counselling and mediation for families with a same sex attracted and or gender questioning child and young person.

Gay and Lesbian parenting programs including parenting agreements, separation services, dispute resolution, and parenting education seminars

The first National Gay Dads Forum 2010 in Melbourne, with over 60 Dads participating.

Specialist family violence service for LGBTIQ couples and individuals in relation to intimate partner violence for both victims and perpetrators (responding to Police L17 Fax Backs) – this program is undertaken in partnership with the Victorian Police Family Violence Unit and The Gay and Lesbian Police Liaison Unit each year (and is completely un-funded work).

'Our Health in Our Hands' – we deliver specialist mental health promotion within the queer community to increase mental health literacy, and a LGBTIQ mentoring program to support same sex attracted young people who are alienated from their families.

Education and training for service providers (including Victoria police) in queer-affirmative practice, LGBTIQ intimate partner violence, Specialises clinical work with LGBTIQ adults, gender diverse, and same sex attracted young people, LGBTIQ parenting issues, and assisting mainstream service providers to develop queer-affirmative agency plans.

LGTBIQ community awareness - campaigns to address discrimination and invisibility within the Queer community – "I am campaign" and Queer Bill of Health – Our Health in Our Hands to raise awareness of a range of health issues impacting on the LGBTIQ community including Intimate Partner Violence, the issues impacting on Trans and Gender diverse community and Bisexual Community.

LGBTIQ research - drummond street is at the forefront of research into issues relevant to queer health and wellbeing, and includes:

1) A National Child Support Policy Analysis for LGBTIQ legal recognition of parents on behalf of the Department of Social Services.
2) In partnership with Deakin University **drummond street** has conducted
    a. The LGBTIQ Community Health Perceptions Audit 2010 conducted at the Midsumma festivals explored and highlighted some of the factors which may be impacting on mental health including IPV.
    b. beyondblue – The identification of specific LGBTIQ risk and protective factors for mental illness – data mining of 600 clinical cases project.

Prevalence and Nature of Intimate Partner Violence Counselling Case Presentations

drummond street is able to provide specific data in relation to LGBTI IPV presentations over the past 8 years of clinical service delivery. This is a unique data set for a mainstream service provider across a range of family relationship, general counselling and mental health counselling with specific data for the LGBTIQ community who present at our counselling services. Whilst it may be expected that we would see higher than estimated rates in both whole of population (i.e. mainstream) and LGBTIQ for Intimate Partner Violence in a counselling program (approximately between 26- 35% of all LGBTIQ presentations per annum of average of 250-300 cases), we have been struck by the complexity of these presentations. The following provides a summary of this complexity:

- Whilst national and international research evidences similar rates of IPV for the LGBTIQ community, there is some indications that this may even be more hidden or underreported for transgender and bisexuals in our clinical cohort.
- The nature of IPV in the LGBTIQ community and within the community presents both in the research and our data differently to that of heterosexual IPV – this includes such issues as possibly slightly higher use and or under report of sexual violence (particularly by gay men and Trans) and the use outing as a means of control. Abusive tactics in Queer IPV includes 'outing' or 'revealing' your partner's gender, sexual identity and/or HIV/AIDS status to family, friends, work, teacher, etc
- IPV is mostly viewed and understood using a gender lens which isn't actually useful for assessing or understanding IPV in LGBTI relationships. It views women as the only victims, who are smaller in stature, and only capable of violence self-defence or retaliation.
- IPV assessment is very specialist to understand both sex and gender identity issues and identify victim, perpetrator in relationships where clinically we see high rates of mutual violence. This tends to be common in LGBTIQ couples where both experience or have histories of child abuse, victimisation and bullying, lack of family supports, difficult experiences of coming out or gender affirmation/disclosure and lack of supports. These cases require intensive servicing with comorbid alcohol and other drugs use, poor mental health, isolation, poor employment prosects and insecure housing.
- drummond street services, as the community provider of support for people engaged in the Royal Commission into Institutional Responses to Child Sexual Abuse, has experienced an over representation of LGBTIQ individuals in this service. Whilst this might be because of Drummond streets reputation as a LGBTIQ friendly service, it is of note that this is the first time that many of these individuals have articulated to anyone their abuse and there is strong anecdotal evidence that they believe they were groomed by their victims as they were as children identified as being possibly "gay" or "gender different". It is also of note that all of these LGBTIQ survivors have gone on to experience IPV in their adult relationships and for some, to perpetrate IPV on their partners.
- Issues of reporting for this community are considerable both in terms of a system geared toward heterosexual family violence and therefore lacking appropriate and safe services for LGBTIQ victims and perpetrators and the perception of not being treated fairly.
- There is a significant perception form our LBTIQ client that the LGBTIQ community refuses to accept the prevalence of IPV as an issue in its own community, and therefore forces victims to non-disclose. "It's a small community, no one wants to

hear anything bad about our relationship", means that victims feel they have nowhere to go wether with their family of origin (especially where relationships are already tenuous) or within the LGBTIQ community itself (via their friendship networks).

- Lack of support services such as suitable emergency and longer-term supported accommodation for those with significant issues is considerably more difficult for this community when the tertiary end has been built to respond to heterosexual women victims and male perpetrators. This coupled with the significant number of LGBTIQ clients already presenting with comorbid mental health, alcohol and other drug issues, unmanaged primary health issues, lack of employment options etc. only exacerbates this situation.
- The vast majority of LGBTIQ clients have lived experiences of homo/trans phobia in seeking services. Many of our LGBTIQ clients travel from all over metropolitan Melbourne and Victoria to access drummond street's Queer programs and services. Despite the presence of these complex health and wellbeing issues, LGBTIQ clients report (based on a recent health audit survey (DSS, 2010) significant negative experiences of help seeking to address their health and wellbeing concerns. This included a lack of understanding or appreciation of LGBTIQ issues, instances of direct and indirect discrimination and prejudice by health care professionals, particularly in general practice and the mental health care system, and police. In addition, research is indicating that because of this complexity and experience, LBTIQ clients are voting with their feet by seeking Queer staffed, specialist LGBTIQ services.
- In terms of tertiary funded family violence services, drummond street has at the request of the Victorian Police Family Violence Unit and Gay and Lesbian Liaison Unit delivered training and development activities to mainstream family violence providers as well as Family Violence Police Liaison Officers. The aim of this to assist mainstream workers and police to better understand and meet the needs of LGBTIQ who are victims or perpetrators of Intimate Partner Violence. In addition to this, drummond street has accepted and provided services via L17 police fax backs to numerous LGBTIQ victims. All of this work was unfunded.

Shared Recommendations

The aim of this paper is to better inform the Commissioners about service gaps for members of the LGBTIQ communities who may need to access family violence services in the future; and to advocate, educate and honour the lived experiences of those who struggle to navigate an imperfect system.

Our recommendations are aimed at improving the responsiveness to address LGBTIQ impacted by intimate partner and family.

We make the following recommendations:

1. A defined and specific workforce training and capacity building strategy for LGBTIQ sensitivity practices which includes; the legal profession, counselling professionals, family dispute resolution practitioners, women's refuge staff and the homelessness sector. These professional groups are the most likely to intersect with families experiencing family violence as a result they need to improve their ability to respond to the emotional, psychological and physical needs of families at immediate risk of family violence;

2. It is becoming more evident that the LBTIQ community both require and want LGBTIQ specialist rather than mainstream services to better understand and meet their complex needs. We would argue that the need for LGBTIQ specific support services may well be more effective and provide safety. In addition, specialist clinical services are required in the assessment of IPV in the LGBTIQ community and to provide services which can respond and navigate complex sex and gender identify issues, along with complex health and wellbeing comorbidities. This would include the delivery of Peer Support programs delivered by individuals from the community with lived experience.

3. The development of judicial guidelines addressing same sex intimate partner and family violence. These guidelines would be developed by the Family Court and Children's Courts in consultation with individuals working in the same sex intimate partner and family violence sector. These guidelines would be available to judges in the Family Court and Children's Court who preside over cases involving intimate partner and family violence.

4. The establishment of a partnership between Victoria Police to develop guidelines to inform police members who are involved in alleged cases of intimate partner and family violence amongst same sex relationships and LGBTIQ individuals.

5. The addition of an annual continuing professional development unit aimed at supporting public prosecutors and solicitors and barristers whose practice involves

cases of same sex and LGBTIQ intimate partner and family violence. The structure of this unit would be informed by a reference group that includes senior members of the Victorian Bar Association, the Law Institute of Victoria, the Human Rights Law Centre and selected members of the intimate partner and family violence sector involving same sex relationships and LGBTIQ individuals.

6. Further research into the Australian context of LGBTIQ intimate partner and family violence data. The current data available seems to focus on same-sex partners and is not overly inclusive of the family context, and the needs of LGBTIQ parents and children;

7. A Family Court environment that is more children friendly e.g. inclusive of a childcare centre with highly trained staff who can support children and parents *insitu* at Court hearings;

8. An intimate partner and family violence public health campaign designed to educate the broader public about all family contexts that might experience intimate partner and family violence. This would be designed to break down barriers such as homophobia and minority group stress;

9. Funding for structural settings such as refuges for Lesbian, Gay and Trans Gender or Gender Diverse parents attempting to leave violent relationships.

We are happy to discuss what is outlined in this submission further and provide more detailed responses to specific service issues for the LGBTIQ community.
Yours sincerely,

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To the Royal Commission

RE: SUBMISSION TO THE ROYAL COMMISSION ON FAMILY VIOLENCE

drummond street services welcomes the opportunity to offer its submission to this Royal Commission based on our 128 plus year history of providing support to families, in particular women and children. More recently, over the last decade our focus has been providing prevention and early intervention support to families to reduce risk and promote wellbeing. In addition, our program and service development efforts have included proportionate universalism and the development of targeted interventions for specific at risk sub-populations and communities (refugee and humanitarians and other emerging communities' including the African Australian and Indian Australian communities, and the Sex and Gender Diverse or LGBTIQ community). Our programs and services embed evidence-based interventions for preventing, or reducing the impacts of a range of health and wellbeing issues including family relationship breakdown and family violence; and at the same time enhancing family wellbeing and functioning, parenting competence and confidence to promote positive outcomes for children across multiple health and wellbeing domains.

Despite the increasing prevalence of and knowledge base regarding the effects of family violence on female victims, children and perpetrators, research reveals a lack of successful interventions. Existing interventions and the family violence service system tend to be tertiary in nature, intervening when violence is already serious and entrenched, with relatively poor outcomes for victims (women and children) and relatively ineffective interventions for perpetrators. On average, it can take up to 6-7 years for a woman to leave a violent relationship (UK, Home Office Reports, 2003, 2007, 2012; PDAV, 2003) and family violence is the leading cause of death and disability in women 15-44 years in Victoria (VicHealth, 2006, 2007).

As a family services agency we see every day the impact on children and women's mental health and wellbeing and we share the Victorian government's concerns regarding the prevalence and the enormous social and economic costs associated with family violence.

drummond street is committed to providing and developing evidence-based approaches and conducting research to identify the most effective preventative and early intervention opportunities.

This submission outlines two key research projects undertaking by drummond street to contribute to the evidence-base around effective early intervention and prevention initiatives targeting family violence. These are:

1. **Just Families Project**. Prevention and Early Intervention in family violence risk for couples transitioning to parenthood.
2. **Australian Indian Family Violence Project** – exploring the nature of family violence and barriers to early help seeking in Indian women

Just Families – Family Violence Prevention and Early Intervention in Couples Transitioning to Parenthood

As an agency, drummond street invested in four years' funded research (and further unfunded work) into the prevention of family violence, with a focus on the critical transition point of parenthood, when family violence unfortunately most commonly commences (Pryor, R. and Field, K, 2014, PADV, 2003). This research, using a range of research methods (including focus groups with stakeholders, counselling file audits, and a review of the existing Australian and international research), identified approximately ten early risk factors which commonly arise during pregnancy and the first 12 months of a child's life: as follows:

10 Common Risk Factors for Family Violence in Families Transitioning to Parenthood

1. Relationship Conflict (including Attachment styles)
2. Parenting Issues
3. Mental Health Vulnerability (Parents and Infants)
4. Anger and Violence
5. Problematic Alcohol and Other Drug Use
6. Lack of Support/Isolation
7. Conflicts in relation to extended family/culture
8. Past experiences of abuse or trauma
9. Financial pressures
10. Problematic gender role attitudes

These risk factors co-occur and cumulate to increase risk of family violence over time (as well as other family health risks such as mental ill-health; substance abuse; and child abuse and neglect, all of which have significant impacts on both individual women and children and the wider community in terms of costs of tertiary end services.

Our early intervention model targets population level interventions at the key family life course transition stage (couples transitioning to parenthood) which is one of the highest risk times for onset of a range of health problems including family violence, mental illness, substance use, and negative health outcomes for infants and children. The model seeks to intervene early to build protective factors in couples and families to increase resilience, skills and coping to support future family life course transitions.

The Just Families suite of interventions clearly target family violence prevention and early interventions, and based on partnerships between universal peri-natal services and family service agencies enables a greater, more effective, broader service system response. It does so, with the potential of preventing further escalation of violence within intimate partner relationships and risks to the lives of women through preventative initiatives such as: provision of health promotion, antenatal prevention psycho-education sessions to pregnant and new parents; use of a screening tool to identify vulnerabilities based on the ten early risk factors; and enhanced pathways from universal peri-natal services to a range of early intervention supports provided within family service settings.

The wider service implications based on the research's results could greatly improve service integration and responses connecting universal services, (i.e. Hospitals and Maternal and Child Health Services, General Practitioners and community health) and specialist early intervention services to achieve population level outcomes to reduce violence towards women and children. It is of note that the evidence base, expertise and skill sets required in public health prevention and early intervention programs and practice are quite different from the skills sets that are both required and exist within tertiary end family violence.

In addition, tertiary service are also directed towards providing evidenced-based programs and services targeting victims/survivors or perpetrators. We must not merely look towards the tertiary end (efforts to reduce the impacts of the violence) to have the answers (science or skill sets) for preventing family violence from occurring.

The aims of our research (conducted over 4 years) was the development and evaluation of prevention and early interventions in order to prevent higher numbers of family violence cases rather than a focus on attempting to ameliorate the trauma of living with violence for years and a primary focus on Men's Behaviour Change Groups and recovery programs for women and child victims, essentially "the ambulance at the bottom of the cliff" and way too late not only for the survivors of family violence, including children but also the women who have been murdered by their partners.

Whilst the effort and funding required in tertiary family violence services is enormous, a commitment and investment into effective early intervention initiatives affords the opportunity to target interventions upstream and therefore avoid the enormous human and financial costs of limiting service responses to 'bottom of the cliff' responses.

Research results after four years showed the potential for clear evidenced based approaches for the prevention and early intervention of onset of family violence for couples transitioning to parenthood. This was demonstrated by pre-post outcomes measures indicating:

- significant improvements in family functioning (specifically, conflict and cohesion) and couple relationship functioning;
- significant improvements in parenting skills and parent – baby attachment for both parents
- significant improvements in mental health symptoms, with mental health symptoms found to be at a clinical level (meet criteria for diagnosis) prior to the intervention, and reduced to a population level after intervention.
- Follow up data also showed that outcomes were sustained over a 12 month period.

These results have the potential of thereby reducing the overall prevalence rates of family violence throughout the family life course rather than just at the parenthood transition point. In addition, given the protective capacity of the family and its role in transmitting values and behaviours from one generation to the next, arguably this may also have a positive contribution on diminishing negative community attitudes which are supportive of family violence including child abuse and neglect.

Key prevention and early intervention family violence learnings from this research included an increased awareness of the other family health risks arising during this transition, and known to commonly co-occur with family violence, while the nature of their complex inter-relationships is still not well understood. We also learnt that it was the number and not the nature of adversities that was associated with long-term poor outcomes for children (Roseman and Rodgers, 2004). The evolution of our research has culminated in us broadened our approach to screen for multiple early risk factors, and to intervene with any or all where possible, in order to address the cumulative and interactive effects of multiple co-occurring risk factors in young families. We continued to consider the 'transition to parenthood' as the ideal transition in which to prevent and intervene early, and that the integration of universal peri-natal services within family services is an effective way to maximise the public health impact of existing services.

The development of a program which sits within a universal service and provides a pathway to early intervention for family violence offers a broader service reach for families. Where family violence has occurred, the program has had the added benefit of being able to provide a supported pathway to tertiary end services.

Indian Australian Community Family Violence Project

Within the Victorian community, another promising prevention intervention within the Indian Australian migrant community of Melbourne, involved a partnership between four agencies including Drummond Street Services (Colucci, Pryor, 2014 in Global Mental Health).

The following summary of this research project was incorporated within a chapter on Global Mental Health co-authored by our drummond streets Director of Research – Reima Pryor. The Indian Australian community may be seen as a community 'in transition', with migration offering women potential to gain empowerment, autonomy, and financial independence, and therefore a threat to the traditional patriarchal structure, and associated potential for increase in family violence.

This project used a participatory action research model based on community interactive theatre methods (particularly Forum Theatre) to:

1. explore the nature of family violence, and
2. Identify barriers to help-seeking within the Indian community.

The method, which is fully described in Colucci et al. (2014), comprised three stages: information/focus group sessions, theatre workshops, and community theatre performances. A total of 54 women took part in Phase 1, 12 in Phase 2, and 111 participants (mainly women, one performance was open to a mixed audience) in Phase 3.

Outcomes for this project included:

- contributing to the knowledge and evidence-base in relation to the nature of family violence and barriers to help-seeking within this community;
- individual level impacts on participants' knowledge and attitudes;
- strengthening of women's support networks;
- building awareness of the community level factors, which silence the issue and prevent support for victims,
- raising community cohesion and activism around the issue; and
- identification of culturally appropriate interventions across the spectrum from prevention, early intervention, treatment and recovery.

The tables below summarise the key findings regarding the nature of domestic/family violence in the Indian community (Table 1) and barriers to help-seeking (Table 2).

Nature of Domestic Violence	Participant's quotations
Emotional/Psychological abuse Also described as one of the most common form of violence	*"The worst one"* *"The one that takes longer to heal"*
Excessive control, being dominated, lack of freedom in decision making	*"Initially my own parents try to command me, then my husband, my in laws and later my own children"* *Imposition, also from the in-laws, on how to behave, what to wear ("touch the feet, cover the head"), which work to do.*
Verbal abuse, insults or/and verbal threats (including deportation or visa cancellation)	*"If a man is violent and the woman leaves him, he can get another wife in India and bring her here without a sponsor or PR so that if she complains he sends her back"*
Silence that is expected being maintained	*"The silence kills… I'm listening since 3 generations"*
Be blamed, humiliated and put down in one's self-esteem; not treated with dignity and equality (used as a way of controlling)	*"For everything happening in their lives the woman is blamed, whether they can't find a home, whether the woman does not have a job or whether he has had car accident. And eventually she becomes convinced of that and genuinely believe that it is her fault"* *"He said that he married her so he can have a hot chapatti cooker"*
Unrealistic expectations	*"Expectations get to a point where they are unrealistic and when these expectations became unrealistic they became social abuse, emotional abuse"*
Social abuse Described as the biggest abuse within the Indian community.	*"The fears of the society never make you change the things that are happening in your life".*
Isolate or not allowed to talk to anybody (including having phone and email use 'tapped')	*"He used to go and tell my friends how bad I am like, you know, he used to give a wrong opinion about me and then slowly people stopped coming to me"*

Pressure to be submissive and quite	*"Men keep say: talk softly*
Physical abuse	
Beating, hitting, punching.	*"I'm going to punch her because she doesn't listen, but she's going to listen this (the punch)".*
Sexual abuse Particularly difficult to identify and to disclose	*"It's my husband, he can do it"* *"The girl cannot go and tell to her parents like my husband is demanding me to do oral sex"*
No consensual sex or kind of sexual demands	*"He asks me to do bad stuff which I really don't want to do"*
Forced into sex during their period, when pregnant or unwell	*"So many women are sexually abused, it's quite a common thing in Indian families"*
Financial abuse	
Control of money and/or other of her possessions	*"If the wife is earning, the husband wants to monitor her money and even control the financial resources"*
Non-acceptance of woman's financial independency	*"Since the day you have got a job, seem you have started talking a lot"*
Dowry and other economic pressures	*"My son is in Australia, he has a PR, drives a BMW, you pay this much money to get your daughter there in Australia and your daughter will have to do this for my son"* *"Expectation that all the money they might need to move in Australia and get settle with visa, tickets…etc. should be given by the girl's family because it's for her betterment. But the girl's family might not be capable of giving that much money and then the emotional abuse starts"*
Spiritual/Religious abuse	
Not let her go to the temple, not let her pray, not let her cook food to offer to God.	*"She is coming from a very religious family and he would not let her go to the temple because of the controlling behaviour"* *"He does not let me cook good food to offer to God because he has adapted too much to the Western culture"*

Table 1 Summary of themes and sub-themes emerged about the nature of DV

Table 2 Barriers to help-seeking

Barriers to help	**Participants' quotations**	**Participants' suggestions**
Generic barriers		
Acceptance of inequality and violence against women	*"When a girl child is born in India, the man is head of the family and she always told that girls should be submissive and not argue"* *"Even a father when you are getting married says you should manage to fit in wherever you go into"*	Empower the community to break the silence and assist the woman in seeking help, and providing "good role models in Indian women" able to challenge the expectation of silence and submission: *"So the need of the hour is to start this new idea to propagate that your daughters are not supposed to submit to whatever has been told to them"* *"It is not considered healthy to ask for help in Indian society (…) if you are going and seeking help means you are sick. So it needs to be changed"* *"All we can do is empowering them by telling them that they are good and by giving them positive feedback but eventually the decision has to be hers"* *"The first step is that we say as a community that it is okay to talk about it. If my husband hits me it's not my fault".*
Expectation that a woman will **maintain silence** in such situations	*"The best strategy in any situation for an Indian woman is to keep quiet and maintain the silence and suffer"* *"It is considered not right to tell people that you're having violence in the house"*	
Social stigma towards a woman victim of violence	*"People don't want to be associate with a woman who has put herself in that situation"*	
Fear for the possible consequences of the disclosure: - be blamed - be re-victimised - regretting the effects	*"women are getting abused physically and emotionally and the whole blame is put on them. And the lady can't go anywhere, they are so scared"* *"People say there must be something wrong with her, that is why the husband is beating her"* *"If a woman asks help, the police gets involved and they ask her to leave the house, but leaving the house is not necessarily the solution she wants".* *"You don't tell much to your family because you don't want to hurt them"* *"If you chose to leave what will be of children".*	

- consequences to the others - on their immigration status/deportation - not to be believed and find understanding in others - fear of being isolated	*"He was so violent (…) he took me back to India and cancelled my visa (…). I wrote to immigration about all [that] happened to me and they revoked the cancellation (…) but I have no clues about Australian laws"* *"But the person* [husband] *is not that bad"* *"People don't want to be associated with a woman who has put herself in the situation"*	
Lack of freedom and dependency	*"My phone was trapped, each conversation I took and each email I sent was trapped".* *"I couldn't talk with anyone, I never was given a money to talk to anyone"*	
Lack of evidence	"*In Australia the domestic violence is only called when you are physically beaten up but that didn't happen to me. so I couldn't prove it that it is domestic violence*"	Give migrant women, especially at arrival, the correct information about their rights and laws available in the host country. *"If the community is given awareness then they can advise the victim to see a GP, a psychologist or a counsellor"* *"Freedom will come with knowledge, education, know what's fair and not fair, what is your right"*
Lack of violence **awareness**, lack of **information** and **knowledge** about laws and their rights	*"You don't realize you have been affected (…) you haven't been brought up that [emotional abuse] is domestic violence. It's just that these are not clearly defined"* *"Women need to be aware that if they do seek an intervention, it is generally the perpetrator of the violence who is asked to leave the home"*	

Barriers specific to services		
Cultural background of the professional	*"If it took me 5 minutes to explain my name, how long is this person (talking about services) going to take even with my first problem"*	Professional from Indian background would be better equipped because of the shared understanding of the culture, easiness to establish a relationship and knowledge of the language: *"(..) she can surely better understand rather than an Australian counsellor because Australian culture is different from our culture"* In some instances, advantages were highlighted also in regard to workers who do not belong to the same cultural communities, but are culturally responsive.
Cultural sensitiveness of the intervention provided by services	*"Go too fast", expect them to do "too big steps"* *Leaving the husband is not a culturally appropriate answer to DV. Although this is a "solution" that Australian people or services can propose, that's not possible for an Indian "is not the Indian way"*	
Lack of knowledge about services: what, where and how to access them	*"The biggest barrier to seeking help is that people don't know who to tell"* *"they [migrant women] feel very isolated and don't know who to go to and what help is available."*	Educating community members about services and access to services:*"People go to services when they are really desperate, before that the help must come from the community. Even just one person in the community who knows where to go, will at least give some hope."*
Kind of help provided	*"[Leaving the husband] is not the Indian way (…), they will cut you out if you did that"*	Some typologies of help were seen positively such as violence prevention and outreach programs, activities aimed to women's empowerment, helplines and community groups such as self-help groups: *"If information was disseminated at prominent point, like you did not have to go and ask someone but the information was just there like at the GP's, community organisations and you could just pick up the leaflets and keep it, I think that would be helpful."* *"Helping someone in the community who is trained to helping those people"*
Bureaucratic barriers as lengthy waiting lists, assessment and consent forms	*"Signing forms is frightening especially if you are a migrant"* *"(..)the paper work came in between and she just wanted to speak to a human being without all these paper works on the table"*	Explain the use of the information collected and the circumstances where the confidentiality might be broken, and do so only when the person has established some engagement with the worker: *"After the victim is engaged and gains confidence that is when you say okay by the way we need to sign this form. But you need to gain that trust first"*.
Confidentiality, **privacy** and **trust** in the services	*"She has fear to disclose anything on the paper because she think*	Assure confidentiality and build trust: *"She has to know that there is someone she can talk to where confidentiality will be maintained."*

	that this might go to her husband".	
Social stigma towards mental health service	*"The immediate answer as why do you want to go to Dr. X, I know her, she is a psychiatrist, what is wrong with you?!"*	Challenge the stigma: *"Counsellors are not a big deal, they are not a disease, and rather they are just people with whom you can share your problems, open your heart out. It is very important to spread out this information to the community".*
Migration-related barriers (see also fear of deportation above)	*"When people come to Australia they are so isolated so they keep in everything until it blows up. Then they can look for extreme solutions, like killing themselves"*	Education, awareness

This unique culturally-specific approach yielded unique learnings in relation to understanding the prevalence and nature of family violence within the Indian Australian community and the significant barriers and impediments to these women getting the support they needed. It also provided rich suggestions from these women in terms of what needed to change in order to increase help-seeking.

Summary Recommendations

These projects highlight the value and importance of building our understanding and evidence-base of prevention and early intervention for family violence (particularly as it relates to specific sup-populations).

One frustration is that most funding for prevention initiatives tends to come from different levels of government as one off/fixed term project funding, or from philanthropy. It is very difficult to get these efforts scaled up or integrated within mainstream service systems which tend to be siloed or issues specific (mental health, or peri-natal services for mothers and infants) or tertiary in nature (family violence, alcohol or other drug).

We would strongly recommend to the Royal Commission into Family Violence that in order to prevent and reduce family violence we need:

- Increased investment in both building the evidence-base of prevention and early intervention models, programs and practice, and this requires a public health scientific-led approach which seeks and requires involvement across sectors and disciplines.
- To build on and scale up existing Australian-based research efforts in prevention and early intervention which include a focus on reducing multiple risks early, and early in life.
- A specific investment in targeted approaches to specific at-risk sub-populations rather than a one size fits all approach to either understanding, preventing or indeed responding to, family violence.

I am happy to discuss what is outlined in this submission further, specifically the import of early intervention and prevention opportunities at critical transition times for women and children.

Yours sincerely

Karen Field
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[redacted]

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