Health Justice Australia

Health justice partnership as a response to domestic and family violence

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Health justice insights

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Abstract

General practitioners, community health services, hospitals and other health settings are often sites of trusted help for people – most commonly women – who are vulnerable to or experiencing domestic and family violence (DFV). Yet the issues arising for those experiencing DFV commonly extend far beyond their health. They include legal issues ranging from the need for violence protection orders to assistance with family separation, housing and money problems.

Health justice partnership embeds lawyers in healthcare settings and teams. It is a strategy to provide accessible, timely legal help to people experiencing the complex array of issues surrounding DFV, while supporting health service capability to act as an effective pathway to support.

This paper describes health justice partnership as an integrated response to DFV: what partnerships currently look like, where they are found, who they support, and what they offer partner agencies, practitioners and their clients. Noting health justice partnership as an emerging model, there is more to test and learn about the placement, design and value of health justice partnerships in different health service settings; and how they integrate with the broader DFV service landscape. As service delivery is reassessed in the wake of the Covid19 pandemic, we identify the opportunity to explore health justice partnership as a tool to provide accessible, safe, client-centred and holistic support for those experiencing DFV.

Key observations

- **Women experiencing domestic and family violence (DFV) are more vulnerable than others to a range of legal needs including family law, victim of crime proceedings, housing, immigration and money issues.**
- **Women experiencing DFV more commonly seek help from or are in contact with health services than legal assistance services. This is in line with health professionals being commonly identified as trusted carers and advisors.**
- **Many health services screen for DFV and yet may not have all the tools required to respond to the range of issues arising.**
- **Health justice partnerships (HJPs) bring lawyers into healthcare settings and teams to address intersecting health and legal issues facing patients.**
- **While only one in five Australian HJPs target DFV, most see clients experiencing DFV. Early indications are that collaboration through health justice partnership can benefit clients and the services and practitioners supporting them. Evaluations of HJPs in maternal and child health services have indicated:**
  - **streamlined access to legal help for people facing DFV**
  - **legal assistance in a convenient, safe, child-friendly space**
  - **legal assistance at time and place appropriate to individual client needs**
  - **greater confidence for health practitioners in identifying DFV and capability to directly link clients with legal help and**
  - **increased use of secondary consultation and expertise-sharing between practitioners.**
- **There is, however, more to learn more about the place and potential of HJP in the broader DFV service landscape – particularly in light of service changes arising from Covid19. Questions to explore include:**
  - **the value of HJP in different health settings, and in supporting health service screening for DFV**
  - **how HJPs connect with and complement other services, including the specialist DFV service sector, to support accessible, trusted and effective pathways to safety for victim/survivors and their families**
  - **the potential for some more generalist HJPs to help support perpetrators towards behaviour change.**

Most evidence identified in this paper relates to men's use of DFV against female partners, although men can also experience DFV, and DFV occurs in same-sex relationships. We refer to women specifically as the evidence indicates but will also speak of people and survivors more broadly, particularly recognising elder abuse as part of DFV and the impact of DFV on children.

Introduction

The experience of domestic and family violence (DFV) can have a detrimental impact upon many aspects of a victim/survivor's life, including their physical health and safety, mental health, housing, employment and financial stability. These effects are often felt amid already demanding circumstances such as separating from a relationship, protecting the wellbeing of children or participating in legal proceedings. As issues intersect and compound, those experiencing DFV can require support provided by a variety of agencies and organisations, but at the same time, be isolated from that help. The support needed will vary from person to person, and for the same person at different points in time. Some issues or situations may require an immediate crisis response while others may involve a longer-term strategy. In the face of this complexity, there is increasing recognition of the need for coordinated, integrated policy and service responses to DFV (Australia's National Research Organisation for Women's Safety 2020; State of Victoria 2014-2016; Breckenridge, Rees et al. 2016).

> ***Women and children experiencing domestic and family violence benefit when services are integrated across sectors. This is especially true for women in rural and regional areas, women with disability, women from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander women, who all face additional barriers to accessing services.***
>
> ***(Australia's National Research Organisation for Women's Safety 2020 p.2)***

Coordination and integration can take many forms and involve a range of combinations: police, specialist family violence services, a range of health services, homelessness services, legal services, courts and others (Australia's National Research Organisation for Women's Safety 2020). This diversity is important as people differ: in their experiences of violence and how it plays out; in the support they may seek or have access to at different points in time; in their comfort or trust of different services; in their opportunities to get help; and in their resulting pathways to safety from violence.

Health justice partnership is a way that health and legal services work together to support people experiencing DFV. Through these partnerships, help for issues as diverse as family law, child protection, housing, fines and debt can be integrated into health responses at the time people are experiencing or particularly vulnerable to family violence and in the places that assistance is accessible and timely. Health justice partnerships support those at particular risk of domestic and family violence, including young women and their children, older people, Aboriginal and Torres Strait Islander peoples, and people in rural and remote areas. While they may provide support at times of crises, they generally address issues to support longer-term change.

As key responders, police are often identified at the centre of integrated approaches (Australia's National Research Organisation for Women's Safety 2020; Spangaro 2017). However, health services also play a critical role, as a widely and routinely accessed and trusted source of support for people facing DFV. Integrating legal help into healthcare settings and teams broadens the resources made available to those experiencing DFV at this critical time.

The prevalence of domestic and family violence

Domestic and family violence touches the lives of Australians young, old and from all backgrounds. One in six Australian women and 1 in 16 Australian men – 2.2 million people in total – have experienced physical or sexual violence by a current or former partner. One in four women and one in six men report experiencing emotional abuse at the hands of a current or former partner. However, vulnerability to DFV varies considerably across the community. Young women, pregnant and parenting women and their children, Indigenous Australians, and women living with restrictive long-term health conditions and/or disability are among those most vulnerable to DFV (Australian Bureau of Statistics 2020; Australian Institute of Health and Welfare 2019b; Hegarty, Spangaro et al. 2020). DFV is also an issue for people facing particular barriers to assistance including older people, LGBTQI+ people and women in rural and remote areas (Australian Institute of Health and Welfare 2019b; Lay, Horsley et al. 2017).

Domestic and family violence

We use the term 'domestic and family violence' (DFV) to describe violence between family members, such as between parents and children, siblings, and current or former intimate partners. Behaviours include:

- **physical violence (hitting, choking, use of weapons, sexual violence)**
- **emotional abuse, also known as psychological abuse (intimidating, humiliating)**
- **coercive control (an assault on autonomy, liberty and equality using physical and non-physical tactics (see Australia's National Research Organisation for Women's Safety 2021)**
- **financial abuse (particularly of older people)**
- **child neglect**

(Coumarelos 2019; Australian Institute of Health and Welfare 2019b; Breckenridge, Rees et al. 2016; O'Reilly and Peters 2018; State of Victoria 2014-2016)

Health and legal impacts of domestic and family violence

Ensuring safety for women and their children is a critical first consideration when assisting a person who has experienced DFV, from the point of disclosure to any ongoing assistance.

And yet the experience of DFV can also have a detrimental impact on other aspects of a person's life such as their mental health, housing, financial stability, relationships (intimate, family and otherwise) and their education or employment. It can also profoundly impact the lives of their dependents/children. The Australian Institute of Health and Welfare (2019b p. 13) reports that mental health issues represent the greatest health impact of DFV, with depressive disorders making up the greatest proportion of this disease burden (43%), followed by anxiety disorders (30%) and suicide and self-inflicted injuries (19%).

A range of issues surrounding DFV also have legal elements. With a focus on safety, apprehended violence orders are an immediate example of this. Criminal proceedings against the perpetrator may also arise in the context of DFV, as well as child protection issues including the threat of removal. However, legal help can also address the challenges that can accompany changed circumstances – such as separation, child custody arrangements, immigration and visa issues, housing and managing financial issues including debt and maintaining income.

Legal problems in general are widely experienced in Australia. It is estimated that one in five people encounter three or more legal problems in a given year (see the Legal Australia-Wide (LAW) Survey, Coumarelos, Macourt et al. 2012). Further analysis of the LAW survey found that women experiencing DFV are 10 times more likely than other respondents to experience other legal problems and more severe legal problems (Coumarelos 2019). While 16 times more likely than others to experience family law issues, women experiencing DFV were also at least three times more likely to have problems related to employment, finances, government payments, health, housing, personal injury and rights issues, and criminal law.

This group was also more likely than others to experience health and other impacts from these legal problems. In addition to effects on housing and income, they were more likely to report their legal problems as leading to stress-related illness (53% vs 19% of problems) and physical ill-health (43% vs 18%) (Coumarelos 2019). Together, health and legal service data highlight the vulnerability of people experiencing DFV to co-occurring health and legal need.

Accessible, appropriate and timely legal assistance has been identified as a tool to help address intersecting legal issues or prevent them from escalating (Pleasence, Coumarelos et al. 2014). Legal assistance can take various forms, from information or advice about options, to support for a client to act for themselves (e.g. helping with correspondence or communication), to legal representation.

Seeking help for legal problems

While legal problems are common in the general community, the LAW survey found that many go unaddressed. People often take no action in relation to their legal issues, for reasons including: not identifying the issue as legal; correct or incorrect beliefs that action is not needed (e.g. it would make no difference, it was trivial or unimportant); and perceptions that legal action is inaccessible or risky for personal or systemic reasons (Coumarelos, Macourt et al. 2012; Forell, McCarron et al. 2005). This is in addition to issues such as the limited availability of free and low-cost legal services, relative to health services.

Yet additional issues affect help-seeking for people who experience DFV. Factors that reduce reporting or help-seeking for family violence include shame, not being ready to address the issue, fear of not being believed, not wanting to get the perpetrating partner in trouble, fear of child protection responses, isolation and coercive control (Feder, Hutson et al. 2006; Voce and Boxall 2018; Wendt, Chung et al. 2017).

Though the circumstances may be challenging, the LAW Survey found that women who experienced DFV were more likely than others to seek advice for their legal problems compared to those who did not report a DFV issue (help sought for 74.6% of problems compared to 50.5%) (Coumarelos 2019 p. 17-18). This may in part reflect the volume and seriousness of legal issues faced by this cohort, relative to other respondents to the LAW survey. Importantly though, the statistic represents advice sought from any kind of professional – whether legal or non-legal.

Analysis by type of professional revealed that advice for issues directly related to the experience of DFV was far more commonly sought from a health or welfare advisor (74.0% of problems) compared to a legal advisor (44.2% of problems) (Coumarelos 2019 p. 20). More broadly, help was sought from a lawyer for 51.6% of legal problems overall (related to DFV and other legal issues), and from a health or welfare professional for 56.4% of problems.

This tendency to turn to health professionals when experiencing DFV is reflected in broader literature. The 2016 Personal Safety Survey found that health professionals were among those most likely to be approached for assistance after partner violence. Of women who had experienced a physical assault by a current or former male partner, 20.4% said they sought advice or support from a general practitioner about the last incident and 13.1% said they had approached another type of health professional (with respondents able to report more than one advisor). In comparison, 19.1% had sought advice or support from a counsellor or support worker, 16.5% from the police and just 7.2% from a legal service. The only category of advisor more common than a general practitioner was a friend or family member (consulted by 43.1%). Significantly, over a third (34.6%) did not seek advice or support from anyone (Australian Bureau of Statistics 2020).

Health services as a pathway to help

The degree to which women experiencing DFV turn to health professionals highlights the critical role of health services not only in addressing the significant burden of disease arising from DFV but as a key access point to support (World Health Organization 2016; State of Victoria 2014-2016; Hegarty, McKibbin et al. 2020; Spangaro 2017).

Even when those affected do not actively seek help for DFV, general practitioners, antenatal, maternal and child health services, mental health, and alcohol and other drug services are all accessed by people at the same time they may be vulnerable to or experiencing DFV (Hegarty, McKibbin et al. 2020; Campo 2015; NSW Ministry of Health 2019; O'Reilly and Peters 2018; State of Victoria 2017; Hegarty, Spangaro et al. 2020; Parenting Research Centre 2017).

> ***General practice, antenatal clinics, community child health and emergency departments are key places for intervention for DVA [domestic violence and abuse], as health practitioners are the major professional group to whom patients want to disclose.***
>
> ***(Hegarty, McKibbin et al. 2020 p.2, citing Feder, Hutson et al. 2006)***

For instance, Victorian studies have identified between 14.2% and 17% of pregnant women or first-time mothers reporting partner violence during pregnancy or in the first 12 months following the birth of a child (Gartland, Hemphill et al. 2011; Hegarty, Spangaro et al. 2020). With maternal and child health (MCH) services in Victoria providing more than 95% of all postpartum care to recent mothers (Hegarty, Tarzia et al. 2016), these women are likely being seen by MCH services, even when they are not activity seeking DFV support from these sources.

Similarly, older people who may be vulnerable to elder abuse are very high users of GP services (Australian Institute of Health and Welfare 2018). As isolation and coercive control can be key features of DFV, routinely accessed health services can provide a rare opportunity for disclosure (Spangaro 2017).

Emergency rooms and hospital wards are also sites of family violence disclosure following injury or ongoing abuse, particularly for some groups vulnerable to DFV. While in 2016–17 there were 6,300 hospitalisations of adults aged 15 and over for assault injuries due to domestic and family violence, people in remote and very remote areas were 24 times as likely to be hospitalised for domestic violence as people in major cities. Indigenous adults were 32 times more likely to be hospitalised for domestic violence compared to non-Indigenous adults (Australian Institute of Health and Welfare 2019a).

Finally, Aboriginal Community Controlled Health Services are also key access points, providing holistic and culturally appropriate care to Aboriginal and Torres Strait Islander people, particularly in rural and remote communities (National Aboriginal Community Controlled Health Organisation 2019; Australian Institute of Health and Welfare 2016).

> ***Some victims of family violence will not contemplate engaging with a specialist family violence service but will interact with health professionals at times of heightened risk for family violence – for example, during pregnancy or following childbirth – or seek treatment for injuries or medical conditions arising from violence they have experienced.***
>
> ***(State of Victoria, 2014-2016 p.28)***

The capability of health services to respond to DFV

As well as being highly utilised by people experiencing or vulnerable to violence, health services can provide a safe, trusted source of advice and support (Spangaro 2017). The vital importance of trust is stressed in the literature around health services as a pathway to respond to DFV (e.g. Feder, Hutson et al. 2006) and trust has long been explored as an element of healthcare relationships more generally.

The recognition of health services as an opportunity to connect people experiencing DFV with support has seen the routine screening or risk assessment for DFV become a common domestic violence intervention for certain cohorts in health services and systems (Spangaro 2017; Hegarty, Spangaro et al. 2020). Hegarty, Spangaro et al. (2020 p. 12) found women using antenatal services were open to being asked by health professionals about whether they had experienced abuse or not. They were less likely to disclose if not invited to.

However, the implementation and results of DFV screening have been variable. In NSW, where screening is more routine than other states, screening rates vary from 88% in maternity services, to 46% in child and family services, 87% in alcohol and other drug services and 60% in mental health services. This variation is even greater when the figures for each service type are examined by local health district (NSW Ministry of Health 2019; see also Hooker, Nicholson et al. 2020). While screening in general does appear to increase the detection of DFV, studies indicate that detection does not necessarily lead to a referral, acceptance of the referral and an improved outcome (O'Doherty, Taft et al. 2014; Hegarty, Gleeson et al. 2020).

The lack of a strong link between screening and positive outcomes in the overall literature may be due in part to varied factors at the service level. A number of studies and reviews point to the challenges health personnel face in identifying and responding to violence when they see it, even with routine screening (O'Reilly and Peters 2018; NSW Ministry of Health 2019; State of Victoria 2014-2016). In addition to practical issues such as time and privacy, key barriers to health practitioners routinely screening for DFV include lack of training to appropriately identify and respond to violence and a lack of connections/referral pathways if violence is identified (Hooker, Nicholson et al. 2020; see O'Reilly and Peters 2018). An evidence review of DFV interventions in health identified the importance of linking screening with interventions to address the issues arising (Spangaro 2017).

Perspectives from healthcare professionals about the support they need for this work align with what is important to patients. A meta-analysis of studies reported the views of women exposed to intimate partner violence that use health services. Women wanted responses which were non-judgemental, non-directive, individually tailored and with an appreciation of the complexity of partner violence. Women also identified the need for services to know about and be active in linking women to appropriate resources. They valued coordinated multi-disciplinary approaches, and training to improve practitioner awareness of DFV and their ability to raise and discuss it (Feder, Hutson et al. 2006, p.22, 34).

> ***Holistic assessment, looking not just at the details of physical abuse, but all the other factors that play into family violence like financial issues, health issues, social isolation and all of that, and trying to address family violence in a holistic way.***
>
> ***(Respondent, Hegarty, Spangaro et al. 2020, p.75)***

However, given the breadth of issues implicated in family violence, the appropriate resources that health staff could need to be aware of and confident to connect their patients with stretch far beyond the medical. The challenge is not for health services to know everything but to have accessible, trusted and safe pathways to other expertise.

Most critical is assistance to address immediate safety concerns. But support to enable and sustain safe change is also vital. This includes help for issues as diverse as family law around separation, parenting and financial arrangements, social security, housing, employment, immigration and child protection related issues. Understandably, health professionals, like many others, may not be aware of which services, including legal services, can assist with this range of issues, nor how to access and engage with legal help appropriate to their patients' contexts and needs (Forsdike, Humphreys et al. 2018; ACT Government Family Safety Hub 2020; see also Pleasence, Coumarelos et al. 2014; Cohl, Lassonde et al. 2018). More broadly Australia's National Research Organisation for Women's Safety (2020) observed that 'victims/survivors often have complex and diverse needs that cannot be met by a single service' (p.1) and that the foundation to improved service delivery is connection and coordination across services and silos.

Health justice partnership as a response to domestic and family violence

Health justice partnership is one form of collaboration to integrate legal help into healthcare settings or teams, to support people experiencing intersecting health and justice issues. In responding to DFV, health justice partnership lawyers provide safe, discreet and timely assistance to health service users, in trusted and supportive settings which they already access. Through the relationship built between health and legal services and practitioners, health justice partnership enables coordination of support for the range of intersecting issues affecting the health, safety and wellbeing of people experiencing DFV.

> ***Having the legal service has been amazing. Women can come for an appointment and no-one knows she's coming in to see a lawyer as well. She's just coming in for a maternity appointment.***
>
> ***(Respondent, Hegarty, Spangaro et al. 2020 p.83)***

At the same time, partnerships build the capability of the partner services, and health practitioners, to identify health-harming legal issues affecting their clients. Similarly, they build the capability of legal services to understand intertwined health and legal need and to support clients appropriately. Common features of health justice partnership include:

- relationship building, cross-disciplinary training and the exchange of expertise and trust between health and legal practitioners to develop the capability of:
  - health practitioners to more confidently and effectively identify and refer patients to their legal partners
  - legal partners to take account of the health and family issues affecting their clients
- streamlined and warm referral processes to an accessible (usually onsite[1]) lawyer
- the opportunity for health and legal professionals to consult about problems their clients are experiencing and coordinate their responses (secondary consultation, case conferencing) (Forell and Boyd-Caine 2018).

The integration of legal help into a healthcare team is itself a service system change – providing a more holistic response to the often complex and intersecting range of issues that DFV involves. The lessons that emerge from this movement can help inform a broader conversation about how we enable, support and value client-focused service systems that are responsive to intersecting need.

> ***We know there's somewhere for them to go, not like it used to be when they were calling and no one answers, [and] the clients couldn't get in to see anyone. Clients need one point [of contact] and someone to support them rather than sending them off somewhere else.***
>
> ***(Health care professional, Evaluation of HJP, ACT Government Family Safety Hub 2020 p.13)***

[1] Pre-Covid19. During Covid19 lockdowns many HJP lawyers had to work remotely and the delivery of services remains dynamic as the pandemic continues.

Domestic and family violence on the Australian health justice landscape

Across Australia, health and justice services come together in a range of ways to provide legal help in healthcare settings. A 2018 census identified 78 such services (Forell and Nagy 2019) and that figure in early 2021 is over 100.[2]

Health justice partnerships are found in primary health settings including Aboriginal community-controlled health organisations, hospitals and community support settings (e.g. family and child services). The health practitioners involved vary from setting to setting but include hospital social workers, nurses, midwives, doctors, maternal and child health practitioners, mental health and community health professionals. Legal help is most commonly provided by community legal centres and legal aid commissions.

A 2018 census of the health justice landscape highlighted that one in five partnerships specifically targeted DFV (e.g. in antenatal, maternal and child health services and specialist elder abuse partnerships).

However, beyond these targeted approaches, people at risk of or experiencing family violence are seen in nearly 90% of all services on the landscape. These include generalist health justice partnerships, partnerships in mental health and addiction services, partnerships supporting young people and partnerships supporting Aboriginal and Torres Strait Islander people (Forell and Nagy 2019). The broad identification of DFV reflects the pervasive nature of DFV within people's lives and across the community. It also highlights the role of generalist health services as an access point for people experiencing DFV.

Domestic and family violence and/or family law were among the most common legal issues being dealt with in health justice services (a 'top three' issue for 62% of 65 respondents). Other common legal issues included housing, money issues and for some, immigration (Forell and Nagy 2019).

Promising practice and outcomes

While more research is needed, early evaluations of health justice partnerships addressing domestic and family violence suggest a range of outcomes for clients and for service capability. These include:

- improved self-reported health provider knowledge, skills and confidence to identify and respond, and refer women experiencing DFV, and increased referrals (Hegarty, Humphreys et al. 2014)
- more timely, streamlined access to legal help for women facing violence
- assistance in a convenient, safe, child-friendly space
- assistance at a pace and place that is safe and appropriate to individual client needs
- greater confidence of health practitioners to identify DFV, and capability to directly link patients with legal help
- increased use of secondary consultation with legal professionals, either formally or informally, about problems clients are experiencing
- greater confidence that referrals made are safe and appropriate (ACT Government Family Safety Hub 2020; Eastern Community Legal Centre 2018).

[2] In addition to health justice partnerships, the health justice landscape includes legal outreach clinics (co-location with less integration), integrated services (where the lawyer is employed by the health service) and service hubs (where a range of service types co-locate in one setting).

> ***MABELS changes the way maternal and child health nurses refer clients for family violence and legal support from a stressful process involving two 'cold' referrals, with extended waiting times and often unknown outcomes for the client, to one streamlined referral, which is accepted promptly and with guaranteed information and feedback. The referral process is strengthened by direct professional relationships between maternal and child health nurses and the MABELS team, clear protocols governing the process, options for secondary consultation and even more timely responses for emergency cases.***
>
> ***(Keating, 2018 p.5)***

The impact of health justice partnership on screening rates, referrals or uptake of referrals across a range of health services is an area for further exploration.

Beyond co-location, studies identify that effective partnership requires the investment of time and resources to build relationships between the health and legal team, and the capacity to build trust and work collaboratively with the client (Forell and Boyd-Caine 2018; ACT Government Family Safety Hub 2020; Eastern Community Legal Centre 2018).

> ***The MABELS model works for a range of reasons, not the least that it has been assiduously built on a range of best-practice features, such as a committed partnership characterised by strong leadership support and involvement, strong governance structures, strong trust and relationships across the partnership, a strong focus on planning, monitoring and continuous improvement, training and preparation provided for all staff, the quality, integrity and commitment of staff members and the complementary combination of partner expertise.***
>
> ***(Keating, 2018 p.9)***

Health justice partnership on the DFV service landscape

Health justice partnerships commenced as a practitioner led movement to more effectively reach and support people experiencing intersecting health and health-harming legal issues. Health justice partnership enables legal services to reach clients with unmet need who would otherwise not access their help. It provides health services with a greater range of tools to address social issues that affect the health of their patients. As the practice has grown, DFV has surfaced as a key area of work for HJPs. Some HJPs were established to specifically address DFV. However, as noted above, DFV also arises in generalist HJPs, HJPs supporting people living with mental health issues and HJPs supporting Aboriginal and Torres Strait Islander communities.

Health justice partnerships have evolved to join a complex landscape of specialist and generalist services responding to DFV (see Australia's National Research Organisation for Women's Safety 2020). While all HJPs link health and legal services, the way they intersect with other services, including specialist DFV services, varies from partnership to

partnership. Some are directly linked to Family Violence Units run by legal services, to Domestic Violence Court Assistance Schemes through their legal partners, or to other services through their health partners and/or local networks. However, there is more to learn about how HJPs best connect with other services that support people with the range of issues arising from DFV. There will be times when legal help is not the most pressing need and the capacity of HJPs to step back and link to others is as critical as their capacity to step forward.

Thinking more broadly, while a number of HJPs focus specifically on the needs of women, others engage with men in health settings (e.g. alcohol and other drug, mental health and generalist health settings). Among these men will be perpetrators of DFV (Chung, Upton-Davis et al. 2020). Chung, Upton-Davis et al. (2020) have suggested that there is much opportunity for human services agencies (which includes health services) to play a role in identifying and responding to perpetrators of violence, and guiding men towards changing their violent behaviours, their violence-supportive attitudes and their use of coercive control. The potential for HJP in this role also warrants further exploration.

Health justice partnership in the context of Covid19

Research has identified an increased vulnerability to DFV through the Covid19 pandemic due to factors including economic stress, disaster related instability, increased exposure to exploitative relationships and coercive control, isolation, reduced options for family support, increased alcohol consumption and people in already volatile relationships being restricted to their homes (Usher, Bhullar et al. 2020; Pfitzner, Fitz-Gibbon et al. 2020a; Pfitzner, Fitz-Gibbon et al. 2020b). The complexity of issues facing women has also increased (Pfitzner, Fitz-Gibbon et al. 2020a; Pfitzner, Fitz-Gibbon et al. 2020b).

> ***Reports show that COVID19 is used as a coercive control mechanism whereby perpetrators exert further control in an abusive relationship, specifically in the use of containment, fear, and threat of contagion as a mechanism of abuse.***
>
> ***(Usher, Bhullar et al. 2020 p.550)***

At the same time, access to face-to-face support for people experiencing DFV was constrained as services moved online, particularly during lockdowns (Pfitzner, Fitz-Gibbon et al. 2020b; Health Justice Australia 2020). Lawyers in health justice partnerships reported the challenge of staying connected with their health partners during the acute phase of Covid19, and with clients they would usually reach through the health service. This was due to having to cease onsite service provision, and to the shift in focus of health services to responding to the pandemic. However, some observed how the strength of pre-existing relationships between partner services was able to support ongoing collaborative practice through the pandemic. Where the relationship was less strong, this was more difficult (Health Justice Australia 2020).

Prior to 2020, people experiencing or at risk of DFV already faced multiple, intersecting health and legal issues. As jurisdictions move out of lockdown to a ‘new normal’ post Covid19, longer term impacts will continue, including additional economic stress and mental health issues.

Previous research showing increases in DFV following natural disasters would indicate that DFV may also

remain elevated (Parkinson and Zara 2013; Parkinson 2017). Further, as crises including bushfires and floods will continue to occur, we can assume circumstances like this will continue to exacerbate situations that are already at or near crisis point in people's lives.

In the face of this new reality, health services remain at the front line, with this complexity of issues coming through their doors. Health justice partnership is one approach to this challenge and early indications are that this collaborative model has benefits for clients and for the services and practitioners supporting them. However, Covid19 has also changed how people access services and how services connect with each other and to their clients. Moving forward we need to explore collaboration and connection beyond co-location, both in the physical space and the digital. We seek to learn more about the impact of health justice partnership, particularly in support of current health strategies to respond to DFV; and about how health justice partnerships, as part of a broader service environment, most effectively contribute to seamless, safe and effective pathways for victim/survivors towards safety.

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Health Justice Australia

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Health Justice Australia is a national charity and centre of excellence for health justice partnership. Health Justice Australia supports the expansion and effectiveness of health justice partnerships and works to change service systems to improve health and justice outcomes through:

Research: Developing and translating knowledge that is valued by practitioners, researchers, policy-makers and funders

Practice: Building the capability of health, legal and other practitioners to work collaboratively, including through brokering, mentoring and facilitating partnerships

Policy advocacy: Working to reform policy settings, service design and funding, informed by the experience of people coming through health justice partnerships, and their practitioners.

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