Appendix K

What proportion of children and young people are exposed to domestic, family and sexual violence in South Australia?

A submission to the Royal Commission into Domestic, Family & Sexual Violence

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BETTERSTART
Health and Development Research

Better Evidence
Better Outcomes Linked Data platform

make history.

Acknowledgement of country

BetterStart acknowledge Aboriginal and/or Torres Strait Islander people as the First Peoples and Nations of the lands and waters we live and work upon. Sovereignty of these lands has never been ceded. It always was and always will be, Aboriginal land.

We acknowledge the Kaurna people who are traditional owners and custodians of the lands this work was undertaken on, and we pay our respects to Kaurna Elders, past, present and emerging. We recognise and respect their cultural authority, cultural heritage, beliefs and relationship with the land.

Acknowledgement

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- SA Department for Health and Wellbeing;
- SA Department for Education;
- SA Department for Child Protection; and,
- the University of Adelaide

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 and non-Government partners.

Suggested citation

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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.

Executive Summary

It is very difficult to estimate the current prevalence of Domestic, Family and Sexual Violence (DFSV). The two possible population-level data sources are surveys which sample part of the population or administrative data covering the whole population that comes into contact with particular services. However, there is evidence that DFSV is often not reported to authorities[1] by victim-survivors for a range of reasons, including fear of the perpetrator, shame, lack of social support, isolation, dependency, and economic pressures (Australian Bureau of Statistics, 2016). Where the primary victim is a child, reporting becomes even more contingent on having strong familial and/or social supports (Campbell et al., 2024).

Under-reporting of DFSV in administrative data means that estimates of the prevalence will be under-estimates.

Currently our ability to use whole population data to construct a view of DFSV relies on using child protection, homelessness (includes the DFV Alliance), and hospitalisations data collections. South Australian police data is currently not available for linkage into our data platform. We know this is likely to result in an under-estimate of the prevalence of DFSV, and there is very limited view of victims and perpetrators.

The aim of this project is to provide South Australia's Royal Commission into Domestic, Family & Sexual Violence (DFSV) with the best available, contemporary estimates of the prevalence of DFSV amongst children in SA.

The key findings include:

- About 1 in 30 (n = 12,518~) South Australian (SA) children experienced DFSV at least once each year in 2020, 2021 and 2022.
- This figure rises to approximately 1 in 18 for children living in Outback SA
- Aboriginal and Torres Strait Islander children experienced DFSV at much higher levels than non-Aboriginal children, with about 1 in 7 experiencing at least one indicator of DFSV each year.
- About one third of all children who experienced DFSV each year were located in Adelaide's North (n = 4,214~), more than in all of the other areas of Adelaide combined

Through undertaking this work, we also identified some key opportunities for consideration which could improve the knowledge of DFSV in South Australia (*detailed further on page 33*):

- Expand the BEBOLD platform to encompass a broader population (i.e., all adults) and integrate data sources with more DFSV-relevant information (e.g., SA Police, NGO, & ACCO data)
- Utilise whole-of-population linked data to inform service design, implementation and to monitor outcomes (e.g., develop rapid evidence feedback loops)
- Increase knowledge sharing and support Indigenous Data Sovereignty by working closely with Aboriginal and Torres Strait Islander people to access, analyse and act on data which relate to their people and communities (e.g., establish partnerships based on genuine reciprocity which use data to develop evidence-informed solutions)

[1] The 2016 Personal Safety Survey reported that 69% of men and women who experienced physical assault by a male did not report the most recent incident to police

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Introduction

Project Background

BetterStart are delivering this project at no cost to the SA Royal Commission into Domestic, Family & Sexual Violence (RC DFSV) as part of their commitment to social justice and in alignment with using the SA BEBOLD for public good.

The aim of this project is to undertake analysis that can improve the understanding of the prevalence of DFSV amongst children within SA. We will:

- Utilise the BEBOLD linked data platform to analyse the prevalence of DFSV amongst children who were born or lived in SA and aged 0 to 17 years old in 2020, 2021 & 2022.
- Take a child-focused approach, focusing on DFSV experienced by the children themselves or their parents, adopting a broad definition of experiences of DFSV.
- Carefully define DFSV and disaggregate data (where possible and appropriate) to provide further context and clarity about the prevalence, frequency, nature and location of DFSV in SA.
- Generate prevalence estimates by focusing on indicators in the administrative data which have a high probability of being related to a child experiencing DFSV.

The Royal Commission into Domestic, Family and Sexual Violence

The SA Government asked the RC DFSV to provide advice about 5 key areas aligned to the National Plan to End Violence Against Women and Children 2022-2032:

- **Prevention -** How SA can facilitate widespread change in the underlying social drivers of domestic, family and sexual violence.
- **Early intervention** - How SA can improve effective early intervention through identification and support of individuals who are at high risk of experiencing or perpetrating domestic, family and sexual violence.
- **Response** - How SA can ensure best practice responses to family, domestic and sexual violence through the provision of services and supports.
- **Recovery and healing** - How SA can embed an approach that supports recovery and healing through reducing the risk of re-traumatisation and supporting victim-survivors to be safe and healthy.
- **Coordination** - How government agencies, non-government organisations and communities can better integrate and coordinate efforts across the spectrum of prevention, intervention, response and recovery.

The overarching focus for the Commission is to examine existing policies, legislation, administrative arrangements, system structure and funding levers in SA so that we can develop recommendations about what needs to change.

Recommendations will be directed at designing a domestic, family and sexual violence system to better meet the needs of those who interact with it, and which is capable of delivering the generational change required to bring an end to domestic, family and sexual violence (Royal Commission Website, 2024, accessed 6th December 2024).

Background to the Research

There are few published DFSV prevalence estimates within Australia and most measure period prevalence over certain historical periods in a person's life (e.g., from 15 years old, as a child) and tend to focus on adults, particularly women. For example the 2021-22 Personal Safety Survey (PSS) reported that 27% of women aged over 18 had experienced violence from a cohabiting partner since age 15 (Australian Bureau of Statistics, 2022). Whilst life-course estimates are an entirely valid means through which to estimate prevalence, they do not provide a contemporary view of how many people may have recently experienced DFSV. Due to the historical-based nature of these estimates, they are also limited in the information they can provide about the current needs of people who have experienced DFSV. This is a key concern for Governments as such information can help to design and deliver effective services and supports.

Few published studies estimate the prevalence of DFSV in recent life periods. The PSS is one of the few Australian studies that publishes recent life estimates of prevalence. According to their survey of 9,832 women, 0.9% reported that in the last 12 months they had experienced cohabiting partner violence (physical or sexual), 1.5% reported intimate partner violence, and 1.9% experienced sexual violence (Australian Bureau of Statistics, 2022). Another survey-based prevalence estimate was published in May 2020 by the Australian Institute of Criminology (AIC). They surveyed 15,000 women about their experience of DFSV during the first 3 months of the COVID-19 pandemic and found that 4.6% reported experiencing physical or sexual violence from a cohabiting partner. Just under 6% reported experiencing coercive control and almost 12% reported at least one from of emotional abuse, harassment or controlling behaviour (Boxall et al., 2020). These two studies provide some insight into the complexity of measuring the prevalence of DFSV using survey methodology. In particular, despite the AIC study measuring violence over a 3-month period compared to a 12-month period, a much greater proportion of women reported experiencing cohabiting partner violence than in the PSS (4.6% vs 0.9%).

Some studies have utilised administrative data to estimate the prevalence of DFSV. However, these studies often focus on sub-populations or on particular measures of DFSV. One example is a recent study undertaken by Australia's National Research Organisation for Women's Safety (ANROWS) which used child protection and hospital data, and found that 33% of children reported to child protection were experiencing DFV, with or without parental substance use and/or mental health issues (Luu et al., 2024). Another recent study by the AIC used linked de-identified police data for 3 birth cohorts in New South Wales (NSW) to estimate the prevalence of perpetration of DFSV. The authors reported that 6.3% of people born in NSW has been proceeded against by police for a family and domestic violence offence by age 37. Importantly, these findings differed by gender with men being much more likely (9.6%) than women (3.0%) to have perpetrated DFSV (Payne & Morgan, 2024). Both of these studies estimate the prevalence of DFSV using administrative data, but neither answers the question of what proportion of the community experienced DFSV within a recent time period in their life.

Prevalence estimates of DFSV in Australia vary on the methodology used and the target cohort examined. There is no "correct" or definitive way to estimate "true" DFSV prevalence. All methods provide particular views of the DFSV problem that can help provide bounds for the true prevalence of DFSV. This analysis addresses the question: What proportion of children and young people were exposed to domestic, family and sexual violence each year in South Australia? To achieve this, we used data from Child Protection, Specialist Homelessness Services and hospitalisations data to identify indicators which were indicative of a child or their parent(s) experiencing DFSV in 2020, 2021 or 2022.

Aims

What this analysis does:

- Focuses on the experiences of children aged 0-17 who were born in SA, or who were living in SA, and of their mother and co-parent.
- Estimates of the number of children who experienced DFSV in 2020, 2021 or 2022, either through direct system contact or through the experiences of their mother or co-parent.
- Situates the estimates of children who experienced DFSV within the whole population of children in SA who were aged 0 to 17 in 2020, 2021 or 2022.
- Provides a potentially lower bound estimate of the prevalence of children who experienced DFSV within a calendar year (2020, 2021 or 2022) by focusing on the service system contacts which are most likely to be indicative of a child having experienced DFSV.
- Improves the understanding of who experiences DFSV, what types of DFSV they experience and where they are located, to inform decision making about appropriate interventions and supports.

What this analysis doesn't do:

- Focus on the DFSV experiences of adults. This means that violence perpetrated in the context of intimate partner or family violence where neither the victim nor perpetrator had children is not able to be estimated in this analysis.
- Specifically identify the scale or seriousness of harm suffered by children who experienced DFSV – administrative data are not designed to capture the significant experience of harm of victim-survivors of DFSV.
- Identify all children or parents who experienced DFSV in South Australia – this is a conservative estimate based on data from a limited number of service systems which, importantly, does not include data provided by South Australia Police, Correctional Services, or the Courts.

Research questions:

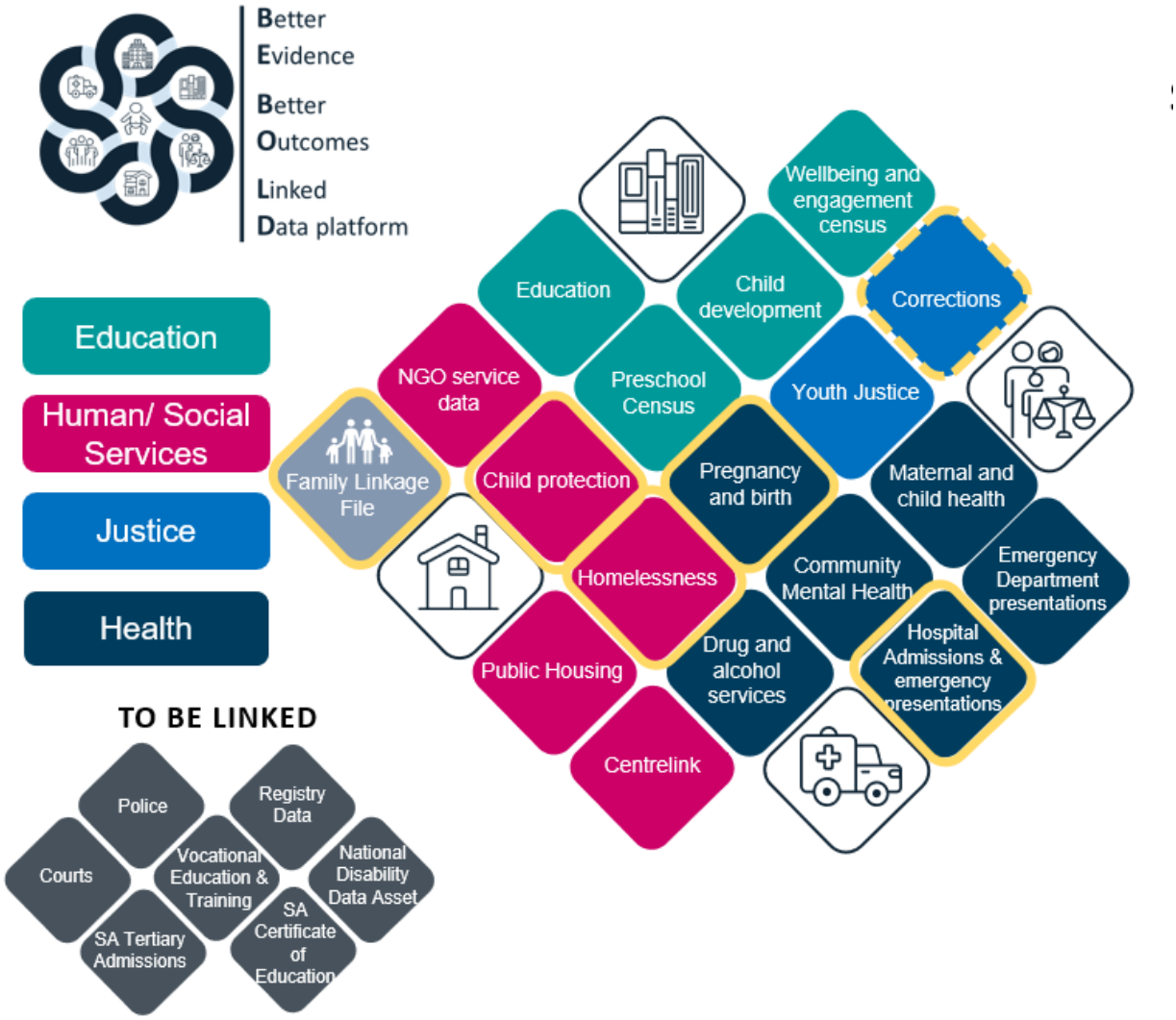
1. What was the annual prevalence in 2020, 2021 and 2022 of children born or living in SA who had experienced a least one indicator of DFSV?
2. What is the most prevalent source for DFSV indicators?
3. Has there been changes in the prevalence and source of DFSV from 2020-2022?
4. What were the key demographic features of the children who did and didn't experience DFSV (E.g., sex, age, cultural background)?
5. In what areas did children affected by DFSV live in (e.g., SA3)?

The SA BEBOLD Platform

This project utilised data from the SA Better Evidence Better Outcomes Linked Data (BEBOLD) platform, a whole-of-population de-identified linked data platform. BEBOLD contains de-identified data on ~600,000 young people in South Australia born from 1991 onwards and their parents, and spans more than 30 different government administrative data sources. Figure 1 illustrates the data sources held in the BEBOLD platform. Those in yellow highlight were used in this analysis.

Note: Data from Corrections was not available in time to complete this work for the RC DFSV.

Figure 1: Description of the BEBOLD platform and data sources



Data used for this analysis came from:

- Birth registrations, Attorney General's Department;
- Perinatal Statistics Data Collection, Preventive Health SA;
- Admitted Patient Care (APC), SA Department for Health and Wellbeing;
- Child Protection, SA Department for Child Protection;
- SA Specialist Homelessness Services (Homelessness to Home, H2H), SA Housing Authority;
- Department for Correctional Services**;** and,
- Family Linkage File.

Study population

To estimate the annual prevalence of DFSV for children aged 0 to 17 born or living in SA in 2020, 2021 and/or 2022 we used data from the BEBOLD platform for children who had a SA birth registration and who were born between 2002 and 2022. This covers all children aged 0 to 17 during the calendar years 2020, 2021 or 2022. Figure 2 shows a visual representation of the births cohorts and ages included in the study population. The study population for 2020 was N=369,542, 2021; N=371,931, and 2022 N=374,848.

Figure 2: BEBOLD births cohorts and ages included in the analysis

	Calendar year		
Year of Birth	2020	2021	2022
	Age (in years) child or young person turns in each calendar year		
1991	29	30	31
1992	28	29	30
1993	27	28	29
1994	26	27	28
1995	25	26	27
1996	24	25	26
1997	23	24	25
1998	22	23	24
1999	21	22	23
2000	20	21	22
2001	19	20	21
2002	**18**	19	20
2003	**17**	**18**	19
2004	**16**	**17**	**18**
2005	**15**	**16**	**17**
2006	**14**	**15**	**16**
2007	**13**	**14**	**15**
2008	**12**	**13**	**14**
2009	**11**	**12**	**13**
2010	**10**	**11**	**12**
2011	**9**	**10**	**11**
2012	**8**	**9**	**10**
2013	**7**	**8**	**9**
2014	**6**	**7**	**8**
2015	**5**	**6**	**7**
2016	**4**	**5**	**6**
2017	**3**	**4**	**5**
2018	**2**	**3**	**4**
2019	**1**	**2**	**3**
2020	**0**	**1**	**2**
2021		**0**	**1**
2022			**0**

Births cohorts and ages included in the analysis

Definitions used for children exposed to DFSV

Children and Parents

A person was considered a child if they were aged less than 18 years old for at least one day in the 2020, 2021, or 2022 calendar year. An experience of exposure to DFSV was defined as an event which was indicative of the child experiencing DFSV whilst they were aged less than 18 in 2020, 2021 or 2022. Parents were identified using birth registrations and only indicators affecting a parent which occurred whilst the child was aged less than 18 in 2020, 2021 or 2022 were counted.

A limitation of any study that uses parent experiences or perpetration of DFSV to measure the prevalence for children is that, in some circumstances, the parent's experience of DFSV may not have directly or indirectly impacted the child. For example, it is possible that some cases of perpetration involving male co-parent may involve violence towards a woman who is not the mother of the child and not co-habiting with the child.

Table 1: DFSV Definitions

	Population	Experience of DFSV	Timing
Child has an indicator suggesting exposure to DFSV	A child aged <18 in the 2020, 2021 or 2022 calendar years	A record which was indicative of the child experiencing domestic, family or sexual or violence, either directly recorded against the child or against a parent of the child.	The record which affected the child occurred in the 2020, 2021, or 2022 calendar year when the child was aged between 0 and 17 years old

Indicators of Domestic, Family & Sexual Violence

This analysis utilizes data held within the BEBOLD de-identified linked dataset Whilst BEBOLD includes data from more than 30 sources, only 3 were identified as providing a robust measure of an experience of DFSV. The definition and data sources used for the indicator of DFSV are shown in Table 2

Table 2: Definition and sources of indicators of Domestic, Family & Sexual violence

Indicator	Definition	Data Source	Child and/or parent(s)	Limitations
Primary child protection allegation indicative of DFSV	Screened-in notifications in 2020, 2021 or 2022 were the primary alleged grounds was either; • Domestic Violence, • Physical Abuse, • Emotional Abuse, • Sexual Abuse, • Threats to kill/injure the child; and • Injury resulting from domestic violence incident	Department for Child Protection	Children aged 0 to 17 years in 2020, 2021 or 2022.	Alleged grounds of a notification are only recorded in structured fields for screened-notifications. Screened-in notifications are deemed to be a child protection matter, those that meet the child protection threshold for further assessment and response. It excludes any notifications that were reported to the Child Abuse Report Line (CARL) or eCARL and weren't screened-in.
Family, domestic & sexual violence Hospitalisation	Family and domestic violence hospitalisation in 2020, 2021 or 2022 with; • injury as a diagnosis in the ICD-10-AM code range S00–T75, T79; • and • External causes of ICD-10-AM code in the range X85 – Y09 (Assault), • and • a perpetrator coded as Spouse or domestic partner, Parent, or Other family member (5th character codes of 0,1,2 respectively).	Admitted Patient Care (APC), SA Department for Health and Wellbeing	Children aged 0 to 17 years in 2020, 2021 or 2022 and/or parent.	Family & domestic violence assault hospitalisations don't include emergency departments presentations as information on cause of the assault is not available in emergency department data. Thus, this is an underestimate of overall hospital activity related to family and domestic violence. These hospitalisations also relate to more severe (and mostly physical) experiences of family and domestic violence (Australian Institute of Health and Welfare, 2025). Also, around 33% of all hospitalisations for assault the perpetrator information was not specified, therefore hospitalisations due to family and domestic violence are also underestimated (Australian Institute of Health and Welfare, 2025).
Presented to a Domestic and Family Alliance Agency and/or a Specialist Homelessness Service (SHS)	Child or parent presented to a DFV Alliance and and/or had contact with SHS with the main presenting need as DFSV during 2020, 2021 or 2022; Includes "Domestic and Family Violence", "Sexual Abuse" & "Intervention/restraining orders – partner"	SA Specialist Homelessness Services, SA Housing	Children aged 0 to 17 years in 2020, 2021 or 2022 and/or parent.	Some service episodes may include circumstances where a parent could have presented to a DFV Alliance and/or a Specialist Homelessness Service that has had no recent contact with the child at the time.

More detailed descriptions of exactly how these indicators are defined can be found in Appendix A.

Findings

Some things to keep in mind as you read this report

This analysis does not provide a complete picture of the prevalence of DFSV. This is the best view we can have with the available data:

- DFSV is generally under-reported by victims.
- What is captured within administrative data is likely to be representative of more serious and/or visible forms of DFSV.
- Large parts of the picture are missing – we do not have data from SAPOL, which is a key source of information about the number of people who experienced or perpetrated DFSV.
- We have also not yet been able to utilise data from Correctional Services, which would provide information about people who perpetrated DFSV and who were parents.
- Data from Non-government Organisations (NGO's such as Women's Safety Services South Australia) and Aboriginal Controlled Community Organisations (ACCO's such as Kornar Winmil Yunti - KWY) may also provide an important source of information about the prevalence of DFSV. But these data sources are not yet linked with the BEBOLD Platform.

A child-focused view means that the experiences of women who do not have children aged 0 to 17 are not included in this analysis:

- Findings from the Personal Safety Survey and the Victorian Royal Commission indicate that women aged in their late teens and 20's, many of whom who will not yet have had children, make up a considerable proportion of people who report experiencing DFSV.
- Many women with adult children also experience DFSV.

We have taken a conservative approach to defining DFSV that may provide a lower bound estimate based on administrative data by:

- Only including descriptions of significant risk factors within DCP notifications which either explicitly referred to DFSV or described an act of harm consistent with DFSV (e.g., sexual assault, threats to harm/kill).
- Only including episodes of hospital admissions where the external cause was an assault recorded as being be committed by a spouse, partner or family member; and/or
- Only including episodes of homelessness involving a DFV alliance and/or a presenting need being recorded as DFSV.

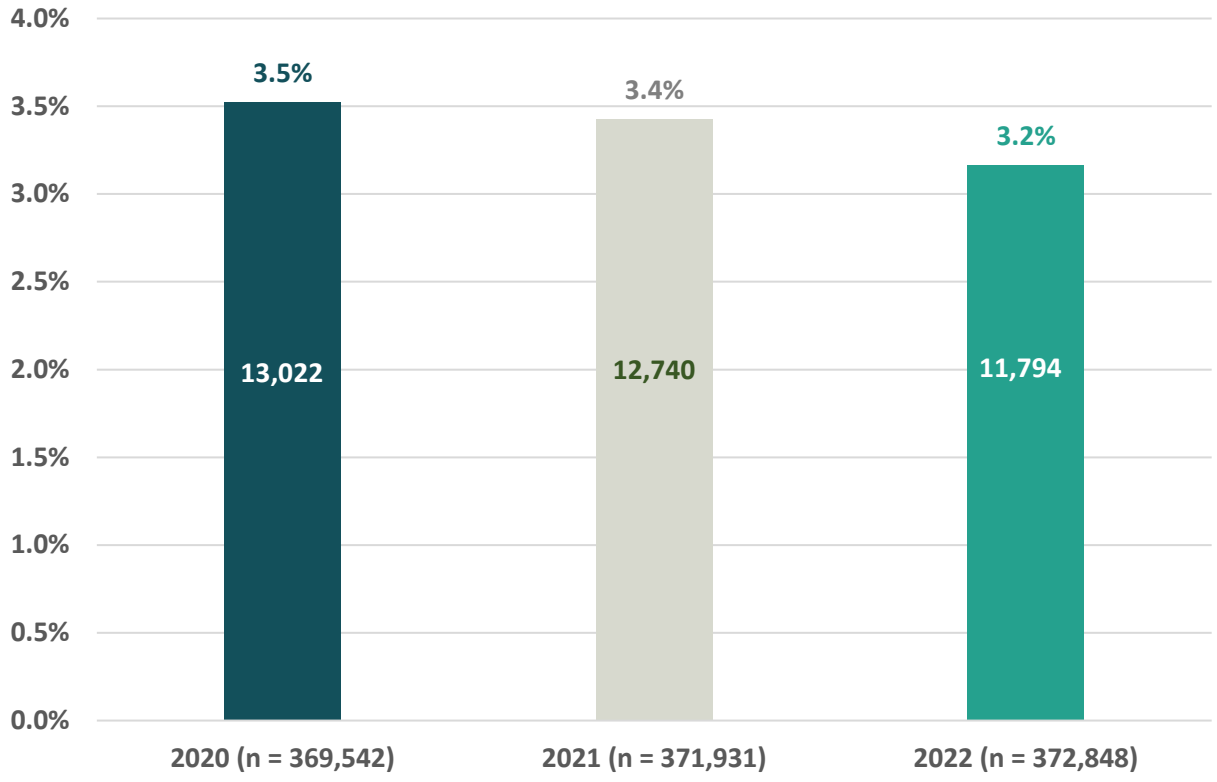
WE REPORT THE FINDINGS IN 3 KEY AREAS – Prevalence, Geography and Demographics

PREVALENCE

Prevalence of DFSV amongst children in South Australia, 2020-2022

Figure 3 shows more than 3% or about 1 in 30 children aged 0-17 in SA experienced DFSV each year.

Figure 3: Proportion of children aged 0-17 who experienced DFSV by year



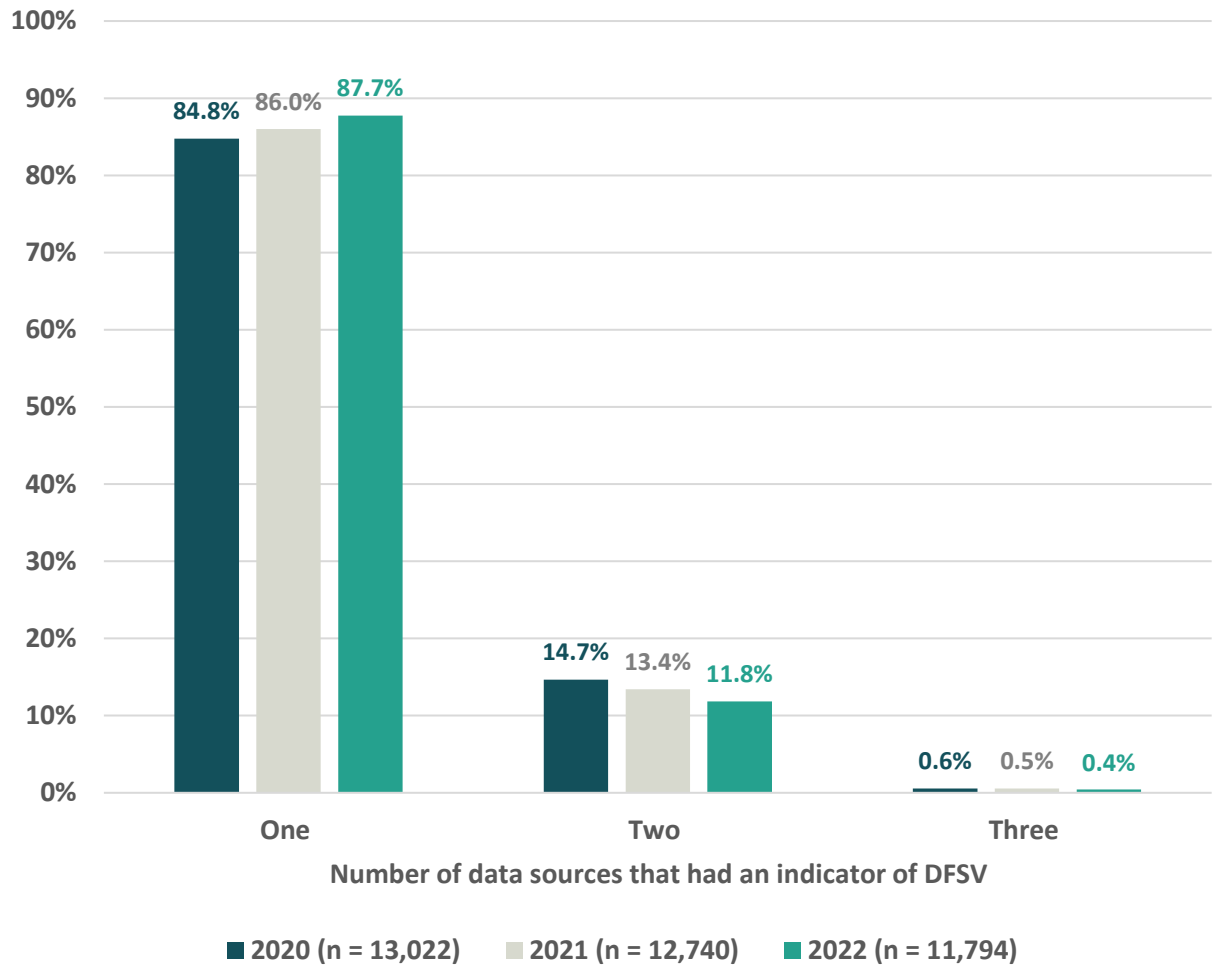
Key Message

- About 1 in 30 children experienced at least one indicator of DFSV.
- This equates to approximately 12,000 children per year who experienced one or more indicator of DFSV.

Number of data sources children had a DFSV indicator recorded

Figure 4 shows children predominantly experienced DFSV recorded from only one data source. About 14% experienced DFSV recorded by two data sources, and very few (0.5%~) had DFSV recorded in all three data sources in any given year.

Figure 4: Number of services with an indicator of DFSV among children with at least one report of DFSV exposure



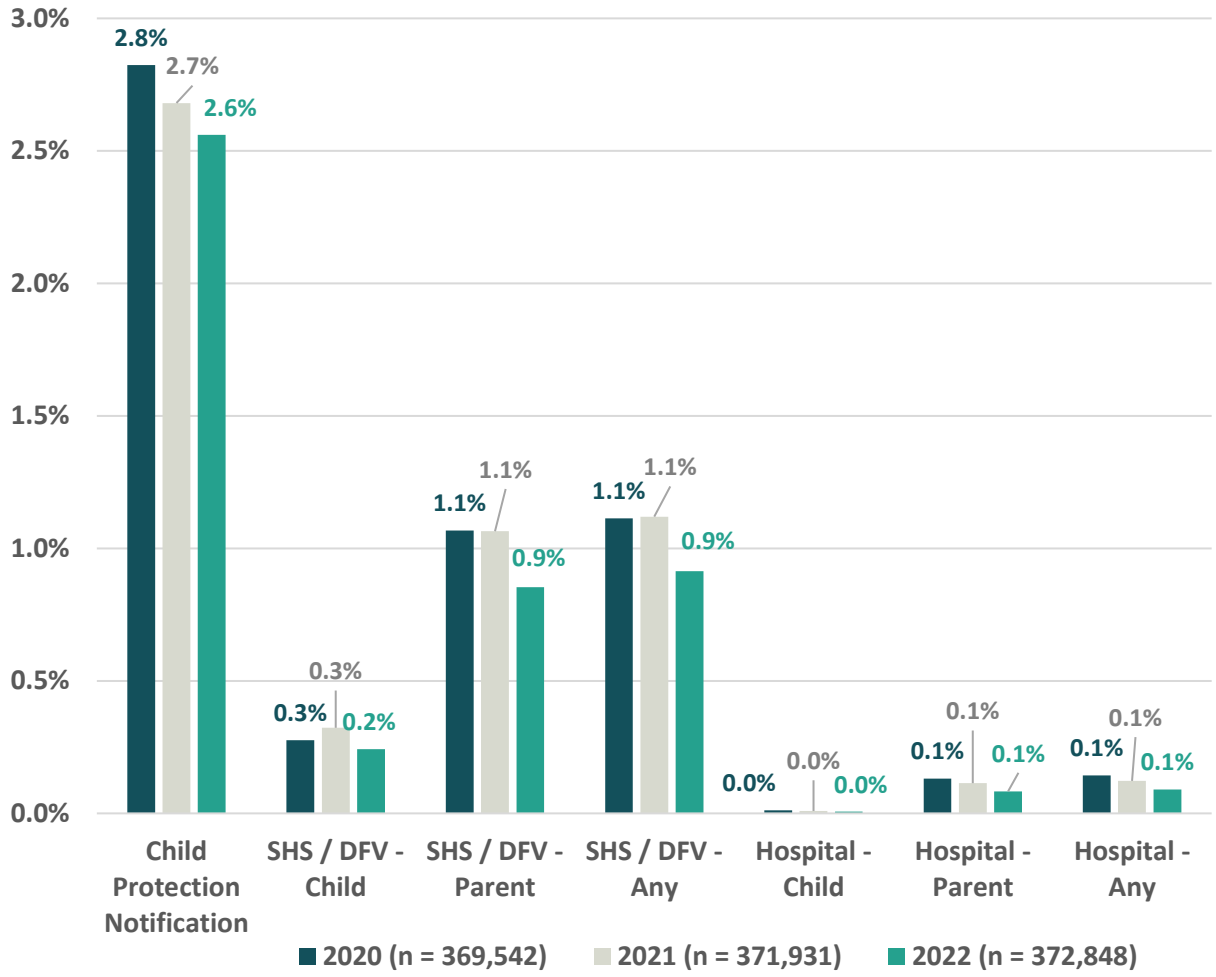
Key Message

- Most children (approx. 86%~) who experienced DFSV only had it recorded in one data source.
- About 14% had two and very few were recorded in three (0.5%~) data sources with an indicator of DFSV.

Sources of DFSV information amongst children in South Australia

Figure 5 shows the data sources for the indicator of DFSV for children in young people in SA. Information on experiences of DFSV was primarily gained from DCP screened-in notifications. Contact with specialist homelessness services was less common and there were very few experiences of DFSV was obtained from a hospitalisation for a DFSV-related assault.

Figure 5: Prevalence of DFSV for children and young people in South Australia from each data source*



***Not mutually exclusive**

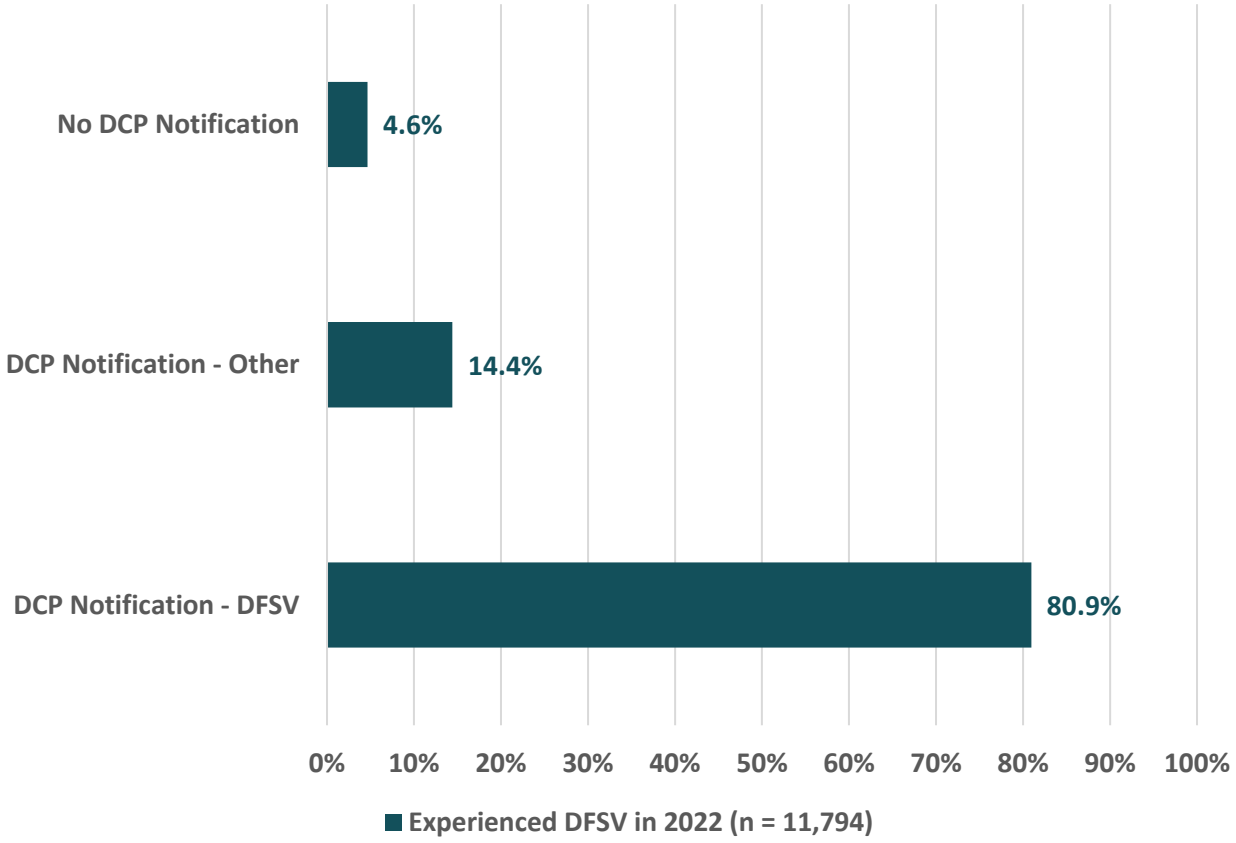
Key Message

- The most common source of DFSV information was from a child protection screened-in notifications, followed by accessing a specialist homelessness service.
- Hospitalisation for a DFSV assault was a rare occurrence for children and adults.

Child protection: Indicators of DFSV amongst children in South Australia

Figure 6 shows, for children and young people who experienced any indicator of DFSV in 2022, what proportion had a child protection notification in the same year. Four out of five (80.9%) children who experienced DFSV had received a Department for Child Protection screened-in notification for DFSV. A further 14.4% had a DCP notification (including screened-out notifications), and less than 5% (n = 547) of children who recorded at least one indicator of DFSV had no recorded DCP notification of any type in 2022. The possible explanations for this could include a parent having contact with a specialist homelessness service or being hospitalised for a DFSV-related assault, but they were not living with or having any current contact with the child. However, more in-depth analysis would be required to definitively answer this question.

Figure 6: DCP notifications by DFSV experience (2022 only)



Key Message

- 95% of children who experienced at least one indicator of DFSV in 2022 had a DCP notification recorded in the same year.

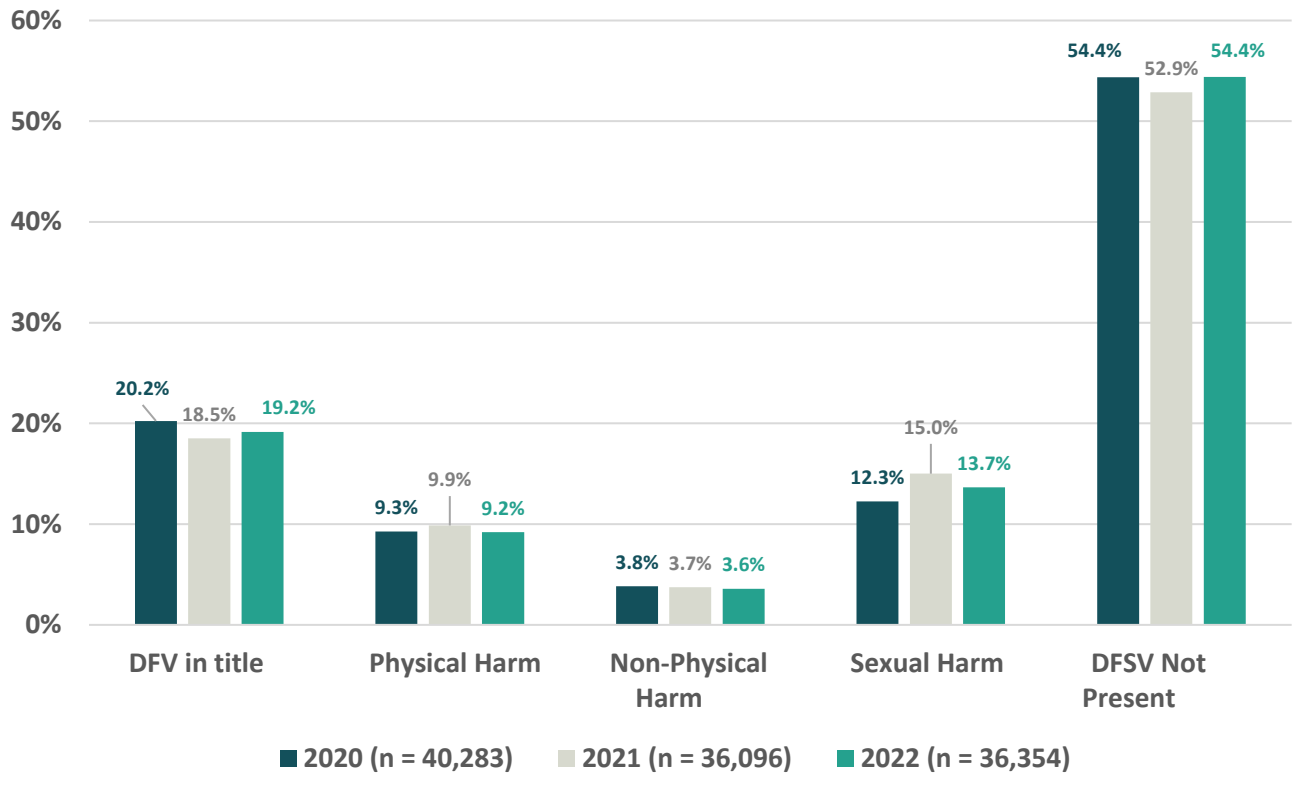
Type of DFSV experienced by children with a screened-in notification to DCP

To understand if a child protection notification has an indicator of DFSV we used the primary alleged grounds of the notification. The alleged grounds for each notification to child protection are only recorded in structure fields for notifications that are screened-in as a child protection matter. There was an average of 37,577~ screened-in notifications to child protection each year, which record primary alleged ground. Just over half (54%) of screened-in notifications didn't include an indicator of DFSV in the primary alleged grounds. Screened-in notifications were separately analysed using these five mutually exclusive categories:

- DFV specified as primary alleged grounds: domestic (not sexual violence) was specifically stated in title, Domestic Violence, Injury resulting from DFV incident
- Physical harm: physical abuse / harm caused by a family member,
- Non-physical harm: emotional abuse, risky behaviour, threats to harm or kill etc.
- Sexual Harm: sexual violence / harm (any perpetrator),
- DFSV not recorded in primary alleged grounds: no indirect or direct indicator of DFSV in primary alleged grounds.

Of these categories, 20%~ of screened-in notifications included DFV specifically stated in the primary alleged ground, 14%~ physical harm, 4%~ non-physical harm, and 9%~ sexual harm.

Figure 7: Type of DFSV within DCP screened-in notifications by year



Key Message

- 45%~ of all screened in notifications included an indicator of DFSV in the primary alleged grounds.
- 1 in 5 specified DFV as the primary alleged ground, 1 in 11 were physical harm, 1 in 27 non-physical harm and 1 in 7 sexual harm.

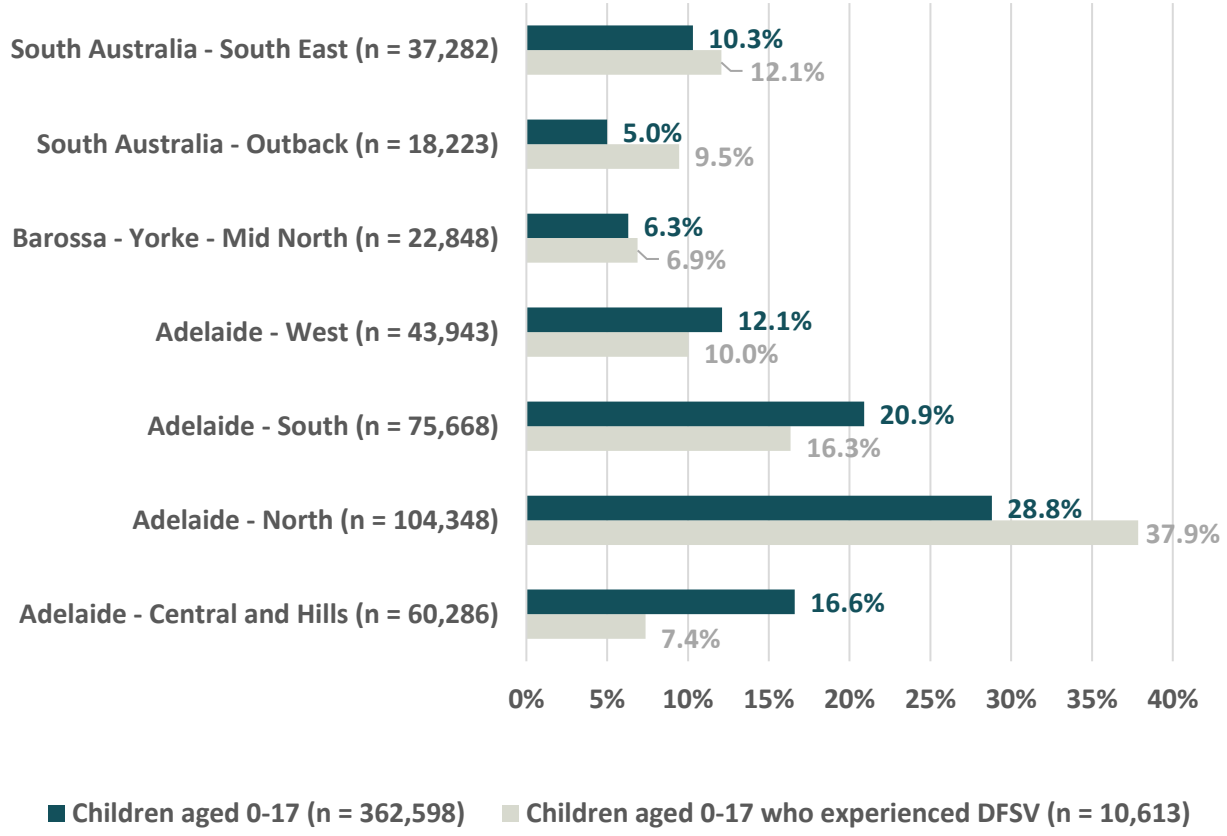
GEOGRAPHY

This section uses location data recorded by DCP to determine where in SA children who experienced DFSV were most likely living at the time. Because most children (95%) who experienced DFSV had a DCP notification, it was possible to determine the location for almost all children who experienced at least one indicator of DFSV. Population estimates from the ABS were used to further contextualise the number of children who lived in each region who experienced DFSV, and allowed us to derive a region-level prevalence estimate of DFSV.

Distribution of children aged 0 to 17 in South Australia by experience of DFSV

Figure 8 shows the proportion and number of children who live in each of the seven SA4 regions in SA by their experience of DFSV. For example, whilst children who lived in Adelaide's North made up 28.8% of the entire SA population of children, they made up a greater proportion - 37.9% - of children who experienced DFSV in SA during 2022.

Figure 8: Geographic distribution (SA4) of children aged 0 to 17 in South Australia who did and did not experience DFSV (only 2022 shown)



Key Message

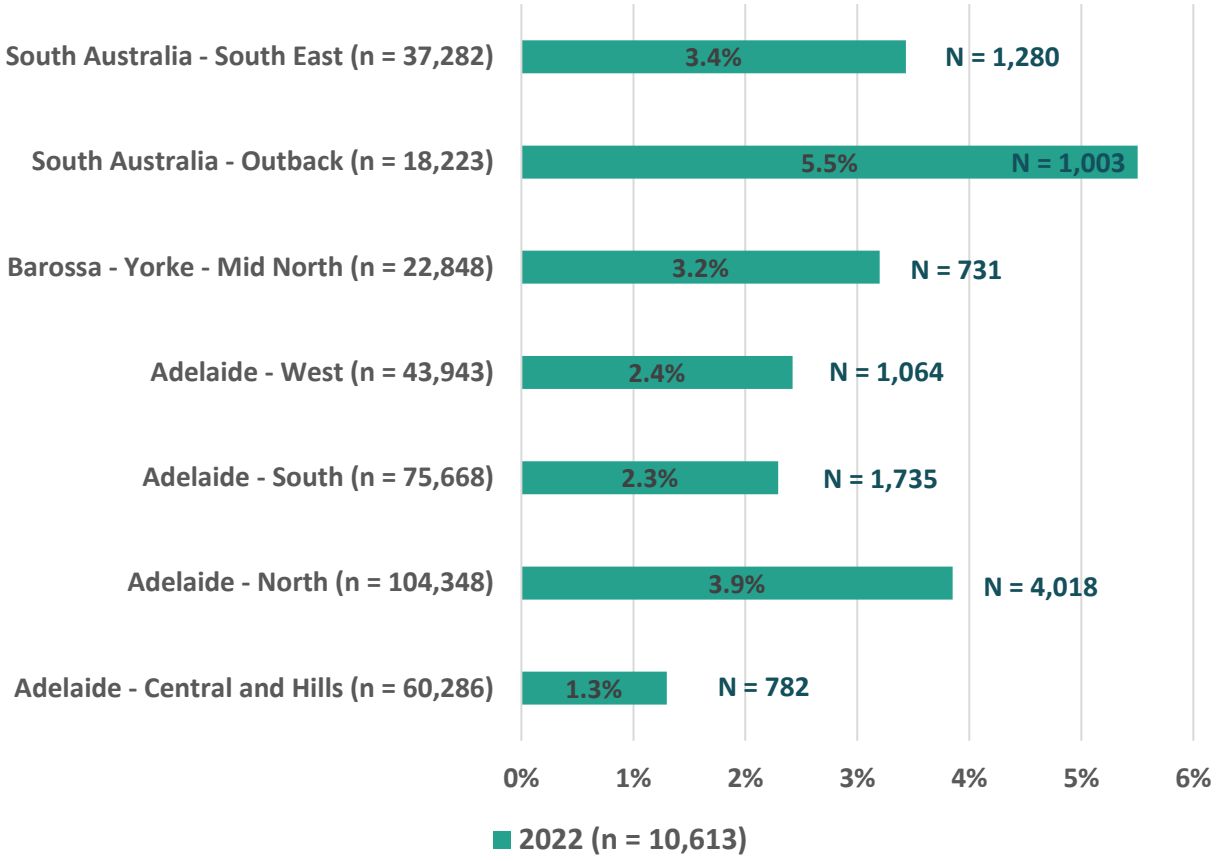
- Children who lived in Adelaide's North were over-represented in experiences of DFSV during 2022 as they only make up 28.8% of the entire SA population of children, but it was the area of residence for 37.9% of those who experienced DFSV.
- Children who lived in SA – Outback made up 9.5% of children who experienced DFSV, but only 5.0% of the whole population of children aged 0 to 17

Prevalence of DFSV for children within large state regions

Figure 9 shows the prevalence of DFSV for children living in a particular region, it is the number of children who experienced DFSV as a proportion of the total number of children living in that region.

The Outback region had the highest prevalence with 5.5%, or about 1 in 18 children experiencing DFSV. This was followed by Adelaide's Northern suburbs (3.9%), the South East (3.4%) and the Barossa – Yorke – Mid North region (3.2%).

Figure 9: Prevalence of DFSV within large state region (SA4), 2022



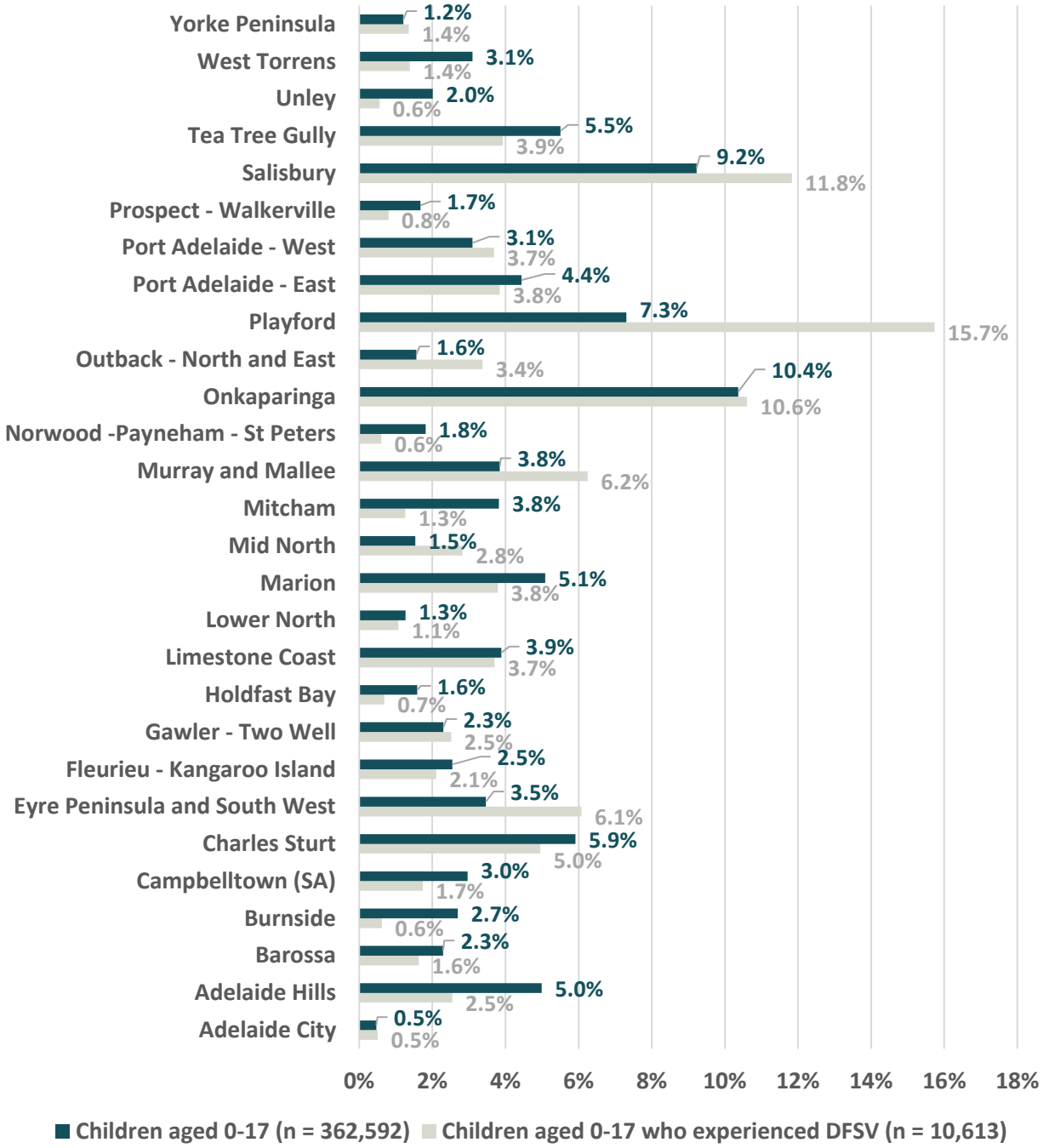
Key Message

- The Outback region recorded the highest prevalence (5.5%) of children experiencing DFSV.
- Children living in the Outback (1 in 18) and in the Adelaide North region (1 in 26) were the most likely to have experienced DFSV.

Distribution of DFSV for children by regional breakdown

Figure 10 shows the proportion of children aged 0 to 17 years living in the 28 SA3 regions in South Australia by whether they experienced DFSV or not. Whilst 7.3% of all children aged 0 to 17 lived in the Playford region, they made up 15.7% of children who experienced DFSV. Similarly, children living in Outback – North and East made up 1.6% of all SA children aged 0 to 17, but 3.4% of children who experienced DFSV.

Figure 10: Geographic distribution (SA3) of ALL children aged 0-17 in South Australia who did and did not experience DFSV (only 2022 shown)



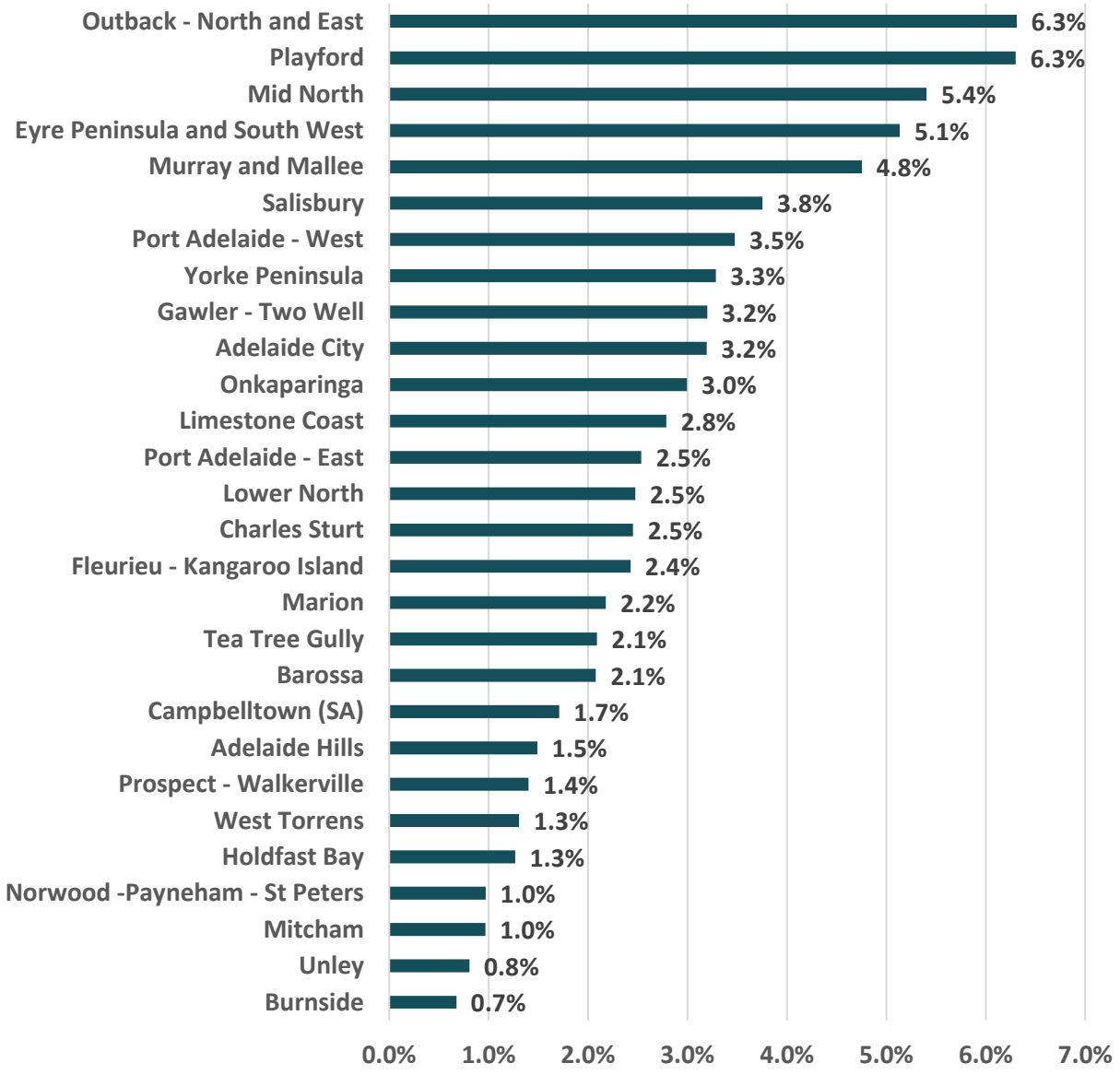
Key Message

- Compared to their share of the population, a greater proportion of children who experienced DFSV lived in Playford (15.7%), Salisbury (11.8%), Eyre Peninsula and South West (6.1%), Port Adelaide – West, and Outback – North and East (3.4%).

Prevalence of DFSV for children within regional breakdown

Figure 11 show the prevalence DFSV for children aged 0 to 17 years within SA3 regions. The SA3 with the highest proportion of children who experienced DFSV was the Outback – North and East (6.3%, or about 1 in 16 children) and Playford (6.3%). The prevalence was elevated (above the whole population mean of about 3.5%) in the Mid North (5.4%), Eyre Peninsula and South West (5.1%), Murray and Mallee (4.8%) and Salisbury (3.8%). The suburbs with the lowest prevalence of children who experienced DFSV were Burnside (0.7%), Unley (0.8%) and Mitcham (1.0%). Generally speaking, regional and remote areas tended to have higher prevalence of DFSV than areas in the Adelaide Metropolitan region.

Figure 11: Prevalence of DFSV within region (SA3), 2022



Key Message

- The Outback – North & East (6.3%, about 1 in 16 children) and Playford (6.3%) communities had the highest prevalence of children who experienced DFSV in 2022.
- The areas with the lowest prevalence included Burnside (0.7%), Unley (0.8%) and Mitcham (1.0%).

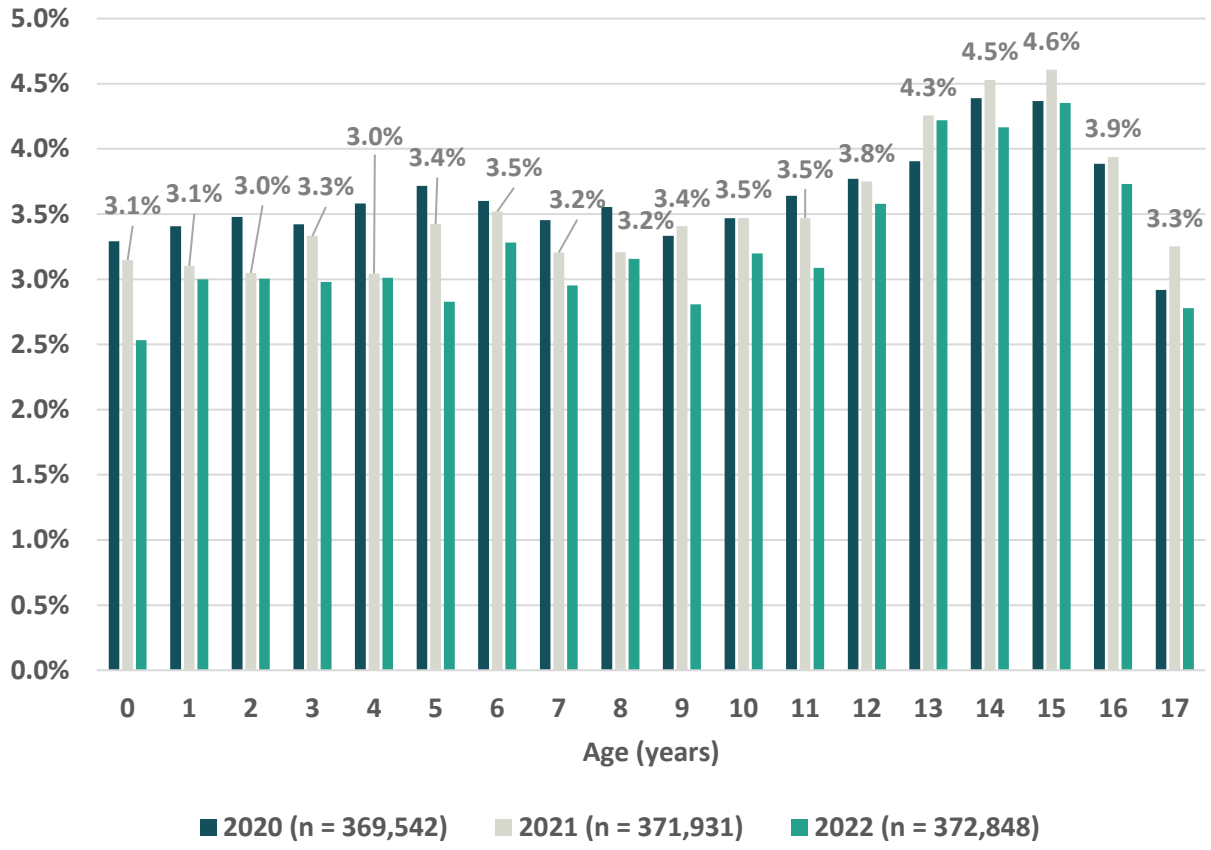
DEMOGRAPHICS

Demographic profile of DFSV amongst children in South Australia

Prevalence of DFSV by age and calendar year

Figure 12 show the prevalence of DFSV within age and year. Children that were most likely to experience DFSV during their mid-teens, with over 4% of children aged 13, 14 and 15 experiencing DFSV each year.

Figure 12: Proportion of children who experienced DFSV by year and age*



**** 2021 proportions shown***

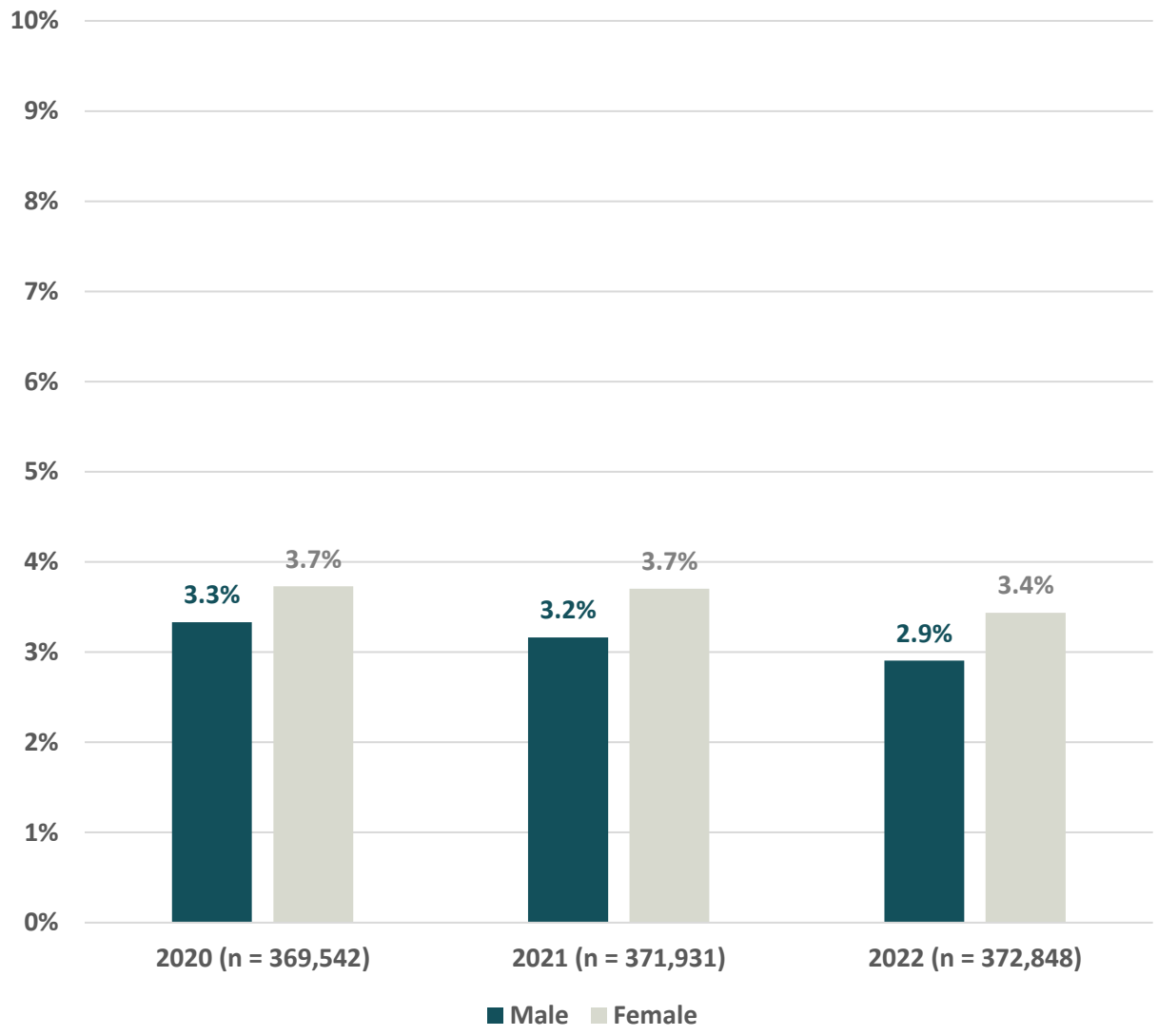
Key Message

- A slightly greater proportion (about 1% point) of children experienced DFSV when they were aged 13, 14 and 15 than at younger ages.

Prevalence of DFSV by sex for each calendar year

Figure 13 shows prevalence of DFSV by sex for each calendar year. Females were slightly more likely to have experienced DFSV in each year. There was approximately a 0.5% percentage point difference between male and female children in each year.

Figure 13: Prevalence of DFSV by sex for each calendar year



Key Message

- Slightly more female children experienced DFSV each year, when compared to their male counterparts.

ABORIGINAL AND/OR TORRES STRAIT ISLANDER CHILDREN

Some Key Context: Aboriginal and/or Torres Strait Islander Children

When undertaking any research involving Aboriginal and/or Torres Strait Islander people and communities It is critical for researchers to ensure that the findings presented do not reinforce a deficit discourse which ignores the broader context of our communities and the history of Australia in which the research is embedded.

> "'*Deficit discourse' refers to discourse that represents people or groups in terms of deficiency – absence, lack or failure. It particularly denotes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded.*" (Fogarty et al., 2018, p. 6)

There is overwhelming evidence published by Government agencies and academics which highlight that Aboriginal and Torres Strait Islander people experience social, health and economic disadvantage at much higher rates than non-Aboriginal people in Australia. These findings are sometimes used within the media and political forums – both dominant forces in shaping discourse about these issues – in ways that re-entrench a deficit-discourse (Vaughan et al., 2015). Unfortunately, even well-meaning researchers publishing findings which compare the experiences of Aboriginal and Torres Strait Islander people with non-Indigenous people risk re-entrenching deficit-focused stereotypes. Indeed, that risk exists with this piece of research, which aims to describe an important problem within our community – namely, the proportion of children who experience DFSV.

There is little evidence about the prevalence of DFSV amongst children in South Australia or indeed anywhere within Australia. Accordingly, this research is critical, as understanding the size and shape of a problem is often the first step towards formulating evidence-informed, effective solutions. However, the risk that these findings might be used within the media and political forums in unintended ways that re-entrench deficit discourse is very real.

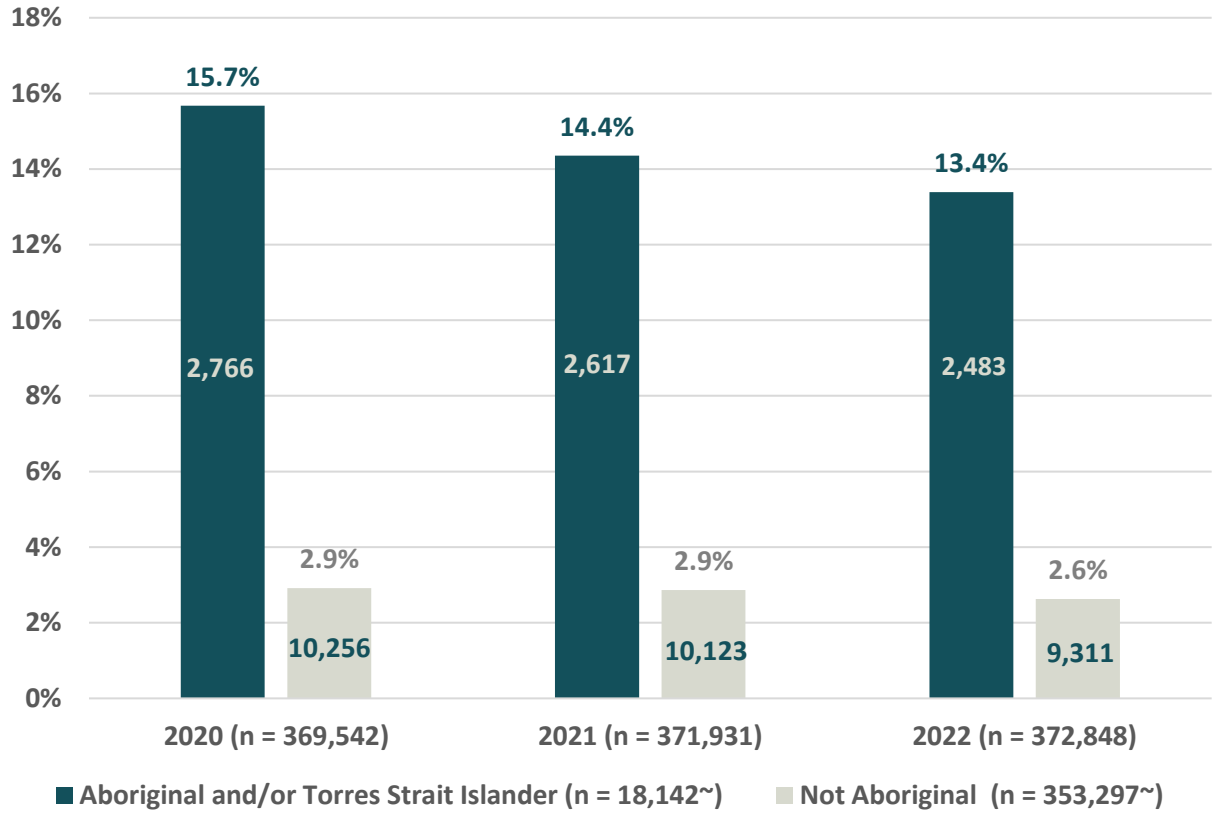
The following findings must be viewed with an understanding that they are occurring in a context of enduring impacts of colonisation, ongoing systemic racism, oppression, and systems setup to remove and assimilate Aboriginal peoples. Between 1910 and 1970 State and Federal Governments enacted policies of forced child removal based on the racist and incorrect assumption that the lives of Aboriginal people would be improved if they became part of white society. These systemic child removals resulted in what is now known as the Stolen Generations. It wasn't until 2007 when Prime Minister Kevin Rudd offered a formal apology to members of the Stolen Generations. Despite this, many recommendations from the landmark 1997 Bringing them Home report have not yet been implemented (Commonwealth of Australia, 1997).

As researchers, we recognise the strength and resilience of Aboriginal and Torres Strait Islander people and respect their right to self-determination. We are committed to working with our Aboriginal and Torres Strait Islander colleagues and communities to ensure our research achieves these aims. We have a strong commitment to social justice, whilst also ensuring evidence is produced that does not detract from the socioeconomic, health and social circumstances experienced by many Aboriginal and Torres Strait Islander people today. Thus, following consultation with the Royal Commission Aboriginal Partnership Committee we are presenting these findings as evidence to inform investment into real-world supports to enable better outcomes for Aboriginal and Torres Strait Islander people.

Experience of DFSV by Aboriginal and/or Torres Strait Islander

Figure 14 shows Aboriginal and/or Torres Strait Islander children were more likely to have experienced DFSV in any given year, with about 1 in 7 experiencing DFSV, compared to about 1 in 35 non-Aboriginal children.

Figure 14: Experience of DFSV for Aboriginal and/or Torres Strait Islander children by year



Key Message

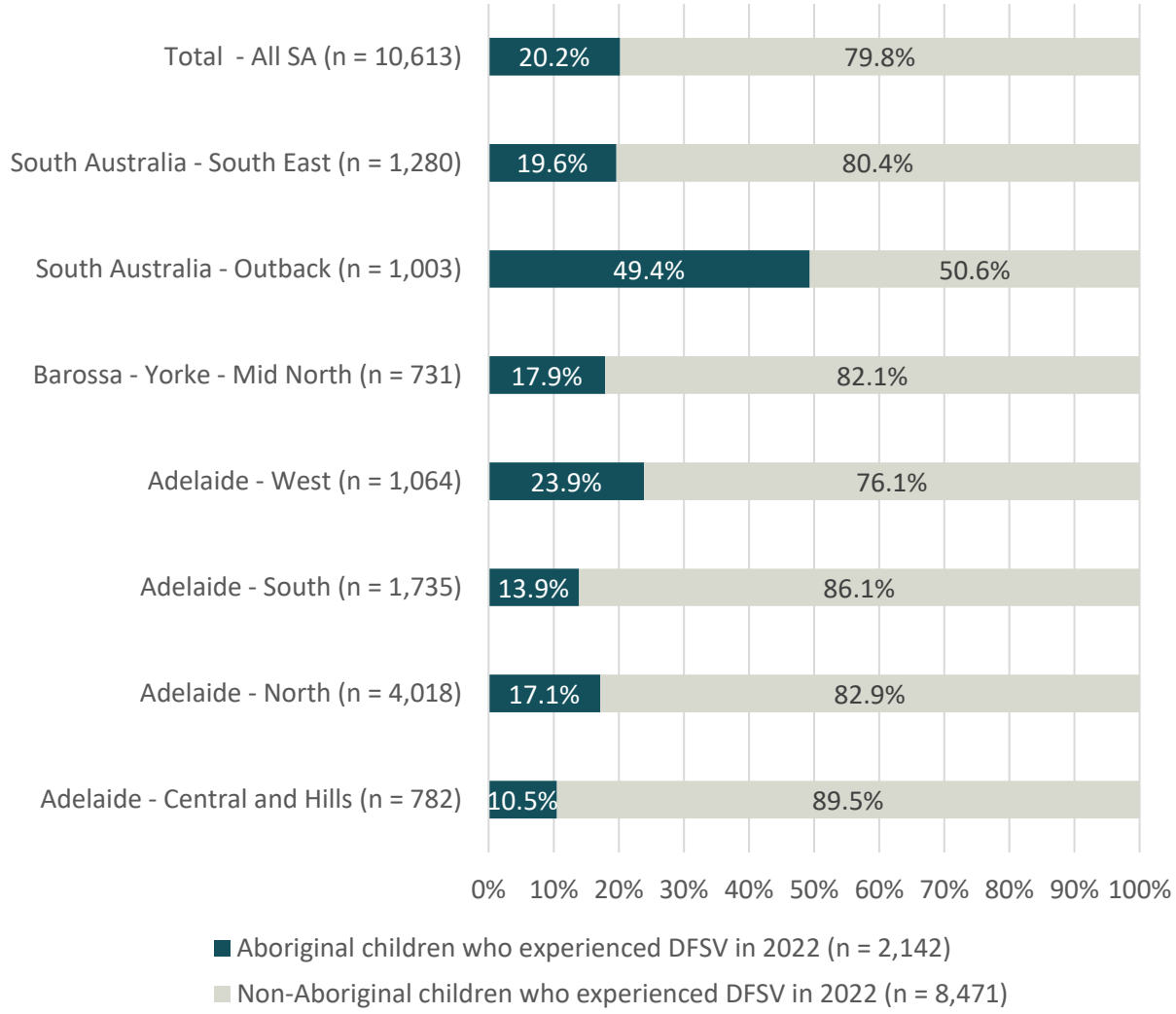
- About 1 in 7 children within each 0-17 cohort who were Aboriginal and/or Torres Strait Islander experienced DFSV each year, compared to 1 in 35 non-Aboriginal children.

Geographical location of Aboriginal and/or Torres Strait Islander children

Figure 15 shows within large state regions what proportion of children that experienced DFSV were Aboriginal and/or Torres Strait Islander.

About 1 in 5 children (20.2%) who experienced DFSV were Aboriginal and/or Torres Strait Islander. This proportion rose to 1 in 4 (23.9%) in Adelaide – West and 1 in 2 (49.4%) in SA – Outback.

Figure 15: Proportion of children who experienced DFSV who were Aboriginal and/or Torres Strait Islander by area, 2022



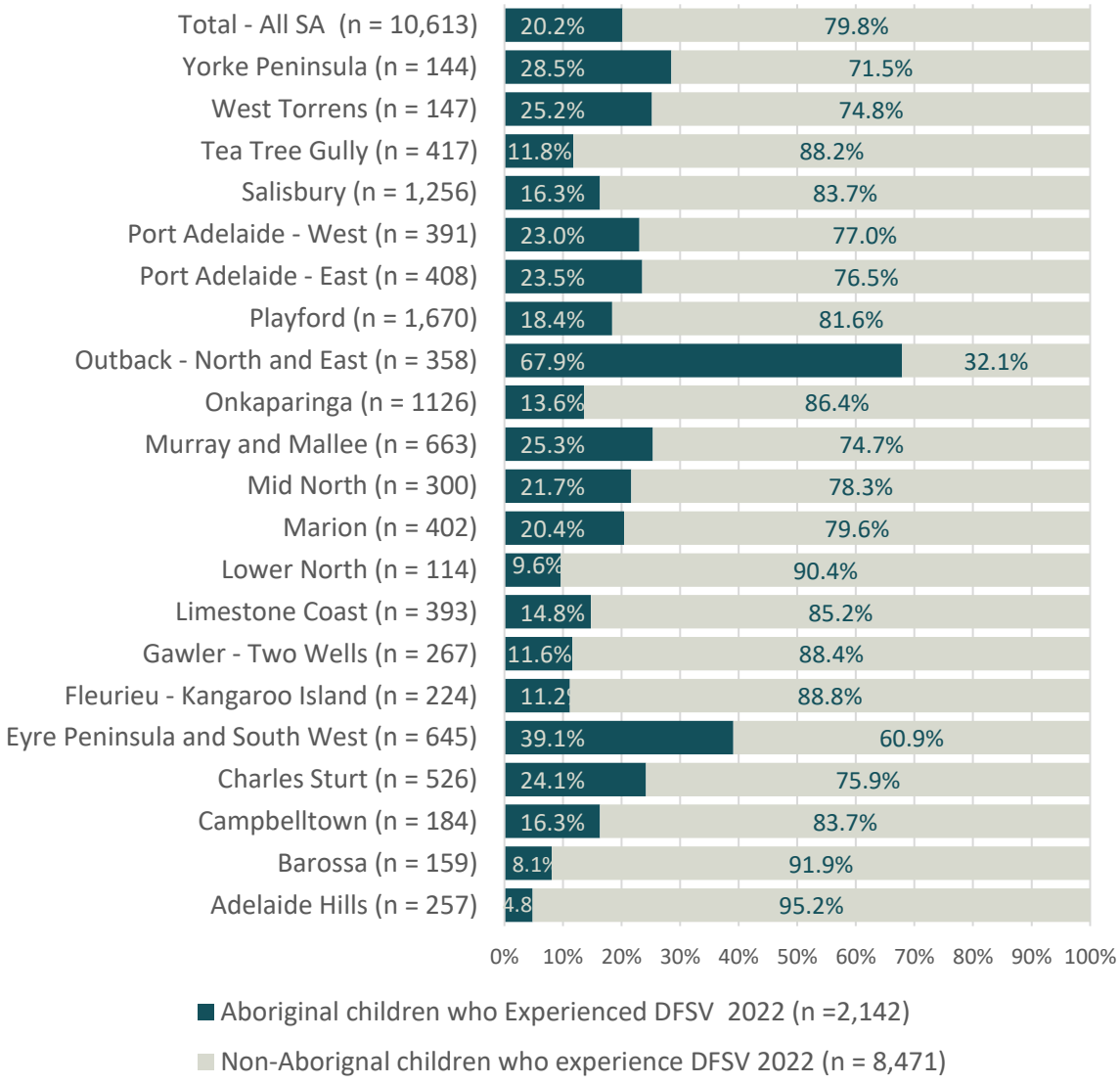
Key Message

- Overall, about 1 in 5 (20.2%) children across SA who experienced DFSV were Aboriginal and/or Torres Strait Islander.
- Aboriginal and/or Torres Strait Islander children comprised between 10.5% (Adelaide – Central & Hills) and 49.4% (SA - Outback) of children who experienced DFSV in each area.

Regional breakdown of Aboriginal and/or Torres Strait Islander children who experienced DFSV

Figure 16 shows what proportion of children who experienced DFSV were Aboriginal and/or Torres Strait Islander within each region, this ranged from 4.8% in Adelaide Hills to 67.9% in Outback – North and East. Other areas with an elevated proportion of Aboriginal and/or Torres Strait Islander children included Eyre Peninsula and South West (39.1%), Yorke Peninsula (28.5%), Murray and Mallee (25.3%), and West Torrens (25.1%).

Figure 16: Proportion of children within small region area who experienced DFSV were Aboriginal and/or Torres Strait Islander by SA3[2], 2022



Key Message:

- More than two thirds (67.9%; n = 243) of children in Outback – North & East and about 2 out of 5 (39.1%) children in the Eyre Peninsula & South West who experienced DFSV were Aboriginal or Torres Strait Islander.

[2] Some SA3 regions were omitted due to small cohort size (n<100) or cell sizes of <10. This included Adelaide City, Burnside, Holdfast Bay, Mitcham, Norwood – Payneham - St Peters, Prospect – Walkerville, and Unley.

Number of Aboriginal and/or Torres Strait Islander children who experienced DFSV by age and SA4

Table 3 provides the number and proportion of Aboriginal and/or Torres Strait Islander children who experienced DFSV in 2022 by three age categories and SA4 region. There were 795 Aboriginal and/or Torres Strait Islander children aged 0 to 4 years who experienced DFSV in 2022, 30.6% (n=243) lived in Adelaide – North and 21.9% (n=174) lived South Australia – Outback, this was similar for those aged 5 to 11 years (31.1% Adelaide- North and 23.7% South Australia – Outback) and 12 to 18 years (34.3% Adelaide- North and 24.0% South Australia – Outback).

Table 3: Aboriginal and/or Torres Strait Islander children who experienced DFSV in 2022 by age and SA4 (n = 2,142)

	Age of Aboriginal and/or Torres Strait Islander children who experienced DFSV in 2022						Total	
	0 to 4 years		5 to 11 years		12 to 18 years			
	n	Col %	n	Col %	n	Col %	n	Col %
Adelaide - Central and Hills	42	5.3	24	3.1	16	2.8	82	3.8
Adelaide - North	243	30.6	246	32.1	199	34.3	688	32.1
Adelaide - South	92	11.6	84	11.0	65	11.2	241	11.3
Adelaide - West	97	12.2	88	11.5	69	11.9	254	11.9
Barossa - Yorke - Mid North	51	6.4	45	5.9	35	6.0	131	6.1
South Australia - Outback	174	21.9	182	23.7	139	24.0	495	23.1
South Australia - South East	96	12.1	98	12.8	57	9.8	251	11.7
Total Aboriginal and/or Torres Strait Islander children who experienced DFSV in 2022	**795**	**100.0**	**767**	**100.0**	**580**	**100.0**	**2,142**	**100.0**

Key Message

- More than 1 in 2 Aboriginal and/or Torres Strait Islander children aged 0 to 4, 5 to 11 years and 12 to 18 years who experienced DFSV lived in either Adelaide – North or South Australia – Outback

Limitations

There is evidence that DFSV is often not reported to authorities[3] by victim-survivors for a range of reasons, including fear of the perpetrator, shame, lack of social support, isolation, dependency, and economic pressures (Australian Bureau of Statistics, 2016). Where the primary victim is a child, reporting becomes even more contingent on having strong familial and/or social supports (Campbell et al., 2024). Therefore, it is integral to acknowledge at the outset that under-reporting of DFSV means that any attempts to estimate the prevalence using administrative data will always generate very conservative estimates. However, this analysis more specifically is further limited by the lack of police administrative data – a key measure of reported incidents of DFSV. Lastly, by focusing on children, DFSV experienced by adults with no children cannot be included in the prevalence estimate.

Currently our ability to use whole population (or whole-system) data to construct a view of DFV relies primarily on using child protection, homelessness (includes the DFV Alliance), and hospitalisations. We know this results in a considerable under-estimate of the experience of DFV, and there is very limited view of victims and perpetrators. To support the creation of whole-system data and the evidence to underpin appropriate resourcing for a comprehensive DFV response spanning early support to crisis services, we need to

1) partner with SAPOL to join their data with other government data and
2) build out the BEBOLD platform to include more birth cohorts so we observe the whole population of SA up to age 65.

Eventually, the whole-population data platform could be used to quantify the experience of DFV, the reach of services into populations experiencing DFV, the impact of service involvement and the identification of service gaps. Ideally, this would be one part of rapid feedback loops helping services engage in a quality improvement cycle that results in better outcomes for communities across South Australia.

[3] The 2016 Personal Safety Survey reported that 69% of men and women who experienced physical assault by a male did not report the most recent incident to police

Key Learnings

The key takeaways from this research include:

- About 1 in 30 (n = 12,518~) South Australian children experienced DFSV at least once each year in 2020, 2021 and 2022.
- This figure rises to approximately 1 in 18 for children living in Outback SA
- Aboriginal and Torres Strait Islander children experienced DFSV at much higher levels than non-Aboriginal children, with about 1 in 7 experiencing at least one indicator of DFSV each year.
- About one third of all children who experienced DFSV each year were located in Adelaide's North (n = 4,214~), more than in all of the other areas of Adelaide combined
- Children aged in their mid-teens and females experienced DFSV at slightly elevated levels
- The data we used are likely to under-estimate the prevalence of DFSV in SA

Opportunities to improve knowledge of DFSV in SA

1. **Expand the BEBOLD platform to encompass a broader population and integrate data sources with more DFSV-relevant information:**
    a. Build the platform to include DFSV-related data held by key government agencies, such as SAPOL
    b. Explore opportunities to integrate DFSV-relevant date held by NGO's and ACCO's
    c. Improve the capacity and capability of agencies / organisations to collect and record information about DFSV more consistently
    d. Expand the BEBOLD platform to include the whole population of SA (not just children, young people and families)

2. **Utilise whole-of-population linked data to inform service design, implementation and to monitor outcomes:**
    a. Better identify service gaps through improved identification and visibility of sub-populations and communities at greater risk of experiencing DFSV
    b. Provide a rapid feedback loop of evidence to help service providers develop a quality improvement cycle

3. **Increase knowledge sharing and support Indigenous Data Sovereignty by working closely with Aboriginal and Torres Strait Islander people to access, analyse and act on data which relate to their people and communities.**
    a. Increase Aboriginal and Torres Strait Islanders peoples' capacity and capability to meaningfully engage with data that affect them
    b. Work in genuine partnership to use data to develop evidence-informed solutions which are culturally relevant and responsive

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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. Research conducted by BetterStart aims to understand how to give infants, children, young people and families the best start to life and to focus on ways to enhance health and development over the lifespan.

Contact us

For further information, please visit our website:

- health.adelaide.edu.au/betterstart/research/

See our latest information pack:

BetterStart and the BEBOLD platform

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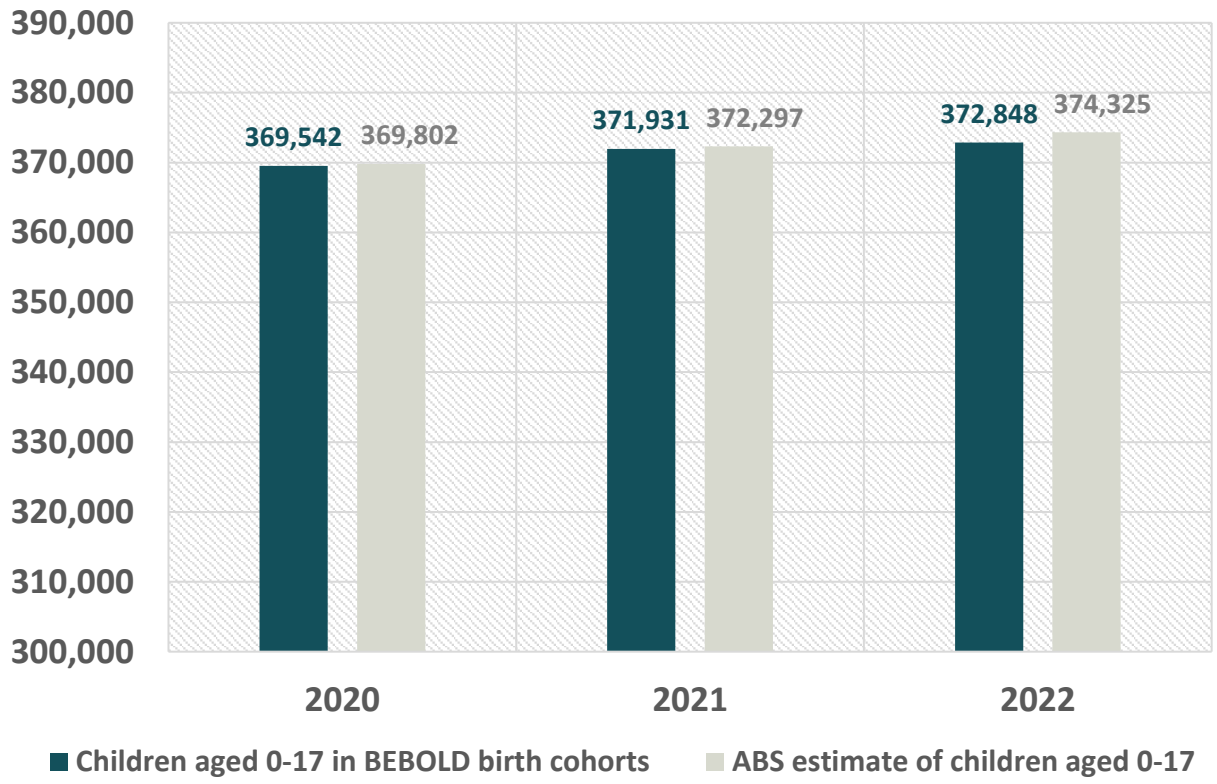
Appendix A: Comparing study population numbers to the estimated resident population

The study population to estimate the annual prevalence of DFSV for children aged 0 to 17 was restricted to those with a birth registration in South Australia due to requiring indicators on parents, as in BEBOLD parents are identified via birth registrations. To understand the number of children and young included in this analysis represent the South Australian children and young people we compared the number of children in the BEBOLD birth cohorts with population estimates published by the Australian Bureau of Statistics (ABS) for people aged 0 to 17 years old in each calendar year.

Figure 17 shows the number of children aged 0 to 17 years old in each calendar year from BEBOLD compared to the ASB estimated resident population for 0 to 17-year-old in South Australia for 2020, 2021 and 2022. There was less than 0.1% difference for 2020 and 2021, and 0.4% for 2022. The similarity between the size of the BEBOLD birth cohort and ABS population estimates should serve to increase confidence that conclusions drawn from the data are relevant and applicable to the whole SA population of children aged 0 to 17.

Figure 17: BEBOLD annual cohorts vs ABS population estimates



Key Message

- Overall, these checks on the population-level characteristics established that the number of children identified in the BEBOLD birth cohorts closely accords with ABS population estimates.

Appendix B: Investigating demographic compositional changes over time

To investigate any demographic characteristics changes over time for the study population in 2020, 2021 and 2022 we compared the age, sex and area level advantage and disadvantage for each to the study populations in each calendar year.

Figure 18 shows the age profiles of the children and young people included in each calendar year to determine whether there was any significant variability. There was very little variability across cohorts by age, with a similar proportion of children making up each year of age.

Figure 18: Annual cohort by age as at 30th June each year

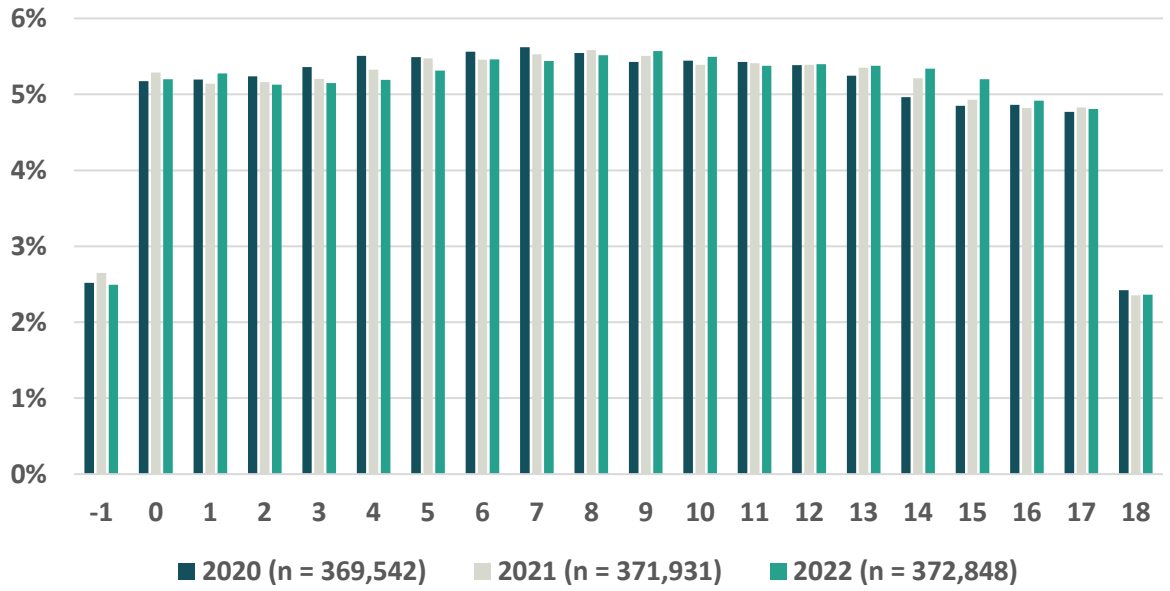


Figure 19 compares the sex of children and young people included in each calendar year, finding almost no variability at all across the 3 cohorts.

Figure 19: Annual cohort by sex

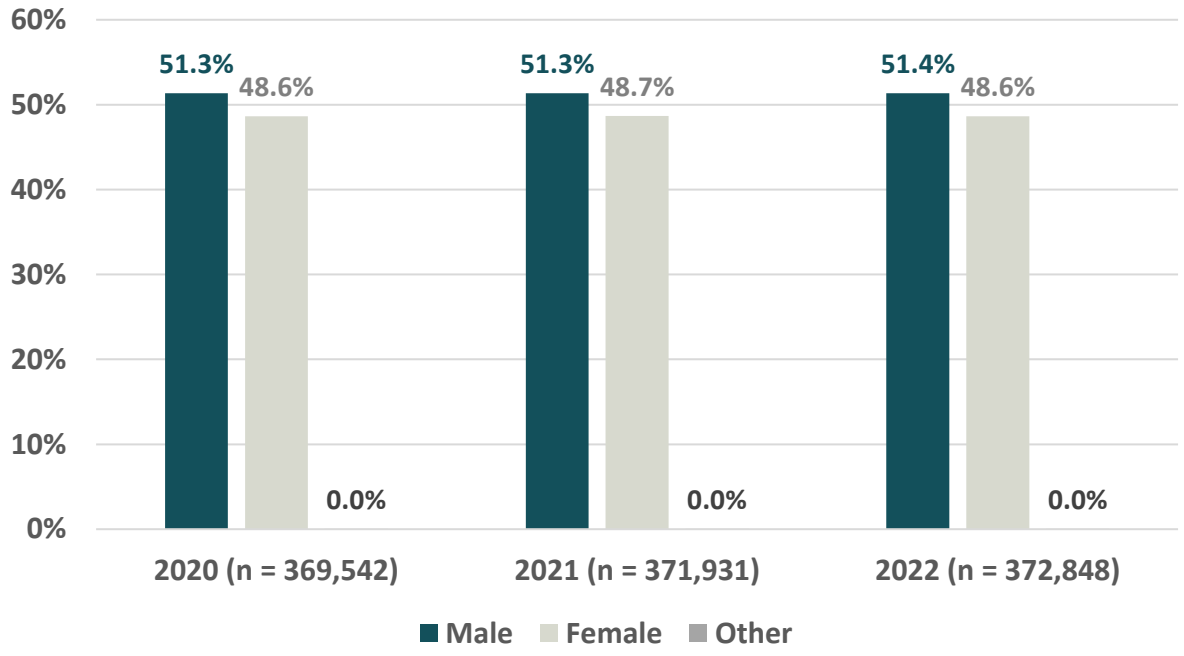
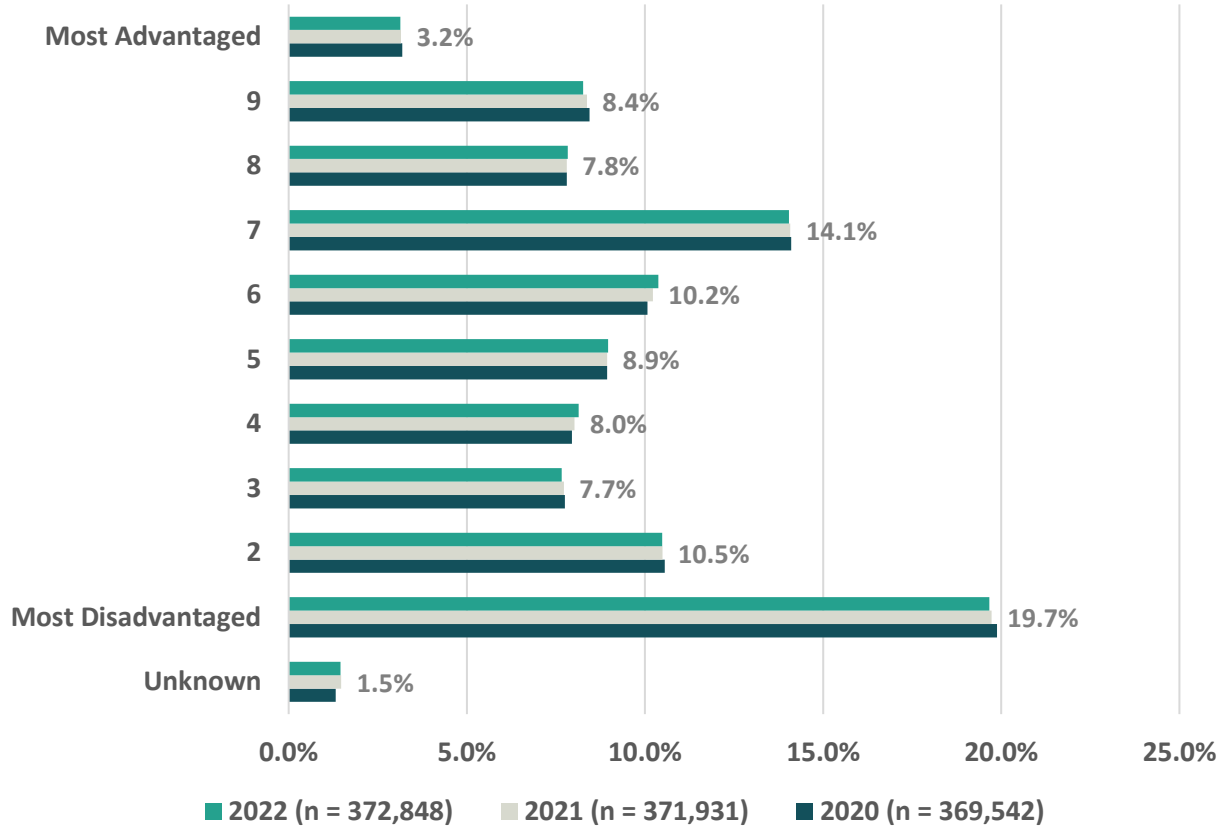


Figure 20 compared the proportion of children in each cohort by the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) based on the area their parents lived in at the time of their birth. There largest difference in proportions across any IRSAD decile was 0.2%.

Figure 20: Annual cohort by IRSAD 2021 Category at time of birth



Key Message

- There was very little variability over time in key demographic features including sex, age and social disadvantage.

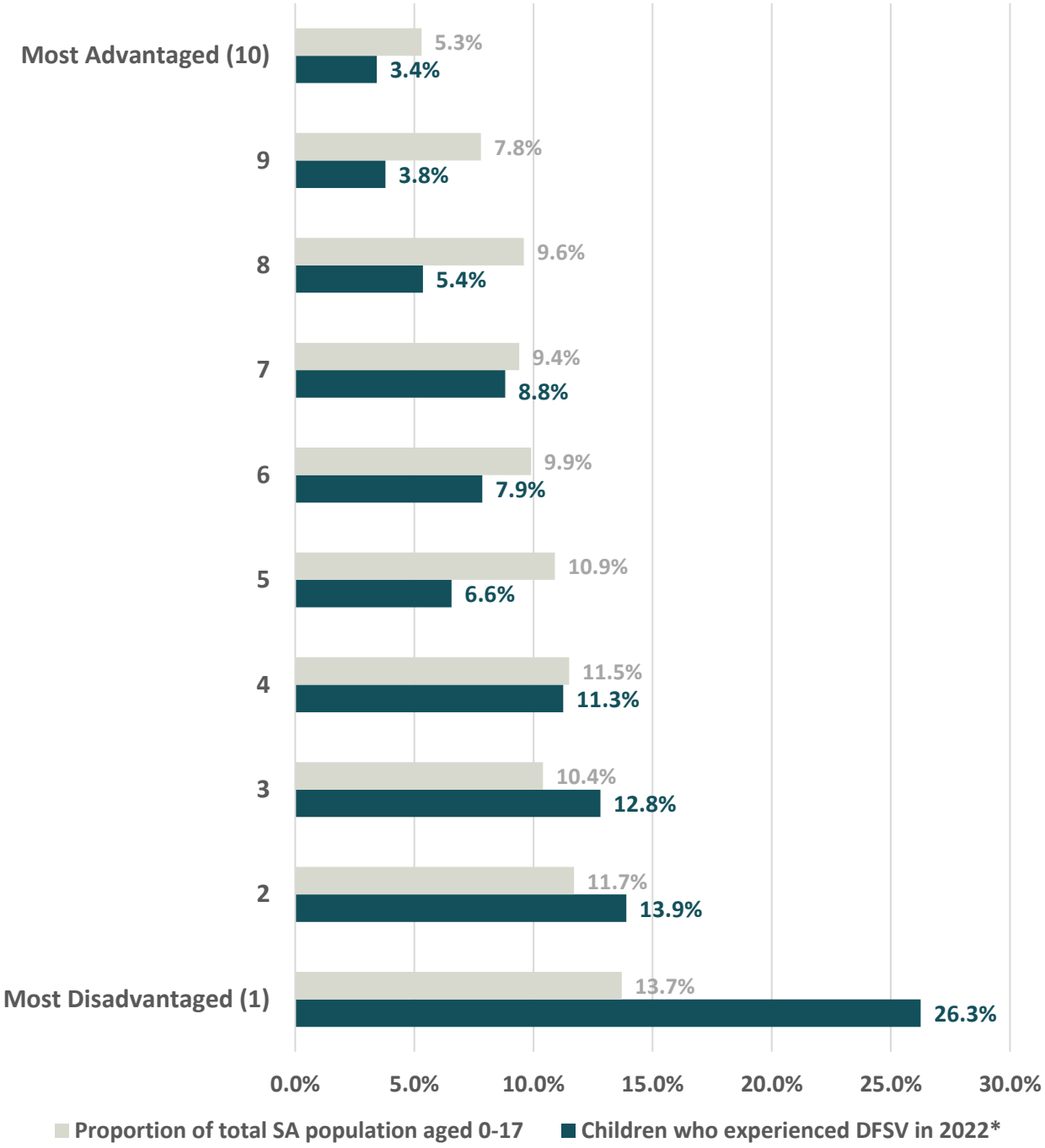
Appendix C: Other Supplementary Analyses

The below figure shows geographic distribution of the "risk" of a child experiencing DFSV. For example, approximately 1 in 18 children who live in the Outback region in 2022 experienced DFSV. In absolute terms this equates to about one child per classroom.

Figure 21: Population prevalence of DFSV by SA4 region

Children who experienced DFSV in 2022 were about twice as likely to live in the most disadvantaged areas (26.3% vs 13.4%). Children who experienced DFSV were over-represented in more disadvantaged areas and under-represented in more advantaged areas.

Figure 22: Experience of DFSV by IRSAD 2021 Decile*



*Of n = 10,558 children who experienced DFSV and who had a known location

Figure 23: Number of children within small region area who experienced DFSV were Non-Aboriginal by SA3, 2022

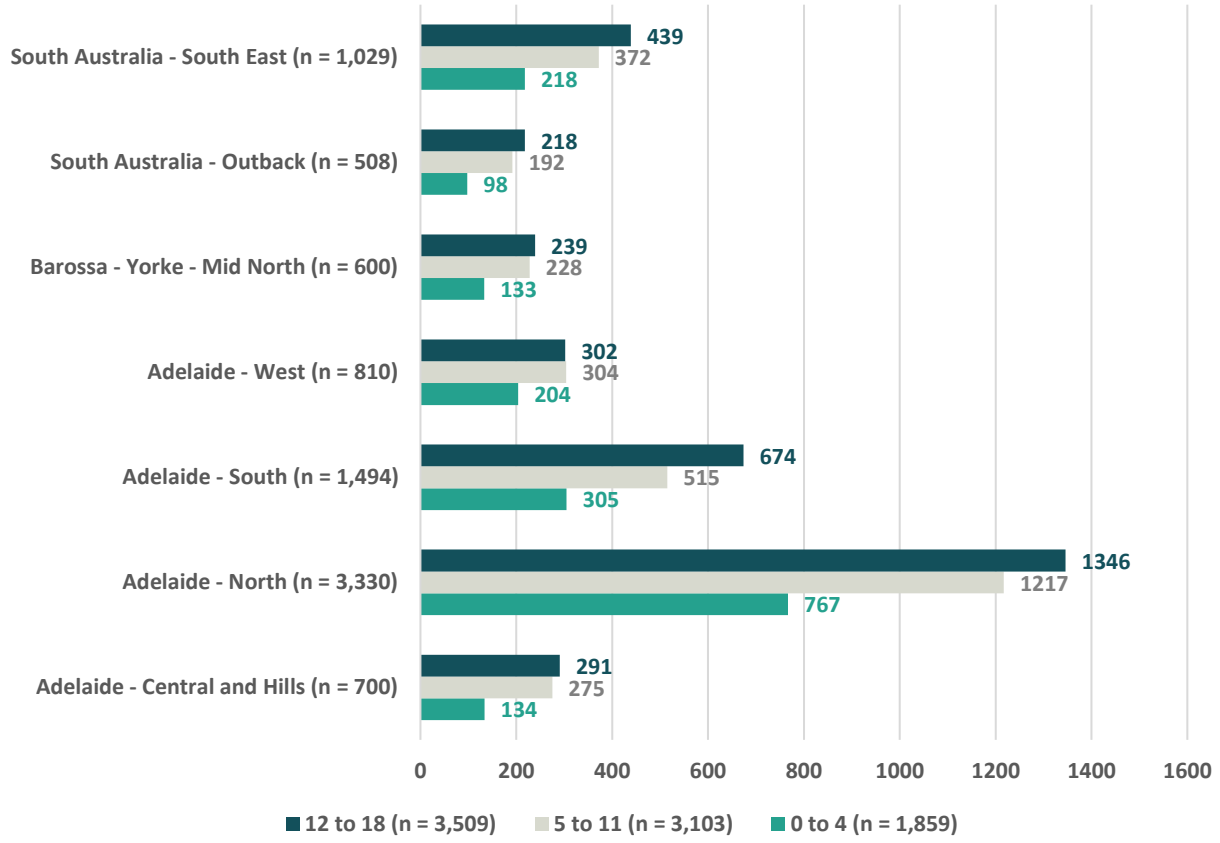
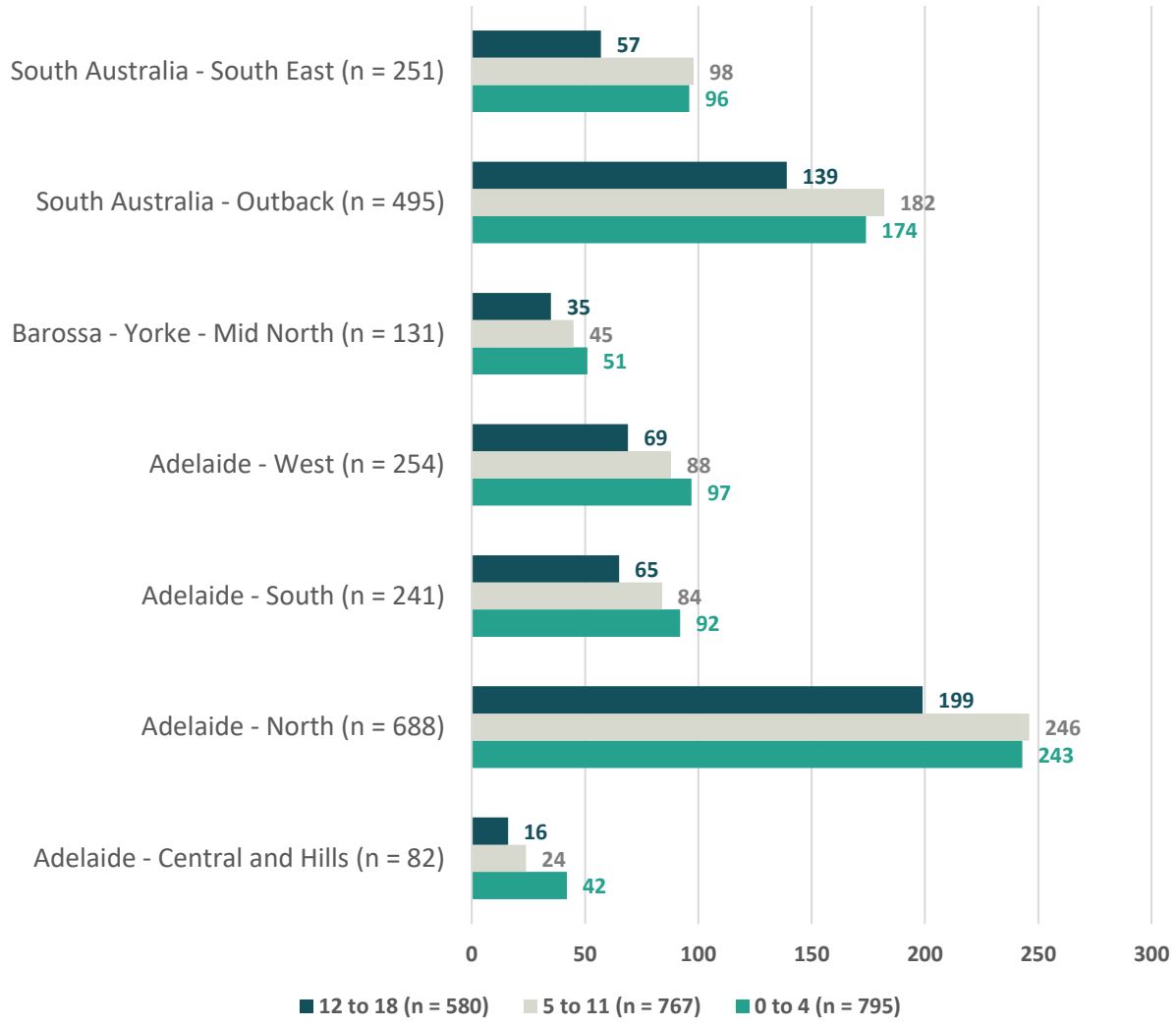


Figure 24: Proportion of children within small region area who experienced DFSV were Aboriginal and/or Torres Strait Islander by SA3, 2022



Appendix D: Detailed descriptions of data indicators of DFSV

Appendix Table 1: Detailed descriptions of data indicators of DFSV

Indicator of DFSV	Data sources	Child / Parent	How it is measured	Descriptors	Relevant Numeric Code in File	Specific Coding	General Coding
Child Protection	DCP - Notifications (2024 file)	Child specific experience of DFSV	Any description of a screened-in notification to DCP which is likely to be indicative of DFSV which appears in the primary alleged grounds of a notification with an intake date in 2020, 2021 or 2022	Domestic violence	9	DFV in title	DFV present in Notification
				Significant risk of emotional abuse - domestic violence	16	DFV in title	
				Significant risk of neglect - domestic violence	35	DFV in title	
				Significant risk of physical abuse - domestic violence	52	DFV in title	
				Injury resulting from domestic violence incident	49	DFV in title	
				Physical Abuse	50	Physical harm	
				Violent behaviour directed toward child	64	Physical harm	
				Excessive discipline/other violent behaviour directed towards child	48	Physical harm	
				Alleged serious inflicted injury	45	Physical harm	
				Alleged other inflicted injury	46	Physical harm	
				Female genital mutilation	65	Physical harm	
				Threats to kill / injure child	62	Other harm	
				Dangerous behaviour involving child	47	Other harm	
				Emotional Abuse	10	Other harm	
				Likelihood of sexual harm	66	Sexual harm	
				Sexual Abuse	67	Sexual harm	
				Sexual act or exploitation	68	Sexual harm	
				Significant risk of sexual abuse	69	Sexual harm	

				Suspicious indicators consistent with sexual abuse Suspicious indicators consistent with sexual harm	70 71	Sexual harm Sexual harm	
Hospital admission	Hospital inpatient data	Child and Parent experience of DFSV	A hospital admission in 2020, 2021 or 2022 where the external cause was an assault of some sort, and the perpetrator was a spouse or family member	Family and domestic violence hospitalised cases are those that have: • an injury principal diagnosis in the ICD-10-AM code range S00–T75, T79. • a first recorded external causes of morbidity and mortality ICD-10-AM code in the range X85 – Y09 (Assault), • and a perpetrator coded as spouse or domestic partner, Parent, or Other family member (5th character codes of 0,1,2 respectively).	T85 - Y09	Perpetrator codes 0, 1 & 2	DFSV-assault related hospital admission
Homelessness	H2H data - Service Episodes	Child and Parent experience of DFSV	A service episode during 2020, 2021 or 2022 where the child or parent presented to a DFV Alliance and/or had a main presenting need identified as domestic violence	Homelessness service episodes that were considered to be indicative of a child or parent of a child experiencing DFSV were: - the parent or child (or both) presented to a DFV Alliance service for a service episode for any reason - the parent or child (or both) presented at any homelessness service and the main presenting issue was identified as relating to domestic, family or sexual violence	21 34 35 59	Domestic and family violence Intervention / restraining orders - partner Intervention / restraining orders - self Sexual abuse	DFV was main issue

Appendix E: Department for Correctional services data indicators of DFSV – yet to be analysed

Appendix Table 2: Department for Correctional Service data indicators of DFSV

Not yet included				
Adult imprisonment and/or court order for DFV offence	An order or imprisonment episode which commenced in 2020, 2021 or 2022 and included at least one prescribed DFSV. A prescribed DFSV offence included the following offences: • Aggravated Assault Against Child or Spouse • Contravene Term of an Intervention Order (Other than Programs) • Choke, Strangle or Suffocate in a Domestic Setting • Other harm causing assaultive offences where the victim was identified (through law part number) as a child or spouse	Department for Correctional Services	Parent	Sexual offences were not included in the count of DFSV indicators as it is not possible to determine the perpetrator-victim relationship. N.B. Imprisonment episodes and orders involving a sexual offence comprised approximately 3.3% of all imprisonment episodes.