LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY
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Inquiry into Domestic and Family Violence—Policy approaches and responses

Submission No. 5
Toora Women Inc

Received by Committee Support Office: 19 September 2017

Authorised for publication: 8 November 2017

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ALCOHOL AND OTHER DRUGS | HOMELESSNESS | DOMESTIC VIOLENCE

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September 2017

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1. About Toora Women Incorporated

Toora Women Inc. (Toora) welcomes the opportunity to make a submission to the inquiry into Domestic Violence and Family Violence – Policy approaches and responses in the ACT by the Standing Committee on Justice and Community Safety.

As the largest domestic violence and homelessness residential and outreach service for women in the ACT, Toora takes a special interest in strong and consistent policy approaches that improve the safety and well-being of women and children experiencing domestic and family violence (DFV) and in the reduction and prevention of the incidence of harm.

As reflected in our mission statement *"Safety, Respect and Choice for Women"*, Toora has a unique role and responsibility to support, empower and advocate for the vulnerable women accessing our services.

Drawing from over 35 years of experience, we provide specialist support in the areas of domestic violence (DV), homelessness and alcohol and other drug services (AOD) to women. Our programs provide a variety of services, including crisis and transitional accommodation, day programs, counselling and outreach support. This broad range of services means that we are in a position to respond to the range of needs of women and children through an integrated system. Our activities in relation to women and children affected by DFV are based on a Trauma-informed care model and include, but are not limited to:

- Providing specialist DFV support for women and their children (0-16), including through advocacy, referral and support which may include safety planning, accessing legal orders and budgeting
- Outreach support to women who are not ready to leave a violent relationship
- Providing support to women and their children who are experiencing difficulties in maintaining their independent living
- Providing information to women and their children and promoting their participation in community activities
- Providing DV and sexual violence counselling.

Further information about our organisation can be found on our official website: www.toora.org.au.

2. Opening remarks

Approaches to tackling DFV have evolved and adapted over decades in response to the changing needs and growing demand of women and children experiencing DFV. As community awareness about DFV increases, so do the pressures on the system to provide safety and improved support for those experiencing it.

Our data indicates that our services for DFV-related matters are increasingly in demand. Our Toora House Supported Accommodation program provides residential and outreach support for women who are homeless due to a variety of issues. In 2013-14, in our residential support service 35% of clients cited DFV as the main reason for accessing this program. This number doubled in 2016-17 to 75.4%. A similar increase in DFV as the reason to access our services can be seen for outreach support service. In 2013-14, 11.3% of clients who used this service cited DFV as the main reason and this number increased significantly to 60.1% in 2016-17.

Given our limited resources, all this has come at a cost. While our Toora House Supported Accommodation program is set up to provide services to all eligible homeless women in need, the increased referrals for women escaping DFV at home has resulted in difficulties to accommodate women who are homeless for a different reason than DFV.

It is without doubt that the increase in women who are affected by DFV accessing these services is due to the efforts of the government and frontline services to raise awareness that DFV is not a private issue but a crime. However, the abovementioned numbers remind us that DFV in Australia is a serious social problem and there is much still to be done in relation to strengthening our policies and practice.

We welcome the increased investment through the ACT package announced last year in preventing and addressing domestic and family violence from all levels of government. Much has been achieved in this past year, however service delivery gaps remain. We look forward to additional investment to increase the support for frontline services to relieve the pressure on our programs.

3. Approaches for a better policy and practice

We are supportive of the action items and priorities as identified in the Third Action Plan 2016-2019. We would like to share a number of the current challenges and best practice strategies in relation to these priorities that are most relevant to our clients, and likely also the wider community.

This submission makes the case that to be fully effective, community responses and support for women and children need to take into account the complexity of women's DFV issues and apply a service model that removes barriers between services.

In addition to a holistic service delivery approach, it is also important that community services' ability to address the long-term impacts of DFV is strengthened. For this reason, we work with the women beyond the initial crisis to source long-term housing, re-connect them with the community, build their self-confidence and support them in addressing mental health issues and their experienced trauma. This improves the chances that these women can build their independent living skills and are not stuck in a circle of violence.

We are aware of a number of gaps, barriers and concerns about the ways the DFV system responds to the safety and long-term well-being of women and children and would like to share our analysis below.

3.1 A barrier-free and holistic service response to address DFV

We are pleased to see an increasing number of initiatives from government and non-government agencies aimed at integrating responses to DFV. We think it is critical to further strengthen our community knowledge on the linkages between alcohol and drug abuse and DFV and to create a better dialogue between service providers and stakeholders from the AOD and DV sector. Therefore, we strongly support initiatives such as the ATODA project 'Promoting Safety and Prioritising Domestic and Family Violence in the ACT Alcohol and Other Drug Sector'.

Alcohol and drug abuse have been identified as one of the main risk factors associated with DFV. National and state-level data shows that DFV is more common and victim's injuries are more severe when substance use is involved. Moreover, the risk of children being abused, neglected or harmed increases when alcohol is involved. For every adult seeking AOD treatment, there is generally one child impacted by problematic parental AOD use (1). Addressing DFV within the AOD sector is also likely to minimise the risk of abuse, harm and trauma to client's children. (1)

Both the ACT Review of Domestic and Family Violence Deaths Public Report 2016 and the NSW Domestic Violence Death Review Team Annual Report 2013-2015 highlight that alcohol abuse is also strongly linked to DFV homicides. For example, the NSW Domestic Violence Death Review Team Annual Report 2013-2015 shows that 50% of all DFV abusers were using alcohol at the time of the fatal episode (2). These numbers highlight the clear need to tackle both AOD and DFV issues in an integrated manner.

Moreover, the high prevalence of AOD clients who have experienced DFV stresses the need for holistic services. In our experience from providing AOD health treatment services for women, we know that nearly 80% of the clients in this service have experienced DFV.[1]

Given the complex comorbid issues of our clients and inspired by the 2016 ACT Domestic Violence Service Final Gap Analysis Report, we have developed and implemented a holistic approach that is critical to respond to the range of needs of women affected by DFV. Our **'One Toora Approach'** removes the barriers between our DFV, homelessness and AOD services and includes an innovative referral pathway within our in-house programs. This allows us to provide a holistic wrap-around approach for women. This has improved access to and coordination among the range of support needs of women. For example, women in AOD service who are victims of DFV have had a higher level of DV specialist support including improved safety planning and successful domestic violence orders.

Based on our positive experience in implementing an integrated service delivery model internally, we recommend that community efforts are not limited to promoting integrated systems externally among service providers. An internal integrated service model which offers support directly to a woman rather than referring her elsewhere has proven critical to respond to the diverse experiences and needs of women affected by DFV.

3.2 Specialised responses to the diversity of women experiencing DFV

Aboriginal and Torres Strait Islander

Aboriginal and Torres Strait Islander people are particularly vulnerable to a range of disadvantages as their lives have been shaped by a history of colonisation, loss of cultural identity, dispossession of land and the structural violence that stemmed from past legislative processes and social policies (4).

National data indicates that there are higher rates of DFV and sexual assault in Aboriginal and Torres Strait Islander communities (5). Many Aboriginal and Torres Strait Islander suffering from the effects of trauma caused by DFV turn to drugs and alcohol in the absence of a specialist care.

Due to their cultural and socio-economic challenges, the use of alcohol and drugs are also often more pronounced and complex among Aboriginal and Torres Strait Islanders. In 2009-10, 13% publicly funded AOD treatment episodes in Australia involved clients who identified as being Aboriginal and Torres Strait Islander origin (1). Our internal 2015-16 data indicates that this figure was 16%.

High numbers of Aboriginal DFV victims also continue to be killed at disproportionate rates compared to non-Aboriginal victims. Studies have revealed that the overwhelming majority (87%) of Aboriginal intimate-partner homicides were alcohol related (5). We are very concerned in relation to the overrepresentation of Aboriginal women.

[1] These numbers at the high end of US research may be due to the fact that highly traumatised women choose to attend a women-only service where possible. (3)

In our experience, many Aboriginal and Torres Strait Island clients have not sought assistance when facing DFV. This is often driven by a fear of being ostracised by their community by reporting their situation to the police and involving child protection. Anecdotally, we have been told by Aboriginal and Torres Strait Islanders clients that they do not always want to be supported by indigenous services due to concerns of confidentiality. In view of this, we consider that non-indigenous service providers have an important role to play in support of Aboriginal and Torres Strait Islander women affected by DFV.

As indigenous groups face more challenges compared to other groups in society, we consider it important to provide a specialised response to Aboriginal and Torres Strait Island women. In view of their special support needs, we strongly recommend that the ACT government works towards increasing the capacity of non-indigenous services. For example, we believe that community programs would greatly benefit from a designated Aboriginal Liaison Officer to provide more culturally appropriate services to indigenous clients.

Women from culturally and linguistically diverse background (CALD)

DFV is a complex issue that requires tailored approaches to address different needs of different communities, including for women from culturally and linguistically diverse backgrounds (CALD). We would like to acknowledge the commitment and strong efforts of the ACT Government to support multicultural communities and to deliver effective services to CALD people in the ACT. We are very pleased to see the achievements over the past years in relation to developing and implementing new frameworks and strategies to enhance service responses and approaches to CALD communities.

We experience that CALD women need extra support to navigate through the system, as they often face immense difficulties, including a lack of social networks, language barriers, socio-economic disadvantage, and a lack of knowledge of their rights and Australia's laws. In view of the specialised support that is required for these women, we are very supportive of the government funded interpreter services. These services have significantly increased the capacity of community services to assist women from CALD background.

In this regard, it is important to note that a high percentage of our DFV clients are from a CALD background. Over the past year, we have seen an increased number of CALD women in need of our services, but who have not had appropriate visas to access social government funds and don't have any other income source. As a result, they are not able to contribute to rent payments while staying with us. While we seek to assist any eligible woman with DFV issues, this has put us under financial strain.

We observe that many CALD women have limited knowledge of their rights as Australian residents. Furthermore, cultural differences mean that there is often a false understanding that DFV only refers to physical abuse and does not include other forms of abuse, including financial abuse, controlling tactics or monitoring everyday activities, which is prevalent as a result of changing technology.

A consistent finding of both the 2009 and 2013 National Community Attitudes towards Violence Against Women Survey (NCAS) developed by VicHealth is that people from CALD communities were substantially more likely than the Australian-born people to a) excuse violence against women in certain circumstances; for example if the violent person is under stress; b) to believe that women who are sexually harassed should sort things out themselves; c) to privilege family privacy and 'keeping the family together' over women's right to safety and d) to transfer responsibility for violence from the perpetrator to the victim (6).

In view of the lower level of understanding of the nature of violence against women and lower level of support for gender equality in CALD communities, we see a need for more initiatives around building respect in relationships and to raise awareness of exactly what constitutes DFV.

To increase the level of awareness and understanding of violence against women in our community, we decided to develop and implement a new program in partnership with EveryMan Australia. As part of our 'Building Respectful Families' program, we envisage to work with couples including CALD couples to address controlling tactics in their relationship and to address factors contributing to abusive relationships at an early stage. This 12-week program provides coordinated gendered service delivery to couples needing support to reconfigure patterns of family violence to move towards more respectful relationships. It is still early days, but have seen positive outcomes for the couples during our pilot program such as a better awareness of signs of DFV and the recognition that they are living in an abusive relationship. Recognising abuse is the first step to getting help and to end a complex cycle of violence. Please refer to section 3.6 of this submission for further explanation on this matter.

As stated in the ACT Prevention of Violence Against Women and Children Strategy 2011–2017, we agree that more needs to be done in relation to DFV prevention. We think it not only important to deal with victims who have experienced DFV, but also to take preventative steps to prevent violence. Moving forward, we suggest providing more funding to educational activities around DFV to reach the general public and in particular the CALD communities. To achieve this, we need more innovative and formal partnerships and multi-agency collaboration to develop and implement tailored activities to CALD groups.

3.3 Responding to children affected by DFV

The Family Violence Protection Act 2016 recognises the serious and long-term impact that DFV can have on children. The Act clearly outlines the agreed understanding that DFV can have a serious impact on children's current and future physical, psychological and emotional wellbeing.

Research has established that DFV often co-occurs with child abuse including child sexual abuse (7). We are aware that children may have suffered from multiple forms of harm and acknowledge that most children are victims of complex trauma.

Reflecting this understanding, in August 2016 our services were adapted to allow us to provide support to children (aged 0-16 years) within our Toora Domestic Violence and Homelessness Services (TDVHS). To give you an indication, over the past 6 months Toora has provided services to 120 children staying at our Toora Domestic Violence and Homelessness Service.

However, under the current funding model, children are not considered clients, but dependants. As a result, we do not receive any funding for children. This means that even though we are providing additional services to vulnerable children we do not receive any additional funding. Consequently, our programs are placed under additional financial strain.

In view of this gap in the funding model, we strongly recommend reviewing the resource allocation for frontline services working with women and their accompanying children. This is so they are appropriately resourced to develop and implement programs where children can feel physically and emotionally safe and account for trauma-informed practices. This would improve the level of support to children within services and mitigate the risk of re-traumatisation.

Further, we often observe how DFV effects the ability to be an effective parent. The mother-child relationship needs special attention in a post DFV situation. We consider that this requires professional counselling for both the woman and her child.

In view of this, we see value in creating Specialist Children's Trauma Counselling positions in DFV services to provide care and support to children.

3.4 Trauma-informed Counselling as post-crisis response

DFV has serious negative impacts on the victim's mental health. We acknowledge the great work of counselling services such as the Women's Health Service in providing gender-specialist counselling services to vulnerable women in the ACT. However, demand is high and waiting lists are long. Given the difficulties that our clients faced in accessing specialist, affordable and timely counselling, we launched our own Toora Counselling Service. This service specialises in both AOD and DFV counselling.

Since launching our in-house counselling service in 2015, we have provided counselling to 119 clients working within a trauma-informed care model.

Our data indicates that at least 30% of our clients who access our counselling service mention DFV as the primary issue. While the impacts of DFV are complex and long-lasting, our data tells us that we have achieved a range of positive outcomes for our clients such as improved motivation for change, better communication skills, better self-awareness and improved relationships with the family and social environment.

Despite these clear benefits of counselling for DFV affected women, at this moment in time, we are limited to provide these services as we do not receive any domestic violence funding to run the counselling service. Our current appointments each week do not nearly meet our experienced demand. To be able to see more clients, our counsellors are currently running a trauma group with our clients rather than having one-on-one appointments.

Moving forward, we propose that funding is increased for DFV Trauma counselling services in the ACT that account for gender-specific responses.

3.5 Measuring outcomes

In order to provide effective services to the community, frontline services need to implement a needs-based service delivery model that takes into account the individual needs of a women affected by DFV. Each woman faces her own specific challenges, needs and will achieve different outcomes along her journey. We would like to stress that a 'successful' outcome greatly differs for each individual.

When measuring outcomes for women and children affected by DFV, it is important to understand a variety of concepts, including the cycle of violence. The cycle of violence often makes it difficult for women to permanently leave domestic violence and abusive relationships. On average, a woman will leave an abusive relationship seven times before she permanently leaves. For one woman, a 'successful outcome' could mean that she is better able to handle everyday situations and can return to her relationship with a safety plan in place for reducing the risk of further abuse. For another woman, a 'successful' outcomes could mean that her increased knowledge about DFV that she has learned to stand up for herself and is ready to leave her relationship.

This means that two different outcomes can be still considered 'successful'. Therefore, it is important that any evaluation system is not simplistic. The outcome methodology need to take into account the variety of forms that success can be.

The continuing challenge for frontline services to meet increasing demand without the appropriate funding remains. An increase of referrals, without additional funding, means for our service delivery that we have less time to spend with a client. As a result, we are concerned that we will achieve less outcomes for women and children at our services.

3.6 DFV and Homelessness

We strongly support the recent transfer of the Coordinator-General for Family Safety formerly based within the Justice and Community Safety Directorate. Even though DFV is against the law and requires a legal response, it is important to note that while most DFV victims want justice, the vision of justice that is embodied by the legal system can often be different in nature from the victim's perspective. Many DFV victim do not pursue a legal response, thus a legal pathway can be perceived as a barrier by the victim. Additionally, we consider the transfer of the Coordinator-General to the Community Services Directorate highlights the strong link between DFV and Homelessness.

Across Australia, escaping domestic or sexual violence remains a leading cause of homelessness (8). Escaping DFV or sexual violence is cited as the main reason for seeking assistance from homelessness services in the ACT by 42% of women with children and 47.7% of single women (4).

However, many women feel ashamed talking about the violence they experience when they initially enter our services. We have found that women often cite 'financial issues' 'interpersonal relationship issues' or 'family break down' as the initial main reason for assistance, while the underlying reason is often DFV. It is not until we have built a relationship of trust with these women that we learn from them about controlling behaviours in their relationships which have led the women to flee their homes.

This suggests that we need to be careful when looking at DFV statistics as they often don't reveal the whole picture. There are many hidden victims of DFV in homelessness services, as well as AOD and mental health services. This becomes especially problematic when services have a lack of understanding around DFV and how to appropriately support the victim. As highlighted in the 2016 ACT Domestic Violence Service Final Gap Analysis Report, only 23% of the surveyed frontline workers indicated that they felt 'very well-equipped' to deal with clients who had experienced DFV (9).

Moving forward, we recommend investing more in education and training across non-specialist services to strengthen the knowledge of frontline workers to identify and better support victims.

4. Next steps

We make the following recommendations for strengthening our ACT policy approach to reduce and prevent violence against women and children:

Recommendation 1: Determine a budget for specialist DFV frontline services that appropriately reflects demands and outputs of service delivery. The resource allocation must be transparent in its distribution and allocation and linked to outcome measures based on best practice approaches that account for the safety and recovery of DFV victims.

Recommendation 2: Explore strategies to promote integrated models within frontline services to offer direct support to a woman to respond to the diverse experiences and needs of women affected by DFV. Efforts should not be limited to promoting integrated systems externally among service providers.

Recommendation 3: Promote early prevention community partnerships and programs across sectors and settings, noting that service providers need to work with both women and men to educate them about the forms of DFV abuse. As the levels of awareness and understanding of violence against women is lower in some CALD communities.

Recommendation 4: Continue to resource the DFV sector to provide specialised culturally specific support services to meet the diverse needs of women from diverse communities. This could be achieved through specifically trained, culturally sensitive specialist workers such as designated Aboriginal Liaison Officers.

Recommendation 5: Provide adequate funding to address complex trauma in children affected by DFV, including for the development and implementation of tailored programs for children in crisis accommodation.

Recommendation 7: Promote the creation of a Specialist Children's Trauma Counsellor positions to work within DFV services.

Recommendation 6: Increase resources to specialist gendered services to provide DFV Trauma Counselling in the ACT to mitigate the longer-term impacts of DFV on women and men.

Recommendation 8: Develop outcome measures in consultation with the frontline services to ensure that outcomes measures take into account the various forms that 'success' for a DFV client can be.

Recommendation 9: Allocate resources to invest more in DV education and training across non-specialist services to strengthen the knowledge of frontline workers to recognise and better support victims of DFV.

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