Domestic and Family Violence Safety Alliance
Submission to Royal Commission

October 2024

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Domestic and Family Violence Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services, alongside government partners (Department for Human Services – Office for Women). The service partners are:

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Community Services (CCCS)
- Centacare Catholic Country SA (CCCSA)
- Yarredi Services, Inc.
- Nunga Mi:Minar Incorporated
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support over 4,500 people annually and include local place-based support and state-wide services such as the Domestic Violence Crisis Line. DFVSA brings together specialist providers of domestic and family violence support and are the primary providers of DFV crisis support in South Australia (emergency accommodation, crisis, supportive and transitional accommodation). The Alliance partners also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing through a uniquely integrated model.

While DFVSA is a collaboration between government and non-government services, we acknowledge the different spaces, roles and responsibilities of all our partners. In considering this, while our submissions reflect discussions and inclusive consultation and engagement, it is submitted on behalf of the following partners;

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Community Services (CCCS)
- Centacare Catholic Country SA (CCCSA)
- Yarredi Services, Inc.
- Nunga Mi:Minar Incorporated
- Uniting Country South Australia
- Junction Australia

While this submission was developed in consultation with all partners, formal endorsement is not provided by The Salvation Army, and government partners.

Acknowledgement of Country

The Domestic and Family Violence Safety Alliance (DFVSA) acknowledges the traditional owners of the lands we work on, and pay respects to Elders past and present, and those future. We acknowledge that sovereignty was never ceded, and that we continue to work and live on unceded land which always was and always will be Aboriginal land.

We also acknowledge that our services provide support within a white colonial context, and that we must continue to walk alongside community, to cede power and create meaningful space for Aboriginal leadership and decision-making. We particularly acknowledge the significant cultural authority that we are privileged to engage with as part of DFVSA.

Introduction

DFVSA welcomes the opportunity to provide further context, detail and recommendations to strengthen our first submission (Attachment 1). We will not reiterate positions or recommendations put forward in our August submission but appreciate the opportunity to expand on key areas of focus, and provide some further data, detail and positions to support the work of the Royal Commission. We strongly recommend that this paper is read in conjunction with our original submission and is considered of equal weight and bearing.

We also acknowledge the support of key groups, consultations and partners in developing the below positions, not least:

- DFVSA's Children's Working Group, for their valuable insights into the needs of children, who have been overlooked too long as victims in their own right;
- DFVSA's LGBTIQA+ Reference Group who have pushed us to do better, to understand more and to stand alongside a community which remains underrepresented and under supported;
- DFVSA's Safe at Home Coordinator and Community of Practice, who continue to deliver a vital and nation-leading service;
- DFVSA's Operational Network, Alliance Management Team and Alliance Leadership Team who provided valuable frontline, operational and strategic guidance and continue to drive DFVSA to deliver client-centred, impactful and outcomes focused services;
- The team at Better Start, who, with funding provided by the Paul Ramsay Foundation, provided invaluable insights into the available data for the alliance, and developed a vital report (pending Data Custodian approval, to be submitted separately). We hope that this partnership is the start of enacting Recommendation 5 (Evidence-Based and Data-Informed System and Services), and clearly demonstrates the impact, value and need for connected data systems, quality data analysis and building the sector's capacity to monitor, evaluation, learn from and understand service impacts, programs, system impacts and sector gaps.

DFVSA reiterates our key recommendations below and have carefully considered the value of providing an exhaustive list of recommendations, or a shorter, more targeted key recommendations. We have opted to retain 6 core recommendations alongside a number of supplementary recommendations (outlined in this and the previous submission), to avoid duplication and to recognise the specialist expertise of partner organisations, and other specialists. Please also review and reference **Error! Reference source not found.**, for a more detailed overview of our core recommendations.

In developing this second submission, DFVSA holds to a number of key principles which augment our recommendations and areas of focus. These should be embedded and considered as core to all the work of the Royal Commission, government, non-government and broader sector when developing a strategic and holistic response to DFV in South Australia:

- That recommendations and actions should be underpinned by an **intersectional framework** that acknowledges the different life experiences, characteristics, social, cultural and economic factors that impact on an individual's life experience, including their experience of family and/or domestic violence – while we have identified some key groups within our submission, we do not intend this to be exhaustive nor exclusive, but merely indicative of specific work and focus we have undertaken as an alliance over the past 3 years. We fully stand behind every person's right to access appropriate, timely and safe services across the state, in a way that is truly accessible for their needs, experience and ability;
- We acknowledge the importance of **place-based knowledge, environment and experiences**. We fundamentally position ourselves as wholly in support of equity of access to appropriate, timely and holistic support no matter where a victim-survivor is in South Australia. We acknowledge that this may not always look the same, and certainly may not be in line with traditional 'value for money' calculations, but fundamentally believe that investing in and ensuring real equity is vital to enabling a

system which is truly responsive to the needs of every victim-survivor, no matter if they are regional, remote, metro, transient or from interstate;

- We strongly recommend that **holistic support across the continuum be available across the state** – too often we see support clustered either in metropolitan/larger regional hub areas, focus only on pilot sites, or rely on ad hoc or inconsistent accessibility of specialist services. This includes 24/7 policing and safety responses, support from prevention, early intervention, crisis response and recovery and healing, access to safe and specialist accommodation (for example, the Fleurieu Peninsula has no access to any specialist DFV accommodation options, and extremely limited hotel/motel options). It is vital that we, as a state, acknowledge the right of every victim-survivor, and their families, to equitable safe, appropriate and timely support and are not disadvantaged due to where they live or inequitable service availability;
- DFVSA acknowledges that no significant change in addressing DFV in South Australia is possible without long-term, sustainable and meaningful changes in **funding.** South Australia continues to perform extremely poorly in terms of investment in addressing DFV compared to other states and jurisdictions, and this is being felt most acutely by services delivering responses on the ground. DFVSA, Embolden and individual agencies have repeatedly brought attention to, and called for, significant investment in services, or risk ongoing workforce continuity, service and support gaps and limited long-term outcomes, to no avail. DFVSA, for example, has written to Federal and State Ministers, Premier, Treasurer and Government Department Chief Executives regarding our significant concerns to meet the demand, needs and expectations of the community. However, we have been unable to engage in meaningful discussion regarding this and remain concerned at the current narrative to 'wait until the Royal Commission is completed' before making funding decisions. In the meantime, we continue to see victim-survivors in need now, but are having to make daily decisions about whose needs are most acute, who is in most crisis, and having to refer many to other parts of the system which we know are also under significant pressure (including the broader homelessness sector, who often provide a 'safety net' for those needing to leave situations of violence, particularly for men, those who do not identify as female, or those for whom their experiences of DFV are more historic, but no less a part of their homelessness experience). We strongly urge the SA government to commit to long-term, meaningful investment across the continuum of DFV, and to strengthen reporting and accountability against this investment to ensure that outcomes are clearly articulated (against both the National Plan to Reduce Violence Against Women and their Children and a state strategy) and monitored.
- Finally, we reiterate that addressing and eliminating domestic and family violence is not the responsibility of any one part of society – it requires **collective effort across the community**, across service sectors and across government. While we bring our perspective working on the frontline of crisis response, we absolutely hold that to provide better, earlier and more holistic responses, we must hold each other accountable as a whole of community approach, and acknowledge the different, interlocking roles across the continuum.

This submission focuses on a number of key programs, areas and communities that we feel are most in need of urgent response but is not exhaustive. We acknowledge and support the submissions of our partners, who provide a more nuanced and detailed place-based response and build on the expertise of frontline staff with decades of experience across the state.

We look forward to the outcomes of the Royal Commission, to the opportunity it provides to refocus South Australia's attention on domestic, family and sexual violence, to improve the lives of victim-survivors, to embed best practice and to address the drivers of violence that sees far too many women, children and people experiencing horrific violence at the hands of those who believe they have the right to power, control and impact over others' lives.

Finally, we recognise those who have experienced violence – victim-survivors who have survived, those who continue to live under the shadow of violence, and those who have lost their lives both directly and indirectly through their experiences. In doing so, we acknowledge that this submission reflects the experiences and

insight of services and staff working in this space, many of whom also have their own experiences of violence, and are encouraged by the Commission's dedication to hear directly from victim-survivors regarding their experiences and centering their voices. We continue to see too many people bear the burden of others' actions, and crimes, and live with the consequences sometimes for decades. We stand alongside them, we honour their strength, their resilience and their journeys.

Definitions

DFVSA currently works to the below definitions of domestic and family violence. While we strongly support calls for an expansion of the definition family violence to include both violence in family of origin (for those who identify as LGBTQIA+) and family violence within culturally and linguistically diverse communities (for example, considering dowry abuse), we acknowledge that capacity limits our ability to expand this in practice in the current environment. We would welcome the opportunity to have sufficient resources and expertise to provide a family violence response encompassing the above as best practice, but this is currently beyond our capacity and service parameters. In line with previous recommendations regarding adequate funding to the sector, and funding direct towards under-serviced communities, we would welcome the opportunity to explore what a broader family violence definition, in line with our expertise and skillset, may look like. We also note that responding to family violence by specialist DFV services should be ringfenced to those areas where our expertise and skills add value – where there is a gendered understanding of violence, and where this is impacted by patterns of control and power. While we acknowledge that not all violence that occurs in a family context needs to be responded to by specialist DFV services (for example, elder abuse, child abuse etc), we reiterate the need for a coherent, connected and responsive service system.

Domestic Violence

is the term used to encompass the range of violent, coercive, threatening and controlling behaviours that are perpetrated predominantly by men against women and their children within current or past intimate relationships. The central element of domestic violence is an ongoing, intentional pattern of behaviour aimed at controlling a partner through fear. Domestic violence is inclusive of behaviours both criminal and non-criminal. Domestic violence can include physical, economic, emotional, sexual, social, technological, cultural/religious abuse, and coercive control. Domestic violence is predominantly perpetrated by men against women (and children), but can be present in any relationship, regardless of the gender identification of the (ex-)partners.

Family violence

is used to describe the range of violence and abuse that Aboriginal and Torres Strait Islander people are subjected to and can include physical, emotional, psychological, sexual, social, spiritual, cultural, technological, financial abuses and prevention of return to Country that may be perpetrated within a family. This behaviour is intentional and results in the victim being fearful and/or endangers their safety and well-being. 'Family violence' is inclusive of the broader impact of the violence on extended families, kinship networks and community relationships, and also recognises that within Aboriginal and Torres Strait communities, this abuse may be perpetrated by extended family members other than (ex-)partners. It has also been used to encompass acts of emotional abuse leading to self-harm and suicide and is adopted as part of the shift towards addressing intra-familial violence in all its forms. It is important to note that not all perpetration of violence within Aboriginal families is undertaken by Aboriginal intimate partners. Often intimate partners who use violence are non-Aboriginal.

The Alliance explicitly recognises that domestic and family violence is not part of any culture, including Aboriginal culture, and is never justifiable due to cultural or religious practices.

Note that those experiencing other forms of family violence (particularly within multicultural communities) may be provided support on a case-by-case basis, based on an assessment of risk, need and capacity of the service.

Key Recommendations

We reiterate our previous recommendations, particularly our overarching 6 key recommendations:

1. Develop and fund a holistic specialist DFV support sector;
2. Build a response model beyond specialist homelessness service limitations;
3. Increase state investment to DFVSA specialist response to meet the actual needs of community and real costs of delivering services, and increased engagement with Commonwealth regarding system gaps and responses;
4. Improved supports through strengthened multi-sector response and whole-of community responsibility;
5. Develop and embed evidence-based and data-informed system and services, building a best practice culture of monitoring, evaluation and learning;
6. Evaluate and develop the alliancing model in line with system governance and oversight, to maximise resources and opportunities.

Develop and fund a holistic specialist DFV support sector

Appropriate, Timely and Tailored Support to All Victim-Survivors

LGBTQIA+ Community

DFVSA has engaged in a significant review of supports available to victim-survivors from LGBTQIA+ communities across South Australia over the past 2 years. This work has been embedded in leadership from the community and allies, deep understanding of services (and gaps), lived experience and opportunities. This work has been foundational not only for the Alliance, but has also underpinned further work across the sector, including Shine SA's training program and specialist worker funded under the Commonwealth 500 worker program (the only specialist DFV LGBTIQA+ staff in the state, to our knowledge), supported engagement and advocacy around coercive control legislation, and led to ongoing adaptations and consideration of this under-supported community through DFVSA's development of service models, strategies and responses.

The full report is available at Attachment 5.

DFVSA acknowledges the limitations of the current system and sector in responding to this community. While the alliance will and does provide support to any victim-survivor, regardless of their sexual orientation or gender, we acknowledge that our services may not always be the most appropriate or safe for victim-survivors from the LGBTQIA+ community for a range of reasons. DFVSA strongly recommends a number of key recommendations are enacted to improve genuine access to safe, appropriate and community-based support for LGBTQIA+ victim-survivors, including:

- **Data collection that better captures gender and sexuality** (current data collection mechanisms merely allow for male, female and other, which does not reflect gender identity appropriately, nor does it match best practice identifiers). This includes ensuring data collection systems prompt for and enable the inclusion of pronouns
- Develop and fund **specialist LGBTIQA+ specialist DFV roles across the state**, either as a state-wide service or embedded within existing services – the current allocation of 1FTE in Shine SA is insufficient to meet demand and practice needs;
- Fund a **state-wide LGBTQIA+ Practice Lead role**, who can support the development, roll out and delivery of best practice, safe and appropriate support across all specialist services. This may work

alongside ongoing training and professional development opportunities (building on the work of Shine SA this year);

- Review and identify appropriate **specialist DFV accommodation options** that can provide safe spaces to LGBTIQA+ people, noting that the DFV specialist services rely on homelessness services to often provide accommodation options for this community due to a focus on supporting women and children, limiting the crisis accommodation options for those who identify as male, or other LGBTQIA+ identities. This may include specialist accommodation, or more flexible accommodation models – these must be matched by skilled service provision that understands the nuances of working with this broad community;
- Ensure that LGBTQIA+ people are **included in mass media campaigns**, but only where there are safe and appropriate service supports to meet their needs;
- Include **LGBTQIA+ people in lived experience work** (see *Lived Experience Roadmap* submitted as part of DFVSA's first submission), including consultation and service design, and any review or updates regarding risk assessment or other tools that should support the visibility of and support for this community;
- Consider the inclusion of **family violence in family of origin as part of DFV responses,** as it is inherently linked to gender-based violence where DFV services often hold specialist expertise, noting that due to current demand, only Aboriginal family violence is generally supported by specialist DFV responses, but that family violence can be, and is, experienced by many others within society.

Aboriginal Community

DFVSA recognises that much more is required beyond data collection to consider culturally appropriate, impactful and community-led responses to violence against Aboriginal women and girls. We reiterate recommendations from our previous submission that we must increase funding available to ACCOs who are providing support in this space, and particularly recognise Aboriginal ways of being and doing. We acknowledge that we continue to work within a white colonial setting, with many of the structures, expectations and service parameters inappropriate to working with communities across the state, while also acknowledging that every community and Country is different, so working with local leaders, women and men as well as young people and Elders, is vital.

We strongly recommend that:

- **Meaningful community engagemen**t is embedded into all services, and that **Aboriginal governance** mechanisms are integrated into all services and organisations to ensure that the voice, leadership and expertise of local Aboriginal people are central to decision-making. This includes considering best ways of engaging and being, noting that traditional 'lived experience' models are embedded in mainstream understandings of consultation and co-creation;
- Services are **enabled, funded and supported to be holistic and family focused**, acknowledging the important kinship links, cultural and family obligations and expectations that may impact on victim-survivors' decisions on leaving violence situations, on how they may engage with perpetrators (both intimate partner or family), and on what support they identify that they need. We strongly encourage this to be considered beyond just the Aboriginal community, and that there are many learnings and practices that Aboriginal services and community can share with mainstream which will have positive impacts on all;
- **We must invest properly in ACCOs**, who often carry a significant cultural load, expectation of cultural leadership and engagement, and significant expectations of staff both within their professional context, but also within a community context. Ensuring that Aboriginal services remain at the forefront of decision-making remains key – while DFVSA is privileged to have Nunga Mi:Minar Inc. as a key partner within the alliance, and acknowledges the leadership that is provided, we also acknowledge that there is a significant cultural load that is borne through this, and ensuring that Aboriginal organisations have the appropriate structures, funding and capacity to meet the needs of community must be central to our collective response to DFV in SA;

- Currently, specialist victim-survivor DFV services offering crisis support for Aboriginal people is only available in metro Adelaide via ACCO Nunga Mi:Minar and non-ACCO Ninko Katangga Patangga (a specialist unit within Womens Safety Services) and in parts of the APY lands (via NPY Women's Council). We recognise the work of other ACCOs in the DFV space as well, including regional areas, but no others are funded to deliver crisis, victim-survivor focused supports. We strongly recommend that a **system response is considered, encompassing the need for choice of providers for Aboriginal peoples**;
- Any state strategy or decisions must meaningfully engage with and, importantly, report transparently against, Closing the Gap, the National Plan to End Violence against Women and Children 2022–2032 and the Aboriginal and Torres Strait Islander Action Plan 2023–2025.

Children as Clients in Own Right

DFVSA strongly recommends that particular care and attention is paid to children and young people who have experienced violence, either as victim-survivors of direct abuse, or as victim-survivors by virtue of being the child of a primary victim, who may have seen, heard or been impacted by violence within a family or care structure. We absolutely recognise that there is a significant dearth of specialist DFV services available to, and targeted towards, children, and remain acutely concerned that children and young people remain without age-appropriate, specialist services and support, including specialist DFV responses, early intervention, recovery, healing and therapeutic support. This includes access to family-based supports as outlined elsewhere.

Children are not all the same, and develop differently, and so supports tailored to age-appropriate and developmentally appropriate levels is required. This includes the need for specialist training for all workers engaged in DFV frontline support, as well as tailored roles and expertise within specialist children's roles. There is a limited number of children's workers in South Australia who currently work with children and young people aged 0-25, which requires an increased skill set and knowledge base to be able to work across this spectrum. We suggest considering different workers dedicated to pre-school age, primary age and adolescents to allow for more specialised approaches.

We recognise the recent addition of a number of roles targeted towards children's support as part of the Commonwealth 500 worker program – some services have chosen to utilise their allocation to embed specialist children's workers in their services. This is rarely funded through core funding (for example, only 1 small specialist support team is funded directly through DFVSA core funding – the Children's Wellbeing Program in Port Lincoln run by Yarredi – with a small number of individual roles in metro Adelaide. 2 specialist services also exist outside of DFVSA-funded programs – Safe and Well Kids, which is only available to WSSSA services in metro Adelaide, and RASA's Together for Kids, which has long waitlists and limited regional accessibility). The current system is limited to these specialist, often place-based, programs, with no systemic access for children to specialist supports.

Current gaps include:

- A lack of therapeutic services available to children and young people and especially, therapeutic supports that have a deep understanding of DFV;
- Two children's services providing specific support for domestic violence exist in metro Adelaide but these are only available to children and young people attached to crisis services;
- Lack of domestic violence services available to children and young people prior to separation or after leaving the crisis services, which excludes children within families who do not wish to separate or wish to remain in their current home;
- Currently domestic violence service responses for children and young people are focused on children with complex needs and exhibiting high externalising and internalising behaviours. Every victim-survivor who presents gets a level of service no matter the risk, the same support should be given to ALL children and young people no matter their presenting issues;

- Children have lived experience and are often not seen through that lens. They are their own experts and need to have their voices heard and understood.

DFVSA strongly recommends that the Royal Commission addresses major gaps in service delivery, access to holistic support and genuine support for children and young people who have experienced DFV as a matter of urgency. This includes:

- **Support for children and young people should be embedded in the standardised processes within domestic violence services** to support case managers to understand their responsibilities in regard to children and young people (e.g safety planning, understanding children's experiences of violence, assessing risk and mitigating risk etc.) This includes recognising that children and young people have the right to be involved in decisions that impact them, and include children in age-appropriate discussions, as children and young people play multiple active roles in a family experiencing violence. Recognising that children have the capacity to understand their experiences of violence and risk as they have been living in it, and have the ability to be involved in their assessment of risk is central to the delivery of appropriate services. We recommend the development or utilisation of **evidence-based risk assessment tools that accurately capture the risk for children** that include child focused questions that can be directly asked to the child and young person, which include **self-assessment tools** for adolescents;
- Longer term therapeutic services for children and young people that are not capped at a certain number of weeks due to the amount of time required to build therapeutic relationships with children and young people.
- Respond to and recognise the need for child therapeutic workers, children case managers and parenting support workers working alongside each other for every child. Ensure that **child and young-person specific workers are funded and embedded in all services across the state,** including for children, teenagers and young people. Ideally, this would also include funding to enable mobile services for children and families for whom accessing physical services is challenging, particularly due to geography. This would also need to consider **supervision led by experienced children's workers** with experience working with children and young people experiencing violence. Currently, supervision is often provided by the line manager who is generally not a specialised children's worker, impacting on the clinical supervision available to specialist workers;
    - Funding would also be required to support the provision of children's programs, including purchase of resources, creating safe children's spaces (indoor and outdoor), mobile support needs and early intervention programs;
- A **specialised domestic and family violence training package** available to children's and young peoples' therapeutic workers to enable them to be highly trained in domestic and family violence and not just working with children and young people through only a trauma lens and including practical tools to work with children and young people experiencing domestic violence;
- **Funding and embedding Culturally Informed and Safe Services across the state**, including:
    - Engaging with and funding Elders and other community members to provide culturally appropriate healing pathways for Aboriginal peoples. Funding to include support/training/assistance;
    - Cultural training opportunities for all workers, including pathways for workers to access cultural understanding for complex cases
    - For Aboriginal healing spaces to be culturally led, with a focus on DV and trauma, based on consultation with local community;
- Greater **whole-of-family domestic violence counselling approaches** that involve working with children and young people directly. This will support with the gap in services for children where their parents remain together.
- **Increased funding for and focus on Prevention and Early Intervention,** including:
    - Healthy relationship/domestic violence education needs to be provided to all children and young people, with healthy relationships school program delivered regularly in all schools, including

separate programs as needed for males and females. This should be developmentally appropriate and delivered from reception to Year 12 by specialist facilitators. An evidence-based group that practitioners can be trained in to be delivered across the service system would be of great benefit, and could include mentorships to identify positive role models, break cycles and norms, and ensure culturally appropriate and tailored programs;

- Increased funding for community engagement and connection with community services around what specialist services provide, and to provide community education and engagement around domestic and family violence;
- Consider evidence-based and specialist program for babies / infants, including engaging with playgroups and kindergartens around early intervention, support for mothers and developing stronger community links and pathways.

Build a response model beyond specialist homelessness service limitations

Workforce that is Supported, Works to Best Practice

Staffing Shortages and Challenges

DFVSA supports Embolden's position regarding the need for a **state and national workforce strategy**. We know from recent experience in recruiting for the few workers allocated to South Australia under the Commonwealth 500 Worker scheme, that recruitment in this sector continues to be extremely challenging – the work is difficult, burnout and vicarious trauma are core risks and it can feel relentless.

We further note the difficulties found in identifying, recruiting and retaining staff across the state. We strongly encourage the Government to consider **including DFV workers as part of those with access to government-supported housing in regional and remote areas**, noting the ongoing challenges in finding suitable accommodation where external candidates have been identified. For example, in Ceduna, the lack of housing available is significantly impacting on the local DFV services' ability to recruit staff as there are few if any local applicants, and no opportunities (with the exception of the local caravan park) for newcomers.

This equally impacts the ability of students to undertake placements in regional and remote areas, where the cost of accommodation can be prohibitive, and impacting their ability to build valuable experience in regional and remote settings.

We also strongly advocate for a **training and professional development program** for all specialist DFV workers, to be rolled out across the state to support the ongoing development of a skilled and specialist workforce. Currently, many services struggle to access training – face-to-face training in particular – due to logistical and financial decisions regarding accessibility to their region.

Finally, we acknowledge the current work being undertaken by the Social Workers Registration Board in South Australia, as well as national registration discussions in both general social work and specialist DFV workforce (led by Commissioner Michaela Cronin). We urge the Royal Commission to take this into consideration as part of recommendations, noting the impacts of registration on services' recruitment and retention, financial obligations, legal obligations and ensuring we maintain a diverse and responsive workforce.

Accommodation, Housing and Safe, Secure Tenancy

DFVSA reiterates our position that South Australia must build a model which provides DFV-specific, safe, accessible accommodation from crisis through to long-term options, which cater to a range of family sizes (including pets), children, accessibility needs and safety responses. We strongly encourage the Commission to consider the trauma-informed building recommendations, accessibility considerations and addressing gaps in the availability of accommodation across the state. For example, we continue to have areas of 'black spots', where there are little to no specialist DFV accommodation for people fleeing violence, which are often coupled with areas which have limited access to hotel/motel options (for example, the Fleurieu Peninsula has no crisis, supportive or transitional accommodation, while Murray Bridge and the Adelaide Hills have no crisis

accommodation, meaning that victim-survivors fleeing must rely on limited hotel/motel options, or access crisis accommodation in metro Adelaide).

For other areas, the demand continues to far outstrip availability, and we continue to have to make almost daily decisions around who is most eligible for transitional, supportive and crisis accommodation, when we know that almost everyone who comes through our services need them. We regularly have up to 5 families nominated for individual properties, which gives a real indication of the true nature of need and demand for equitable access to appropriate accommodation across the state.

Safe at Home

The Safe at Home program addresses the critical need for enhanced home safety and security of women and their children who are impacted by domestic and family violence, through the provision of tailored safety packages. The Safe at Home program is designed to support women and their children as they recover from the trauma of domestic and family violence by helping survivors regain a sense of control and security in their own homes, fostering an environment where healing can begin. Safe at Home supports individuals to rebuild their lives within a space of their choosing, offering protection from further harm while addressing their unique safety needs, so they can move forward on their journey to recovery. Without this intervention, families and individuals are at increased risk of homelessness and disruption of social support networks. By enabling them to remain safely in their homes, Safe at Home prevents further dislocation and helps alleviate pressure on a homelessness sector already operating at capacity.

The following recommendations aim to strengthen the Safe at Home program and ensure it continues to effectively support women and children recovering from domestic and family violence. These recommendations focus on enhancing service delivery, improving collaboration across agencies, and ensuring the program remains responsive to the complex needs of as many survivors as possible.

- **Adopt a no wrong door policy between state and national services, and expand SAH eligibility to support any victim-survivor who requires it regardless of risk level:**

DFVSA notes that the original intent of the Safe at Home program, when led by Victim Support Services, was to provide equitable access to security upgrades to all women and children, regardless of risk level. This was in acknowledgement of the fluid nature of risk, the importance of holistic responses and the impact of earlier intervention in achieving better outcomes. It enabled services to meet the needs of victim-survivors when and where they needed it, when and where they reached out, and diverted them away from requiring crisis DFV support or homelessness services. However, as the service has evolved both in a national and a state context, this focus has changed, and we now see a state-based service that only provides support to women and their children at high risk of violence – requiring referrals to the national Safer in the Home (SITH) program delivered by The Salvation Army. We strongly recommend that, as part of a *no wrong door* approach, that place-based services within South Australia are enabled to provide Safe at Home to any victim-survivor who requires it, including at standard, medium and high risk, to avoid victim-survivors having to retell their story, to link with appropriate local supports (specialist DFV or otherwise) and to provide a more holistic and impactful response. This would not negate the services by SITH, but rather augment it by providing additional pathways to support based on choice and accessibility for victim-survivors.

A no wrong door approach must include standardizing the risk assessment process and improving transparency between SAH and SITH. This partnership is crucial in ensuring a continuum of care, and a no wrong door policy would result in enhanced collaboration, reduce service gaps, prevent clients from falling through the cracks, foster better coordination across the sector and reduce the need for clients to retell their stories, supporting more trauma-informed care.

An increase in funding would allow for timely risk assessment for clients of all risk levels seeking urgent lock changes, safety packs, and mobile phones. This approach acknowledges the inherent risk in domestic violence situations and offers quicker access to safety measures, making access to safety services after experiencing DFV a right.

- **Provide additional funding to increase staff capacity statewide:**

Safe at Home currently has a total of 6.75 FTE staff to deliver services to over 600 adult clients and 800 children annually. In many regional areas, this translates to just 0.1 FTE, meaning case managers often have to take on SAH duties in addition to their regular work. Due to the high demand and limited staff, metro wait times from referral to audit exceed 50 days, with regional areas facing 2–3-week delays. The demand for services and low staff numbers has forced a majority of the program to be delivered via phone, which can limit the effectiveness of safety planning, understanding the specific needs of clients, and ensuring contractors are receiving accurate work orders. Additional funding would allow for more face-to-face audits, offering valuable in-home support like installing alarms, safety app guidance, involving children and other household members in safety planning, and ultimately reducing wait times and improving client outcomes.

- **Provide additional funding for regional and remote service providers:**

Delivering the SAH program in regional and remote areas comes with unique barriers such as difficulty sourcing contractors, and inflated costs for parts, travel, and labor. These higher costs often result in clients in more complex situations receiving fewer security upgrades despite also facing longer SAPOL response times, isolation, and limited resources. Clients may also require items and services not typically supplied by SAH, such as security cameras, fencing, general yard work, or a dedicated safe room. To address these challenges, regional and remotes services need a multi-faceted response including additional funding, along with government-subsidized financial incentives—such as travel allowances, accommodation, and bonuses—to attract contractors to work in remote locations and ensure timely, effective security upgrades.

- **Provide additional funding for direct client costs:**

Rising living costs have significantly impacted on the affordability of security upgrades, with many clients now needing additional items that the current $1,500 budget per client cannot cover. As a result, more clients are self-funding critical upgrades. This budget cap limits the number of clients SAH can support annually and reduces the program's effectiveness in securing homes. This is especially true in regional and remote areas with inflated costs for parts and travel. Additional funding is essential to ensure that homes are properly secured, and clients are not forced to bear the financial burden themselves.

- **Expand eligibility criteria to support clients of all genders, and those experiencing family violence:**

Additional funding would enable SAH to expand its services to more victim-survivors. Currently, the program is restricted to high-risk women experiencing intimate partner violence or Aboriginal family violence. Historically, SAH has supported clients facing family violence, and the exclusion of this group has created a significant gap. Women experiencing family violence are also ineligible for emergency accommodation through DV services, leaving them vulnerable to homelessness and ongoing violence. Additional funding would also enable SAH to support victim survivors regardless of gender identity. We recognise that DFV is an inherently gendered space, and overwhelmingly women are the targets of violence perpetrated by men, however including this criterion in DFV spaces leaves victim-survivors of other genders, especially those who identify as part of the LGBTQIA+ community, without critically needed support.

- **Expand access to housing and tenancy protections for survivors of domestic violence:**

Stable housing is a fundamental eligibility criterion for the Safe at Home program, and the cornerstone for recovery. The sector needs urgent policy changes that would facilitate survivors' ability to remain in their homes and enable the removal of perpetrators from these residences in a timely manner. Enhancing these protections for survivors should also correlate with a broader effort to provide dedicated and supported housing options for perpetrators, thus addressing the issue from multiple angles ensuring comprehensive safety and recovery for all affected and breaking the cycle of violence.

- **Enhance access to comprehensive case support services:**

While SAH serves high-risk clients, the support provided often does not reflect the complexities of their recovery journey. Many clients have moved beyond the crisis phase and already have stable access to housing,

income, and basic services. However, they frequently require additional assistance in areas such as ongoing safety planning, legal support, court advocacy, domestic violence education, counseling, and family services. Furthermore, the wait times within the current SAH program make it impossible to appropriately identify and respond to clients whose risk levels change, in a timely manner. Connecting clients with these services for the duration of their SAH journey would provide a more holistic and sustainable approach to recovery and healing and reduce clients re-presenting to the service. This enhanced support would also ensure more seamless referrals to SITH, as SITH requires that clients be linked to additional services before engaging with their program. By strengthening access to short-term case support programs, both SAH and SITH can provide more effective, coordinated care, leading to improved outcomes for all clients at any risk level. Such services are currently scarce in South Australia and are also under-resourced to handle the demand. E.g. EASE, CSR, MWSP

- **Improve efficiency and prioritisation for SAHT DFV clients, including improved communication between Housing Trust and Safe at Home:**

Secure a commitment from the South Australian Housing Trust (SAHT) to reduce the average wait times between home audits and prioritise the completion of DFV safety upgrades. In FY 2023-24, SAHT's completion times were significantly longer than those of Safe at Home. Additionally, SAHT must improve communication by providing timely confirmation when upgrades are completed, as only 16 of 78 recommended cases were confirmed as finished.

- **Standardise consent policy across community housing providers:**

Introduce a uniform consent form and inherent consent policy for upgrades across the community housing sector. Currently, Safe at Home experiences significant delays in obtaining consent from community housing providers, contributing to the program's lowest completion rate—only 19% of audited tenants receive upgrades. Streamlining consent processes would reduce delays, minimize disengagement, and ensure timely upgrades for clients at risk.

Developing a System that Responds to and Leverages Community and Business Opportunities

As noted above, responding to domestic and family violence is a whole-of-community responsibility, and we know that many community and commercial entities regularly explore ways of being able to support victim-survivors, via a wide range of pathways. DFVSA has noticed an increasing interest in partnering with specialist services to provide safe accommodation to those fleeing violence, particularly over the past year as DFV has become more visible in the media, and the impacts of the cost of living and housing crises become more pronounced. We welcome the opportunities this provides – as noted in our previous submission, we strongly encourage a focus on a key recommendation from the recent review of the Emergency Accommodation Program (EAP) to explore and develop options for crisis and emergency accommodation that is not linked to the utilisation of hotels/motels, but rather specialist, trauma-informed, DFV-specific accommodation options for all victim-survivors. However, this continues to be challenging as there remains no clear pathway for collaboration and partnership between private providers, service providers and government to quickly assess and respond to such opportunities.

DFVSA has had a number of sincere offers from developers and community groups interested in providing assets such as accommodation (ranging from short term emergency to longer-term recovery and healing) in support of the clients that we work with. While eager to engage with these opportunities, we lack the capacity to respond adequately to these opportunities. The reasons for this is manifold, including:

- The need to ensure that any supported accommodation option (i.e. any option other than the provision of long-term housing outcomes) is **adequately resourced**, including adequate staffing and practical support to ensure that victim-survivors have access to specialist case management, tenancy support, tenancy management and referral pathways and that we are embedding all new additions to the system in a systemic response;

- Ensuring that **all DFV specialist properties have appropriate safety features, policies and procedure**s, individualised to the location, type and purpose of the accommodation (we strongly recommend reviewing research regarding trauma-informed design, and also refer to our responses to the Safer Places grant round, the National Housing and Homelessness Plan and response to SA's housing enquiry);
- **Clear roles, responsibilities and system responses** that consider key partners and decision-makers, including government, non-government and developers;
- **Ensuring a systemic response that considers risk, governance, sustainable funding and long-term accommodation pathways**;
- **Clear processes** regarding vetting potential partners, legal and risk management (particularly regarding built environment assets, which many service providers do not have), sustainable funding pathways

Currently, we are at risk of, and have, lost opportunities to engage meaningfully with community members, including developers, who have expressed sincere interest in engaging in this space. We require a multi-disciplinary approach, including cross-government - SA Housing Trust (as responsible for assets in the sector), Dept Human Services/Office for Women (as the government lead for DFVSA programs), Department of Treasury and Finance (as required to support sustainable funding options) - Community Housing Providers (DFVSA includes Uniting Country, The Salvation Army and Junction Australia as members, and engage regularly with them regarding housing issues, but a more structured response is required to engage with different parts of the business) and service delivery providers. While significant efforts have been made to bring key stakeholders together, we are struggling to get traction in this space, and are at risk of 'missing the moment'.

DFVSA is strongly in favour of collaborative processes, of bringing stakeholders from across government, services and community together, and to developing agile, responsive and impactful pathways to increase access to timely, appropriate and safe support for victim-survivors, and strongly feel that the development of this pathway would significantly support the expansion of support offerings in South Australia.

Improved supports through strengthened multi-sector response and whole-of community responsibility

Multi-Agency Collaboration

DFVSA supports Embolden's position regarding the need for increased multi-agency collaboration and responses across the state. We recognise the need for an integrated response to those experiencing violence, where key parts of the sector work alongside each other to achieve the best, safest and most impactful outcomes for victim-survivors. The Northern Hub model is one example of this, bringing together police, DFV services and others to provide a more holistic response to victim-survivors seeking support. This may look different in different contexts, but numerous examples both nationally and internationally exist, and DFVSA strongly advocates for an evidence-led review and implementation of best practice multi-agency collaboration models to be embedded across the state.

Importantly, this must include regional areas, and in particular those which lack a permanent DFV response – we know that there are significant areas of SA where victim-survivors find it extremely difficult to access their 'local' service, which could be located hours away at the nearest regional centre. We know that this puts these victim-survivors at risk, and that support-seeking remains low in these areas where supports are difficult to access or functionally non-existent. A stronger multi-agency collaborative model may enable better access to support, through co-location, better pathways and communication between police, specialist services and other parts of the system, and continue to prioritise the safety and wellbeing of all victim-survivors, regardless of where they are in the state. It could also enable the establishment of satellite 'hubs', with increased funding for place-based DFV staff, who could be physically present in smaller regional areas on a rotational basis, to ensure that all victim-survivors are seen, heard and supported.

Improved multi-agency responses could also support improved outcomes across a range of other areas where DFVSA sees systems which are either under resourced or underperforming. This includes:

- **Family Safety Framework**: While originally funded with administrative backbone support from Victim Support Services, and with a mandate and expectation for decision-makers to make swift, immediate decisions at meetings, we are concerned that the current FSF process has been diluted, and does not have the impact that was previously felt. This is due to a range of factors which, if addressed, could support FSF to redevelop and renew it's vital role within the system. This includes:
    - Accountability for all parties to FSF to priorities meetings
    - ensure that decision-makers are present, active and engaged;
    - Re-establish backbone funding to enable administrative support;
    - Accountability and shared responsibility.

Courts, Police and Corrections

DFVSA recognises the core function and importance of the Courts, Police and Correctional services within the system, and the vital role that they play. We reiterate our position that significantly better training, culture building and awareness is needed, and must be embedded at all levels and included in regular continuous improvement and updated information and skills. We remain concerned that we continue to see magistrates bailing perpetrators of DFV back to a family home where a victim-survivor is staying – we have even seen recent examples of perpetrators bailed to specialist DFV victim-survivor accommodation, which is wholly inappropriate. Ensuring that magistrates are provided with regular, and ongoing training, including an awareness of their local service system, is vital.

Develop and embed evidence-based and data-informed system and services, building a best practice culture of monitoring, evaluation and learning

As noted in DFVSA's first submission, we continue to be concerned at the **lack of accurate, place/state-based data around domestic and family violence in South Australia.** As the primary crisis DFV services in the state, our current data capture mechanisms (the Homelessness2Home system) is not designed to capture domestic or family violence information, and so lacks the ability to capture simple, but vital data, around incidence and prevalence of domestic and family violence – including the types of violence that clients experience, their risks and impact of service interventions. While we strongly support the recommendation of the recent H2H review regarding the need for a bespoke, fit-for-purpose and future proofed data management system, we remain concerned that this will continue to prioritise housing and homelessness outcomes, and miss the opportunity to build a DF(S)V data system which provides timely, accurate and meaningful data related to the experiences of victim-survivors, links between systems and services and, importantly, outcomes and impacts.

We acknowledge the work being done by DHS to integrate the homelessness outcomes framework, but support the call from Embolden for a centralised DF(S)V entity to provide oversight of DFV, particularly ensuring that data capture, data linkage, usage, monitoring and evaluation maintains and strengthens the lens of DFV, and particularly links to key outcomes frameworks and impacts to better monitor SA's obligations under the National Plan, and impact within communities.

The need for improved data collection, utilisation and management has recently been highlighted by the addition of a number of staff funded under the Commonwealth 500 Workers scheme to alliance programs. While this is very much welcomed, it did highlight the shortcomings of the current data system, as there is a need to ensure that client information, case noting and general administration is managed appropriately, but no formal process was included within that funding mechanism to develop this. For many DFVSA programs, these workers will, by necessity, need to utilise the H2H system to align with the wider programmatic requirements, but this risks impacting on the data fidelity as there is no way to delineate between workers funded under Alliance contract (required to use H2H) and 500 Workers contract (using H2H to align with

operational requirements within programs and system). A more sophisticated system which could provide more nuanced data, owned by and accessible to all services, could alleviate this and provide a clearer picture of both investment impact (i.e. what staff funded under different funding schemes are achieving) and client impact (i.e. what outcomes we are delivering for victim-survivors).

Finally, we reiterate previous positions regarding the need for robust linked data systems (see below regarding brief project with Begin Better), access to real-time dashboards and/or service data to enable services to better monitor, learn from and utilise service data, and ongoing transparency around data sharing and access – the ability to have a statewide view of DFVSA services through the alliance structure has demonstrated the strength of collaborative and transparent data sharing and visibility, and we strongly encourage this to be embedded further throughout the sector and system to ensure that both service level data (to support delivery of programs, place-based understanding and localised knowledge) and sector level data (to understand broader context, gaps, challenges and opportunities) is vital.

Enhanced use of existing data opportunities

DFVSA has partnered with the University of Adelaide's Better Start team, utilising their BEBOLD platform to analyse DFVSA's data as part of a broader linked data platform and develop the attached Analysis of Specialist Homelessness Services Data report. This is the first time that we have had the capacity to review our H2H data (primary dataset) alongside key linked data sources including child protection and health. This underscores the need for increased capacity and access to linked data to truly make meaning from the broad data that is collected across the sector, and to build the skills, capability and utilisation of data to inform our understanding of service delivery patterns, client needs, unmet need, demand and areas of underservicing. This collaboration represents a piece of 'partnership research' which we hope is the start of a longer-term collaboration. However, it also underlines our key recommendations regarding the need to embed greater data capability, skills and utilisation across the sector, at system, alliance, organisation and service level, while recognising Indigenous Data Sovereignty and the importance of Aboriginal and Torres Strait Islander people's right to autonomously decide what, how and why Aboriginal and Torres Strait Islander data are collected, accessed and used.

Attachments

DFVSA Response to Royal Commission Issues Paper

Amendments to the migration framework to support visa holders experiencing domestic and family violence

Lived Experience Roadmap

DFVSA Response to Housing and Homelessness National Plan

DFVSA Recommendations for Improved Services to LGBTQIA+ Community

DFVSA Response to South Australia Housing Enquiry

DFVSA Response to Escaping Violence Payments Announcement

DFVSA Response to Safer Places Grants Round

BetterStart Analysis of Specialist Homelessness Services Data report

Domestic and Family Violence Safety Alliance

Response to Issues Paper

Royal Commission into Domestic, Family and Sexual Violence

August 2024

Domestic and Family Violence Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services, alongside government partners (Department for Human Services – Office for Women). The service partners are:

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Community Services (CCCS)
- Centacare Catholic Country SA (CCCSA)
- Yarredi Service, Inc.
- Nunga Mi:Minar Incorporated
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support over 4,500 people annually and include local place-based support and state-wide services such as the Domestic Violence Crisis Line. DFVSA brings together specialist providers of domestic and family violence support and are the primary providers of DFV crisis support in South Australia (emergency accommodation, crisis, supportive and transitional accommodation). The Alliance partners also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing through a uniquely integrated model.

While DFVSA is a collaboration between government and non-government services, we acknowledge the different spaces, roles and responsibilities of all our partners. In considering this, while our submissions reflect whole of alliance discussions and inclusive consultation and engagement, it is submitted on behalf of the non-government partners.

Introduction

DFVSA are pleased to submit an initial response to South Australia's Royal Commission into Domestic, Family and Sexual Violence. This submission provides a brief overview of the key areas of concern, focus and opportunity for DFVSA, which will be further expanded upon in our primary and more substantive submission in September 2024.

We have not specifically responded to the questions outlined in the Issues Paper, however our response represents a holistic response to the overarching key areas of inquiry. Due to our expertise and focus in the provision of frontline support – particularly the areas of the Royal Commission described as Response and Collaboration - we have chosen to focus on these areas through our submission, noting the significant linkages, expertise and experience in particular with Early Intervention and Recovery/Healing, and the expertise of others in these and Prevention spaces. We strongly submit that, while reflecting the outline of the National Plan, Early Intervention, Response and Recovery/Healing, in particular, must be considered together.

DFVSA will focus primarily on a response to domestic and family violence. We acknowledge that domestic and family violence encompasses sexual violence within the context of domestic and family violence relationships, and include it in such contexts. However, while we acknowledge the deep links across all forms of gender-based violence, we are not experts in the response to sexual violence, and acknowledge the expertise of key voices such as Yarrow Place and Embolden in this space.

South Australia needs to develop a service system that enables the provision of appropriate support at the right time and the right place for victim-survivors in line with their needs, when and where they choose to

seek support, and in a way that meets their needs. We need a flexible and responsive model of support that ensures that no matter where a victim-survivor is, they can access the support they require – this may be earlier intervention to work with the whole family, through to engaging with other victim-survivors in a therapeutic healing space which supports them to re-establish their lives and move forward (from financial health, to employment, to social and emotional wellbeing). Currently, these artificial barriers create significant barriers, as too often victim-survivors' needs shift between these arbitrary lines, finding themselves ineligible for services due to the impacts of the violence.

We strongly advocate for a shift towards a **holistic approach** to domestic and family violence, noting that this will take time and that additional resourcing will be required to enable a shift from crisis focused response to holistic, prevention and early intervention activities. DFVSA, as frontline services, strongly posit that this will require a strategy that serves to complement, rather than reduce, existing services, noting that the development and expansion of South Australia's prevention and early intervention spaces will take time, and that the need for current services to be maintained and expanded is vital to ensure that we do not disadvantage or risk victim-survivors who need support in the interim.

Finally, we also acknowledge the **importance and linkages between other submissions**, and have worked collaboratively with individual partners, and Embolden, to develop mutually reinforcing and supporting submissions that enable a deeper understanding of the local, regional, state, service policy and advocacy landscape. We encourage this submission to be read alongside those of our service delivery partners, who can provide more nuanced and specialised insights into the specific barriers experienced in their areas of operation and expertise. Similarly, we support and acknowledge Embolden's submission as the peak body for DFSV in South Australia, particularly regarding the policy, strategic and national context.

Key Recommendations and Positions

Recommendation 1: Develop and Fund a Holistic Specialist DFV Support Sector

South Australia requires a genuinely **holistic response sector** which is inclusive of a cultural, family and holistic lens, including evidence-based, best practice responses to all victim-survivors, including those who may require respite, to return to a family home with a person who uses violence, or may not wish to leave, as well as those at different stages of their experience or support needs.

The current system is overly focused on crisis response, and homelessness/accommodation-focused outcomes, creating significant barriers to victim-survivors accessing specialist support. An over-reliance on a simplified, western understanding of crisis response limits South Australia's ability to meet the holistic needs of victim-survivors, and creates a system which is over-stretched, over-burdened and frustrated by systemic barriers to best practice response. DFVSA strongly advocates for a holistic system which:

a. **Embeds holistic victim-survivor responses into all frontline services state-wide**, noting that victim-survivors' experiences are not linear, and require a more fluid and person-centered response to meet their needs. Currently, eligibility and funding criteria mean that many victim-survivors are not eligible for supports due to not being at risk 'enough', not at risk of homelessness or living in an area that is not part of specific pilot programs. South Australia owes each victim-survivor the right to equitable support, which includes place-based, funded and inclusive support options across the state. This includes access to crisis, transitional, supportive and long-term accommodation, meaningful access to earlier intervention, crisis and recovery and healing options and localised options for therapeutic and long-term support across life domains;

b. **Supports children as clients in their own right** through child-specific roles funded and embedded in all services as standard, including support to services and staff to build specialist expertise, skills and responses for children as clients in their own right – current capacity and funding puts significant limitations on access to child-specific supports, and also reinforces the 'postcode lottery' of where specialist supports are available. Too often in our current system, children are supported via primary

support towards their parent/caregiver, and are not provided specialist age-appropriate, intensive, therapeutic responses. Providing support to children impacted by DFV, is both a response and a prevention strategy, knowing the long-term impacts of DFV and the correlation between experiences of DFV and future life trajectories. This includes for unborn children and babies, noting the increasing evidence of the impacts of early trauma;

c. Includes significant investment and capacity building in **working with perpetrators and families**. South Australia has a significant dearth of opportunities for perpetrators to engage meaningfully with services, and often only in specific areas or regions, limiting access due to geography. Perpetrators mut be visible and accountable for their actions – too often we see victim-survivors, primarily women, bearing the responsibility for the safety of themselves, and their children, and carrying the financial, social and family burden of their experiences. This includes:
    i. Accommodation options for perpetrators to leave the family home (e.g. DFV-Perpetrator program);
    ii. Opportunities for family and perpetrator early intervention, behaviour change and non-custodial interventions;
    iii. Genuine accountability and visibility of perpetrators through the utilization of existing mechanisms such as IVOs, breaches and child protection;
    iv. Place-based responses which go beyond telehealth or custodial programs.

d. Improved responses to **intersectional needs**, and recognition of the need for a culturally appropriate, diverse and inclusive support sector:
    a. Currently Aboriginal Family Violence (AFV) is the only type of **family violence** that is meaningfully responded to by DFVSA, but we know that family violence can be wide-ranging. While we provide some limited support to victim-survivors from CALD backgrounds, defining what we mean by family violence as a sector, and funding it appropriately, including where other sectors have a responsibility (for example aged care and child protection), is vital. It is currently ill-defined and may not sit within the gendered drivers of domestic/interpersonal/Aboriginal family violence. However, we know that there are significant impacts across the community, and particularly for those from CALD backgrounds, for those who identify as LGBTIQA+ (including young people who are impacted by family violence due to gender or sexual identity);
    b. Roughly a quarter of DFVSA's clients identify as Aboriginal, and yet our system and services remain tied to white, Western constructs of response, significantly impacting the cultural safety of not just services, but of the system as a whole. South Australia needs to **proactively build support systems that are truly culturally informed, safe and responsive**, across mainstream and specialist services, and focus on centering and embedding Aboriginal ways of being and doing across all elements of the DFSV sector. As noted in Recommendation 3, this includes increased funding and leadership by ACCOs and Aboriginal community, recognising the important role they play not only in directly supporting victim-survivors, but in working with community;
    c. **Specialist and expanded LGBTIQA+ response,** including practice lead resourcing to support increased capacity and safe, inclusive accommodation options across the state. DFVSA has been heavily involved exploring and understanding how to better work with this community, and is currently reviewing and updating our recommendations in this space, and will include specific recommendations on this in our second submission;
    d. Expand specific responses and engagement with and for **migrant and refugee communities**, noting that in-person responses only available in metro Adelaide, though a state-wide service is available virtually, including:

1) Considering and responding to the specific barriers and types of violence faced by those from culturally and/or linguistically diverse backgrounds, migrant and refugee communities, including barriers to accessing support due to a lack of income, which automatically disqualifies them from mainstream supports such as emergency accommodation (see, for example, DFVSA's response to Dept. Home Affair's consultation on *amendments to the migration framework to support visa holders experiencing DFV*);
2) Expanded place-based and community engagement response that provides an in-person state-wide response – currently Migrant Women's Support Program's funding and staffing curtails their ability to deliver full services across the state.

Recommendation 2: Build a Response Model Beyond Specialist Homelessness Service Limitations

Currently, frontline domestic and family violence response, primarily delivered via DFVSA, is actually a homelessness response, rather than a specialist DFV response. While DFVSA holds a specific role and space within the homelessness sector, our ability to meet the needs of victim-survivors is significantly constrained by contractual obligations regarding eligibility around '*at risk of, or experiencing, homelessness'.* We fully acknowledge that homelessness response and funding will always be an important element of DFV crisis response (as in other states), and strongly advocate for the maintenance and expansion of homelessness support alongside many of our homelessness sister services (particularly in light of the recently-released report by the Auditor General regarding the management of homelessness services[1]). However, homelessness should not be the primary or only focus of the DFV specialist sector, and the specialisation of DFV crisis response, including but not limited to crisis, medium and long-term accommodation options, must be recognised, strengthened and preserved.

We absolutely acknowledge the important linkages between homelessness and DFV, and the importance of working alongside partners across the system[2]. We also recognise that many victim-survivors are supported via homelessness support pathways, sometimes due to choice (including for those who identify as LGBTIQA+ who may not feel safe accessing predominantly women-focused services), often due to their experiences being historical or at lower risk at the time they seek support. Victim-survivors should not have to make themselves homeless or be at risk to access support, but too often, particularly in metro Adelaide, the current structures leave services with little option. See, for example, DFVSA's response to the Housing and Homelessness National Plan Issues Paper (September 2023) here.

DFVSA calls on the Royal Commission to support the expansion of DFV specialist services beyond homelessness responses to:

a. Develop **DFV-specific accommodation responses** that cater to the needs and drivers of DFV, rather than alignment to homelessness processes which may not be appropriate for victim-survivors – we must acknowledge that accommodation requirements for victim-survivors of DFV are different to those experiencing homelessness (acknowledging the significant trauma, systems failures and systemic barriers also faced by those experiencing homelessness, many of which cross over with those experienced by the DFV sector). At a minimum, we must look at:
    i. Swift and meaningful actioning and embed Emergency Accommodation Program review recommendations, particularly regarding alternatives to hotels/motels and the specialist needs of victim-survivors of DFV, and considering differential requirements for victim-survivors;

[1] See Report of the Auditor-General: Report 8 of 2024, Managing Homelessness Services
[2] See, for example, Homelessness Australia's Report *Homelessness and Domestic and Family Violence: State of Response Report 2024*

ii. Access to appropriate, trauma informed, client-centred accommodation – including a broader remit that incorporates the experiences of victim-survivors, including respite, crisis, short-, medium- and long-term, including supported long-term. For example, currently, respite options (where someone requires a short-term accommodation response for their safety, but are not 'homeless' as they intend to return), is out of scope for emergency and other accommodation but is a cornerstone of many victim-survivors' safety planning and management. Currently, the backlog in access to longer-term properties is creating a bottleneck in the system where clients are remaining in transitional and supportive accommodation sometimes beyond their support needs, but without appropriate exits, requiring them to continue to engage in supports that may not be appropriate to their current situation. These must be available across the state – currently, there remain accommodation 'black spots', where crisis or other accommodation types simply do not exist;

iii. Develop Aboriginal and Torres Strait specific accommodation options, with leadership from specialist ACCOs and Aboriginal community, that provide culturally safe accommodation options for community;

iv. Expand, fund and equitably distribute perpetrator accommodation options, to decrease the burden of response on victim-survivors, hold perpetrators to account and provide additional pathways for specialist services to support the safety and wellbeing of victim-survivors.

b. **Fund specialist DFV responses for those not at risk of homelessness**, but still in need of support – many victim-survivors who are at high risk may still have safe (or relatively safe) accommodation, or may not be in immediate danger, and so are at significant risk of falling through gaps in the service system;

c. **Fund the specialist crisis response to DFV alongside those requiring homelessness and/or housing support** – the current system makes it difficult to co-case manage across homelessness and DFV services due to eligibility linked to 'at risk of or experiencing homelessness' for both, and a lack of capacity to provide non-accommodation-based support, particularly in metro Adelaide. South Australia must recognise and develop the specialised DFV response, which goes beyond those experiencing or at risk of homelessness, ensuring that existing programs have the capacity to deliver the services required. This includes immediate investment in:

i. Brokerage and direct client costs, which currently stand at around 3% of total budget, as specific funding for ISSP has ceased and ongoing needs to work within diminishing budgets has reduced available funding for client costs;

ii. Increased funding for Safe at Home, to enable meaningful delivery of safety and security upgrades to all victim-survivors (not only those who are assessed as high risk and identify as female);

d. Invest in and prioritise specialist practice, including **translation of evidence and innovation into practice on the ground** – we must invest in and support Practice Lead(s) and enhance services' ability to engage with, inform and learn from emerging research and evidence to enable practice to remain innovative and in line with best evidence both nationally and internationally.

Recommendation 3: Increase State Investment to DFVSA Specialist Response to Meet the Actual Needs of Community and Real Costs of Delivering Services, and Increased Engagement with Commonwealth Regarding System Gaps and Responses

The current system is **overly reliant on Commonwealth funding, with limited true State funding for DFV services.** DFVSA receives over $17m per year of homelessness funding (primarily via Commonwealth National Social Housing and Homelessness Plan, previously National Housing and Homelessness Plan), but limited long-

term state investment for the DFV specialist support. While we acknowledge the funding included in state budgets, this does little to provide a systemic, state-wide, holistic response, focusing on short-term, limited funding which do not meet the level of need in services and community.

This was clearly evidenced in the recent 2024-2025 budget, where no additional funding was provided to frontline services in the face of increased demand due to the visibility through the Royal Commission itself, and increased national focus, and indexation once again failed to meet the base needs of services.

SA is significantly behind other states' and territories' investment in services, leaving alarming gaps in our ability to meet the needs of the community. Recent analysis of DFV specific funding opportunities included in the Commonwealth's Safe Places Inclusion tender[3] put this into stark contrast, where the only DFV-specific funding for South Australia in FY23-24 noted was $7.3m over 4 years for DFV-CAP/PERP. This stands in stark contrast to, for example, Northern Territory which included $55.1m in their 23-24 budget, including an additional $20m over 2 years to support implementation of their second Action Plan. This lack of state funding has left South Australia behind nationally and risks the existing support system.

DFVSA has engaged in significant advocacy regarding the ongoing **structural deficit** embedded in contracts, including writing to Commonwealth, SA Premier, Ministers and the Treasury, both as an individual alliance and in partnership with other homelessness alliances. There has been no meaningful response, and in fact has demonstrated the lack of State investment or understanding of the financial challenges faced by DFVSA, and other specialist services, cumulatively over the past number of years.

Current funding is **not keeping pace with current service delivery needs** and is in fact facing ongoing structural deficits and real-world decreased funding. This was also reflected in the recent Report from the Auditor General on Managing Homelessness Services, which noted that even in light of increased clients across the specialist homelessness sector (which includes DFVSA), funding has reduced in real terms.

Indexation continues to lag behind benchmarks, meaning DFVSA continues to struggle to maintain current levels of service delivery. Indexation must, at the very least, match CPI across the full contract amount (not only Commonwealth contributions), building on actual end of year baselines, or we will continue to be underfunded to deliver on core service requirements. Current significant risks include:

i. Reliance on organisational contributions to maintain baseline service delivery;
ii. Reliance on client rent and derived income, meaning decisions have to be made regarding access to services for those with no ability to pay rent;
iii. Frontline staffing reductions;
iv. Brokerage reductions;
v. Increased travel, energy and core service delivery costs.

If we truly wish to meet a higher threshold for the delivery of appropriate responses to DFV, South Australia requires:

a. **new and additional state funding** to enable a more holistic DFV focused response – this must come from State matching Commonwealth funding and ensuring that indexation actually keeps pace with increases in CPI, staffing costs and costs of living, and that funding amounts reflect the true cost of delivering services in an increasingly complex and resource-scarce broader operating environment;

b. **Increased meaningful investment in ACCOs** and community oversight of use of Aboriginal specific money to ensure it meets the needs of community when administered by mainstream organisations;

c. Meet the operational needs and ensure equitable access to support in **regional/remote areas,** including increased cost of delivering services, tighter recruitment environment and lower access to mainstream services. This requires a revision of value for money considerations, and an understanding that ensuring truly place-based and equitable access to support across the spectrum of need for victim-survivors may not meet traditional value for money thresholds, but must acknowledge that

[3] *Analysis – State and Territory Alignment List, Resources to Support Safe Places Inclusion Round Applications*. Downloaded October 2023

each victim-survivor deserves to access the support they need, no matter where they are located in the state;

d. **Re-funding of brokerage supports**, such as ISSP, which were initially funded by Commonwealth, but with no state-funding to continue, ceased in 2023, significantly impacting on the ability of services to meet the basic financial needs of clients;

e. The pressures of delivering services in the current environment are significantly impacting on the ability of the sector to **recruit, train and retain experienced and qualified staff**. This is creating significant stresses on an already-stretched sector, where burnout and vicarious trauma are very real. While the recruitment environment looks different in different areas, maintaining and developing a specialist workforce with deep understanding of gender-based violence, risk, trauma and person-centered support requires a considered response. This includes considering the impact of the Social Worker Registration Scheme on the recruitment and retention of staff.

Recommendation 4: Improved Supports through Strengthened Multi-Sector Response and Whole-of-Community Responsibility

Responding to, and preventing, DFV is **a whole-of community response**. It cannot be responded to only by specialist services, particularly where there is an over-reliance on crisis response as there is in the current system. Building a state, system and society where DFV is everybody's business is vital, and can only be achieved through cutting through systemic barriers, reducing silos between sectors and services, building a culture of accountability and empathy within key organisations and structures, and ensuring a strong, cross-sector, government-led strategy, with outcomes and deliverables that cut across departments, sectors and silos. While there is much to be done in this space, some initial recommendations from DFVSA include:

a. Maximising the use of **existing options** for response and accountability, including, for example:
   i. Reinvigorating <u>Family Safety Framework,</u> to support swift, trauma-informed, multi-sectoral responses for victim-survivors at high risk. This includes ensuring that the intent and opportunity provided by FSF is maintained, including managing administrative and backbone responsibility, accountability and prioritisation for all partners and ensuring decision-makers are active participants;
   ii. Ensuring that <u>bail, remand and Intervention Orders</u> are utilised, monitored and implemented to their fullest ability to support the visibility and accountability of perpetrators and the safety of victim-survivors and their families;

b. **Safe at Home** currently has significant gaps due created through DSS contracting arrangements, significant underfunding and misses important groups including those not assessed as high risk and who do not identify as female;

c. **Strengthening Police, Corrections and Court responses** to DFV, including:
   i. <u>Improved training</u> and capacity building, to support culture change at all levels, and build genuine understanding of DFV, its impacts and the role of different parts of the system. This must be embedded on an ongoing basis across all levels to develop best practice and trauma-informed responses that keep the safety of victim-survivors, and accountability of perpetrators, at their heart;
   ii. <u>Expanding specialised perpetrator responses</u> both within Corrections and the community;
   iii. Supporting <u>Police and Courts to work collaboratively</u> to ensure perpetrator accountability, including accountability for perpetrators who breach IVOs or bail conditions with meaningful repercussions. This is particularly important in building knowledge and understanding of coercive control;

iv. Supporting best-practice, appropriate police responses across the state, including in regional areas where there can be an over-reliance on individual Family Violence Officers who carry a significant burden and are at risk of burnout, and in small communities where police taking leave can result in no police response for victim-survivors at risk;

d. **Developing and increasing opportunities for co-location, co-case management and multi-sector response.** This includes building on evidence-based models of co-location in South Australia and across other jurisdictions, including between statutory and non-government services (e.g. Women's Safety Services SA (WSSSA) and SAPOL Northern Hub) and across social and community services (e.g. in Havens or regional areas). This includes the capacity to work across sectors and silos, to develop robust ways of co-case managing effectively and with the best outcomes for clients at the heart of the work – ensuring that South Australia maximises the opportunity of the AOD, homelessness, mental health, primary health, DFV and other sectors to work collaboratively at an individual, local, regional and state level.

Recommendation 5: Evidence-Based and Data-Informed System and Services, building a best practice culture of monitoring, evaluation and learning

South Australia lacks a robust strategy for the utilisation of data and evidence for best practice, innovation, monitoring and evaluation. Many services still do not have access to the totality of their data (e.g. Homeless2Home data system), while across the sector we are lacking the requisite capacity, skills and resources to use data effectively to inform decision-making at all levels. This is impacting our ability to meaningfully evaluate and continuously improve our offerings, to build service models which reflect best practice and emerging research, evidence and experience, and to bring together data from across sectors to provide a holistic understanding of the needs, experiences and gaps in the system.

a. South Australia continues to lag behind best and emerging practice nationally and internationally regarding how we engage with, centre and prioritise the leadership of survivor-advocates. We must meaningfully **fund and embed lived experience across entire sector.** DFVSA and Embolden have collaborated to develop a Roadmap (see here) for the sector that outlines the necessary steps to immediately strengthen and centre this vital work – which plays a central role to the evidence, evaluation, monitoring and learning capacity of the sector;

b. To support building improved **evidence-informed decision-making and practice**, South Australia must create opportunity to buy in the skills and expertise to manage this. This includes:

i. Funding Monitoring and Evaluation roles to better utilise data, identify trends/issues, evaluate and learn - currently there is extremely limited capacity to engage with or utilise data beyond performance reporting;

ii. Monitoring, evaluation and learning must have dedicated funding within all contracts to build the sector's understanding and utilisation of more sophisticated monitoring, evaluation and learning (MEAL) tools and focus on learning and improvement;

c. South Australia has no central capacity to understand or analyse outcomes, impact or whole-of-community data regarding DFV. **Increased investment in and oversight of outcomes and impacts** of the system is vital to achieving change – DFV is currently invisible across key Outcomes Frameworks within government, including both DHS and Homelessness Outcomes Frameworks. Without a clear strategy and focused, measurable and visible outcomes measurement, we will continue to be unable to understand the true impact of interventions and commissioned programs.

a. This should sit alongside a state-wide strategy, action plan and implementation plan, to support visibility of activities across the entire DF(S)V sector, understanding the intersections and relationships between services and programs, and to truly understand the depth and scope of DFV in South Australia – currently, we do not even have reliable data regarding

demand, or the type(s) of violence victim-survivors are experiencing. This must include specific and meaningful understanding of data sovereignty, including how data is used, collected, accessed and interpreted, particularly by and for Aboriginal communities;

d. **Build sophisticated data collection and utilisation infrastructure** that includes linked data, reduced administrative requirements and supports an outcomes framework that reflects DFV. At a minimum, this should include;

   i. Action and fund recommendations from H2H review, and particularly develop capability to better collect information on DFV and the specialised nature of service delivery;

   ii. Currently data is owned by government, with services only able to access data via monthly service delivery and KPI reports, significantly limiting the capacity to utilise, engage with and view holistic service and client data. Data should be accessible to services and alliance, supported by improved data capability.

Recommendation 6: Develop the Alliancing Model in Line with System Governance and Oversight, to Maximise Resources and Opportunities

DFVSA echoes Embolden's position on overarching system governance, noting that the DFV system governance remains challenging as it is diversified across a range of portfolios and responsibilities.

DFVSA favours the retention of a potentially adapted alliance model for frontline services, noting the significant importance of collaboration, coordination and accountability that has led to several key successes over the past 3 years and builds on a legacy of collaboration across the sector. However, the machinery of government changes which moved responsibility from Minister Nat Cook and SAHA (as it was) to Minister Katrine Hildyard and Office for Women, splitting DFVSA from the 4 homelessness alliances and wider alliance system, provides an opportunity to review key areas of compliance, governance and risk management which have dogged the alliancing model since inception. DFVSA therefore recommends:

a. **In-depth, formal evaluation of the alliance system**, building on Auditor-General's recent report and SAHT/Flinders light touch governance review that focuses on:

   i. Best outcomes for clients;
   ii. Governance and compliance requirements;
   iii. Legal implications of non-incorporated alliancing model, including risk management, financial accountability and compliance;
   iv. Impact of alliancing on services and capacity;
   v. Appropriate funding for alliances/frontline services, and equitable funding decisions;
   vi. Differences between state-wide and regional alliancing models;
   vii. Roles and responsibilities, including that of government, partners and lead agencies.

b. Review and strengthen **whole-of-sector response**, reflecting the recent Machinery of Government move to DHS, including:

   i. Establishment of an outcomes-focused, impactful and robust sector steering group to replace the now-defunct ASSG, learning from significant consultations and trials (noting that there is work being conducted by DHS to progress);

   ii. Cross-government and cross-sector engagement across whole-of sector DFV and whole-of-system responses (including homelessness) to ensure cross-government, whole of community responsibility to prevent and end DFV;

c. **DFVSA is recognised as a specialised voice within the sector**, as a point of consultation, reference, advocacy and input:

i. Specialist frontline DFV services are strengthened by a collective voice and the Alliance provides the best platform we have currently to ensure that this voice, perspective and expertise is prioritised. DFVSA must be recognised as central to DFV strategy, sector, system and operations in South Australia, and included as a key partner in strategic, policy and system discussions and decisions. DFVSA holds a unique perspective, bring operational knowledge and bridging the gap between operations and strategy to provide important insights into strategic decision-making;

ii. As the Royal Commission's recommendations are likely to open opportunity for significant changes across DF(S)V sector, the importance of maintaining the specialisation in the response to victim-survivors is paramount. DFVSA works well alongside the peak body and other key parts of the sector (e.g. perpetrator responses), and provides an opportunity to ensure that decisions are considered in light of best outcomes for clients, impacts on the ground, service continuity and ongoing collaboration.

Conclusion

DFVSA appreciates the opportunity to provide this brief response to the Issues Paper for the Royal Commission, and provide initial priorities and recommendations to support the first phase of work of the Commissioner. We look forward to providing a more fulsome and expansive response as part of our main submission in September.

In the meantime, should you require any further detail, information or direct consultation, please reach out to Laura Cremen, [redacted]

SUBMISSION TO CONSULTATION PAPER

Amendments to the migration framework to support visa holders experiencing domestic and family violence

Introduction

Domestic and Family Violence Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services and programs, alongside government partners. The service partners are:

- Women's Safety Services South Australia (WSSSA
- Centacare Catholic Family Services (CCFS)
- Centacare Catholic Country Services (CCCSA)
- Yarredi
- Nunga Mi:Minar
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support around 5,000 people annually, and include local place-based support and state-wide services such as the Domestic Violence Crisis Line. Services provide support in a range of accommodation types, primarily including hotels, motels, caravan parks and other providers of Emergency Accommodation Program accommodation, service-led crisis accommodation (often congregate sites of 4-10), Supportive and Transitional Housing Program accommodation. We also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing in a uniquely integrated model.

As the primary providers of frontline crisis DFV specialist support, we are uniquely positioned to provide input and feedback on these issues, and welcome the opportunity to ensure that the barriers, gaps and needs related to ensuring that victim-survivors of DFV from culturally and linguistically diverse backgrounds are better responded to.

The Alliance is proud to include the state-wide Migrant Women's Support Program, who deliver specialist responses to victim-survivors of DFV. This gives us a unique and important role in advocating for policies, practices and services which are proactively delivering culturally safe, appropriate and impactful responses to women from culturally and linguistically diverse backgrounds. As part of our commitment to service improvements and sector collaboration, our CALD Working Group is leading work to improve our practice, engage with partners and continuously improve how we as services, as a sector, and a community, are ensuring that all victim-survivors, regardless of their visa status, are safe and supported through their experiences.

Responses to Consultation Topics

Temporary visa holders who experience domestic and family violence face a multitude of challenges and disadvantages. Their vulnerable immigration status can be wielded as a tool of control and coercion by perpetrators, exacerbating their predicament. Moreover, these women often encounter significant barriers when seeking assistance from health and family violence services. Compounding their isolation, many of these women lack a support network and rely on the abuser for social and community connections.

At DFVSA, we deeply value the safety of all women and their children, recognizing their right to be free from violence, irrespective of their visa status. Consequently, we offer the following recommendations to ensure the safety and well-being of all women and their children.

Recommendations for Amendments to the Migration Framework

> *We must do all we can to prevent women from having to choose between their safety or their visa status.*

Part A.

Primary issues affecting temporary visa holders experiencing DFV

Through extending the temporary stay for DFV victim-survivors, we can empower and protect individuals who are already vulnerable due to their experiences of domestic and family violence. This proposal aims to prevent these victim-survivors from becoming unlawfully present or losing their visa status, providing them with the necessary time, resources and support to rebuild their lives and access the appropriate legal and community assistance they require to recover and thrive.

In taking this proactive step, we demonstrate our commitment to humanitarian values and ensure that DFV victim-survivors have a fair chance at securing their safety, wellbeing and long-term stability.

In the below, we outline the most pressing issues, including both those listed in the consultation paper and additional issues which we feel require further consideration.

Recommendation 1: Ensuring Victim-survivors' Safety

Extending the stay of DFV victim-survivors is fundamentally driven by the need to prioritize their safety and security.
To effectively address this issue, it is crucial to establish robust measures that safeguard the information shared between Centrelink/Medicare, police and other relevant government services.

These measures should ensure that such information cannot be used to the detriment of the woman or her dependents, including visa cancellation, deportation, or any negative immigration-related consequence. Clear protocols for information sharing must always prioritize the safety of women and their children.

Recommendation 2: De-linking the visa status of a secondary visa applicant from a primary applicant perpetrator of violence to protect their privacy

We strongly endorse the implementation of measures to ensure that the visa status of secondary applicants is not contingent upon the primary applicant, who may be the perpetrator of domestic and family violence.

This entails enabling secondary applicants to maintain their visa status independently, regardless of the actions of the perpetrator. It is imperative to guarantee that secondary visa applicants, who may be victim-survivors of violence, have the freedom to access support services without the fear of their visa status being connected to the perpetrator.

Through adopting this recommendation, we aim to sever the link between the visa status of secondary applicants and primary applicants who engage in violence. This step is crucial in safeguarding their privacy, empowering them to seek assistance and fostering an environment that promotes safety and support. Ultimately it encourages individuals to come forward to seek help and break free from situations of domestic and family violence.

This could reduce the use of visa status as a form of control and fear, providing a clear message to all people that victim-survivors of DFV will be supported by Australia to be safe and supported.

Recommendation 3: Ensuring streamlined eligibility to equitable access support services and Extending Temporary Stay in Australia

To ensure the safety and recovery of DFV victim-survivors it is essential to prioritize their eligibility and access to services and government support, regardless of their migration status. Ensuring that victim- survivors can make meaningful decisions that prioritize their safety, well-being and recovery is vital. This includes facilitating their access to specialist services such as housing, health care, legal aid, social security benefits, education and stable visa status. We know that lack of access to crucial social and economic supports creates an enormous barrier to victim-survivors leaving unsafe situations, which is exacerbated when access is fundamentally denied due to their status. It is crucial that victim-survivors and their dependents have the right to safe accommodation and access to support without interference from the perpetrator.

It should also be considered and recognising that DFV victim-survivors often require a comprehensive range of support services to address their needs. This may include stable financial support, trauma and other specific needs counselling, legal assistance and emergency accommodation.

An extended stay allows victim-survivors to fully engage with support networks, such as domestic violence services and shelters, counselling centres and community organizations. This facilitates improved access to essential resources and ensures victim-survivors receive the necessary assistance for their physical and emotional recovery.

Recommendation 4: Appropriate Funding for Support Services

DFVSA strongly advocates for the allocation of additional and dedicated funding to services who support victim-survivors who may be impacted by the extension of visas. Through securing adequate funding, we can ensure the availability and sustainability of specialized programs and initiatives that cater to the complex needs of temporary visa holders facing domestic violence. This funding should encompass culturally sensitive support services, legal aid, emergency accommodation, financial assistance and ongoing case management.

Furthermore, it is imperative that existing support services receive specific and appropriate funding to address the unique circumstances faced by temporary visa holders and their children. This funding would enable organizations to strengthen their capacity to provide culturally sensitive and linguistically appropriate support tailored to the needs of these vulnerable individuals. Furthermore, the funding for specialist organisations to provide free interpreting and translating services should be included.

We are concerned that without the above, services risk being unable to provide appropriate support to victim-survivors who may be made eligible for support. We remain committed to ensuring we support as many victim-survivors as possible, but strongly advocate that any changes in access to services is linked to appropriate funding for those services to be delivered in a safe, timely and culturally appropriate manner.

Recommendation 5: Access to sustainable funding to specialist legal services

Many victim-survivors of DFV may require engagement with legal processes, such as obtaining restraining orders, initiating divorce proceedings, or pursuing criminal charges against their abusers. Extending their stay provides sufficient time for victim-survivors to navigate the legal system and seek justice, without the added pressure of prematurely leaving the country. It enables victim-survivors to fully engage with law enforcement agencies and receive support during court hearings, thus ensuring a fair legal process that upholds their rights and promotes their overall safety.

Recommendation 6: Children’s right to support and safety

Recognising that focusing on the adult victim-survivors alone is insufficient; it is equally crucial to consider the needs of the affected children who are also victim-survivors in their own right. Witnessing and experiencing domestic and family violence can have profound and long-lasting impacts on the well-being and development of these children. Therefore, any proposed extension of support services and/or temporary stay must encompass addressing the specific needs of these children.

Extending their stay would allow these victim-survivors to prioritize the safety and well-being of their children, ensuring that they can seek appropriate protection and support services. This includes accessing child protection agencies, enrolling children in schools, and establishing a stable environment that fosters their recovery and development.

This would also remove a significant barrier to leaving unsafe relationships, at the real risk of deportation of a victim-survivor on a temporary visa, potentially separating them from children who are Australian citizens. This has a significant impact on fears for parents in reporting DFV and the impact on their ability to remain in Australia with their children, particularly as there are often concerns regarding custody arrangements, safety or support in their home country, and managing international custody hearings and arrangements.

An extended stay for visa holders would ensure that they can make the best decisions for themselves, and often their children, without fear of imminent separation and potentially leaving children with their abusive parent

Recommendation 7: Economic Stability

DFVSA advocates for several measures to support victim-survivors of DFV who are on temporary visas. These measures aim to address the financial hardships faced by victim-survivors and provide them with the necessary support to secure housing, healthcare, income and independence.

- Eligibility for Social Security Payments: DFVSA suggests that a new temporary visa category should be created to provide victim-survivors of DFV with access to appropriate social security payments and entitlements, similar to those available to permanent residents or citizens. This would help alleviate financial burdens and provide victim-survivors with the necessary resources to rebuild their lives;
- Exemption from Waiting Periods: Currently, women who are granted permanent residency through their application for family violence provisions may be subject to a four year newly arrived resident's waiting period. DFVSA recommends that these women be automatically granted an exemption from this waiting period as part of their visa approval. This would ensure they receive immediate support without further delay;
- Immediate Parenting Payment Access: Women who are sole parents and victim-survivors of DFV should have immediate access to the parenting payment. Currently, these women may have to wait for a decision on their family violence provision application before being eligible for this payment. DFVSA asserts that immediate and ongoing funding support is necessary during the waiting period to assist these women;
- National implementation of women without income programs to provide financial assistance to victim-survivors and services to provide sustainable support to meet the safety needs of women and their children.

Through implementing these measures, DFVSA aims to reduce the vulnerability of victim-survivors on temporary visas and support them to regain their independence and financial stability.

Recommendation 7: Collaboration and Partnerships

To address the needs of victim-survivors and their children effectively, it is crucial to foster collaborations between government agencies, community service organizations and support networks. Through joint efforts, comprehensive and integrated approaches can be developed, providing holistic and coordinated support that promotes the safety, empowerment and long-term recovery of victim-survivors.

Additionally, it is essential to prioritize the implementation of comprehensive training programs for service providers and community organizations working with this vulnerable population. By equipping personnel with the necessary knowledge and skills to address the unique challenges faced by temporary visa holders, we can enhance their ability to provide effective support while reducing potential barriers arising from cultural or linguistic differences. We would also encourage broader training and understanding of the FVPs, and the rights of those on temporary visas, within Home Affairs, Border Control and related departments to ensure victim-survivors are recognized and supported appropriately no matter where they seek support, disclose or where a staff member may have concerns.

Recommendation 8: Cultural Challenges and the Need for Extension

The family violence provision visa serves as a crucial lifeline for victims of domestic and family violence on secondary visas in Australia. However, the current restriction of accessing this visa only when violence occurs within Australia, overlooks a significant reality of cultural barriers.

For individuals originating from cultural backgrounds where divorce or separation is not supported or where this is stigmatized, seeking legal assistance becomes extremely challenging, sometimes exacerbated due to experiences of judicial systems which discriminate against women, or particular communities.

DFVSA advocates for expanding access to the family violence provision visa beyond instances of violence within Australia, as it is imperative to acknowledge and address this safety concerns of victim-survivors who endure violence perpetrated by family members from their home country.

By dismissing the experiences of those who face violence originating from their home country, we disregard the unique and complex barriers they face in obtaining safety and protection.

Restricting access to the family violence provision visa solely to cases occurring in Australia perpetuates a cycle of abuse, leaving victims trapped and without the means to escape their abusive situations.

Recommendation 9: Recognising the role of deception and coercion

DFVSA fervently advocates for a temporary visa extension to be granted to victim-survivors of coercive control, recognising the formidable obstacles they face in collecting the necessary evidence to meet visa requirements.

Victim-survivors of coercive control face well-documented challenges in gathering evidence to meet the criteria for a visa extension. It is vital to recognize that the dynamics of coercive control within relationships are not fixed; they often escalate over time, leaving victim-survivors in increasingly vulnerable situations. Perpetrators of coercive control frequently isolate their victim-survivors, making it even more difficult for them to seek assistance or collect proof of the abuse they endure.

Additionally, coercive control primarily operates through psychological manipulation, which can be harder to substantiate compared to physical violence. This perpetuates a vicious cycle where victim-survivors remain trapped in abusive circumstances, unable to meet visa criteria, resulting in prolonged suffering.

Besides advocating for a more compassionate approach to eligibility requirements, it is crucial to ensure that victim-survivors receive the essential support and protection they need. As more and more states introduce or consider legislation on coercive control, it is imperative that the migration framework keeps pace and reflects

the increasing understanding of the risk, safety and impact of coercive control.

Part B.

Expanding the Family Violence Provisions (FVPs) to additional permanent visa subclasses

Recommendation 10: Permanent Visa Subclasses who Require Expansion of Access to FVPs

The family violence provisions of the Migration Regulations 1994 (Cth) currently only allows individuals on certain visa pathways, primarily Partner visa applicants or related Bridging visa holders, to continue their application for permanent residency after experiencing domestic violence by their intimate partner.

However, DFVSA recommends expanding access to these provisions to include additional applicant groups who are also experiencing family, domestic, and sexual violence.

This expansion should encompass:

- Prospective Marriage (Subclass 300) Visa holders who have not married their sponsor before the relationship breakdown or violence has occurred;
- Onshore permanent visa applicants who have applied as a secondary (dependent) applicant;
- Onshore applicants who have applied for a family visa;
- International Student visa holders.

Implementing this recommendation would ensure that a wider range of individuals affected by domestic violence can access the necessary support and protections provided by the family violence provisions.

Part C.

Temporary visa for victim-survivor of domestic and family violence

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Recommendation 11: Key Elements of a New Temporary Visa for Victim-Survivors

- The visa application should include a provision for a bridging visa with work rights to ensure applicants can maintain households and care for dependents effectively;
- The visa should not impose any limitations on work or study and should grant victim-survivors access to essential services like Medicare, Centrelink and social security support;
- The temporary visa should offer a clear pathway to obtaining a permanent visa, providing victim-survivors with a sense of safety and certainty;
- It is crucial to introduce a new substantive temporary visa to protect victim-survivors of domestic and family violence, regardless of whether their temporary visa was cancelled onshore or offshore;
- This visa should also cater to individuals who are involved in ongoing family court matters concerning their children;
- Victim-survivors who are unable to provide evidence of their spousal relation due to domestic, family, or sexual violence should also be eligible for this visa;
- The visa should have a pathway to a permanent visa, specifically designed for parents of Australian children;

- There should be no application fees associated with this visa and waivers should be granted for health and police check requirements.

Recommendation 12: Evidentiary requirements

The requirement for the relationship to have ended before a victim-survivor of domestic and family violence can access the Family Violence Provisions is a problematic aspect of the process.

This condition poses risks as the perpetrator may escalate their violence to reclaim power and control. Additionally, leaving the home may not be feasible due to limited access to support services, income and housing options. In such situations, if homelessness becomes the only alternative, some women may choose to provide evidence of domestic and family violence and seek assessment for a permanent visa while still residing with the perpetrator.

Recommendation 13: More Understanding Requirements toward Coercive Control

In recognising the unique challenges faced by victim-survivors of coercive control, it is crucial to revise the visa requirements to be more empathetic and understanding. Current requirements tend to focus heavily on evidence-gathering, often disregarding the complexities and nuances of abusive dynamics. Thus, a revised and comprehensive approach should be adopted, taking into account the psychological, emotional and financial constraints faced by victim-survivors.

South Australia Domestic and Family Violence Safety Alliance (DFVSA)

Response to Housing and Homelessness National Plan Issues Paper

September 2023

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- Yarredi
- Nunga Mi:Minar Incorporated
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support over 4,500 people annually and include local place -based support and state-wide services such as the Domestic Violence Crisis Line. DFVSA brings together specialist providers of domestic and family violence support and are the primary providers of DFV homelessness support in South Australia (emergency accommodation, crisis, supportive and transitional accommodation). The Alliance partners also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing through a uniquely integrated model.

DFVSA acknowledge that housing instability and homelessness is a multifaceted and complex problem caused by multiple push and pull factors that span social, cultural and economic domains. However, due to the scope of service provision of the DFVSA, this paper will primarily address issues associated with domestic and family violence and housing instability and/or homelessness. Our responses to the Plan are therefore framed within this context. Our response also incorporates input from sister services to the Alliance, in particular the Coober Pedy Homelessness and DFV service which, while not formally part of DFVSA, is an important partner in delivering homelessness and DFV services in remote South Australia.

General Comments

Links between DFV and Homelessness

Women who experience DFV often face disadvantage across the spectrum of housing instability and homelessness for a range of reasons, including decreased earning capacity (gender pay gap and burden of care), single parenthood and multiple moves in their efforts to secure long -term, safe, stable, secure and affordable housing[4]. Housing instability and homelessness may continue across the lifespan for women and children experiencing DFV. This could mean moving 3, 4 or more times in a very short period, across urban and regional locations. This impacts significantly on the capacity of these women and children to build supportive community connections and stability. For example, children may have to switch schools at short notice, and, similarly, women who may be employed may need to terminate employment and sever local, supportive connections.

DFVSA is significantly concerned at the lack of visibility of domestic and family violence throughout the issues paper. As one of the primary drivers of homelessness for women and children, we expected the paper

[4] Ann Summers' excellent research report *The Choice: Violence or Poverty,* clearly articulates these links and the impacts of structural programs on individual socio-economic and personal wellbeing.

to be more explicit about responses to DFV. This is especially surprising given that the National Housing and Homelessness Agreement underpins the funding of many specialist DFV crisis services across the country. In South Australia, homelessness funding remains the biggest funding tranche for crisis DFV services (DFVSA currently receives just over $16million to deliver 19 frontline services and programs across the state). In not recognising and articulating the extensive links between DFV, housing and homelessness in the Issues Paper, we are concerned that such links remain hidden and segmented and do not acknowledge the impact on victim-survivors, communities, policy and support programs, such as DFVSA.

The links between DFV and housing and homelessness are well-evidenced via longitudinal data and research. We therefore strongly recommend that any Housing and Homelessness National Plan clearly articulates the link between, and appropriate responses to, DFV and homelessness, while aligning with the National Plan to End Gender-Based Violence, Closing the Gap and other key strategies. This includes how homelessness programs, services and systems are flexible and adapted to the differing needs of different communities and groups.

By erasing intersectionality and difference, albeit with good intent, we risk a generic system that is inflexible and does not cater to the needs of the many different communities we work with across the state – communities impacted by geography, culture, experiences of violence (including domestic and family violence), age, gender, sexuality and socio- economic differences.

Investment

Specialist homelessness and DFV services are feeling the impact of cumulative years of financial stress, with modest funding increases unable to meet statutory staffing increases and inflation (particularly considering the disadvantage faced by services who are funded primarily via Commonwealth regarding the equitable application of CPI).

YEAR	CPI	Min Wage Increase	Super increase	State Funding Indexation	Alliance Funding Indexation (SAHA)	Funding Received	Actual $ Increase (year on year)	Actual % Received	Minimum funding required to meet CPI and wage increase	% Increase required (minimum)	Actual additional minimum funding required to meet increases
2021-22	3.8%	2.5%	0.5%	0%	N/A	$15,543,000					
2022-23	5.1%	4.6%	0.5%	2.6%	2.25%	$15,650,900	$107,900	0.69%	792,693	5.10%	684,793
2023-24	7%	5.75%	0.5%	2.5%	2.42%	$16,196,519	$545,619	3.49%	1,007,527	6.44%	461,908
Total						**$47,390,419**	**$653,519**		**$1,800,220**		**$1,146,701**

In the years covered by the table above, we have seen services diminished by the expectation of doing the same, or more, with less. Services are expected to continually find savings where there are none and run increasingly lean service models to remain financially compliant and viable. This has resulted in a base funding gap of over $653k over the past 3 years for services which are already running on extremely fine margins and/or deficits [3], in addition to the cumulative impacts of underfunding over previous years.

Funding must also be long-term and sustainable, with clear plans for long-term funding for successful pilots. Equally, funding must support the policy-driven models enacted to support service delivery, e.g. the Alliance model in South Australia, with its increased administrative costs.

South Australia has recently seen the cessation of COVID-era Individual Safety and Support Packages (ISSP), which has reduced the brokerage available to DFVSA services by around 65% this financial year, having been injected into the sector for over 3 years. Without sustainability planning and greater collaboration between State and Commonwealth to invest in sustainable, evidence-based service options, and a true equity lens across the country, we continue to risk sector instability, reduced access to quality services and ultimately the potential to provide timely, safe interventions to people most at risk.

Pilots must have clear sustainability and long -term planning attached from the outset, so that there is a clear pathway to **long-term, sustainable funding** for pilots that work. Too often, services get caught between state and Commonwealth funding, which ultimately impacts on those seeking support. For example, the newly -launched early intervention and recovery pilots in South Australia, funded under the National Plan, must have sustainability measures built in, particularly in the case where pilots are shown to be successful. Risking the longevity of services that are demonstrated to work through a lack of long -term financial planning risks the integrity of the system, and of services who are responsible for responding to community needs and expectations.

Focus area 1: Homelessness

What are the different challenges for people experiencing homelessness in urban, regional and rural areas?

Homelessness presents a variety of challenges irrespective of location. However, the specific nature of these challenges can differ in urban, regional and rural settings due to the distinct characteristics of each environment.

Access to Crisis Accommodation

DFVSA supports an average of 35-45 families (up to 100 individuals) in emergency accommodation (hotel/motel) every night, with 75-85% of these being in the greater Adelaide area. This reduces the capacity of services to provide support to victim-survivors outside of crisis accommodation (including Emergency Accommodation (EAP), DV-Crisis Accommodation Program (DV-CAP), Supportive Housing Program (SHP), Transitional Housing Program (THP) and core and cluster/shelter), Such services are only available to a very limited degree.

There are no approved EAP providers in regional areas at all, though services can access local providers if available. In regional areas, where accommodation options are limited, services must provide support to clients in other forms of accommodation (including clients' own homes) - the lack of options does not necessarily denote a lack of need. Significant blockages to alternative accommodation may also be the result of family, cultural or other connections where clients, understandably, are reluctant to relocate.

While it is important to maintain place-based responses - and this fundamental to the policy and principles that support DFVSA - it does lead to inequitable access to safe accommodation options for those experiencing or at risk of homelessness due to DFV. This can and does look different in different areas and contexts and has a direct impact on the scope of services and support that is available through crisis services.

	Core and Cluster/ Crisis	DV-CAP	Supportive Housing Program	Transitional Housing Program	Total
Metropolitan Adelaide	42	10	74	76	202
Aboriginal-Specific (metro)	11	0	9	10	30
Regional	32	5	23	44	104
Remote[5]	2	1	2	0	5
Total	**87**	**16**	**108**	**130**	**341**

Table 1. DFVSA Accommodation Options across the state

In regional centres, where services may already be limited, inflow from remote communities can create

[5] Including 2 crisis properties in Coober Pedy

waitlists and access issues. A clear example of this is evident within the more rural and remote areas that DFVSA services are delivered. Some regional areas have no crisis accommodation at all, and most regional and remote areas have extremely limited (if any) access to hotels/motels for emergency accommodation. Access to appropriate crisis accommodation for victim-survivors of DFV is severely limited. Thus, there is a significant difference between the availability of crisis accommodation options across South Australia. Geography also impacts the type of services available – regional and rural services often cover vast distances, with case managers often hours away from clients. While technology has done much to bridge these gaps, it leads to inequitable access to support, in-person engagement and reduced safety options for those at high risk.

Urban Areas

In urban areas, high living costs make it harder for people experiencing homelessness to afford essentials. Competition for limited resources such as shelter, community support, food and medical services is significant. Safety is a concern due to crime and exploitation and although there are generally more services such as mental health, AOD and financial wellbeing supports in urban areas than rural, accessing them is a challenge due to waitlists and high demand. Urban areas also experience inflow from regional and remote areas, as hubs for services and community, with more limited flow out from urban areas to regional and rural areas. This can result in tighter eligibility criteria for access to urban services, where higher demand may mean that delivery is constrained to those who are in crisis or at highest risk. Whilst public transport may be more readily accessible in urban areas, distance between services and supports can impact on accessibility, particularly for victim-survivors of DFV who may need to move out of one area for safety but maintain ties with that area through children's education or work.

Regional Areas

In regional areas, support services like shelters, transitional housing, medical assistance, and mental health resources are often scarce. People experiencing homelessness in these areas are more likely to feel isolated due to close-knit communities and the heavier stigma attached to DFV and Homelessness, resulting in reduced support options. The challenge of limited public transportation can hinder access to services, work opportunities, and appointments. Moreover, fewer job prospects in regional areas can make it more challenging for individuals to secure stable employment. Confidentiality can be difficult or impossible to maintain, where the location of DFV crisis services and accommodation are often well-known in the community. While this can increase community commitment to safety, it means that perpetrators or their families often know the location of victim-survivors, requiring additional safety planning and risk management. There is also fewer private rental, public or community housing options in regional communities, particularly where industry or commercial business interests have the capacity to book out rentals and short-term accommodation. This lack of availability is further exacerbated by close community ties, impacting access to hotel/motel or other emergency accommodation where someone is known, or is linked to specific families, cultural groups etc.

Rural/Remote Areas

In more remote areas, basic services like medical care, mental health resources and housing options are either scarce or entirely absent. Where they do exist, they are often provided via fly-in, fly-out or telehealth service delivery modes. In these places, access to food, shelter and safety can be extremely difficult and increases vulnerabilities and isolation. In smaller communities, there is more likely to be heightened stigma regarding homelessness and DFV, leading to increased isolation and diminished support. Transport to even the most basic services can be expensive and difficult to access, where lack of access diminishes rights. For example, the inability to easily access legal, health or other supports because of non-availability locally, can limit the exercise of those rights.

What short, medium and long-term actions can governments take to help prevent homelessness or to support people who may be at risk of becoming homeless?

Services often fall short in addressing the **distinct and localised needs of specific clients and communities**. Homelessness is not a one-size-fits- all issue. It is intrinsically linked to the cultural, economic and social fabric of each person's situation and community. Solutions and options often overlook the nuances that define personal or community challenges and strengths. Service planning, options and pathways often neglect to account for the availability or lack of local resources and capacity, cultural sensitivities and community dynamics that significantly impact the effectiveness of interventions. To meaningfully address homelessness, it is crucial to tailor solutions to the unique characteristics of each community, fostering an approach that acknowledges and embraces the diversity of the challenges faced by those experiencing homelessness in different places. Lessons from the last two years of the Alliance Model in South Australia, and particularly for DFVSA as the only state-wide alliance specialising in DFV, has underscored the importance of responses that are flexible enough to be adapted to local, place-based contexts, communities, and needs.

The current homelessness service model in South Australia, is not fit-for-purpose, **relying too heavily on crisis response**. Without a move towards a **public health model** of addressing DFV and homelessness, we will continue to over-emphasise crisis response while under-investing in impactful, evidence-based earlier intervention and prevention models proven to provide better outcomes and longer-term wellbeing. Without additional investment in earlier responses, crisis services will continue to be forced to neglect those who could be supported through earlier intervention to avoid homelessness whilst (rightly) prioritising the immediate needs of those in crisis and at greatest risk.

Whilst there is significant evidence to support earlier intervention, the situation in South Australia is further exacerbated by the **lack of true outcomes measurement and frameworks.** While we applaud the work that is being undertaken at both state (South Australia is currently finalising a homelessness outcomes framework) and a national level (the recently- released National Plan to End Violence against Women and Girls outcomes framework), we acknowledge that we need to be able to better monitor, measure, manage and invest in what is working. To do so, we need investment in effective monitoring, evaluation and data analysis tools to enable us to better understand the data and the efficacy and impact of our work. Only in this way can we build on what is working and learn from what could be improved. This is also contingent on developing linked and connected data across sectors (and even across programs within the same services), and the capacity to adapt and modify services in line with emerging trends, environmental changes and evidence-based best practice.

Post-crisis and early intervention services are also an important support for victim-survivors of DFV. The impact of multiple moves as a flight response to safety issues can have significant lingering psychological impacts that often remain unsupported. Such impacts and effects can manifest once the person is safe. Supporting those experiencing homelessness where the root cause is DFV requires comprehensive interventions to address psycho-social challenges. Recovery and post-recovery programs must be funded, piloted and evaluated to properly consider their cost/benefits. Additional supports for this cohort could include legal assistance and expanded tenancy support in public and private rentals. Recognizing the root causes of homelessness is crucial in prevention, especially in cases where it stems from domestic and family violence, and providing post-crisis support further demonstrates a commitment to prevention though building resilience and meaningful recovery (see section below for further points regarding early intervention). By providing comprehensive support, preventing homelessness, addressing emotional and mental health challenges, promoting economic stability, and offering legal assistance, early intervention and recovery/post -crisis programs effectively support individuals and families affected by domestic and family violence. Recognizing the importance of investing in these programs is essential to breaking the cycle of abuse as well as homelessness. Ensuring that victim- survivors have the right support, at the right

time, from the right service, is vital to addressing their short, medium and long-term needs.

How can the homelessness system more effectively respond to those at risk of, or already experiencing homelessness?

How can the homelessness system ensure those at risk of homelessness or in crisis receive appropriate support to avoid homelessness or, so they are less likely to fall back into homelessness?

Put simply, it is imperative to **invest in earlier intervention and recovery**, including post-crisis response following exits to longer-term accommodation. This is further discussed in the section on early intervention below.

Current Supportive and Transitional Housing Programs in South Australia remain unfit for purpose, as they **presuppose access to longer term housing options which are unavailable** in the current housing environment. Linking DFV support to housing outcomes and exits without clear specialist pathways and longer-term supportive housing models, takes focus away from DFV support and pushes into homelessness and housing first responses which are not always most appropriate. Ensuring that programs are flexible for those engaged in them is vital in tailoring supports to specific needs. Linking support directly to accommodation options, rather than client needs, means that clients are forced to engage with services as part of lease agreements that can last up to 2 years (depending on their housing options). The capacity to transfer leases from supported accommodation and connected supports, to long -term independent leases would allow for flexible support which rewards clients who are ready for independent living. Ensuring access to support following exit from formal crisis programs could also lead to greater stability and positive outcomes.

We consider it imperative that programs that do currently exist, such as 'Safer in the Home' (national program) and 'Safe at Home' (state programs), funded under the **Keeping Women Safe in Their Homes** Commonwealth initiative, are connected to support women across the continuum of risk and need. Currently, SITH provides support to people at low/medium risk, while those at high risk are supported by state Safe at Home initiatives. However, there is limited case management or short-term support available via SITH, which is focused on brokerage and security upgrades, and often those clients are not at high enough risk to access crisis support services. In South Australia, the Safe at Home program only enables access to case management support beyond security upgrades if the victim -survivor meets the eligibility criteria for crisis DFV services. However, the South Australian model for delivering Safe at Home via DFVSA has ensured true state-wide coverage, local response and partnerships with local housing and trades partners, and we encourage similar models nationally to address inequitable access to support wherever possible. Ensuring that there are supports available locally where additional needs are identified is vital for those at lower risk to prevent escalated risk. Security upgrade interventions need to be coupled with appropriate social or other supports (usually short-term).

Access to appropriate, long-term, safe accommodation is essential, and we simply do not have enough. Further, the lack of culturally appropriate housing (see elsewhere in this paper and in the attached briefing to SA Government) exacerbates this issue. The client group with whom we work are most often those with no other options. By accessing DFV-specific accommodation and services, victim-survivors have usually exhausted any and all other options. The funding provided to DFVSA focuses on providing support to those at risk of, or experiencing, homelessness due to DFV.

We know that the lack of appropriate housing can, and does, lead to women deciding not to leave, or returning to a DFV perpetrator. This is particularly risky in the current service provision environment, where women and their children are being forced to spend more time in crisis, supported or transitional housing due to the dearth of appropriate and safe long-term housing exits. DFVSA data tells us that:

- The length of time women and children are spending in emergency accommodation (hotel, motel, caravan parks) has been increasing an average of 1 night / quarter since July 2022, indicating that exits into appropriate housing options (both supported and otherwise) are more difficult;
- The length of stay in Transitional Housing Program properties is also increasing (by almost 20 nights on average over FY22-23).

The proportion of DFVSA clients who are successfully exiting into long -term accommodation is decreasing, mostly due to reduced options for long-term housing.

We also highlight the impact of visa restrictions on those with **temporary visas**, which limits income and therefore affordable and safe housing options. At least 10% of DFVSA's clients identify as CALD, and 105 clients last year were on temporary or student visas, severely restricting their access to safe, affordable housing. This creates a significant barrier to identifying appropriate long -term housing options, with many migrant families waiting months and years in **crisis accommodation** due to the lack of alternative viable options. Ensuring availability and access to safe, appropriate accommodation for those on temporary visas must be supported.

Many existing **financial supports**, such as the Private Rental Assistance Program, focus on supporting those who already have an independent income, but there are extremely limited, if any, options to support those who have no income, and no right to any government support (for example, the Escaping Violence Payment is only available to those on permanent visas or to Australian citizens), although we note and welcome the trial announced in the recent budget for this to be extended to those on temporary visas. Ensuring victim-survivors of DFV from all backgrounds and socio-economic situations have access to the housing and support they need to safely settle and thrive in Australia must be addressed.

Considering the current housing market, and the significant competition for affordable properties, better engagement with private landlords and rental agents is vital. Considering ways to combat the ongoing discrimination against, and lack of options for, low-income earners through incentives or head-leasing could be explored. We welcome South Australia's recent roundtable on renting and DFV, but note that without all relevant government, private and service partners together (including senior representatives from housing, homelessness, DFV, health and others), providing a coordinated and efficient response remains cumbersome.

What actions can governments take to facilitate early intervention and preventative responses?

We must review and reconsider the current models of support, which heavily rely on crisis interventions to bolster the whole sector. We argue that homelessness and DFV are public health issues and must be treated as such – through a **public health model of support**. Continuing to invest in homelessness or crisis DFV responses will continue to push people into systems that we know aren't working. We need new investment to support earlier intervention and prevention and reduce the impact on tertiary services, enabling them to work holistically with those with complex needs.

Governments must consider **broader definitions of early intervention and prevention**. Current definitions are narrow and applied within a 'housing first' paradigm. Housing instability and homelessness are often impacts experienced as a result of other factors. Early intervention must be viewed through a broader lens, considering the holistic needs of a person experiencing housing instability or homelessness. Doing so would enable earlier intervention and/or prevention by addressing intersectional issues such as DFV, substance misuse, psycho-social and mental health issues, all of which are significantly associated with increased risk of homelessness. We must foster **cross-sector and cross-governmental strategies and responses**. For many of the clients with whom we work, housing instability or homelessness resulted from a range of other factors – especially DFV. An approach that privileges people, in place, in intersectional ways,

rather than programs ensconced within specific and siloed policy portfolios is vital to address the complexities that exacerbate housing instability and homelessness.

In South Australia, for example, the primary early intervention service funded for victim -survivors of DFV through homelessness is the 'Safe at Home' Program – which is only appropriate for those where the perpetrator is no longer living at home, where the owner of the property has consented and where physical security upgrades are deemed the primary response. While this is a welcome service, with DFVSA supporting around 700 clients through this program last year across the state, it does not fill the gap of earlier intervention programs that address the risk of repeat or chronic homelessness, where insecure housing and crisis-focused support reduce the opportunity for long -term impacts.

Many crisis services end support once a medium-term accommodation option has been identified outside of homelessness programs (in South Australia, that would be outside of programs such as emergency assistance program, crisis accommodation program, crisis accommodation, transitional and /or supportive properties). There is extremely limited support available for clients following the identification of a successful tenancy, which is often when someone is finally able to focus on their recovery, resilience, and long-term plans. For many victim-survivors of DFV, this is when support can be most impactful, but most difficult to access.

Ensuring that there are supports available to clients to settle into accommodation following the identification of appropriate long -term options (which remains a significant challenge in itself) is vital. This is often the time when people need support to re-establish their lives having been in temporary accommodation of various types for some time. Too often, due to service pressures, contractual parameters and/or services available, support will 'drop off' after someone finds an appropriate exit from the homelessness support system. Being able to provide a more meaningful supportive housing model could provide the longer-term support needed to enable clients to settle into tenancies, and rebuild their lives, thus reducing the risk of 'falling back' into homelessness.

How can governments capture better evidence on 'hidden' or 'invisible' homelessness (e.g. couch surfing, living in a car and overcrowding)?

AIHW data, collected directly by services, informs much of our work in this context (at a service, state and national level). However, this data relates only to clients who are actively supported by DFV or homelessness services funded under the National Housing and Homelessness Agreement (NHHA). It remains notoriously difficult to measure unmet or unseen demand, or broader population level homelessness, where people have not actively reached out to, and been supported by, funded services.

Improving connected datasets – including specialist homelessness services, specialist DFV services, justice, health, child protection and others – alongside population level data from ABS, HILDA, census and others, would provide a more holistic and robust understanding of broader homelessness issues. This should be tailored and supported by Commonwealth, state and local government. This would require investment in systems and people to collect, collate and analyse such data, but would provide a far richer picture of homelessness and the broader factors that impact upon housing instability and homelessness. A common data dictionary developed across government portfolios and co-designed with service providers could enable the collection of data to inform unseen and unmet needs. Social services and their delivery should be underpinned by a minimum data set informed by intersectionality which drives service improvements and adaptations. Over time, such data could inform greater efficacy and joined up service delivery, create savings that could drive earlier intervention and prevention services.

While some methodologies, such as By-Name-Lists, have shown success in rough sleeping and specific areas, these remain resource-intensive and also not appropriate for some groups. For example, to protect safety and confidentiality of victim-survivors of DFV, BNLs may not be an appropriate mechanism (particularly

beyond localised responses).

Is the Canadian National Occupancy Standard measure of overcrowding, and the way it is applied in Australia to define homelessness, suitable for the Australian context?

We believe that the Canadian National Occupancy Standards (CNOS) imposed by government can have a negative impact on the capacity for victim-survivors' of DFV to find appropriate, long-term accommodation, and in making decisions for their family and situation. This is particularly relevant to large families, Aboriginal communities and CALD communities. The current occupancy standards often reflect a systemic bias towards white social constructs and understanding of living arrangements that don't align with different cultural groups and don't align with the availability of appropriate housing options. This results in women and children becoming 'trapped' in the housing instability and homelessness system for no other reason other than there being insufficient properties that can accommodate their family size/make-up.

There can be inconsistencies in how these standards are implemented between crisis, short/medium term and long-term housing options. One large family can feasibly be supported in homelessness/DFV transitional or supportive accommodation but due to a lack of appropriate housing options and CNOS, are unable to find long-term options. This can leave a family without housing exits for years, impacting on their wellbeing and recovery, while also reducing the crisis housing available within the system[6]. Conversely, this can also impact on single people, who can find it difficult to access housing outcomes due to 'under-occupancy'.

For these reasons, we strongly recommend that the CNOS measure of overcrowding is reviewed with special consideration for First Nations and CALD communities, and includes appropriate consultation and leadership, with such consultations aligned to appropriate child development, health and related input. We appreciate the need for standards to ensure that public housing in particular is providing safe, hygienic and appropriate housing options for tenants, but this needs to be balanced by empowering families to make decisions regarding their own, and their family's, lives.

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[6] The ABS Survey of Income and Housing 2019-20 found that, applying CNOS, almost 4% of Australian households required at least one additional bedroom to meet the requirements of the household, while 77% had at least one bedroom spare. Source: https://www.abs.gov.au/statistics/people/housing/housing-occupancy-and-costs/latest-release#:~:text=Applying%20the%20Canadian%20National%20Occupancy,at%20least%20one%20bedroom%20spare.

Focus area 2: Homelessness Services

What are the main challenges in addressing chronic and repeat homelessness?

Chronic and repeat homelessness is the result of a range of **social and systemic failures** for those made vulnerable by circumstance or experience. **Siloing homelessness** as a single issue sidelines many of the causes and influences on homelessness. Challenging the disconnect between the ways in which our services address these causes and influences, and thus considering the wide range of cultural, structural, socio-economic, psycho-social and other impacts on a person's journey is vital to addressing chronic and repeat homelessness.

Understanding 'repeat' homelessness episodes and the reasons for them is also very important. While repeat homelessness episodes may indicate that services have not met the needs of some clients, or they require further or different support options, for others repeat episodes of homelessness and help-seeking can be indicative of the exercise of both protective and positive strategies. For victim-survivors of DFV for example, re-presenting at a crisis service (in South Australia, these are homelessness services specialising in DFV) forms part of a safety plan and often reflects a positive previous experience of feeling safe, supported and knowing where to go. The data is clear that it takes women 7-9 times to finally leave an abusive relationship, and each time is an opportunity to build their skills, to take time to reflect and make decisions and plans, to understand their options and consider their safety. Addressing repeat homelessness in this context must take a nuanced and client-focused perspective, acknowledging that safe, short-term, respite or similar options remain vital to the safety journey of victim-survivors.

Similarly, **access to appropriate and specialised respite and short-term options** would reduce the impact on crisis accommodation and enable the provision of short-term safety responses for the many women who do not want to leave a perpetrator, but for whom short-term homelessness is a viable and necessary safety option. This is particularly important for Aboriginal communities, where family healing, rather than relationship breakdown, is what the client seeks. However, our current social constructs, often based on a mainstream, individualistic lens, often requires a woman to leave a relationship and/or make herself homelessness to access mainstream support.

For victim-survivors of DFV, a lack of **sustainable, evidence-based, appropriately funded prevention, earlier intervention and recovery models** severely impacts the capacity of the sector to provide long -term responses to the community, as outlined in the section above.

What housing or dwelling models may need to be considered to provide appropriate options for people experiencing chronic and repeat homelessness?

Longer-term supported, multi-sector housing options, are imperative, where there are appropriate supports available to address the core drivers of someone's homelessness experience (for example AOD support, DFV, mental health, therapeutic support, skills building and access to work placement and support). Current models and systems move too quickly from crisis/medium-term accommodation linked to support, to long -term (if available) accommodation which is unsupported and fully independent. A phased approach, where supports are provided if and when people need them, would provide a more supportive environment that acknowledges the impact of chronic or long -term homelessness, and the ongoing support needs individuals, young people and families may face.

As noted above, ensuring that future planning reflects the demographics and requirements of

the range of individuals and families impacted by homelessness is vital. Adequate flexible housing options, including for singles and for large families, must be considered through any future investment.

What are the medium and longer-term steps that can be taken to ensure we have a more consistent and coordinated service system to support people who are experiencing or at risk of homelessness?

1. **Collaborative and coordinated response**: In South Australia, the Alliance model of service delivery is improving the coordination and navigation of a complex homelessness service system. The importance of information sharing, collaboration and shared accountability has clearly led to greater engagement and coordination across homelessness and specialist DFV services. However, the next evolution must also consider how an alliance or collective impact model brings in expertise and engagement with the broader service system to address root causes and upstream failures which result in people needing crisis support. This includes improved coordination and collaboration between government housing authorities, community providers and specialist homelessness support services, as well as broader strategic and operational engagement and collaboration with ancillary services from health, corrections, child protection and others to use resources and funding efficiently and effectively. The experience of a state-wide DFV alliance has shown that being able to develop state-wide processes, responses and understandings has significantly improved relationships and collaboration across specialist DFV services. Conversely, rather than creating a 'one-size-fits-all' approach that could potentially be expected from such a model, the DFV Alliance has created a greater collective awareness amongst service providers of the nuanced needs of place-based communities. This can be attributed in part as a result of the relationships created between Alliance members and the capacity for shared consideration of service issues.
2. **Multi-sector response**: Too often, the 'service system' reflects the homelessness system only, with the addition of DFV services in some areas. In South Australia, as crisis DFV services are funded by the SA Housing Authority via DFVSA, DFV services are specifically referred to as specialist homelessness services, with some nuance regarding their role in responding to those at risk of or experiencing homelessness due to DFV. However, this narrow definition of a system does not incorporate the need for a multi-sector, community response to homelessness due to DFV. We know that significant numbers of the victim -survivors we work with also experience a range of other psycho-social, physical and community impacts including:
    - 32% experiencing mental health issues
    - 6% experiencing AOD issues (which we know is a significant under-report)
    - 6% with a disability
    - Only 12% are actively employed, and of them at least 67% are part time

If we do not actively engage with, plan, and hold to account other parts of the service sector to develop a truly coordinated service system for all people, including those experiencing or at risk of homelessness, we will continue to develop siloed approaches to wicked problems, rather than solutions that can only be arrived at through collaboration. Understanding our communities through better connected data, holding relevant parts of the system to account to develop innovative collaborative approaches and working together to address the root causes of

homelessness is the only way we can develop a system which can deliver better outcomes. This takes leadership at all levels, from Commonwealth, State Government, department leads and serv ice organisations and must be holistically and consistently addressed at all levels. Homelessness is not just the absence of a home, but it is the cumulative result of multiple system failures for a person made more vulnerable by a disconnected sector.

What are the best specific early intervention approaches to prevent someone becoming homeless?

Addressing homelessness must come with a multi-sector response – too often earlier intervention or prevention approaches focus on private rental assistance (for example, in South Australia where private rental assistance is the basis of diversion/prevention from emergency accommodation in an ongoing review of the current program). Programs such as private rental assistance and Intensive Family Support remain, rightly, incredibly important early intervention programs, and ones which we fully endorse as vital for many people experiencing or at risk of homelessness. However, these are not appropriate for all victim-survivors, so a more holistic model of early intervention which looks at social determinants of homelessness (such as DFV) must be included in a holistic early intervention approach.

While of course vitally important, if this is not explicitly linked, both programmatically and through funding, to a multi-sector and holistic response that recognises the **intersectionality of people and communities**, then the focus will continue to be overly narrow and hyper-focused on housing, rather than the social, community, structural and personal issues that we know are key drivers of homelessness. It is telling that in South Australia there is no specialised DFV or homelessness response for those who identify as LGBTIQA+.

It remains **concerning that earlier intervention supports for victim-survivors of DFV are not considered as part of a suite of early intervention programs for addressing homelessnes**s, even though it is so strongly correlated. Providing services that support safe access to early support, which may include safe exit planning to long -term, appropriate and safe accommodation, would reduce the pressure on emergency accommodation and/or crisis support. Currently in South Australia, for example, one of the only earlier intervention programs that exists is a recent pilot started through the National Partnership. There remains clear messaging from government that there is no scope to include earlier
intervention in DFV through homelessness funding (except for Safe at Home, which is partially funded through SAHA alongside Commonwealth KSWITH), despite the evidence on correlation. Such limited investment in earlier intervention specific to DFV significantly curtails the capacity of services to engage in any meaningful, tailored, DFV early intervention which would reduce the impact of homelessness on victim-survivors. These interventions, were they available, would provide a more effective early intervention model to reduce episodes of homelessness. Ensuring that Commonwealth and state governments work together and collectively is vital and ensuring that Commonwealth and state priorities marry into a cohesive system with long -term, multi-sector funding, is vital.

In discussing homelessness, we must also consider the intersectionality of a diverse range of experiences and systems, where homelessness is the result of failures across the life course, and across the social services sector. Without a cross- sector vision for early intervention encompassing DFV, mental health, child protection, the justice system, AOD, racism and fundamental poverty, early intervention options will continue to focus on ‘Housing First’ rather than a holistic, human-centered approach. Thus, there is a need to **engage with key**

sectors in any plan to address homelessness.

Perpetrator responses remain severely lacking across the country – for as long as DFV remains an issue, we need to identify and invest in appropriate perpetrator responses. This includes removal of a perpetrator from the family home – too often it is women and their children who are forced to leave and engage with homelessness services because of the power imbalance and structural barriers. Recent trials in South Australia of the perpetrator beds program should be evaluated and built upon. Without appropriate accommodation options for men to exit family housing, women (particularly in remote communities) will remain forced to leave and take on the economic, social and personal burden of leaving the family home due to the actions of perpetrators. We strongly encourage better consideration for appropriate perpetrator accommodation and interventions to ensure that perpetrators, rather than victim-survivors, remain visible and accountable for their actions.

Additionally, reframing early intervention is also important in considering **healing responses** to DFV – not all women want to, or choose to leave. If earlier intervention programs can work with families and perpetrators to heal, and successfully become a safer environment for women and their children, then this may also reduce the risk of homelessness for one or multiple family members.

In what areas of the homelessness service response are people who are experiencing or at risk of homelessness not getting the support they need?

There are significant gaps in the delivery of support for those experiencing or at risk of homelessness, particularly around holistic support model based on a public health model of support as noted earlier. This is further complicated by an environment which is extremely complex, and where the need and pressures of the cost of living and lack of housing is putting immense pressure on so many parts of the community.

In our view, the lack of consistency and clarity on some key issues is further exacerbating the issue. These include:

1. No clear definition of 'at risk of homelessness';
2. The cost and practical impacts of 'No Wrong Door' policies in the current housing and cost of living crisis;
3. Lack of short-term options for victim-survivors of DFV – particularly those who may return to the relationship. For example, in SA, it is very difficult to access emergency accommodation if a client is clearly remaining in a relationship with the perpetrator. While the risk to her safety may mean that she is experiencing homelessness temporarily (as the alternative is inherently unsafe), the fact that she has a home and does not wish to leave severely limits her options for safety when risks escalate;
4. Crisis-focused model means that there is limited access to early intervention or prevention approaches (particularly for those experiencing risk of homelessness due to DFV), as noted elsewhere in this paper.

We know that access to **long-term, appropriate housing** is vital – and current availability is inadequate. As mentioned above, and in the attached submission to the SA Government consultation on housing options, we do not have the right mix of housing to ensure that those who are experiencing homelessness can access safe and culturally appropriate options. Access to public housing, often the most viable option for clients accessing and requiring crisis homelessness support, is severely limited. For example, almost 16,000 people are on the Single

Housing Register in South Australia (May 2023), 21% of whom are on Category 1 (the highest level). The average wait before being housed is 7 months, but 15% are waiting over a year – and that does not account for the 69% of people on Categories 2 and 3. While maintenance remains an issue, there is simply not enough housing stock, nor enough *appropriate* properties, to support people to move through the homelessness or DFV system smoothly. This also means that specialist DFV staff spend significant resources supporting clients to search for housing, detracting from their capacity to engage in managing and responding holistically to risk and safety.

How can the availability of accessible (particularly in relation to the physical environment) crisis and/or transitional accommodation be increased in the short to medium-term?

Funding for infrastructure must be **matched by appropriate investment in support.** While there are excellent opportunities such as 'Safe Places' to identify opportunities for new builds or redevelopments, support is limited without matched funding to provide a 'safety first' model of care.

What strategies can be used to build awareness of available services and supports for people who are at risk of homelessness or experiencing homelessness?

Whilst we support raising awareness of available services and supports for people, we do **caution against raising community expectations where services remain stretched.** It is important for people to know where to go, and most services and sectors do this well, but we also know that community expectations are not always matched by the capacity and capability of what homelessness or crisis DFV services can provide. Clarity is required to ensure service awareness, but this must be managed with messaging that immediate access to safe housing may not be available, and that much of the support provided is via temporary accommodation. This is vital, to protect the safety of women seeking supports.

We also emphasise, that where there are changes in legislation and/or awareness campaigns (including DFV prevention campaigns), due consideration must be given for flow-on impacts on services and community expectations. For example, recent discussions on coercive control legislation and awareness raising in South Australia is extremely positive, but services are bracing for potential increases in requests for support due to the increased awareness, which we will struggle to absorb without additional resources.

Ensuring that the community is aware of resources and options which can support them without having to enter the homelessness system, and which they can access themselves, is vital – whether that is private rental assistance schemes, or specialist options such as the DV Disclosure Scheme or 'Safe at Home'. Strategies to remove the stigma attached to asking for help or seeking information or support is important, as are the information outlets. By normalising information provision about where to access support, we can reduce the stigma of help-seeking.

Focus Area 3: Aboriginal and Torres Strait Islander Housing

We remain very concerned at the **lack of culturally appropriate housing options for Aboriginal and Torres Strait Islander people**. This includes access to crisis accommodation, which is often not designed by, for, or with Aboriginal people, and often does not align with cultural expectations or culturally safe responses. We strongly advocate for the provision of specialist

accommodation options to be available across the country. In South Australia, while there are some designated Aboriginal crisis accommodation options attached to metro Aboriginal-specific and/or ACCO services, these are still mostly mainstream properties allocated to Aboriginal clients – with no specific Aboriginal accommodation outside of metro Adelaide. The DFV Alliance has committed to exploring options for Aboriginal-specific crisis responses in regional SA, where we know there is little to no emergency accommodation, and where racism and bias means that access to the minimal available hotel and motel accommodation is extremely limited. This must be designed with community, to reflect the needs of traditional women and families, acknowledging that non-Aboriginal expectations and ways of working are not culturally appropriate, and this extends to the built environment as well as services available.

DFVSA strongly advocates for a re-established **Aboriginal Community Housing Authority**. We reiterate the **Closing the Gap Target**, and in particular Outcome 9 (Schedule 3) that *Aboriginal people can secure appropriate and affordable housing aligned with their priorities and needs.* This work must reflect and align with the *SA Aboriginal Housing Strategy,* to prioritise Aboriginal voice and decision-making and equitable access to safe, secure and affordable homes which maintain Aboriginal people's personal, social and cultural wellbeing.

Any actions to improve housing accessibility and affordability must consider and implement proactive strategies to **mitigate barriers to Aboriginal people** accessing safe long -term housing, while also developing appropriate models of Aboriginal community housing that reflects the cultural and Country -focused needs of First Nations people. Tenancies and standards must reflect community expectations, and support, rather than inhibit cultural obligations, family and kin networks and practice. This must be a consideration for metro, rural and remote Aboriginal housing and include Aboriginal leadership from across the state and from different communities. Only in this way, will appropriate strategies proactively address systemic racism and barriers experienced by Aboriginal community in the housing market be addressed. Such strategies should also include ensuring that all housing programs, and programs related to earlier intervention, recovery and prevention, proactively and intentionally include the development of models that are appropriate and impactful for Aboriginal communities. This may mean developing alternative models that better reflect Aboriginal community needs. One exemplar might be 'Safe at Home' initiatives that are designed specifically for community, reflecting that healing and recovery may include remaining in a home with a partner who uses violence and working with the family holistically.

Policies affecting the housing and homelessness outcomes of Aboriginal and Torres Strait Islander people should be developed by First Nations Peoples and organisations. They should also link into and support work on the Closing the Gap target of 'People can secure appropriate, affordable housing that is aligned with their priorities and need'. Policy setting should support the creation of an environment for First Nations Peoples to exercise self-determination in addressing the unique housing and homelessness issues they face.

Focus area 4: Social Housing

As we have shown, a 'one-size-fits-all' approach to housing support does not work. This extends to the provision of infrastructure. Ensuring that **future housing stock is an appropriate mix of housing options is vital and** must consider the diverse needs of those experiencing homelessness as a result of DFV, e.g. single women, older women, large families, specific cultural needs and accessibility. The current public housing stock mix is inappropriate in this regard. There are extremely limited safe options for single women (or indeed men), for example, as they often do not

meet the occupancy standards for the 2-3 bedroom properties that are more common, thus it can be extremely difficult to identify appropriate housing options for them. Another area of concern is older women, for whom there are extremely limited affordable options. We regularly face barriers for safe housing exits for single older women, with limited public housing options and poor affordability in the private sector. Ensuring that future housing stock considers the demographics of the community and particularly longer-term population and demographic trends, is vital to ensuring housing stock is fit for purpose.

Similarly, for large families, there is extremely limited stock available. This particularly impacts families from multicultural backgrounds and Aboriginal families, for whom multigenerational living and larger families may be more common and sought.

Recently, the New South Wales Government imposed a freeze on the sale of public housing. This is a positive step toward addressing both the availability and the suitability of public housing. Similarly, the South Australian Government has committed to creating new housing opportunities and to halt the planned sell-off of public housing. We see such strategies as essential in ensuring adequate housing options into the future.

With the **National Rental Affordability Scheme** ceasing in South Australia by 2026 (noting that many properties have already started to phase this out), this should be evaluated and expanded to support ongoing access to private rental properties for those on low incomes. A reversion to full market rates by landlords for private rentals will increase pressure on community and public housing, and lead to increased waitlists and reduced secure tenancies. More flexible rental, home loan and rent-to-buy schemes would also be effective measures to support whole of community access.

Victim-survivors of DFV are having to remain in the homelessness system for longer than they may need or desire, due to the lack of appropriate, safe, and affordable longer-term options and a lack of holistic support services. For people with chronic histories of homelessness and more intensive support needs, there should be parameters that allow for a focus on an economically and socially viable and personally valuable approach to addressing homelessness. Currently, many **services exit clients once they identify a long-term housing** option, due to their contractual obligations and funding capacity and the growing need for crisis support. Lack of ongoing support can put new tenancies at risk for those who may still be dealing with trauma or the legal, financial and social impacts of DFV. We need to focus on ensuring people can access appropriate and long-term housing, which is linked with appropriate long-term support where required or requested. People experiencing homelessness need effective responses to help them regain stable housing and, if necessary, access ongoing assistance with health, wellbeing, education, employment and other issues to prevent future homelessness.

Attached For Further Reference:

- Response to SA Housing Inquiry (joint submission between Embolden and DFVSA) May 2023
- DFVSA Submission to Home Affairs re DFV Visa amendments August 2023
- DFVSA Safer Places Accommodation Feedback March 2023

A Roadmap for Lived Experience Engagement

Supporting South Australia's Specialist Domestic, Family and Sexual Violence Services Sector

August 2024

A joint project between:

The Project

In February 2024, Embolden SA Incorporated[7] and the Domestic and Family Violence Safety Alliance[8] partnered on a project to understand and develop a pathway to strengthen sector-wide lived experience engagement practices across South Australia. *A Roadmap for Lived Experience Engagement* (the Roadmap) represents a shared vision for the South Australian specialist DFSV services sector towards true engagement with survivor-advocates and accountability to those who have lived experience of DFSV. The Roadmap charts a course for the specialist DFSV services sector to demonstrate leadership in a way that recognises the centrality of lived expertise in ensuring a sector that is responsive, respectful and safe.

Project Team & Contributors

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[7] Embolden is South Australia's member-based peak body for specialist domestic, family and sexual violence services.
[8] The Domestic and Family Violence Safety Alliance (DFV Safety Alliance) is a statewide specialist domestic and family violence homelessness alliance consisting of 8 service partners (19 services) and government partners. All DFV Safety Alliance services are individually members of Embolden.

Acknowledgements

Aboriginal & Torres Strait Islander Sovereignty

We acknowledge the sovereignty of Aboriginal and Torres Strait Islander Peoples over the lands, skies and waterways of Australia. We pay respect to Elders past and present as the traditional owners and custodians of the lands across Australia and acknowledge their cultural authority on ways of being in relationship with Country. Colonisation brought patriarchal violence that has impacted all Aboriginal and Torres Strait Islander Peoples, particularly women and children. We acknowledge the cultural knowledge and wisdom that has sustained and strengthened First Nations peoples in resisting, responding to, and healing from violence on these lands since 1788.

This roadmap was developed with consideration of the community in South Australia including those living on Kaurna, Peramangk, Ngarrindjeri, Boandik, Ngadjuri, Nukunu, Barngarla, Nauo, Wirangu, Kokatha, Mirning, Ngalea, Ngargad, Erawirung, Thanggali, Malyangapa, Antakirinja, Yankunytjatjara, Pitjantjatjara, Arabana, Dieri, Dhirari, Wangkangurru, Yarluyandi, Ngamini, Yandruwandha, Yawarrawarrka, Pirlatapa, Adnyamathanha and Kuyani lands.

People with Lived Expertise

We recognise the valuable knowledge, skills and perspectives of people with lived experience of domestic, family and/or sexual violence. The specialist DFSV services sector must be grounded in the perspectives of those with lived expertise. Without the expertise of people with lived experience, this roadmap and other efforts of the DFSV services sector would struggle to truly recognise and effectively respond to the needs of the victim-survivors we work alongside. We hold great respect for this expertise, and we ground this roadmap in a pursuit of justice for victim-survivors of DFSV, past and present.

We acknowledge the strengths and limitations of our collective voice - recognising that it does not represent the experiences or perspectives of all victim-survivors or professionals across the community. To the best of our abilities, we have aimed to develop the *Roadmap for Lived Experience Engagement* through a highly critical and holistic lens, holding a strong appreciation for diverse, intersectional identities. As lived experience approaches are strengthened across the SA specialist DFSV services sector, there must be an ongoing commitment to amplify the voices of victim-survivors and communities, with particular consideration for marginalised groups.

Terminology

The following definitions are primarily derived from key national policies and lived experience resources. *We acknowledge that these terms do not reflect the identities or experiences of all people who have lived experience of DFSV.*

Domestic and family violence includes all forms of violence that can occur within relationships. This includes intimate partner violence (commonly referred to as domestic violence), violence perpetrated between family members and in family-like settings (including carer relationships and Aboriginal and Torres Strait Islander kinship relationships), coercive

and controlling behaviour and sexual violence. It encompasses physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses. This Roadmap acknowledges the gendered nature of domestic and family violence, which is primarily perpetrated by men against women, but acknowledges that it can impact on anyone regardless of gender identity, sexual orientation, culture or experience.

Sexual violence includes any sexual activity that happens where consent is not freely given or obtained, is withdrawn or the person is unable to consent due to their age or other factors. Sexual violence occurs any time a person is forced, coerced or manipulated into any sexual activity. Sexual violence can be non-physical and include unwanted sexualised comments, intrusive sexualised questions or harassment of a sexual nature.[9]

DFSV is a shortened form of domestic, family and/or sexual violence. Similarly, **DFV** is a shortened form of domestic and family violence.

The specialist DFSV services sector (the sector) refers to the statewide collective of services directly funded to deliver services to support those who are experiencing or have experienced domestic, family and/or sexual violence or those who are using or have used DFSV. The Roadmap focuses on engagement with victim-survivors of DFSV.

Lived experience describes the knowledge, insights and expertise that arise from the direct experience of domestic, family and/or sexual violence. Clients, the workforce and survivor-advocates are key sources of lived experience for the specialist DFSV services sector. [10] The focus of this document is survivor-advocates, who may include current and former clients.

Victim-survivor refers to people who have direct, first-hand experience of domestic, family and/or sexual violence.

Client refers to victim-survivors who have been provided with support by a specialist domestic, family and/or sexual violence service. Note that clients can also engage as survivor-advocates, either during or after their experiences of support. Client and survivor-advocate are not mutually exclusive in this context, as clients are often a valuable and integral source of expertise and insight into operational and strategic work in the DFSV specialist sector.

Survivor-advocate refers to a victim-survivor who actively engages in advisory, policy or program work on the issue of domestic, family and/or sexual violence, basing their work on their lived experience of DFSV.

Gender-based violence refers to violence that is used against someone because of their gender. Gender inequality and other forms of discrimination create the social context in which violence against women and children occurs. Overwhelmingly, men are the perpetrators of violence against women in Australia. By referring to violence as gender-based, it strengthens our understanding that gender-based violence against women is a social problem requiring comprehensive responses that go beyond specific events, individual perpetrators and victim-

[9] The *National Plan to End Violence against Women and Children 2022-2032*

[10] Sources of Lived Experience in the Family Violence Sector, Issues Paper, July 2022, Safe+Equal <https://safeandequal.org.au/resources/sources-of-lived-experience-in-the-family-violence-sector-issues-paper/>

survivors. Gender inequality, rigid gender norms and stereotypes, and discrimination including racism, are at the heart of the problem.[11]

Introduction

Engagement with lived experience perspectives is critical to the effectiveness of the specialist DFSV services sector and constitutes an important mechanism of accountability to victim-survivors, who are best-placed to identify gaps and opportunities in practice, services and systems.

The Roadmap for Lived Experience Engagement (the Roadmap) emerged from a project between Embolden and the DFV Safety Alliance in 2024 to understand the current practices, strengths and challenges of lived experience engagement across the South Australian specialist DFSV services sector, and to map these to best practice approaches identified in the lived experience literature and implemented within other Australian jurisdictions. The development of a statewide lived experience roadmap is a key deliverable for Embolden and aligns with the DFV Safety Alliance's strategic commitment[12] to centre victim-survivors' perspectives within service design and delivery (including through the DFV Safety Alliance Lived Experience Plan). It also aligns with work being undertaken across other states and territories to embed lived experience perspectives into DFSV service planning, practice and policymaking.

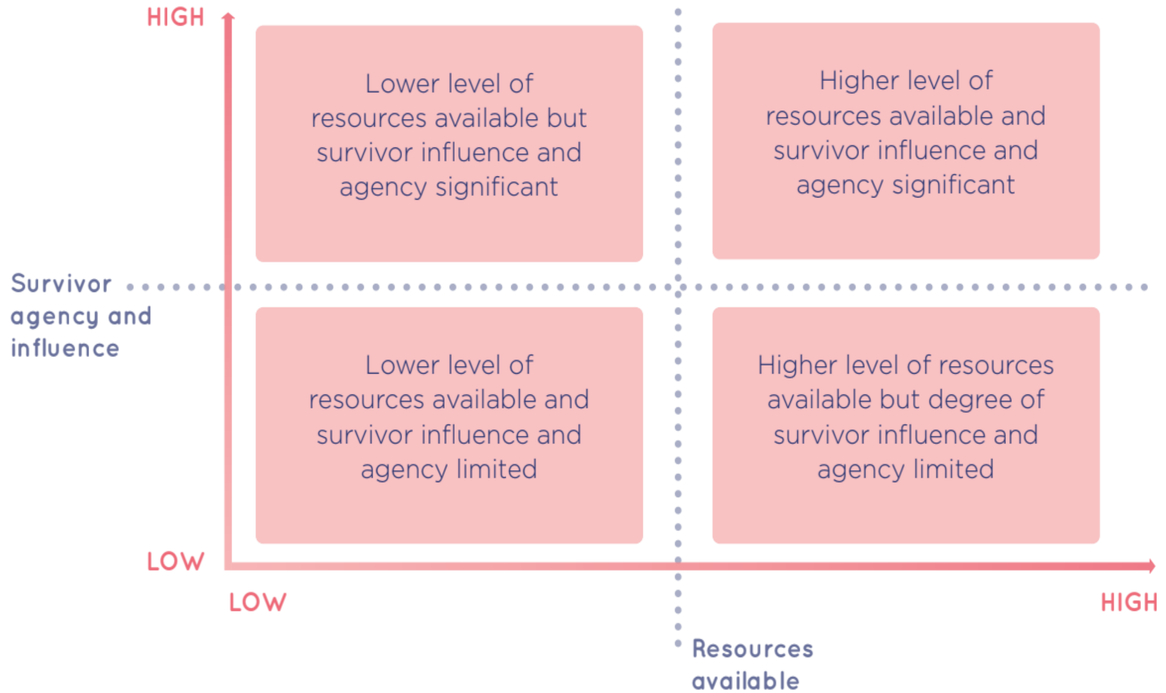
People with lived experience of domestic, family and/or sexual violence (DFSV) have a unique standpoint that is derived from their knowledge, insights and expertise. Ensuring that the diverse lived experiences of victim-survivors are informing policies and solutions is reflected in the *National Plan to End Violence Against Women and Children 2022-2032*[13] as a cross-cutting principle, and underpins the theory of change for addressing DFSV. The National Association of Services Against Sexual Violence (NASASV) also encourages engagement with lived experience perspectives in the National Standards of Practice Manual for Services (3rd edition); Standard 2 on valuing client experience states '*organisations must seek the feedback of clients to improve service delivery and ensure that they are meeting client needs*'.

Of the key sources of lived experience for the specialist DFSV services sector (clients, workforce, survivor-advocates), the relationship with survivor-advocates presents a significant opportunity for further engagement regarding policy development, service planning and practice. Thus, the Roadmap will focus on strengthening lived experience engagement by maturing the sector's relationship with survivor-advocates (some of whom may be current or previous clients) in mutually beneficial ways, with a particular focus on the infrastructure and governance arrangements that can support effective and sustainable long-term engagement. This Roadmap was particularly influenced by the Family Violence Experts

[11] Theory of Change for the National Plan to End Violence against Women and Children 2022-2032 <https://www.dss.gov.au/the-national-plan-to-end-violence-against-women-and-children/theory-of-change-2022-2032>
[12] Domestic and Family Violence Safety Alliance. (2023). DFVSA Strategic Plan.

[13] The National Plan to End Violence Against Women and Children, 2022-2032 <https://www.dss.gov.au/ending-violence>

by Experience Framework and practice resources created by Safe + Equal[14] for the Victorian specialist family violence services sector. Exemplifying good practice lived experience engagement, these documents were co-produced by people with lived experience (WEAVERs)[15], DFV researchers at University of Melbourne and DFV practitioners. For example, the Experts by Experience Framework highlights that with a similar level of resources, some lived experience engagement activities offer more impact than others (Figure 1).



(Source: Family Violence Experts by Experience Framework)

Figure 1: Available resources and victim-survivor agency/influence are key factors that can guide a service's choice of lived experience engagement activity

[14] Safe+Equal is the peak body for specialist family violence services that provide support to victim survivors in Victoria.

[15] A group of survivor-advocates who engage in the co-production of research and training with the University of Melbourne.

Purpose of the Roadmap

The Roadmap for Lived Experience Engagement has been developed to provide South Australia's specialist DFSV services sector with practical actions to more fully engage and embed lived expertise in policy development, service planning and practice.

In South Australia, specialist DFSV services play a leading role in responding to gender-based violence and their quality is derived from the combination of lived expertise, practice expertise and academic expertise. While practice and academic expertise are firmly embedded in SA's specialist DFSV services sector through supervision, training and professional development, approaches to engaging with the lived expertise of survivor-advocates are in the early stages of development and are missing whole-of-sector implementation (Figure 2). The Roadmap will present current practices of lived experience engagement in South Australia (Part 1), a vision for future lived experience engagement (Part 2) and recommendations to guide the way (Part 3). It is underpinned by a holistic approach to lived experience engagement that is intended to strengthen practitioner-level, service-level and whole-of-sector engagement with survivor-advocates.

The Roadmap also functions to inform the work of policy makers and government about pathways forward to improve prevention and response to DFSV. For government bodies and funding partners, the Roadmap can be used to inform strategic policy and funding decisions. For Embolden, the Roadmap can serve as a blueprint for engaging with victim-survivors in the community, including those who do not engage with specialist DFSV services. For the DFV Safety Alliance, it can help inform better practices for embedding lived expertise into service-level engagement, service planning, monitoring and evaluation. It is hoped that this roadmap will build the collective capacity, capability and accountability of the specialist DFSV services sector to engage with lived expertise.

"You think you know something and then you ask the lived experience advocates, and you get this wealth of knowledge that you'd never get in any other way." - Sector Professional

Where we are now

Where we want to be

ROADMAP

Practice expertise

Lived expertise

Academic expertise

Practice expertise

Lived expertise

Academic expertise

Figure 2: Conceptual framework for this Roadmap

Audience

- Organisations that provide services to people with experience of domestic, family and sexual violence, including collectives such as Embolden, DFV Safety Alliance, and individual organisations and/or services
- Policymakers
- Government bodies

Other Key Stakeholders

We acknowledge the important role of survivor-advocates in the DFSV services sector. This roadmap is designed to place the responsibility for change with the sector and the bodies that govern it, not with victim-survivors or survivor-advocates. As such, this roadmap focuses on systemic and practice changes that are required to meaningfully centre people with lived experience in decision-making.

Structure

Part 1 provides a snapshot of current practices of lived experience engagement across SA's DFSV services sector.
Part 2 presents a vision for future lived experience engagement.
Part 3 outlines a roadmap toward that vision that builds on current strengths and recommendations for good practice.

PART 1 - Where Are We Now?

A vision for the future practices of lived experience engagement by the SA DFSV specialist services sector needs to be based on a clear understanding of the South Australian context including current practices, strengths, challenges, barriers, gaps and opportunities.

Approach to Understanding Current Lived Experience Engagement Practices

To understand the current context of lived experience engagement in SA's DFSV services sector, the project team undertook the following activities:

1. A **desktop review** to identify best practice and useful tools for lived experience engagement across Australia. For a full list of the key documents included in the review and a description of the approach used to undertake the review, please see Appendix B. Useful resources can be found in Appendix C.

2. A **survey** on lived experience engagement practices was circulated to specialist DFSV services to understand the breadth of lived experience engagement activities across the sector, identify areas of good practice, explore challenges and understand gaps. The survey received 27 responses from staff across 14 different organisations/services. Further details including survey questions can be found in Appendix A.

3. Extended semi-structured key informant **interviews** were undertaken with seven practitioners comprising diverse roles (frontline staff, team leader, program manager) about the lived experience engagement practices undertaken by the specialist DFSV services sector. Key informants for follow up interviews were identified from the surveys. A full list can be found in Appendix A.

4. The project team met with 18 **survivor-advocates** in individual and group interviews to understand survivors-advocates' experiences of lived experience work in the specialist DFSV services sector.

FEB

PROJECT OUTLINE

Project Outline developed and endorsed by Embolden & DFV Safety Alliance. This included project purpose, staging, deliverables, scope, risks & engagement approaches.

FEB-APRIL

DESKTOP REVIEW

Engagement with lived experience engagement literature to identify good practice approaches. This included survivor-advocates' reflections, academic literature, practice guides and reviewing the lived experience engagement practices undertaken in other Australian states.

APRIL

SURVEY

A survey was developed & released to Embolden members & DFV Safety Alliance services to identify the breadth of lived experience engagement activities in SA, practitioner approaches, successes, challenges/barriers & opportunities. 27 responses were received from 14 different services/organisations.

MAY-JUNE

INTERVIEWS

Individual & group interviews were conducted with seven sector professionals and 18 survivor-advocates to understand their perspectives on the strengths, limitations and challenges of lived experience engagement.

MAY-JUNE

ANALYSIS

Analysis of the survey responses & interviews to identify common themes, develop an understanding of what lived experience engagement currently looks like in SA, and opportunities for the sector.

JULY

DRAFT ROADMAP

A draft version of the roadmap was created based on the findings from the interviews, surveys & key ideas identified in the desktop review. An iterative process of review & feedback among the project team.

JULY

FEEDBACK ON DRAFT ROADMAP

A cohesive draft version of the roadmap was provided to Embolden members, survivor-advocates & key stakeholders for review/feedback.

AUGUST

FINALISED ROADMAP

Feedback from the sector, survivor-advocates and key stakeholders incorporated and roadmap finalised.

Figure 3: Project Timeline & Methods

A Snapshot of Current Lived Experience Engagement Practices in South Australia

Survey responses from 14 specialist DFSV services, in-depth interviews with seven professionals from the services represented in the survey, and interviews with 18 survivor-advocates generated insights into the diversity of lived experience engagement practices undertaken by the SA specialist DFSV services sector (Figure 4), as well as valuable perspectives on the strengths, challenges, gaps, barriers and opportunities for lived experience engagement in the South Australian context. The project team focused on eliciting insights which had the potential to be relevant for the lived engagement practices of other services, the peak body and government/funding bodies. Care has been taken to consider the diversity of insights provided based on the type of service and client group.

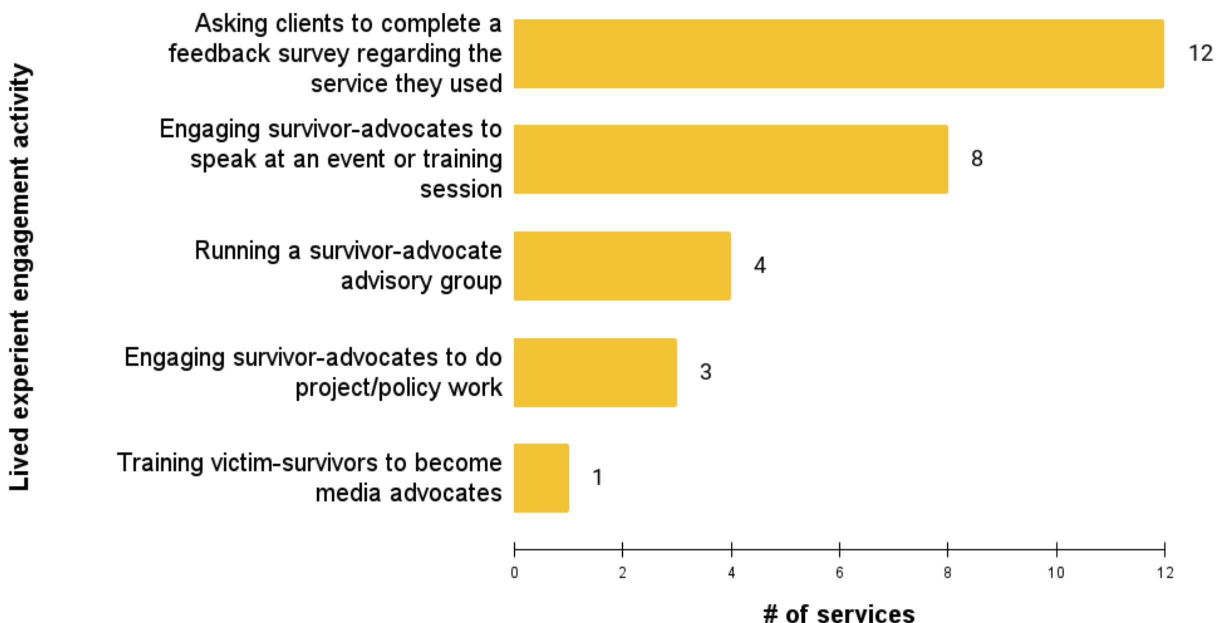


Figure 4: Lived experience engagement activities undertaken across the SA specialist DFSV services sector based on survey responses from 14 services.

Key Insights into Current Lived Experience Engagement Practices in South Australia

Table 1: Summary of Key Insights into Current Lived Experience Engagement Practices in South Australia

1.	A diverse set of lived experience engagement initiatives exist across the sector, but the most common approaches (informal feedback and feedback surveys) offer limited agency and influence for survivor-advocates.
2.	The specialist DFSV services sector has essentially reached its ceiling for lived experience engagement within current resourcing and conditions.
3.	Current practices of lived experience engagement have resulted in improvements at the practitioner and service level. However, there is significant scope to strengthen the sector's relationships with survivor-advocates to elevate lived expertise in policy development, service planning and practice.
4.	Current lived experience engagement practices have resulted in limited engagement with the perspectives of survivor-advocates who experience systemic exclusion and marginalisation.

Key Insight 1: A diverse set of lived experience engagement initiatives exist across the sector, but the most common approaches (informal feedback and feedback surveys) offer limited agency and influence for survivor-advocates.

- Informal feedback from clients and feedback surveys are the most common engagement approaches used to gather lived experience perspectives across the sector (Figure 4). 12 out of 14 services reported using informal feedback and feedback surveys to engage with lived experience perspectives. For 50% of these respondents (six in total) informal feedback and feedback surveys were the only form of lived experience engagement undertaken by the service.

- Advisory groups emerged as an effective mechanism for leveraging the perspectives of survivor-advocates into existing governance mechanisms.
  - Four of 14 services reported having an advisory group of survivor-advocates. 50% (two services) had long-term engagement with the advisory group (>four years), while two services were in the early stages of establishing an advisory group.
  - Dedicated staffing was identified as a key factor for successful engagement with the advisory group, and as a barrier for services that did not have an advisory group. 75% of services with an advisory group had dedicated staffing at a minimum of 0.4 FTE.

- Victim-survivors become involved in lived experience engagement opportunities almost exclusively through informal pathways. Frontline staff play a key role in identifying potential survivor-advocates and connecting them with lived experience opportunities, with key factors being the victim-survivor's perceived capacity for using their lived experience safely and suitability for current lived experience engagement initiatives. As a result, there are limited opportunities for victim-survivors to self-identify their interest in using their lived experience to influence policy development, service planning and practice.

- All 14 services demonstrated limited knowledge of the lived experience engagement practices occurring elsewhere in the sector both within and outside of South Australia.

- Services that engaged in the most diverse range of engagement activities described long lead times when setting up a new initiative and a period of latency before lived experience perspectives were reflected in policies and services.

Key Insight 2: The specialist DFSV services sector has essentially reached its ceiling for lived experience engagement within current resourcing and conditions.

- Funding for lived experience engagement (the significant staff time required, reimbursement for survivor-advocates) is not built into funding contracts. As a result, services are self-funding lived experience engagement, or seeking out grants. Services want to engage more fully with lived expertise but are under considerable pressure to deliver services that can meet demand. Without additional funding for lived experience engagement, services are faced with the dilemma of directing existing funds away from frontline and crisis services. Services expressed concerns about the negative impacts of under-resourced lived experience engagement including feelings of abandonment and re-traumatisation for survivor-advocates, and burnout/moral injury for staff. The effect of short-term and pilot funding on relationships with survivor-advocates was also highlighted as a key barrier to lived experience engagement.

- Current practices of lived experience engagement are overly dependent on individual staff members, rather than operating at a whole-of-service or whole-of-sector level. Deepening lived experience engagement will require the development of lived experience infrastructure and governance mechanisms across the sector, including lived experience advisory groups, dedicated staffing and embedding identified survivor-advocate roles into existing governance structures.

Key Insight 3: Current practices of lived experience engagement have resulted in improvements at the practitioner and service level, however there is significant scope to strengthen the sector's relationships with survivor-advocates to elevate lived expertise in policy development, service planning and practice.

- In the survey responses and interviews, services highlighted a range of improvements that arose from engagement with lived experience perspectives. At the service level, improvements included accessibility and inclusiveness of services for people who experience intersectional barriers to support, trauma-responsiveness of services, language used in written materials for clients and updates to practice guides. At the practitioner level, feedback resulted in improvements to staff practice approaches and staff training content/materials.

- Understandings of what lived experience is, why it should be valued and practice approaches to support it varied amongst organisations, services and professionals. This led to differing perceptions of the impacts and support needs related to engaging with survivor-advocates, and the role of this work in supporting recovery and healing, potentially limiting services' readiness to engage more fulsomely in this space and reducing opportunities for survivor-advocates to engage.

- Staff noted risk of re-traumatisation for victim-survivors as a significant barrier to increased lived experience engagement at their service (30% of respondents; six of 16 responses to a question on challenges). However, survivor-advocates considered their work to be an important element of their recovery and healing, despite the challenges. Lived experience work was described as "meaningful", "powerful" and "educative", and said to have contributed to survivor-advocates' empowerment, positive self-perception, social connection, professional capacity and resilience.

- Survivor-advocates described issues with remuneration that impacted their engagement and relationship with services. Examples included long delays in receiving remuneration and some instances of never receiving payment. Staff identified that the lack of formal processes and the complexity of financial acquittal processes has meant that the rates, timeliness and right to remuneration for lived experience engagement is not consistent across the sector.

Key Insight 4: Current lived experience engagement practices have resulted in limited engagement with the perspectives of survivor-advocates who experience systemic exclusion and marginalisation.

- Services expressed their awareness of the limited diversity of the lived experience perspectives informing their service. Survivor-advocates also noted that increasing the diversity of their advisory groups was important to them. Aboriginal and Torres Strait Islander women, women who live with disability, people who identify as LGBTQIA+

and women from culturally and linguistically diverse backgrounds were identified as key perspectives that services and survivor-advocates wanted to elevate.

- Frontline staff identified that the perspectives of children and young people are missing from the sector. The challenges to future lived experience engagement include the need for age- appropriate engagement tools and addressing concerns regarding safety, parental consent and the capacity of children and young people.
- Stigma is a barrier for survivor-advocacy in some regional areas, due to the small size of communities. It was noted that particular modes of lived experience engagement may be less favourable in regional contexts due to stigma (e.g. public speaking, survivor-advocate groups).

How does South Australia compare with other states and territories?

A review of the approaches to lived experience engagement in other states and territories identified considerable investment and prioritisation of lived experience in line with the National Plan and offered insight into possible statewide mechanisms that could be relevant for South Australia. Several other states and territories have established a standing advisory group to the peak body for specialist DFSV services and an increasing number are establishing a standing advisory group to the government that is specific for DFSV. Victoria is leading the way with a standalone lived experience strategy in addition to well established advisory groups to the peak body and government. At a national level, the Domestic, Family and Sexual Violence Commission has also developed a Lived Experience Advisory Council. It is expected that the landscape for statewide lived experience mechanisms will evolve due to the increasing investment in lived experience engagement across Australia.

For South Australia, the combination of a standing lived expertise advisory group to government specific to DFSV, a standing advisory group to the peak body for specialist DFSV services, and a dedicated lived experience strategy to guide statewide efforts offer South Australia an opportunity to create meaningful improvements to lived experience engagement with long-term impact.

PART 2 - Where Do We Want To Go?

A vision for good practice lived experience engagement with survivor-advocates that is tailored for the South Australian context.

The Lived Experience Roadmap stems from the understanding detailed in the *National Plan* that successful lived experience engagement is essential to drive effective, fit-for-purpose responses to DFSV nation-wide. The vision for lived experience engagement, key elements of the vision and guiding principles are outlined below for SA's specialist DFSV services sector and designed to guide the sector. The vision has been informed by the perspectives of survivor-advocates, sector professionals and existing research[16] to respond to the key needs identified by those involved in the Roadmap's development. All direct quotes have been consensually sourced from survivor-advocates and sector professionals during the interview stage of this project.

The Vision for SA's Specialist DFSV Services Sector

A whole-of-sector approach where lived experience is proactively and meaningfully embedded in all aspects of SA's specialist DFSV services sector, including individual practice, services and the peak body.

Key Conditions:

Lived experience engagement is central to the work, not an add-on or obligation.

A whole-of-sector approach where every level of the sector (practitioners, services, the peak body) is resourced and equipped to engage with lived expertise.

Infrastructure and governance arrangements enable the conditions for meaningful engagement with lived expertise.

Place-based and tailored approaches enable services to respond to the context and needs of specific communities and experiences of DFSV.

[16] See Appendix B

Guiding Principles for effective, respectful & sustainable lived experience engagement

Recognition of Expertise	Survivors-advocates' experiences of the sector and of DFSV are essential, expert knowledge that should be used to inform and strengthen all areas of the sector, from service design to policy development. Advocates are given the appropriate reimbursement for their time and expertise and regarded as experts in their own right. *"The foundation of our work is that women have the expertise."* - Sector Professional
Flexibility	Flexible, responsive and tailored ways of undertaking lived experience engagement are prioritised to 'meet victim-survivors where they are at' by making adjustments that respect the safety, cultural, spiritual, social, physical and psychological needs of advocates. *"The advocates don't have to stay involved consistently. They choose what they want to share and how and when they are involved"* - Sector Professional
Self-determination & Empowerment	Survivor-advocates have influence over how, when and how much they engage. The sector uses its power to elevate, rather than filter, the voices of survivor-advocates. Survivor-advocates' professional boundaries are respected, and their strengths are recognised and utilised. *"I've turned my past into my power."* - Survivor-advocate
Plurality & diversity	Diverse ways of knowing, being and doing are equally valued. An intersectional perspective is used to understand experiences of DFSV, such as those related to race, gender, sexuality, age, ability and economic status, with an understanding of how these interact and impact victim-survivors in unique and complex ways. The sector proactively increases engagement with a plurality of voices, perspectives and experiences, with a particular focus on those who are systemically marginalised. Diverse approaches to engagement are also utilised to improve engagement with survivor-advocates. *"T There's always something new to consider."* - Sector Professional
Informed Engagement	Survivor-advocates are provided with the information they need to engage in a timely and appropriate way to enable them to meaningfully engage with opportunities. This may include early provision of relevant policies, practices, system information, service guides and scope/purpose of the engagement opportunity and should be provided in a format that is best suited to the survivor-advocate (e.g. written, verbal, presentation etc.). This briefing and support is ideally provided prior to any engagement opportunity and incorporated into remuneration. Transparent and clear communication requires sector professionals to adapt to the communication needs or styles of each individual survivor-advocate, such as those with different linguistic backgrounds, learning styles or developmental stages. *"Clarity of expectations sit with workers as well as clients."* - Sector Professional

Healing & Safety	Healing and safety is fundamental to appropriate and safe lived experience work. Survivor-advocates should be provided the opportunity to opt in/out at any stage, to avail of debriefing with an appropriate support person and to change their minds regarding engagement at any time. Survivor-advocacy should be acknowledged as part of a healing journey, and therefore capacity and readiness to engage should not be assumed. Different topics may be of more/less interest for individual survivor-advocates and their choice should be central to any decision-making. *"Clients don't need saving…they need someone to walk alongside them."* - Sector Professional
Appropriate timeframes and planning	The pace of lived experience engagement should allow for quality, meaningful work to take place that aligns with the capacity of survivor-advocates and staff. Work should be done gradually, thoroughly and with deep consideration to uphold the sustainability and effectiveness of lived experience engagement within its specific context. Taking time to establish strong foundational processes of lived experience engagement in the initial stages allows for long-term work to be fruitful, effective and stable. In the instance of unavoidable time restraints, any and all constraints should be clearly communicated with survivor-advocates prior to and throughout their engagement. When the lived experience engagement activity is time bound, consideration should be taken to develop timelines that are achievable and respectful of the level of involvement required by victim-survivors. "We're a team, we're a partnership…it's providing a space to really learn from one another." - Sector Professional

Survivor-Advocates
Provided with opportunities that: - honour survivor-advocate agency - are influential - feel empowering & meaningful for the survivor-advocate Features of lived experience work - Clarity on expectations, responsibilities & their role (e.g. reform versus input/advice). - Feedback on the impact & outcomes of their engagement. - Streamlined remuneration processes & payment within 1-2 weeks. - Involvement from the beginning of an initiative. - Continuous program of training offered to strengthen key survivor-advocacy skill sets (e.g. trauma-informed story sharing) Provided with support - By a trusted staff member in a way that feels right for the survivor-advocate. - Opportunities to regularly connect & collaborate with peer survivor-advocates. - Availability of experienced 'mentors' to guide those who are new or embarking on a new area of advocacy.

Practitioners

Role within the sector: Supporting survivor-advocates to engage directly with services on improvements to policy development, service planning and practice.

Responsibilities to Survivor-Advocates

- Preparing, debriefing & checking-in
- Working alongside & collaborating
- Addressing power imbalances in relationships
- Using knowledge & position in the organisation/sector to elevate survivor-advocate perspectives
- Tailors their approach to the context.

Specialist DFSV Services

Role within the sector: Ensuring that lived expertise is reflected in service governance, planning, program logic & practice.

Responsibilities to Survivor Advocates

- Developing & cultivating relationships
- Creating service-level structures/initiatives for lived experience engagement
- Culture of responsibility & accountability to those with lived experience
- Onboarding, training/professional developing & ongoing support
- Streamlined processes for remuneration
- Embedding lived expertise into service planning & delivery
- Increasing the diversity of lived experience perspectives
- Explore peer support models
- Elevating and embedding lived experience perspectives across the sector to influence service models as well as individual services

Responsibilities to Staff

- Training on practice approaches for lived experience engagement
- Communicating lived experience perspectives across the service
- Ensuring that lived experience perspectives are available to decision-making groups

Peak Body

Role within the sector: Engaging with lived expertise to inform policy submissions & advocacy efforts.

Responsibilities to Survivor-Advocates

- Direct engagement with survivor-advocates, including those have not engaged with a specialist DFSV service
- Development of policy submissions that are informed by the combination of lived, practice & academic expertise.

Responsibilities to Specialist DFSV Services

- Providing opportunities for services to share insights, reflections & learnings on lived experience engagement
- Keeping abreast of noteworthy lived experience engagement initiatives nationally

PART 3 - How Do We Get There?

The Roadmap identifies a path to move from current limited practices to whole-of-sector practices where lived expertise is embedded across the specialist DFSV services sector.

In South Australia, the specialist DFSV services sector express significant commitment and enthusiasm for lived experience engagement. However, the sector lacks formal structures to support sector-wide lived experience engagement that is sustainable, effective, ethical, diverse and inclusive. The infrastructure and governance arrangements that are required to create the conditions to cultivate and leverage lived expertise are not embedded across the sector, resulting in missed opportunities to improve policy development, service planning and practice. As previously outlined, work is being undertaken nationally to develop and strengthen whole-of-sector approaches to lived experience engagement, which provides SA with an opportunity to join these nationwide efforts.

A Roadmap to Strengthen Lived Experience Engagement in SA's DFSV Services Sector

Building on the good practices described in the lived experienced literature, this section outlines specific recommendations for South Australia's specialist DFSV services sector to strengthen engagement with survivor-advocates at the practitioner, service and peak body level: a whole-of-sector approach. These recommendations are guided by the vision articulated in Part 2 and tailored to the South Australian context, from the insights into current lived experience engagement practices outlined in Part 1.

The recommendations are grouped into three key areas to reflect the needs of the South Australian context:

Key Area 1: Invest in the infrastructure to elevate lived expertise (Recommendations 1-5)
Key Area 2: Invest in survivor-advocates (Recommendations 6-7)
Key Area 3: Leverage existing sector strengths and skills (Recommendation 8)

While the Roadmap's recommendations primarily focus on the specialist DFSV sector, it encompasses recommendations targeted to the State Government. Additionally, several recommendations are contingent on government funding decisions.

Recommendations

Table 3: Summary of Recommendations to Strengthen Lived Experience Engagement in South Australia

	Recommendation
Key Area 1: Invest in the infrastructure to elevate lived expertise	
1.	That the State Government establish and effectively resource a lived expertise advisory council that directly advises government on DFSV policy.
2.	That the DFSV services sector is effectively resourced to support best practice lived experience engagement in policy development, advocacy, and service design, delivery and practice.
3.	That lived experience engagement is funded as a line item in service contracts to enable service-level engagement with survivor-advocates, including within a service's governance structure.
4.	That the DFSV services sector is resourced to develop and implement an Impact Framework for the Roadmap, to be reported on annually, to ensure that all parts of the sector remain

	Recommendation
	accountable to the Roadmap's vision and goals.
Key Area 2: Invest in survivor-advocates	
5.	That the specialist DFSV services sector is effectively resourced to develop and implement a training and professional development program for survivor-advocates, building on existing resources and expertise nationally.
6.	That the specialist DFSV services sector is effectively resourced to develop and implement standardised remuneration scales for survivor-advocates, which are reflected in funding agreements (Rec 3).
Key Area 3: Leverage existing sector strengths and skills	
7.	That the specialist DFSV services sector is effectively resourced to enable services to consolidate and embed current innovative and diverse lived experience engagement practices and share learnings on good practice lived experience engagement across the sector.

Appendix A: Lived Experience Project Methodology

Desktop Review

Key terms: "lived experience", "domestic violence", "domestic and family violence" and "domestic, family or sexual violence".

From February-April of 2024, the project team conducted a desktop review of the existing literature and qualitative research available through the Google search engine that included the key term 'lived experience' when paired interchangeably with the other key terms 'domestic violence', 'domestic and family violence' and 'domestic, family or sexual violence'. The resulting research was used to identify further relevant and related information through the use of available reference lists.

The documents included in the desktop review were restricted to those within Australia that had been published within the last four years (from 2020 onwards).

To our knowledge, all documents included in the desktop review are reliable, being either reviewed academic articles or being sourced directly from the relevant organisation or government body.

Survey Questions

1. Sector Information
    a. Organisation
    b. Service
    c. Your role
    d. Your name (optional)

2. What activities does your service/organisation undertake to engage people with lived experience? Choose as many options as relevant.
    - Informal feedback from clients about the service they received
    - Asking clients to complete a feedback survey regarding the service they used
    - Regularly reviewing client feedback
    - Supporting survivor-advocates to prepare a submission to an inquiry
    - Running a one-off advisory group
    - Running a standing group that includes survivor-advocates among its membership
    - Dedicated positions for survivor-advocates in the organisation
    - Dedicated positions for survivor-advocates on a governance group
    - Engaging survivor-advocates to do project/policy work
    - Engaging survivor-advocates to speak at an event or training session
    - Training victim-survivors to become media advocates
    - Training for lived experience advocates (including but not limited to those who have experience DFSV)
    - Peer staff
    - Other

3. Please provide additional details of the activities selected above.

4. How do victim-survivors become involved in these initiatives? *How were they identified and invited by the organisation?*

5. How are survivor-advocates supported throughout the initiative (before, during, after)? *E.g. debriefing, training, childcare.*

6. Did the organisation make improvements or changes as a result of victim-survivors' input? *E.g. actively engaging in service improvements based on feedback, changes in practice, etc.*

7. Were victim-survivors informed of how their feedback was being used?

8. What challenges have you encountered when developing or implementing lived experience activities?

9. What worked well when developing or implementing lived experience activities?

10. Are there lived experience engagement activities you would like to implement? *If so, what are these and what barriers (if any) exist for implementation?*

Programs & Services that Responded to the Lived Experience Survey (14 services)
Centacare CFS - Whyalla, Limestone Coast, Riverland & Murray Mallee-Adelaide Hills
Connection, Strength & Recovery Program
Domestic Violence Disclosure Scheme
Earlier Access to Support & Recovery (EASE)
Haven, Centacare
Health & Recovery Trauma Safety Services (HaRTTS), which includes Yarrow Place
Junction Australia
No To Violence

NPY Women's Council
Relationships Australia
Salvation Army - Bramwell House
Uniting Country SA
Women's Safety Services South Australia
Yarredi Services

Interviews with DFSV Sector staff (7)
Manager: Integrated Programs[17], Women's Safety Services SA
Community Programs Team Leader, NPY Women's Council
Head of Engagement, No To Violence
Community Voice Project Lead, Junction Australia
Training & Community Engagement Coordinator, Yarrow Place, HaRTTS[18]
Program Manager: Connection, Strength & Recovery, Women's Safety Services SA
Coordinator: Safe and Well Kids, Women's Safety Services SA

Interviews with Victim-Survivors & Survivor Advocates (18)
Individuals (1)
HaRTTS Consumer Engagement Committee (10)
Voices for Change (7)

[17] Domestic Violence Disclosure Scheme (DVDS), Multi-Agency Protection Service (MAPS), Safety, Accountability & Responsibility through Integration (SARTI), Safe & Well Kids (SAWK), Women's Safety Contact Program (WSCP)
[18] Health & Recovery, Trauma Safety Services, Women's & Children's Health Network, SA Health

Appendix B: List of Key Documents Resulting from the Desktop Review

Backhouse, C., Toivonen, C., & Funston, L. (2021). NSW Voices for Change: Preventing domestic, family and sexual violence through survivor-led media advocacy. Sydney: DVNSW

Cataldo, M. & Wark, W. (2024). Cultivating lived wisdom: Translating experience to expertise [Desktop Review]. Eastern Metropolitan Regional Family Violence Partnership. RFVP_Cultivating Lived Wisdom report_final.pdf

Domestic Violence Victoria. (2020). Family Violence Lived Experience Strategy https://www.vic.gov.au/family-violence-lived-experience-strategy

Lamb, K., Hegarty, K., Parker, R., Amanda, Cina, Fiona, & the University of Melbourne WEAVERs lived experience group. (2020). The Family Violence Experts by Experience Framework: Domestic Violence Victoria. https://safeandequal.org.au/working-in-family-violence/service-responses/experts-by-experience-framework/

Loughhead, M., Hodges,E., McIntyre, H., Procter, N. G., Barbara, A., Bickley, B., Harris, H., Huber, L. & Martinez, L. (2023). A model of lived experience leadership for transformative systems change: Activating Lived Experience Leadership (ALEL) project. *Leadership in Health Services, 36*(1). https://www.lelan.org.au/wp-content/uploads/2023/11/Article-LEx-leadership.pdf

Safe and Equal. (2022). Sources of Lived Experience in the Family Violence Sector Issues Paper https://safeandequal.org.au/resources/sources-of-lived-experience-in-the-family-violence-sector-issues-paper/

Domestic, Family and Sexual Violence Commission (2023). *Best Practice Principles: Engaging People With Lived and Living Experience* https://dfsvc.gov.au/sites/default/files/2023-10/Best-practice-principles---Engaging-people-with-lived-and-living-experience.pdf

Wheildon, L. (2023). Towards meaningful engagement: Key findings for survivor co-production of public policy on gender-based violence.
Wheildon-ANROWS-Towards-meaningful-engagement-Key-findings-for-survivor-co-production-of-public-policy-on-gender-based-violence-2023.pdf (anrowsdev.wpenginepowered.com)

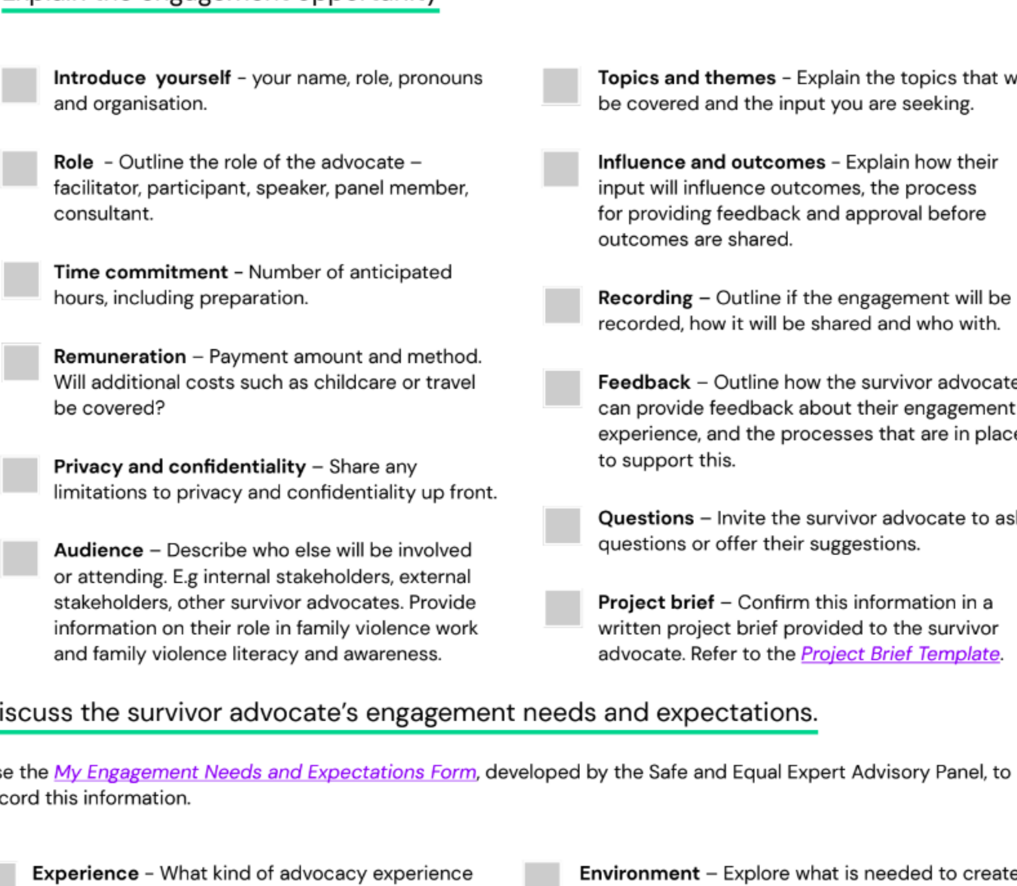
Appendix C: Useful Resources

[Planning Best Practice Engagement with Survivor Advocates (Safe & Equal)]

Do's Things that contribute to good engagements	Don'ts Things that contribute to poor engagements
"Ensuring we have all the information required to be informed. A checklist of who the audience is and what needs to be talked about." *"Take time to set up a supportive safe space."* *"By sharing your pronouns and asking what pronouns they use, you will create safe space for the survivor."* *"Providing opportunity for debriefing. Having access to a trauma informed support person from the organisation who knows us well or having the choice of bringing our own support person."* *"To be involved in the process from the beginning and of course being adequately renumerated for our time."*	*"Don't assume someone's gender by their appearance and use wrong pronouns. If you don't know what pronouns they use, just ask!"* *"When organisations take the positive feedback only and not the constructive feedback."* *"When there are no considerations in place about triggers or safe space. For example, the impact of walking into a space and being confronted with uniformed Police. That's a big trigger for me."* *"Any information can be detrimental and compromise safety. When we say we don't want our location to be disclosed, for some reason it gets disclosed anyway."*
"Good engagements plan for how to manage disclosures. While we often get disclosure, this should not be the responsibility of survivor advocates." *"Asking survivor advocates about triggers and boundaries and respecting those boundaries."* *"Allow us to determine what is safe and what is not safe. Ensure you are led by us as to how to support and maintain our safety throughout the engagement."* *"Providing flexibility and allowing to be human beings – being survivors it's not just something we are reading from a book, it's something we are living."* *"Being clear about how our information and experiences are going to be used and share –having transparency around that."* *"Understanding that lived experience is not the past tense but it is continuing – even though we may not be in a violent situation, the risk factors can be high."* *"Provide clear parameters or limitations. Articulating what you want and what you don't want is a matter of respect when it comes to engagement. This doesn't mean coming with all the answers, but ensuring there is clarity on the direction, outcomes or where you hope to get to."*	*"Having an engagement opportunity is not an invitation into my private life or for professionals to hunt me down on social media."* *"Not supporting new advocates. In the beginning I would disclose too many details of my story, there needs to be a level of understanding from the support person in where a survivor advocate is at in their journey."* *"Sometimes consulting with us is used like a checklist 'tick- we got their input' and they interpret our words to fit the answers they desire. That can have serious consequences."* *"Engagements that see us as only able to offer a story or case study feel tokenistic. We are more than our experiences of violence and abuse."* *"We don't like surprises."* *"Small things can have big impacts on power imbalances. For example, providing survivor advocates sticker name tags if the other participants are not wearing them."* *"When we don't receive feedback or hear about the outcome. Too often, we are forgotten after an engagement."*

Survivor-Advocate Engagement Checklist (Safe & Equal)

Before the engagement



Explain the engagement opportunity

- **Introduce yourself** - your name, role, pronouns and organisation.
- **Role** - Outline the role of the advocate – facilitator, participant, speaker, panel member, consultant.
- **Time commitment** - Number of anticipated hours, including preparation.
- **Remuneration** – Payment amount and method. Will additional costs such as childcare or travel be covered?
- **Privacy and confidentiality** – Share any limitations to privacy and confidentiality up front.
- **Audience** – Describe who else will be involved or attending. E.g internal stakeholders, external stakeholders, other survivor advocates. Provide information on their role in family violence work and family violence literacy and awareness.
- **Topics and themes** - Explain the topics that will be covered and the input you are seeking.
- **Influence and outcomes** - Explain how their input will influence outcomes, the process for providing feedback and approval before outcomes are shared.
- **Recording** – Outline if the engagement will be recorded, how it will be shared and who with.
- **Feedback** – Outline how the survivor advocate can provide feedback about their engagement experience, and the processes that are in place to support this.
- **Questions** – Invite the survivor advocate to ask questions or offer their suggestions.
- **Project brief** – Confirm this information in a written project brief provided to the survivor advocate. Refer to the *Project Brief Template*.

Discuss the survivor advocate's engagement needs and expectations.

Use the *My Engagement Needs and Expectations Form*, developed by the Safe and Equal Expert Advisory Panel, to record this information.

- **Experience** - What kind of advocacy experience and professional development have they had prior to this engagement?
- **Introductions** - How would they like to be introduced (e.g. as a survivor advocate, as a speaker with lived experience of family violence)? Would they like to introduce themselves and their role? Are they acting as an independent advocate, or representing a group or network?
- **Access requirements** - Explore access or support requirements E.g Auslan interpreter, interpreter, accessibility, breaks, how do they prefer to receive information, reminders or prompts, sending slides and questions in advance, technology requirements.
- **Safety** - Are there any legal, physical, emotional or cultural safety considerations? If so, what support or protection can your organisation put in place to support engagement?
- **Privacy and confidentiality** – How would they like their privacy and confidentiality to be maintained (use of first or full name, use of pseudonym, visibility of email address, use of image or recordings)? Develop a privacy and confidentiality agreement, including for what purpose their information will be used and for how long.
- **Environment** – Explore what is needed to create a safe space, whether in person or online. This could include knowing who else will be in and have power in the space, how the space is set up, where the exits are located and having an agreed way to communicate if the person is uncomfortable.
- **Boundaries** – Explore ways to uphold the survivor advocate's personal and professional boundaries and whether there are topics or themes they are not comfortable speaking about.
- **Support** – What type of support would the advocate find useful? Pre-briefing and debriefing, support from your organisation, from other survivor advocates or their own support person.

Pre-briefing

- **Written information** – Confirm the purpose, participants or audience and any agreed actions to support safe engagement and when you will be in touch after the event at least seven days before the engagement. This could include a run sheet, agenda or Terms of Reference.
- **Pre-meeting** - Depending on the nature and scope of the engagement, explore the option of meeting beforehand to collaborate on planning and meet other contributors.

During the engagement

- **Welcome** – Welcome the survivor advocate and introduce them the way you have agreed. Acknowledge them when they first enter the room, whether it is online or in-person.
- **Ways of working** – Whether through a Terms of Reference or group agreement, set agreed ways of working and give permission to take a break or step out of the session if needed. Remain flexible and open. Be mindful that you might need to adapt your timelines or approach to support participation.
- **Language** - Where possible, minimise jargon, acronyms and overt displays of hierarchy.
- **Power dynamics** – Address power and hierarchy, for example the physical set up of the space or use of titles. Check out the Experts by Experience Framework video on addressing power imbalances when working with people with lived experience of family violence.
- **Audience engagement** –Consider how much direct contact other event attendees or meeting participants will have with the advocate during the session, and whether additional supports need to be put in place. For example, if an audience has low level family violence awareness or literacy, it may be useful to have an extra colleague available to ensure the survivor advocate is not left unsupported at any point.
- **Discussions** - In group discussions, be intentional in asking survivor advocates to contribute. Give permission to pass or come back to a question.
- **Disclosures** – Ensure you have a plan to respond to disclosures of family violence and communicate what supports available for all participants. It should never be the responsibility of a survivor advocate to manage disclosures when engaging with a family violence service.
- **Respect** – Respect the survivor advocate's time and start and finish engagements on time.
- **Thank you** – Have a clear process for what the conclusion of the engagement looks like. Thank them for their contributions and the value they brought.

After the engagement

- **Debrief** – Check in with the survivor after the engagement. Did anything occur during the engagement that impacted them? Did anything come up that could affect their legal, physical, emotional, and cultural safety? Ensure they are comfortable with what they shared, for example, was anything disclosed that they would like edited from a recording or submission? Ensure the time for debrief or time to decompress following an engagement is remunerated.
- **Invite Feedback** - check in how they felt it went, ask if they have feedback about the session. Could anything have been done differently or better? You might consider multiple ways to provide feedback, with the option of anonymity.
- **Offer feedback** – share your reflections on how the engagement went, what the survivor advocate did well, the value they contributed and constructive feedback.
- **Next steps** – Confirm next steps, including how any outcomes from the engagement will be collated and shared. Confirm the process for remuneration including when they will receive payment.

Other Useful Resources

Survivor Advocate Feedback Template
My Engagement Needs and Expectations
Survivor Advocate Project Brief Template
Skills and Capability Self-Reflection Tool

The Domestic and Family Violence Statewide Alliance LGBTIQA+ Working Group: Recommendations and Actions

Background

The Domestic and Family Violence Statewide Alliance (DFVSA) LGBTIQA+[19] Working Group have undertaken extensive consultation to understand the complexity, barriers and appropriateness of how the DFV sector engages with the LGBTIQA+ community in South Australia including the barriers to inclusive and appropriate access to support.
A summary of the key findings and recommendations are as follows;

- Across multiple sectors, including the domestic violence and homelessness sectors, the LGBTIQA+ Community is an invisible cohort with many data systems unable to capture basic and specific data related to the LGBTIQA+ Community, impacting on our understanding of, and response to, the needs of the community.
- There is a lack of visibility within the DFVSA, with individual organisations having diverse understandings and practice related to this community, potentially limiting the safety, appropriateness and inclusivity of services available.
- While most organisations have some training included as part of induction or ongoing professional development, these tend to focus on being 'queer friendly' rather than 'queer educated', highlighting the need for more appropriate and streamlined education.
- Consultation shows diversity across the workforce, although survey responses highlight that not all responders feel that they can be themselves in their individual places of work.
- There has been a significant increase of LGBTIQA+ youth accessing homelessness services with the intersectional experience of domestic or family violence, indicating that DFV services may not be recognised as safe options for the community. This also highlights the varying ways that young people identify, and the need for services to adapt and future-proof their services/supports. For example, whilst homelessness services are adapting to include gender neutral accommodation, South Australia remains without safe accommodation and specialised case management for an LGBTIQA+ person experiencing violence where it is unsafe to return home.
- The DFV Alliance does not currently have a shared understanding of eligibility, access and support for LGBTIQA+ victim-survivors.

[19] For this paper, we will be using LGBTIQA+ (Lesbian, Gay, Bisexual, Intersex, Queer, Asexual +) as the acronym, consistent with the Department of Human Services (SA). We acknowledge that there are a number of variations of the acronym, and the existence of a broad spectrum across sexual orientation and gender identity, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse conceptions of gender and sexuality. We also note that different acronyms may be used for different purposes (e.g. when discussing sexuality or gender and specific contexts).

The DFVSA need to recognise and acknowledge that the drivers of gender-based violence are the same for women and for people within the LGBTIQA+ community, and take a collective approach to solutions that provide best outcomes for all people experiencing family and domestic violence. Accordingly, the recommendations below are made to expand support for LGBTIQA+ communities, without detracting from the vital support for women experiencing DFV.

Context

The LGBTIQA+ working group created the guiding principle when undertaking this work that 'exclusion is assumed unless inclusion is explicit'.
The working group wanted to focus on the intersectional oppression faced by the LGBTIQA+ Community, acknowledging that 'the focus on responding to the high prevalence of men's perpetration of family violence against women and children within Anglo, heteronormative, cisgender contexts have shaped service responses to family violence over the years. This has contributed to ignoring the intersectional oppression that underpins family violence and created inadequate responses for people of diverse populations who experience social marginalisation. The rates of intimate partner violence within same sex relationships are as high as the rates experienced by cisgender women in heterosexual relationships, and possibly higher for bisexual, transgender and gender diverse people'. [20]

Objectives

- Transparency and voice – Inclusivity and voice from the LGBTIQA+ Community for the LGBTIQA+ Community
- Clear visual presence within Alliance culture and practice
- Embedded language that aligns with language the LGBTIQA+ Community identifies with

The review has been guided by the following questions:

- Where does the LGBTIQA+ community currently go to access support for domestic and family violence, and what supports are available in SA for the LGBTIQA+ Community experiencing domestic or family violence?
- What are the help-seeking barriers?
  - Stigmatisation and ostracisation
  - Barriers related to children and parenting
  - Structural / systemic barriers
- What are the nuances the LGBTIQA+ community, and the organisations providing support, want and need?

Methodology

The working group has undertaken research and consultations between January (approx.) and July 2022. A mixed methods approach was undertaken, drawing on both quantitative and qualitative data and analysis.
Qualitative data including consultations

- The working group had consultations with many people, organisations and Alliances. Significant contribution to the recommendation and actions have been made by the following advocates, people and organisations
  - Mathew Morris and Nicole Lionnet
  - Uniting SA
  - Lucy Hackworth
  - Bryan Atherton
  - Thorne Harbour Health
- Statewide DVFSA and Generic Homelessness Survey

[20] The Salvation Army – Social Mission – Family Violence Model of Care

- Consultations with Alliance Senior Managers, Towards Home Alliance and Padninthi Kumangka Wardli Adelaide North-West Homelessness *Alliance*
- *Informal consultations with other sectors*

Findings

Key learnings have highlighted several priority areas for consideration, including data, training, safe accommodation and specialised case management, visibility and transparency, clear pathways, incorporation of recognition of family violence (in specific terms related to the LGBTIQA+ community) and inclusion and diversity.

Where does the LGBTIQA+ currently go to access support for domestic and family violence and what supports are available in SA for an LGBTIQA+ Community member experiencing domestic or family violence?

Presently in South Australia there is no specialised services for LGBTIQA+ people experiencing violence. Through consultation with the generic homelessness sector and through anecdotal data collected in the frontline worker survey, responses indicate a significant increase in LGBTIQA+ people seeking assistance with the intersectionality of homelessness due to domestic and family violence; unfortunately, there was little data to establish a comprehensive comparison.
The front-line worker survey highlighted that the DV sector is seeing an increase in LGBTIQA+ people seeking support with the homelessness sector, and more specifically the metro-based services, having 14 individual case managers respond that in the last 3 years they have each individually case managed 10 or more LGBTIQA+ people.

'Research informs us that 1 in 3 LGBTI[21] people experience intimate partner and/or family violence from a partner, ex-partner, or family member, inclusive of family of choice'[22]

In South Australia there are limited pathways for safe and appropriate accommodation, this includes the accommodation pathway from refuge through to access to Transitional Housing and Supportive Housing where eligibility criteria is indistinct for a Trans or gender diverse individual, or a male who identifies as bisexual or gay.

'A person's sexuality shouldn't limit or define their housing outcomes' – Anon (Metro Homelessness Service)

During consultation with the homelessness sector, youth homelessness services shared that they have seen significant increases with LGBTIQA+ youth seeking safe accommodation due to homelessness which has been a direct result of domestic and family violence, but more specifically family violence. Bryan Atherton (Manager Ruby's Reunification Service – Uniting SA) stated that they had seen 60% of the Youth (Ruby's supports people up to the ages 12 to early 20's) that they support identify as being part of the LGBTIQA+ Community and that Ruby's have seen a significant increase in the last 3 years.

'Working in a shelter there have been times where a room was not suitable for a trans or gender diverse young person' – Anon - LGBTIQA+ Community Member (Metro Homelessness Service)

Identified through consultation was the increase in Transsexual and gender diverse individuals accessing homelessness services with some organisations considering changing their accommodation options to include 'gender neutral' options. Whilst this is supportive of the LGBTIQA+ community it lacks the specialised domestic and family violence lens (including but not limited to risk assessment, DFV education and safety planning) for when there is the intersectionality of the experience of domestic or family

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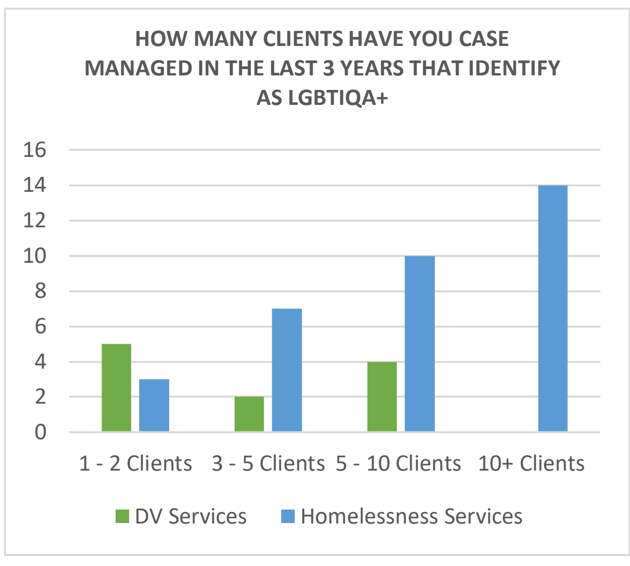
[21] LGBTI is the acronym used by Thorne Harbour Health

[22] Thorne Harbour Health - https://thorneharbour.org/lgbti-health/relationship-family-violence/

violence. Whilst this is a positive move forward toward inclusivity it requires time and funding, and there are still incidents where individuals are turned away.

'No, despite being a member of the LGBTIQA+ community, the referral pathways I have to offer to LGBT folks are insufficient and often unsafe i.e trans women are at increased risk of violence, but a general DV service may not be equipped to provide a safe service to her' – Anon (Metro DV Service)



During analysis of the frontline worker survey, the working group was surprised to learn that 4 individual metro DFV Case Managers have case managed 5 – 10 LGBTIQA+ clients in the past 3 years, indicating that there are several clients that are serviced through the DFVSA. In comparison to this, the data stipulates those 10 individual metro Homelessness case managers have case managed 5 – 10 LGBTIQA+ clients in the last 3 years and a further 14 metro Homelessness case managers have case managed 10 or more LGBTIQA+ clients in the past 3 years. Unfortunately, the survey did not go into the intersectionality of DFV for the homelessness clients. The survey was not answered by all front-line workers and is a 'snapshot' yet the evidence indicates that the client numbers are significantly higher than anticipated.

What are the help-seeking barriers? (Stigmatisation, ostracisation, structural and systemic barriers)

The ostracism of LGBTIQA+ people originates in cultural stigma that is reproduced and reinforced at all levels, from discriminatory laws and institutional policies to the actions of community, services inclusive of gender specific services that create alienation of an already marginalised cohort. An integral component of our learnings is that there are consistent barriers preventing LGBTIQA+ people from accessing service and supports.

The LGBTIQA+ cohort both as a community and as individuals do not fundamentally have an awareness of the existence of the Domestic Violence sector. Domestic Violence as a societal issue is discussed and presented through a heteronormative lens, therefore the LGBTIQA+ community face an implicit lack of awareness of Domestic Violence and its many forms, leading to normalising and minimising Domestic Violence within their relationships. During consultation with Thorne Harbour Health (a LGBTIQA+ specific service who provide Alcohol and Other drug services in SA), who in Victoria provide DFV support to the LGBTIQA+ Community, they informed the working group about specific systemic barriers to statutory responses including:

- Reporting to police – examples given that police often lack the education and awareness to LGBTIQA+ interpersonal domestic violence, with incidents commonly recorded as 'a dispute between house mates'
- Court System - directly related to the incident of violence being misreported, which has the flow on effect to court mandated perpetrator behaviour change programs
- Perpetrator Behaviour Change Programs – Thorne Harbour Health shared that in partnership with No To Violence (NTV) they run a LGBTIQA+ perpetrator behaviour change program for men (inclusive of birth gender, gender identity and gender expression) that are using power and control towards their partners. It is a 20-week program delivered via Zoom.
- Multi-agency responses – examples given in response to RAMP (FSM equivalent in Victoria) and the difficulty with having high risk LGBTIQA+ people accepted.

- Coronial investigations and inquests – Thorne Harbour Health shared that the combination of systemic barriers faced by the LGBTIQA+ community mean that there is little data on LGBTIQA+ specific DFV homicide and that there is little to no recommendations for systemic change due to the deaths not being categorised as DFV homicides.
- The LGBTIQA+ community are reluctant to engage with heteronormative services particularly those that are faith based, due to historical marginalisation, mistreatment and deeper and more ingrained traumas. It is important to note/remember that the LGBTIQA+ community did not have equal rights in regard to marriage equality until 2017 and many members of the community still face discrimination and inequality today. In summary, there is a lack of trust and a reluctance to engage with services that appear to cater only to the heteronormative cisgender community.

'We have had no activities or training to raise awareness other than very basic training on pronouns and understanding the difference between gender and biological sex. Most staff have a very limited understanding of the queer community' – Anon (Metro DV Service)

Other factors that impact help-seeking barriers have been identified through consultations include;

- The LGBTIQA+ community do not see the services to exist and do not see themselves in the organisations.
- Intake forms that have a cis-heteronormative lens create a disbelief that the service will be able to assist, as it does not represent or lacks inclusion of the person. This can lead to fear of being mis-gendered, judgement and ridicule, therefore creating an overall mindset of 'do I feel like I am going to be treated fairly?'
- Lack of inclusivity and transparency, creates mindsets of 'will this service be able to help with what I am dealing with'? Most organisations are 'queer friendly' and openly display the 'Welcome Here' sticker however also lack the deeper foundations for creating safe access for the LGBTIQA+ community. As a specialist domestic violence Alliance we need to ensure that we are intentionally inclusive, ensuring we are using inclusive language, and avoid making assumptions about gender and sexual orientation.

'Survivor participants wanted to see service providers commit to real change to make their own practice and organisations safe for LBGTQA people across access. This included a process of service providers reflecting on their own values and seeking out education from and partnership with LGBTQA services and community groups'[23]

Family Violence is particularly prevalent within the LGBTIQA+ community, particularly amongst youth and the CALD community, in instances where there has been a rejection of the person's sexuality or gender identity for cultural or religious reasons. Presently in South Australia our domestic and family violence responses do not have the resources and responses for family violence outside of Aboriginal Family Violence. Anecdotally, the evidence would suggest that the increase in LGBTIQA+ youth accessing homelessness services would have the intersectionality of the experience of family violence. There is therefore a sense that specific and tailored services are required that cater to the LGBTIQA+ community and that there will be a need for the sector to have an expectation that it will take time to develop both an awareness of Domestic Violence and Family Violence support for this community.

'Safe spaces including emergency and short-term accommodation, inclusive DV policy that recognises same gender violence, broadening of eligibility criteria to be inclusive' – Anon (Metro Homelessness Service)

[23] Queering Survival: LGBTQA People's Experiences of Living Through Sexual Violence [Doctoral thesis, RMIT University] - Mortimer, Shaez. (2022).

The ostracism of LGBTIQA+ people originates in cultural stigma that is reproduced and reinforced at all levels, from discriminatory laws and institutional policies to the actions of community, services inclusive of gender specific services that create alienation of an already marginalised cohort.

What are the nuances that the LGBTIQA+ community and the organisations providing support want and need?

The requirements and preferences of the LGBTIQA+ community are multifaceted due to the variety and complexity of the different cohorts within the acronym; therefore, when supporting the LGBTIQA Community, considerations need to be made for the nuances of the different cohorts for Lesbian, Gay, Bisexual, Transsexual, Non- Binary, Queer, Intersex, Asexual, and members of other gender identity/expression and sexuality communities.

'…this means staying informed on LGBTIQA+ issues, speaking up for equality, and fight for policies that protect LGBTIQA+ folks. In service delivery this means understanding barriers for accessing services, understanding the unique risks and vulnerabilities associated with being part of the LGBTIQA+ community, and assisting with safe, inclusive, and appropriate pathways' Anon- (Metro DV Service)

As an Alliance we need to consider the following key issues.

Inclusivity

It is vital to recognise that the LGBTIQA+ Community experience domestic and family violence, with research indicating that the rates may be as high as 1 in every 3.[24] As the Statewide DV Alliance we need to follow our principle of 'every door is the right door' and create pathways for the LGBTIQA+ community to access appropriate and adequate support.

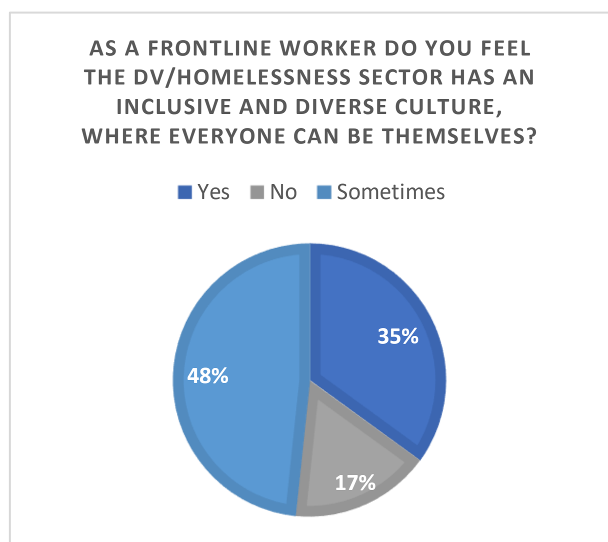
'Intake' and entry points do not necessarily need to look different for an LGBTIQA+ person; rather, 'mainstream' intake should have small changes to be inclusive of the LGBTIQA+ community. This can be achieved through inclusive language and recognition of diversity, such as asking preferred pronouns, gender expression / gender identity, while allowing non-disclosure of this information as the individual feels comfortable. As an Alliance we need to educate all staff how to respectfully ask these questions, and create transparency for how this information will be used, stored and how it would benefit the clients. When asked in the survey whether services already asked inclusive questions as intake, results were mixed, with some but not all answering in the affirmative. The working group highlights the need for consistency in this area, with simple additions to intake forms to assist with inclusive language to foster visibility and enhance safety for the LGBTIQA+ communities.

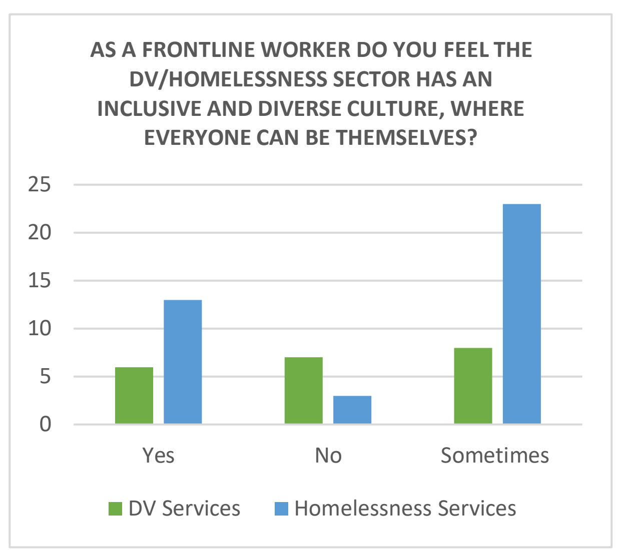
Through consultation it was identified that like 'mainstream' cis-heteronormative services, LGBTIQA+ people do not want to have to re-explain themselves and re-tell their story. As an Alliance this is something that we have not yet successfully achieved, with clients sometimes having 2-3 different case managers, each time feeling obligated to re-tell their story. This issue is part of the broader spectrum which requires a whole Alliance focus of the client journey, information sharing and breaking down 'relevant information' in that journey.

The working group sought to gain an insight into inclusion and diversity within different organisations that sit within the Homelessness Alliances and the DFVSA; in the frontline worker survey it was asked if workers felt that the DV and homelessness sector had an inclusive and diverse culture where everybody felt they could be themselves. The results were surprising, with the declaration that almost half of the respondents stating that they only sometimes feel that they can be themselves in their workplace, indicating that whilst

[24] https://www.acon.org.au/what-we-are-here-for/domestic-family-violence/#domestic-family-violence

we strive for an inclusive and diverse culture within our Alliance and individual organisations, we have a long way to go until this is achieved.





Visibility

The LGBTIQA+ community need to see themselves represented in the Alliance/sector; similarly, to public campaigns, the general workforce and organisations that provide services. The LGBTIQA+ community, as a group and individuals, already experience ostracisation and systemic barriers, which can lead to experiencing shame about accessing services; this may be cumulative, with a feeling of exclusion and the fear of being misrepresented and misunderstood. We as an Alliance need to build strong foundations around 'every door is the right door' and be inclusive and transparent that if an individual that identifies as LGBTIQA+ presents seeking assistance for domestic or family violence, that they will be treated fairly, equally and be provided a holistic service that incorporates the safety-first principle.

"I have completed training and studies in relation to gender and LGBTIQA+ to be queer educated, not just queer friendly. For many other people this training should be embedded into the processes as it's not just about being 'tolerable' towards LGBTIQA+ folks but having an education and deeper understanding to the complexity of gender and sexuality." – Anon (Metro Homelessness Service)

Strong feedback was received from the frontline worker survey around skill development and adequate training for staff working with the LGBTIQA+ community. Responses indicate that many organisations have different 'LGBTIQA+ friendly' training modules, with varying degrees of information, yet the consensus is that there is no consistency across the Alliance. Frontline workers are eager for training to further develop their skills.

'We definitely require more training as a service on supporting women with diverse gender expressions and more clear guidelines on what it means as an all-female DV service when we get clients who don't fit the CIS-Female gender assumption' – Anon (Metro DV Service)

Safety

As an Alliance, the safety-first principle is the foundation of everything we do. Presently in South Australia the LGBTIQA+ communities, like other marginalised cohorts, may have a higher risk of experiencing domestic and family violence, but unlike 'women and children' in the heteronormative cis-female context there are no safe accommodation options for an LGBTIQA+ individual seeking support and safety. Safe accommodation options are limited with women's shelters being unsuitable to some and men's shelters being unsafe. Some LGBTIQA+ individuals will access emergency accommodation; however sometimes this is not a safe option as it places the individual at further risk of 43ostracisation and verbal abuse, with some

LGBTIQA+ people have been forced to sleep rough, placing them at further risk of violence and sexual assault.

'*Working in a shelter there have been times where a room was not suitable for a trans or gender diverse young person' – Anon LGBTIQA+ Community Member (Metro Homelessness Service)*

Youth homelessness services have a similar experience with seeing an increase in LGBTIQA+ youth seeking supports; unfortunately, there is limited data to support this as databases and H2H do not adequately capture the data. The DFVSA need to consider the potential trajectory of this, with youth having 'early life experiences of domestic and family violence' and how this will shape future interpersonal relationships, potentially leading to further experiences of domestic violence, with violence becoming 'the norm'. How will our domestic and family violence sector respond to the need?

'We need to stop making assumptions about what is and isn't safe for female victim survivors and ask them whether they would feel safe including people of diverse gender in services. We need an inclusive practice framework across the Alliance, to ensure all frontline practitioners receive training in inclusive practice, we need to partner with specialist service providers to create referral pathways into the Alliance and into specialist services to offer choice' – Anon (Metro DV Service)

Family violence is a common experience for individuals across different cultural backgrounds; but while the DFV sector currently recognises and responds to Aboriginal Family Violence, the current funding model restricts the sector's ability to respond to family violence in other contexts. Experiences of family violence are common across LGBTIQA+ communities, and is a prominent cause of homelessness, especially among young people in religious or culturally and linguistically diverse families. Different cultural expectations around acceptable familial behaviour, and religious or cultural beliefs regarding sexuality and gender identity may contribute to instances of family violence for people in LGBTIQA+ communities. The LGBTIQA+ Working Group acknowledges the need to further explore the incorporation of a broader conception of family violence, while acknowledging that this is currently constrained by funding arrangements.

Throughout the consultation a common identification was the need for appropriate and safe crisis accommodation options with wrap-around support. Appropriate and safe accommodation options for the LGBTIQA+ community are limited Australia wide; some states have specialised case management and others have limited supports with South Australia being one of the latter. Shine SA, Thorne Harbour Health and Yarrow Place were identified as support options for the LGBTIQA+ community however none of these organisations, aside from Yarrow Place, which supports with rape and sexual assault, are specifically for domestic and family violence.

'A dedicated service providing support for LGBTIQA+ clients experiencing DV or Homelessness…. This would increase the safety of trans and gender diverse clients immensely, and should cater to trans women AND trans men, and non-binary people regardless of their assigned gender at birth, as well as those experiencing same sex violence' Anon -(Metro DV Service)

The DFVSA operates with a trauma informed and empowerment lens, assisting the clients we support to have choice and gain control of their lives after surviving domestic and family violence. If the DFVSA was to consider incorporating a specialised service for LGBTIQA+ communities, based on the anecdotal information the LGBTIQA+ working group has compiled, the working group would advocate that the same lens be considered for LGBTIQA+ communities, and that service delivery and modelling would need to remain holistic and cannot solely focus of the gender and/or sexuality of the individual seeking support.

Based on the above findings, we propose the following recommendations.

Recommendations

Short Term Recommendations (under 12 months)

1. ***Inclusion***
   - 1.1. Intake to be inclusive of the LGBTIQA+ community. First point of contact (e.g. common access tool) to incorporate pronouns and gender identity/gender expression.
   - 1.2. The LGBTIQA+ Working Group and the DFV Alliance to clarify the Acronym to be used moving forward for representation of the working group, acknowledging that the acronym can be represented differently across individual organisations (inc. government), states and territories and across different cohorts
   - 1.3. Inclusive recruitment and advocacy work across the marginalised cohorts.
   - 1.4. 'Family Violence' to be defined across the DFVSA, in the context of LGBTIQA+ experiences as there is anecdotal evidence to suggest that large portions of the LGBTIQA+ have experienced violence perpetrated by a direct or indirect (chosen family) family member.

2. ***Partnerships***
   - 2.1 Holistically explore potential partnerships and linkages / pathways with other key stakeholders within South Australia that provide support and services to the LGBTIQA+ Community.
   - 2.2 Consider existing community diversity and specialised programs for the LGBTIQA+ community which will assist with the development of shared resources and the future direction of adequate training.

3. ***Data Collection***
   - 3.1 Alliance partners that are able to capture sexual identity, gender identity / gender expression and pronouns on their case management systems to commence this as soon as reasonably practical to do so.
   - 3.2 SA Housing Authority to consider changes on Homeless 2 Home (H2H) to adequately capture sexual identity and gender expression / gender identity data. In the interim, consider the use of 'Other' on H2H with additional training and data analysis.

4 ***Domestic Violence Crisis Line (DVCL) Review***
   - 4.1 To consider / be aware of potential limitations and access restrictions, ensuring an inclusive lens, when supporting the LGBTIQA+ community.
   - 4.2 Ensure the visibility of LGBTIQA+ community is integrated into all discussions on accessibility, referral pathways or specialised tools.

5 ***Emergency Accommodation Program (EAP) Review – DFVSA and Homelessness Sector / SA Housing Authority***
   - 5.1 Emergency Accommodation access is reviewed to ensure an inclusive lens that entitles equal access to financial support for nights paid through SA Housing Authority
   - 5.2 Ensure there is an inclusive lens for an LGBTIQA+ person accessing services who is experiencing the intersectionality of DFV and Homelessness. Consideration of consistency of response across the access gateways regardless of gender identity / gender expression or sexuality (Homelessness Connect, DV Crisis Line and SA Housing Authority managed EAP clients)
   - 5.3 Explore how an individual seeking support can be adequately assessed for domestic and family violence, if accessing support through a homelessness service - this may be a pathway of 'warm referral' to DV Crisis Line.

6 *Education and Training*

6.1 Specialised DFV LGBTIQA+ training be considered as a joint sector investment, including directly contracted services (Such as Homeless Connect), to be focused on being 'queer educated' not just 'queer friendly'. Prioritise a basic foundations training rolled out in the first 12 months, and endorse commitment to work towards a more in-depth training model that is inclusive of the nuances of the different cohorts.

6.2 Education across all levels of staff (from CM to CE level), to increase people's comfortability with understanding the community/cohort and understanding why knowledge, language and proper terminology is essential for community inclusion, reinforced with development of shared resources.

Resource development

6.3 Development of an internal suite of fact sheets to guide frontline workers on LGBTIQA+ specific domestic violence behaviours to increase awareness to what constitutes violence and different types of violence with explanations of how and why this may impact the individual (such as dead naming, outing, withholding medication, etc).

6.4 Development of shared resources to increase understanding across all levels of services on why language and terminology is important including but not limited to gender expression / gender identity and the use of pronouns.

6.5 Training or scripts to be developed for front line workers to be able to respond to clients regarding why we ask pronouns/gender identity/expression, how the information will be stored and how it may benefit the client's experience.

7 Marketing and Branding

7.1 Embed visibility across Alliance resources and communications, including inclusive language.

7.2 Actively promote inclusive recruitment (visibility, marketing emblems, and 'LGBTIQA+ encouraged to apply').

8 Internal Visibility

8.1 Internal visibility – supporting and committing to celebrating days of visibility (wear it purple, IDAHOBIT, etc) by way of email or communication through the DFVSA regular newsletter to all staff and Alliance members on what the day is, what it represents, events that may be occurring in areas of SA, days of action, useful information, etc.

8.2 Commitment to celebrating or supporting days of visibility (internally or externally), and acknowledging as appropriate at meetings.

8.3 Explore having an AMT/ALT only lunch and learn with a lived experience LGBTIQA+ survivor and case manager who has had experience working with an LGBTIQA+ person. The aim would be to highlight the systemic barriers that may have been faced. Further build an opportunity for the lived experience LGBTIQA+ individual to speak at a town hall to the frontline staff.

8.4 Create a comprehensive case study.

8.5 Transitioning the current LGBTIQA+ working group into a Community of Practice, clarify the role of the committee, terms of reference, and possible expansion to include allies and advocates for consultation.

9 ***Alliance Leadership***

9.2 Explore LGBTIQA+ funding availability and opportunities for specialised support, this may include partnering with another service who may be better suited to providing the specialised case management.

9.3 Mapping of support options (including accommodation) available to LGBTIQA+ community, to be shared with all services.

10 ***Homelessness/DFV Sector and SA Housing Authority***

10.1 The appointment of an LGBTIQA+ Project Officer, whose role will be focussed on embedding the necessary practice, culture, inclusion and diversity required for successful implementation of the recommendations. The role would also include a responsibility for implementing relevant training, resource development, creating safe working environments for staff, liaising with lived experience cohorts, creating safe Employee Assistance Pathways, creating policy and process guidelines for protection of marginalised communities. A Project Officer with lived experience would be preferred.

The working group would advocate for consideration of the Project Officer role as a whole of state investment, with the candidate envisioned to work across all Alliances and directly contracted services, ensuring consistency in service delivery. Ideally, the role would be 1 FTE and suggested funding options include the National Partnership Funding, ACON, DSS, DHS or other alternative space, with a 3-year pilot of the role.

We have recommended this as a short-term action, as we feel it is important that a dedicated resource is on-board from the initial phases of changes being implemented, this will demonstrate a genuine commitment to the importance of the project and will ensure that the LGBTQI voice is paramount in improving access to services within their community.

'Participants described inclusive practice, support, and allyship as processes of continuous reflection, consultation, and action – noting that there is no 'silver bullet' or 'one-size-fits-all' answer to improving support for the LGBTQA survivors'[25]

<u>Medium Term Recommendations (12 to 24 Months)</u>

1. ***Inclusion and Internal Visibility***

1.1. Diversity and Inclusion competency plan for a 3-year period.

1.2. LGBTIQA+ Lived experience working group for best practice (consultation), considerations to be given to the nuances of different cohorts. The LGBTIQA+ Working Group acknowledge the amazing work of Voices for Change as a lived experience group but advocate that as the LGBTIQA+ is an additionally marginalised cohort that initially there should be a dedicated lived experience working group.

2. ***Front line***

2.1 Development of expert people for consultation as a short-term investment for specialised case management. Having individuals that can be contact points or mentors for frontline staff to be able to contact for specialised information if case managing an individual from the LGBTIQA+ Community (consider having this built into the Project Officer position).

2.2 Development and mapping/access of appropriate referral pathways for Employee Assistance Programs that provide inclusive support specific to the LGBTIQA+ community.

2.3 Create a holistic service map for of key stakeholders, network pathways and community connections, consider a traffic light report and matrix identifying Unsafe (uneducated), Queer friendly, Queer educated, and LGBTIQA+ controlled service.

3. ***Alliance Leadership***

3.1 Explore philanthropy for the lease or donation of property for safe crisis accommodation. Explore co-contribution from government rather than asking for the whole funding. Recommendation is that if successful, advocating for pilot to be 5+ years which allows time to build adequate relationships and pathways with the LGBTIQA+ Community and facilitates reasonable timeframes for evolution of the model and sufficient data selection for evaluation.

[25] Queering Survival: LGBTQA People's Experiences of Living Through Sexual Violence [Doctoral thesis, RMIT University] - Mortimer, Shaez. (2022).

3.2 Service modelling for specialised crisis accommodation and case management (entry points through to safe exits) including investigating interstate LGBTIQA+ DFV service models, Eligibility for service model is inclusive of 'family violence' and 'Chosen Family' through a LGBTIQA+ lens acknowledging that the person using violence may be of the individuals own or chosen family.

4. ***Education / Training - Cross Alliance Development***

4.1 Building across the basic foundation training and educational packages previously mentioned- cross development of a training package that is delivered to all Alliances and directly contracted services to ensure a consistent approach for all staff - Option for SA Housing Authority to be included.

Long Term (24 months and beyond)

1. ***Specialised Service / Frontline***

1.1 Clear pathways (entry to exit) agreed and understood across the sector, including key referral and connections across services, considering the needs of different groups within the LGBTIQA+ community.
1.2 Specialised services in place for support.
1.3 Specialised tools including LGBTIQA+ specific risk assessment and safety assessments.

2. ***DFV Alliance***

2.1 No wrong door or barriers to an individual seeking the support that they need.
2.2 The DFV Alliance is inclusive of 'family violence' in the context of the experience of an LGBTIQA+ individual (also including chosen family) across all service elements.
2.3 Ongoing visibility and proactive inclusion of LGBTIQA+ community embedded across all parts of Alliance.
2.4 Ensuring that service options are articulated through campaigns (Embolden, government) and marketed appropriately.

3. ***Embolden***

3.1 Work with Embolden to advocate for inclusion in prevention or other advocacy campaigns.

Conclusion

The consultation undertaken by the LGBTIQA+ Working Group has brought to light a range of systemic challenges for people in the LGBTIQA+ communities, and indicates a need for a diversity and inclusion lens over current strategies and processes. It is clear that there are significant sector-wide considerations required to ensure that people across diverse marginalised communities experiencing DFV can be supported. Building upon what we know about gender-based violence against women, the LGBTIQA+ lens enables the sector to hear and support people across different intersecting needs and experiences.
The recommendations in this report are the first steps to broadening the sector to support people across the LGBTIQA+ community. We have endeavoured to make the recommendations both ambitious in scope and as achievable as possible. The Working Group asks for consideration and feedback for the recommendations, and, where possible, options for actions that can be taken to operationalise and implement.

Appendix A: LGBTIQA+ Working Group

This paper was prepared by the Domestic and Family Violence Statewide Alliance (DFVSA) LGBTIQA+ Working Group (the Working Group), comprising members from a diversity of backgrounds and services, including members of the Toward Home Alliance (THA).

Working Group Membership

Name	Pronouns	Organisation
Pearl Bailey	She/her	DFVSA – Bramwell House – The Salvation Army
Shannan Kimberley	She/her	DFVSA – Women's Safety Services SA
Suzanne Clarke	She/her	DFVSA - Uniting Country SA
Michelle Merrick	She/her	DFVSA – Nunga Mi:Minar
Jody Taylor	They/them	DFVSA – Women's Safety Services SA
Dr Victoria Skinner	She/her	THA - SA Housing Authority
Jacqueline Evans	She/her	THA – Baptist Care (no longer in role)
Stephanie Keightley	She/her	THA – Baptist Care

The Working Group was brought together under the guiding principle that 'exclusion is assumed unless inclusion is explicit'.

The scope of the Working Group was to consider and make recommendations regarding inclusivity and diversity within Domestic and Family Violence (DFV) services for people in the LGBTIQA+ community. The Working Group focused on intersectional oppression, including challenging the underlying heteronormative, cisgender contexts that exist in traditional notions of DFV. The goal of this focus was to understand and seek to remove barriers to support for people in the LGBTIQA+ community experiencing DFV.

Appendix B: Resources

The following resources provide further information and support regarding DFV and the LGBTIQA+ community. Some were used to inform the report, others extend the knowledge and can be used to inform future work.

Advice, support, and advocacy organisations

Rainbow Health Australia: https://rainbowhealthaustralia.org.au/
Shine SA: https://shinesa.org.au/
South Australian Rainbow Alliance: https://www.saraa.org.au/
Thorne Harbour Health: https://thorneharbour.org/

Research papers

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Hill, AO, Lyons, A, Jones, J, McGowan, I, Carman, M, Parsons, M, Power, J, Bourne, A (2021), *Writing Themselves in 4: The health and wellbeing of LGBTQA+ young people in Australia*, National Report, Monograph Series 124, Melbourne, Australian Research Centre in Sex, Health and Society, La Trobe University, https://res.cloudinary.com/minus18/image/upload/v1613351553/Docs/Writing-Themselves-In-4-National-report_ua6oza.pdf

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Society, La Trobe University, https://ltu-figshare-repo.s3.aarnet.edu.au/ltu-figshare-repo/37829127/ARCSHS_OpeningDoorsResearchReportFA.pdf?AWSAccessKeyId=RADjuIEnIStOwNiA&Expires=1665704030&Signature=bQAEpEB6WaKMKhg6GN9m8kh8d1w%3D

Miscellaneous

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Catalyst Foundation, *Toward a Safe Place: LGBTIQA+ Domestic Violence Information & Resource Booklet*, http://www.catalystfoundation.com.au/wp-content/uploads/Toward-a-Safe-Place-booklet.pdf

Child Family Community Australia, *Intimate partner violence in lesbian, gay, bisexual, trans, intersex and queer communities* (Practitioner Resource), Campo, M & Tayton, S, https://aifs.gov.au/sites/default/files/publication-documents/cfca-resource-dv-lgbti-2020_0.pdf

Department of Human Services (SA), *Data Collection and Gender Guideline: Data collection and working with the LGBTIQA+ community*, July 2021, https://dhs.sa.gov.au/__data/assets/pdf_file/0020/105653/Data-Collection-and-Gender-Guideline-Data-Collection-and-Working-with-the-LGBTIQA-Community-2021.pdf

National LGBTI Health Alliance & Pride Foundation Australia*, LGBTIQ+ inclusive practice guide for homelessness and the housing sectors in Australia*, https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/663/attachments/original/1604283772/LGBTQIHomelessness_GUIDE_Final-March2020.pdf?1604283772

Rainbow Health Victoria, *Pride in Prevention Messaging Guide: A guide for communications and engagement to support primary prevention of family violence experienced by LGBTIQ communities*, https://ltu-figshare-repo.s3.aarnet.edu.au/ltu-figshare-repo/29080026/PrideinPreventionMessagingGuide.pdf?AWSAccessKeyId=RADjuIEnIStOwNiA&Expires=1665705154&Signature=okjuRBWuu%2BYEk1pr1C84yAH4g4w%3D

Safe and Equal, *Top tips for inclusive responses to lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual (LGBTIQA+) people experiencing family violence*, https://safeandequal.org.au/wp-content/uploads/DVV_Switchboard_RespondingToVictimSurvivors_TipSheet_01_01.pdf

Domestic & Family Violence Safety Alliance, and Embolden

Submission to Economic and Finance Committee Inquiry into South Australian Housing Availability

May 2023

Domestic and Family Violence Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services, alongside government partners. The service partners are:

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Family Services (CCFS)
- Centacare Catholic Country Services (CCCSA)
- Yarredi
- Nunga Mi:Minar
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support over 4,500 people annually, and include local place-based support and state- wide services such as the Domestic Violence Crisis Line. DFVSA brings together specialist providers of domestic and family violence support, and are the primary providers of DFV homelessness support in South Australia (emergency accommodation, crisis, supportive and transitional accommodation). We also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing in a uniquely integrated model.

Embolden

Embolden is the South Australian state-wide peak body of organisations working to respond to and eliminate domestic, family and sexual violence in South Australia.

Our members (which includes all DFVSA partners) provide services that promote women and their children's safety and wellbeing, and work to prevent and respond to violence against women.

We advocate for women's rights to respect and safety, and represent providers of specialist services in the domestic, family and sexual violence and related sectors, including services that work with men who use violence against women and Aboriginal specialist services.

Overview

This submission builds on and reiterates many of the issues raised in Embolden's Position Paper on housing and Homelessness from July 2020. Then, as now, Embolden is primarily concerned with increasing the stock of affordable, accessible and social housing; ensuring that people experiencing violence are able to stay in their own homes through Safe at Home initiatives and improving the availability of accommodation for perpetrators, with that

accommodation being supported by both police and relevant social services.

DFV remains the leading cause of homelessness for women and children in Australia[1], and that is no different in South Australia. We acknowledge that many people accessing mainstream homelessness services also have significant experiences of DFV, and that there are many others who choose not to disclose their history for a wide range of reasons.

It is therefore vital to ensure that housing policy, and affordable housing policy, in particular, reflects the needs to ensure that victim-survivors of DFV have access to safe, affordable, long-term and fit-for- purpose housing outcomes. This is a community issue, and one which DFV specialist services cannot manage alone. Fundamentally, a lack of safe, appropriate, long-term housing risks victim-survivors of domestic or family violence remaining in, or returning to, unsafe relationships and situations. We recognise the choices that victim-survivors make for themselves and their children, but feel strongly that ensuring the fundamental right to appropriate housing and support is vital to supporting real choice, viable and safe options to leave and support to move forward with their lives.

We are at the frontline in supporting victim-survivors of DFV to find appropriate, affordable and safe long-term housing exits. Over the past year, this has become increasingly difficult, as affordable rental options have plummeted, public housing waitlists have increased and for many of the people we work with, purchasing a property remains out of reach.

Culturally Appropriate, Affordable and Accessible Housing

DVSA and Embolden also underscore the importance of safe, appropriate and affordable housing options for Aboriginal communities, as led by a re-established **Aboriginal Community Housing Authority**. We reiterate the **Closing the Gap Target**, and in particular Outcome 9 (Schedule 3) that *Aboriginal people can secure appropriate and, affordable housing aligned with their priorities and needs.* This work must reflect and align with the *SA Aboriginal Housing Strategy*, to prioritise Aboriginal voice and decision-making and equitable access to safe, secure and affordable homes which maintain Aboriginal people's personal, social and cultural wellbeing.

Any actions to improve housing accessibility and affordability must consider and implement proactive strategies to mitigate barriers to Aboriginal community accessing safe long-term housing, while also developing appropriate models of Aboriginal community housing that reflects the cultural and Country-focused needs of First Nations people. Tenancies and standards must reflect community expectations, and support, rather than inhibit, cultural obligations, family and kin networks and practice. This must have authority and consideration for metro, rural and remote Aboriginal housing. This must include Aboriginal leadership from across the state and from different communities, and

[1] National specialist homelessness service (SHS) data from 2018-2019 shows that 61% of people presenting as at risk of homelessness were due to an experience of domestic and family violence. Domestic and family violence predominately affects women and children, with females making up 90% of specialist homelessness service clients experiencing domestic and family violence, and half of specialist homelessness service clients under 18 years of age reporting an experience of domestic and family violence. *Flatau, P., Lester, L., Seivwright, A., Teal, R., Dobrovic, J., Vallesi, S., Hartley, C. and Callis, Z. 2021, Ending homelessness in Australia: An evidence and policy deep dive, Perth: Centre for Social Impact, The University of Western Australia and the University of New South Wales*
Victim-survivors and their children often flee their home for their immediate safety, while those who are responsible for the violence are often the ones to remain in the home. Many victim-survivors and their children are forced into an experience of homelessness as a result of violence, SHS data from 2020-2021 shows that 42% of all people presenting to Homelessness services in Australia reported they were escaping Domestic and Family violence. *2022, Housing, homelessness and domestic and family violence brief, AHURI, Housing, homelessness and domestic and family violence | AHURI*

support development of appropriate strategies and developments that proactively address systemic racism and barriers experienced by Aboriginal community in the housing market.

This also includes ensuring that all housing programs, and programs related to earlier intervention, recovery and prevention, proactively and intentionally include the development of models that are appropriate and impactful for Aboriginal communities. This may mean developing alternative models that better reflect Aboriginal community needs – for example, through Safe at Home initiatives that are designed specifically for community, reflecting that healing and recovery that may include remaining in a home with a partner who uses violence and working with the family holistically.

The decreasing availability of affordable housing for both purchase and rental

The client group we work with are most often those with no other options – by accessing DFV-specific accommodation and services, victim-survivors have usually exhausted any and all other options. The funding provided to DFVSA focuses on providing support to those at risk of, or experiencing, homelessness due to DFV.

We know that **the lack of appropriate housing** can, and does, lead to women deciding not to leave, or returning to a perpetrator. This is particularly risky in the current environment, where women and their children are being forced to spend more time in crisis, supported or transitional housing due to the dearth of appropriate and safe long-term housing exits. DFVSA data tells us that:

- The length of time women and children are spending in emergency accommodation (hotel, motel, caravan parks) has been increasing an average of 1 night / quarter since July 2022, indicating that exits are more difficult into appropriate housing options (both supported and otherwise);
- The length of stay in Transition Housing Program properties is also increasing (by over 50 nights on average between July 2022-April 2023;
- The proportion of DFVSA clients who are successfully exiting into long-term accommodation is decreasing, mostly due to reduced options for long-term housing.

Housing needs relative to the demand from marginalised groups including those with low income, serious health and disability challenges, and older people – especially older women – with limited private resources.

Different housing options required by, and suitable for, marginalised groups in our community.

Housing needs are not a 'one-size-fits-all' option - ensuring future stock is an appropriate mix (considering single women, large families, cultural and accessibility needs) is vital.

The current public housing stock mix is inappropriate to the needs of the community. There are extremely limited safe options for single women (or indeed men), as they often do not meet the occupancy standards for the 2-3 bedroom properties that are more common, and so it can be extremely difficult to identify appropriate housing options for them.

This includes older women, who may have older non-resident children, and for whom there are extremely limited affordable options. We regularly face barriers for safe housing exits for single women, with limited public housing options and poor affordability in the private sector.

Similarly, for large families, there is extremely limited stock available. This particularly impacts on families from multicultural backgrounds and Aboriginal communities, for whom multigenerational living and larger families may be more common.

Ensuring that future housing stock considers the demographics of South Australia, and particularly projected demographics over the coming decades, is vital to ensuring it remains responsive to community needs and expectations.

The Alliance and Embolden were heartened to see a recent decision by the New South Wales Government to place a freeze on the sale of public housing. This is a step in the right direction in terms of addressing the suitability of housing, as well as ensuring that there are public homes available. We also acknowledge the SA's government commitment to creating new housing opportunities and to hold the planned sell-off of public housing. We recognise previous significant sale of public assets, impacting on the availability of social housing. We cannot afford to go backwards and

encourage a full freeze on the sale of public housing, with transparent replacement and replenishment strategies, is a vital component to this work.

We also call for policy and planning to consider the housing needs of **those on temporary visas** which limit income and therefore affordable and safe housing options. At least 10% of DFVSA's clients come from CALD backgrounds, many of whom are on temporary visas which severely restrict their income and public/community housing options (with no income, private pathways are virtually inaccessible). This creates a significant barrier to identifying appropriate long-term housing option, with many migrant families waiting months and years in crisis accommodation due to no alternative viable options. Ensuring the availability and accessibility to safe, appropriate accommodation for those on temporary visas must be delivered.

Many existing financial supports, such as the Private Rental Assistance Program, focus on supporting those who already have an independent income, but there are extremely limited, if any, options to support those who have no income, and no right to any government support (for example, the Escaping Violence Payment is only available to those on permanent visas or citizens, though we welcome a trial was announced in the recent budget for this to be provided to those on temporary visas). Ensuring victim-survivors from CALD backgrounds have access to the housing and support they need to safely settle and thrive in Australia must be addressed.

With t**he** National Rental Affordability Scheme coming to an end in South Australia by 2026 (noting that many properties have already started to phase out), this program must be evaluated and expanded to support ongoing access to below market rent properties for those at low income. The financial incentives provided to landlords, if not maintained, will reduce the stock of affordable housing, with many reverting to charging full market rates. This will put increased pressure on community and public housing, and likely lead to increased waitlists and reduced secure tenancies. More **flexible rental, home loan and rent-to-buy schemes** would also be welcome to support whole of community access.

These are all areas which Embolden, as South Australia's peak, will be exploring in future advocacy efforts.

The community expectation that every South Australian should have reasonable access to housing that meets their needs.

Currently, **community expectations are not being met**. For victim-survivors of DFV, they are having to **remain in the homelessness system for longer than they may need or want** to due to the lack of appropriate, safe and affordable longer-term options and a lack of holistic support services. Currently, many services exit clients once they identify a long-term housing option due to their contractual obligations and funding, capacity and the need for crisis support – however, this can put new tenancies at risk as there are limited supports available to those who may still be dealing with trauma or the legal, financial and social impacts of DFV.

The increased length of support for clients in the system is also having a related impact on **the accessibility of specialist DFV services,** crisis and transitional housing. With limited exit options, clients are forced to remain longer in programs that are no longer fit-for-purpose, to avoid exiting directly into homelessness, while impacting the availability of these properties to those in current crisis and at high risk.

Key market barriers – including land, labour, and materials – that are limiting the delivery of social and affordable housing even where funding is available.

South Australia is changing, and housing needs must change with it. Much new development continues to focus on Adelaide and metro areas – while this is welcome and vital, it must not be to the cost of **regional areas** who often feel the brunt of social and economic change much quicker than metro due to smaller, more remote geographic locations.

Future housing must consider the **changing demographics and industry in South Australia**, considering what community needs will look like not just in 5 years, but over the next generation. This includes identifying and targeting areas of growth and migration (including settlement programs for new migrants and areas of new growth and/or expansion), and areas of industrial expansion and economic growth. This often leads to the pricing out of low-income communities, while also reducing stock available. This must include private, public and community housing, as in many regional areas in particular, the only affordable housing available remains public housing which, coupled with limited tenancy support, can impact significantly on pathways for victim-survivors.

The necessary policy settings – at all levels of government – required to deliver suitable housing outcomes.

The economic impacts arising from lack of social and affordable housing, including barriers to economic development in specific locations; and the additional costs on other sectors including but not limited to health, disability, justice, and emergency relief.

Increased investment in **prevention and early intervention supports**, including housing, would also reduce the pressure on the crisis intervention space, which research consistently demonstrates is the most expensive intervention. Support for a public health model of funding for DFV services, including prevention and earlier intervention to avoid having to come into crisis accommodation and support (for example, through staying at a home of their choosing, or to safely plan alternative options with a support provider), and recovery to support victim-survivors when they do find housing, would support a more holistic, client-centred and cost effective DFV support system. This would be less reliant on costly hotels, motels and homelessness interventions, and better pivot to providing support where victim-survivors need, when they need, and how they need.

The costs associated with the Emergency Assistance Program (which is under review) continue to increase, but there are such **limited alternative options**, including housing exits, that we continue turning to hotels/motels (commercial businesses) to provide emergency and crisis support – essentially propping up social responsibility through corporate payments. This is not an acceptable situation. Having safe, appropriate and available affordable housing is a right, supporting better options for those leaving DFV situations, and also an opportunity to recover, take time to explore options and not have the pressure of having to find exits immediately. It would also reduce the time that victim-survivors would spend in emergency accommodation, reducing the pressure on, and cost of, EAP.

Innovations in housing that can lower costs, expedite new supply, and deliver a greater diversity of housing options to meet current and emerging trends.

We strongly encourage the exploration of well-planned innovations including:

- **Modular housing** in both congregate and individual situations – this could be particularly helpful in regional areas where there are limited trades or materials for traditional builds, and can also be sourced and installed more quickly than traditional builds. These must be linked to the establishment of key standards for modular housing (if not already extant) and associated quality checks to ensure they are of an appropriate standard;
- Increased opportunities to identify safe **density options** for housing, including apartments which include safe access/egress and are associated with appropriate amenities to support the number and range of tenants/owners;
- Better **manage community expectations** when it comes to housing options, including apartments, modular houses and other innovations as the expectation for a house and land is less accessible than previously;
- reviewing **council and state laws** regarding additions to existing homes, including granny flats and similar, to support multi-generational living;
- Consider **sustainable building**, beyond the current focus on solar, to include double-glazing and other innovations that reduce property running costs, reduce the negative impact on the environment and promote sustainable living (this is linked to community expectations) – this could include energy standards and expectations for public, community and private housing.

This should also include **the expansion and long-term funding of key initiatives such as Safe at Home and Safe and Secure Housing,** to support women and children to remain safe in their homes, and to have the support to transition themselves, and their families, to new areas, new housing and new lives. Public housing must also come with consideration for **safety needs of victim-survivors of DFV**, for example through strengthening and enhancing the Safe at Home program (delivered by DFVSA), to support women and their children to remain at a home of their choosing, rather than having to relocate, or wait for a housing transfer. Options for **perpetrator accommodation and housing** must also be considered, along with the appropriate supports, reducing the onus on women and children to leave the home.

Leveraging of government assets – by all levels of government – to maximise the delivery of additional housing.

Increase **maintenance capacity and capability**, to ensure that existing stock is maximised and remains available and online wherever possible. There remain significant issues with maintenance timeframes, which result in reduced available stock across all portfolios. This should include clear prioritisation regarding safety and reallocation needs, to ensure that those at risk are not forced into homelessness pathways due to inadequate safety provisions to tenants. Significant wait times for maintenance – for example, in one country area, approximately 50 properties are offline and the wait time for properties to become available has been pushed out to December 2023, with informed that renovations to existing properties to expand capacity are unlikely to occur for another year. This impacts on the whole of community, reducing affordable and safe housing options and increasing the risk of people remaining in unsafe situations.

Partnerships with the social housing providers and the private market to deliver additional social and affordable housing.

Continue to work with community, social and private housing providers to identify innovative and meaningful ways to **increase 15% affordability mix**, considering the current housing crisis and socio- economic situation of those most in need of housing.

We appreciate and commend the government for undertaking this important enquiry, and look forward to improved outcomes and options for victim-survivors of domestic or family violence, and the broader community, through this government's clear commitment to this space.

Yours,

On behalf of DFVSA and Embolden

Laura Cremen
Alliance Senior Manager, DFVSA

Domestic and Family Violence Safety Alliance

Rhiannon Burner
General Manager, Embolden

embolden

Re: Federal Announcement of Leaving Violence Payment

We write on behalf of the non-government partners of South Australia's Domestic and Family Violence Safety Alliance (DFVSA), regarding the 14th May announcement of the Federal Budget, and in particular the announcement of the long-term funding for the Leaving Violence Payment (LVP). While we welcome the continuation of a version of the Escaping Violence Payment (EAP) pilot, we wish to draw your attention to a number of areas of concern regarding the scope of the existing program, and the engagement of specialist domestic and family violence (DFV) services in developing the LVP.

We note that this funding represents ongoing support for an existing pilot and does not represent new funding into a sector that continues to struggle to meet the needs of victim-survivors and community expectations. We would welcome any opportunity to provide input and feedback to the new LVP, noting and having engaged with the 2023 evaluation of EVP, but with limited clarity regarding which, if any, recommendations may be taken up in the new iteration of the payment.

We hope that the LVP is rolled out in genuine consultation with the broader sector, noting the challenges in delivering crisis supports in South Australia now, and the barriers rolling out under an embargo meant for the delivery of a program truly embedded in the wider sector.

Domestic and Family Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services, alongside government partners. The service partners are:

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Family Services (CCFS)
- Centacare Catholic Country SA (CCCSA)
- Yarredi
- Nunga Mi:Minar Incorporated
- Uniting Country South Australia
- Junction Australia
- The Salvation Army

Our services support over 4,500 people annually and include local place-based support and state-wide services such as the Domestic Violence Crisis Line. DFVSA brings together specialist providers of domestic and family violence support and are the primary providers of DFV crisis support in South Australia (including through emergency accommodation, crisis, supportive and transitional accommodation). The Alliance partners also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing through a uniquely integrated model.

Disconnection from Specialist Services

DFVSA remains significantly concerned that the administration of this program is disconnected to specialist DFV services. While we appreciate and agree that access to financial support should not be limited only to those who can access or are eligible for (sometimes limited) direct service support, we feel strongly that this program would be better situated within services with DFV specialist skills and capability – particularly considering the case management element to the program, which remains unclear. We would recommend that learnings from the implementation of COVID-era payments such as ISSP (South Australia) or ongoing programs such as FSP (Victoria) could inform the most appropriate administrative processes, to align with support options and greater responsiveness, flexibility and specialist response.

We particularly note the reliance on a referral pathway element to the LVP announcement, inferring that it enables and promotes access to specialist DFV supports. However, DFV specialist services have not received additional funding (either through the federal or state budgets in South Australia) to account for likely increases in referrals or support requests, and indeed have seen increased workload due both to referrals from EVP (anecdotal) and the administrative requirements to apply for external funding. This includes recent requests for photographs of clients as a validation measure, which DFVSA is unwilling to engage in due to both client safety considerations and a lack of clarity regarding the purpose and impact of this (staff already confirm sight of photo identification as part of application).

We strongly advocate for clear and meaningful consultation with specialist services regarding the Leaving Violence Payment, including at a local, state and national level, to ensure that frontline services are actively engaged in the design and implementation of this program, to ensure it maximises impact and minimises pressures elsewhere in the system. Learnings from similar brokerage options (such as ISSP in South Australia and FSP in Victoria) should be actively considered and embedded, alongside learnings and recommendations from the 2023 evaluation of EVP.

Eligibility

There are a number of significant barriers to accessing EVP, which makes it inaccessible for a large number of clients, particularly for those from migrant communities or who are experiencing Aboriginal family violence:

Currently, EVP is not available to **non-citizens/permanent residents** – those victim-survivors who are on visas are required to access support via the Red Cross. While the availability of specialised funding is welcome, we would like clarification regarding whether the $152.3m over 3 years to extend EVP and Transitional Visa Holders Experiencing Violence trials references the current Red Cross program, indicates that this will be folded into LVP, or represents a separate funding stream. We strongly feel that a reduction in administration and streamlined pathways is important – rather than having separate services providing similar funding for different groups of people;

We are extremely concerned that EVP does not provide support for those experiencing **family violence** – we recognise that this particularly impacts on victim-survivors from Aboriginal communities, but also on those from other marginalised groups such as migrant and refugee communities, those who identify as LGBTIQA+, and young people. This represents a significant gap in the system, with no pathway for those who are experiencing family violence in need of this support. Limiting the scope to intimate partner violence only means there are significant numbers of victim-survivors left with extremely limited access to supports, particularly where they may not want, or be eligible for, broader service offerings. Ensuring that we are providing equitable access to support to those fleeing family violence, and particularly considering the importance of building culturally appropriate support pathways and aligning with the National Aboriginal and Torres Strait Islander Action Plan and Closing the Gap, is vitally important to ensuring the safety of all those experiencing DFV.

Scope of Funding

To be eligible for EVP, victim-survivors must have left the relationship/accommodation within the previous 3 months – for many women, they may have left over 3 months previously, and used savings/other supports in the immediate aftermath, or may have been in crisis accommodation for over 3 months, making it can be difficult to access. While we appreciate the flexibility of EVP in responding to this where possible, we also acknowledge that for many women, this precludes them from accessing this funding when they need it – for example when they have secured long-term housing and therefore need support with removalists, furniture and white goods.

We note that EVP funding is a flat structure – that anyone applying is eligible for $5000 in cash/goods/services. However, this creates inequity when considering family size and the impact that this can have on families in particularly – for example, a single woman could receive the same amount as a mother with 5 children. This again puts pressure on the brokerage budgets of individual services or requires significant work to identify alternative funding sources. A more flexible approach, which better takes into consideration the needs of individual applicants, their family make-up and circumstances, could enable a more equitable approach. Our learnings from using ISSP show that having a flexible model enabled us to be responsive to a range of needs throughout the service experience, rather than funding which is limited by both amount, scope and time.

Consistency

Our experience is that there is a lack of consistency in requirements and communication about the program – some offices require slightly different information (see, for example, request for photos example above), while communication regarding changes to the administration or scope of the program are not consistent. This means that there can be differential delivery of the program, which can impact on accessibility.

We appreciate that the initial roll out of the program was under embargo, which significantly impacted on the ability of Uniting to communicate clearly with the sector, and strongly advocate that improved practice, communication and consultation is embedded in future iterations.

We look forward to more clarification regarding this program, including the inclusion of family violence and cultural considerations, clarity regarding the case management and referral expectations (noting no additional services have been

funded to meet this demand), and general understanding of how the recommendations from the 2023 evaluation will be incorporated.

We would welcome any opportunity to provide input and feedback into the Leaving Violence Payment scope and structure. Feel free to reach out to [redacted] for communication purposes.

Thank you for your ongoing commitment to ensuring the safety of victim-survivors of DFV across Australia, an we look forward to continuing to work with you

Yours,

Mish Di Pinto,
Chair, DFVSA Alliance Leadership Team

DFVSA Feedback March 2023

Safe Places Accommodation Inclusion Round

Domestic and Family Violence Safety Alliance (DFVSA)

The Domestic and Family Violence Safety Alliance (DFVSA) provides specialist domestic and Aboriginal family violence services to victim-survivors across South Australia through our 8 service delivery partners and 19 services, alongside government partners. The service partners are:

- Women's Safety Services South Australia (WSSSA)
- Centacare Catholic Family Services (CCFS)
- Centacare Catholic Country Services (CCCSA)
- Yarredi
- Nunga Mi:Minar

- Uniting Country South Australia
- Junction Australia
- The Salvation Army

The Alliance is proud to have 2 Aboriginal-specific services as partners in this work - Nunga Mi:Minar is an ACCO based in Adelaide, and Ninko Kurtangga Patpangga is a specialist Aboriginal service provided through WSSSA in southern Adelaide.
Our services support over 4,500 people annually, and include local place-based support and state-wide services such as the Domestic Violence Crisis Line. Services provide support in a range of accommodation types, primarily including hotels, motels, caravan parks and other providers of Emergency Accommodation Program accommodation, service-led crisis accommodation (often congregate sites of 4-10), Supportive and Transitional Housing Program accommodation. We also provide SA-wide Safe at Home support, supporting women and children to remain in a home of their choosing in a uniquely integrated model.

As the primary providers of frontline crisis DFV specialist support, we are uniquely positioned to provide input and feedback on this proposal, and welcome the opportunity to ensure that specialist services, including Aboriginal-specific services, are included in the framing this important work.

DFVSA Feedback

General Feedback

While DFVSA is pleased to see specific funding and resources allocated to Aboriginal, multicultural and disability communities, we acknowledge that by defining 'inclusion' to specific communities, there are other communities who may need or benefit from specialist responses who are not considered – in particular, those who identify as LGBTIQA+. For example, in South Australia we do not have a specialist LGBTIQA+ service, nor specialist emergency or other accommodation tailored to this community's needs. However, this is a significant recommendation of a recent review of support for LGBTIQA+ community by the Alliance, and we would be happy to discuss this further. We absolutely acknowledge and honour that DFV is gender-based violence, and that women and children remain most at risk, but would welcome an opportunity to further explore safe accommodation options for victim-survivors who do not identify as female.

We also acknowledge that limiting to these communities negates opportunities for perpetrator responses (for example, where a police intervention may lead to the perpetrator being removed from the property, rather than the victim-survivor and children). We would be interested in exploring options where women were better supported to stay in a safe home and the perpetrator, ultimately responsible for the violence, can be removed.

Defining inclusion thus also potentially pits different communities against each other in a competitive tender process, which may result in additional inequity of access to accommodation across the country (for example, where some states only tender for accommodation for disability community without proportional funding available to all community needs based on a state-wide analysis of need). We do have some concerns that this funding may further 'other' communities who should be considered and included in all DFV service delivery, including built environment, and so would encourage strong engagement with broad community, with a strong intersectional lens and clear messaging regarding other funding and options available to communities outside those listed in this round.

Finally, and vitally, we strongly encourage specific and active engagement with leaders and those with lived experience from these communities in the development and procurement process for this process, including active inclusion in the decision-making process to ensure that appropriate, community-informed and victim-survivor-led processes are embedded. This could be embedded through the Selection Advisory

Council, if appropriate.

Questions:

1. Are the proposed funding amounts of between $500,000 and $8 million per project appropriate for Inclusion Round grants?

We feel that having a minimum funding amount may reduce opportunities for small, but impactful, projects. This may particularly impact on regional areas where there may be limited demand or capacity for large-scale projects, but there are opportunities for refurbishing or retrofitting existing decommissioned or under-utilised stock to provide better options for local communities. We would encourage a reduction or elimination of the minimum amount to ensure that local, impactful projects are eligible.

While we appreciate that this is a capital works project, and acknowledge that this is sorely needed in our state (as evidenced by ongoing reform around the existing Emergency Accommodation Program), we are concerned that there are no funds allocated to partner service delivery agencies who provide direct specialist services for victim-survivors. We fully agree with the position that emergency accommodation must be linked with specialist, quality case management and client support services provided by specialist DFV services. However, ensuring that the case management/support element is adequately funded is hugely important. This is a sector that is consistently required to do more with less, and the power imbalance created by funding solely for capital works without funding to support administrative and/or service delivery components of partner agencies may put increased pressure on service delivery organisations. We acknowledge that for some, this may be incorporated into business as usual (particularly if the capital works directly replace inappropriate existing accommodation types), but we also know that as demand continues to rise, the sector will continue to absorb increased workload in response. We would encourage flexibility in enabling a proportion of funding to go towards partner organisations, at a minimum to manage the administrative, reporting and associated costs, but ideally to support case management and support costs where this is unable to be redirected from elsewhere. If this is unavailable through this funding stream, ensuring that this is clearly linked to future funding options, and can be considered, would be appropriate.

We would also strongly encourage all proposals to ensure that ongoing tenancy maintenance and management costs are included for the lifespan of the project, and are adequately included in budgets and financial statements as they are fundamental to the operation of emergency accommodation and should be the responsibility of the applicant/accommodation provider rather than the specialist DFV service.

2. Should applications for mixed-use type proposals secure funding (e.g. loans, state funding, philanthropy) for the long- term housing aspects of their proposal prior to seeking Inclusion Round funding?

We encourage proposals to consider the long-term sustainability of the housing/accommodation as part of proposals. While funding may not be fully secured, there should be a strong basis for any assumptions of longer-term funding with clear risks articulate. This should also be informed by specialist services to consider the longer-term accommodation needs of the sector and of emergency accommodation.

3. Is the proposed milestone schedule the best model for delivering capital grants under the Inclusion Round?

4. Will Development Periods encourage community-based FDV service organisations to apply for funding?

a. Is 6 months an appropriate timeframe for the Development Period?

As this is contingent on budget remaining following the initial grants round, this may impact on the interest of, and ability for, community-based DFV organisations to apply, as there is no guarantee that this funding will be available. As this is a capital-based project, we would encourage the main grants round to include either a reduced threshold (see Q1 above) or to ringfence a proportion of funding to community-based organisations seeking smaller grants for local projects with a specific impact on their community.

5. Are there other ways to support applicants to develop high quality proposals?

Scope to consider financial support to smaller organisations to develop high quality proposals would be of benefit to those organisations with the skills and specialty but with limited capacity to commit to developing large high-quality proposals. This was provided by the South Australian state government 15 years ago and was well-received by the sector to both support quality proposals and to limit the impact on existing service delivery and organisational management requirements.

6. Are the proposed eligibility and assessment criteria appropriate and able to be demonstrated?

'New (additional) safe places' should be defined – does this include an option to repurpose or reform existing accommodation, for example through refurbishing to increase capacity?
Defining the role of partnering specialist agency, where the primary applicant does not have specialist DFV service delivery as part of existing core business. While this may vary between applications, some consistency in ensuring that administrative or other costs (if not direct service delivery, which would be preferable) are included in any funding application, and identifying appropriate contracting modalities (I.e. sub-contracting, consortium bid, partnering proposal) to support agencies to understand the risk and responsibilities incurred in engaging in this process.

Priority locations should be developed as part of proportionate state allocation, to ensure that smaller states are not disadvantaged through this process. South Australia has a much smaller population than other states and territories, and those outside of metro areas are often relatively small populations across large distances and significant complexities. When compared with more densely populated states, this could disadvantage South Australian proposals where the need may seem lower, but there are extremely limited services or facilities available and where access and distance can be a significant barrier to emergency accommodation support. We would advocate for a minimum proportion of funding to be earmarked for each state/territory, with an additional amount to be based on more generalised criteria.

There are no minimum standards of EA included in this document – we know that current commercial offerings in SA are unfit for purpose, and we would encourage consideration for what minimum standards could be included in this process to ensure that victim-survivors' dignity, rights and needs are meaningfully addressed. This may include access to appropriate cooking facilities, laundry, outdoor/child-friendly spaces etc (noting that some of these are identified, but without specifics of what the requirements may be to be appropriate).

7. Are there additional criteria that should be considered?

Assessment should also include if the target community was engaged in the development of the proposal, and on evidence on the local needs that are being addressed through clear partnership or engagement with specialist DFV services and government to ensure that a holistic proposal suitable for the local target community is developed. While the capital works are important, the utility, appropriateness (cultural, accessible, safety, family-focused and otherwise) must be a core element of the assessment.

8. What are the best measures to determine an applicant's suitability to meet the needs of First Nations women and children?

This should be co-designed with the Aboriginal and Torres Strait Islander community (at a minimum – led by would be preferable), noting that an appropriate mechanism for ensuring that local perspectives and input should be proactively sought and incorporated.

9. What are the best measures to determine an applicant's suitability to meet the needs of women and children from CALD backgrounds?

This should be co-designed with the multicultural community, noting that an appropriate mechanism for ensuring that local perspectives and input is proactively sought and incorporated and due consideration given to the diversity of this group.

10. What are the best measures to determine an applicant's suitability to meet the needs of women and children with disability?

This should be co-designed with the disability community, including peak bodies, and with due consideration for intersectional life experiences.

11. What standard of the Livable Housing Australia design guidelines should emergency accommodation for First Nations women and children, women and children from a CALD background and women and children with disability meet?

12. Is the proposed designated use period of 15 years appropriate?

This should also consider any projected demographic changes over the future years to ensure that built environment remains fit for purpose into the future (for example, ageing and/or younger populations)

13. What is the best measure for determining an applicant's ability to support clients using the emergency accommodation over the designated use period?

Experience and expertise in this space, including existing service delivery scope and practice, engagement with and appropriate support to target communities and endorsement from those communities. Aboriginal organisations should be prioritised to provide support and services with Aboriginal communities.
We would also encourage reference checks and/or letters of support from key government and specialist services to ensure that applicants have the appropriate skills, expertise and relationships with specialist services and departments to ensure high quality, evidence-based and client-centered specialist responses.

13. Are the definitions for 'emergency accommodation', a 'safe place', and a 'specialist service' appropriate?

a. Should the definition of 'emergency accommodation' include longer stays?

While there is a definite dearth of emergency accommodation/safe place across the nation, and in SA in particular, how this impacts on and links to broader housing needs, medium-to long-term housing outcomes and recovery and healing support is currently missing in the definition of 'emergency accommodation'. This should include a consideration for those who may struggle to find appropriate housing outcomes due to a range of issues (including visa status impacting on ability to earn income or be

eligible for public/community housing, institutional racism impacting on private rental options, accessibility needs impacting on the suitability of alternative housing exits).

Ensuring a flexible, person-centered and trauma-responsive service

is crucial to ensure that victim-survivors have access to the support and healing they need without unnecessary pressure to identify housing exits.
The definition of emergency accommodation should include information on minimum standards of the built environment (see point above), how it links to and supports the broader housing market and existing local/state/national systems and what appropriate options may include.
It should also encompass inclusive options, including options for single people and families and an

assumption that nobody will be disadvantaged due to the size of household or occupancy rate requirements.

'Specialist service' should also have expertise and experience in supporting children, and have specialist staff/training/support for Aboriginal community, those with disability and/or multicultural community.

14. Are there alternative accommodation options that should be considered as eligible or not eligible for Inclusion Round funding?

There should be options to include accommodation for differing needs and circumstances, based on input and guidance from key communities with lived experience of DFV or from the target communities themselves. This would support the development of potentially innovative, more responsive and appropriate accommodation options which may not be considered otherwise.

15. What advice/templates/checklist items would assist applicants in developing quality proposals?

Analysis of Specialist Homelessness Services Data

This work is to support to Domestic and Family Violence Safety Alliance Submission for the Royal Commission into Domestic, Family and Sexual Violence

Jessica Dobrovic

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for the BetterStart Health and Development Research Group
The University of Adelaide

September 2024

BETTERSTART
Health and Development Research

Better
Evidence
Better
Outcomes
Linked
Data platform

Acknowledgement of country

BetterStart acknowledge Aboriginal and Torres Strait Islander people as the First Peoples and Nations of the lands and waters we live and work upon.

We acknowledge and pay our respects to the Kaurna people, the traditional custodians of the lands we live and work on. We acknowledge the deep feelings of attachment and relationship of the Kaurna people to country and we respect and value their past, present and ongoing connection to the land and cultural beliefs.

We extend our respects to all First Nations people, and acknowledge that sovereignty of the land was never ceded, it always was, and always will be, Aboriginal land.

The University acknowledges the historical impact of colonisation and its continuing effects, and is committed to the Council for Aboriginal Reconciliation vision: 'A united Australia which respects this land of ours; values the Aboriginal and Torres Strait Islander heritage; and provides justice and equity for all'.

The aim of the reports that we deliver is to provide an evidence base from which decisions can be made that will lead to improved outcomes for families and children experiencing different forms of disadvantage. However, as these reports primarily focus on data analysis, this can appear to depersonalise the real-life experiences that underlie these data. We would like to acknowledge the data in these reports represent serious experiences that can have a lifelong impact on children and families.

Using data in this way is only one way to tell important stories, however, we hope that this work contributes to ensuring South Australia is able to make more informed decisions about how best to support children and families.

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- SA Department for Health and Wellbeing;
- SA Department for Education;
- SA Department for Child Protection;
- SA Department of Human Services

We would like to thank SA NT DataLink and all of the data custodians and data managers from all government departments at State and Federal levels who have contributed to the development of the BEBOLD platform.

Disclaimer

The views expressed here do not necessarily reflect those of our government partners.

Suggested citation

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Who we are

The *BetterStart* Health and Development Research Group comprises inter-disciplinary researchers from epidemiology, public health, criminology, paediatrics, biostatistics, and psychology who are trying to better understand how to ensure infants and children have the best start in life that will enhance their health, development and human capability formation over the life course.

Contact us

Background

Using the Better Evidence (BE), Better Outcomes (BO), Linked Data (LD) BEBOLD platform, the following report presents an investigation of selected client characteristics and service contacts with Domestic and Family Violence Safety Alliance (DFVSA) service providers. In collaboration with DFVSA we designed analyses that would investigate evidence relevant to the DFVSA Response to Issues Paper to the Royal Commission into Domestic, Family and Sexual Violence[1].

The cohort included in this analysis reflects the BEBOLD platform which has a focus on children and families, but also includes young adults up to age 31. We report on the process of identifying the relevant population in BEBOLD which includes a cohort of children and their parents as identified on their South Australian birth registration. We then report on a demographic overview of individuals included in this report, and present an analysis of SHS data to investigate previously unexplored patterns of client characteristics and contact with both Other SHS services and the DFV Alliance.

Key Findings

Demographic information in SHS data shows differences between people who are accessing the DFV Alliance, and other SHS services.

- DFV Alliance clients include a higher proportion of females (84.7%) than the Other SHS (58.8%) group.
- While 15.1% of clients accessing support from the DFV Alliance are male, over 95% (569/608) of those males are children. This is compared with approximately 30% (1866/5960) of male clients accessing Other SHS groups who were children (aged 17 or under at time of support period).
- The DFV Alliance saw almost double the proportion of people identified as CALD than the Other SHS group (8.4% and 4.5% respectively).

People accessing assistance from the DFV Alliance and Other SHS services present with different patterns of support need indicators:

- Just over 1 in 20 (4.8%) people accessing support from Other SHS services were experiencing four co-occurring indicators (mental health, family support, homelessness, and DFV) of support need, compared to just under 1 in 5 (17.5%) for the DFV Alliance.
- Compared to other SHS services, a lower proportion of adults (6.8% vs 8.2%) and children (3.8% vs 5.8%) who presented to the DFV Alliance had 3 or more support periods in 18 months.
- Compared to Other SHS services, a lower proportion of adults who presented to the DFV Alliance had mental health challenges (39.8% vs. 53.3%), disability (6.5% vs. 14.0), and alcohol and other drugs (6.5% vs 12.2) recorded as presenting issues.
- A lower proportion of those who presented to the DFV Alliance were homeless at entry and exit (20.6%) compared to those who presented to other SHS services (25.5%)

People accessing both the DFV Alliance and Other SHS services are likely to have had contact with the health system in the 12 months before their support period start date:

- A high proportion of people across both the DFV Alliance, and Other SHS services had presented to an ED or were admitted to hospital in the year prior to accessing support from an SHS service.
- 1 in 3 people accessing support from the DFV Alliance or other SHS service had attended an emergency department at least once in the 6 months prior to their support period.

- 1 in 4 people accessing support from the DFV Alliance or other SHS service were admitted to hospital at least once in the 12 months prior to their support period.

Children accessing the DFV Alliance and Other SHS services have different patterns of child protection contact, and present with complex needs:

- Compared to Other SHS Services, a similar proportion of children were notified to child protection, but a higher proportion of children supported through the DFV Alliance had more serious types of child protection system contact across the 6- and 12-month periods prior to the start of their support period.
- Children with prior contact with child protection were more likely to be homeless at entry and exit (11.2% vs 6.4%), and be repeat clients (65.2% vs 36.2%) when compared to children who had no contact with Child Protection in the 12 months prior.
- Almost 50% of children who presented to DFV Alliance services experienced 3 or more co-occurring support need indicators.

There are differences in selected characteristics of clients between metro, regional and state-wide services:

- People accessing DFV Alliance services in metro areas were more likely to be experiencing homelessness at both entry and exit (30.8%, 23.4%), and have mental health as a presenting issue (70.1%), when compared to all other regions. For example, 21.6% of people accessing regional DFV Alliance services were experiencing homelessness at entry (compared to 30.8%), 9.4% were experiencing homelessness at exit (compared to 23.4%) and 62.8% had a mental health presenting issue. However, the prevalence of being a repeat client is comparable across all regions.
- Individuals in Metro DFV Alliance were more likely to receive support for homelessness (91.4%), but were also more likely to be experiencing homelessness at exit of their support period (23.4%) than other regions.

[1] Domestic and Family Violence Alliance (2024). Response to issues paper: Royal Commission into Domestic, Family and Sexual Violence.

About this report

This report explores evidence relevant to key recommendations in the Response to Issues Paper for the Royal Commission into Domestic, Family and Sexual Violence, submitted by the Domestic and Family Violence Safety Alliance (DFVSA). We have used data included in the Better Evidence Better Outcomes Linked Data (BEBOLD) platform which includes a cohort of people born from 1991 onward, and their parents as identified on their South Australian birth registration. The analysis population includes those who received support from DFVSA from the 1st of July, 2021 to the 31st of December, 2022 and a second cohort who received support from other Specialist Homelessness Services (SHS) in the same time period. We also report on a sub-population of those cohorts, children aged 17 and under who received support from SHS services during the same time period.

The report is structured to present analyses relevant to recommendations in the DFVSA response to Issues Paper.

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Project Overview

The BetterStart Team at the University of Adelaide is supporting DFVSA with their submission to the Royal Commission into Domestic, Family and Sexual Violence. Through leveraging information included in the BEBOLD whole population de-identified linked-data platform, we present analysis relevant to several recommendations in the first Response to Issues Paper, submitted by DFVSA.

Domestic and Family Violence Safety Alliance

In July 2021, the South Australian Government reformed the specialist homelessness sector, creating alliance partnerships between non-government organisations to develop integrated service networks. Under this reform, there were 4 regional alliances created for specialist homelessness services based on geographic boundaries and a whole of state domestic and family violence (DFV) alliance, called the Domestic and Family Violence Safety Alliance (DFVSA).

DFVSA are the primary providers of DFV supports across South Australia. DFVSA provides specialist domestic and Aboriginal family violence services across the state through 19 agencies/programs:

- Bramwell House - Adelaide Domestic Violence Crisis Accommodation Service
- Ceduna Regional Domestic Violence and Aboriginal Family Violence Service
- Domestic Violence Crisis Line (DVCL)
- Eastern Adelaide Domestic Violence Service
- Fleurieu and Kangaroo Island Domestic Violence Service
- Limestone Coast Domestic Violence Service
- Migrant Women's Support Program
- Murray Mallee & Adelaide Hills Domestic Violence Service
- Ninko Kurtangga Patpangga Southern Regional Aboriginal Domestic Violence and Family Violence Service
- Northern Adelaide Domestic Violence Service
- Nunga Mi:Minar - Northern Regional Aboriginal DV and Family Violence Service
- Port Augusta Regional Domestic Violence and Aboriginal Family Violence Service
- Port Lincoln Regional Domestic Violence Service
- Riverland Domestic Violence Service
- Southern Adelaide Domestic Violence Service
- Western Adelaide Domestic Violence Service
- Whyalla Regional Domestic Violence Service
- Yorke and Mid North Domestic Violence Service
- Safe at Home

Domestic and Family Violence Safety Alliance submission to the South Australian Royal Commission into Domestic and Family Violence

This report presents an investigation of selected client characteristics and service contacts with Domestic and Family Violence Safety Alliance (DFVSA) service providers. The analysis presented was designed to generate evidence relevant to considering the recommendations made by DFVSA in the DFVSA Response to Issues Paper to the Royal Commission into Domestic, Family and Sexual Violence (2024)

BetterStart and The BEBOLD Platform

BetterStart Health and Development Research is led by John Lynch, Professor of Epidemiology and Public Health. We are an interdisciplinary public health team including epidemiologists, biostatisticians, psychologists, social workers, and occupational therapists. We undertake research related to the wellbeing of children, young people, families and communities, which includes a focus on child maltreatment, justice, social and economic inequalities, housing and

homelessness, mental health, substance misuse, and early childhood education and care. Our aim is to generate better evidence to inform policy and practice to improve health, wellbeing, and development outcomes.

Underpinning our research program is a de-identified whole-of-population big data platform called BEBOLD (Better Evidence Better Outcomes Linked Data). The platform can be used to help us understand patterns of annual and lifetime experiences of service system contacts that represent different forms of disadvantage. For this report, BEBOLD has been used to provide a view of DFV for a cohort of families and young adults, across multiple service systems.

Data source

This project utilised data from BEBOLD, a comprehensive whole-of-population de-identified linked data platform. BEBOLD contains de-identified data on a cohort of ~1.5 million people in South Australia that includes a population of births from 1991 onwards, and their parents, and spans more than 30 different government administrative data sources. The oldest birth cohorts are now aged in their early 30s.

Figure 1: Description of the BEBOLD platform and data sources

Data used for this report came from:

- Child Protection, Department for Child Protection
- Admitted Patient Data Collection (APDC), SA Department for Health and Wellbeing;
- Emergency Department Data Collection (EDDC), SA Department for Health and Wellbeing; and
- SA Specialist Homelessness Services (Homelessness to Home, H2H).

About individuals and families included in this report

The BEBOLD platform includes individuals who were born from 1991 onwards and their parents registered on their birth certificate. This means the BEBOLD platform does not includes individuals who were born prior to 1991, or who are not a parent of a child born in South Australia from 1991. Therefore, while BEBOLD includes families and young adults aged up to 31, our analysis is unable to include all individuals who have had interactions with a Specialist Homelessness Service in South Australia.

To understand the sample of clients we are able to see in BEBOLD, we compared client characteristics from H2H reports for the DFV Alliance from the 1st of July to the 31st of December 2021, to the platform. This comparison showed that BEBOLD includes approximately 65% of all individuals who have accessed a service from the DFV Alliance in

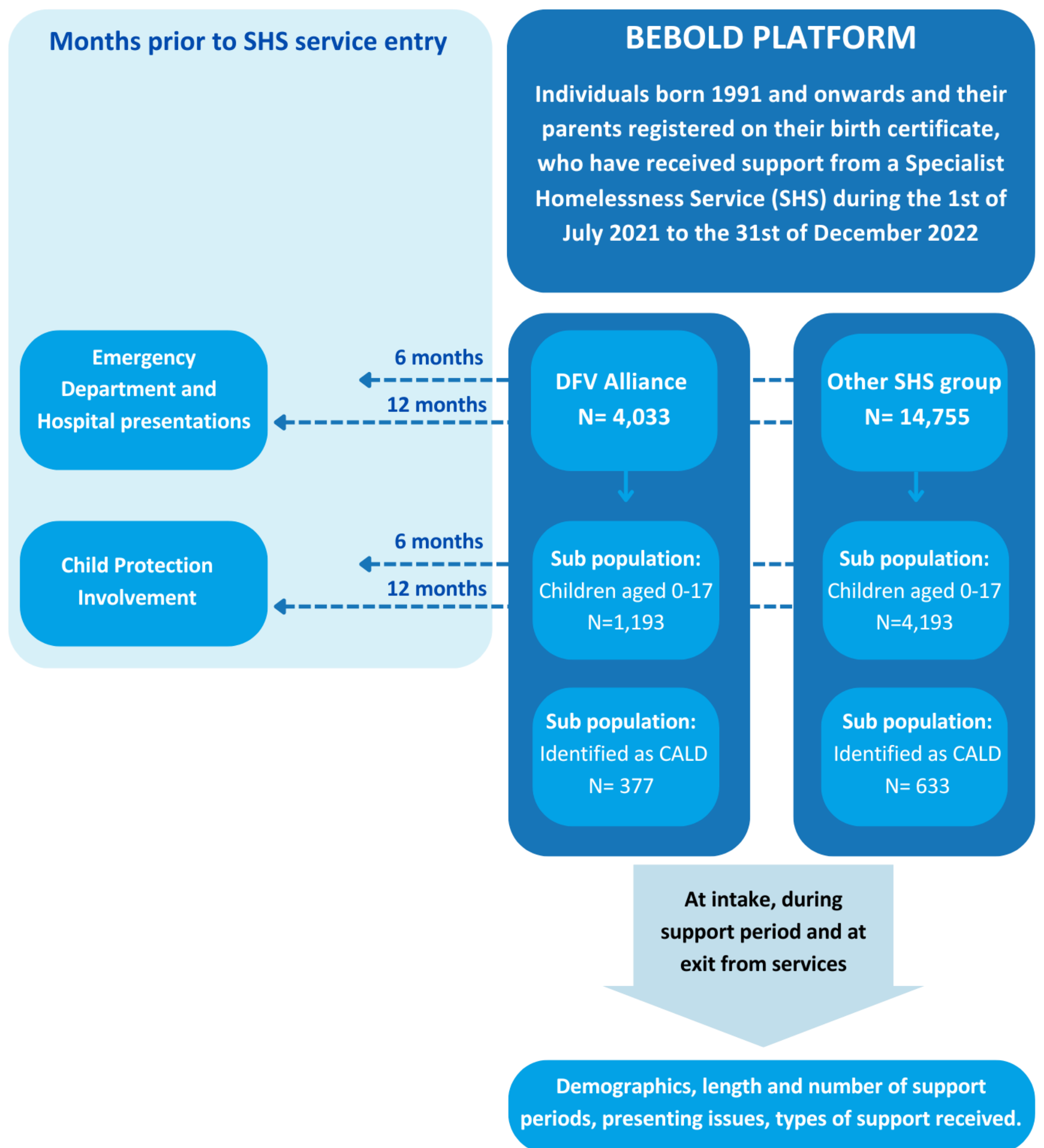
this time period. Discussions with staff from the DFV Alliance suggested there was no reason to think the population included in BEBOLD is systematically different from the population of DFVSA clients we are unable to observe.

Figure 2 below presents a visualisation of the analyses undertaken for the BEBOLD cohort. This report includes individuals who have received support from a Specialist Homelessness Service (SHS) funded service during the 1st of July 2021 to the 31st of December 2022. It included individuals who were currently in a support period on 1st July 2021 and those who started a support period during 1st of July 2021 to the 31st of December 2022. We have grouped individuals according to whether support was received from a DFVSA agency (DFV Alliance group, n=4,033), and those who received support from all other SHS funded services (Other SHS group, n=14,755). We investigated child protection system contact, emergency and inpatient hospitalisations in the 6 and 12 months prior to SHS service engagement. We describe client demographics and characteristics.

The analysis represents what data is currently available within the BEBOLD platform and does not encompass the total population of individuals in South Australia who would be accessing SHS services. BEBOLD is in the process of being updated and this analysis will be reviewed using the most current data when available.

Considering presenting units

Figure 2: Description of data included in this report



All analyses that follow are based on the individuals who were recorded in the SHS data as part of the presenting 'unit'. Presenting units are characterised by the number of people who were present at service intake, or first service meeting, as recorded in the SHS data. It is important to note that there are no formal obligations for case managers to enter information for people they are *not* providing support to. It is possible varied recording practices may have resulted in an undercount of people presenting as part of a group, however there is no way for us to know to what extent this might occur.

People presenting as part of a group versus presenting alone to all SHS

Table 1 illustrates what proportion of the population present as part of a group and what proportion presented alone as individuals, for the entire analysis and the under 18 population.

Table 1: Presenting units by alliance and other SHS groups, and children (aged 17 and under).

	DFV Alliance (n=4,033)		Other SHS (N=14,755)	
	n	Col %	n	Col %
Child or Adult				
Child – aged <= 17 years	1,193	29.6	4,193	28.4
Adult – age >= 18 years	2,840	70.4	10,562	71.6
Presented alone or part of a group				
Alone	2,602	64.5	8,786	59.5
Part of a group	1,431	35.5	5,969	40.5
Child or Adult and presented alone or part of a group				
Child: presented alone	369	9.1	1,284	8.7
Child: presented in a group	824	20.4	2,909	19.7
Adult: presented alone	2,233	55.4	7,502	50.8
Adult: presented in a group	607	15.1	3,060	20.7
Total	**4,033**	**100.0**	**14,755**	**100.0**

Table 1 shows that:

- Of all clients presenting to the DFV Alliance and Other SHS's 35.5% and 40.5% were presenting as part of a group, while 64.5% and 59.5% presented alone, respectively.
- Of the children and young people, nearly 1 in 5 (17.8%) presented alone to both the DFV Alliance and Other SHS.
- The Other SHS group saw a slightly higher proportion of people presenting in a unit.

The client groups detailed in the above tables form the populations analysed in the following report sections. To coordinate analysis findings with the Royal Commission Submission from DFVSA, the chapters below each reflect a recommendation from the DFVSA Response to Issues Paper. Findings to support the recommendations accompanies each chapter.

People presenting as part of a group versus presenting alone to DFV Alliance

Table 2 illustrates selected characteristics of those who presented to the DFV Alliance as individuals, compared to those who presented as part of a group, among those who presented for support at least once from the 1st of July 2021 to the 31st of December 2022.

Table 2: Service and client characteristics according to type of unit presentation

	DFV Alliance- Total population (n=4,033)		DFV Alliance- Presenting Alone (n=2,602)		DFV Alliance- Presenting as part of a unit/group (n=1,431)	
	n	Col %	n	Col %	n	Col %
Homeless at Entry to Services						
Yes	814	20.2	390	15.0	424	29.6
No	3,219	79.8	2,212	85.0	1,007	70.4
Had income at beginning of support period						
Yes	2,299	57.0	1,787	68.7	512	35.8
No/Unsure	1,734	43.0	815	31.3	919	64.2
Repeat Client(s)						
Yes	2,510	62.2	1,678	64.5	832	58.1
No	1,523	37.8	924	35.5	599	41.9
Support needed with 3 or more Domains of Health						
Yes	1,288	31.9	666	25.6	622	43.5
No	2,745	68.1	1,936	74.4	809	56.5
Received more than 25 services in support period						
Yes	1,160	28.8	553	38.6	607	23.3
No	2,873	71.2	878	61.4	1,995	76.7
Homeless at Exit from Services						
Yes	500	12.4	251	9.7	249	17.4
No	3,533	87.6	2,351	90.4	1,182	82.6
Had income at end of support period						
Yes	2,027	50.3	1,566	60.2	461	32.2
No	996	24.7	369	14.2	627	43.8
Unsure	1,010	25.0	667	25.6	343	24.0

Table 2 shows that:

- Individuals presenting to the DFV Alliance alone are more likely to have income at the beginning of their support period, be a repeat client, receive more than 25 services in a support period and have income at the end of their support period.
- People presenting to the DFV Alliance within a unit are more likely to present as homeless upon entry into services, have 3 or more health related support needs, and be homeless at the end of their support period.

Demographic Overview

Table 3 outlines selected demographic characteristics for DFV Alliance and Other SHS groups. The two columns on the left show characteristics for the entire BEBOLD cohort who received a service by DFV Alliance, and Other SHS groups during 1 July 2021 to 31 December 2022. The two columns on the right include a sub-population of children and young people aged 17 or under at time of intake.

Due to the birth cohorts currently included in the BEBOLD platform, we are unable to observe 0- and 1-year olds who may have been recorded as presenting as part of a group. We will review this analysis as the BEBOLD platform is updated in the coming months.

Table 3: Demographic client characteristics by alliance and other SHS groups.

	DFV Alliance (n=4,033)		Other SHS (N=14,755)		Sub-population of children and young people aged under 17			
					Children presenting to DFV Alliance (n=1,193)		Children presenting to Other SHS (n=4,193)	
	n	Col %	n	Col %	n	Col %	n	Col %
Age Group								
2 to 9	602	14.9	1,433	9.7	602	50.5	1,433	34.2
10 to 14	425	10.5	1,316	8.9	425	35.6	1,316	31.4
15 to 17	166	4.1	1,444	9.8	166	13.9	1,444	34.4
18 to 24	521	12.9	3,248	22.0	-	-	-	-
25 to 34	1,106	27.4	3,310	22.4	-	-	-	-
35 to 44	810	20.1	2,141	14.5	-	-	-	-
45 to 54	337	8.4	1,410	9.6	-	-	-	-
55 to 64	61	1.5	420	2.8	-	-	-	-
65+	5	0.1	33	0.2	-	-	-	-
Sex								
Male	608	15.1	5,960	40.4	569	47.7	1,866	44.5
Female	3,414	84.7	8,672	58.8	616	54.6	2,271	54.2
Other	11	0.3	123	0.8	8	0.7	56	1.3
Aboriginal and Torres Strait Islander								
Yes	1,053	26.1	3,949	26.8	358	30.0	1,133	27.0
No	2,980	73.9	10,806	73.2	835	70.0	3,060	73.0
Culturally and Linguistically Diverse								
Yes	337	8.4	663	4.5	62	5.2	104	2.5
No	3,696	91.6	14,092	95.5	1,131	94.8	4,089	97.5
Total	4,033	100.0	14,755	100.0	1,193	100.0	4,193	100.0

Table 3 shows that:

- The DFV Alliance clients include a higher proportion of females (84.7%) than the Other SHS (58.8%) group.
- Across both the DFV Alliance and the Other SHS groups, just under 30% of all clients are aged 17 and under.
- While 15.1% of clients accessing support from the DFV Alliance are male, over 95% (569/608) of those males are children. This is compared with approximately 30% (1866/5960) of male clients accessing Other SHS groups who were children.
- 26% of all DFVSA and Other SHS clients were identified as Aboriginal and Torres Strait Islander within SHS data. Only people who provided this information to service providers are represented here. Nationally, 28% of all people assisted by SHS services were identified as Aboriginal or Torres Strait Islander.[2]
- The DFV Alliance saw almost double the proportion of people identified as CALD than the Other SHS group (8.4% and 4.5% respectively).

[2] Australian Institute of Health and Welfare (2022). Specialist homelessness services annual report 2021-22. Retrieved from: https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-21-22

Exploring indicators of support needs and presenting issues

This section relates to the following recommendations in the Response to Royal Commission Issues Paper:

- Recommendation 1: Develop and fund a holistic specialist DFV support sector
- Recommendation 2: Build a Response Model Beyond Specialist Homelessness Service Limitations

The Royal Commission Issues Paper by DFVSA notes that the ability of DFV services to meet the needs of people experiencing DFV is constrained by contractual obligations, as eligibility criteria includes a requirement that individuals need to be at risk of, or experiencing homelessness, in order to receive support[3]. This is due to DFVSA being funded primarily by the specialist homelessness sector. While there are clear links between homelessness and DFV, and an acknowledgment these sectors need to work in close partnership, DFVSA proposes that homelessness should not be a primary criterion for a DFV response, and that people experiencing DFV should not need to be at risk of, or experiencing homelessness, to receive support for DFV[2].

Selected Characteristics in SHS Data

Table 4 presents selected characteristics related to service engagement and responses for adults and children as two separate sub-populations, accessing support from other SHS funded services, compared to the DFV Alliance.

Table 4: Selected characteristics for adults and children presenting to the DFV Alliance, or other SHS services

	Adults DFV Alliance (n=2,840)		Adults Other SHS (N=10,562)		Children DFV Alliance (n=1,193)		Children Other SHS (n=4,193)	
	n	Col %	n	Col %	n	Col %	n	Col %
3 or more support periods in 18 months								
Yes	194	6.8	862	8.2	45	3.8	244	5.8
No	2,646	93.2	9,700	91.8	1,148	96.2	3,949	94.2
Presenting Issues and support received for^								
Mental Health	1,131	39.8	5,665	53.6	121	10.1	1,127	26.9
Disability	185	6.5	1,477	14.0	25	2.1	197	4.7
DFV	2,743	96.6	1,582	15.0	1,143	95.8	517	12.3
Alcohol and other drugs	185	6.5	1,288	12.2	##	##	176	4.2
Family	70	2.5	38	0.4	37	3.1	##	##
Repeat Clients								
Yes	1,979	69.7	6,908	75.1	606	50.8	1,900	45.3
No	861	30.3	2,293	24.9	587	49.2	2,293	54.7
3 or more domains of support needed								
Yes	977	34.4	4,189	39.7	311	26.1	1,648	39.3
No	1,863	65.6	6,373	60.3	882	73.9	2,545	60.7
Over 25 services received in support period								
Yes	948	33.4	2,772	26.2	212	17.8	1,096	26.1
No	1,892	66.6	7,790	73.8	981	82.2	3,097	73.9
Homeless at Entry and Exit								
Yes	585	20.6	2,697	25.5	105	8.8	462	11.0
No	2,255	79.4	7,865	74.5	1,088	91.2	3,731	89.0

^ not mutually exclusive groups

[3] Domestic and Family Violence Alliance (2024). Response to issues paper: Royal Commission into Domestic, Family and Sexual Violence.

Table 4 shows that the presentation characteristics of both adults and children to the DFV Alliance is different to the population presenting to Other SHS services across almost every selected characteristic, despite service responses having significant overlap in both design and funding.

For example, results in Table 4 illustrate that:

- Compared to other SHS services, a lower proportion of adults (6.8%) and children (3.8%) who presented to the DFV Alliance had 3 or more support periods in 18 months
- Nearly all who presented to the DFV Alliance had DFV recorded as a presenting issue, compared to 15% of adults presenting to Other SHS services
- Compared to Other SHS services, a lower proportion of adults who presented to the DFV Alliance had mental health challenges (39.8%), disability (6.5%), and alcohol and other drugs (6.5%) recorded as presenting issues.
- A lower proportion of those who presented to the DFV Alliance were homeless at entry and exit (20.6%) compared to those who presented to other SHS services (25.5%)

Co-Occurrence of Selected Characteristics in SHS Data

To quantify the overlap of characteristics identified through selected characteristics in the SHS data, we used UpSet plots. UpSet plots are a way of understanding the relationships between three or more characteristics, and how they overlap with one another.

Table 5 below outlines how each characteristic was defined in SHS data.

Table 5: Characteristic definitions in SHS data

	Definition
Mental Health, Domestic and Family Violence, Alcohol and Other Drugs	• Had at least 1 support period within the Alliance timeframe where this characteristic was recorded as a presenting issue • Received at least 1 unit of support for reasons related to this during support period within the alliance timeframe
Family	• Had at least 1 support period within the Alliance timeframe where family related issues were a presenting issue • Received at least 1 unit of support for reasons of family support, or child support/protection during support period within the alliance timeframe
Homelessness	• Was experiencing homelessness at the beginning of at least 1 support period within the alliance timeframe • Received at least 1 unit of support for reasons of accommodation support or homelessness during support period within the alliance timeframe

Figure 3 depicts the top 10 combinations of client presenting issues and other recorded characteristics sourced from the SHS data.

How to read Figure 3:

The bar graph on the left side of the figure shows that, of all clients (n=4,033) who presented to the DFV Alliance for support:

- 61.3% of people had an indicator of mental health challenges
- 61.8% of people had an indicator of homelessness need.
- 34.0% of people had an indicator of family related issues.
- 98.1% of people had an indicator of DFV*.
- 6.8% of people had an indicator of alcohol or other drug challenges.

** As this analysis includes data relating to DFV specific supports, it is to be expected that a high proportion of individuals would present with DFV needs. DFV as a presenting issue or support need has been included in the below analysis (Figure 3) to demonstrate to what extent individuals experiencing DFV also experience selected co-occuring characteristics.*

The column graph illustrates the combinations of indicators aligned with the shaded circles below them and are presented in order of population size. For example -

- Start by looking at the first column - this represents the most common pattern and shows that 17.8% of people accessing DFV Alliance services presented with co-occurring issues or received support relating to mental health, and homelessness, and DFV.
- Then look at the second largest column - this shows 17.5% of people accessing DFV Alliance services presented with co-occurring issues or received support relating to mental health, and family, and homelessness, and DFV.
- The fourth column from the left illustrates there was 15.2% of people accessing DFV Alliance services who had DFV recorded as their only issue.

Figure 3: Top 10 combinations of selected presenting issues and characteristics for all DFV Alliance clients (adults and children) presenting from 1 July 2021 to 31 December 2022 (n=4,033)

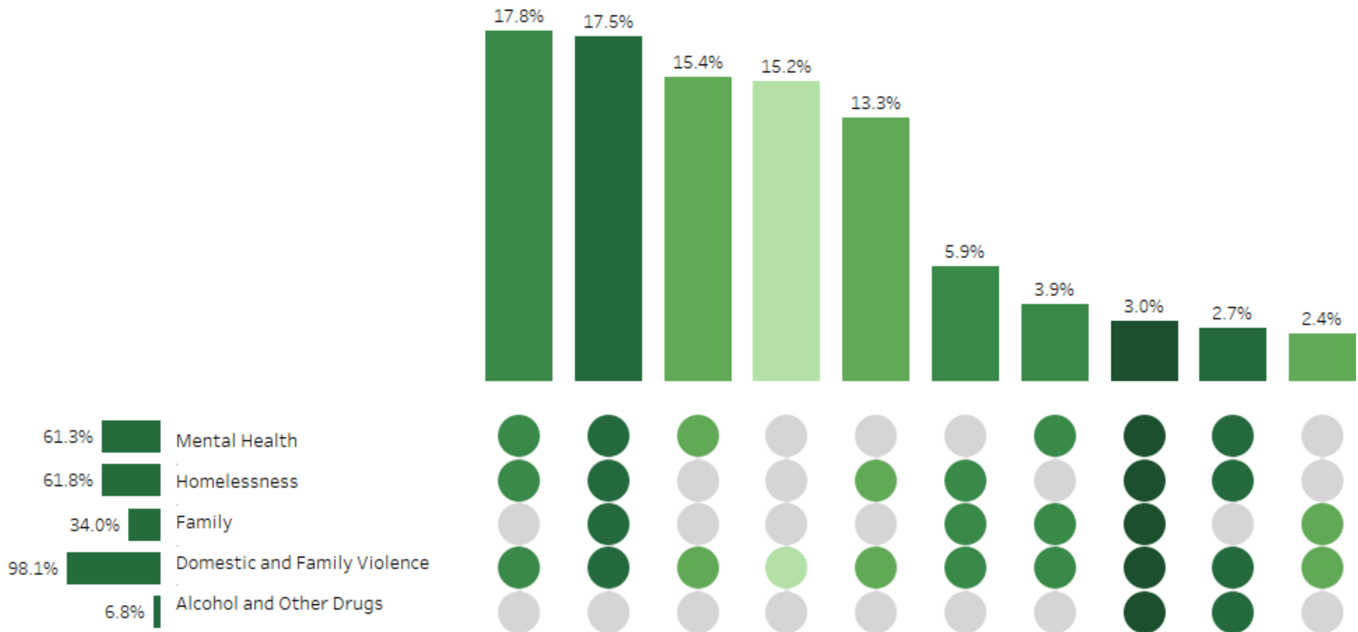


Figure 3 shows that:

- The two most common combinations of support need indicators relate to the co-occurrence of mental health, homelessness and DFV, followed by the co-occurrence of mental health, family support, homelessness, and DFV.
- Approximately 1 in 3 (17%) people presenting for services with the DFV Alliance had at least 3 support need indicators co-occurring

- 1 in 33 (3.0%) people accessing DFV Alliance support presented with or required support for all 5 categories
- 15% of people accessing DFV Alliance support had a support need indicator pattern that included an identified need for DFV supports, with no indication of mental health, family, homelessness or AOD challenges

Figure 4 depicts the top 10 combinations of client presenting issues and other recorded characteristics sources from the SHS data.

How to read Figure 4:

The bar graph on the left side of the figure shows that, of the clients who presented to other SHS services for support:

- 53.9% of people had an indicator of mental health challenges
- 82.4% of people had an indicator of homelessness need*.
- 30.4% of people had an indicator of family related issues.
- 19.4% of people had an indicator of DFV.
- 11.5% of people had an indicator of alcohol or other drug challenges.

** As this figure includes individuals accessing homelessness specific supports, it is to be expected that a high proportion of individuals would present with homelessness related needs. Homelessness as a presenting issue or support need has been included in the below analysis (Figure 4) to demonstrate to what extent individuals experiencing homelessness also experience selected co-occuring characteristics.*

The column graph illustrates the combinations of indicators aligned with the shaded circles below them, and are presented in order of population size. For example -

- Start by looking at the first column - this represents the most common pattern and shows that 22.9% of people accessing other SHS services has an indicator of homelessness alone
- Then look at the second largest column - this shows 19.6% of people accessing other SHS services presented with co-occurring issues or received support relating to mental health and homelessness.

Figure 4: Top 10 combinations of selected presenting issues and characteristics for all Other SHS clients presenting from 1 July 2021 to 31 December 2022 (n=14,755)

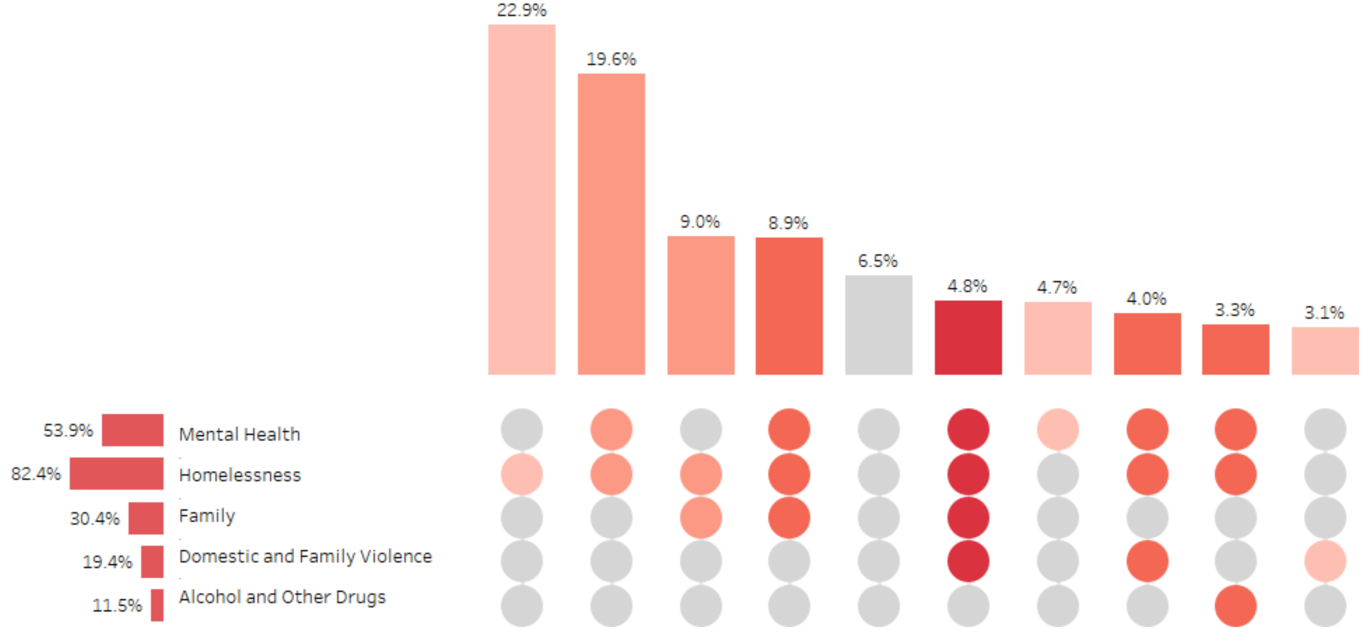


Figure 4 shows that:

- The most common indicators of support need were homelessness alone (22.9%) and co-occurring mental health and homelessness (19.6%)
- 4.8% of Other SHS clients had indicators of co-occurring mental health, homelessness, family related issues, and domestic and family violence

Comparing Figure 4 to Figure 3:

- Just over 1 in 20 (4.8%) people accessing support from Other SHS services were experiencing four co-occurring indicators (mental health, family support, homelessness, and DFV) of support need, compared to just under 1 in 5 (17.5%) for the DFV Alliance.
- Approximately 1 in 15 Other SHS service clients (6.5%) who did not have any of the selected indicators of support need, while this combination was not observed in the top 10 combinations of support needs for the DFV Alliance
- A higher proportion of people in the DFV Alliance were experiencing combinations of 3 or more selected co- occurring indicators of support need than in other SHS services. Across the top 10 combinations pictured, 1 in 2 (50.8%) people accessing support from the DFV alliance were experiencing 3 or more selected co-occurring characteristics, compared to 1 in 5 (21.0%) in other SHS services.

Table 4 presents results that illustrate differences in most SHS characteristics between adults and children accessing the DFV Alliance and Other SHS services, but the question remained if there were differences in the level of support received. Table 6 presents data on the number of support days for DFV Alliance and Other SHS clients for a support period from 1st July 2021 to 31 December 2022. If an individual had more than one SHS support period, the days for each support period are combined to generate the total number of days.

Table 6: Total number of days individuals spent in SHS support period(s) from 1 July 2021 to 31 December 2022 comparing DFV Alliance and other SHS services

	DFV Alliance (n=4,033)				Other SHS (N=14,755)			
	Number of individuals		Total Days in SHS support period		Number of individuals		Total Days in SHS support period	
	n	Col %	n	Col %	n	Col %	n	Col %
Total number of days in SHS support period Jul 21- Dec 22								
1 week or less	404	10.0	1,117	0.2	625	4.2	1,990	0.1
> 1 week-1 mth	811	20.1	14,456	3.1	2,420	16.4	44,870	1.9
> 1 mth-2 mths	742	18.4	32,581	7.0	2,261	15.3	102,305	4.3
> 2 mths-3 mths	479	11.9	35,447	7.6	1,637	11.1	121,637	5.1
> 3 mths-6 mths	751	18.6	96,433	20.7	2,997	20.3	389,053	16.3
> 6 mths-9 mths	323	8.0	72,205	15.5	1,606	10.9	356,852	14.9
> 9 mths-12 mths	225	5.6	69,832	15.0	1,053	7.1	331,538	13.9
> 12 mths-15 mths	109	2.7	44,061	9.5	770	5.2	314,090	13.1
> 15 mths-18 mths	189	4.7	99,366	21.3	1,386	9.4	728,550	30.5
Total	4,033	100.0	465,498	100.0	14,755	100.0	2,390,885	100.0%

Table 6 shows from 1st July 2021 to 31 December 2022 that:

- The DFV Alliance provided a total of 465,498 days of support to 4,033 individuals and 13.0% (n=523) of individuals contributed 45.8% of those days.
- Other SHS services provided a total of 2,390,885 days of support to 14,755 individuals and 14.6% (n=2,156) individuals were responsible for 43.6% of those days.
- While the pattern of a small proportion of individuals accounting for a large proportion of support days is comparable between DFV Alliance and other SHS services, there are differences in the proportion of people receiving a small number of days of support. While 1 in 3 individuals (30.1%, n=1,215) in the DFV Alliance received less than a month of support, 1 in 5 individuals (20.6%, n=3,045) in the other SHS group received less than a month of support.

Prior Contact with The Child Protection System

We investigated patterns of child protection system contact related to children recorded as presenting alone or as a group to the DFV Alliance of Other SHS services. This is relevant to the second recommendation in the Response to Royal Commission Issues Paper which discusses the need for DFV specific responses that cater to the needs and drivers of DFV, which may be different to that of other homelessness presentations that are not experiencing DFV.

Table 7 investigates the proportion of children who had different types of child protection system contact relative to the date of their first SHS support period from 1st of July 2021 to 31st of December 2022, 6 and 12 months prior to this date. The child protection contact groups are not mutually exclusive, as they reflect an 'ever' algorithm, that captures the proportion of children experiencing each for of child protection contact.

Table 7: Levels of ever child protection contact for children in the DFV Alliance and other SHS services

	Child, DFV Alliance (n=1,193)		Child, Other SHS (n=4,193)	
	n	Col %	n	Col %
6 months prior to start of support period				
Notified	432	36.2	1,430	34.1
Screened-In	325	27.2	891	21.2
Investigated	65	5.4	176	4.2
Substantiated	32	2.7	77	1.8
Out-of-Home Care	9	0.8	14	0.3
12 months prior to start of support period				
Notified	601	50.4	2,087	49.8
Screened-In	459	38.5	1,385	33.0
Investigated	101	8.5	303	7.2
Substantiated	59	4.9	151	3.6
Out-of-Home Care	18	1.5	33	0.8

Table 7 shows that:

- Compared to Other SHS Services, a similar proportion of children were notified to child protection, but a higher proportion of children supported through the DFV Alliance had more serious types of child protection system contact across the 6- and 12-month periods prior to the start of their support period.
- For example, in the 12 months prior to the support period - 50.4% of children presenting to the DFV Alliance were notified, similar to 49.8% of children presenting to other SHS services. However, 1.5% of children presenting to DFV Alliance services were removed at least once into out-of-home care, nearly double the other SHS proportion of children (0.8%) removed into out-of-home care.

Figure 5 and Figure 6 below show the proportion of the DFV Alliance and Other SHS service populations aged 17 and under who transition from different child protection system contact types, to the next most serious type.

Figure 5: Transitions to more serious child protection system contact for children who were notified, in the 6 months prior to SHS start date

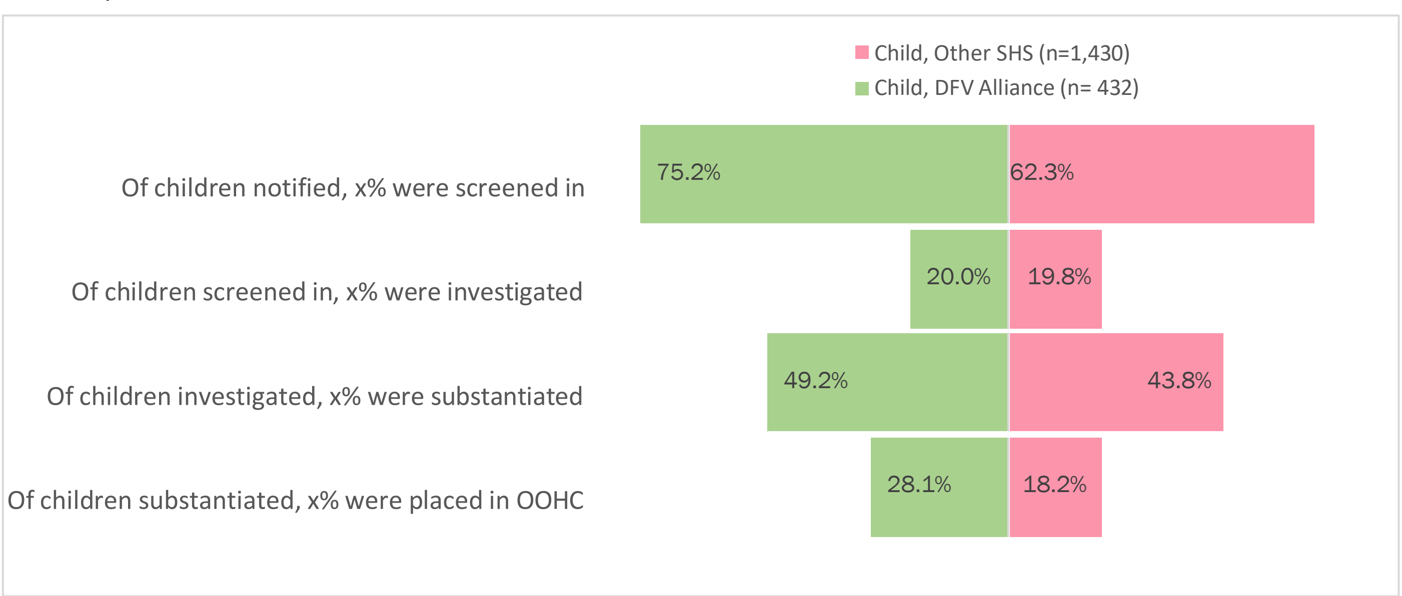
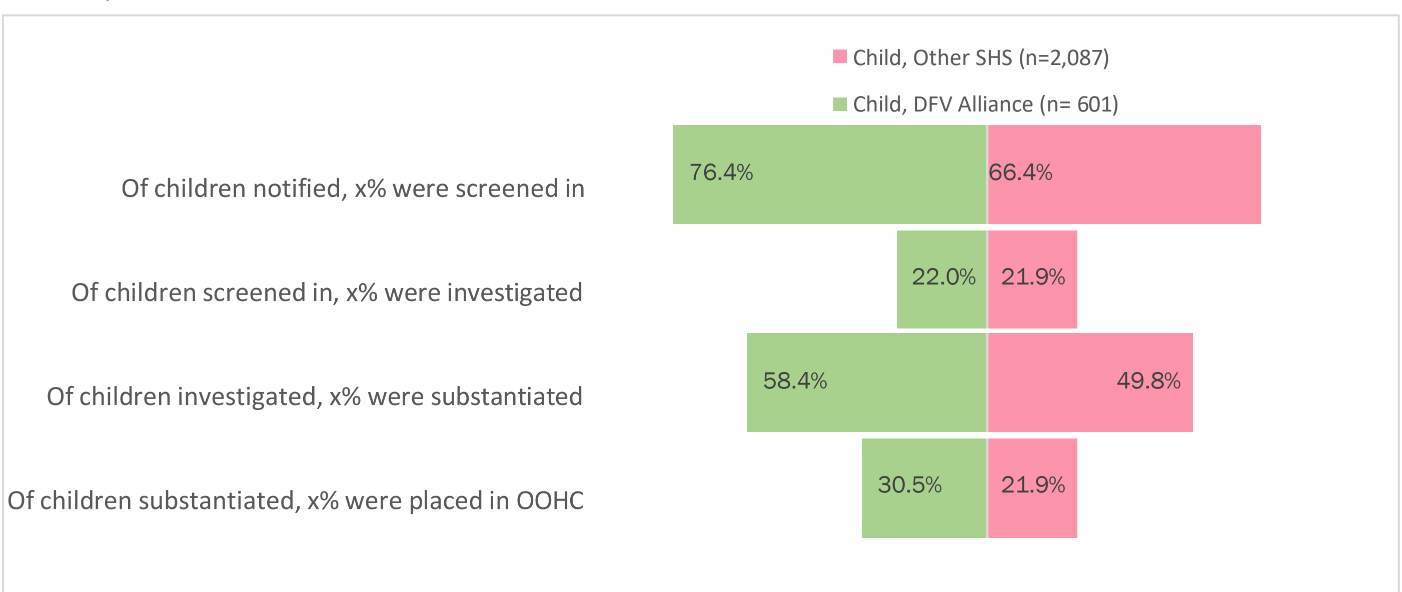


Figure 6: Transitions to more serious child protection system contact for children who were notified, in the 12 months prior to SHS start date



For key results, we are focusing on Figure 6 - this shows that:

- The transition to more serious forms of child protection system contact starts to diverge at the investigation point for children who were supported by Other SHS services compared to the DFV Alliance. Once notifications were investigated, a higher proportion of children receiving support from the DFV Alliance were substantiated, and of those substantiated a higher proportion were removed into out-of-home care

Specific findings relating to transitions across each form of child protection contact are:

- Of children notified, 66.4% of Other SHS clients (pink, right hand bar) and 76.4% (green, left hand bar) of DFV Alliance clients were screened-in for at least one notification
- Of children with at least one screened-in notification, 21.9% of Other SHS clients and 22.0% of DFV Alliance clients were investigated by the Department of Child Protection at least once

- Of those children subject to at least one investigation, 49.8% of Other SHS clients and 58.4% of DFV Alliance clients were substantiated for abuse or neglect by the Department of Child Protection at least once
- Of those children who were subject to at least one substantiation, 21.9% of Other SHS clients and 30.5% of DFV Alliance clients were removed into out-of-home care

Hospital and Emergency Department Use

It is well established there is significant overlap of health issues and experiences of homelessness. To explore indicators of health issues as a driver for access of SHS and DFV Alliance services, presentations to emergency departments and hospital admissions 6 and 12 months prior to a support period were investigated.

Table 8 shows the number and proportion of individuals who presented to an emergency department, or were admitted to hospital, at least once, according to whether they went on to present to the DFV Alliance or Other SHS services.

Table 8: Hospital and Emergency Department access in the 6 and 12 months prior to support period

	DFV Alliance (n=4,033)		Other SHS (n=14,755)	
	n	Col %	n	Col %
Emergency Department Presentation				
Ever attended ED 6 months prior to SHS start date	1,229	30.5	4,472	30.3
Ever attended ED 12 months prior to SHS start date	1,801	44.7	6,520	44.2
Hospital Admission				
Ever admission 6 months prior to SHS start date	677	16.8	2,238	15.2
Ever admission 12 months prior to SHS start date	1,077	26.7	3,593	24.4

Table 8 shows that:

- While there are no marked differences between groups, a high proportion of people across both the DFV Alliance, and Other SHS services had presented to an ED or were admitted to hospital in the year prior to accessing support from an SHS service.
- 1 in 3 people accessing support from the DFV Alliance or other SHS service had attended an emergency department at least once in the 6 months prior to their support period.
- 1 in 4 people accessing support from the DFV Alliance or other SHS service were admitted to hospital at least once in the 12 months prior to their support period.

Table 9 shows emergency department presentations, and hospital admissions for selected causes, 12 months prior to a support period with the DFV Alliance, or other SHS services.

Table 9: Hospital and Emergency Department access for selected causes, 12 months prior to support period

	DFV Alliance (n=4,033)		Other SHS (n=14,755)	
	n	Col %	n	Col %
Emergency Department Presentation 12 months prior				
Mental Health	422	10.5	2,001	13.6
Substance Use	117	2.9	647	4.4
Injury	681	16.9	2,339	15.9
Hospital Admission 12 months prior				
Mental Health	368	9.1	1,591	10.8
Substance Use	233	5.8	1,116	7.6
Injury	304	7.5	995	6.7
Domestic and Family Violence	129	3.2	141	1.0

Table 9 shows that:

- In both the 6 and 12 months prior to accessing services, individuals accessing DFV Alliance services were more likely to present to ED with an injury. However, they were less likely to present to ED with a mental health in the preceding 12 months, or substance use issue in the preceding 6 or 12 months, than people accessing the Other SHS group.
- For hospital admissions, individuals accessing DFV Alliance services were more likely to present in the 6 or 12 months prior to service entry for DFV related issues and injury, and were less likely to present with mental health and substance use issues than people accessing the Other SHS group.

Exploring supports provided to children and adults

This section relates to the following recommendations included in the DFV Alliance the Response to Royal Commission Issues Paper:

- Recommendation 1: Develop and fund a holistic specialist DFV support sector
- Recommendation 2: Build a Response Model Beyond Specialist Homelessness Service Limitations
- Recommendation 4: Improved supports through strengthened multi-sector response and whole of community responsibility

Support provided to adults and children by category

Table 10 shows the types of support provided to adults and children in the DFV Alliance as mutually exclusive groups. Table 10: Support Provided to Children and Adults accessing DFV Alliance services

	Adults DFV Alliance (n=2,840)		Children DFV Alliance (n=1,193)	
	n	Col %	n	Col %
Instances of Support Provided				
Accommodation	112,796	17.5	3,879	15.9
Advice/Information	118,862	18.5	1,766	7.3
Advocacy	116,780	18.2	4,958	20.4
Alcohol and Other Drug Use Related	3,491	0.5	9	0.0
Cultural Related	5,234	0.8	251	1.0
Daily Living Skills	57,921	9.0	570	2.3
Domestic and Family Violence	56,631	8.8	4,824	19.8
Disability	218	0.0	##	##
Education Related	492	0.1	12	0.1
Employment Related	8,304	1.3	29	0.1
Family	34,124	5.3	2,350	9.7
Financial Related	25,058	3.9	161	0.7
Gambling	37	0.0	##	##
Interpreter Services	163	0.0	##	##
Legal	6,833	1.1	56	0.2
Material Aid	16,502	2.6	1,033	4.2
Mental Health	25,473	4.0	2,679	11.0
Other	38,532	6.0	1,042	4.3
Outreach	770	0.1	18	0.1
Physical Health	4,039	0.6	35	0.1
Transport	10,979	1.7	666	2.7
Total	643,239	100.0	24,344	100.0

Table 10 shows that:

- Supports provided to children presenting to the DFV Alliance were most commonly related to

accommodation (15.9%), advocacy (20.4%), domestic and family violence (19.8%), family (9.7%), and mental health (11%)

- Supports provided to adults presenting to the DFV Alliance were most commonly for accommodation (17.5%), advice/information (18.5%), advocacy (18.2%), daily living skills (9.0%), and domestic and family violence (8.8%)

Co-occurring characteristics for children

How to read Figure 7: The bar graph on the left side of the figure shows that, of children aged 17 years and under who presented to the DFV Alliance for support:

- 41.9% had an indicator of mental health challenges
- 73.3% had an indicator relating to homelessness.
- 42.3% had an indicator relating to family challenges.
- 96.6% had an indicator relating to domestic and family violence*.
- 0.5% had an indicator relating to alcohol or other drug use.

**As this analysis includes data relating to DFV specific supports, it is to be expected that a high proportion of individuals would present with DFV needs. DFV as a presenting issue or support need has been included in the below analysis to demonstrate to what extent children recorded with an indicator of DFV also experienced selected co-occuring characteristics.*

The column graph illustrates the combinations of indicators aligned with the shaded circles below them and are presented in order of population size. For example -

- Start by looking at the first column - this represents the most common pattern and shows that 27.1% of children accessing DFV Alliance services presented with or received support for co-occurring homelessness or domestic and family violence issues.
- Then look at the second largest column - this shows 17.8% of children accessing DFV Alliance services presented with co-occurring issues or received support relating to mental health, family, homelessness, and DFV.
- The first group for which we see a single indicator is the fifth column from the left, where 11.2% of children accessing DFV Alliance services presented with only one issue, in this case, relating to DFV.

Figure 7: Co-occurring characteristics for children (n=1,193) accessing support from DFV Alliance services

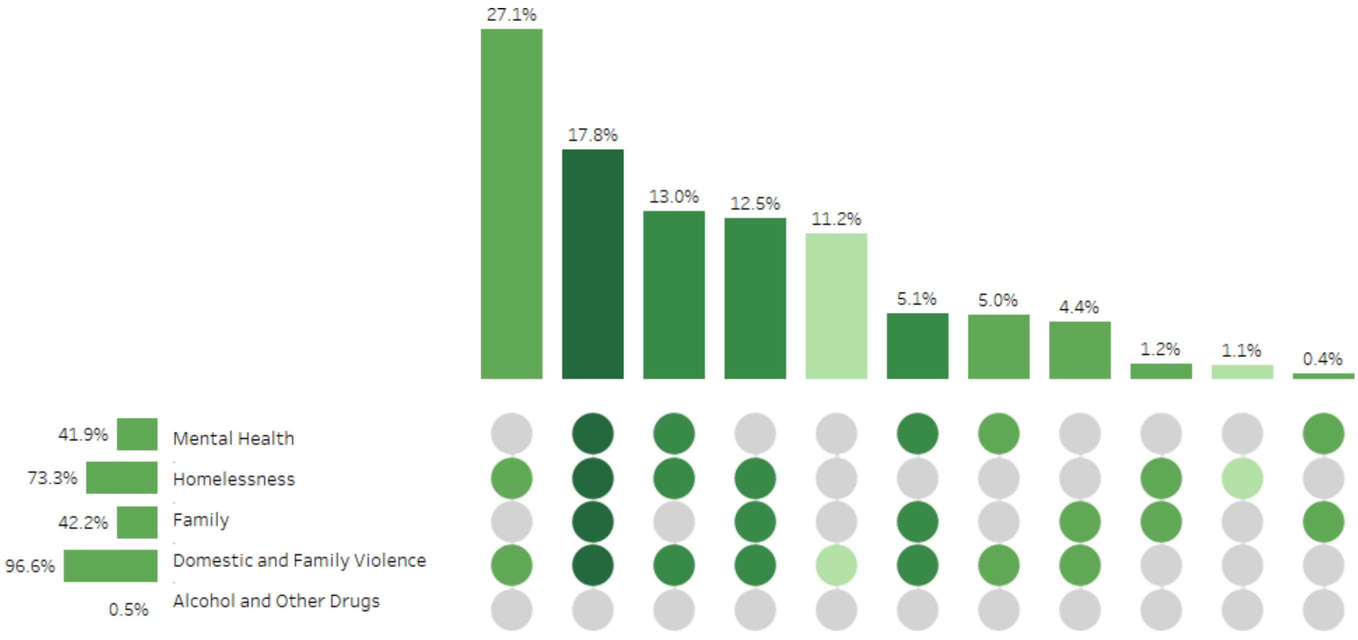


Figure 7 shows that:

- Almost 50% of children present to DFV Alliance services experiencing 3 or more co-occurring characteristics.

- When we examine these patterns of need in combination with support types provided (see Table 10), we can see there is a mismatch in recorded support provided to the child compared to support needs. For example, 41.9% of children had an indicator of mental health challenges (Figure 7), while 11% had a support type recorded as relating to mental health (Table 10).

Table 11 includes children who accessed DFV alliance services and investigates selected characteristics of support in SHS data by children who were ever notified to child protection, 12 months prior to their support period, compared to children who had no contact with child protection in the 12 months prior to their first DFV Alliance support period.

Table 11: Characteristics of children accessing DFV Alliance services, by notifications at 6 and 12 months, and no child protection contact

	Ever notified to Child Protection 12 months prior (n=601)		Not notified to Child Protection in the 12 months prior (n=592)	
	n	Col %	n	Col %
Presenting issues or supports provided^				
Mental Heath	276	45.9	224	37.8
Alcohol and other Drug Use	##	##	##	##
Homelessness	466	77.5	408	68.9
Family Related	85	14.1	55	9.3
Domestic and Family Violence	582	96.8	570	96.3
Other Characteristics^				
Homeless at Entry and Exit	67	11.2	38	6.4
Repeat Clients	392	65.2	214	36.2

^Not mutually exclusive categories

Table 11 shows that:

- A higher proportion of children that had contact with Child Protection during the 12 months prior to DFV Alliance involvement presented with mental health, family related and homelessness support needs than children who had no contact with Child Protection.
- Children with prior contact with child protection were also more likely to be homeless at entry and exit (11.2% vs 6.4%), and be repeat clients (65.2% vs 36.2%) when compared to children who had no contact with Child Protection in the 12 months prior.
- Nearly all children had DFV needs identified or supports provided, irrespective of child protection contact.

Culturally and Linguistically Diverse

This section relates to the following recommendation in the Response to Royal Commission Issues Paper:

- Recommendation 1: Develop and fund a holistic specialist DFV support sector

Cultural and Linguistically Diverse characteristics

The following analysis explores characteristics in SHS data for individuals identified as Culturally and Linguistically Diverse (CALD).

CALD individuals were defined using SHS data, based on 1) an individual identifying as non-Indigenous; and 2) whether their country of birth was *not* Australia, New Zealand, The United States of America, Canada, England, Scotland, Ireland or Wales. Approximately 1 in 12 (8.4%) people accessing support from DFVSA in the measurement period were identified as CALD based on this definition.

This definition of CALD is not perfect. The SHS data we hold in BEBOLD does not reflect self-identification of multicultural background, and nor does it provide information on VISA status or primary language spoken, which could be a useful indicator of recent arrivals and other sub-populations. An improved ability to identify CALD populations is foundational to being able to quantify the experiences of CALD communities, and the nuances within different cultural communities.

Figure 8 below shows proportion of the CALD (n=337) and total population according to selected characteristics relating to homelessness, repeat presentations, and presenting issues, who received support from the DFV alliance from the 1st of July 2021, to the 31st of December 2022 (n=4,033).

Figure 8: Proportion of CALD and other DFV Alliance populations, according to selected characteristics

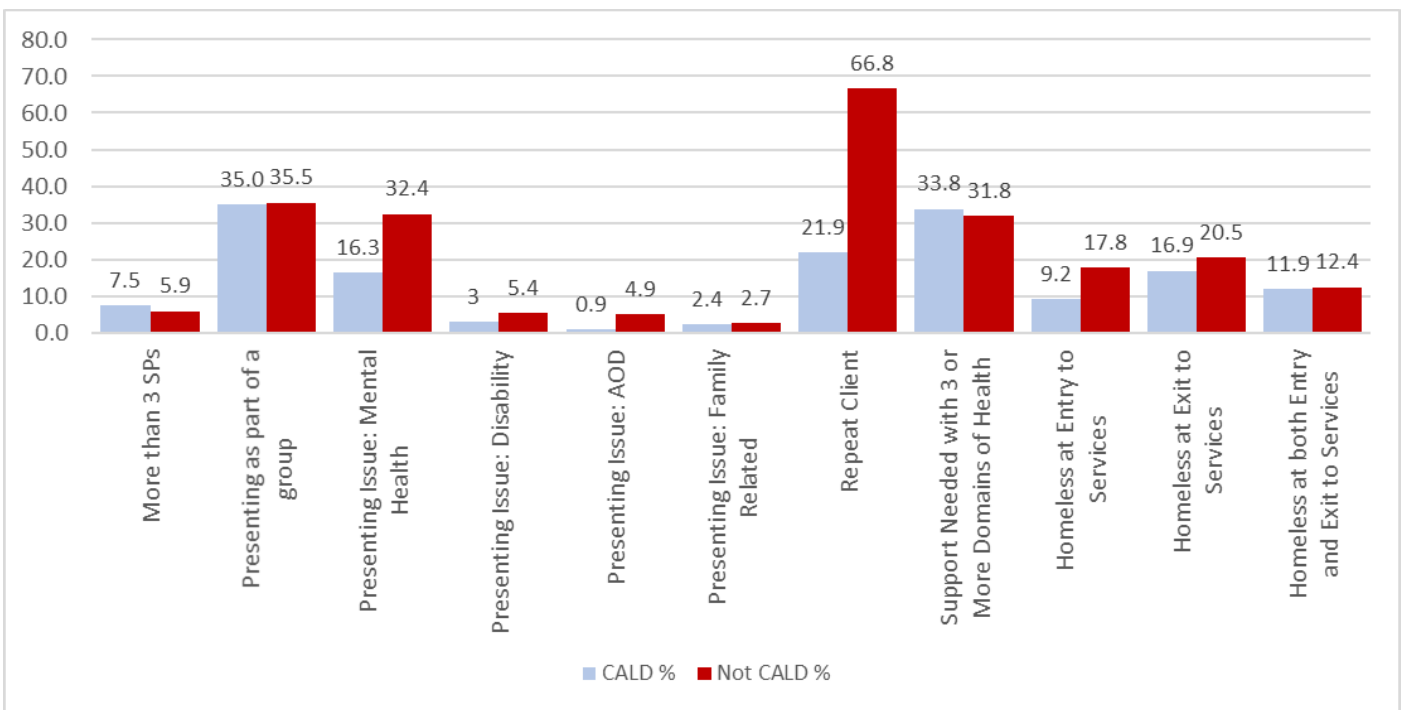


Figure 8 shows that:

- Most selected characteristics are comparable across CALD and not CALD populations within the DFV Alliance, with the exception of: presenting with a mental health issue (16.3% CALD, 32.4% non-CALD), and repeat client (21.9% CALD, 66.8% non-CALD)
- While the overall proportion remains low, non-CALD populations within the DFV Alliance are fourfold more likely to present with an AOD issue than CALD populations.

DFV Alliance characteristics by geographical region

This section relates to the following recommendations in the Response to Royal Commission Issues Paper:

- Recommendation 1: Develop and fund a holistic specialist DFV support sector
- Recommendation 3: Increase state investment to DFVSA specialist response to meet the actual needs of community and real costs of delivering services, and increased engagement with commonwealth regarding system gaps and responses.
- Recommendation 4: Improved supports through strengthened multi-sector response and whole of community responsibility
- Recommendation 6: Develop the alliancing model in line with system governance and oversight, to maximise resources and opportunities

Characteristics of people presenting in different geographical areas

To explore differences in selected characteristics of people accessing DFV Alliance services by region, we grouped services within the DFV alliance by service delivery area.

Metro, regional and state-wide services were determined by a support period start date within the measurement period, and by geographic service area based on publicly available information. To note, these groups are not mutually exclusive; an individual may have received support from a metropolitan service, and a regional service within the measurement period, and as such would be counted in both areas.

We note that this analysis is based on location of service provider, not suburb of usual residence of clients accessing SHS services. Discussions with the DFV Alliance highlight that a client perspective would be able to provide insights more specific to service access and regional support capacity. We are investigating the possibility of this for future analyses.

Characteristics by region

Figure 9 shows selected characteristics of clients accessing DFV Alliance services by whether the services they accessed were classed as Metropolitan, Regional or State-wide. It also provides an overall proportion for all clients recorded as accessing DFV Alliance services.

Figure 9: Summary of selected characteristics in SHS data for individuals presenting to the DFV Alliance by region.

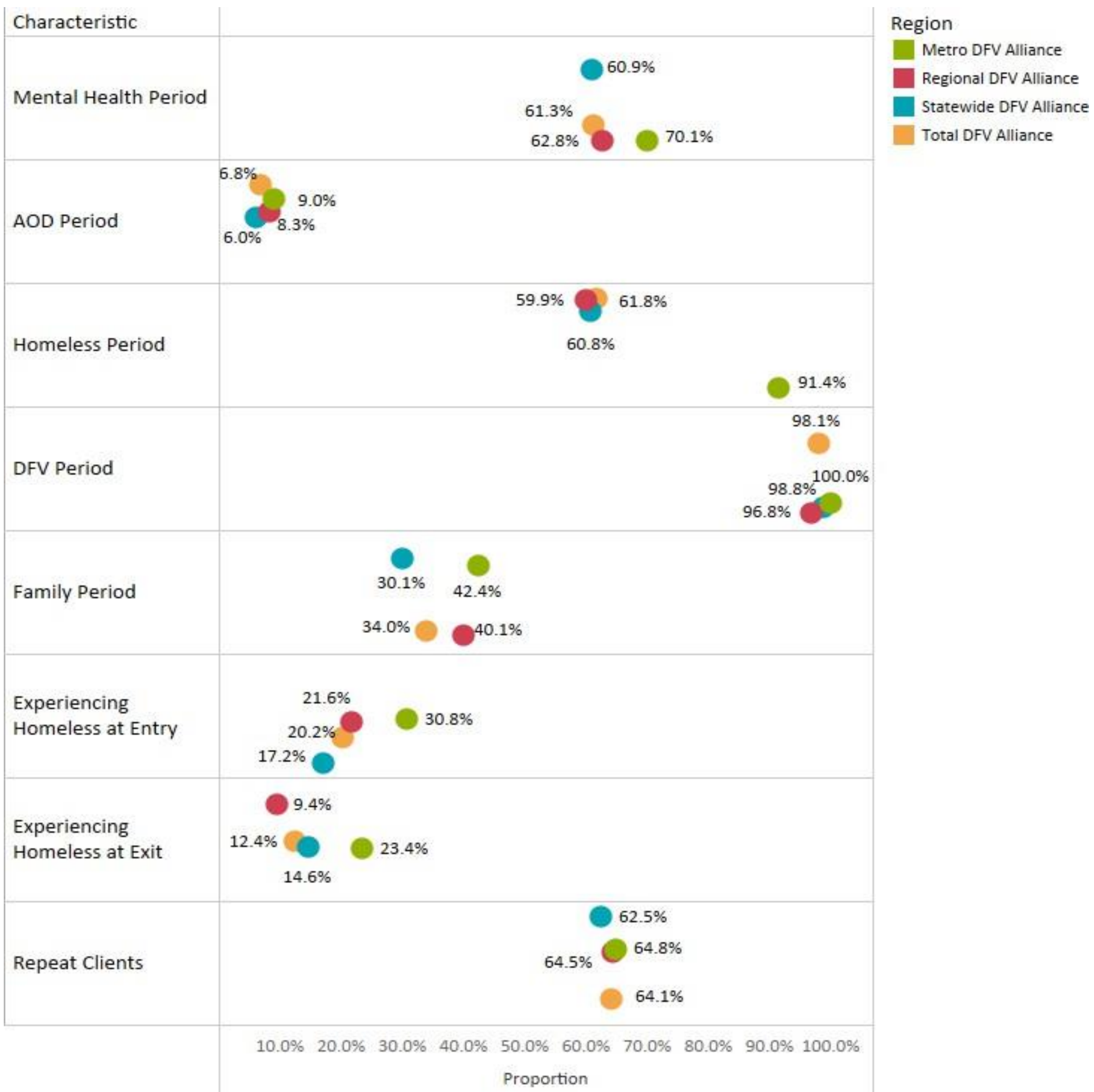


Figure 9 shows that:

- There are differences in selected characteristics of clients between metro, regional and state-wide services.
- People accessing DFV Alliance services in metro areas were more likely to be experiencing homelessness at both entry and exit (30.8%, 23.4%), and have mental health as a presenting issue (70.1%), however, the prevalence of being a repeat client is comparable across all regions.
- Individuals accessing DFV Alliance services in metro areas were more likely to receive support for homelessness (91.4%), but were also more likely to be experiencing homelessness at exit of their support period (23.4%).

Child protection trajectory by region

Table 12 shows the differences in Department of Child Protection trajectory across service regions within the DFV Alliance and Other SHS groups. The proportions indicate a proportion of the previous total. For example, if you look at the Metro DFV Alliance, you will see that 300 people aged 17 or under at their SHS start date had contact with the child protection system in the 12 months prior to their SHS start date. Of this 330, 78.5% had at least one notification that was screened in. Of all notifications that were screened in, 11.6% were investigated. Of all investigations, 46.7% were substantiated, and so on. The darker colour indicates a higher proportion of notification trajectory.

Table 12: Notification Trajectory across DFV Alliance by service region

12 MONTHS PRIOR	Total DFV Alliance*	Metro DFV Alliance	Regiona l DFV Alliance	State-wide DFV Alliance
Number of children notified in the first 12 months	601	330	205	282
Of those children notified, x% were screened in	76.4%	78.5%	73.2%	78.7%
Of those children screened in, x% were investigated	22.0%	11.6%	36.0%	18.9%
Of those children investigated, x% were substantiated	58.4%	46.7%	61.1%	59.5%
Of those children substantiated, x% were placed in OOHC	30.5%	7.1%	48.5%	4.0%

*These groups are not mutually exclusive. For example, 33.9% (n=204/601) of all children accessed support from both state-wide and metro DFV Alliance services.

Table 12 shows that:

- Approximately 1 in 2 (48.5%) children were placed in OOHC following a substantiated notification in regional areas in the DFV Alliance. This compared to approximately 1 in 14 (7.1%) of children serviced in metro areas of the DFV Alliance.
- The proportion of children being notified and screened into child protection was proportional across regions for the DFV alliance.
- When compared to metropolitan and state-wide services, regional services appeared to have the proportionately highest investigation, and substantiation trajectories across the DFV Alliance.

Hospital and ED presentations by region

Table 13 shows the number and proportion of individuals presenting to ED, or being admitted to hospital 6 and 12 months prior to their first support period with the DFV Alliance by region.

Table 13: Hospital and Emergency Department access in the 6 and 12 months prior to support period

	DFV Alliance, Metro (n=1,369)		DFV Alliance, Regional (n=1,584)		DFV Alliance, State-wide (n=2,293)	
	n	Col %	n	Col %	n	Col %
Emergency Department Presentation						
Ever attended ED 6 months prior to SHS start date	411	30.0	526	33.2	674	29.4
Ever attended ED 12 months prior to SHS start date	570	41.6	772	48.7	1,003	43.7
Hospital Admission						
Ever admission 6 months prior to SHS start date	240	17.5	240	15.5	419	18.3
Ever admission 12 months prior to SHS start date	349	25.5	407	25.7	642	28.0

Table 12 shows that:

- Individuals had comparable rates of ED presentations and hospital admissions in both the 6 and 12 months prior to accessing DFV Alliance services across geographic areas.