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200 Hoddle Street
Abbotsford VIC 3067
(Registered Office)
P 61 3 9865 6700
F 61 3 9826 2700
Toll Free 1800 134 840

1 / 122 Carrington Street
Adelaide SA 5000
(South Australian Office)
P 61 8 7078 4128
Toll Free 1800 134 840

Positive Living Centre
51 Commercial Road
South Yarra VIC 3141
P 61 3 9863 0444
F 61 3 9820 3166
Toll Free 1800 622 795

Centre Clinic
3A / 79-81 Fitzroy Street
St Kilda VIC 3182
P 61 3 9525 5866
F 61 3 9525 3673

PRONTO! / Equinox
200 Hoddle Street
Abbotsford VIC 3067
P 61 3 9416 2889

SAMESH
57 Hyde Street
Adelaide SA 5000
P 61 8 7099 5300

Thorne Harbour Country
58 Mundy Street
Bendigo VIC 3550
P 61 3 4400 9000

thorneharbour.org

Thorne Harbour Health Ltd.
ABN: 52 907 644 835
ACN: 606 806 204

VAC/GMHC Ltd
ABN: 87 652 472 253
ACN: 662 163 484

Natasha Stott Despoja AO
Royal Commissioner
Royal Commission into Domestic, Family and Sexual Violence
via email: RoyalCommissionDFSV@sa.gov.au

Dear Royal Commissioner

Re: LGBTIQ+ conversion practices as a form of family violence

Thorne Harbour Health has welcomed the opportunity to make a submission to the Royal Commission, highlighting the unique impacts of domestic, family and sexual violence on LGBTIQ+ South Australians. We are also heartened by the recent, long-awaited progress toward banning conversion practices in South Australia that continue to cause life-long harm to many LGBTIQ+ people.

In our submission to the Royal Commission, we identified conversion practices as a form of family violence that uniquely affects LGBTIQ+ people, which are practices that intend to change or make someone hide their sexual orientation, gender identity or gender expression.

As a community we are all too familiar with this violence. Having formed in response to HIV in 1983, many of our staff, volunteers, clients and community members we have supported over the years have experienced these devastating practices. In the South Australian Parliament recently, we again heard personal stories of the often immense trauma conversion practices has on the lives of LGBTIQ+ South Australians.

The Royal Commission presents a vital opportunity to make recommendations relevant to the prohibition of conversion practices. Subjecting any family member to conversion practices is a form of emotional and psychological abuse. Reforms to South Australia's DFSV system should include funding of necessary supports to LGBTIQ+ victim-survivors of conversion practices and developing mechanisms to prevent and respond to this form of family violence.

In Victoria, with the prohibition of conversion practices in 2021, the Family Violence Protection Act was amended to make conversion practices a form of family violence, recognising the role family members often play in initiating and perpetuating these harmful practices. Thorne Harbour Health worked closely with the Brave Network and SOGICE Survivors, as well as the Victorian Government in this reform process, and we continue to advocate for and support our community heal from this violence.

In South Australia, Thorne Harbour Health currently provide Specialist Mental Health Services and Specialist AOD Services, this comorbidity model of best practice provides a holistic, affirming and client-centred approach. An evaluation of Thorne Harbour Health SA's Alcohol and Other Drugs Treatment Service client data from 2021 – 2024 indicates that 64% of all LGBTIQ+ clients have experienced family or intimate partner violence at some stage throughout their lives, including 44% of clients currently experiencing violence. Of those 64% of clients, 67% reported being a victim/survivor of intimate partner violence and

60% reported being a victim/survivor of family violence. 67% of victim/survivors reported experiencing physical abuse, 80% reported psychological/emotional abuse and 44% reported sexual abuse.

Thorne Harbour Health South Australia is committed to serving LGBTQIA+ South Australians and are responsive to our community's needs. We welcome the opportunity to collaborate and find outcomes for the safety and well-being of South Australians.

Yours sincerely

A handwritten signature in grey ink, appearing to read 'Rebecca Ellis', with a small mark to the right.

Rebecca Ellis
Director, South Australia

thorneharbour health*

Submission to the South Australian Royal Commission
into Domestic, Family and Sexual Violence

16 August 2024



Acknowledgment of Country

Thorne Harbour Health acknowledges all Aboriginal people across South Australia, who are the Traditional Custodians of the land and waters and the oldest continuous living culture on Earth. We pay our respects to Elders past and present. We acknowledge that sovereignty was never ceded, and this was and always will be Aboriginal land.

About Thorne Harbour Health

Thorne Harbour Health (THH) is one of Australia's largest LGBTQIA+ community-controlled organisations. Operating since 1983, THH supports people of diverse sexualities and genders, as well as all people living with and affected by HIV, operating in South Australia and Victoria, but also leading on national projects.

THH has extensive experience in Victoria providing domestic, family and sexual violence supports to LGBTQIA+ people who are experiencing or have experienced violence. THH also runs a 20-week accredited behaviour change program for gay, bisexual, queer and trans men who use violence. THH's co-located alcohol and other drug (AOD) and general counselling services, which also operate in South Australia, provide holistic, wrap-around supports.

THH has over 40 years of experience delivering community driven health promotion across HIV, sexual health, alcohol and drug use, and family violence, including its Safe Always campaign. As an LGBTQIA+ community-controlled health service, its approach to everything that it does – *by community, for community* – ensures services are culturally safe, contextually appropriate, and trusted by the people who need them.

Contact

Ms Rebecca Ellis (she/her)
Director, South Australia



Language used in this submission

Terminology in queer communities is complex, dynamic and ever evolving. LGBTQIA+ is used to refer to lesbian, gay, bisexual, trans and gender diverse, intersex, queer, asexual, and people otherwise diverse in gender, sexual orientation and/or innate variations of sex characteristics. It is the acronym used by this Royal Commission - however there are many other terms that people use to describe their experiences and identities, which can change across contexts and lifetimes. In Australia, sistergirl and brotherboy are terms often used by trans and gender diverse Aboriginal people.

Variations of the acronym will be used throughout this submission when referring to a particular subpopulation(s), or when citing research or data sources limited to particular groups.

It is also important to acknowledge that we talk about LGBTQIA+ communities, plural. While discussing, celebrating and advocating for LGBTQIA+ people together provide useful insights, it can conceal diversity across these communities. When we look at domestic, family and sexual violence, there are risk factors, experiences, support needs, and existing barriers that differ across the diversity of sexual and gender identities within LGBTQIA+ communities.

People living with HIV (PLHIV) have, and continue to be, subject to stigma and discrimination as a result of their serostatus. Language can exacerbate or ameliorate this stigma. We always speak of a person/people living with HIV to centre their humanity, rather than the virus. It is also fundamental to distinguish between HIV (a virus), and AIDS (a range of conditions). When speaking of both, we refer to HIV & AIDS, rather than HIV/AIDS.¹

This submission uses the language of 'person who uses violence', 'user of violence' or 'adult using violence' rather than stigmatising language such as 'perpetrator'. Where appropriate, we use language used by police such as 'respondent', 'affected family member', and 'predominant aggressor'. It is best to avoid gendered language often used by mainstream services such as 'women's program' and 'men's program', which is exclusive of trans and gender diverse people.

The term "community-controlled organisations" is used to refer to organisations that are initiated by, governed by, operated by and accountable to their communities. They are based within their communities and deliver safe services that empower their communities.

Executive Summary

Thorne Harbour Health (THH) welcomes the opportunity to make a submission to the South Australian Royal Commission into Domestic, Family and Sexual Violence.

LGBTQIA+ people experience domestic, family and sexual violence (DFSV) as the same, if not higher rates, compared to heterosexual and cisgender people. However, these experiences are often made invisible by heteronormative and cisnormative assumptions regarding who is affected by DFSV, and what this violence looks like. As a result, significant barriers exist for LGBTQIA+ victim-survivors in accessing appropriate supports and reporting violence. Systemic problems, such as misidentification of the predominant aggressor, poor data collection and information sharing disproportionately affect LGBTQIA+ South Australians.

To address these inequities affecting LGBTQIA+ South Australians, structural changes – and a clear strategy for implementation – are needed. Long-term (5-10 years) sustainable, core funding for South Australian-based LGBTQIA+ community-controlled organisations are required to deliver a range of LGBTQIA+-specific domestic, family and sexual violence work, that is consistent, reliable and can sustain positive change. This will address barriers LGBTQIA+ people face in accessing support, improve cultural appropriateness of services, and centre the unique needs of LGBTQIA+ victim-survivors.

This submission makes a number of recommendations regarding:

- Better supporting LGBTQIA+ victim-survivors of DFSV.
- Building the capacity of the mainstream domestic, family and sexual violence sector to better support LGBTQIA+ South Australians.
- Improving criminal justice responses to DFSV.
- Working with Government.
- Improving data systems and information sharing for improved DFSV responses.
- Reforming discriminatory legislation and practices that act as drivers of LGBTQIA+ DFSV.
- Improving research and the evidence based surrounding LGBTQIA+ DFSV.

In reading the Royal Commission's Issues Paper, the following submission responds to questions:

1. What causes domestic, family and sexual violence?
2. What works, or will work, to prevent domestic, family and sexual violence?
4. What systems, including systems outside of government, receive information which may allow for the identification of individuals who are at risk of experiencing or perpetrating domestic, family and sexual violence?
5. What is needed to allow for this information to be used by government and specialist domestic, family and sexual violence services?
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?
7. What are the barriers to reporting domestic, family and sexual violence to police or seeking support from domestic, family and sexual violence services?

8. What are the elements of a best practice crisis response which will meet the needs of:
 - a. A victim-survivor?
 - b. A victim-survivor who is a child?
 - c. A perpetrator (acknowledging that one need is to hold a perpetrator to account for their use of violence?)
9. What are the elements of a best practice health response?
10. What are the elements of a best practice police response?
11. What are the elements of a best practice justice system response?
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?

Summary of recommendations

Supporting LGBTQIA+ victim-survivors

- Fund LGBTQIA+ community-controlled organisations to deliver LGBTQIA+-specific domestic, family and sexual violence work. There is currently no LGBTQIA+ community-controlled organisation in South Australia funded to do this essential work. This work should include:
 - Services to support victim-survivors of domestic, family and sexual violence, including family of origin violence.
 - Co-location of DFSV services with alcohol and other drug (AOD) and mental health services.
 - Brokerage programs to support people leaving and establishing themselves after violence relationships.
 - Programs targeting LGBTQIA+ people who use violence.
 - LGBTQIA+ training and capacity building of mainstream services.
 - LGBTQIA+ community awareness raising initiatives.
- Adopt long-term (5-10 years) sustainable funding arrangements to ensure service and support continuity for LGBTQIA+ South Australians affected by domestic, family and sexual violence.

Building the capacity of the mainstream DFSV sector

- Build sector-capacity to ensure refuge access for LGBTQIA+ South Australians.
- Develop a partnerships framework between LGBTQIA+ community-controlled organisations and mainstream domestic, family and sexual violence services.
- Embed more LGBTQIA+ family violence specialists in mainstream services and strengthen relationships with, and client pathways to, specialist LGBTQIA+ services.

Criminal justice responses

- Ensure training of South Australia Police to better understand, identify and appropriately respond to LGBTQIA+ domestic, family and sexual violence.
- Ensure all judges and prosecutors involved in the hearing of family violence cases are provided with training in the specific issues relevant to domestic, family and sexual violence affecting LGBTQIA+ people, and the structural underpinnings of it.
- Recognise technology facilitated abuse (TFA), including dating app facilitated sexual violence (DAFSV), as forms of domestic, family and sexual violence, and its disproportionate impact on LGBTQIA+ people.

Working with government

- Convene a state-based LGBTQIA+ expert advisory group to support the South Australian Government implement its strategy to end domestic, family and sexual violence, and to give ongoing advice to the South Australian Government and the DFSV sector more broadly.

Data systems and information

- Ensure all agencies and services responding to domestic, family and sexual violence apply data standards relating to diversity of gender, sexual orientation and sex characteristics.
- Ensure all specialist domestic, family and sexual violence services have direct access to a central information point to support more informed and timely responses to DFSV.
- Develop an accessible, effective, and responsive mechanism to rectify misidentification of the predominant aggressor across relevant data systems.

Discriminatory legislation and practices

- Reform stigmatising and discriminatory legislation and practices that drive LGBTQIA+ and HIV domestic, family and sexual violence including:
 - Prohibiting discrimination on the basis of sexual orientation and gender in faith-based schools.
 - Prohibiting conversion practices.
 - Prohibiting medically unnecessary deferrable medical interventions on intersex minors.
 - Decriminalising sex work.
 - Prohibiting mandatory disease testing of people whose bodily fluids come into contact with police.

Research

- Fund research in LGBTQIA+ domestic, family and sexual violence.
- Fund evaluations of LGBTQIA+ domestic, family and sexual violence services to develop greater evidence of best practice.

Background

LGBTQIA+ and PLHIV communities in South Australia

South Australia's LGBTQIA+ population is significant. LGBTQIA+ make up 7.2 to 10 percent of the population², and this proportion is even higher among younger people.³ One recent US study found 28 percent of Gen Z adults (ages 18-25) identify as LGBTQ+.⁴

At the end of 2022, there were 28,870 people living with HIV (PLHIV) in Australia. Of the 555 new diagnoses in 2022, 22 were in South Australia. There were a further 21 notifications of HIV in South Australia that had already diagnosed overseas.⁵

Domestic, family and sexual violence in LGBTQIA+ communities

Domestic, family and sexual violence (DFSV) has devastating impacts. The World Health Organization estimates that one in three women worldwide has experienced physical and/or sexual violence, most often from an intimate partner.⁶ A dominant narrative of such data suggests that DFSV is something that primarily involves male users of violence and female victim-survivors and their children. This narrative has been crucial in raising awareness in recent decades about the devastating effects of DFSV, however it is not the whole story. The underlying assumptions about who uses and experiences violence can render LGBTQIA+ people invisible in policy frameworks, service delivery and legal responses.⁷ This dominant framing of DFSV further diminishes the ability of some within LGBTQ+ communities to recognise their own experiences of violence.⁸

Findings from both global and national research suggest the same, if not higher rates of DFSV among people who identify as LGBQ compared to non-LGBQ people,⁹ as well as higher rates of family violence among trans and gender diverse (TGD) people compared to their cisgender peers.¹⁰ Research looking at experiences of bisexual people has mostly investigated the experiences of bisexual women, finding higher rates compared to lesbian-identified and heterosexual women.¹¹

Experiences of family violence are compounded by experiences of abuse and violence in public spaces, educational settings and work places, impacting LGBTQ people in all areas and at all stages of their lives.¹²

There is little South Australia-specific data with regard to LGBTQIA+ health and wellbeing generally, and DFSV in particular. However, several key national studies¹³ highlight prevalence of DFSV within LGBTQIA+ communities, much of it summarised below from *Rainbow Realities*.¹⁴

- 41.7 percent of LGBTQIA+ adults reported that they had ever been in an intimate relationship in which they felt they were abused by their partner/s, and 60.7 percent reported experiences indicative of IPV.¹⁵
- 48.2 percent of LGBQ+ women reported having experienced intimate partner violence in their lifetime.¹⁶

- 24.8 percent of trans and gender diverse young people reported having experienced physical abuse within the family, 7.5 percent had ever experience familial sexual abuse, and 57.9 percent reported having ever experienced other forms of familial abuse (verbal, emotional or neglect).¹⁷
- 30.9 percent of trans and gender diverse young people reported having ever experienced abuse within an intimate relationship.¹⁸
- 38.5 percent of LGBTQA+ people stated they had ever been abused by a family member, and 64.9 percent reported experiences indicative of abuse from a family member.¹⁹
- Verbal abuse (41.5 percent) was the most commonly reported form of violence from a family member, followed by LGBTQA+ related abuse (40.8 percent), emotional abuse (39.3 percent), physical violence (24.2 percent) and sexual assault (9.7 percent).²⁰
- 18.7 percent had reported the most recent incident of family violence to a counselling service or psychologist, followed by 5.9 percent to the police and 4.4 percent to a doctor or hospital.²¹
- Participants reported feeling most supported by a counselling service or psychologist (89.4 percent) and least supported by police (including LGBTQA+ liaison officers) (45 percent).²²

There are some further variations by gender:

- Non-binary people consistently indicated higher proportions of sexual assault by any perpetrator when compared to other gender identities.²³
- Transgender men reported experiencing the second highest proportion of sexual assault, followed by cisgender women, trans women and cisgender men.²⁴

There are major gaps in research such as an examination of the gender and sexual identity of perpetrators within LGBTQIA+ DFSV; research that separates out the experiences of trans and gender diverse people assigned male or female at birth; and research that investigates the specific experiences of non-binary people.²⁵

Unique forms of DFSV experienced by LGBTQIA+ people and PLHIV

LGBTQIA+ people face unique forms of violence from intimate partners (IPV) and from family members, (family of origin violence; FOV), including:

- Identity abuse, including threats to reveal someone's sexual orientation, gender identity or HIV status to family, an employer or social circle.²⁶
- Rejection or abuse from family due to their sexuality or gender.²⁷
- Degrading or humiliating language about HIV and AIDS.
- Withholding gender-affirming care, such as hormone replacement therapy (HRT).²⁸
- Withholding HIV medication, or not allowing someone to attend medical appointments²⁹
- Forcing a family member into conversion practices.³⁰
- Targeted rape (a hate crime in which the victim is raped because of their perceived sexual orientation).³¹
- Intersex people experiencing body shaming, along with forced and coercive medical interventions and body modifications in infancy, childhood and adulthood.³²

Gay, bisexual and queer (GBQ+) cisgender men

High rates of DFSV are observed among GBQ+ men, however there are low levels of reporting. Over half of all GBQ+ men (53.1 percent) have reported ever experiencing intimate partner violence, and nearly one third of GBQ+ cisgender men (31.9 percent) have ever experienced family of origin violence.³³

GBQ+ men are also disproportionately affected by technology facilitated abuse (TFA)³⁴, including dating app facilitated sexual violence (DAFSV), both online and in-person, compared to heterosexual men and women.³⁵ In Thorne Harbour Health's experience, most male clients of our family violence program have experienced TFA.

Technology-facilitated abuse (TFA) is a wide-ranging term that encompasses many subtypes of interpersonal violence and abuse utilising mobile, online and other digital technologies. These include harassing behaviours, sexual violence and image-based sexual abuse (IBSA), monitoring and controlling behaviours, and emotional abuse and threats.³⁶

Many gay, bisexual and other men who have sex with men (GBMSM) have positive, pleasurable, and healthy sexual experiences using dating and hookup apps and websites, however, there exists a high prevalence of sexual violence resultant from these platforms. The Australian Institute of Criminology (AIC) found that 30.9 percent of men had been verbally pressured to perform unwanted sexual acts; 22.5 percent had experienced attempts to engage in sexual acts they could not consent to; 21.4 percent had been threatened with or experienced physical force to perform unwanted sexual acts; and 9.9 percent had had their drink spiked to try to coerce them into performing a sexual act.³⁷

Types of violence can include sexual violence (physical sexual assault, verbal sexual coercion, intoxicated assault/coercion); sexual health risk behaviours (condom use resistance and coercion, deception related to STI status); non-negotiated behaviours (undiscussed/unexpected sex acts, rough sex, sexualised racism, undesired substance use by the partner); and threats to physical safety beyond sexual violence (being blocked from leaving, stalked, robbed, drugged).³⁸ Thorne Harbour Health has supported clients that have experienced premeditated assaults, including group assaults, that have been located and tracked using hook-up apps, often across multiple apps.

It is essential that family violence services and supports are available to meet the needs of GBQ+ cisgender men who are subject to DFSV and understand the context in which this violence occurs.

Lesbian, bi+ and queer (LBQ+) women

Almost half (48.2 percent) of LBQ+ women have experienced intimate partner violence in their lifetime.³⁹ Relative to lesbian participants in research, participants who identified as bisexual, queer or selected multiple sexual orientations were most likely to report having experienced intimate partner violence.⁴⁰

For the first time in 2021-22, the ABS Personal Safety Survey (PSS) collected data on sexual orientation. It found that LGB+ women were over five times more likely than heterosexual women to have experienced sexual violence in the past two years (13 percent compared to 2.4 percent). For the vast

majority of LGB+ and heterosexual women who had experienced sexual violence in the past 2 years (98 percent), the perpetrator was male.⁴¹

First Nations LGBTIQ+ people

Significant diversity exists in gender identity, sexual orientation, sexual expression and lived experiences amongst First Nations LGBTQIASB+ people. Brotherboys, Sistergirls and other First Nations LGBTQIA+ people may experience a number of significant and intersecting points of discrimination in Australia.

The Australian Human Rights Commission (AHRC) acknowledges First Nations LGBTI people may face specific difficulties in:

- maintaining cultural ties and family support which may contribute to DFSV.
- gendered cultural initiation processes that are unable to accommodate an individual's gender expression.
- the gap between Aboriginal-specific service provision and service provision that accommodates for broader LGBTI populations.

Additionally, there is a lack of research that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how this may affect the individual, individual expression, and experiences of DFSV.⁴²

Stigma, discrimination and prejudice

Discrimination by faith-based service providers

A victim-survivor's perception that a faith-based provider might discriminate against them because of their sexuality or gender identity can be a powerful deterrent to seeking help. In some cases, anticipation of experiencing stigma or discrimination has been found to have a greater negative impact on people than actual experiences.⁴³ This is likely a reflection of broader experiences of discrimination, and is a significant barrier to services access.⁴⁴ The Royal Commission into Victoria's Mental Health System also found that experiences of stigma and discrimination by LGBTIQ+ people increase the likelihood that they will have poor mental health outcomes.⁴⁵ Australian and international studies show that LGBTIQ+ people underutilise health services and delay seeking treatment due to actual or anticipated experiences of stigma and discrimination from service providers.⁴⁶

A significant amount of anti-LGBTQIA+ stigma and discrimination are rooted in faith-based prejudice. Worryingly, almost 1 in 10 of Australia's largest faith-based service providers publicly discriminate against LGBTQ+ people while almost 4 in 10 are silent in their positions on LGBTQ+ inclusion.⁴⁷ Between one third and one half of the workforce in education, aged care, healthcare and welfare agencies in Australia are employed in organisations with religious affiliations.⁴⁸

Trans and gender diverse people and accommodation

Transgender people experiencing DFSV face significant barriers in accessing appropriate accommodation. Emergency accommodation is typically gendered (i.e., for women or men only), meaning trans and non-binary people are not safe to disclose their identity or this information is

disregarded during allocation or provision of accommodation. This leads to discrimination by accommodation staff and reduced safety for the client due to discrimination from other occupants.

Some mainstream family violence services will often overtly discriminate against trans and gender diverse people, refusing to refer them to refuges or place them in hotels where other victim-survivors are staying. One trans female client of Thorne Harbour Health has been told by mainstream family violence services that “we don’t help people like you,” and been referred to a men’s service.

Another barrier to accessing accommodation can result from discordance between a person’s name and gender and their identity documents. Thorne Harbour Health has trans and gender diverse clients that utilise student or questionable accommodation that do not check a person’s old ID, which may have their deadname. For smaller, specialist services such as Thorne Harbour Health, provision of organisational verification for clients is often not accepted, which is not an issue that more established/mainstream services have.

Gay, bisexual, queer and trans men and accommodation

Gay, bisexual, queer and trans (GBQT) men experiencing violence often have no safe place to stay. There is no shelter accommodation for men experiencing violence. Accommodation that will accept men is often unsafe due to cisnormative and patriarchal discrimination or violence by workers or other occupants. GBQT victim-survivors may even be placed at the same accommodation as the person who used violence against them. What accommodation is available is often substandard in quality. Many GBQT people experiencing violence will end up sleeping rough or returning to unsafe places known to the person using violence against them. Thorne Harbour Health has many family violence clients, especially people who are migrants or refugees with even fewer accommodation options, who end up using Grindr or other hookup apps and having to have sex with people to find accommodation for the night.

Discriminatory legislation and policy in South Australia

South Australia was nation leading as the first state to decriminalise homosexuality in 1975, however there remain numerous laws, policies and prevalent social attitudes that perpetuate stigma, discrimination and prejudice toward LGBTQIA+ South Australians and PLHIV. These contribute to social systems that exacerbate domestic, family and sexual violence (DFSV) toward LGBTQIA+ and HIV-positive South Australians.

- South Australian law still permits faith-based discrimination in schools against students and staff on the grounds of sexual orientation and gender identity, in contrast to most other states and territories.
- South Australia has not banned conversion practices, which have been passed in Victoria, NSW and the ACT. Queensland has banned conversion practices in health settings.
- South Australian law does not prohibit deferrable medical interventions modifying a person’s sex characteristics without personal consent, which can result in intersex people experiencing body shaming, along with forced and coercive medical interventions and body modifications in infancy, childhood and adulthood.

- Sex work remains criminalised in South Australia, exacerbating risks to sex workers of sexual violence, and creating barriers to reporting and seeking support.
- The South Australian Government has proposed Mandatory Disease Testing laws, which are opposed by health officials, unsupported by science, and stigmatise people living with HIV.
- There has been ongoing transphobic rhetoric in the South Australian Parliament in 2023-2024, questioning the life-saving benefits of gender-affirming healthcare.⁴⁹

Discriminatory legislation must be reformed to address drivers of DFSV experienced by LGBTQIA+ South Australians.

Preference for types of services

LGBTQ people are less likely to seek support and face significant barriers to accessing affirmative family violence support services. Efforts to improve family violence service access must be grounded in the preferences of LGBTQ people themselves. Existing research shows that among LGBTQ people, 57.5 percent indicated a preference for mainstream services that are known to be LGBTQ-inclusive and 33.8 percent for LGBTQ-specific services, while only 8.8 percent indicated a preference for a mainstream service.⁵⁰ Trans and nonbinary identified people are more likely to prefer LGBTQ-specific services than cisgender people, while bisexual, pansexual and asexual are more likely to prefer LGBTQ-inclusive services.⁵¹ Participants who had not felt supported the most recent time they reported an experience of family violence were more likely to prefer LGBTQ-specific services.⁵²

The importance of LGBTQIA+ community-controlled services

The term “community-controlled” arose out of civil rights movements and is used by a range of movements internationally. Community-controlled organisations are initiated by, governed by, operated by and accountable to their communities. They are based within their communities and deliver safe services that empower their communities.

In Australia, community control is most commonly associated with Aboriginal and Torres Strait Islander community-controlled organisations, recognising and reflecting Indigenous community ownership and meeting the needs of Aboriginal and Torres Strait Islander peoples. The first reference to Aboriginal “community-controlled” health services was in 1978, although use was not widespread until about 1987, following the establishment of the Aboriginal non-government organisation program. Separately, the term “community controlled” was used in Australia in the early 1970s in references to childcare services at a women’s centre in Melbourne, which operated as a feminist and lesbian space, and used in reference to healthcare for lesbians in Sydney around the same time. The first documented use of the term for the Victorian AIDS Council (the previous name of Thorne Harbour Health) was in its annual report of 1987.

Thorne Harbour Health recognises the value and significance of the term “community-controlled” for Aboriginal peoples of Australia. THH shares with Aboriginal organisations a belief that services for LGBTQIA+ people are most effective and impactful when they are designed and delivered by organisations that are governed by, led by and accountable to LGBTQIA+ people and communities.⁵³

Prevention

1. What causes domestic, family and sexual violence?

For LGBTQIA+ people, the drivers of violence are both similar and different from those experienced by heterosexual and cisgender women, involving rigid gender norms, cisnormativity, and heteronormativity. Carmen et al.⁵⁴ developed a conceptual model to understand the drivers of family violence in LGBTIQ communities, highlighting inequalities related to LGBTIQ identities and relationships across societal, system and institutional, organisational and community, and individual levels.

Societal level

Rigid gender norms produce the attitudes that only cisgender and heterosexual expressions of sex, sexuality and gender are 'normal' and acceptable. Discrimination like homophobia, biphobia, transphobia, and intersexphobia targets those outside these norms, leading to stigma and violence. LGBTIQ individuals often face abuse within families due to beliefs that they are 'less than' or need correction, reinforced by broader gender inequalities and cultures of violence.

System and institutional level

In Australia, legal protections for LGBTIQ people have improved, but gaps remain particularly for trans, gender-diverse, and intersex individuals. LGBTIQ people face institutional failures to recognise their identities and relationships, along with systemic discrimination in work, religion, schooling, healthcare, and social services. Negative media portrayals reinforce stereotypes and justify violence, while lack of recognition in policy and services leaves LGBTIQ family violence unaddressed.

Organisational and community level

LGBTIQ individuals often encounter exclusion in organisational policies and cultures. Community and family discussions perpetuate stigma through silencing and negative stereotypes, allowing violence to be excused. Lack of positive models for healthy relationships and limited support from families and communities increase social isolation. Inclusive family violence services are a recent recognition in Victoria, but there is often reluctance within LGBTIQ communities to acknowledge intimate partner violence to maintain cohesion and positive appearances.

Individual and relationship level

Rigid gender norms, cisnormativity, and heteronormativity harm LGBTIQ individuals' self-worth, leading to acceptance of violence. Discrimination from families and partners, motivated by societal norms, normalises violence. Understanding the link between stigma, self-worth, and violence can help prevent family violence in LGBTIQ relationships. Negative self-perception often results in condoning abuse, impacting mental health. People who use violence must be held accountable to foster prevention strategies.

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

Understanding the drivers of family violence experienced by LGBTQIA+ communities is essential in targeting primary prevention efforts. Existing primary prevention organisations and programs have significant expertise in understanding and acting to challenge the drivers of gender-based violence. However, programs addressing or including LGBTQIA+ communities have not yet been consistently implemented. There is significant expertise in LGBTQIA+ community-controlled organisations in addressing these issues, which need to be resourced to carry out this work. Partnerships need to be developed between LGBTQIA+ community-controlled organisations and mainstream DFSV services to better draw on this expertise and implement it into broader prevention work.

Early Intervention

4. What systems, including 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?

Systems that receive information which may allow for the identification of individuals who are high risk of experiencing or perpetrating domestic, family and sexual violence include South Australia Police, Courts, the Department of Correctional Services, area hospitals and emergency departments, Child Protection, Housing Services, local family violence services, community mental health services, alcohol and other drug services and schools. Any system with statutory/mandatory requirements should be providing and receiving information, particularly if there are children involved.

To identify LGBTQIA+ people at high risk of experiencing or perpetrating DFSV, data information needs to include sexual orientation and gender identity, so that LGBTQIA+ people may be referred to appropriate services.

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

Information needs to be collected, and consistently

Without consistent and comprehensive data, the true scope of domestic, family and sexual violence affecting LGBTQIA+ remains incomplete. At present, government departments, agencies and service providers choose whether to adopt data collection standards for LGBTQIA+ people, and how these standards can fit into their respective data collection guidelines and infrastructure. These inconsistencies lead to significant gaps and inaccuracies in the data, especially regarding LGBTQIA+ communities.

It is also worth noting that government and other funding bodies often cite the lack of LGBTQIA+ family violence data as a rationale for no or limited funding, or otherwise there being no need for LGBTQIA+

specialist services. However, because there is no government mandate or support to collect this information, it becomes harder to advocate for targeted services and supports.

The Australian Bureau of Statistics Standard for Sex, Gender, Variation of Sex Characteristics, and Sexual Orientation Variables 2020⁵⁵ ("the ABS Standard") can standardise the collection, utilisation, and dissemination of data on DFSV affecting LGBTQIA+ South Australians. Developed by the ABS in collaboration with LGBTQIA+ community organisations and researchers, the ABS Standard has undergone extensive testing to ensure the data collected is both useful and not burdensome to gather. Work to implement the standard in national surveys has commenced and will improve the availability of data on LGBTQIA+ people. The 2021–22 ABS Personal Safety Survey (PSS) collected data on sexual orientation for the first time to support understanding of the prevalence of DFSV among people with different sexual identities.⁵⁶

Specialist DFSV services need access to information

It is essential that specialist DFSV services have the same access to information as mainstream services. In Victoria, Victoria Police send referrals to the Orange Door as a central entry point, which was established following the Victorian Royal Commission into Family Violence. However, there is a problem in that the app is owned by the Department of Families, Fairness and Housing (DFFH) and Victoria Police. Established, mainstream services such as SafeSteps can access the portal, however, smaller agencies do not have access.

The experience of Thorne Harbour Health as a state-wide, LGBTQIA+ specialist service is that crucial information inaccessible. Access to necessary information can be reliant on individual connections with staff at Orange Doors who are knowledgeable about LGBTQIA+ DFSV – however, in Thorne Harbour Health's experience, most staff at Orange Doors are not knowledgeable about LGBTQIA+ DFSV. It is essential that a system is established in which substantial advocacy is not required to obtain information, and that access to information does not rely on individual worker discretion at other services. The impact of this on timeliness of information access presents more opportunities for violence to be perpetrated. All services need to be able to access risk-relevant information.

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

Interventions that should be considered to manage the risks of a person who is identified as being high risk of experiencing or perpetrating domestic, family and sexual violence include funding and expanding LGBTQIA+ specific behaviour change programs. Men's behaviour change programs can be inaccessible to, and inappropriate for gay, bisexual, queer and transgender men who use violence. They are also unlikely to understand, or address, unique factors and dynamics that existing in GBQT+ men's intimate relationships. More healthy relationships programs generally are needed; however, these need to be inclusive of LGBTQIA+ relationships, and recognise homophobia as a factor in shaping rigid gender norms which drives 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?

Barriers to reporting domestic, family and sexual violence to police

LGBTQIA+ negative attitudes towards police are the result of a history of criminalisation, discrimination, and brutality at the hands of police. This presents significant barriers to reporting DFSV to police.⁵⁷ Previous negative experiences with police and fear of police because one's LGBTQIA+ status (as well as other intersectional factors including cultural background, Aboriginality, age and socio-economic status) can add to, and reinforce these attitudes.⁵⁸

More specifically, police often do not take LGBTQIA+ relationships seriously, or have not received adequate training to respond to the unique presentation of DFSV in LGBTQIA+ relationships. Lack of confidence in the police is substantiated by patterns in police activity that systematically prioritise reports by victim-survivors that fit the idea of 'the perfect victim' - white, heterosexual, cisgender, female victim-survivors. Studies show that police officers regard male-to-female intimate partner violence as more severe than same-sex intimate partner violence, as well as misidentification of victim-survivors in violent acts based on stereotypes and patriarchal gender roles.⁵⁹

In working with victim-survivors of DFSV violence, Thorne Harbour Health has seen a pattern of negative experiences among clients with police not believing them, particularly among LBQ+ women. These women are often confronted by the attitude of 'how much damage could a woman do?' Further barriers include being blamed for what happened to them, and that reporting will increase the risk for the victim-survivor. There are further concerns that reporting will take control or autonomy away from the victim-survivor and will undermine their own decision-making around the investigation and proceedings. There can also be an enormous toll to the victim-survivor by reporting to police – being part of a criminal investigation can be significantly re-traumatising, prevents recovery and healing, and rarely achieves a justice outcome.

An additional and unique barrier exists for victim-survivors who are perceived as male. The example in Victoria is that a male a victim-survivor of DFSV is referred to Victims of Crime (VoC), which is a crime hotline, not a DFSV service, and is both inadequate and inappropriate for a person in crisis needing comprehensive support. South Australian reforms need to learn from this shortfall in Victoria.

Barriers to seeking support from DFSV services

Despite the prevalence of DFSV affecting LGBTQIA+ communities, LGBTQIA+ victim-survivors are less likely to seek support than their heterosexual peers.⁶⁰ Most professional DFSV supports are tailored to the needs of cisgender, heterosexual clients. Further, they also support-victim survivors of intimate partner violence or similar, not regarding family of origin violence, or resulting community violence, as family violence.

Additionally, LGBTQIA+ inclusive and affirming services are limited – Thorne Harbour Health’s experience in Victoria is that only a few mainstream services explicitly state that they will support any victim-survivors that aren’t women or children, even those services with Rainbow Tick Accreditation. Some services that do claim to be inclusive will only support clients assigned female at birth (AFAB) or only provide assessments before referring the client on. LGBTQIA+ people – particularly cisgender and transgender men - are unable to access a full-service response compared to cisgender counterparts, particularly outside of regular business hours.

This is likely to contribute to the low utilisation of these services by LGBTQIA+ individuals. LGBTQIA+ victim-survivors may refrain from utilising mainstream DFSV services due to a combination of anticipated discrimination, and perceptions that these services are ill-equipped to support LGBTQIA+ individuals.⁶¹ This barrier is exacerbated by the high proportion of DFSV services by faith-based organisations. Even when these organisations pursue policies to improve inclusion, association with religious institutions that hold prejudiced positions toward LGBTQIA+ communities create a barrier to accessing services.

A further barrier to LGBTQIA+ people seeking support is concerns around privacy. In LGBTQIA+ communities, which can be small and deeply interconnected, there is also the high risk of social ostracisation due to disclosure of violence that discourage victim-survivors from seeking support.⁶² This indicates a need to increase awareness of support services for LGBTQIA+ people experiencing DFSV, as well as expansion of services to increase access to support programs.

Other barriers include lack of awareness of LGBTQIA+ specialist DFSV services, long waitlists due to under-resourcing, and geographic inaccessibility, such as lack of transport to get to services. Low literacy in identifying DFSV affecting LGBTQIA+ people – among DFSV service providers, as well as LGBTQIA+ people themselves – creates additional barriers to seeking support.

The Family Violence Multiagency Risk Assessment Management Framework (MARAM), a product of Victoria’s Royal Commission into Family Violence, asks questions regarding intersectional experiences or identities at its end. Identifying LGBTQIA+, migrant, and other intersectional experiences at its end, frames this as if an afterthought. Not recognising these can have significant impacts on risk and safety.

Existing research has found that LGBTQIA+ people are more likely to report experiences of family of origin violence and intimate partner violence if that have a regular GP, are aged 45-54, have a university education, have experienced homelessness (likely due to being in contact with other services), and are non-binary. LGBTQIA+ people are less likely to have reported experiences of family of origin violence (FOV) and intimate partner violence (IPV) if they are aged 18-24, born in a non-English speaking country, and are a cisgender man.⁶³ Barriers for cisgender men and people from non-English speaking countries must be addressed.

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

a. A victim-survivor?

The elements of a best practice crisis response which meets the needs of a victim-survivor is one that uses a trauma-informed, rights-based, evidence-based and strength-based approach that prioritises the rights and choices of the victim-survivor and provides them with information and appropriate supports to make informed choices in their own time. The response must be timely, ensuring service provision is accessible and responses are provided as soon as possible, particularly for recent sexual assaults. The victim-survivor must have access to appropriate supports, including sexual health checks, counselling, financial support, and support to report to police. Best practice responses include the co-location of services – in the experience of Thorne Harbour Health, many sexual assault clients are also seeing alcohol and other drug (AOD) counsellors and require mental health supports. Services should also be located far from police, whose presence can be retraumatizing, as well as removed from criminal justice responses, rather taking place in therapeutic spaces.

There need to be settings such as shelters available to cisgender men who need support to leave violent relationships, as well as trans and gender diverse people who may face exclusion and discrimination from cisgender women's only spaces.

Flexible support packages to help people leave violent relationships and establish themselves after are needed. These packages need to be flexible, allowing LGBTQIA+ community-controlled organisations providing DFSV services to control what items are funded for people, enabling a client-led approach, rather than a top-down, systems-led approach. When a person has had so much agency taken away from them, allowing some control over very basic needs is significant. Transparency from Government over how organisations are funded to provide support packages is also important.

b. A victim-survivor who is a child?

A child who is a victim-survivor of domestic, family and sexual violence, or is in an environment where DFSV is happening, can experience significant and irreversible developmental impacts. A significant challenge for child welfare is an incorrect assumption that children are not present in LGBTQIA+ families to be affected by violence. One challenge Thorne Harbour Health faces is that our services do not do client outreach, and so do not have face-to-face contact with children, and are not able to assess for child wellbeing. Given the barriers for mainstream DFSV services for LGBTQIA+ people, children in LGBTQIA+ families with family violence may be disproportionately affected.

As a LGBTQIA+ family violence services that is not funded to work with children, Thorne Harbour Health may receive a client referral from SafeSteps of the Orange Door. The most appropriate referral for a child involved in the DFSV situation is to Family Services, but we are limited to work with that client and cannot refer on a child.

LGBTQIA+ families often look different to heterosexual 'nuclear' families. Some parents or guardians may not have the same legal rights and cannot protect children when they are not legally a child's

parent. This discrepancy in legal protections can facilitate systems abuse and collusion via the use of children, can be a significant way of continuing the violence (for years oftentimes) after the dissolution of dynamics of initial violence.

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

Best practice responses to LGBTQIA+ specific domestic, family and sexual violence are that they are LGBTQIA+ specific. In recognising that the majority of people who use DFSV at the population level are heterosexual, cisgender men, this is not the case within LGBTQIA+ communities. Responses that meet the needs of perpetrators must be appropriate for a greater diversity of people who use violence. Responses for heterosexual cisgender men are not going to be appropriate for gay, bisexual, queer or trans men.

Responses specifically targeting LGBTQIA+ perpetrators of domestic, family and sexual violence are lacking. Thorne Harbour Health, ACON (NSW), and Queerspace (a program run by Drummond St services in Victoria) are the only services nationally that offer LGBTQIA+ specific behaviour change programs. Of these, THH is the only organisation operating in South Australia. Some mainstream DFSV services indicate they are LGBTQIA+ friendly, but these can be unsafe places for LGBTQIA+ clients and the materials are not tailored or relevant, making it difficult to engage the client in the work.

Thorne Harbour Health delivers accredited men's behaviour change programs (MBCP) for gay, bi, trans and queer men and non-binary people. These are delivered in person in Melbourne, as well as online nationally given the high demand. Participants in THH's men's behaviour change program also have access to case management and other individualised support.

The program runs for 20 weeks and is called START. The focus of START is on building relationships which are **Safe, Trusting, Accountable, Respectful and Transformative**.

The program provides a non-judgemental environment to explore the impacts of participants' behaviour and beliefs on themselves, their partners and others in their lives, so that they can start making the positive changes needed to develop and maintain healthy relationships.

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

A best practice health response needs to be timely and sensitive. Victim-survivors of sexual violence often report ongoing health issues sustained as a result of their trauma; however, healthcare responses are generally one-off, and crisis oriented. Comprehensive sexual health screening and healthcare follow-up is necessary. Non-invasive testing should be undertaken where possible, as many victim-survivors report that rape kits can be very retraumatizing. Victim-survivors need to be provided with the information and time to make decisions and choices about their own healthcare and wellbeing and supported in doing so.

Co-location of support services is fundamental to the needs of DFSV victim-survivors. For example, data from Thorne Harbour Health's Victorian Primary Health Network alcohol and other drug (AOD) clients

shows a large overlap between AOD supports and experiences of DFSV. Of 708 clients, 4 percent showed an indication of using violence in the previous 4 weeks. Of 654 clients, 22.5 percent indicated they were a victim-survivor of family violence, and 10.2 percent indicated they were someone who uses violence. Members of Thorne Harbour Health's family violence team have indicated many DFSV clients experience AOD issues.

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

Support victim-survivors through the reporting process

Best practice police responses tend to come from involvement with specialist DFSV units and officers trained in DFSV. DFSV and LGBTQIA+-specific DFSV training should be mandatory for all officers and would increase best practice responses. Any officer should be able to provide as informed response as a specialist family violence unit officer would. This would reduce workloads for all and provide a safe and inclusive response for the consumer (client).

In Thorne Harbour Health's experience supporting DFSV victim-survivors, our clients will often speak about how intimidating and re-traumatizing their experiences with police are. This can be the result of a lack of sensitivity around language (e.g., referring to the sexual assault as 'rape', not enquiring with the victim what language feels supportive for them), the nature of interview rooms, the length of interviews, as well as the level of detail required for a statement. Victim-survivors often report that they are required to reenact their trauma to police, are often interrupted in re-telling their account, and questioned - even interrogated - about their own behaviours, reinforcing an internalisation of blame and shame around their experience.

In reporting DFSV, victim-survivors report that they are often required to repeat themselves over and over again after giving their initial statements and are often unsure of why this is the case. One client reported that they were interviewed for 56 hours about their experience of childhood sexual abuse.

A best practice police response must involve police listening to, and believing the victim-survivor, not questioning their decisions or behaviours in the re-telling of their sexual trauma. Options for conducting interviews in trauma-informed spaces, rather than police interview rooms should be considered, e.g., at other services. Trauma-informed practitioners should be able to support the victim-survivor throughout the interview/statement process, and/or there should be the provision of support to the victim-survivor during the interview/statement process. Victim-survivors should be asked if they have a preference regarding who conducts the interview, how the interview is conducted, and what language they would like to use in relation to their experience. Victim-survivors should be empowered to make informed decisions at each stage of the process.

Address misidentification of predominant aggressor

Misidentification can be understood as falsely assessing victims of IPV as perpetrators by members of the justice system.⁶⁴ However, this can also work both ways - sometimes users of violence are misidentified as victim-survivors. LGBTQIA+ people are at greater risk of being misidentified as a perpetrator of violence, along with Aboriginal women, migrant and refugee women, women with disabilities and criminalised women.⁶⁵ LGBTQIA+ victim-survivors and perpetrators alike often experience

inappropriate responses from police, including misgendering and overt discrimination based on their sexual orientation or gender identity.

Heteronormative stereotypes, when applied to a relationship between two cis-gendered men, may lead police to assess a more “masculine” appearing man as the predominant aggressor based on his relative physical size to his partner. This is a clear example of a general lack of appropriate responses to LGBTQIA+ victims and perpetrators resulting in misidentification. Biases such as these may cause a range of system-derived negative consequences.⁶⁶ One study has found that police were more likely to arrest if they felt intimidated by someone involved in the reported case and that the perceived severity of the report varied depending on the gender and sexuality of those involved, indicating that the determination to make an arrest does not follow a standardised protocol.⁶⁷

Timing-based assumptions exacerbate misidentification – where police cannot make heteronormative assumptions about cisgender man being the respondent, and a cisgender woman being the affected person, they will often believe whoever they speak to first; wanting to get the job done, rather than get the job right. In Thorne Harbour Health’s experience, LGBTQIA+ people of colour are more likely to be misidentified as the predominant aggressor and white people more likely to be believed. Australian-born, English-speakers, more likely to know how the system works are further able to exploit their power to ensure they are believed by police.

Thorne Harbour Health’s LGBTQIA+ family violence specialist service frequently has to ‘correct’ data that it receives in referrals from police, courts, The Orange Door and other mainstream services. This included data regarding people’s gender and sexuality and most commonly the assessment of the predominant aggressor in an LGBTQIA+ relationship.

The impact of failure to accurately capture data at the first point of contact within the DFSV system cannot be understated – it completely changes the trajectory of somebody’s life. Misidentification can result in criminalisation, wrongful imprisonment, limited access to support services, further harm, loss of child custody, restricted housing and employment opportunities, visa and residency complications, and significant mental health issues. Mandatory schemes such as sex offenders registries disproportionately affect LGBTQIA+ individuals who are wrongfully identified as perpetrators.

Recognising the impact of technology-facilitated abuse

Technology-facilitated abuse (TFA) is a wide-ranging term that encompasses many subtypes of interpersonal violence and abuse utilising mobile, online and other digital technologies. These include harassing behaviours, sexual violence and image-based sexual abuse (IBSA), monitoring and controlling behaviours, and emotional abuse and threats.⁶⁸ Significantly higher rates have been found among LGBTQ+ and intersex populations. For instance, in the United States, the Pew Research Center found 70 per cent of lesbian, gay or bisexual people have experienced online harassment.⁶⁹

Gay and bisexual men, and LBQ women are also significantly more likely to experience dating app facilitated sexual violence (DAFSV) compared to heterosexual women and men.⁷⁰

However, at present there are not laws that recognise TFA, and police often do not take TFA seriously. Given the lack of legislations surrounding TFA, the eSafety Commissioner is limited in their power to act. There is a significant underreporting of technology facilitated abuse, however many people are experiencing.

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

Centering the needs of victim-survivors

The elements of a best practice justice system response will focus on restorative justice principles to prioritise the unique needs of the victim-survivor to uphold their dignity and prevent further re-traumatisation. This will involve reducing the burden on the victim-survivor to participate in criminal justice proceedings, and developing justice responses that can occur outside mainstream criminal justice settings. This response will further need to centre the voice and rights of the victim-survivor and focus on holding people who use violence accountable.

As misidentification of predominant aggressor disproportionately affects LGBTQIA+ people, systems abuse is rife within LGBTQIA+ DFSV, which has enormous implications on intervention orders (IVOs) and parenting agreements. Intersectional vulnerabilities can exacerbate this. Different systems literacy can result from partners being Australian-born/overseas-born, and native English-speaker/non-native English speaker, and can further disadvantage LGBTQIA+ people experiencing violence, and favour the people using violence against them. Discrimination within systems, and limited understanding within the justice system of presentations of abuse within LGBTQIA+ relationships cause further harm. As LGBTQIA+ families often take a greater diversity of forms compared to heterosexual families, parents/guardians can often have different legal rights to a child. This can be leveraged by someone using violence within the justice system to further victimise their partner. Thorne Harbour Health has supported many clients that have experienced DFSV and continue to experience systems abuse long after the initial violence has ended.

Judges, prosecutors and others within the justice need training to be able to address these forms of system abuse rather than contributing to it.

Recovery and Healing

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?

Victim-survivors often face significant barriers in accessing the timely, trauma-informed therapeutic supports they need. Many report that the available support is too short-term to effectively address the emotional aftermath of their experiences. Ongoing, long-term counselling is needed beyond crisis supports immediately following an incident of violence, and for LGBTQIA+ people having this come from LGBTQIA+ co-located specialist family violence, alcohol and other drug (AOD) and mental health services can be crucial to long-term healing.

Many victim-survivors report a sense of overwhelm and confusion following an experience DFSV regarding service-navigation and being contacted by several different services requesting similar information. Services and systems that effectively talk to each other and share information will better support victim-survivors recover from trauma.

Financial instability is a common consequence of DFSV, as violence can severely disrupt a victim-survivor's ability to maintain employment or continue studies, leading to housing insecurity or the need to relocate for safety. Financial dependence can keep people in violent relationships or situations. Those who experience sexual violence outside the context of family violence often struggle to access timely financial support. For LGBTQIA+ people experiencing violence, LGBTQIA+ community-controlled brokerage programs can minimise risk factors around cost of living, meeting basic needs, keeping the victim-survivor safe, and making sure the worst available accommodation is not the only place a person has to stay. Brokerage can be used to provide inclusive and affirming supports that give greater autonomy to the individual.

Abbreviations

AOD	Alcohol and other drugs
DAFSV	Dating app facilitated sexual violence
DFSV	Domestic, family and sexual violence
FOV	Family of origin violence
GBMSM	Gay, bisexual and other men who have sex with men
GBQ	Gay, bisexual and queer
IPV	Intimate partner violence
LBQ	Lesbian, bisexual and queer
LGBTQIA+	Lesbian, gay, bi+, trans and gender diverse, queer, intersex asexual, and other identities
LGBTQIA+ community-controlled organisation	Organisation based in LGBTQIA+ communities that is initiated by, governed by, operated by and accountable to its communities
MBCP	Men's behaviour change program
PLHIV	Person/People living with HIV
TFA	Technology facilitated abuse
TGD	Trans and gender diverse

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