The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

South Australian Branch

RANZCP SA Branch

Royal Commission into Domestic, Family and Sexual Violence

Response to Issues Paper

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Royal Commission into Domestic, Family and Sexual Violence: Issues Paper

RANZCP SA Branch submission

Acknowledgement of Country

We acknowledge and respect Aboriginal peoples as the state's first peoples and nations, and recognise them as traditional owners and occupants of land and waters in South Australia.

We acknowledge that the spiritual, social, cultural and economic practices of Aboriginal peoples come from their traditional lands and waters, that they maintain their cultural and heritage beliefs, languages and laws which are of ongoing importance, and that they have made and continue to make a unique and irreplaceable contribution to the state.

We honour and respect their Elders past, present and emerging, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Acknowledgement of Lived Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members.

We affirm their ongoing contribution to the improvement of mental healthcare for all people.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training and maintaining professional standards of medical specialists in the field of psychiatry in Australia.

Its roles include support and enhancement of clinical practice, advocacy for people affected by mental illness and it plays a key advisory role to governments on mental health care.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college, has strong ties with associations in the Asia and Pacific region. The RANZCP has over 8400 members, including more than 500 psychiatrists and those training to qualify as psychiatrists in South Australia.

The RANZCP South Australia Branch Committee (RANZCP SA Branch) partners with people with lived experience, including through an active partnership on our Branch Committee.

Royal Commission into Domestic, Family and Sexual Violence: Issues Paper

RANZCP SA Branch submission

Introduction

The RANZCP welcomes the opportunity to respond to the Issues Paper published by the South Australian Royal Commission into Domestic, Family and Sexual Violence (the Commission). We developed this submission in consultation with our South Australian Branch, Family Violence Psychiatry Network, Faculty of Forensic Psychiatry, Faculty of Child and Adolescent Psychiatry and Section of Perinatal and Infant Psychiatry.

In its Position Statement #102: Family Violence and Mental Health, The RANZCP recognises the significant impact of domestic, family and sexual violence (DFSV) as a public health, social and human rights issue affecting communities across South Australia and in every state and territory.

We are committed to supporting the mental health and wellbeing of victim-survivors of DFSV, as outlined in our Position Statement #100: Trauma-informed Practice. We also recognise that at its core, DFSV is a perpetrator problem, and that a stronger understanding informed by research is needed to ensure treatments and other prevention efforts are evidence-based.

Members of the RANZCP are involved and have expertise in all aspects of DFSV management and service delivery. They work with potential victim-survivors and perpetrators before incidents occur, are often an integral part of interventions and responses within both the health and justice systems, and work with victim-survivors as part of the recovery and healing process, as well as perpetrators as part of rehabilitation efforts.

The RANZCP considers strategies to address DFSV to be an extremely important area of public policy, and the SA Branch would welcome the opportunity to provide additional advice and assistance to the Commission as it engages and consults with the sector.

Higher risk populations

The questions raised by the Issues Paper are deliberately broadly scoped and wide ranging. Further, the RANZCP acknowledges that the majority of victim-survivors of DFSV are women. However, it is worth highlighting there are many other priority populations with increased risks of experiencing DFSV, including members of the Aboriginal or LGBTQIA+ communities, those living with a disability, and those with an existing mental health condition.

For this reason, we use the non-gendered terminology adopted by the Commission in its Issues Paper in this submission, i.e. ‘victim-survivor’, ‘perpetrator’, and ‘individual at high risk of experiencing or perpetrating DFSV’. The term ‘Aboriginal’ will be used to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander.

Women from culturally and linguistically diverse (CALD) backgrounds are another group at heightened risk of being the targets of DFSV.[11] Migrant women may also be subjected to culturally-specific forms of violence through cultural practices like female genital mutilation, dowry abuse, as well as forced sex within marriage.[11]

It is also important to be aware of factors or signs which may make a person more vulnerable to perpetrating or experiencing this kind of violence, such as an older person with dementia experiencing coercion and abuse from a support person or family member.

We also acknowledge that sexual violence occurs in many contexts. However, where we mention sexual violence in this submission, including in the acronym DFSV, we refer to any kind of violence of a sexual or sexualised nature that occurs in family and domestic settings. This includes sexual or sexualised violence perpetrated by family members, and by partners as a form of intimate partner violence.

Recommendations

1) More research into and evaluation of the efficacy of men's behaviour change programs be undertaken to generate stronger evidence for their funding and use.
2) An audit be undertaken to identify existing education programmes around gender norms and attitudes.
3) Continued funding and expansion of the Multi-Agency Protection Service.
4) All individuals identified by SAPOL as potential or actual DFSV perpetrators, or as being at high risk of perpetrating DFSV, be considered for mental health assessment.
5) Increased public housing resources to address the shortfall in the number of South Australians experiencing DFSV who are unable to find suitable accommodation.
6) Funding be provided for mediation and counselling services to undertake training on how to identify DFSV risk.
7) The development of an education program for new migrants to Australia on laws relating to DFSV.
8) Law enforcement procedures be streamlined and confidential to make them easier and safer for victim-survivors to navigate when reporting DFSV.
9) Funding for legal aid be increased so that they are better able to support DFSV victim-survivors.
10) Funding for Local Health Networks (LHNs) and Primary Health Networks (PHNs) to ensure all health settings have access to a specialist service they may consult, to provide advice on working with DFSV perpetrators and victim-survivors, and referral pathways to other services.
11) A review of South Australia's public mental health services be undertaken, including evaluating:
    a. Whether current models of care represent best practice or are a result of compromises due to limited resources and staff.
    b. The degree of need for mental health services in the community, and to what extent services are meeting that need.
    c. Where deficiencies in either of the above are discovered, strategies to implement change and address the shortfall.
12) Police procedures be improved in relation to trauma-informed practices, coercive control and CALD strategies
13) Dowry abuse be included in laws across Australia that criminalise coercive control.
14) The Criminal Law Consolidation Act 1935 be reviewed following implementation of the Criminal Law Consolidation (Coercive Control) Amendment Bill 2023, to ensure it is fit for purpose.

Prevention

1) What causes domestic, family and sexual violence?

The origins of DFSV are multiple and complex, and involve personal, psychological, social, and cultural factors. They include, but are not limited to, gender inequality, childhood exposure to violence, and mental illness and addiction. However, these factors do not necessarily predetermine DFSV.

DFSV is recognised as a social problem both rooted in and perpetuated by gender inequality. The unequal distribution of power, resources and opportunity between men and women is rooted in societal gender norms, laws, and policies, which contribute to the social context in which violence against women occurs.[1] As a result, women are more likely to experience violence from a current or former partner than men in Australia.[2]

Childhood exposure to DFSV is correlated with higher rates of offending in adulthood. Children who have developed in the context of ongoing danger, maltreatment, and inadequate or maladaptive caregiving systems, are more likely to develop emotional, social, and health-related complications as adults, with the potential to replicate trauma within future families.[3]

Perpetrators are more likely to victimise people living with mental illness or disability. For instance, women with pre-existing depression or major mental health disorders are more likely to experience intimate partner violence victimisation and re-victimisation.[9] In addition, an individual's disability, including psycho-social disability arising from mental illness, may become the target of coercive control by family members and carers.[10] These people may withhold medications, or use an individual's diagnosis to victimise and abuse them, including by threatening to report them to child protection services.[10]

Mental illness and DFSV Perpetration

Mental illness is also commonly found in perpetrators of DFSV, often intensifying or accelerating their offending. Though not present in all cases, certain mental health conditions, including psychosis, obsessive sexual jealousy, depression, post-traumatic stress disorder, alcoholism, gambling abuse and substance abuse, and psychopathic, narcissistic, and borderline personality disorders often occur in individuals who interact with the criminal justice system due to DFSV.[4] Although prevalence data varies across research, one study found that in perpetrators of domestic and family violence homicides, there was a history of mental health issues (33.3%), problematic substance use (50.4%), suicidal ideation (17.1%) and suicide attempts (13%).[5,6]

DFSV perpetrators who become forensic patients often present with mental health issues that are significantly different from the broader social and psychological factors influencing this type of offending. Rather than the normalisation of violence against women, for example, offending by forensic patients is more commonly driven by delusions that arise during psychotic episodes.[7] Individuals living or frequently interacting with forensic patients may become the focus of their delusions and subsequently the targets of their offending purely due to proximity.[7] However, it is important to note that even among this type of DFSV offender, mental illnesses like psychotic disorders often overlap with other factors, such as substance abuse.[8]

2) What works, or will work, to prevent domestic, family and sexual violence?

Prevention of DFSV requires a mixture of interventions delivered within the health system and education system and by family violence services. However, more evidence is needed to ensure interventions are effective.

It is important to note that in some cases, interventions designed to address the impacts of DFSV are implemented largely in isolation, with poor interconnectivity with other strategies. This may particularly be the case where they fall under the purview of different government entities, e.g. justice interventions by the Attorney-General's Department and mental health interventions by the Department for Health and Wellbeing. A best practice approach in DFSV should strive to be holistic, multipronged and interconnected, as well as targeted towards higher risk settings and populations. Continued funding and expansion of South Australia's Multi-Agency Protection Service (MAPS) would be a good way to help implement such strategies.

Secondary prevention strategies such as men's behaviour change programs, may reduce the prevalence of DFSV perpetration.[12] However, they are not effective for all men and changes may not aways be sustained in the long-term.[12]

We recommend more research into and evaluation of the efficacy of men's behaviour change programs to generate stronger evidence for their funding and use.

Treatment of mental illness in DFSV perpetrators does not negate social or cultural drivers of DFSV. However, given many offenders suffer from treatable disorders[13], treatment may represent an underutilised pathway to secondary prevention.[14] We note that although violent behaviour and psychopathology often co-occur, there has been little research on mental illness among DFSV perpetrators in psychiatric treatment, and there is therefore limited data on which treatments are most effective in reducing their offending.[13]

The need for better data to understand perpetrators cannot be understated. If effective strategies and programs for both prevention and rehabilitation are going to be implemented and funded, they must be based on evidence and subject to robust evaluation as to their impact. Programs which do not consistently change perpetrators' behaviour may draw resources away from better interventions – or more concerningly, create a false sense of security where a perpetrator is perceived to be receiving effective treatment when they are not.

Identifying future offending is complex and challenging. Research and clinical experience can identify risk factors for violent behaviour. However, these do not allow psychiatrists and mental health professionals to predict the future. Mental health issues or risk factors can be masked or go unrecognised due to the complex nature of clinical relationships. Funding for research on identification of mental illness in DFSV perpetrators and psychiatric treatments for this group would help determine best practice interventions.

It is important to note that prevention of DFSV is a societal duty and should not fall solely on any one group. Ultimately It is the combined responsibility of individuals and organisations within and outside government, across health, criminal justice, and social and family violence services to identify and intervene to prevent DFSV perpetration from escalating in seriousness. Intimate partner homicides, for example, are rarely isolated events but are more commonly the escalation of offending over time, with multiple services failing to intervene and prevent this outcome.

3) What existing initiatives are directed at addressing the attitudes and systems that drive domestic, family and sexual violence? Are they effective?

Social drivers of DFSV can be targets of change within primary prevention strategies. For example, research shows that childhood education programmes around gender norms and attitudes are one initiative which can help prevent family violence by moulding positive understandings about women and relationships before problematic ones become entrenched.[15]

Given this evidence, we recommend the South Australian Government undertake an audit to identify existing education programs of this nature in the state.

Early Intervention

4) What systems, including systems outside of government, receive information which may allow for the identification of individuals who are at high risk of experiencing or perpetrating domestic, family and sexual violence?

Information identifying individuals at high risk of experiencing or perpetrating DFSV is received or collected within the criminal justice system. South Australia Police (SAPOL) receives reports of DFSV incidents, which may contain information identifying individuals at high risk of experiencing or perpetrating DFSV. However, a significant number of sexual assaults are not reported to SAPOL, and only a small proportion of those which are reported proceed to trial, with an even smaller percentage resulting in a conviction.[16] SAPOL also collects information identifying individuals at high risk of experiencing or perpetrating DFSV when they attend incidents and take statements or record other details. In addition, courts receive information identifying individuals at high risk of experiencing or perpetrating DFSV when evidence indicating this is presented during legal proceedings. Information identifying children at high risk of experiencing or perpetrating DFSV may be received and collected within the youth justice system.

The health system also receives and collects information identifying individuals at high risk of experiencing or perpetrating DFSV. Patients may disclose that they are at high risk of experiencing or perpetrating DFSV to doctors, nurses, or other health practitioners. In some instances, a patient may not disclose that they are at high risk of experiencing or perpetrating DFSVP, but a health practitioner may be able to identify that they are, based on the patient's presentation and their clinical observation of them. In other cases, psychiatrists may have forensic patients who are at risk of perpetrating DFSV referred to them for assessment and treatment.

Other government agencies and non-government organisations outside of the criminal justice and health systems receive and collect information identifying individuals at high risk of experiencing or perpetrating DFSV. These include the Department for Child Protection (DCP), Drug and Alcohol Services South Australia (DASSA), and the Department of Education. They may also include the many services, including community-based ones, which support DFSV victim-survivors.

5) What is needed to allow for this information to be used by government and specialist domestic, family and sexual violence services?

Government agencies and specialist DFSV services share information identifying individuals at risk of experiencing or perpetrating DFSV. South Australia has a Multi-Agency Protection Service (MAPS) that allows for this information to be shared between South Australia Health, the Department of Education,

the Department of Human Services, DCP, SAPOL, and other agencies. MAPS helps to identify individuals at high risk of experiencing DFSV and provide real-time information to frontline workers, including health and mental health practitioners, to use in their work with those at risk. In the experience of many South Australian psychiatrists, this information is highly valuable.

We therefore recommend continued funding and expansion of MAPS

However, South Australian health practitioners are limited legally in their ability to provide government and specialist services with usable information about DFSV. Health practitioners are required to retain health records in accordance with the privacy and health records legislation of the state. As such, there are restrictions associated with providing access to patients' health records, including those that contain information about individuals at high risk of experiencing or perpetrating DFSV. These may only be shared via a subpoena as part of legal proceedings.[17]

6) What interventions should be considered to manage the risk of a person who is identified as being at high risk of experiencing or perpetrating domestic, family and sexual violence?

Interventions to manage individuals at risk of perpetrating DFSV

A range of health and social interventions are needed to manage individuals at risk of perpetrating DFSV.

Given the high prevalence of mental health issues among DFSV perpetrators, we recommend that all individuals identified by SAPOL as potential or actual DFSV perpetrators, or as being at high risk of perpetrating DFSV, be considered for mental health assessment.

This would help to ensure that those individuals with mental health issues receive appropriate treatment. Where assessed as being of benefit in specific cases, other interventions may include employment support, housing assistance, relationship counselling, behaviour change programs, and drug and alcohol services. Such treatments and interventions might in the long term lower the risk of that person perpetrating DFSV.

In terms of the justice system, intervention orders are an important mechanism to manage individuals identified as at high risk of DFSV perpetration. We welcome recent laws introduced by the South Australian Government to subject individuals who breach a domestic violence-related intervention order by threatening or committing a violent act to mandatory home detention and electronic monitoring.[18]

Interventions to manage individuals at risk of experiencing DFSV

While intervention orders are the primary mechanism for protecting individuals at high risk of experiencing DFSV, housing is another key intervention. Providing housing or emergency accommodation is critical for individuals wanting to leave a potentially dangerous or threatening situation. We note that the South Australian Housing Trust provides housing or emergency accommodation for individuals who have had a domestic violence-related intervention order issued against someone.[19] We also welcome the South Australian Government's recent commitment to fund Catherine House, which provides similar emergency accommodation in the state.[18]

However, we note that there has been noticeable increase in the number of South Australians experiencing DFSV who are unable to find suitable accommodation. As a result, victim-survivors are being forced to live in cars or in the bush.[33]

The RANZCP therefore recommends the South Australian Government increase public housing resources to address this shortfall.

Lack of stable accommodation is associated with an increase in mental health conditions. This is an ongoing matter of concern within South Australia in general, and can only exacerbate issues for those who have recently experienced the trauma of DFSV.

Interventions to manage individuals at risk of experiencing or perpetrating DFSV

Certain interventions are suitable for both potential perpetrators and potential victims of DFSV. Both would benefit from information and education about their rights and legal options. When there is a risk of DFSV, mediation and counselling services for both groups may be beneficial in some cases. Such services can help those at risk of experiencing DFSV and those at risk of DFSV perpetration by mediating between partners, parents, and other family members to develop parenting plans and resolve disputes.

We recommend funding be provided for these services to undertake training on how to identify DFSV risk.

This is particularly important in mediation and counselling settings, where identifying DFSV risk can be complex and challenging because one person or multiple people are equally at risk of experiencing and perpetrating DFSV.

Response

7) What are the barriers to reporting domestic, family and sexual violence to police or seeking support from domestic, family and sexual violence services?

There are several social, cultural and economic barriers inhibiting victim-survivors from seeking support after experiencing DSFV. A major economic barrier for those experiencing DSFV from leaving their partner, who is the perpetrator, is the lack of available and affordable accommodation.

Lack of confidence in, or fearfulness towards, DFSV response procedures and law enforcement often act as a barrier to reporting DFSV. Based on past experience or perception, individuals may feel that they will not be taken seriously, or that appropriate action will not be taken, when they report experiences of DSFV. They may also fear that DSFV reporting procedures will retraumatise them by requiring them to recount painful details, result in their actions being questioned, blame being placed on them, confidentiality being breached, or them being wrongly identified as a perpetrator. Factors such as stigma, discrimination and misogyny may also play a role in negative experiences or perceptions of reporting DFSV. In addition, individuals may not report DFSV out of fear of certain behaviours, such as illegal substance use, being discovered.

Mental illness can also act as a barrier to reporting experiences of DSFV. DSFV victim-survivors commonly suffer from post-traumatic stress disorder, major depressive illness, eating disorders, problematic substance use, chronic pain, generalised anxiety, or other mental health conditions.[20, 21] Common symptoms include feelings of fear, guilt, shame, hopelessness or helplessness, and nihilistic, catastrophic and suspicious thought patterns. These symptoms inhibit an individual's capacity, willingness, and motivation to report experiences of DFSV, or to even recognise reporting is an option, and as such, they act as psychological barriers to reporting. More also needs to be understood about why victim-survivors with a mental disorder are more likely to receive a negative response to their DSFV help-seeking.[22]

There are barriers to reporting DFSV that are specific to CALD communities. Migrants often lack support networks, language skills, and knowledge of available services, reducing their ability to report or seek

help for DFSV. Research also shows that migrant women in Australia sometimes lack understandings of their legal and human rights in relation to DFSV.[11]

We therefore recommend the development of an education program for new migrants to Australia on laws relating to DFSV.

New migrants with a temporary visa status may be reluctant to report DFSV perpetrated by their sponsor out of fear sponsorship will be withdrawn and they will be deported. In such cases, abuse can often take the form of coercive control of finances, with perpetrators leveraging the power imbalance between themselves as citizens or permanent residents and others as temporary visa holders, by making demands for dowry or restricting access to finances, for example.

8) What are the elements of a best practice crisis response which will meet the needs of:

a. a victim-survivor?

In general, a best practice crisis response to meet the needs of DFSV victim-survivors involves available and accessible wrap-around services. These services must undertake rapid risk assessments and coordinate integrated and trauma-informed medical, family, legal, financial, and accommodation support to victim-survivors. Integration of services through information sharing and shared training, for example, is critical to building trust and communication between organisations.[23] This will help prevent silos and develop a holistic and streamlined DFSV support system.[23] In addition, trauma-informed practice is needed to ensure support is provided within a safe environment.[24]

When reporting DFSV to law enforcement, procedures should be streamlined and confidential to make them easier and safer for victim-survivors to navigate.

For example, common negative experiences involve an individual having to wait for considerable time to make a report. Victim-survivors also often find that reporting procedures are not private and discrete, requiring, for instance, a statement to be made to a general inquiry desk in front of members of the public. One possibility to resolve these issues is to develop a mobile rapid response DFSV team within SAPOL to ensure the provision of appropriate reporting, assessment, and response procedures.

DSFV services need to be easier for victim-survivors to find and contact. These services also need to be adequately staffed to ensure phone calls to them are answered in a timely manner. Victim-survivors frequently report putting themselves at risk to make calls to services, only for them to not be answered. It may also be unsafe for them to answer the phone in cases where services call them back later.

Legal aid is also an essential response service for DFSV victim-survivors to support them with family law procedures. However, legal aid services are often under resourced and unable to provide the highest level of representation to their clients.

Funding for legal aid needs to be increased so that they are better able to support DFSV victim-survivors.

b. a victim-survivor who is a child?

The elements of best practice crisis response which will meet the needs of a DFSV victim-survivor are largely the same for a victim-survivor who is a child. However, responses to children who are victim-survivors must be developmentally informed. They must understand how exposure to DFSV can cause health and social problems throughout the life-span, at all stages of development, including mental illness.[25] We welcome recent changes to family law in South Australia that shift away from equal shared parental responsibility to consideration of the impact of parental relationships on a child's developmental

and psychological needs. These changes will help enable better justice responses for children exposed or subjected to DFSV.[26]

c. a perpetrator (acknowledging that one need is to hold a perpetrator to account for their use of violence)?

While DSFV perpetrators need to be held to account within the criminal justice system in a balanced and fair way, a best practice crisis response to their offending also considers, when relevant, their mental health and addiction needs. As discussed earlier, mental health and addiction issues are common in DFSV perpetrators and addressing these is critical to rehabilitation and prevention.

9) What are the elements of a best practice health response?

It is important that health professionals have training in DFSV, including how to enquire about exposure, the nature and intersectionality of this violence, and how best to provide support.[27] It is essential to respond to disclosure through safe and comprehensive assessment and to address subsequent development of individualised immediate and long-term care plans .

We recommend funding for Local Health Networks (LHNs) and Primary Health Networks (PHNs) to ensure all health settings have access to a specialist service they may consult, to provide advice on working with DFSV perpetrators and victim-survivors, including infants and children, and referral pathways to other services.

Due to the association outlined earlier between mental health and DFSV, a best practice health response recognises the importance of identifying patients who are at risk of experiencing or perpetrating DFSV. As such, mental health practitioners need to be part of a multi-disciplinary approach to the health needs of patients experiencing or perpetrating DFSV.[23]

Psychiatrists can play an important role in clinical leadership as well as identification, risk assessment, referral, and treatment of victim-survivors and perpetrators.[20] As medical professionals are often the first point of contact, they are uniquely situated to identifying and responding to those experiencing or perpetrating DFSV. This includes being aware of factors or signs which may make a person more vulnerable to perpetrating or experiencing this kind of violence.

There is evidence of positive outcomes for a range of therapeutic interventions for DFSV victim-survivors, such as psychological therapies, psychotropic medications, and support networks.[28] Acknowledgement of the complexities around the relationship held between the person experiencing violence and the perpetrator is also necessary.

However while mental health interventions can be effective in addressing DFSV, South Australia's mental health services are currently under-resourced to meet demand in a way that represents best practice. People needing support face significant challenges in accessing services and inadequate continuity of care across the health system. For those experiencing DFSV, this can result in trauma being underrecognised, underdiagnosed, and undertreated as a result of the ongoing and increasing pressures on the mental health system.

We recommend a review of South Australia's public mental health services be undertaken, including evaluating:

- **Whether current models of care represent best practice or are a result of compromises due to limited resources and staff;**

- **The degree of need for mental health services in the community, and to what extent services are meeting that need;**
- **Where deficiencies in either of the above are discovered, strategies to implement change and address the shortfall.**

Given the significant impacts of DFSV on perinatal and infant mental health, a best practice health system response to DFSV should also include a state-wide framework for perinatal and infant mental healthcare that is interconnected with state DFSV services. However, this does not currently exist in South Australia, where there is high perinatal and infant mental health acuity but fewer pathways to care than in other jurisdictions, with support often only offered by general practitioners rather than specialist services. Under a state-wide framework, health services would focus on addressing the longitudinal impacts of perinatal exposure to DFSV for infants and children, including the intergenerational transmission of trauma and violence.

10) What are the elements of a best practice police response?

We recommend police procedures be improved in relation to trauma-informed practices, coercive control and CALD strategies

Trauma-informed practices need to be embedded into law enforcement DFSV incident procedures. Trauma-informed practice recognises that events such as DFSV incidents can produce experiences of overwhelming fear, stress and anxiety within individuals, who require a safe environment and relationships of trust when being provided with support.[24] Embedding trauma-informed practice would help ensure procedures are sensitive, nuanced, and culturally safe, and avoid the misidentification of survivors as perpetrators, which is a significant problem in Australia.[29] Trauma-informed practices will also help ensure survivors are not retraumatised, feel they have been listened to and are confident in the reporting of incidents to authorities.

Law enforcement DFSV incident procedures also need to be strengthened in consultation with service providers to identify and record preceding long-term patterns of coercive control through in-depth interviews. Coercive control includes threats, isolation, manipulation and emotional and financial abuse. In-depth interviews would help reduce the risk of misidentifying survivors as perpetrators. In addition, the data these procedures would collect on long-term patterns of coercive control and the behaviour of perpetrators would provide evidence that could be used to better inform policy and service delivery focusing on DFSV prevention.

Law enforcement DFSV incident procedures for CALD communities need to be strengthened in consultation with cultural experts. They should include the use of interpreters and in-depth interviews designed to capture culturally specific forms of coercive control, such as control of migration status. Such forms of control are often complicated by the presence of multiple perpetrators. Incident procedures also need to be better tailored to Aboriginal community contexts. Several factors which commonly complicate DFSV are even more apparent in these settings, including contradicting narratives, forensic evidence of mutual injuries, and deficits in recall due to substance use or trauma.

Frontline responses to DFSV must also involve appropriate responses to perpetrators. As mentioned earlier, this should involve referral of all perpetrators for mental health assessment.

11) What are the elements of a best practice justice system response?

Appropriate laws are critical to a best practice justice system response to DFSV, including those relating to coercive control. We welcome the South Australian Government's commitment to criminalising coercive control.[30] However, as mentioned earlier, law enforcement procedures need to be improved so

that they can adequately identify instance of coercive control. In addition, while certain cultural practices involving DFSV, like female genital mutilation, are illegal in Australia, we believe the law should go further.

We recommend dowry abuse be included in laws across Australia that criminalise coercive control.

Changes to how courts deal with DFSV are also needed to reach a best practice justice system response to this type of violence. More work is required by the courts to better safeguard the mental health of adults, children and families involved in proceedings, to provide consistently safe outcomes for DFSV victim-survivors.[31]

DFSV victim-survivors also frequently report experiencing retraumatisation at multiple stages in the criminal justice process, with court proceedings often exposing them to triggering experiences that leave them feeling further disempowered, stigmatised, and shamed.[34]

Greater protections are also needed to prevent DFSV perpetrators from using court proceedings to continue their abuse, including utilising the justice system to further deplete the financial resources available to their previous partner or family member.[32]

12) Taking into account your response(s) to questions 8 to 11, which elements are already in place in the domestic, family and sexual violence systems in South Australia?

DFSV laws in South Australia are currently being expanded. This includes the introduction of the Criminal Law Consolidation (Coercive Control) Amendment Bill 2023.[30] While we welcome the Bill, we urge the South Australian Government to ensure it is introduced to Parliament and operationalised in a timely manner.

We also recommend the South Australian Government review the subsequent Act, after it comes into effect, to ensure it is fit for purpose.

There are also several health services in South Australia that are critical to the state's DFSV system, including:

- The Health and Recovery Trauma Safety Service provides training and education to those providing support to DFSV victim-survivors.
- the Adolescent Sexual Assault Prevention Program, which is operated by the Child and Adolescent Mental Health Service, provides counselling for young people who perpetrate sexual abuse and violence.
- the Women's and Children's Hospital provides staff with training in DFSV and operates Child Protection Services, which takes referrals accepted from DCP and SAPOL.
- Yarrow Place Rape and Sexual Assault Service provides support to anyone who has been sexually assaulted.
- Adelaide Narrative Therapy works with DFSV perpetrators to engage them in a non-threatening and therapeutic manner.

Despite the provision of these laws and services, more needs to be done to ensure South Australia has a best-practice response to DFSV. As mentioned, this requires improvements within the social, health, and criminal justice systems.

Recovery and Healing

13) Acknowledging that every victim-survivor will have different needs depending on their personal circumstances, are there universal needs that will arise for all victim-survivors?

As mentioned earlier, from a mental health perspective, the consequences of DFSV are complex and there are no universal impacts for victim-survivors, meaning personalised immediate and long-term care plans are necessary. However, all treatment and support for DFSV victim-survivors should be underpinned by a trauma-informed approach.[24] While impacts are not universal, DFSV victim-survivors commonly suffer from post-traumatic stress disorder and problematic substance use.[20,21] As such, the treatment and support needs of these individuals are often similar.

Access to mental health supports and services is therefore extremely important to manage trauma and help to minimise the long-term effects of DFSV on victim-survivors.

Regarding social support, providing safe and affordable housing or emergency accommodation is critical for individuals wanting to leave a potentially dangerous or threatening situation. However, we note that there has been noticeable increase in the number of South Australians experiencing DFSV who are unable to find suitable accommodation. As a result, victim-survivors are being forced to live in cars or in the bush.[33] The RANZCP therefore urges the South Australian Government to increase public housing resources to address this shortfall.

Lack of stable accommodation is also associated with an increase in mental health conditions. This is an ongoing matter of concern within South Australia in general, and can only exacerbate issues for those who have recently experienced the trauma of DFSV.

14) What are the best practice approaches to supporting a victim-survivor to recover from trauma and the mental, physical, emotional and economic impacts of violence?

From a mental healthcare perspective, supporting the recovery of DFSV victim-survivors requires a range of therapeutic interventions, including psychological therapies, psychotropic medications, and support networks.[28] However, at the broader mental health system level, mental health services must be well-resourced. When services are stretched, capacity to undertake assessment, admit patients, provide treatments, and follow up with patients post-discharge decreases.

Mental health services must be strongly connected with services within the health, social, and criminal justice systems, to ensure an integrated approach to supporting DFSV victim-survivors with their physical and mental health, housing, families, and finances. Across services, support must also be trauma-informed at every touch point with victim-survivors to prevent retraumatisation and a compounding of undertreated or unrecognised trauma. This will ensure services are gentle enough, skilled enough, and resourced enough to genuinely meet the needs of victim-survivors.

15) Taking into account your response to question 14, what best practice approaches are already in place in the domestic, family and sexual violence systems in South Australia?

As listed above, there are several health services in South Australia with best practice approaches to DFSV.

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