DVCONNECT
Be heard. Be safe.

DVConnect Submission to
The Queensland Parliament Mental Health Select Committee
Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Date of Submission	4 February 2022

DVConnect respectfully acknowledges and celebrates the Traditional Owners/Custodians throughout Australia and pays its respects to Elders, children and young people of past, current and future generations. We are committed to helping anyone experiencing domestic, family and/or sexual violence. This includes the LGBTIQ+ community, people of all ethnicities, religions, ages, abilities and pets.

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DVConnect receive funding from the Queensland Government.

About DVConnect

DVConnect was established in 1980 and is Queensland's state-wide crisis response service for domestic, family and sexual violence. DVConnect helps Queenslanders find pathways to safety 24 hours a day, 7 days per week. Annually, DVConnect takes in excess of 100,000 calls across all lines and provides crisis intervention across a number of key services. Womensline receives one call for help every five minutes (across a 24 hour period). Crisis support is provided in the form of emergency telephone support, emergency crisis accommodation placement and transport for families affected by abusive relationship, counselling for men, women and victims of sexual assault, education and support for men, community education, and care for pets of families experiencing domestic and family violence. DVConnect also operates Bella's Sanctuary a 5-unit medium-term accommodation residence that exists to provide women and children with a safe housing option after leaving a shelter/refuge. We are a not-for-profit organisation, predominantly funded by the Department of Justice and Attorney General, Office for Women and Violence Prevention.

DVConnect are a partner agency for Australia's national sexual assault, domestic and family violence support service, 1800RESPECT. This service provides information, referral and counselling 24 hours a day, 7 days per week. DVConnect's 1800RESPECT services are delivered in partnership with Medibank Health Solutions on behalf of the Australian Government as part of the National Plan to Reduce Violence against Women and their Children, 2010-2022. DVConnect have recently been successful in a tender to provide this service nationally from 1 July 2022 for the next 5 years, alongside Telstra Health.

DVConnect operates from an intersectional feminist framework, acknowledging that domestic, family and sexual violence (DFSV) is gender-based violence. This gendered analysis is supported by research, evidence and data, and indicates that DFSV is most often perpetrated by men against women, and that perpetrators of this violence are fully responsible for their actions. This framework acknowledges and responds to the intersectional experience of DFSV.

The clinical services provided by DVConnect are inclusive and trauma-informed. We are guided by the diverse voices of survivors and recognise our clients as the expert in their own lives. The abilities, strengths, goals and needs of people living with disability are respected, as for individuals from culturally and linguistically diverse backgrounds. DVConnect acknowledge that Aboriginal and Torres Strait Islander people know best what their communities need and want. Importantly, the intersectional approach of DVConnect considers and responds to how overlapping forms of discrimination may impact a client's experience of DFSV.

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1. Opening Statement

DFSV is one of the most prevalent, pervasive, and serious human rights violations. It is recognised as a major health and wellbeing issue in Australia, with one in six women experiencing physical or sexual violence by a current or former partner by the age of 15[1]. The link between domestic and family violence (DFV)[a] and negative health impacts, including poor mental health and mental illness are well-known[2,3]. These impacts are numerous, including:

- how DFV can cause, exacerbate and interfere with mental health experience and presentation;
- how DFV impacts women's, men's and children's presentation, circumstance and behaviours impacting on mental health assessments, treatments and support;
- how poor system integration and lack of education and training can result in siloed and inadequate experiences; and
- the experience of DFV causing significant impacts on individual and family wellbeing including mental health, thereby increasing pressure on the health system.

Barriers exist at systems, community, and individual levels for women with a mental illness who are impacted by DFV. These challenges are further exacerbated in regional and remote areas, for women with comorbidities, those with a disability, First Nation's women, women from culturally and linguistically diverse (CALD) backgrounds, and from the LGBTIQ+ community. These identities, along with a woman's socioeconomic status and her age can overlap and intersect to shape experiences of discrimination and inequity. In a DFV service delivery context, recognition and consideration of intersectionality is vital for informing effective and safe trauma-informed care[4]. The variety of mental health and psychological approaches available, such as biological or cognitive perspectives, may not complement a trauma-informed DFV model which can be problematic for meeting a client's multiple needs. The levels of holistic wellbeing and safety a woman experiences are influenced by numerous factors that are often addressed in isolation, despite their inextricable interactions.

At a systems level**,** challenges such as service fragmentation, criminal justice system involvement, availability of appropriate referral pathways, access to specialist services, and recognition of the complex interplay between DFV and poor mental health are widespread. Community level attitudes and perceptions of a woman experiencing DFV are varied and can be influenced by a range of biases (both conscious and unconscious). These factors are often static and entrenched, requiring a whole of community approach to address. Individual level influences can be cumulative, episodic, isolated and non-modifiable. They frequently span multiple areas related to the social determinants of health as well as violations of human rights. What makes the nexus of these three levels (systems, community, individual) so complex from a policy and service delivery perspective is the identification of, and acknowledgement that there are likely to be multiple priorities requiring attention.

The presence of a mental illness is a significant vulnerability for how DFV is experienced by a woman, and potentially exploited by the person in her life using violence. For example, prohibiting help seeking behaviour, preventing medication compliance or using it coercively, self-medication, and subjecting her to gaslighting behaviour. Inherent challenges exist for individuals and service providers in navigating risk, assessment, and service responses that can effectively respond to the needs of a woman experiencing DFV and mental illness. The immediate, longer term, and sometimes competing needs add additional complexity requiring specialist services and interagency collaboration.

[a] DVConnect support DFSV victims/survivors, however DFV is hereafter referred to in this submission to match the cited literature and government documentation.

There is significant overlap between poor mental health and people who use violence (PUV). This intersection effects the PUV, and, most importantly those who are impacted by their use of violence. A considerable proportion of men who use violence have complex trauma backgrounds (see Section 3.2). Whilst poor mental health can interfere with and exacerbate the use of violence in the home, it is not the cause of that person choosing to use violence. However, failure to address intersecting mental health issues limits the ability of perpetrator interventions to be effective in reducing the use of violence. Conversely, addressing complex trauma without holding men accountable for their use of violence colludes and permits violent behaviour, resulting in increased risk of harm for women and children.

It is essential to acknowledge that the responsibility for stopping violence against women and children sits with the person choosing to use it. It is preventable. Like other social and public health issues, a whole-of-system, government and community approach is needed to help address perpetrator actions, responses and needs. The causes and exacerbators of mental illness are multi-faceted, with psychosocial influences from DFV and related factors clearly aligned. For the purpose of this submission, DVConnect largely focuses their response on the experiences of women impacted by DFV who have a mental illness (suspected or confirmed diagnosis), with reference to PUVs in the context of how this interacts with the mental health and DFV response to victims/survivors. It is acknowledged that the nuanced differences in mental health and DFV needs for victims/survivors and PUVs are too complex to adequately articulate within the scope of this submission. As such, the primary focus is commensurate with the representation of women as victims/survivors of DFV and their needs with respect to mental illness and DFV prevention and support.

An overview of relevant policy will be provided to contextualise state government actions, plans and priorities relevant to the submission. Systems, community and individual level considerations will be expanded upon, with reference to where the levels can and often intersect. There is cross-over of content in each of the three levels, and information has been organised and included in the most relevant section of the document. The content is reflective of DVConnect's purpose of creating pathways for a life free from violence and fear, and therefore has a DFV lens on mental health as experienced by women impacted by DFV. The aim of this submission is to contribute an underrepresented voice to the Mental Health Select Committee's Inquiry. Specifically, sections 1. (b) (c) (C a.) (C b.) (e) of the Terms of reference.

2. Policy context

Queensland's Domestic and Family Violence Prevention Strategy 2016-2026 is the government's response to the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* 2015 report. This strategy underpins the state's approach for government and community DFV services. *Shifting Minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023* is the state's whole-of-person, whole-of-community and whole-of-government approach for improving the mental health and wellbeing of Queenslanders. Both strategies make reference to the interwoven policy and service ecosystems in place to improve outcomes for individuals experiencing DFV and/or mental illness.

The overlap between the policy and service delivery frameworks in place to keep women safe and healthy with respect to DFV and mental illness does not arguably translate into comprehensive and integrated care. The negative impacts of service fragmentation for women experiencing DFV and mental illness are well-documented, with a lack of shared definitions about what constitutes effective service integration compounding the problem[5]. Inconsistency in data classifications used to inform policy and practice is a further issue as the lack of standardised data makes it difficult to assess the true burden at individual and population levels. A foundation of shared definitions and accurate data is essential for evidence-driven policy that targets DFV prevention at early intervention, crisis and recovery-focused stages to achieve immediate and longer-term benefits. **In addition to DFV and mental health policy focused on the needs of women and children, the importance of perpetrator behaviour change policy for DFV interventions and support cannot be underestimated.**

2.1 Domestic and family violence services Practice principles, standards and guidance

The current iteration of Domestic and family violence services Practice principles, standards and guidance have been in place since January 2021 and apply to the broad range of DFV services working with victims/survivors and perpetrators. The practice standards provide a comprehensive and evidence-based framework for funded services. It is relevant to make reference to them in this submission as they can also be applied by other agencies to enhance their DFV services, such as police and mental health services. In particular, Standards:

7.1 Working with other domestic and family service providers; and

7.2 Working with organisations outside the service system.

2.2 Hear her voice report

The Hear her voice (HHV) report[7] released by the Women's Safety and Justice Taskforce in late 2021 is the first in a series of reports part of a four-phase plan in preparation for the introduction of coercive control legislation. Primary prevention, perpetrator programs, education and awareness, and police and judicial responses to DFV are main elements of the first report.

Key findings reveal that most DFV funded services in Queensland are directed at crisis responses. In a DFV legislative and service context, crisis response means responding to imminent risk. **This downstream approach does not emphasise recovery from the impact of DFV which can lead to further experiences of harm, including enduring impacts of trauma, revictimisation, and perpetration which are all contributors to negative mental health.**

HHV acknowledges that DFV specialist services are pushed to respond to the case management demands of crisis responses and counselling that support victim/survivors through periods of crisis. This reality provides limited opportunities to respond to the psychological wellbeing of women during recovery or early intervention periods. The report further emphasises the critical role an intersectional approach has for recognising how mental illness influences a person's experience of DFV and their help-seeking behaviour.

Recommendation 16 of HHV call for a common approach for the broader sector (including mental health) to respond to people with intersectional experiences. HHV refers to the importance of greater integration, education and training between the broader service system for mental health and DFV support to improve referral pathways, service models and responses. The report highlights these as necessary for victim/survivors as well as perpetrators.

The need for mental health (and alcohol and other drugs [AOD]) services to play an active role in integrated responses from DFV High Risk Teams is described in Recommendation 19 of HHV. This reflects recommendations from the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) in that all Queensland Health frontline workers should understand DFV and "be confident" to refer and support clients to specialist DFV services and supports. This confidence must stem from workforce being provided with training, resources and support about all facets of DFV to guide their practice and responses. Recommendation 19 also highlights the need for Queensland Health workers to understand complex trauma presentations and the link between suicidality and experiences of DFV.

3. Systems, community and individual level considerations

3.1 Help-seeking and service response

Victim/survivors of DFV may have multiple touch-points across systems. They may have no contact with services. The very nature of DFV aims to prohibit a woman's sense of agency to seek safety from violence and control. Mental illness presents additional barriers that influence a woman's willingness and/or capacity to present for support. In terms of willingness, she may be deterred to initiate help-seeking to a service that is funded and designed to support one aspect of her life e.g.

mental illness, but does not integrate service for another priority need e.g. DFV. Siloed services can prevent women from accessing support, as well as increasing risk of disengagement through frustration and unmet needs. The often chronic nature of DFV and mental illness (together or in isolation) increases the likelihood of encountering negative experiences from a variety of support services over time.

Historical contact with services will influence a person's willingness to engage, and for systemic issues, the onus must be on the system to adapt and promote how they can support clients impacted by DFV and mental illness. There are documented system failings such as the closure of the Barrett Centre and responses to DFV situations resulting in homicide after repeated police notifications. However, ensuing reform creates opportunities to improve how we can best meet the needs of vulnerable people. Recent legislative change such as the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021*, and the incoming coercive control legislation are opportunities to redefine expectations, standards of care, and delivery for both clients and service providers.

A challenge for service providers (clinical and non-clinical) is to disentangle and interpret interactions with different services that may be a one-off, occasional or frequent. The scope of services can include judicial, health, mental health, specialist DFV, LGBTIQ+, youth, community, housing, child-safety, AOD, and other relevant groups the woman identifies with. These interactions present opportunities to support women and children. However, the aforementioned service fragmentation and potential reservations for a client to engage can play a role in re-traumatising or alienating a DFV victim/survivor.

The presence of mental illness in someone experiencing DFV increases complexity in several areas. Practitioner skill in identifying DFV in the context of mental illness is critical. It is vital that service providers can recognise the nuanced differences in presentation of DFV and/or mental illness, and the impact they have on how an individual may experience both. **The misdiagnosis of DFV symptoms as a mental illness can have devastating effects**. Victims/survivors may not only miss out on specialist DFV support, but the PUV may manipulate systems for collusion and as a method of coercive control. The ability for an individual to seek help can be significantly compromised and restricted if services do not believe a woman is being impacted by DFV, or if they attribute her symptomology exclusively to mental illness when that is not the case.

3.2 Complex trauma

Research supports that policy and practice are often found to inadequately address the needs of women with complex trauma resulting from repeated experiences of victimisation[6]. Twenty-five per cent of DFV victims/survivors in Australia have complex trauma which is not readily recognised when they access mental health and other trauma services[6]. The common approach of using a psychological or biological understanding of complex trauma can lead to inappropriate and ineffectual treatments, labels and negative experiences for women which is known to deter ongoing or future therapeutic engagement.

Individuals with complex trauma have high utilisation of health, police and crisis services[6]. Policy focused on supporting effective responses for acknowledging, identifying and responding to complex trauma in practice could create opportunities to positively influence a vulnerable DFV cohort with complex and chronic needs. In addition to improving service responses and therefore outcomes for women with complex trauma, considerable benefits from reducing multi-sector expenditure and burden of disease could be realised. A system that responds to a PUV with historical complex trauma whilst keeping accountability for violence can also greatly improve the safety of others.

3.3 Cross orders

The vulnerabilities associated with mental illness and DFV can heighten the risk of system manipulation by the PUV. The presentation of complex trauma and inappropriate system responses can result in women experiencing increased contact with DFV crisis responses, including police[6]. Increased exposure to police intervention, as well as complex presentations can lead to

misidentification as perpetrators of violence[6,8]. This exposure intensifies a woman's experience of oppression and trauma as well as changing her help-seeking behaviour as system responses fail to meet her needs. It can also result in women using violence, as women are more likely than men to use violence in self-defence, retaliation or in response to current or past trauma[8].

Once a woman is named as a DFV respondent on a civil domestic violence order (DVO), their chances of incarceration due to breaches of orders increase. This is particularly prevalent for Aboriginal and Torres Strait Islander women, with the majority of women in jail (69% in 2014/15) for DVO offences being First Nations women which is significantly overrepresented in comparison with the general population[8]. **Furthermore, a review of DFV deaths by the Domestic and Family Violence Death Review Unit found that almost 100 per cent of First Nation's women murdered by DFV were subject to a cross order.**

3.4 Forensic contact

Forensic contact increases the need for integrated services teams including the involvement of High risk teams for women impacted by DFV who have a mental illness. Women in prison are known to experience higher rates of mental illness, DFV and subsequent acquired brain injuries (ABI) than the general population[9]. Injuries commonly associated with DFV such as ABI impair an individual's regulation, responses to violence, and stress which are already amplified in a forensic setting.

Poor system responses whilst in prison and upon release increase the chance of being incarcerated again. The HHV report further acknowledges that women in custody have typically experienced significant trauma/violence and need support services that appropriately recognise and respond to this, with consideration of mental illness and any other underlying conditions.

Transition from forensic contact are highly vulnerable periods where women need access to stable housing complemented by wrap around services including mental health and AOD support (where appropriate) to assist with support that can prevent re-incarceration[9]. The risk of disengagement from referral pathways and increased suicide risk are also elevated during these transition periods. Support for culturally appropriate services that respond to the complex trauma, colonisation, DFV and mental illness experiences of First Nation's women is vital and under-resourced with consideration that this cohort represents 34% of the female prison population nationally[9].

3.5 Perceptions of DFV and mental illness

The perceptions of DFV and mental illness can have a damaging and defining effect on those effected. Both DFV and mental illness have historically been subject to stigma and discrimination. Individuals impacted by both may have also experienced shame, feelings of worthlessness, blame and hopelessness. These perceptions and feelings are often self-perpetuating and can damage how they engage with services, as well as how they are responded to.

Women are more likely to be portrayed as 'crazy' in a DFV incident whereas men may be considered to have a 'mental health condition'. The differences in language and perception can influence the service experience from first responders though to specialist services and judicial responses. These differences are steeped in patriarchy and historical narrative which are problematic as they affect the emergency and clinical responses a woman may receive as a victim of DFV, as well as for the PUV which can heighten risk for the victim/survivor.

Discrimination also influences how the woman is perceived when presenting for support. Prejudice can relate to the woman's identity/identities as well as her experience of DFV and mental illness. These biases are damaging at each stage of a woman's experience on the care continuum, influencing initial interaction such as presenting for support, through to being considered suitable for services such as a refuge or transitional housing. **It is therefore critical that discrimination is actively challenged through policy, education and practice.** Clinicians need to be sufficiently skilled to use a DFV lens to assess examples such as a woman presenting unwell, elevated and dysregulated so that assessments can consider appropriate responses including consulting a DFV case worker and/or mental health worker as an alternative to contacting police. This level of acuity

is also required to inform the most appropriate referral so the immediate underlying condition can be responded to.

Outside of clinical and service environments, community responses also have an important role in responding to DFV risk and mental health crisis when they see it, and this is strengthened through awareness, education and inclusivity. The connection provided by community is increasingly important to help alleviate isolation and enhance informal supports that can feed into specialist care when required.

Many women experiencing DFV and mental illness participate in employment.
The workplace can be a considerable protective factor for providing safety, education, support, financial independence, and pathways from violence. In addition to supporting the individual, a DFV aware and safe workplace environment contributes to DFV prevention at all levels and supports those with a mental illness to effectively engage with mental health services.

3.6 Intersections and intersectionality

Both the intersection of a women's needs and presentations, such as her mental health, AOD use, DFV experiences, gender diversity, being culturally and linguistically diverse, living with disability, etc. can greatly impair the way a woman seeks mental health support, as well as service and system responses. Accessibility can be restricted, inappropriate or unavailable for women experiencing barriers such as language, poor literacy and temporary vias status. These factors further compound her vulnerability and can also be exploited by the PUV.

For example, having insecure housing because of DFV can result in a woman needing to move between properties and at times regions to find safety from violence. This can dislocate her from mental health support, disrupt NDIS packages, and remove her from community, spiritual or cultural support. As a result, a woman may choose to stay with the PUV. As violence may interfere with expected mental health intervention engagement and outcomes, services may exit a woman from programs if it appears her participation is either a poor fit for her current need, or if it is assessed that her safety is compromised while she lives with violence, thereby being too high risk for mental health services to continue working with her. This results in reduced support, further marginalisation, and increased risk for both DFV and mental health.

Similarly, finding housing solutions for women escaping DFV can be significantly impacted by mental health needs, as crisis and transitional housing responses lack the resourcing and capacity to respond to mental health presentations. This frequently leads to a cyclical pattern where her primary need can be misunderstood and not addressed. For example, should she be referred to a housing, mental health or DFV service?

As you layer a woman's intersections and intersectionality, her vulnerability increases and her help-seeking behaviours can become maladaptive, resulting in diminishing the systemic ability to respond adequately. These cumulative experiences increase her dependence on informal supports, which is often only the PUV who has actively limited her social supports over time.

This precarious and dependent support structure is further impacted by her previous and often intergenerational experiences with systems that have not met her needs, and in some cases contributed to trauma. For example, child removal, revictimisation and misdiagnosis**. A trauma-informed lens is essential for clinicians and other service providers to see beyond the presenting characteristics that may be masking trauma and risk.**

3.7 The importance of lived experience

Women with a lived experience of DFV and mental illness have an essential and valuable role in informing and influencing how to best engage women. They know what they need to support them, and what they want to see in service delivery. Their insights are needed to co-design support for themselves, their families and their communities. Women with a lived experience provide legitimacy for advocacy that can help drive policy and practice changes developed through genuine

partnerships. This expertise of young people must also be elevated to reflect their experiences as DFV as well as mental illness.

As highlighted in Section 3.6, the diversity and gender inequalities that impact a woman's experiences of DFV and mental illness also mean that no one group or person advocates for all. The power of lived experience lies in authentic and legitimate representation of someone with a personal experience who helps build understanding, knowledge, and reduce stigma. In Queensland, both mental health and DFV leaders have embraced the value that lived experience brings to informing policy and practice in recent years. The insights can only be improved by strengthening the voice of women experiencing both DFV and mental illness.

4. Conclusion

The impacts of DFV and mental illness on health, social, judicial and police services are one of the largest, if not largest, burdens on our society. The associated effects at a broader community level are also immense, including repercussions for engagement in education and employment. Combined, the human and financial costs of DFV and mental illness are rightly recognised by the government to be priority areas.

Acknowledgement that gender-based violence such as DFV, and mental illness have been subject to perceptions influencing how they are responded to creates opportunity for evidence-based and human-rights focused change. Historically, they have both been subject to policy and service delivery that has not been equitable, informed, or designed to support women and children in a trauma-informed and integrated model free from bias. Advancements are happening, and HHV is a recent example of the shift and willingness for improvement. The Women's Safety and Justice Taskforce analysis that effective and efficient interventions and system response will improve outcomes for women, children and men, as well as reduce costs to the community through reduced need for crisis responses over time demonstrates how consideration of the problems as a whole is supported.

We know DFV victims/survivors have significant contact with the health system, specifically the mental health system. Acknowledgement of this often hidden interface is a key step towards appropriate assessment, treatment and referral pathways that can meet the holistic needs of a woman in a cohesive and multidisciplinary way. Similarly, there needs to be improved identification of when a woman with mental illness or experience of DFV changes from needing the support of one specialist service to additional ones that meet her life circumstances. This also needs to be matched and guided by her capacity and willingness to engage, not based solely on what referrals are available at the time. Lived experience has a vital role in partnering with policy and practice to ensure these reforms are made through consultation and codesign.

The systems levels considerations described in this submission demonstrate the complexity of service responses required for meeting the integrated care needs and pathways of multi-agency and cross-sectoral approaches. By addressing current models of care that are typically designed to treat the presenting problem, access to specialist services for the secondary issue/s can be improved and evolve from being reliant on local service provider relationships rather than standardised and appropriate referral pathways.

In addition to the DFV impacts on the experience of and the treatment of mental health responses for women, mental health responses for men who use violence must be prioritised and include accountability for violence with pathways that create positive and clear collaboration between service systems. Existing DFV policy and responses prioritise the need to keep women and children safe and this is fundamental for supporting those impacted by DFV. The aspirational goal must be for the balance of need to shift from victim/survivor support to perpetrator behaviour change and prevention. In short, the need for DFV support for women and children will reduce as men stop perpetrating violence against them.

DVConnect would like to thank the Mental Health Select Committee for the opportunity to participate in this inquiry. The points introduced in the submission provide a high-level summary and we would welcome an opportunity to explore them in greater detail. We look forward to hearing from you and learning of the Committee's findings.

Kind regards,

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