ROYAL COMMISSION
INTO DOMESTIC, FAMILY
AND SEXUAL VIOLENCE

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TUESDAY, 25 MARCH 2025

COMMISSIONER NATASHA STOTT DESPOJA, Presiding

COMMISSIONER DESPOJA AO: Good morning and welcome to day nine of the public hearings for the Royal Commission into Domestic, Family and Sexual Violence. My name is Natasha Stott Despoja and I am the Commissioner for this Royal Commission. I begin by acknowledging the traditional owners of the land on which we gather today, the Kaurna people, and I pay my respects to elders past, present and emerging, and to any elders from other communities who may be present or listening today.

This is a significant week on which to close our public hearings phase. I want to thank all of those witnesses who have already given evidence and in advance I would like to thank you, those of you who are giving evidence today and tomorrow. As we've said previously, these public hearings for the Royal Commission are an important way for us to examine the large amount of information and critical issues impacting the sector right across the state of South Australia. Today we're going to cover the topic of family violence and tomorrow we're going to focus on what will make communities thrive. How do we move towards a future without domestic family and sexual violence? I understand today we will be hearing from a number of witnesses, including on topics around the efforts of the Victorian Royal Commission.

We're going to hear about the development of the National Aboriginal and Torres Strait Islander Family Safety Plan. We're going to talk about the issue of domestic family and sexual violence in relation to older Australians and the issue of elder abuse. And we're going to talk about the support that's provided in this state for vulnerable people including people with disabilities and older people. And, finally, I understand from counsel assisting that we will explore the links between animal abuse and domestic, family and sexual violence, and why pet inclusive responses are important in this context.

So it will be a busy day, probably a long day, counsel assisting, but I look forward to the evidence being presented. So now I hand over to counsel assisting to provide us with a more specific overview of the day. Thank you.

MS K. ORR: Thank you, Commissioner. Today and tomorrow bring the Royal Commission's ninth and tenth days of public hearings. As the commissioner indicated, today's hearing will be focused on family violence. Tomorrow's hearing is entitled Helping Communities Thrive, and aims to ask the question, what do communities need to thrive? As I will explain in a moment, I anticipate that there will be some overlap in the evidence of some witnesses across these two days.

I again acknowledge the domestic, family or sexual violence lived experience of anyone involved in the hearings, following on the live stream or watching the recording of this hearing at a later time. I also advise that people may find the content of today's hearing distressing. I remind anyone watching or listening that if you wish to seek support or advice, a list of support services can be found on the Royal Commission's website, www.royalcommissiondfsb.sa.gov.au.

In relation to terminology, we will continue to use the term victim survivor to refer to people who have experienced or who are currently experiencing domestic, family or sexual violence. And the term "person who uses violence", when referring to an

individual who uses domestic, family or sexual violence to cause harm to another. The Royal Commission has three categories of violence in its terms of reference. Domestic violence, otherwise known as intimate partner violence, family violence and sexual violence, both in and out of domestic and family relationships.

While there is often significant overlap between these categories, it is important to understand and address the distinct features of each. As we've said, today's hearing is focused on family violence. Family violence is an umbrella term that is often used to describe physical and non-physical violence and coercive, controlling behaviour in family and family-like settings. It is a broad term and encompasses violence in the context of a range of relationships.

For example, parents and guardians' violence against children and young people, adolescent violence in the home, sibling violence, kinship violence, elder abuse by adult children and family members and carer violence towards people living with disabilities. Sexual violence can occur in a family violence context, just as it can be a feature of intimate partner violence. It can, of course, also occur outside of a family or intimate partner relationship altogether.

It is important to note that while the Commission, both for today's hearing and more broadly, is using the term family violence to describe a distinct category of violence, other jurisdictions such as Victoria, have adopted family violence as a broader umbrella term to also include intimate partner violence and sexual violence in the intimate and family context. The term is also generally preferred by Aboriginal communities as it can better encapsulate and describe their experience of violence within kinship and community networks.

But for today's purposes, when we refer to family violence, we mean violence outside of intimate partner violence, as I've just explained. The Commission has consistently heard that the vast majority of South Australia's current domestic and family violence systems and services are focused towards intimate partner. The Commission has learned, including through evidence given at public hearings, that specialist service responses to domestic, family and sexual violence in South Australia are almost entirely limited to women who are at a high risk of intimate partner violence and also at risk of homelessness with other victim survivors, including victim survivors of family violence, receiving little to no support. The Commission has been told that this is primarily due to resourcing and capacity constraints. In an attempt to meet these unmet needs of many victim-survivors of family violence, mainstream services, advocacy groups and charities are often absorbing the costs.

The Commission has also learned that much more is known about intimate partner violence than other forms of family violence due to more sustained research into intimate partner violence, victimisation and homicide. What is known is that children and young people experience alarming rates of family violence. The Australian Child Maltreatment Study from 2023 revealed that 62 per cent of the Australian population experienced at least one type of childhood maltreatment. The prevalence of violence against children has been a consistent theme in the information received by the Commission, and it was explored during our public hearing on children and young people last month.

What is also known is that some adult population groups can be more vulnerable to and experience unique kinds of family violence. These include, but are not limited to, older people, people with disabilities, Aboriginal communities, culturally and linguistically diverse communities, and LGBTQIA plus communities. It was apparent in the Australian Bureau of Statistics Personal Safety Report from 2023 and is again consistent with what the Commission has heard through its work so far. The Commission has heard that family violence usually involves a power imbalance between the person using and the person experiencing violence, and that people can be made particularly vulnerable to a power imbalance and to violence by factors such as those I've just mentioned.

The Commission has also heard that while in some cases family violence might occur quite separately from intimate partner violence, in other situations they are inextricably linked. For all of these reasons, the Commission has made a deliberate decision to focus a day of evidence on the issue of family violence. I will explain more about the vulnerabilities of certain population groups in the context of the witnesses we will hear from over the next two days. The first witness today is Dr Chelsea Tobin from Safe Steps Victoria. Safe Steps is a large organisation that provides a 24-7 family and domestic violence crisis support service for all people in Victoria who are experiencing family and domestic violence.

They aim to be inclusive and accessible so that anyone, who doesn't feel safe, can call for help. Next we will hear from Adjunct Professor Muriel Bamblett AO from VACCA, the Victorian Aboriginal Child and Community Agency, along with Craig Rigney from South Australia's KWY Aboriginal Corporation. They are members of the Steering Committee for the National Aboriginal and Torres Strait Islander Family Safety Plan. The evidence of these two witnesses will be centred around the question, "What do Aboriginal and Torres Strait Islander communities need to thrive?", which is the focus of tomorrow's evidence. It's for logistical reasons only that they are giving evidence today.

However, I anticipate that their evidence will also touch on family violence in the Aboriginal and Torres Strait Islander context. As I said earlier, the Commission has heard that the term "family violence" is often preferred by Aboriginal communities to describe their experiences of domestic, family and sexual violence as it better encapsulates the dynamics of extended families, kinship networks and Aboriginal community relationships in which violence can occur. The Commission has learned that violence occurs within these close kinship networks that's experienced as family violence and can include sibling violence, parent-child violence, reciprocal violence and feuding.

The Commission has also heard that family violence in Aboriginal communities is complex and is often underpinned by the experience of ongoing intergenerational trauma, colonialism, discrimination and racism and socio-economic disadvantage. The next witnesses will be Ms Miranda Starke and Ms Rachel Nielsen from Council on the Ageing, known as COTA, from South Australia. They will give evidence about elder abuse and how older South Australians are experiencing family violence. The Commission has heard that age causes significant vulnerability when it comes to family violence. While children and young people experience higher rates of family violence,

older people aged 65 and older are also more vulnerable to family violence when compared with adults under 65. The Commission has heard that while a power imbalance tends to be a common theme, elder abuse can take a variety of forms, some of which are unique types of abuse experienced by older people.

In the National Elder Abuse Prevalence Study in 2021, the Australian Institute of Family Studies found that almost 15 per cent of older people experienced one or more forms of elder abuse, and that the abuse was often carried out by adult children and other family members. The Commission has heard that family violence experienced by older people can regularly occur in circumstances where the person using violence is a carer as well as a family member.

And the Commission has heard that older people can face additional barriers to seeking and receiving help. The Commission has heard that living with disability also makes people more vulnerable to domestic, family and sexual violence, including unique forms of that violence, and makes people more likely to face barriers to seeking and receiving help. Accordingly, this afternoon we will hear from Belinda Lake from South Australia's Adult Safeguarding Unit.

The Commission has heard that although research and data is lacking, it appears that people with disability are more likely to experience violence as a child and more likely to experience both intimate partner violence and family violence after the age of 15. The Commission has also heard that both children and adults with disability are more likely to experience sexual violence than those without a disability. The Commission has heard that there are very few specialist services for people with disability experiencing or using domestic family or sexual violence in South Australia.

The Commission's online Share With Us tool revealed a very significant overlap in respondents experiencing domestic family and sexual violence and those living with a disability. Of the 634 victim survivors who provided demographic information using the survey tool, 37 per cent lived with a disability and three per cent cared for someone with a disability. People spoke about difficulties in recognising that what they were experiencing was domestic family or sexual violence, difficulties accessing the justice system and specialist services, and about caring for children and young people with disabilities who were using violence in the home.

Tomorrow we will hear from the Australian Refugee Association, who will give evidence about family violence in refugee and migrant communities. The Commission has heard that culturally and linguistically diverse, or CALD communities are another population group who can be vulnerable to family violence, who can experience specific forms of violence, and who can face additional barriers to seeking help. There are added complexities when there has been pre-migration trauma, which is common for refugees, and when cultures have different attitudes towards gender roles and family dynamics.

I will address this further at tomorrow's hearing. Also tomorrow we will hear from Mr Ben Bjarnesen from the LGBTQ Domestic Violence Awareness Foundation. His evidence will centre around what do LGBTQ communities need to thrive, but I anticipate that he will also address some of the ways in which those communities

experience and are vulnerable to family violence. The Commission has heard that LGBTQIA plus communities experience domestic, family and sexual violence at similar or higher rates than heterosexual and cisgender people, that they can face unique forms of violence and, again, that they can face significant and additional barriers to seeking and accessing help.

Coming back to the witnesses for today, as the Commissioner said, our final witness will be Ms Jennifer Howard from Safe Pets Safe Families. Pets are often important members of families and can, sadly, play a significant role in domestic and family violence settings. The Commission has heard that pets can themselves be the subject of abuse and that harm or threats of harm to them may be used to control and intimidate victim survivors. Further, animal abuse is a recognised risk factor for violence perpetration.

According to ANROWs National Risk Assessment Principles, cruelty and harm directed to pets and other animals can indicate risk of future or more severe violence and are often used as a control tactic by perpetrators. Pets can also present a barrier to escaping violence if a victim survivor has to leave pets behind in order to flee. Ms Howard will talk about the role of pets in domestic, family and sexual violence and will tell us about some of the things that Safe Pets Safe Families are doing in this space. Thank you, Commissioner. I call Dr Chelsea Tobin.

CMR DESPOJA: Thank you.

CHELSEA TOBIN, SWORN

MS ORR: Dr Tobin, you are the CEO of Safe Steps?

MS TOBIN: That's correct.

MS ORR: Can you tell us, or can you give us an overview of what Safe Steps is?

MS TOBIN: Sure, and thank you for having us here today. Safe Steps is a key part of the family and domestic violence and intimate partner violence ecosystem for nearly 50 years in Victoria. We play a critical role in trust in community with most of our contacts coming from victims who are very scared and unsafe, but we work along many, many others in the prevention or intervention recovery and response space and there is a number of specialist providers for particular cohorts that have specific needs that we work alongside.

So I could only really speak about what we see as a front line statewide provider, and not on behalf of the whole sector. In terms of what Safe Steps does, Safe Steps is Victoria's only 24/7, 365 days a year crisis service for anyone who is scared to go home. The services we provide are the 24/7 crisis centre where you can call, web chat, email a number of channels to contact us. We provide pet services for those fleeing violence with pets.

We provide the statewide disability service for those fleeing violence with disabilities. We provide the family violence accommodation register, which is really

the supply and demand of long-term refuge across the whole state, and how we maximise the usage of beds available. We provide court services through the Family Advocacy and Support Service, and we're a delivery partner for 1800RESPECT across Australia. And we provide crisis accommodation mostly through our sanctuary model as a better alternate to motels.

What this looks like on a daily or yearly basis is we would take and make over 130,000 contacts per year from very scared and unsafe people. We provide over 33,000 nights of crisis accommodation. And so what does that look like in terms of a victim survivor? We have a 77 year old woman with a disability in a rural area in Victoria escaping the farm, to a 45 year old man experiencing coercive control from his female partner, to a 17 year old young man, gay man, experiencing abuse from his own family, to a 25 year old CALD woman in arranged marriage being raped by her partner and condoning from family.

So if you're scared to go home tonight in Victoria, you would call, chat, text us. We're very focused on how we make that first moment of help seeking really matter. In terms of building trust, we would do a risk assessment to understand the risk of escalation, the risk of lethality. We would provide crisis accommodation, and we would be very focused there on building up your protective factors to change the trajectory or increase your choices that you have available with a lot of agency.

70 per cent of the risk assessments that we complete are in the top two risk categories, or as we would know, the MARAM, the multi-agency risk assessment tools that came out of the Royal Commission. So 70 per cent are serious risk requiring immediate protection or serious risk. And over 60 per cent we would estimate have no police involvement. So very scared, very unsafe, and the belly of the work sort of sits outside the police system and, you know, 90 per cent of the calls are from victim survivors themselves. We have two core functions or capabilities. One is help-seeking, so how do we make help-seeking more accessible, more helpful, more relevant? And then within that help-seeking moment, how do we really understand risk of what could happen next as protective factors? And then the second core function we have is once somebody seeks help, how do we make sure that we are evidence-informed in what really is an effective intervention for them and that will change the trajectory.

MS ORR: I want to ask just a little bit more about this accessible service that anyone can go to. What does it look like now to provide an accessible service in that way?

MS TOBIN: So it looks like a very accessible website. It looks like very proactive outreach to all the communities and cohorts, particularly those that we see as unrepresented in the service system. It looks like disability action plans. It looks like memorandums of understanding with all LGBTIQA plus service providers for referrals. It looks like having rainbow tick accreditation. It looks like significant calendar of training and professional development to make sure that the service is seen as accessible, and then when somebody seeks help it is culturally responsive and safe.

MS ORR: I will ask you a bit more about that in a moment, but if we can turn now to some sort of observations if I can, what is Safe Steps' experience - excuse me - over time in the nature and trends in family violence and help seeking? Can you help us with

some of those?

MS TOBIN: Yes. I preface this by just saying I'm a CEO of quite a practical crisis service provider and there would be experts that would be better placed to speak to the drivers and causality of family violence. But what I do know as a front line service provider is what we see in family violence versus intimate partner violence is obviously a broader scope.

So we would see family violence encompassing a broader range of relationships including between family members such as parents, children, siblings, extended family, family-like relationships, you know, such as carers and guardians. So, for example, we would see violence from a partner, and then coercive control from in-laws. We would see violence against ex-partners in the family violence space, we would see violence against older members of the family, adolescent violence in the home or siblings, and often that violence in the family, we would see as a front line provider, is that intergenerational trauma, so where the violence has been passed down through the generations.

And we would see, sort of, cultural and social norms being played out where there can be, sort of, expectations of how violence is perceived or condoned or justified in family relationships. So, for example, deeply ingrained dowry systems, you know, justification for abuse, extended family condoning. We would see violence, there would be some enforcing factors that we would see play out in our contact centre, and then we would see barriers to help-seeking, such as shame and cultural expectations, you know, views that family matters should be solved internally, and, sort of, and probably broader community condoning of violence.

I think in family violence, again, there would be experts better placed, but as it plays out as a front line service provider, we see, sort of, complex power dynamics. So you might have, in family settings where you might have multiple relationships, so you might have intimate partner violence, and then father to son violence, and that might be being used as some form of weaponisation.

We might see separation being weaponised with the idea that separation is some kind of vaccine for abuse, and we don't see that working at all in the family violence set up, and particularly in our court services. I think support systems are also pretty different in family violence. They're more limited. People can feel more isolated or unable to seek help. There can be barriers to help seeking, you know, the fear and shame and the lack of awareness, particularly in some deep cultural groups or religious areas. Probably not the people that call us that we worry about, it's the people that don't call us or don't call anybody because they don't see services accessible, helpful or relevant, or they don't know about them, or that information is kept from them. And we see that play out in family violence. The last thing I would just mention around family violence is the types of abuse we see. So we can see, you know, particularly weaponising of preventing contact with family members or cultural practises. And we absolutely see a correlation between where we have festive events or seasons and increasing calls.

So where there is alcohol, where there is gambling, where there is cost of living pressures, where there's Christmas family functions and there's sort of social tensions,

we will see an increase in calls. So between Grand Final day in Victoria and last weekend of September to Grand Prix day just gone, we will see a minimum 10 per cent increase in calls over that period of time.

MS ORR: Is that a consistent pattern?

DR TOBIN: Yes, every year.

MS ORR: I understand that Safe Steps, you say that you take a human rights approach in terms of responding?

DR TOBIN: Yes. I mean whether it's family and domestic violence or intimate partner violence, our approach would recognise the causes and the correlations of what's driving family violence, but we would respond in a culturally sensitive human rights approach no matter what. And that's really focused on how do you understand your situation? What would you like to do? How do we increase your choices and give you agency in that process? And fundamentally the belief that everybody deserves to be safe in a first world country. And so our focus really is on what do you want to do, and how can we get you to safety through your choices?

MS ORR: Coming back to trends or observations that you've seen over time at Safe Steps, how about the prevalence of violence? But I suppose you're making an observation about that based on the number of calls that you're receiving.

DR TOBIN: I think prevalence is a tricky question. I mean, you know, if we just look at pure police call-outs in Victoria, we know we saw an increase in recorded incidents in the calendar year 2024. We had an 11.3 per cent increase in the number of police incidents where they were called out to a family scene. Over 104,000 call-outs. However, I would also say as a frontline service, we see increased reporting. So we see new people calling that would not have called 10 years ago. We see an increase in recording practises as community awareness across all service systems that might interact with family and domestic violence have more awareness, and I think that's really one of the benefits that's come out of the Royal Commission in Victoria. I still think however we see significant under-reporting so that the people that don't call us. And the demand for services, it's just under significant strain.

MS ORR: Have seen changes in the nature of violence? This is a big question, so perhaps in an overview sense. Have there been changes in the nature of violence that you're hearing about or seeing reported?

DR TOBIN: I think so. I think the nature of physical violence is well known. We would - and there would be better experts to talk to this. However, what I would say as a frontline provider, we see the physical violence but the new frontiers of violence, particularly around coercive control and stalking and strangulation, and these issues are concerning for us. So to give you an example, if you call us today, we assess your risk using the MARIN. Your serious risk requiring immediate protection. We bring you into crisis accommodation. There's a 50 per cent chance you'll disclose to us a mental illness, but we'll know that 100 per cent of those that come in will have symptoms of mental illness. There's a 40 per cent chance, or nearly 40 per cent chance, 39.22 per

cent chance we will have to initiate a suicide safety plan. There's a 64 per cent chance you will disclose a risk of harm to yourself and there's a 60 per cent chance you will tell us you're at risk from alcohol or other drug misuse often as a form of coping. So the intersectionality that we see in the calls, or the contacts, is really important, and it's those nuances, you know, treating the family violence in itself, it's not an isolated thing.

So we certainly see more coercive control, particularly financial control and emotional, psychological, spiritual abuse. 62 per cent of our clients report stalking, jealousy, tracking. You know, the number of devices we're finding, particularly with women fleeing violence, is significant. Suicidality is a huge issue for us, particularly with the use of motels as an inappropriate response and strangulation. So in the calendar year 2024, over 50 per cent of people had been strangled coming into service, and we're really concerned about that, as it relates to, you know, the increase in pornography, kink and all that kind of stuff.

MS ORR: Yes.

MS TOBIN: But particularly as a predictor of future homicide is very concerning for us and the medical implications of strangulation, the long-term impacts of that. So that's what we're seeing in our services now.

MS ORR: And I want to move on a little bit and ask about providing those truly accessible, available services. So how do you ensure that the services are available for all people, are diverse, are inclusive?

MS TOBIN: Yes, so our change probably happened over two and a half years and I wouldn't say we got it all right. So there's some good learnings there, but it started initially - well it started with constitutional change to make sure our constitution was contemporary and inclusive, which it was not, and that obviously required board support which was unanimous and steadfast, and it obviously required changes at the board in order to have the inclusive and diverse representation at the board which we have.

MS ORR: I should probably clarify, sorry, did Safe Steps start as an organisation for primarily women, and then it went through a process of change?

MS TOBIN: Yes, so our service, you know, over 50 years ago, was really deeply rooted in the feminist movement and providing services for, I think, originally, battered women. And whilst our contract didn't say we should serve only women, I think the interpretation had been that. So we were really worried about who was missing support. And I think two and a half years later, the data would show that we were missing people.

And so we were really keen to correct that. So obviously it required constitutional change. It required board support and change. And then I think there's, sort of, really eight things that we needed to do to make that change. One was the workforce skillset. So the change didn't suit everybody, and we absolutely saw some attrition. There was some learnings, definitely, around the difference between communicating change and consultation, and I certainly would do that differently.

We needed to give general and very specific training so that practitioners were confident and competent. You know, how you speak to a CALD woman about coercive control versus how that presents itself with a 17 year old boy is quite different. And we needed to make sure practitioners felt confident and competent to be able to answer those calls or contacts. We need to make sure our staff reflected the diversity of our populations. That was also a change. And staff now speak over 20 languages, and we have multiple interpreter services on site.

So I would say constitutional change, workforce, and skill set. Then there was a significant number of practice changes that needed to occur around what does the evidence tell us around practice guidance, and that is always live. That shouldn't be set in stone. Languages that we use, external expertise that we get in. We have a number of MOUs with a number of service providers for specialty expertise, and it's a continual growth and learning around making mistakes, owning them, correcting, changing, and moving on.

Some of the challenges we absolutely saw in that time was, as I said, consultation versus communication. Change is hard. And we've got a long, 50-year legacy of doing things a certain way and, you know, rightly reflects the gendered nature of violence. And there were some hard fought wins to make sure it was - violence was recognised as a gendered issue. We didn't want to take away from that, but we wanted to make sure we were a service for everybody. I think we're one part of the ecosystem, and so you need to be able to make referrals downstream and upstream, so you can't make that change in isolation. And so, ensuring, for example, that refuges were also going to be inclusive, was really important to understand before we asked people to help seek, and then couldn't provide a service.

I think we had to own our own past a little bit and just keep fronting up, taking the feedback, changing practises, changing policy, and working through. And, you know, now, you know, the world hasn't fallen over, and we have recently cisgendered a man and his children in - at one of our refuges, and it's been fine. Today, though, I'd say we've still got a long way to go if you look at who calls us. So what does the data say? 14 per cent of our clients are Aboriginal and Torres Strait Islander; nearly 20 per cent identify or disclose a disability - we suspect it would be much more; 26 per cent are culturally and linguistically diverse; 28 per cent are born outside Australia; 4.5 per cent are non-permanent residents; 2 per cent are straight males over the age of 18; 1.5 per cent are GBTIA men, and other, LGBTIQA+ community is 6 per cent.

So I think, in terms of what that would have looked like 10 years ago versus what it looks like now, I think the data would tell us we were missing key cohorts that were experiencing significant harm, but we've still got a long way to go. You can be accessible, but you can then not be helpful when somebody calls. And you need to make sure the equity in what happens next. And there's still some cohorts, we worry, that aren't showing up in the service system.

MS ORR: Which - can you give some examples? Are there particular cohorts you're worried about?

DR TOBIN: Yes, children and young people - particularly young people. Really, as a, you know - if you're a 17, 19, 21, 15-year-old scared to go home tonight or wanting some support with family violence in Victoria, there really is very limited options. Now, there is children's services - I'm not saying there's nothing, but they're not available everywhere, and I - we worry that young people are stuck between child systems and adult systems, and that a response is very different from a service, which is what young people need. It's only when harm is undeniable that we will get a children's response, and it will predominantly be a statutory response. And if we want to end violence in a generation, the stated goal of our National Plan, we need to make sure that we are supporting young people in seeking help, addressing trauma, and not just providing a response, but also a service.

I think, similarly, with people with disabilities, we think that's significantly under-represented. Some of the things we see as the disability statewide provider, probably the abuse that makes me, personally, the most upset in terms of under-medication, over-medication, removal of mobility devices, sometimes from the carer, and we really worry about the under-reporting and inaccessibility of help-seeking options for disability. And, similarly, I know you're hearing from Coda later today around elder abuse; they don't show up in our service system, and we're worried about that.

MS ORR: You've talked about disability, and you do have some particular initiatives - disability initiatives at Safe - excused me - Safe Steps; is that right?

DR TOBIN: We do. So we run the statewide disability initiative, if I get the name correct, and that provides three things. So, one, we administer brokerage, which is funds to support clients with specific needs associated with their disability, when they've fled violence. So that might be physical aids, sensory toys, support workers whilst they're in crisis accommodation. We also provide secondary consultations to the rest of the State, to practitioners where they have a client with family violence so they can call Safe Steps 24/7 and we provide that secondary disability expertise, and that gets really high use from practitioners across the State, and we provide a role in educating both the family violence sector, the disability sector and the health sector on what disability abuse might look like, how it might show up and how those services can get support through Safe Steps.

MS ORR: Excuse me. You've mentioned earlier in your evidence intersectionality in calls and contacts. Can you talk to us a bit more about the sort of intersectional work that Safe Steps does?

DR TOBIN: I don't think it would be an overstretch to say every single client has multiple risk factors when they call us. And so, mental health, drug and alcohol, disability, we would see most, you know, I don't have the number on me, but I would say that most clients have multiple risk factors. And so, I think one of the challenges as a front line practical service is how do you manage the scope of what's being presented versus just the domestic violence.

So the way that Safe Steps does that is to try to understand risk very well, to build trust in that moment of help-seeking, so people feel like they can disclose, and then in terms of when somebody's staying with us, how do we have a response that's intensive,

supportive, that wraps around that person, that addresses all of those intersectional needs, and our sanctuary model would be the best example or evidence-based example I've seen of that.

MS ORR: I will get you to explain the Sanctuary Model a bit in a moment, if that's okay. In your view, what are some of the key, sort of, principles or elements of a sustainable, viable crisis response model?

DR TOBIN: So again, I can only probably speak credibly of the front line provider, and I don't pretend to speak on behalf of the sector, but from what we see, there would be five or six elements. So, firstly, to be really clear on the purpose of a crisis ecosystem, so in terms of, you know, obviously immediate safety and support, but what is its role as a secondary prevention opportunity, that's enabled by collaborative and a joined up ecosystem of family violence in South Australia or Victoria. So, you know, being really clear on what the purpose is, both immediate safety, but using that crisis moment as a really effective intervention and secondary prevention tool.

MS ORR: Can you just explain, sorry, what you mean by secondary prevention?

DR TOBIN: So I think every moment we—so when I opened by saying we play a critical role in trust, people call us - they call mini services, but Safe Steps is one of them, at their most vulnerable, probably one of the worst times of their life. By the time you call us, as I said, 70 per cent of the risk assessment is a serious risk requiring immediate protection. Very unsafe and very scared. So we have a moment to build trust which will determine what they do next. And so that's a responsibility we hold. You know, that's the bit that keeps you awake at night, because you want to make sure you're doing that in an evidence-informed and trust-building way. Could you repeat the question?

MS ORR: I asked what you meant by secondary prevention.

DR TOBIN: Sorry.

MS ORR: No, it's okay.

DR TOBIN: So once somebody seeks help, what - and they've leant into us to support, how do - what is effective help, and how do we build an intervention that changes their trajectory, that gives them more choice, that doesn't have them needing to come back through the crisis system? So, what will actually change their circumstances? And, again, that's, you know, an example of how we've tried to do that is through the sanctuary model, where we have 97 per cent safe and sustained exits six and 12 months later, versus in motels where we have 30 per cent unsafe exits and higher repeat cycles back through motels, because in one situation, our view would be that we are band-aiding and in another situation, depending if you turn left or right once you come through the doors, we are increasing your protective factors, changing your circumstances to give you more choice and outcomes. So in that situation, it acts as secondary prevention because you can get somebody income, you can sort out their visa abuse, you can get an IVO, you have plainclothes police on site sorting that out, you keep the children in school through the refuge stay, you get their health needs up to

recency, you give them an income, and then all of a sudden, in a very short period of time they have a different choice there. And that is secondary prevention.

MS ORR: Lowers the risk of further violence.

DR TOBIN: Yeah. Yeah.

MS ORR: I'm sorry. I interrupted. You were asked a the question about some of the principles or elements for a (indistinct) response model.

DR TOBIN: So yes, I think being clear on the purpose, but then secondly being clear on the KPIs and outcomes. So, you know, what are the outcomes we're trying to achieve in a crisis response system? Obviously a reduction in needing to revisit the crisis system is one that we just talked about. We'd like to see an increase in help seeking as it becomes more accessible. What are the quality measures we want to see both in in terms of the quality of risk assessments, because it's a value-adding tool and in the agency clients feel that they report that they were given through the process. We'd like to see focus on underrepresented cohorts as a KPI, particularly children and young people, and longitudinal studies telling us what the outcomes are for particular cohorts.

And I think maybe, you know, a move to less throughput, output, input, bed nights, calls-type measures, and a move to more of an outcomes-based framework, where we're looking at quality and client outcomes as opposed to numbers. I think the third element of a crisis response that we would consider important, but may be surprising, is just sustainability, both in terms of the energy to sustain the system, the economics both to fund it and to intervene properly and to reduce the cycles of violence, but something that you can still afford in 10 years' time. So energy, economics; I think around future-proofing it in terms of sustainability, so crisis response will be very different very soon as the baby boomers move on and the next generation come through. So how do we future-proof help-seeking and crisis response?

What is the role of tech and particularly the role of AI, which is where Safe Steps is spending a fair bit of time at the moment. I think sustainability would also talk to the economies of scale and the benefits in statewide and regional and remote access, You know, 24/7, 365 Victoria-wide is very helpful as a safety net under the belly of all Victorians. Being clear on the data dictionary and the data you want in 10 years' time, so what do we want to measure? This is why I sort of started with the goal, the purpose and the KPIs. What do we want to measure and how do we set up a data dictionary and a data platform and a CRM so that we can have that statewide view and be clear on what we want to measure and monitor?

I would also say under sustainability is investing in evaluations and evidence base. So what worked 10 years ago is different to what works now, as we see changes in the type of violence. And so building that evidence base so we can have very rational discussions about what is and isn't working. You know, I think that's a key component of any ecosystem. The fourth thing I would say was just to be clear on the principles that you want in a crisis system. So from Safe Steps' perspective, we would say the principle to focus on secondary prevention is a principle we adopt to give - ensure the

client has agency and it's always client-centric. That we build trust through belief. I think that's a critical component of why we get so many calls.

Twenty-four-seven, 365, because family violence doesn't happen nine to five, Monday to Friday, I think is a principle we hold. In Victoria, we have a no wrong door policy, so no matter what door you go through, whether it's The Orange Door, whether it's Safe Steps or your local family violence service provider, there's a high degree of confidence that you will be supported and the right referrals and responses given. I think that's terrific. We'd also say, you know, under clear and the principles, a principle around timely responses. You know, we see significant waitlists, and that just seems very jarring when you're very unsafe and very scared. Case management, so what is, you know, be clear on the principle of whether it's a brief intervention or it's journey walking with case management. So where does it start and stop? What is the crisis response? And connected. So, you know, we absolutely have benefited in Victoria from information-sharing legislation and a common risk-assessment framework being the MARIN. It's used every single day, and we can have a victim call us.

We can be understanding her risk whilst looking him up in the police portal and getting a broader view of what's happened historically with that family. And that has undoubtedly saved lives. In terms of key principles of a system, the last couple of points I would make is being evidence-led on what's effective. To the point I made before both in terms of what does the evidence tell us about help-seeking and what does the evidence tell us about what an effective intervention looks like. We continually advocate strongly that motels are not appropriate crisis response. We're essentially using a private sector to solve a social services problem.

And as I talked about intersectionality before, you have a 60 per cent chance you'll have a diagnosed mental illness. 50 per cent chance you'll be using AOD as a coping mechanism. 40 per cent of our clients need suicide safety plans, and we're putting them in a motel with four walls and their thoughts. And it costs $840 a night, unit cost, and we have 30 per cent unsafe exits. It doesn't make any sense to me to pour that much money into a system to get those kind of outcomes. And that's why we built the Sanctuary Alternate. The last thing I'd just say around key components as I mentioned was just some of the enablers that came out of Victorian Royal Commission have been game changers for us.

So a common risk assessment tool we use the MARIN, but, you know, that you tell, theoretically, you tell your story once and that story goes wherever you go. So you don't have to retell your story and re-traumatise. In terms of predictor of escalation and risk, as a CEO, it's the best tool we have to understand what's on our books every night and what might happen next. Information sharing around police, child protection, health services, that sharing of information allows us to get a much more holistic view of what is happening for that family. No wrong door, you really can mostly turn up in Victoria anywhere, and get a service and the right referral.

And one of the things I love about Victoria is we might get 200 calls inbound today. We might get 150 outbound. And whoever is at serious risk or serious risk requiring immediate protection, we can bring them into crisis accommodation. So it's not capped and that's the way it should be. That's the way we think it should be. So, yeah, I

think there are principles that are helpful.

MS ORR: And you've mentioned motels, accommodation and the Sanctuary model. Can you tell us a bit more about that?

DR TOBIN: Sure. I think it was innovation out of desperation, if I'm honest. But, you know, Safe Steps for 50 years has been providing crisis accommodation and the data that I gave to you has not changed over the years in terms of the use of motels and the unsafe exits from those motels and our inability to be really effective as a secondary prevention provider in that moment. So Sanctuary was built as an alternative to motels. So the analogy we would use is motels and Sanctuary, we would say Sanctuary is like the ICU unit of the hospital that you may need to go to before you go to the ward or longer-term transitional or refuge-based housing.

If you take a day in the life of Safe Steps, somebody would call in very scared, very unsafe, potentially with children. And we will be assessing their risk and trying to get more people to go to Sanctuary than motels. When you go to Sanctuary, it's cheaper. It costs $100 less a night than a motel on a unit cost basis, given the sort of consortiums we've been able to bring together, and it's better outcomes. And that is driven by within two hours of arriving you'll have a case management meeting. Your children will go straight into the schoolroom, the education. So we keep education as a constant through that. Your health needs will be met through the nurse in terms of either treating your injuries or getting your health needs up to recency. Plain-clothes police will come and do intervention orders. Centrelink is onsite separating you on My Government accounts or getting you an income. Legal Aid is onsite sorting out intervention orders or child protection issues.

Child Protection comes onsite. Immigration will sort out your visa abuse. There's animal therapy, music therapy, the list goes on and on. Our counselling services, etcetera. And what we've found and what the evaluation has found through that is that we can provide that $100 less a night to the taxpayers and the outcomes we're achieving there are really great. So 97 per cent safe, and sustained exits 6 and 12 months later. And I think that underlying difference in the two systems is if you wrap around somebody in their time of need, and you practically get safety and stabilisation, and you actively work on how we can build up protective factors, get them an income, sort out the visa abuse, keep their kids in school, get the health needs met, start therapy, at a very short period of time, like, two weeks, we can change somebody's circumstances.

And they have more choice about what they do next. And so we'll see much greater safer and sustained exits, but a much greater agency around, you know, social housing, private rental, interstate moves, safer home measures, you know, with intervention orders and police involvement. And so we would like to see more people go into that type of model than into motels.

MS ORR: Thank you. That brings me to the last topic and that is thinking further ahead now, do you have any views about the likely future of help-seeking?

DR TOBIN: Yes, I think I just did a Churchill Fellowship on this, and I think help-seeking will look very different in the future. 44 per cent of the people that stay with

Safe Steps on any night are children and young people. And we know that trauma untreated becomes intergenerational trauma. And so we'd really like to see, as I said before, a much stronger focus on the recovery, response, healing and service provided to children and young people. They're not going to call a 1800 number, and I say that as a 1800 number, both with 1800RESPECT and as Safe Steps Crisis. I think we really need to look at our relevancy to young people going forward.

You know, at the moment they're in platforms, roadblocks, Twitch, Snapchat, all those platforms. And we ask them to leave that and come and call a 1800 number. We would be really advocating strongly for services taken to the places and spaces where young people work, play and exist. And that is much more tech-enabled, digital, outreach-based models, pop-ups in the platforms that they're in that is relevant in the language that they use, that is not adulting or pathologising or parentifying. I don't think we're particularly relevant to young people. They see services like ours as sort of more middle-aged women type services.

And so we looked at models overseas that really have sort of taken that head-on and said, "How do we future-proof the health-seeking ecosystem?" So what will that look like in 50 years time? And what are the incremental steps we need to get there? And I think technology and AI will play a really important role in that.

MS ORR: Thank you. I have no further questions, Commissioner.

MS DESPOJA: Thank you, Counsel Assisting. Thank you, Doctor. I think you just pre-empted my first question, because I was curious about your references to the use of AI. But I can see when you talk about some of those social platforms and how to appeal to young people, and not only when you're talking about adulting, I imagine not infantilising young people and children as well. But are there other uses for AI in the context of the work that you're doing?

DR TOBIN: Look, I think obviously bias and privacy are significant issues and so I don't discount them, but there's certainly countries overseas that have taken that on. And, you know, we've seen some models where AI is used particularly when your demand exceeds supply of service provision, where AI will be used for triaging. So any connotation of suicide in the chat function will bring you to the top of the list and that's, you know, as long as it's done safely and securely, and with privacy and bias, all that, I think that's a really good triaging addition.

MS DESPOJA: Yeah.

DR TOBIN: The thing that I'm really interested in that is where they've used AI to mirror language. So you know, it might say, "Hey, Chelsea. There's a five-minute wait. Just while we're waiting, do you want to give us a sense of what you are contacting us about today in a chat or text?" And then we would use your language and mirror that back to you through natural language processing to build trust. You might use the word "toxic" or "harmful" as opposed to "family" or "intimate partner violence", which no young person ever uses.

MS DESPOJA: Yes.

DR TOBIN: So we would use that language when we speak to you to make you feel listened and heard. We would also use it for issue identification around, "Hey, these are the types of issues that this young person is speaking about. Here's some prompters for what might be helpful from the evidence-base or the practice-guidance that we have in place." And then from an efficiency and effectiveness perspective, we're interested in terms of how it writes up case notes. So that we can get the caller back onto the next call, and we can't answer every call that we've got. How do we provide a - how do we use technology to enable, never replacing professional judgement ever, but how do we use technology to write up those case so that we can have - so that we can get onto the next call.

Now there's significant bias, privacy issues within all that. However, there's other countries particularly around Canada and the Nordic countries that have taken those issues on. And for example, Kids Help Phone in Canada have a 90 per cent accuracy rate around issue identification and triaging through partnership with the Vector AI Institute, a not-for-profit institute, and that is helping them get to more people. So this is a personal view from Safe Steps, but we think we need to lean into that as opposed to fight that off.

MS DESPOJA: Really interesting because we've heard about, sort of, the weaponising of AI in this context but that concept of enabling is very helpful for us. You've given us a lot of statistics. I've tried to keep up with most of them, but I'm trying to do some math here. And that is you've mentioned a lot of different cohorts, but in terms of your calls or the people that you are helping, how many would identify as female?

DR TOBIN: So the way I would just deduce that would be - - -

MS DESPOJA: Adult female, if that helps?

DR TOBIN: Because the reason I hesitate is that it can be in multiple groups.

MS DESPOJA: Absolutely.

DR TOBIN: So when I listed off who calls us, you could be disability and CALD and a member of the LGBTI group. So I think by deduction I can give you the exact number. It would be 85 per cent, thereabouts.

MS DESPOJA: Thank you. How do you plan for, given that it is a regularity, that 10 per cent increase in demand that happens, you know, between AFL and Grand Prix season, for example. Do you get extra funding for that or do you allocate additional staff? How do you manage those peak periods which are, as you've said, in response to council assisting, they're predictable. We know this happens. How do you manage it?

DR TOBIN: So we roster to demand. So we'll look at the seasonal pattern every day. Like, every single day I'll know how many calls have come in and how many calls have come out and what the risk profile of that is. And we'll track that every day over 50 years, and you get, you know, that kind of - you see that seasonal pattern and cycle. So we will roster to demand. You know, I think you had South Australia Police here with their heat maps around how they do that?

MS DESPOJA: Yes.

DR TOBIN: They wouldn't be dissimilar, so we will roster to demand. We know what happens after public holidays, after certain events, and we'll have more staff on. In terms of the funding, the funding is block funding, and we will allocate that smartly over the year as we need. What I would say that is a little bit trickier is the changing nature of violence around that seasonal pattern and the role of coercive, sort of insidious, incestuous, pervasive kind of abuse, and that as a predictor for escalation or homicide or suicidality that is the tricky bit after events to understand. You know, we know there will better experts to speak to this than me, but you know, when we hear strangulation, we're very concerned about what could happen next if we don't intervene as a predictor of, you know, future homicidal, future harm. Certainly after events where we've seen significant alcohol or gambling or cost of living pressures, how that manifests in a coercive, control, stalking type of environment, I think we're still learning about what the seasonal pattern of that looks like.

MS DESPOJA: Yeah.

DR TOBIN: Does that make sense?

MS DESPOJA: It does make sense. And it was interesting going back to one of your first statistics that you mentioned that, you know, when you do the risk assessment you were saying, like, 70 per cent were in that top two per cent of risk.

DR TOBIN: Top two categories.

MS DESPOJA: Top two categories, sorry.

DR TOBIN: So the MARIN had, yeah - - -

MS DESPOJA: Top, yeah, sorry, 70 per cent top two categories.

DR TOBIN: Yeah.

MS DESPOJA: That's what I meant, yeah. That's quite confronting. We've talked about a number of services, and you have mentioned other available services in Victoria including Orange Doo. Just can I clarify because we've heard a bit about Orange Door, is the most fundamental difference between the two the business hours, the reference to sort of non-urgent cases or is it the face-to-face dimension? If you had to clarify the difference, and I'm sorry if that's an unfair question because I'm not sure if it's exactly that linear, but let us know - - -

DR TOBIN: Yeah, I mean, there would be better experts to speak to The Orange Door, but there's a No Wrong Door policy in Victoria. So no matter what door you go through, you should, and I have confidence that you will get a trauma-informed family violence response and appropriate referral. The Orange Door was set up out of the Royal Commission under the recommendation of safety hubs.

MS DESPOJA: Yes.

DR TOBIN: So how do we have a more holistic view of a family and so onsite in Orange Doors we have perpetrator services, victim services and child well-being and child protection services.

MS DESPOJA: Yes.

DR TOBIN: And that's fantastic. They are physical locations in each local government area, and they're open 9 to 5, Monday to Friday. Safe Steps is predominantly a phone, you know, webchat-type service, 24/7 statewide, and they're both intake services. And we will both - whether you go The Orange Door or Safe Steps, you will be believed. You will have a MARIN completed around your risk assessment and then a referral made as intake services, and that should be fairly consistent. So one of the differences I see is the business hours absolutely, and you need to correct this. But I think historically a lot of The Orange Door work has been police response work and Safe Steps has been victim calling, you know, victims calling us response.

So an NGO separate from the government where victims call. And I understand it is changing, but historically a lot of work for Orange Door has been responding to police call-outs.

MS DESPOJA: Thank you. That's really helpful because while we're reflecting on some of the outcomes of the Victorian Royal Commission in this space, obviously there, you know, are a couple of issues that are relevant to the work that we're doing. So Royal Commissions can do good things in this space.

DR TOBIN: Absolutely, we will benefit. Information sharing, the MARIN, The Orange Door and the uncapped nature, it is really important.

MS DESPOJA: Yes. No pressure. My final question just out of curiosity, the Sanctuary resident profile is really, really informative and helpful, thank you. Am I missing something? Are pets allowed?

DR TOBIN: Absolutely. I think I'm going to get the number right. It's 200 or 300 pets we had in the last calendar year through services. We'll either, and your expert this afternoon will be better placed with this, but we have agreements and funding with a number of pet providers where we'll either have the pets in service, and we've had some really interesting pets staying with us, or we'll have foster care services or crisis services. But absolutely, and your expert this afternoon will be better informed, pets have often been the only form of comfort for a victim-survivor. I have seen firsthand pets getting weaponised. I've seen text messages where he's threatening to, you know, knife the cat on a photo if she doesn't come home right now or do what he says.

So the role of pets in family violence, would say pets are part of the family, and people won't leave unless they can take their pets, so why would we have that as a barrier?

CMR DESPOJA: Indeed, and you're right. I look forward to the evidence presented this afternoon from counsel assisting, but yes, I do recall seeing some rather lovely rats

in – pet rats, in one of the facilities that Chedi and I were able to visit but –

DR TOBIN: I think we had a horse not too long ago.

CMR DESPOJA: Okay. Well, that's not big. Okay. Thank you very much for your evidence. I hand back to counsel assisting.

MS ORR: Thank you, Commissioner. I ask the witness to be excused.

CMR DESPOJA: Dr Tobin, you're free to go. Thank you.

CMR DESPOJA: And we will take a break. Thank you.

ADJOURNED

RESUMED

CMR DESPOJA: Welcome back to day nine of the public hearings for the Royal Commission into Domestic Family and Sexual Violence. I hand over immediately to counsel assisting us all.

MS ORR: Thank you, Commissioner. I call Adjunct Professor Muriel Bamblett and Mr Craig Rigney.

MURIEL BAMBLETT, AFFIRMED

CRAIG ANTHONY RIGNEY, AFFIRMED

MS ORR: Thank you, both. I'm going to start with just some very brief introductions - or background, if you like. Starting with you, Ms Bamblett, you are the CEO of VACCA, and have been since 1999; is that correct?

PROF BAMBLETT: Yep.

MS ORR: Could you tell us what VACCA is; what is VACCA?

PROF BAMBLETT: The Victorian Aboriginal Child and Community Agency.

MS ORR: Is that a provider of family violence services in Victoria?

PROF BAMBLETT: We provide child welfare, family violence, housing, homelessness, justice - a full range, over 80 programs we offer.

MS ORR: Is it correct that you are active in many advisory groups concerning the Aboriginal community nationwide?

PROF BAMBLETT: Yeah. I co-chair the steering committee to develop the first ever stand-alone family safety plan. So, with Craig, I have the absolute honour to be on the

steering committee, to develop the action plan and the national plan as well. In Victoria, I'm on the Dhelk Dja Family Violence statewide family violence form.

MS ORR: I understand that you were made an adjunct professor in School of Social Work and Social Policy at La Trobe.

PROF BAMBLETT: Yep.

MS ORR: And you have an honorary degree by the University of Sydney in recognition of your outstanding contribution to Aboriginal child and family welfare.

PROF BAMBLETT: That's, yeah, the University of Sydney. Thanks.

MS ORR: And you've been recognised with many awards, including the Order of Australia, for your work in this space.

PROF BAMBLETT: Yep, thank you.

MS ORR: And you're very modest about it.

MR RIGNEY: Very.

MS ORR: I'll move on, because I can tell you don't like the attention.

CMR DESPOJA: You've got a litany of accolades, so – but you're so modest, you really are.

MS ORR: And I will ask you more about the steering committee and the family safety plan in a moment. Mr Rigney, you are the CEO of KWY Aboriginal Corporation in South Australia. Could you tell us briefly what KWY is and does?

MR RIGNEY: Sure. KWY is an Aboriginal community control organisation. We were created out of the need to work with men who use violence against Aboriginal women, predominantly in South Australia. And since then, our business has grown in the domestic violence and sexual space, sexual violence space, quite considerably over the last 15 years, where we offer a holistic response to families' experience, or who have experienced DV and particularly from its cultural formats, what does that look like through family violence. And sadly the intersectionality between other government systems has drawn us into those spaces as well, the Department of Child Protection, Education and Health. And that's predominantly the work that we do now at KWY.

MS ORR: And when did you start at KWY?

MR RIGNEY: 2011.

MS ORR: You're also a representative on national advisory councils in relation to Aboriginal family and domestic violence and childhood strategy. Is that correct?

MR RIGNEY: Yes, I am.

MS ORR: And as Ms Bamblett's mentioned, you are also on the steering committee for the National Aboriginal and Torres Strait Islander Family Safety Plan.

MR RIGNEY: Yes I am.

MS ORR: Great. I just want to ask a little bit about that Family Safety Plan. Perhaps, Ms Bamblett, if you can give us some information, what is it?

PROF BAMBLETT: It's obviously the first stand-alone national plan on domestic, sexual and family violence, and so we've been on a journey to really establish that plan over the last – well, nine months?

MR RIGNEY: Yeah.

PROF BAMBLETT: Nine months. And so I think the work that we've done is really to, sort of, understand the journey in family and domestic and sexual violence, although at times not as much on the sexual violence. So we've been really trying to really elevate that a lot. But the journey, the why, the plan, we've worked on a vision, our principles. Our groups are focused. We've taken a phased approach to a roadmap. We've – in our report you'll see consultation themes. You would understand the complexity of – this is no easy issue, otherwise people would have solved the issue of family violence a long time ago. The context for this plan is obviously in relation to a range of strategies, policy.

The Commonwealth really wants it to be a policy framework, not a plan. And so, they're really keen to, sort of, implement a policy framework. And so, on this journey, we've had all the jurisdictions, states, and territories. So the name of the plan is "Our Ways – Strong Ways – Our Voices." So very much, we worked on that. The principles that we've landed on are: agency, self-determination, and human rights; around voice, strength, resilience, healing; in transformation of institution and systems, inclusions, intersectionality, evidence, data, ecosystems, accountability; and respect for country waters, lore – L-O-R-E – and language.

Particular focus, particularly in relation to the work that you're doing is that we had – our focus is really around governance and partnerships around the centralised voice of victims, and particularly women and children, self-determination and agency. We've got to focus on, rebuild, and re-engage with strengths and I know that Craig really wants to talk to that and so it's really important to see resilience and therapeutic healing and other elements of cultural practise and seeing our culture and the way that we use culture as healing.

The second phase would be around laying the groundwork for institutional systems reform, strengthening evidence and data ecosystems. The last phase that we put in is embed and expand institutional system reform; sustainability of Aboriginal and Torres Strait Islander-led solutions; strengthen housing and financial security programs; measure, monitor, evaluate and institutionalise data sovereignty and indigenous research leadership. And so, I think what you're going to hear from Craig today, really, is about

lack of evidence, lack of evaluation of what works and how do we actually do that. So, as you can hear, there's quite a lot of depth of work that we've done with the National Plan. The National Plan actually came after the first action plan, so when the government, you know, did the National Plan to end violence, there was a lot of Aboriginal content within it. And sadly, a lot of that content hasn't been delivered on, so there's always a danger, everybody puts a lot of things in, but don't, actually.

So we were responsible for the first action plan. We travelled all over Australia, the Torres Strait. We went to each community, and so we were able to get a rich lot of evidence from across the state to inform the action plan. So a lot of the things that have come out of the action plan are particularly focused on refuge - the Escaping Family Violence Payment, but also putting some resources, particularly into remote communities to support those. And so the evidence and the information that's coming out is really critical to say that almost 70 per cent of those accessing the Escaping Family Violence Payment are first time accessing family violence, so it talks too. And there's also over-representation, obviously, of Aboriginal and Torres Strait Islander women accessing that. So that's a very long answer to one question.

MS ORR: Not at all. I just wanted to ask you one more thing. It's now - you've talked about the action plan, but this is now another stand-alone plan, which is called a Family Safety Plan, isn't that right. On a day of evidence about family violence, it's important to - - -

PROF BAMBLETT: Yeah, I think that - yeah. And our plan has all the jurisdictions on board, and so we've really tried to align it as well with the Close the Gap and the implementation. And so the reform priorities, which are Aboriginal shared decision-making, that's the first one. The second one is investment in Aboriginal community control. The third one is, basically, mainstream accountability and cultural safety, and the fourth one is data. And so, I think a lot of our focus is - and, you know, Craig's spoken about, what's the data? How do we know? Often, we don't know what the problem is, because the data doesn't tell us. And so I've just brought - Justice have put out, and so I thought I'd give you, that's the Justice data that we get, data from our family violence, as well, in Victoria, so just to give a sense of how important data is in telling the story.

MS ORR: Thank you. I'll come now to the sort of very broad question, the theme of your evidence today, and that is, in your opinion and based on all the work that you've done, what do Aboriginal and Torres Strait Islander communities in South Australia need to move towards a future without domestic, family and sexual violence? And in preparing for this evidence today, you've identified some sort of key points in response to that question, so I'll take you to some of those now and ask you to elaborate on them for us.

PROF BAMBLETT: Can I just - I'm terrible, I haven't acknowledged the land, because I'm, obviously, Yorta Yorta, Dja Dja Wurrung, Taungurung, Boon Wurrung woman, and I'm visiting here, on Kaurna land, so I just want to acknowledge the Kaurna people, their elders past, present and emerging, and really sort of pay homage to, obviously, Craig. And I just want to put in the room that Craig's been the lone voice for South Australia for a very long period of time, and I'm absolutely honoured to

sit here with him, but you have a treasure in that we don't have a lot of men that come to the National Forum, that can speak with authority and respect. And, I think, South Australia, you know, really doesn't understand the value of an Aboriginal man speaking about family violence and being able to stand behind their word, and so I just wanted to sort of say, that ought to be appreciated at the national level, and, you know, the work that he does. Thank you.

MS ORR: Thank you for that.

CMR DESPOJA: That is well noted.

MS ORR: So the first point that you have identified is a coordinated system that privileges voice of lived experience and survivors, but above all else culture and self-determination, which means dedicated Aboriginal-led responses. Mr Rigney, is that something that you'd like to expand on a bit more for us?

MR RIGNEY: Yes. Thank you, Aunt, for your very kind words. And I also just want to acknowledge that we're meeting on Kaurna land here today, and those ancestors, and those women, and children, and men that have come before us and, particularly, in this space, and the leadership that they've shown around these types of conversations, and that their and our cultural connection is as strong today as it always has been, so thank you for that.

Look, I think it's a very big question, with lots of complex responses available, but I think, when we talk about Aboriginal-led decision-making or the research, globally, it really highlights the point that First Nations responses are best done by First Nations peoples. And in South Australia, in particular, we have two specific Aboriginal and Torres Strait Islander organisations, being Aboriginal community-controlled organisations in this space, and we know that there is more need and, I guess - I'm just trying to be very mindful of my language, that the need for Aboriginal community to access our services is there. What we do know is, there is, I guess, a real lack of funding for the ACCOs in this space, for the very specialised work that we do and they "why" that we do it.

I think there's also a misunderstanding, certainly not through a lack of the sector wanting to know, but certainly the ability and having the resources and the time for the ACCOs to really do the work that we know we can do well. And there just seems to be, from my very narrow point of view, I guess, in the sector in South Australia, what is, and where is, the specific Aboriginal and Torres Strait Islander funding, both from the State and from the Commonwealth? And, you know, that'll lead on to some other comments and statements around what is the responsibility of the State here in, I guess, going to Commonwealth for specific funding - and we can talk about closing the gap targets, but, really, at the end of the day, I think the need for an Aboriginal and Torres Strait Islander specific response is most definitely required here.

That's not to say that all Aboriginal and Torres Strait Islander people are going to want to access that, but I think the choice needs to be given. And we know, anecdotally speaking and through the other work that we do in the community, that there is absolutely a need, directly and indirectly, for those families, children - the voices of

children and, of course, women and men to be able to access and have multiple access points, I think, across the governance streams, and the government streams in South Australia. And Aunty Muriel, I'm sure, we'll talk more about that later on, around what does the governance system look like for us in South Australia. So, I think, you know, the basic fundamentals for us is access for Aboriginal and Torres Strait Islander people.

Very importantly, Aboriginal children that are experienced - or have experienced, sadly, DV in their homes and in the communities, and the traumatic effect - the lifelong effect that that's having, and the overlap of the removal of such, you know, children going into the child protection system, when we see a huge percentage of our Kaurna notifications for Aboriginal families to the child protection system are for family violence. So we've got the pointy end response that we know, obviously, is where everyone is focused, but I also think, you know, what does our intervention and primary prevention responses look like, again, from a cultural perspective and from an ACCO's perspective.

And there just seems to be a real lack of acknowledgement around the holistic work that we do for our communities and the overlap, you know - to use this very Western governing language, the overlap across - and intersectionality across - all systems, where our families sadly, yeah, are experiencing DV, and what does that look like, and a real lack of communications between those systems, and certainly a real lack of communication to us, as ACCOs. And, you know, the data - the availability of data that we see interstate and where does that sit across South Australia.

MS ORR: I will come back to data in a moment. Aboriginal-led responses, that includes, I imagine, Aboriginal governance and infrastructure.

MR RIGNEY: Absolutely, yes.

MS ORR: Workforce.

MR RIGNEY: Yeah, absolutely; yeah.

MS ORR: Workforce strategies.

MR RIGNEY: Yeah, workforce strategies, recruitment, retention, you know, qualifications, what are, you know, qualification framework, as well as, you know, the transparency and accountability framework that sit within that as well

MS ORR: But moving on to the second point - and you have touched on some of this already, you identified commitment to an Aboriginal stand-alone system and policy platform. Would you like to talk about that?

MR RIGNEY: Yeah, and, you know, I will probably ask for Aunty Muriel's support here as well, you know, given what we are doing at the national level and what we've seen in Victoria, and how, you know - there's no perfect, you know, or silver bullet for this type of work, but I think we've got to start somewhere. And when we talk about self-determination and self-management, and what that means in the reality of the work that we do, currently there's a real lack of that. So my glass-half-full outcome to this is, we absolutely need a governance framework here, in South Australia. We need a

standalone Aboriginal and Torres Strait Islander domestic violence peak body that oversees and advocates for the organisations, the ACCOs and, of course, the community members in the space around the work that's needed and required.

And, you know, to really scaffold and build up the foundations for that, we have to, of course, have funding and implementation around what does that look like. And I think, for us, that is probably one of the crucial points in a long term implementation plan beyond the royal commission. And I think, for us, the ability, we're ready and willing to do it, and I think that's the important part here. You know, we sadly hear catchphrases thrown and directed at ACCOs around capacity building, and if you had the capacity, well, it's simple, the capacity comes with funding. We will resource that. We will be able to do the work. So, again, it's what does this look like through our world view versus everybody else's, and I think what the commission does is, it gives us an opportunity to put some of those voices forward, but very broadly.

And with the two, I guess, larger echoes in this space that are doing the work, you know, we are ready and willing to take more on where we can. And, you know, the downside of that is we're doing so much work outside of scope, outside of funding, because we don't want to increase the risk to women and children. For us, it's how do we work in that holistic manner, where safety is at the forefront, and safety or women and children is t the forefront of what we're doing, and also working with those men who choose to use violence from a gendered perspective. So there's a lot to go in there and to break that down, but certainly from that governance structure, we've seen it probably work well interstate, and I'd be more than happy for Aunty Muriel to outline some of that governance and how that works.

MS ORR: Yeah, could you do that for us?

PROF BAMBLETT: I think my approach today was to say that South Australia can, and absolutely every state and territory needs to, do better. In Victoria, we're the largest provider of family violence services. So at the moment, we are based in 13 of the safety hubs across Victoria, in the six regions. We provide one of the two Aboriginal access points, so we're piloting Aboriginal access points, and so ours is located in Aboriginal health services. We provide two of the four Aboriginal-led sexual assault services as well, which are often very full of (indistinct) so many numbers coming in. We have a five-bedroom - five-unit refuge, and in Victoria there are five refuges. We provide therapeutic support, financial counselling, men's and women's groups, including health and behaviour change, as well as being a pilot site for men's perpetrator housing scheme.

Our prison outreach programs are well utilised, with many of the men in our prisons, perpetrating violence or being victims of violence, and so being able to work with them in the prison system. And even we run Koori Women's Diversion and Koori Men's Diversion, and so working with women around understanding that the violence that, you know, they've experienced, that, you know, that's unacceptable, and so we're really working with women. We run, what we call, deadly loving camps. They're with a focus on relationships for 13 to 17 year olds. We are also now starting to run for 10 to 13 year olds, camps and educational awareness, so that we can get into young people a lot earlier, not just girls, but young fellas as well.

We run a number of project, including educational videos, communities of practise, and so we've got a lot of young people speaking about violence. We do actual videos of what violence - how violence is perpetrated in Aboriginal communities. We have a statewide lead for cultural safety, and so, within nine of our regions, we work with mainstream around making them culturally safe. We do receive between 400 to 600 family violence referrals each month, so that give you an idea of how big the impact of violence is. We see clear patterns of reporting, particularly when school goes back, so we believe education is a critical, you know, sort of part of the system that we need to work on. If we compare Victoria and South Australia, we've got similar Aboriginal population numbers, but obviously, clearly, we're a little bit richer than you are over here, and so infrastructure and system response is different.

We have - and what's made the biggest difference is, government has committed to 10 per cent of all funding to go Aboriginal. Obviously, it's not enough; it's not proportionate to demand, but it has allowed us to be able to build on innovation, therapeutic responses. We now, in the child protection space, are undertaking investigations, and what we're seeing is, a number of those investigations are family violence. So 72 per cent of children in care in Victoria come into care because of family violence. And so, it makes sense that we have the ability to work in that family violence. Therapeutic work - just touching on Craig's comment about governance in Victoria, 21 years ago we had a taskforce. Out of that taskforce, the Victorian Government did a response, and so, since that taskforce, we've had two 10-year plans - I'm sorry.

Out of that, we established 11 regional action groups, and so each of the regional action groups come together, and we meet with senior people within the department, senior people within the police, and everybody, and we have - because we have a dedicated Aboriginal Family Violence Courts, as well, and protocols with police, all those things, system-things start to come. And then, we have housing and other providers that provide input into what we need around prevention, what housing issues, what child protection issue, what policing issues, what Court issues, and so you start to see and get a better sense. And so, I think data in the police, we do get data from the police, as I said. We also see the L17s, and so we're part of the L17 referrals. We've got the Aboriginal Access Point. We're piloting some of the journey workers, so that's a new program that's mapping our journey.

MS ORR: Can I just stop you, sorry. What's an L17?

PROF BAMBLETT: The police response. We have local Aboriginal practice, and so we have the family violence. The Orange Door have Aboriginal practice leads in the children's family violence. So the expertise, the referral pathways, often when a family goes to the Orange Door, they have to wait up to two to three months before they ge a referral to a service. Our waitlist is just two weeks, so we're able to turn around, get families. But we don't just work with women and children; we work with men, and so being able to have men (indistinct) circles, being able to work with and have Aboriginal men. When I started, in fact I think, we had one male. Now, we have (indistinct) And having Aboriginal men in the workplace has really strengthened all of our parenting programs, our practice approach, our work with prisons. It's just changed the whole landscape around, being much more inclusive. And so, yeah, I'll

probably stop there and hand over to - - -

MS ORR: I want to ask you a couple of questions coming out of that. Perhaps, Mr Rigney, would you like to add anything to the importance of, well, men being involved in the workforce, men being involved in the work, but also working with Aboriginal men, in this context?

MR RIGNEY: Yes, I'd like to add something. And I think it's just some real basic 101 responses that I'm about to give you. You know, from a gendered perspective. And we're talking about gendered violence against women. We need to be talking to men. We need to engage men and boys, and in order to do that we need a workforce that can reflect the need for that, and we need a – as crazy as this sounds, we need a safe space for that workforce, for men to be safe, and particularly for Aboriginal men to feel safe in that space when we're talking from a cultural response.

And with that become – we heard Aunty Muriel mention lore, L-O-R-E, as well. So we're very lucky that we have three loremen working at KWY at the moment across our family violence responses and holistic models in our men's behaviour change programs. So we're using culture as a strength, and culture – within our culture, the strength-based responses of accountability and discipline and responsibility; but also of gender balance, and roles, and what does that mean for Aboriginal men and their identity.

So for Aboriginal men to want to be in the workforce, we have to ensure that cultural safety is there, and whether that's within an ACO or an NGO or otherwise. So the importance for Aboriginal men, and men generally, just cannot be underestimated when we're doing this work, and when we're talking and asking and wanting men to have those conversations around accountability and responsibility, then of course the workforce needs very specialised training to be equipped to have those conversations.

The last thing we want to do is for people to assume and not feel safe with the work that we do, and you know, think that we're going to collude in some way with these men who choose violence. So we are really, I think as a sector, yearning for that; and particularly ACOs, we seem to do that very, very well. We do do that very well. The evidence is there. The recruitment and retention of Aboriginal men within KWY in this space. But also I think it's their knowledge and what they bring and the importance of that in the broader workplace as well.

So, you know, we want to be having questions and conversations through a multidisciplinary response. Where we're working with children, we have a children's worker; we have the men's worker working with men, the women's worker working with women. There is accountability frameworks all over the place there, there is, you know, the safety aspect of that, but it's also the knowledge sharing that takes place at that practitioner level. And Aunty Muriel, when we're talking about data and what that means, you know, the KPIs can often be skewed, you know, versus, you know – it's a cattle mentality.

How many people are coming in and how many people are leaving? It's what we do in between that matters. So we have these huge data voids from our funding criteria,

which not a lot of people are interested in, and they're certainly not interested in the way we do that in a cultural response and the understanding the need for that to take longer, because that's just the way that we've been doing business for 80,000 years. So, you know, we're trying at some points to get a square peg into a round hole as well, which affects recruitment and retention of Aboriginal men in this space, and feeling safe to do that work.

MS ORR: I was going to come back to data, so I'm glad you mentioned it. Throughout your evidence, you've both talked about the importance of data; collecting data and, sort of, that being needed to design an effective system. Can you talk a bit more about that? I don't know if either of you wants to start.

PROF BAMBLETT: I think data's critical. I mean, it's the ability to look not only at the narrative, but also the analysis and understand because one of the things that we picked up in one of our regions is 85 per cent of violence perpetrated against Aboriginal women was by non-Aboriginal men. And so that sort of challenges – well, wait a minute, we're focusing all of this and the deficit language is on Aboriginal men. And so how do we understand? And so I think data is, you know, in the court system, and you've got like this data here, and I think other data that we get – we get really rich data, but – and how it affects, like – we're working on this, obviously. I'm part of the Coalition of Peaks, and we're looking at data projects, and looking at how do we actually better localised data, because most – if you go to most of the communities, you can ask them what they know about the data, and they will say to me have I got a - you know, if you say, "What do we do about family violence? Have we got a family violence program?" And so who - where's the violence? What's the age? Who's perpetrating the violence? And so a lot of the communities don't get that richness of knowing what the local data is, and so how do you come up with a plan? How do you address it?

And I think, for me - you know, like, the data as well needs to as well be able to pick up Aboriginal evidence and evaluate Aboriginal ways of knowing, being and doing. So quite often - like, I spoke to one of Craig's staff, Tom. He would pick me up, and we were going back, and he's saying that he has got this new funding, and I said, "Have you got an evaluation framework in?" "No." And I said, "How long have you been operating?" "12 months." And I said, "You're missing a lot of really rich information already that hasn't been collected."

So it will get to the end of the valuation and they won't, you know - and we miss the nuances of Aboriginal, and so picking up a client doesn't mean much to, you know, mainstream Australia, but it means people will turn up and come, putting on a meal, being much more sociable. Those things work, and so how do we, you know - and a lot of the work that we're doing in Victoria is to build an Aboriginal evidence base about what works, Aboriginal practice frameworks, and being able to make our culture visible in the work, and I think that's really critical because - I think you've talked about - you've touched a little bit on workforce, and so we've been doing some work around the multi-agency risk assessment framework.

We've been doing the work around minimum mandatory quads, which is killing us, because we want skilled workforce, but we're not getting any workers out of the

universities or TAFEs. We're not getting social workers, and so what they've written in Victoria - that to work in family violence, you've got to have a qualification. We are absolutely bringing in trainees, and there has got - you know, we've had to do a truckload of work to be able to negotiate about how do we bring Aboriginal people in, because the future will be we will have less of a workforce, and so how do we get that expertise? How do we build it?

And so there are a lot of the things that we're trying to think - but we're trying to put it into it - rather than child protection over here and family violence, let's - what can we do together about workforce? And so I think if we don't - if this inquiry doesn't recognise you've got to build the Aboriginal workforce, you've got to be able to future-proof it because if you don't think about it now, when you start to put the 10 per cent funding out and say, "We want you to run therapeutic. We want you to run prevention. We want you to work in housing. We want you to work in all those areas," that you haven't matched your workforce and you haven't got a workforce ready to take on all responsibilities. So I think that's really, really critical.

MS ORR: You mentioned earlier, Ms Bamblett, a task force in Victoria.

PROF BAMBLETT: Yes.

MS ORR: Is that something that might be considered in South Australia? Do you think that would be valuable?

MR RIGNEY: Absolutely.

MS ORR: I'm asking the hypotheticals, but what could that involve? How could that benefit the system moving forward?

MR RIGNEY: Look, I think the stand-alone task force - you know, it's - it - what the evidence and what the knowing and doing that can bring to the table outside of a commission would absolutely build on the evidence base that Aunty Muriel has been talking about and gathering the data around the responses, why it's practised, what does that look like, the localised responses that are required, and in particular, the way that Victoria have ran that task force over the last decade and where they've gone out to communities to get that local flavour and to get the real on-the-ground data, to be able to feed that back into, you know, that governance structure that we mentioned earlier.

So it's something, again, that - in South Australia, where we were once leaders, we've kind of fallen behind. So I think - I'm not sure why we continue to look overseas, elsewhere, particularly in the DV space or the child protection space. We've got the opportunity, from an Aboriginal space, to learn from each other here, and particularly when we've got such great modelling. And, again, it's not to say that that is 100 per cent true and correct or that it would fit here, but we've got an opportunity to look across borders and enhance what has worked to bring back to South Australia, and to partner with – you know. We're talking about silos and breaking down barriers. That goes from state to state as well and, you know, we do it at a very local level. We do it at an ACO level very, very well across the country; supporting each other and sharing our knowledge and intellectual property, because it's not ours. It's cultural. So I think a task

force will enable us to really encapsulate all of that knowledge and bring it to the table for the benefit of everybody.

MS ORR: With a view to then designing the response, designing the governance structure.

MR RIGNEY: Absolutely.

PROF BAMBLETT: I think it gives you an opportunity to hear the harsh truth, I think, sometimes, localised. You know, to be able to hear – I mean, what we've discovered in Victoria. And we didn't really match it because we heard about sexual violence but because we were all focused on family violence and domestic we didn't really, and we still haven't picked up, and we keep, like, missing the nuances of sexual violence and the impact in Aboriginal communities, and that's because it's such a harsh reality to deal with. But if we don't come up with it, we just perpetrate the silo.

But I think Aboriginal communities, well, after the task force, and then we developed 11 groups. And they came up with things we would never have thought about, you know, and funded different things. So they had, in Gippsland, they had the men saying, "We're going to march through the street." And we're like, you're going to march? "We're going to stand up for our women and say, you know, like we're not perfect, but we, you know, we're prepared for that." So they started doing different things.

Then they started funding, like, t-shirts for kids to play basketball, and participate and then encouraging them to, you know, some of our Aboriginal football teams to sign up to No to Violence. And so it was just really innovative, different ways of attracting and getting local communities. But people don't realise, just like the basketball carnivals, and the football carnivals, they're like our corroboree today, you know. That – you hear about the big one that happens in New South Wales, but we have our basketball carnival. That's the only time where Aboriginal kids see other Aboriginal kids.

And so it's so important to get imagery and t-shirts and, you know, messaging out about, you know, No to Violence. And I think Aboriginal people know how to get messages out into what forums and how to do it. And if you went to local communities, they would say, just come out and yarn with us. Don't, you know, come out with your big, you know, big box of people, sit in a room and, you know. Yarn on the – sit down under a tree, yarn with us. And so people want different ways. And I think you cannot design a family violence system that would work in, you know, Adelaide here, but not work in the (indistinct) and so – Port Augusta, or so – what would it look like?

And so having the opportunity to have regional and come up with – and so in Victoria we've got funding, what we call CIS: Community Infrastructure. And what it does – it's a small bucket of money, but it gives communities money to do innovative things. The sad part is we never evaluate it, and so, you know, and then they don't get funded long term. So some of the things we suffer with is lack of recurrent funding, sustainable funding. And so, I think if you're going to fund – because I was speaking to Craig's staff, and they say, "Oh, we've got 12 months' worth of funding." And then, you know, they're trialling really great, innovative work, but it's only 12 months, and then it

lapses and drops off and so on.

I just think, thinking about some of those sustainability – I know you talked before about implementation, but any implementation plan must have an investment strategy aligned to it, so not just be resource neutral and think about what that is because I just think there's a great opportunity right now because we're – as I said, Close the Gap are doing all the implementation plans. We're really interested to look at what South Australia's implementation plan around target 13 years, because if it hasn't got anything that aligns to the direction that you're hearing, then it's a missed opportunity for the next three years to inform the budget process and to inform the process.

MS ORR: That is a perfect lead-in because the next point I was going to mention was your point about the need for a commitment to uphold the commitments the SA Government signed under the Close the Gap National Agreement, which is I think what you've just referenced.

PROF BAMBLETT: Yes, because that has got a lot of - and people just see the national agreement as the way that the (indistinct) reform priorities or the target, but it has got a number of clauses in there, particularly as it relates to workforce. So it has got workforce. It has got as well - clause 55(a) and (b) is about recommissioning. And I'm not quite sure that the South Australian Government was supposed to put out an expenditure review around what it spends on family violence. So I think it's important to know how much funding - what is the investment in Aboriginal family violence because the expenditure review was very clear.

And, you know, like, we've done so much work to improve the - you know, reporting it. It gets the full priority reforms, shared decision-making. What does that - how do you assess - how would the government assess it? So about shared decision-making. When we began the advisory committee and when we did the work around coming to the State, Craig was the only one we could - where's the debt of South Australian, you know, people that can inform policy, legislation, practice, who could sit around the room and actually drive high-level reform in family violence? And that's where you've got to build it. You know, you've got to, sort of, start to think about the future of a governance system that doesn't rely on one person to be the national, the State, and be the repository of everything family violence.

MS ORR: Do I also understand you to be saying that because Closing the Gap is a national agreement, but the States have made a commitment to it - - -

PROF BAMBLETT: Yes.

MS ORR: And so you would like to see action, response - I don't know the right words, but from the States in response to that commitment.

MR RIGNEY: Yes. In a very cheeky way, it's - we have got to see it on the ground. What I - the banter and the rhetoric at the moment, forever and a day, has been it's a Closing the Gap target. What does that mean to the women and children experiencing - or the murdered or missing Aboriginal women? It doesn't mean anything. So we've got a language around here that just seems to want to push everything into Closing the

Gap, but there's no actions that drive - there's outcomes. There's no responses.

We're not seeing anything that has made any inroads, except for some contract management, which is coming from the Commonwealth, through the State, to a pilot program, as Aunty said, or a 12-month very - you know, minimum amount of funding, with no evaluation funding resource attached to that. So absolutely we need, from an Aboriginal perspective around - if we're going to talk about closing the gap, then let's get real and let's see what we're doing as a State and come out and ask us, not just look at the money that's being pushed around.

And as we've asked for at the national level, where is the money going, the NGOs versus the ACOs versus the government departments? And let's look at some outcomes. But it has - it has to come from the ground up, and I think that's the missing part for all of this and that's where we don't have the voices on the ground. I mean, here I am sitting as a lone Aboriginal South Australian - besides this Commission, no one reaches out and wants to talk to me. My voice is at the national level with like-minded Aboriginal women and men. So there's a real opportunity being missed here.

PROF BAMBLETT: I think the timing is right, and I think you can get it right here because jurisdictions have signed up to the National Action Plan, so the first Aboriginal and Torres Strait - we've seen little evidence that South Australia has actually done a response or even looked at implementing that. We're - you know, there's also - I mean, they've signed up to - and there's so much, particularly in the overarching plan and particularly around justice and improving justice response - and there's different models being touted, like justice reinvestment, looking at different ways - rather than just thinking about it as - you know, addressing the violence, but actually how do we invest in different ways of doing things?

But there's a national plan now. As we put this stand-alone plan, it's signed up to by jurisdictions. So how will the implementation and investment - what will the South Australian Government be putting on the table as a show of, you know, good intent to invest? So we've got people sitting around - the danger for me is that if we don't have a government structure here to hold government to account, who's doing the work, then it's going to fall to Craig, and he's got really – he can be seen as having a conflict of interest because he's running the service. So he can be cut out of conversations around probity. So where is the independent advice, particularly if you're thinking about governance, informing the plan, the National Plan, the State Plan, the Close the Gap, looking at the data, who does that work, who introduces better policing, who introduces better housing on Aboriginal, who provides all that expert advice, and how do you bring that into a room, and how do you get.

And so, to me, it's a bit of a no-brainer as far as, you have a dedicated Aboriginal plan, and you have, you know – if you can regionalise it, you may do it a little different than our 11 regions. But you know, what does local planning, local input, how do we give local data to engage local communities. Because local communities want to come up with solutions. Many will say, you know, when we were putting a child protection response in one of the communities, that one of the elders said to me, have I got a child protection problem?

Because, never seen the data, didn't know, just knew that children were being removed and not, you know, coming home, so. And, you know, those communities are now all delivering child welfare, family violence. We didn't have that footprint in Victoria, we now have 16 ACOs delivering child and family welfare and family violence, and so the investment is paying off for government.

MS ORR: And unless, Mr Rigney, you've got anything to add on that point, I have no further questions Commissioner.

CMR DESPOJA: Thank you, counsel assisting. I've just got a few follow-ups, if that's okay. Can I just clarify – and I'll start, Mr Rigney – is there a response in relation to State Government expenditure, in relation to the safety plan, the family safety plan? Has there been any evidence of that? Do you have an understanding of what they are seeking to contribute in specific response to the National Plan?

MR RIGNEY: The short answer would be no.

CMR DESPOJA: Okay, did you want to expand or is that – no, I'm happy with short answers. Don't get me wrong, but was there –

MR RIGNEY: Well, at both the National Safety Committee and the Advisory Council, we've sought that information. We know it's gone out, and we haven't got a detailed response back.

CMR DESPOJA: Target 13 is pretty big. If you're talking about reducing, by 50 per cent, abuse and family violence against Aboriginal and Torres Strait Islander women and children – obviously and then hoping to progress to zero – but by 2031, that's a high target. Are we doing what we need to do?

PROF BAMBLETT: I was part of the discussion when we established it. And the real question was in the room – is any form of violence acceptable? So we were like – and so originally the language was, you know, towards zero. We sort of said, well, we have to have something that's achieved. So it's that 50 per cent, it was trying to sort of look at, how do we reduce the disparity between Aboriginal family violence and non-Aboriginal? And so if we target at 50, at least we get some traction.

CMR DESPOJA: Yes.

PROF BAMBLETT: So then, that was the most difficult discussion. We had so many, you know, we shouldn't condone any violence against, saying that, you know, that, but we knew that we couldn't end family violence within 10 years as well. So that was the challenge.

CMR DESPOJA: And obviously, you know, we have to have targets that are aspirational as well as achievable. And you know, you made the point in your opening comments, Ms Bamblett, around you know the notion of us doing this in a generation, regardless of background or communities. My concern is not with targets that seem high. I think they should be. But are we putting in the necessary infrastructure support funding and resources to achieve that, and particularly in our home state of South

Australia, and you know, the idea of a task force, to go back to counsel assisting's questions on that.

And forgive me, I'm not confused. It's just that I just want to check the terminology, because I think, at one point, you talked about peak body as well as task force. Is that because that would seek to encompass the governance structures to which you refer or are we talking slightly different ideas?

PROF BAMBLETT: From my point of view they're two different things.

CMR DESPOJA: Yep.

PROF BAMBLETT: The peak agency is obviously the body that want - we want to really sort of start to know our - the plans - to sit down with them because, you know, at the moment, Craig is virtually the person that's responsible for the National Plan, for the State Action Plan, for, you know, implementing - and when you, you know, speak to people, have you spoke to Craig about what - you know, I'm like - you know, because when we were doing the rapid response review, Craig - - -

CMR DESPOJA: Yes.

PROF BAMBLETT: - - - was the go-to person for it, you know, and he convened the - you know, the national consultation online of, you know, how do we do better with perpetrators and how do we want to manage - and so he led that conversation really well but it was - he's, like, the South Australian person so what resources and support so the peak would be the body to enact the plan, to work on the plan, to - you know, and the task force, to me, is to really - to understand how do we actually get to the nuances of community, what does community want, and get buy-in from local communities. Give them really good data.

Get them to - because I mean, as I said, our approach is around police protocols. It's around better course - courts - better - how do we - you know, what can local communities do and how do they want to govern the issue of family violence and what response, because the big language at the - buzz language is place-based and so it could be South Australia decides to want to put a place-based project in one of the communities and start to look at how do we - what would our response to family violence look like in the APY Lands and so what infrastructure - I - to my point - the point I wanted to make is when we were looking at - as the advisory committee and looking at each state and territory, the architecture wasn't there for South Australia.

CMR DESPOJA: Yeah.

PROF BAMBLETT: It was - - -

CMR DESPOJA: That's interesting.

PROF BAMBLETT: - - - really complex. We couldn't understand who held accountability for family violence outcomes for - for the whole of South Australia and

so who do we go and speak to, and so we were told that you had to go to Women's Policy and then we were told you had to go to legal and then we told that we had to go to Child Protection and so - - -

CMR DESPOJA: Yeah.

PROF BAMBLETT: - - - who - who has the data. Who has the coordinating role. I think it was a bit confusing. Sometimes it just lands in Women's Policy - - -

CMR DESPOJA: Yes.

PROF BAMBLETT: - - - but then it lets Housing off the hook and then it lets police and justice - and so we - we were - we just found it really, really, you know, hard in - in South Australia to understand the architecture and how it fitted in with the National Plan and who - you know, obviously Minister Hildebrand was the Minister for Family Violence and Child Protection but - and she signed off the National - National Plan. She signed off the Action Plan - - -

CMR DESPOJA: Yes.

PROF BAMBLETT: - - - but no resources, no money, no - no Action Plan, no - nothing behind it. It was just a basic signing of a document. No - nothing.

CMR DESPOJA: And when we're talking about, you know, these peak bodies and/or task force, we're talking Aboriginal designed and led.

PROF BAMBLETT: Yep.

MR RIGNEY: Yes.

CMR DESPOJA: Just clarifying that.

MR RIGNEY: Yes.

CMR DESPOJA: And can I - I'm sure Mr Rigney knows this but for your benefit, Ms Bamblett, I can assure you that the Royal Commission takes very seriously any recommendations that we put forward around Aboriginal and Torres Strait Islander people will be led and designed by or co-designed by Aboriginal and Torres Strait Islander representatives, and that is why I have a partnership committee - - -

PROF BAMBLETT: Yep.

CMR DESPOJA: - - - with the - with SAACCON.

PROF BAMBLETT: I - I think in answer to that and with the greatest of respect, is sometimes they include Craig when they want to and then when they want to get someone else's advice - so it is that - like, the question and, you know, I think Craig was upset not long ago about, you know, they're setting up a peak and, you know, and it's all

with a different body and they're setting it up and - without, you know - and it seemed to me a bit of a kick in the guts, I suppose. A nice way to put it. You know, about the work that he has done, the commitment that he has done and so it - it is about, you know, being respectful of people that, you know, have done the hard yards and so - - -

CMR DESPOJA: Absolutely.

PROF BAMBLETT: - - - including - and - and you know, I - I think a peak is needed. I think you've got a lead agency. I - we're not a peak but we have - certainly sit around the table with a lot of influence because we've got a lot of family violence. I think Craig is - recognising that expertise is critical to establishing a peak. But I did send Craig a document, which is about the - setting up an Aboriginal peak. I'm happy to send that to - - -

CMR DESPOJA: Please - - -

PROF BAMBLETT: - - - the Secretary.

MR RIGNEY: Send it through.

PROF BAMBLETT: It's about what's different in an Aboriginal peak.

CMR DESPOJA: Yep, if you're happy to table that for us or provide it to us so - sound like an old politician there. Sorry. Thank you both. I do recognise your respective expertise and, Ms Bamblett, thank you for your acknowledgment of Country. I can assure you that we add to that acknowledgment and have - in - started the proceedings today - - -

PROF BAMBLETT: Yeah. Yeah.

CMR DESPOJA: - - - with that acknowledgment as well as - - -

PROF BAMBLETT: I knew that but I just was mindful that - that I - - -

CMR DESPOJA: Of course.

PROF BAMBLETT: - - - hadn't done it.

CMR DESPOJA: And - but also acknowledging Elders from other communities of which you are an incredibly distinguished one, and so, Aunty Muriel, it is a great - - -

PROF BAMBLETT: Thank you.

CMR DESPOJA: - - - privilege and honour to have you here today. Thank you, and thank you, Mr Rigney. Any other questions, counsel assisting?

MS ORR: No, thank you, Commissioner. I would ask the witnesses - - -

CMR DESPOJA: And - - -

MS ORR: - - - be excused.

CMR DESPOJA: Now you're free to go. Enjoy lunch.

PROF BAMBLETT: Thank you.

MR RIGNEY: Thank you very much.

CMR DESPOJA: And we will take a halt in proceedings and return after lunch. I think the lunch break is scheduled to end at 2.15.

MS ORR: 1.15. Early today.

CMR DESPOJA: Sorry, at 1.15. That's - I'm reading wrongly. 1.15. So thank you very much.

PROF BAMBLETT: Thank you.

ADJOURNED

RESUMED

CMR DESPOJA: Good afternoon, everyone, and welcome back to day 9 of the public hearings of the Royal Commission into Domestic, Family and Sexual Violence. I hand over to counsel assisting.

MS ORR: Thank you, Commissioner. I call Ms Miranda Starke and Ms Rachael Nielsen.

MIRANDA STARKE, AFFIRMED

RACHAEL NIELSEN, AFFIRMED

MS ORR: Thank you both. You are both here from the Council on the Ageing, South Australia. Is that correct?

MS STARKE: Yes.

MS NIELSEN: Yes.

MS ORR: Otherwise known as COTA. I just want to ask you to explain your roles if you can. So, Ms Starke, what's your role at COTA?

MS STARKE: I'm the chief executive at COTA SA.

MS ORR: And you, Ms Nielsen?

MS NIELSEN: I'm the head of The Plug-in at COTA SA.

MS ORR: And what's The Plug-in?

MS NIELSEN: The Plug-in is a research and consultancy agency. We conduct research all to do with people aged over 50 years old.

MS ORR: And, Ms Starke, could you give us a very brief overview of what COTA is.

MS STARKE: Yeah, certainly. So we're Council on the Ageing. We are the peak body representing 700,000 South Australians over the age of 50. We are there to represent their views to government in terms of policy advice, to other decision-makers outside of government as well, so policy and advocacy. We also provide a range of services and programs and information to help older people age well. That includes navigating aged care, helping with - with strength and fitness, community visitors for isolated people, and also The Plug-In, as you've heard, so research and engagement.

MS ORR: And what involvement does COTA have in relation to the experiences of domestic, family, sexual violence for older South Australians?

MS STARKE: So it's not an area that we directly provide services or supports in. We engage with a really wide range of older South Australians through our work, including people who've experienced violence and abuse. Most recently, our Plug-in team conducted a - a research project supported by the Office for Women in South Australia and the goal of that project was to understand the experience of older women when it came to family, domestic and sexual violence. This is an area that has been often overlooked and invisible, and we really appreciated the opportunity to - to do some in-depth research into that, to provide insights into what that experience looked like and to conduct a public awareness campaign or create resource materials as a result.

MS ORR: So it's that research project that I want to ask you about today and I understand will probably form the basis of most of the evidence that you give. To start with, Ms Starke, could you give us a brief overview about what that project was.

MS STARKE: Certainly. So it was supported by the Office for Women in South Australia. It was a 12 month project, really to, as I say, look at or understand what is the experience for older women. So for us, older is over the age of 50 and it was to understand what their experience was in community, so not in institutional settings, not in residential aged care, but in the home, in community, women living independently, and their experience of family, domestic and sexual violence. It's important to say that, you know, there are a lot of grey areas in this particular topic area, not least when it comes to older women, the grey area and overlaps with elder abuse. And - and that's something we will talk about in our evidence today, is where those overlaps are and perhaps some ambiguity or confusion or, in some cases, women's experience being diminished or not properly identified because it's seen as elder abuse or because it's not seen as elder abuse and it's seen as domestic violence.

MS ORR: How - I think, Ms Nielsen, this is probably a question for you, but in general terms or a brief overview, how did you go about the research for that project?

MS NIELSEN: Yeah, so the research had multiple stages over a 12 month period. First of all we conducted a literature review of the grey and the academic literature to scope the issue and to estimate the prevalence of the issue. We then conducted workshops and interviews with 37 specialised and non-specialised services to explore their experience with working with older women, victim survivors of domestic, family and sexual violence. So in these interviews and workshops, we explored awareness, perceptions and experience as well. We identified gaps and we also explored the service capacity solutions and pathways.

The next stage was our consumer - community engagement stage and we surveyed 431 women over 50 years old living in South Australia to understand the prevalence of driving attitudes and also practices, which can increase the risk of family, domestic and sexual violence for older women. We also interviewed seven older women who were victim survivors of family, domestic and sexual violence, and the final stage of the project was, really, bringing together the evidence from all of the previous stages to produce a resource to raise awareness of this issue within the community.

MS ORR: I'm going to ask you today about some of the themes that came out of the report but before I do, what can you tell us about the prevalence of violence against older women?

MS NIELSEN: Yeah, so when we talk about violence against older women, this encapsulates both intimate partner violence but also family violence, which includes elder abuse, and as Miranda sort of mentioned already, for older women the lines of both definition and therefore support options are quite blurred and murky. So we do suspect that the instances are - of abuse are likely highly under-reported and because of this, the true prevalence of violence against older women is largely unclear. The best estimate we have is from the National Elder Abuse Prevalence survey, which was done in 2021, and they found that 16 per cent of older women aged 65 years and older had experienced elder abuse. So this area in general is vastly under-researched and this impacts our understanding of prevalence but it also creates a real challenge in terms of both addressing the issue and also meeting the needs of victim survivors.

MS ORR: So with that being said, I want to now ask you about some of the themes that came out of your work. So in relation to domestic, family, sexual violence experienced by older people, what types of violence were particularly prevalent or were unique - - -

MS NIELSEN: Yes.

MS ORR: - - - to older people?

MS NIELSEN: Yeah. So as part of our literature review, we found that for older women the types of violence are varied and it's really not just limited to neglect as a form of elder abuse, but it also includes intimate partner violence, financial abuse, coercive control, as well as both physical and sexual violence. So older women in particular are vulnerable to the impacts of family violence, particularly violence perpetrated by their adult children. In these instances, emotional and psychological abuse is common and older women subjected to manipulation and threats that can

exploit their vulnerabilities.

So we did hear from service providers as well that financial abuse is particularly prevalent for older women and this is mainly perpetrated by adult children who are exploiting an older woman's finances. So this is sometimes termed inheritance impatience and - and aged care can also be used as a means of accessing assets by moving older women into an aged care facility and out of their home sold that - so that the home can be sold to generate money. So financial abuse is also experienced in intimate partner situations and this highly increases an older woman's vulnerabilities later in life, as she has limited - much reduced access to resources and this is just reduces her options in terms of seeking support.

MS ORR: We've heard about isolation as a form of violence. Is that something that you saw?

MS NIELSEN: Definitely. So this was mentioned to us by one of our lived experience survivors in terms of being moved away from a metropolitan setting into a regional or rural community to further isolate a woman so she has less connections to the community, so this is part of coercive control.

MS ORR: You've touched on this in the evidence you've just given but did you see any patterns in who is using violence against older people?

MS NIELSEN: Yes. So we know from the literature that the main perpetrator of the violence against older women is adult children, so sons and daughter, but then also partners and spouses, but other family members such as adult grandchildren, siblings, extended relatives - they're also reported as perpetrators. So it's important to note, though, for older women violence is often lifelong and she may have had many different perpetrators throughout her life, so this may have started with a parent, moving on to the intimate partner and then moving on to the adult children or carer.

So it's incredibly complex and it's very layered. So although she may have experienced elder abuse later in life, this may have been preceded by years of violence so she may have had many different perpetrators across her lifetime, and this, of course, makes older women particularly vulnerable when we think about the normalisation of violence that she has occurred throughout her whole life. And we've got a quote from a victim survivor who told us, "No one would listen. No one believed me. I didn't have a voice back then and from then on I just thought, well, that's all I'm used for. All I'm good for is to be used and abused. So all my life I'd been used and abused, bashed and assaulted." So for older women it is incredibly complex and it means that their situation can often be quite misunderstood and can remain hidden out of view as well.

MS ORR: And is that lifelong violence, cycles of abuse, a theme that was present in the research that you did?

MS NIELSEN: It's a theme that's present in the literature, both the grey and academic literature, but it was definitely something that we found through talking to service providers and also through the older women victim survivors we spoke to as well. And for older women it can also exist that these cycles of violence can also increase or

escalate later in life as changes in health, in relationship dynamics, can - can occur as well but that normalisation of violence for a woman is really important to note as well because it can be a massive barrier to her accessing or seeking support because she may have a complete lack of awareness that her situation is unsafe or that she is any - even experiencing abuse.

MS ORR: I will come back to barriers in a moment. Ms Starke, I wanted to ask you if you had any comments or if you could help us on the concept of ageism and how that plays in to elder abuse.

MS STARKE: Absolutely. So I think it's important to remember that abuse against older people doesn't happen unless ageism exists, so ageism is a necessary factor for violence and abuse of older people and older women. Added to that, the issue for women is ageism plus sexism and the difference when you're an older person is that you've had more time for these factors to compound, so not just to compound in terms of your experiences, your vulnerabilities, your exposure to violence and abuse, but also your conditioning to the normalisation of that experience and your conditioning to society's views that that is acceptable or that that might be acceptable. So a key focus for COTA SA is to challenge ageism and to call it out. Certainly, as Rachael has indicated, there - there needs to be a greater awareness, in the general public but also, you know, amongst older women themselves, but let's not forget perpetrators, you know, at - that - that ageism is a - is a - a root problem combined with sexism. I can add, actually - - -

MS ORR: Yep.

MS STARKE: - - - I guess, similar to sexism, we sometimes might hear that term benevolent sexism and that certainly exists in ageism as well. So when we think about violence or abuse being perpetrated by adult children, benevolent ageism can creep into this and some of that might look like thinking that because someone in your life is older, that they necessarily have lost capacity to make their own decisions and therefore that you, as their adult child, might be better placed to take control of that for them. So decision-making about finances, about living situations, about any part of somebody's life, can start to be taken over by an adult child for maybe good intentions, but nevertheless it's diminishing the rights and opportunities of that older person.

MS ORR: Thank you. Are there factors for older people that might increase their vulnerability to violence? I think you've touched on a couple already this morning but could you explain a bit more about that to us, Ms Nielsen.

MS NIELSEN: Yes, certainly. So from the outset, I want to acknowledge that it's the perpetrator's behaviour that is always the primary cause of violence against older women. But there are documented risk factors for increasing the risk of domestic and family/sexual violence for women, and additional factors for older women associated with ageing and also generational attitudes as well. So we do know that for older women it's diminishing physical and cognitive capabilities result in an increased dependency on partners and adult children, which can expose them to situations of abuse.

Additionally, from the literature, we know that other risk factors include disability; past experience of abuse; financial disadvantage across the life span, including income dependency; carer responsibilities, so older adult children and also grandchildren, caring for grandchildren; co-residency with the perpetrator; a lack of awareness of what violence is, as I've sort of touched on already; then aged care as a tool or location for abuse, and also social isolation and loneliness.

So we do also know from the literature that for older women there are life stone - a - life-stage milestones which can present an increase in risk, such as retirement, so it means that at retirement of a partner or retirement of the older woman, both are home more often and that can result in heightened abuse occurring. Service providers did also tell us that carer burnout can increase violence perpetrated by a carer or adult child, maybe either due to system issues or a refusal to accept outside health - outside help, sorry, and this is more likely to impact women aged over 65 years old.

MS ORR: Right.

MS STARKE: If I can build on that, I think that we - we know that with the current cost of living and housing crisis, there are more adult children moving back in or living with their older parents and this is really increasing the likelihood and - and increasing those risk factors that - that would lead to abuse against older people.

MS ORR: I want to ask now about barriers to seeking support faced by older people. Can you explain what your research showed about how - the barriers that older people might face.

MS NIELSEN: Yes, so first and foremost, the main barrier that older women face for seeking support is shame and guilt. So this was told to us by service providers but it's also reiterated in the literature as well. For older women there's often a great deal of shame and guilt associated with experiencing any form of abuse, and for older women, particularly if the perpetrator is an adult child, also, this presents an additional layer of guilt and also a reluctance to seek support for the fear of consequences for her adult child.

There's also a lack of awareness for some older women. So as I've sort of touched on, it's this interplay of societal misconceptions that - generational attitudes, sexism ageism and also the shame and guilt, alongside that belief that what happens in the home is private. This can contribute to a sense of disbelief regarding the nature of their own experiences of domestic, family and sexual violence. As one victim survivor described to us in an interview, "I just think there's a lot of older women out there who haven't had support throughout their life. Particularly with the domestic violence, you were often told to put up with it. Growing up, we knew that there were women in our neighbourhood who were experiencing this but I don't think we did enough for them. It was, 'What went on in their home was their business'."

So for older women - well, older people as well and those within the community, they may not recognise that they're in the domestic or family/sexual violence because their expectations but also their tolerance for this sort of behaviour has been shaped by generational attitudes and potentially traditional gender roles that they grew up with. So

that's quite a large barrier to accessing support and it means that it's - presents a real challenge for service providers, as they're trying to cut through this lack of awareness to be able to assist women. So raising awareness is therefore vital for prevention along with educating community members to identify those signs of domestic, family and sexual violence, and also for older women to recognise those signs themselves.

Another barrier is lack of resources. So this includes both housing and finances. So in terms of housing, there's an inability for older women to find secure and stable housing that meets their needs specifically, and our victim survivors, they describe to us how the current housing crisis combined with ageism and also discrimination faced by older women seeking housing were major barriers for them being able to, if they chose to, move away from a perpetrator. So this does increase the likelihood of older women remaining in abusive situations.

MS ORR: And then we've also - sorry to interrupt you. We've got the situation that Ms Starke described. where adult children might move back into the family home if they are the ones committing the violence.

MS NIELSEN: That's right. Because of the cost of living, yes. So it's a perfect storm, if you like.

MS STARKE: If I can just add there, one of the reasons that I believe we heard from older people that an adult child might move back into that family home is actually that adult child's own relationship breakdown, potentially due to domestic violence. So it just reinforces the generational experience, and this is something that just continues through the lifespan.

MS NIELSEN: And just on finances, so for older women, some of them, they have experienced financial abuse for their whole married life. So this can result in a lack of assets, but also significantly less superannuation and also low financial literacy skills itself. So this places older women in a particularly vulnerable situation. I have a quote here from a victim survivor who said:

Economics was a big part of it for me. We didn't have superannuation in the 1960s. There was no such thing as superannuation fund for nurses, and I didn't have a secret bank account. I was a completely dependent wife on him.

So there's another major barrier, which is also lack of specialised services. So on top of all these barriers of social norms, generational attitudes, lack of financing and housing, there's also a lack of specialised services for older women. So many services are not designed with older women in mind, and this creates major barriers for access. So some service providers told us that crisis services are at capacity and older women who need specialist support are often not able to access it, so then they're being referred on to non-specialised - non-crisis services.

An added barrier for older women is that they are deemed by some service providers as less critical because they don't have dependent children. So they're put down the list, in terms of need. They also may have some assets. So it seems that they're in a better position. And a couple of other barriers include digital exclusion and also transport

limitations as well.

MS ORR: We've talked a little bit about this, but the idea of the violence being entrenched over time and the generational views. I understand you to be saying that, of itself, is a barrier to help seeking or reporting as well.

MS NIELSEN: Yes. Yes, because it's a barrier to recognising the violence.

MS ORR: Yes.

MS NIELSEN: Yes, which is, in turn, a barrier to seeking support.

MS ORR: And I think, Ms Starke, you touched on this before, but about the violence has occurred for such a long time and then you have less time to do anything about it, if you like.

MS STARKE: Correct.

MS ORR: Do you see earlier attempts at disclosure and how that might impact older people? Can you explain that for us.

MS STARKE: Do you want me to?

MS NIELSEN: You can if you like.

MS STARKE: We certainly did hear about that through the research - the importance of receiving a response from some - so if an older woman - or a woman at any point in her life, at any age, chooses to disclose her experience to somebody, if that disclosure hasn't been well-received or if the response from that person has been, "That's normal. You should put up with it," or, in fact, in some cases - and we certainly saw this, particularly in CALD communities. If the response from that other person was, "There's nothing available that's suitable," you know, maybe some stories - first or second-hand stories of others in that community that had sought support and the services that were available were not culturally sensitive, not appropriate, and it was considered better to be back in the domestic environment, even though that would expose them to abuse, rather than be in that unacceptable of a environment. And so that experience of disclosing and not having your concerns validated, not being supported, could be a major barrier to ever disclosing again. So it reinforces the importance of everyone in the community and in the general public increasing their awareness that age is not a factor when it comes to violence. So older women can also experience violence, and we must listen to it, validate it and help to provide support and not shut it down.

MS ORR: On that, the awareness in the community, we heard evidence this morning about reaching children and young people and the use of tech and online spaces. What do you say about reaching older people in the community, in terms of awareness?

MS STARKE: Yes. Well, look, certainly a majority of older people are online. You know, we - that's the fact of it. However, a large proportion are not or they prefer not

to. They don't feel comfortable or confident. So offline services are going to be really important in order to provide information to older people and to help provide services. Through COTA SA, we know that a lot of older people, particularly when experiencing a crisis or navigating a major life event or a new system, really, really benefit from having one-to-one navigation support, so having a human approach where someone can provide advice and guide them through that new landscape that can be a bit scary and listen to their story, understand what services or supports might be needed and help refer them to those services and supports.

MS ORR: Is that sort of system navigation something that you've seen work in other contexts?

MS STARKE: Yes, absolutely is. So COTA SA provides system navigation for the aged care system. That's a Commonwealth-funded program called Care Finders. We've also delivered it during COVID, in fact, to help older people reconnect back into their communities with a peer to peer support model. So we've seen firsthand how effective it is. Generally, older people supporting older people or a trusted expert providing intensive support as needed to an older person over time, not just in a one-off, but as much as might be needed to get them on the right track, is absolutely what we think would be helpful for older women experiencing family, sexual and domestic violence. It doesn't exist at the moment. We feel it would be an area to invest in, particularly for older women.

MS ORR: Ms Nielsen, before, I think you said that transport can sometimes, of itself, be a barrier. What about in regional or remote areas?

MS NIELSEN: Yes. Regional - older women living in regional or remote areas face additional barriers. So that's a lack of services, in themselves, but then the isolation element of living somewhere so removed from other communities, potentially, if they have been isolated on purpose by a perpetrator. So - but, also, for women living in regional or remote areas, it can be harder to access services that may be private or anonymous because of the - I guess size of community is often quite small. So that presents as a major barrier to accessing services.

MS ORR: I want to ask about intersectionality and what you see in that regard.

MS NIELSEN: Yes. So although - but handling domestic and sexual violence against older women is severely under-researched, when we take into account intersectionality, so migrant women, CALD backgrounds, First Nations, LGBTIQ+. This is severely under-researched. So the data that exists is very, very limited. And this was not a focus of the project that we did, was looking at women from these backgrounds, although we very much welcome conducting a research project that focuses on women from diverse backgrounds, because it's sorely needed, in terms of what kind of support services they need, but also what their barriers may be. But from the literature, we do know that it's women from diverse backgrounds. They do face additional barriers, like language barriers, and then a lack of culturally appropriate services. So for migrant women, they can experience a lack of knowledge about the legal system and also older women's rights within the system. And for some women, they may have sought help previously in their home country and then faced issues with those services, and they

may then be reluctant to try seeking help in Australia.

So we did find a significant issue with the lack of culturally appropriate services for First Nations Australians. For those people who - victim survivors who identified as First Nations, they reported that there was very few services in their locations that they felt comfortable using, and they emphasised the need for culturally appropriate services close to their communities. For LGBTIQ+ older women, they experience heightened vulnerabilities as many have faced historical discrimination and may have a distrust in the mainstream services in general. So just as there is grey areas when defining domestic, family and sexual violence for women, there's also grey areas for women from diverse backgrounds.

MS ORR: And we've heard evidence across a lot of this Royal Commission about any disadvantage, any vulnerability, and the compounding factors of that.

MS NIELSEN: That's right.

MS ORR: I want to move on now and ask a question that will take us towards tomorrow's evidence, really, but that is, in your view and based on your experience at COTA, what do older South Australians need to move forward with a reduction, or ideally an end, to domestic, family and sexual violence? Do you have some key themes that you would think are important?

MS STARKE: I think so. So, firstly, it's that public awareness is the first area to address, understanding that violence doesn't discriminate by age and really starting to think, as one of the service providers in our research report said, violence against older women is everyone's issue, so starting to raise awareness of what it looks like - what elder abuse and what violence against older women and older people looks like so that, in general, we're more able to identify it when we see it, where - in the case of benevolent ageism and where it might be misuse of power attorney or, you know, taking away someone else's decision-making for them, thinking you're doing the right thing, just being able to identify that more. So none of this can turn around until we address ageism and our awareness of those sorts of things.

Certainly, as Rachael highlighted, in the research, there's a distinct lack of services right now. So there would need to be more services, but also more services that are specifically tailored for older women, and that would mean that they are aware of those services, they know how to access them, they're accessible in a way that meets the needs and preference of older women, so not just online, you know, in their areas, in locations where they might naturally want to turn for help and support.

What I mean by that is, you know, it could be through their GP. It could be through a community centre or a library. It could be information that's made publicly available and that's readily visible in supermarkets, in - through public advertising, through all sorts of other methods, so not requiring the individual to be fully aware and have full agency to go and seek out information and support, and then, as we've touched on, that support to navigate what is a complex system, and very likely an unfamiliar system to older women. And in COTA SAs view, that is a person-to-person navigation service. I think there's some of the - the key areas that we would see is if we can have all of those

- if we could have all of those factors addressed, I think we would absolutely see a reduction in abuse against older women.

MS ORR: You've mentioned accessing services through, for example, a GP. Is that kind of a general entry point a useful thing, in your view?

MS STARKE: It is. It also requires the GP, as a member of the public and a - or the medical professional to identify somebody that could be at risk or to synthesise what they're hearing and listening to when they're meeting with an older person and thinking, "Could this be elder abuse? Could this be domestic violence?" So, again, not taking an ageist - not making any ageist assumptions about domestic violence being something that exists for younger women or women with children, younger children, but being mindful that this is a scenario that can happen at any age and ask the right questions and to offer the right information.

MS ORR: And that comes back to your awareness and education point that we started with.

MS STARKE: Yes.

MS ORR: Thank you, Commissioner. I have no further questions.

CMR DESPOJA: Thank you, Counsel Assisting. Thank you, both. I want to pick up on the education piece, although I think counsel assisting has probably done all the work there, because I'm fascinated by - you know, there was a quote in your submission around something to which you just referred and that notion of, you know, seeing a lot of senior citizens gathered in community centres in their free time, noticed all kinds of workshops, from how to survive scammers, gardening, all types of workshops, and yet, as you've pointed out, the specific training and education and awareness around not just elder abuse generally, but specifically abuse of women - older women - I was going to ask, then, what other avenues apart from those - you've mentioned GPs, and then, again, that goes to the piece of training and making sure that people are skilled.

I'm wondering - and please don't think I'm conflating the role of residential aged care, so that sort of institutional role and responsibility with community and home and other outlets, but what training do you believe aged care facilities have in identifying - and I'm not talking victims of elder abuse that may be perpetrated by an unrelated carer. I'm wondering if they have an understanding of domestic violence, family violence and sexual violence, because we know older women are subjected to all of these things. Any training that you know of, any ideas or best practice that you can tell us about?

MS STARKE: So, look, I don't think that we could speak on the training in residential aged care. I think, you know, the Aged Care Act is very much focused on human rights and a person-centred approach. I think that we should have generally a lot of confidence at the level of care and concern and oversight and regulation in aged care, not to say there's not always room for improvement. What we at COTA SA would focus more on in this evidence is the need for everyone to be actively aware of what the signs are of abuse and of family, sexual and domestic violence. Although our research was very much focused on how that manifested in the community, we are talking about

violence and abuse perpetrated by family members generally.

CMR DESPOJA: Yes.

MS STARKE: And that will follow the person, wherever they are. So if someone moves from their home to go and live in residential aged care. it will still be the case quite often that that violence and abuse will still exist in that new setting because it's still being perpetrated by family members, and that may not be physical assault or violence, but it may still be coercive control, financial abuse, neglect, exclusion from grandchildren as a coercive control manipulation technique and the like. So that's probably - - -

CMR DESPOJA: But you do have couples, spouses that live in aged care facilities together, so there is still, sort of, potential for intimate partner incidents, issues and violence.

MS STARKE: True. Yes.

CMR DESPOJA: But I suspect we might need some more research.

MS NIELSEN: Absolutely.

MS STARKE: I think that would be a great idea, Commissioner.

MS NIELSEN: Yes. It's sorely - - -

MS STARKE: COTA SA is ready to undertake more research.

CMR DESPOJA: And, again, you also - you deftly answered Counsel Assisting's questions in relation to that notion of, you know, COTA can provide and what's needed, but one thing I'm a little overwhelmed by, and this might be a personal reflection, is that when we talk about older people, it's over 50, so hands up, but it's an extraordinary and different - I mean, there are many generations - - -

MS STARKE: Yes.

CMR DESPOJA: - - - within the age group to which you refer. So, you know, making sure that awareness raising and the availability of services is targeted in an effective way, I can't imagine is particularly easy.

MS STARKE: You're absolutely right, and the reason - I mean, we do talk about older, as being ever the age of 50, and that may be confronting for some, but, again, that's our own ageism at work. And so, we really encourage people to question why they feel that that's something that's an issue.

CMR DESPOJA: It's just we have, I guess, more of that sense it's not heterogenous, you know.

MS STARKE: It's not heterogenous, absolutely not. So there's no one universal experience of getting older or what it means to be older - absolutely not. But why it's important to have that line in the sand and 50 - what - why not just 65? There's plenty of evidence to show how ageism starts to creep in even from 45, you know, so in terms of seeking employment, seeking other services, attitudes to women particularly change from that sort of 50 age. So age discrimination and its impacts are absolutely felt in every part of society from that point where we might be defined as older.

CMR DESPOJA: And, I guess, the statistics are telling us that women over 50 is the fastest growing group into homelessness, largely to do with domestic violence as well, but also, I presume, that presents a risk factor to the lack of housing and homes for additional violence.

MS STARKE: Yes.

CMR DESPOJA: What kind of work are you doing on that more generally, may I ask?

MS STARKE: Well, housing, we know, is one of the top priorities for older South Australians, generally. We've been pleased to contribute to the Department of Human Services' Taskforce for Housing Security for Older Women and contribute to 40 recommendations in that report that the State Government continues to work through. We're constantly speaking to older South Australians and asking them to tell about their experience. We hear stories, like, women who have not experienced domestic violence, but who are grateful, and express how grateful they are that they have not, and that they're not in a violent relationship, because they would not be able to afford to leave the home that they live in. So it's a point of awareness, particularly for older women, that potential for vulnerability, you know, that life event of a relationship breakdown or loss of a job, that can make you dependent on a partner that may be violent, and having to live with that person.

CMR DESPOJA: That goes, yes, to those heightened risk factors that you were referring to. It's all interlinked, so I didn't mean to take anyone on a tangent, then, but it's, yeah, really important evidence, so I thank you both for appearing before the Royal Commission today. Counsel assisting.

MS ORR: I'd ask the witnesses be excused, thank you, Commissioner.

CMR DESPOJA: You're free to go. Thank you.

MS STARKE: Thank you.

MS NIELSEN: Thank you.

MS ORR: We'll just take a short break before the next witness, if we can, Commissioner.

CMR DESPOJA: Okay. We'll take a short break. Thank you.

ADJOURNED

RESUMED

CMR DESPOJA: Good afternoon and welcome back to day 9 of the public hearings for the Royal Commission into Domestic, Family and Sexual Violence, and on that note I invite counsel assisting to continue introducing witnesses for this afternoon.

MS ORR: Thank you, Commissioner. I call Ms Belinda Lake.

BELINDA LAKE, AFFIRMED

MS ORR: Thank you. You work at the South Australian Adult Safeguarding Unit. Is that correct?

MS LAKE: Yes, I do.

MS ORR: Known as ASU - - -

MS LAKE: Yes.

MS ORR: - - - commonly. What's your role there?

MS LAKE: I'm the chief adult safeguarding practitioner with the unit.

MS ORR: What - can you just give us an overview about what is ASU. What is the - - -

MS LAKE: Yeah, I can.

MS ORR: - - - Safeguarding Unit?

MS LAKE: Yep. So within my role at the unit, I oversee the day-to-day operations of the unit. The unit is established under legislation and that's the Ageing and Adult Safeguarding Act. We've been around for five years and we respond to concerns of suspected abuse regarding adults who may be vulnerable and that might be by way of age, disability, ill health, social isolation or other vulnerabilities.

MS ORR: And what - this is a big question but can you give us a brief overview about what you do sort of day to day - - -

MS LAKE: Yeah.

MS ORR: - - - at ASU.

MS LAKE: I - yep. So the primary role and purpose of the unit is - there's a number of things that we do. So we provide information, advice and support to callers who've got concerns or suspicions that someone may be being abused, so we're talking about adults

over the age of 18. We take and assess reports that are made to the unit and we also provide a tailored safeguarding response to people who we take reports about. Another part of the work that we do is around community education in relation to the role and functions of our unit but also about safeguarding more generally.

MS ORR: Is it correct that you started off with a focus or a scope, I guess, just for older people?

MS LAKE: Yes, that's right. So when the legislation was established, there were some transitional provisions in place and so for the first three years we were to only respond to reports of abuse or mistreatment in relation to older people. What happened is in that first year of the unit being around, there was the unfortunate death of a woman called Anne-Marie Smith here in South Australia. There was a - a state-based task force and one of their recommendations was for our unit to open up earlier and respond to reports in relation to people with disability as well, so after the first year we commenced that and then at the three-year mark we were essentially open to hear concerns or take reports regarding anyone who might be vulnerable

MS ORR: And what's the workforce makeup - sort of structure - - -

MS LAKE: So - - -

MS ORR: - - - of your workforce?

MS LAKE: - - - yeah, the - the structure of our workforce - I'm a social worker and everyone in my team is a social worker so at the moment it's a social work workforce and there are 21 - 21 of us and we're - we're headed up by a director as well.

MS ORR: Statewide service?

MS LAKE: It is a statewide service. We take contacts or reports via our phone line, email or online form and anyone can contact our unit but there's no mandatory requirement or legislative requirement to make a report to us.

MS ORR: Can you help us with some demographic information about the clients that you assist.

MS LAKE: I can. So I will just clarify in our unit, when we refer to people who may be being - may be subject to abuse, we usually refer to them as the adult and where we're talking about people who are - are potentially perpetrating abuse, we call them the person of concern, so if I use that language, that's what I'm meaning.

CMR DESPOJA: Right.

MS LAKE: So I will - yeah, give you some demographics in relation to the unit. So in the last financial year we had 3353 contacts altogether to the unit and that consisted of 1624 reports and 1729 inquiries. I will just distinguish between those two.

CMR DESPOJA: Yeah.

MS LAKE: So reports are where we take a contact and we categorise it as a report to be assessed under our legislation, and an inquiry is where we're able to provide some information and advice to a caller in that single contact for them to be able to go away and take some further action themselves. So really, it's around about a 50/50 split of what we see as inquiries versus - - -

CMR DESPOJA: I see.

MS LAKE: - - - reports, but all with the ultimate goal of building capacity within the community to safeguard people. I can go on and give some further data in relation to the types of - or the people that are reported to our unit.

MS ORR: Yes, please.

MS LAKE: So the main types of abuse that we see are psychological, verbal, emotional abuse, financial abuse, physical abuse and neglect of care. We see much less reports of sexual abuse.

CMR DESPOJA: Okay.

MS LAKE: It's most often a family member other than a partner that is the person of concern. There's often formal support services involved in the adult's life, such as aged care or disability services. Mostly we - people contact us in relation to older people over the age of 65 so that makes up about 60 per cent of our contacts and then about 30 per cent of our contacts are people with a disability, and then 10 per cent relate to people who might have another type of what you would describe as vulnerability, so it could be a chronic health condition. It could be homelessness, social isolation or a range of other things but generally in that other 10 per cent it is people - mostly people with chronic health conditions.

MS ORR: When you - - -

MS LAKE: And just - - -

MS ORR: Sorry.

MS LAKE: Sorry.

MS ORR: When you talk about 30 per cent with disability, is that all types of - a variety of types of disability?

MS LAKE: Yes. But primarily, people with a disability are people with intellectual disability, neurological disability, psychiatric or other form of cognitive disability. So that's the - the - the main type of disability that we hear about within our unit.

MS ORR: I think I interrupted you. I'm sorry. Were you going to say something else?

MS LAKE: I was just going to add that in terms of the gender of people who - adults who are reported to our unit, it's approximately 60 per cent women and 40 per cent men.

MS ORR: And you're using adults there in the context that you've just explained.

MS LAKE: That's right. People who are suspected to be experiencing abuse or mistreatment.

MS ORR: It's probably quite obvious from your evidence but I understand your - ASU deal with people who have experienced domestic, family, sexual violence.

MS LAKE: That's right. We - we generally would take a report only regarding someone who's currently experiencing abuse because the main - the - the main role or the main aim of our unit is to provide a safeguarding response.

MS ORR: Yes. And these calls or reports that you get: are they from individuals themselves ever?

MS LAKE: They are. I can give you the details of who we hear from, so who contacts our unit to - to make an inquiry or a report. We - so the two - two biggest cohorts that I was talking about are people with disability and older people. So for people with disability, it's mainly NDIS providers that contact our unit, hospital employees, plus the ambulance service and the police. When it comes to older people, it's aged care services that contact - contact us, followed by daughters and the police.

MS ORR: I want to ask now primarily about violence experienced by people with a disability.

MS LAKE: Yes.

MS ORR: And you have touched on this but can you give us a bit more information about what you see in relation to the types of violence used against people with a disability.

MS LAKE: Yes. Can I just say that in terms of what's reported to us in the violence, there's not actually a lot of difference between what's reported in relation to people with disability versus older people, so it's quite consistent across those groups. So I'll give some examples. Sorry, I'll - I'll just remind again that it's primarily psychological, emotional and verbal abuse that's reported to our unit in about 55 per cent of cases, financial abuse or exploitation in around 47 per cent of cases, neglect of care in around 20 per cent of cases, and physical abuse in around 22 per cent of cases. So that's the - the statistics that we're looking at.

MS ORR: Can you give some examples of what those types of violence might look like for someone with a disability.

MS LAKE: Yes, I can. So psychological, emotional or verbal abuse can look like a

number of things, so it could be being called derogatory names and I - I'll give a couple of examples or sort of de-identified quotes from our records. "They call her names such as a retard or a baby and they degrade her in front of other people and laugh at her," or, "The support worker was verbally aggressive towards her, laughing and antagonising her," so terrible, terrible things, really, in terms of the verbal abuse. There could be threats regarding the provision of accommodation and care, threats to withdraw care, threats to go into care - - -

CMR DESPOJA: Yes.

MS LAKE: - - - or emotional manipulation regarding care. There could be standover tactics and intimidation such as demanding money for things like cigarettes and drugs or demanding money when the person of concern has run out. When it comes to financial abuse or exploitation, that can include things like someone not having access to their bank - their bank card or their accounts, told their money is being - going towards bills but with no oversight of that, being concerned to change their nominee status for the NDIS or for Centrelink, not having money to go shopping and buy basic personal items, being overcharged rent for substandard accommodation and someone else having complete control of the disability support pension or Centrelink income.

When it comes to neglect of care, this can look like a - a parent or a care - a carer continuously hiring and firing NDIS providers saying, "They're not good enough; they're not doing the things the way I want them done," under-utilising a person's NDIS plan, not allowing services in or using services to assist with daily living or community participation. It could look like not having access to food, having utilities cut off, living in substandard accommodation on a property like in a caravan out the back or in a tent.

CMR DESPOJA: Gosh.

MS LAKE: Not providing care in line with proper practice standards. So this - what this looks like is not following, like, safe transfer practices for someone with a disability or following a mealtime management plan to manage risk of choking or aspiration, over-medicating someone to manage their behaviour, or not - not providing a safe care environment for a support worker to come into, so it could be, like, a squalid environment.

CMR DESPOJA: Yes.

MS LAKE: When it comes to physical abuse, that can be the - the usual things like physical assaults or unexplained bruising but it - or injuries but it could also include things like someone puncturing the tyres of a wheelchair so that's - that a person - - -

CMR DESPOJA: God.

MS LAKE: - - - can't move around, abusing or damaging the equipment that someone needs to function independently, or dismantling a wheelchair to stop movement or isolate someone. One last type of abuse that I want to describe is the use of unauthorised restrictive practices. That could be things like - I will give just a couple of

examples, so a person with autism having their hands shackled with a rope to stop them self-harming or someone being contained or locked in a room to be sort of kept safe while the family member goes out.

MS ORR: What does your data say about who is committing the violence against these people?

MS LAKE: This is where the data actually does differ a little bit for older people versus people with a disability.

CMR DESPOJA: Yeah.

MS LAKE: So for older people, and I'm really picking up on the - the evidence that COTA gave just before, it's usually an adult child, so a son in most cases, followed by daughter, husband or other family. But when it comes to people with a disability, mother, followed by service provider and then father and - and sibling.

MS ORR: And when you talk about - when you say service provider, that's sort of an external carer, would it - - -

MS LAKE: That's right.

MS ORR: - - - normally be?

MS LAKE: A - a paid service provider like an NDIS service provider, for example.

MS ORR: And do those sort of types of violence - so we've got the external service provider and then the family member. Do they tend to present differently?

MS LAKE: They do. Yes. Yes.

MS ORR: I want to ask you a bit about - more about that in a moment.

MS LAKE: Yes.

MS ORR: But are there unique considerations also for people with a disability around help-seeking and reporting?

MS LAKE: Yes. As I said before, for our particular service it's often not self-report or self-referral. In only six per cent of cases a person contacts us directly. So the - the other thing that is interesting is that it can be quite - in the contacts to our unit it can be difficult to identify or establish if abuse is occurring, so it can be difficult for workers in the field who are calling us to establish that, but then also for our - - -

CMR DESPOJA: Yes.

MS LAKE: - - - own staff to establish that. So it might be that the person with the disability might not have the language to describe the abuse or the understanding of

what they're experiencing is abuse, and it can be difficult for service providers to identify that and they might have to rely on interpreting behaviours to raise that suspicion or to have that concern. And I will give an example of that. "The reporter was not sure exactly what was going on but observed the person to have heightened behaviours around personal care and noticed that there were words that triggered heightened behaviours: 'Dad' and 'van'," and that was what was making them concerned that sexual abuse was occurring. So that's the - some of the - I guess the unique considerations or some of the issues in terms of identifying and then help-seeking.

MS ORR: Is it fair to say that the person interpreting those behaviours needs a fair degree of skill and expertise in order to be able to analyse and make something of that?

MS LAKE: I would say, yes; yes.

MS ORR: Going back to the sort of two types of violence that we spoke about, based on what you see in your work, are you able to explain what you think is leading to those types of violence occurring? And I'm treating them in two separate categories, because the sort of external providers, I think, sit slightly separately from family - people using violence within family.

MS LAKE: So - I've got my pages a bit - so violence for people, we're talking within the family unit. Can you just remind me of the question that you are asking?

MS ORR: Sure. The cause of the violence, so what do you think is leading - - -

MS LAKE: Yeah. Sorry - - -

MS ORR: - - - to that type of behaviour? No, that's okay.

MS LAKE: - - - I had a mis-numbering of my pages. So I think that there's a number of contributing factors to that violence within the family unit. So there's the issue of system or service failure, and mistrust. And so what I mean is, the issue of parents or carers who might have had previous experience of either a real or a perceived system failure that results in them mistrusting services. And so, for example, we had a report where a young woman with a disability was sexually assaulted at a Day Options program, when she was younger, and that was what led to the parent's mistrust of services.

Just one other example is where a mother of two adult children with a disability, died. The father didn't think that the doctors treated her well, in terms of her care, and he then developed a serious mistrust of services, and he wouldn't allow his two adult children with a disability to go out of the home, and he wouldn't allow his daughter access to a medical appointment, because the doctors didn't want him to be present in the room, so he just didn't take her. So that - there is that real mistrust of services that can develop. And we hear things, like, other sort of complaints that parents of children with - or adult children say - there's too many different workers; the services are too unreliable; they don't do things the right way - and really don't trust that anyone else can care for their adult child.

Going alongside of that is that sort of needing to maintain control - so maintaining control over the care of their adult child with a disability, rather than allowing what they perceive to be substandard care, and they're thinking, "No-one can care for my child the way that I do." Other contributing factors are carer stress or carer burnout, which can develop and lead to unintentional abuse and neglect. And I know COTA picked up on this issue in relation to older people as well. A lack of forward planning for care - so the adult with a disability remains in the family home, with the older parent, there is no outside services, and, basically, it's just waiting for a health crisis or other crisis to occur.

Other contributing factors include using outdated and unauthorised ways of managing, like chemical or physical restraint. Basically, parents can use the strategies and means that are available to them, and they might not know what to do differently or how to do differently. I think, more generally then, there's also the attitude of general attitudes towards people with a disability, that they might be viewed through a lens as still being a child and not being able to be independent, or being seen in a paternalistic way. And then, there is also the other factor of the impact of intergenerational violence, where there may have been violence at the parental level that then impacts on the way that that person with a disability is treated. I think - just one last thing - is, sometimes I think it is hard for parents to navigate the service system, and so they simply give up and just do it themselves.

MS ORR: What about the violence from outside families, so from care service providers?

MS LAKE: Yes. Remember that I said, in relation to people with a disability, that service providers were sort of this second most reported person of concern. So, interestingly - yeah, this is an interesting area. So people with a disability might have a high value NDIS claim, so it could be hundreds of thousands of dollars, all the way up to a million dollars. And they may be vulnerable to exploitation. They come into contact with an unregistered NDIS provider, who, essentially, uses strategies to gain their trust or their parents' trust to use their service. The unregistered providers only need an ABN; they don't need any screening checks; they don't need any training; they don't need any qualifications. So examples of what has been reported to us from service providers are that they engage in bribery, harassment and verbal abuse.

They're isolating the person from other services, so they might be telling the person to sack all of the other services involved, forcing them to only use their service or the service of their friends, family and associates, providing unprofessional or substandard care, or charging for services that aren't actually provided; workers with no training being responsible for personal care, manual handling, medication management, sleeping over - a person sleeping over at a worker's house. In one case, it was reported to us that the person was kidnapped by the worker, being talked out of using medications or seeking medical help. And we see, sometimes, these workers might have criminal dealings or criminal histories, and the person or their family can be quite controlled by that service provider.

We've also seen professional or, like, personal advocates fit into this category, to where they come on board to sort of - to represent the person of concern and make efforts to

stymie or delay safeguarding for the person.

MS ORR: Is this, sort of, a category of people who are taking advantage of the situation as it exists?

MS LAKE: I think they're being opportunistic, yes.

MS ORR: For, probably, financial gain in most circumstances.

MS LAKE: Exactly; that's right.

MS ORR: I want to move to a different topic now, and ask about available services. So are there, as far as you are aware, many - or any - services in South Australia for people with a disability who have experienced or are experiencing domestic family sexual violence?

MS LAKE: Yes. I'd like to talk about that in terms of a gap in services. Are you - can I respond in relation to what I see as the gaps?

MS ORR: Definitely; yes, absolutely.

MS LAKE: Yes. So I think there are a number of system gaps, and I will talk about a few of the different ones, including the available domestic violence services. So, first of all, I think the gaps - there are some gaps within the NDIS system itself. There's quite a narrow focus of the NDIS; it's a scheme, and it's to fund disability-related needs only; there is no really a space for holistic support or a wraparound model of care, or long-term case management to support someone to work across all of their life domains, essentially. The NDIS places a dollar value on a person with a disability - and I've explained the concerns about that, and the system can enable risk factors and erode protective factors by allowing decision-making to be put into the wrong hands, so parents or some of these unscrupulous providers can change services or fire providers if there are challenges to the abusive behaviour. Services can fear being fired if they don't support the world-view, or the parent, or the person of concern. And it can provide an environment for disjointed services, disengagement and, ultimately, less eyes on the situation.

Another gap, I think, is the voice of the person with a disability getting lost. So it could be that there is a nominee involved in the person's situation in relation to NDIS services, and that the role - and the voice of that person overrides the voice of the person with a disability, or direct contact with them. And, for example - this is something that we hear quite a bit in our unit, we might get a caller from a disability provider, saying - you know, telling us their concern, and we might say, "Have you had a conversation with the person themselves?" "No, we've only spoken to Mum," and Mum might be the person who is responsible for the abuse. So there, sort of, can be that default of the provider going to the parent rather than to the person themselves.

Just going back to the issue of training for support coordinators, they play quite a central role in people's lives, and they are often working in that space of fear to, sort of, speak up or take actions; they, you know, are concerned that they might be sacked. Or if they

haven't been trained, they might not even understand, like, you know, how to communicate appropriately with their clients. I think the voice of the person can also get a bit lost when there are guardianship orders in place, for similar reason - that's that default to the nominee or the guardian. There does, also, seem to be a disconnect between the expected roles and responsibilities for NDIS providers with the NDIA - and I'll explain this, in that there seems to be a lack of clarity about who is responsible for taking action about abuse when it comes to the NDIA and service providers.

Providers, in some circumstances, will contact us, and we will say, "Oh, have you done this?" or, "Have you done that?" and they'll say, "Oh, it's not my job," or, "Oh, my manager said I can't do that," or, "I'll get fired if I have that conversation with, you know, the parent." But the NDIA say that these providers have a central role in responding to the abuse, but we see that refusal to go to do that or take those actions. And the other thing is that providers often will say, they don't know how to deal with the complexity of the situation. And, in fact, sometimes their response might be to remove themselves - remove their workers from the situation, which then can increase the risk.

The regulatory response from the NDIS Quality and Safeguards Commission regarding unregistered providers can - I think, also, there's some gaps there, in that it takes a long time for action or banning orders to occur, or be put in place, despite ongoing exploitative behaviour. And it is easy for providers to involve their other associates or friends as service providers, even when they're banned. And there's quite limited scope what the NDIS Quality and Safeguards Commission can do when it's looking at the conduct of people who are NDIS providers, if they're not directly drawing down on someone's NDIS plan, that there needs to be that link. So the scope is an issue.

And I think the other thing that I touched on before, around advocates - so, in some circumstances, we might see the person of concern engaging a professional advocate to represent them, and those people, kind of, try and stymie safeguarding efforts. And there seems to be a gap in the regulatory environment, where these advocates don't seem to meet the threshold for breaches to codes of conduct for either the NDIS Quality and Safeguards Commission or the Health and Community Services Complaints Commission.

I'll now touch on the question that you first asked me, which was about services for people with disability, like, domestic violence specific services. And I think back to what COTA was saying about, you know, the services not being designed with older people in mind, and I would say the same thing for people with disability. I think it can be difficult for mainstream domestic violence services to meet the needs of people with disability - especially complex disabilities, and the focus does primarily seem to be on intimate partner violence and women with children, rather than those other forms of family violence that might happen from a parent, or a child, or another person in the family. The option of going into crisis accommodation, like a motel, would - you know, comes with its obvious challenges regarding accessibility, particularly for people who have got mobility, behavioural, sensory or cognitive disabilities.

And usually, the crisis accommodation and that wraparound case management comes together, and so if you're not accessing the accommodation, you're not accessing the DV

- domestic violence - specific case management. People with disability might have specific needs, so they may be more time-intensive; they might require longer episodes of service; they might have specialised communication needs, behavioural needs or support needs. And the workers in domestic violence services have got a specialised domestic violence skill set, not necessarily a disability skill set. Some people hold the view that the NDIS would be responsible for that accommodation if someone needs to move out of the home, but that's not always the case, so if it's not a disability related need then it wouldn't be seen as a disability related support, yet your mainstream services may not be able to support them either.

So you've got two separate service system, each with their own specialisation, I suppose, dealing with a complex set of issues, and they might see the presenting issue as, sort of, out of their wheelhouse or out of their area of expertise. COTA raised the housing crisis and the issue of accommodation - or limited accommodation - options for older women, and I would say that that is the same for people with disability, that, generally, it would be NDIS supported independent living options; if they're eligible, that's available - or public, or disability, or community housing. They would be reliant on their NDIS support coordinator or their local area coordinator to assist them navigating the accommodation rather than a specialist DV - domestic violence - service.

And the other thing that, I think, is a gap is that lack of housing for perpetrators of abuse, and I will - I think, very similar to what you've heard today is, where the adult son is perpetrating abuse and, then, might be bailed to the parents' address as there's no other option, or they might be staying there because there is an intervention order in place with the partner, or post jail release, so they're staying with their older parent. And then, there is also questions around the suitability of that arrangement, if you then have another person, like, an adult with a disability living in that place as well, because there doesn't seem to be, when people are, sort of, bailed to those addresses or are living in those addresses, there is not really that holistic overview or consideration of the whole family dynamic, or what risks they might pose to others in the household.

I think another gap is accountability and support for perpetrators, and I'm sure you've heard about this before as well. We do - at our unit, we do take limited actions with the person of concern - or the perpetrator, and that might be that we take a role in speaking to the person about the concerns. We might write to the person, asking them to stop the behaviour. We might provide general advocacy for the adult when they're interacting with the person of concern, or give extra support to the person of concern, where we see that it's going to add to the protective factors for the adult. But there's no programs to really refer adult children who are violent toward their parents - or parents who are abusive towards their adult children with disability - for direct therapeutic engagement and support.

I know that DHS has recently done some work, and I think they did a one-day forum - and I think it was called Working with Dads and Men Who Use Violence. And they provided training to staff, and they're developing a practice guide. And I think the scope of that type of work really does need to be broadened to include those other nuances of family violence that don't fit it in that sort of intimate partner paradigm, where other people in the family are responsible for the abuse.

MS ORR: Thank you, that's really helpful information. I want to finish with a similar question to what I asked COTA just before. In your view, what do people with disability need to move forward towards a future without domestic family and sexual violence?

MS LAKE: There's a few things that I'd like to tell you about. I think one of the things is, the early identification and responding to issues about parental control and refusal of supports, because it only compounds and becomes worse over time for the person with a disability if they're not receiving external services and support. So policy settings, say, for example, within the NDIA that can identify and respond to at-risk adults early - so where they're saying there's no uptake of formal supports, or regularly changing providers, or there's significant underutilisation of NDIS plans, and also promoting and providing early planning for older carers with adult children with disabilities, so taking a more of a life course approach to disability care planning, and addressing those different life stages and what needs to happen at those stages in advance for an older parent, who is caring for an adult child with a disability, and ensuring, generally, that there's easy navigation, good service provision, and dealing with issues of mistrust or dissatisfaction early.

I think recognition of people's voice is also another thing that is required moving forward, so that broad recognition by service providers to listen to the voice of the person with a disability - and I said before, it can get lost when you've, sort of, other formal people appointed. And I think it's important for us to have a framework in place to support agency for people with a disability, a supported decision-making approach or a tool that allows for the capture of what people's views are, what their preferences and what their values are, to inform more broadly how we work with people with disability, but to also inform how to deal with the abuse. I think community education and awareness regarding abuse needs to occur. And I've got some thoughts on particular themes, so themes around care versus control - so targeting parents or family of people with disability.

Looking at community education about building protective factor for abuse, so social connection, connection to mainstream services, having stable, positive relationships with others and good support around you. Gender expectations about the role of caring - so it's not just mum's responsibility to care for their adult child with a disability. And picking up on what you've heard today about violence against older women being everyone's issue, I would say that safeguarding is everyone's business, so building community understanding that we've all got a role in that space. I think building workforce capability is also important, so building the capability of disability workers, of doctors and other mainstream providers, who've got regular touch-points with people with a disability, because it's a missed opportunity when you've got someone who is trusted and engaged, but who, perhaps, doesn't have the skills to identify or respond to abuse or know how to address those concerns.

Looking at the training requirements for disability workers, there's currently no minimum training; there's recommendations, but there's no minimum requirement to provide disability support. And these are the workers that are providing people with support in some of the most precarious situations - and GPs and other health professionals being able to recognise and respond. Having safe and appropriate

accommodation during a crisis, or to remove yourself from the domestic and family violence, and access to specialised supports for people with a disability, so universal options for people with disability to access crisis accommodation and access intensive case management support, and for responses to be both specialised, in terms of domestic violence - domestic or family violence - support, but also disability informed.

So you've got training and capability to address the specific needs of people with disability, and maybe that would be increased funding or partnerships between domestic violence and disability services. And I think, also, the good regulatory service or environment for disability services is important to respond to these, and to make things better for people with disability in the future, so a top-down approach from the NDIA and the Quality and Safeguards Commission regarding expectations of workers in responding to abuse, communicating this broadly among the sector and taking appropriate and timely regulation action where it's required. And I know that there are some upcoming changes to the NDIS landscape, as of 1 July, and that does point to the registration - excuse me - arrangements for providers, and it might have an impact on unregistered providers, but it's unclear whether it's going to go far enough to deal with the types of providers that we've seen take advantage of people with a disability.

MS ORR: Thank you. Commissioner, I have no further questions.

CMR DESPOJA: Thank you. I've got just a few quick ones, if I may.

MS LAKE: Yes.

CMR DESPOJA: Forgive me if this was obvious, but an adult or someone who is concerned about someone, and reports it to you, can that be anonymous?

MS LAKE: Absolutely, it can be anonymous, yes.

CMR DESPOJA: What proportion, would you say, of those complaints would be anonymous?

MS LAKE: It is common for someone to want to be anonymous. The downside of that is that we can't necessarily go back to them and give them any further information about what's happened in the situation.

CMR DESPOJA: Yep.

MS LAKE: I would be guessing if I told you how many, but I could certainly get that data. But, certainly, it's common for people to want to be anonymous, and we need to really maintain that, to maintain trust in the community, that they can contact us and that they can remain anonymous.

CMR DESPOJA: Thank you for that. I was fascinated by the statistics or the percentages that you gave us around not only the kind of abuse, but who was responsible for perpetrating that. And, as I think you were making very clear, when it comes to people with a disability, that mothers are being the primary source of that, but

as it was clear from your discussions with counsel assisting, it's quite complex - - -

MS LAKE: Yes.

CMR DESPOJA: - - - which made me wonder - a couple of things. First of all, your comments around some of those gendered expectations, whether or not dad is - and, again, forgive me if this sounds that I'm asking for anecdotal responses, but I suspect there is some research around it, but, firstly, those gender expectations mean that mothers are more likely to be looking after the child with a disability - or adult. And, secondly, I was curious about the composition of that family, whether or not they may be - the number of family units where that mother is the only parent or guardian in that - or caregiver in that situation.

MS LAKE: Yeah. Yeah. That is true. There are - it's common for the mother to be the only care provider. And another piece of anecdotal information that I would tell you was, when we see reports coming regarding culturally diverse communities, there are times where that role of the mother as being the primary carer of the adult with a disability is very clear within that family unit.

CMR DESPOJA: Yes. Thank you for that. Look, you've talked comprehensively in response to Ms Orr's questions around workforce, need for training, et cetera. I'm just sitting here, listening to some of the things that you said today, thinking, gosh, some of the issues with which you deal and some of the things that you and your colleagues see are pretty intense - or the reports that you get - - -

MS LAKE: Yes.

CMR DESPOJA: - - - and having to analyse and respond to those assessments and reports, which goes back to some of those issues around fatigue, but also just burnout of workforce. You mentioned that everyone in the team has a social work degree. Do you find that there is enough supply when it comes to your workforce needs?

MS LAKE: I think that, for a number of years now - I've been a social worker for a long time, and I've been in management roles, and supply and being able to get staff has been a longstanding issue for social workers. Within our organisation, I think we can - we're at a place of maturity now, after five years of being established, that we may be looking more broadly at our workforce to look at other, sort of, people, with different skills and specialisations, to complement our workforce. But, certainly, it is a workforce that - it can be difficult to attract staff, and because of the content, as you say, it can be difficult to retain staff. So there has to be a strong focus on providing a workplace and a work environment that can assist longevity of your team, and acknowledge and respond to the trauma that they experience as staff members by hearing the things that go on every day. So we are mindful of that, and we put things in place to support our team.

CMR DESPOJA: I've got no doubt. Thank you for your evidence, and, counsel assisting, if there's anything else.

MS ORR: No. I'd ask the witness to be excused. Thank you, Commissioner.

CMR DESPOJA: In which case you are free to go.

MS LAKE: Thank you.

CMR DESPOJA: Thank you for your evidence. We'll take a short break.

ADJOURNED

RESUMED

CMR DESPOJA: Welcome back to the final witness for today, day 9 of the public hearings, the Royal Commission into Domestic, Family and Sexual Violence. I invite counsel assisting to introduce the final witness for this afternoon.

MS ORR: Thank you, Commissioner. Thank you. I call Ms Jennifer Howard.

JENNIFER ELIZABETH HOWARD, SWORN

MS ORR: Thank you, Ms Howard. You are the CEO and founder of Safe Pets Safe Families; is that correct?

MS HOWARD: Yes.

MS ORR: Can you tell us what is Safe Pets Safe Families?

MS HOWARD: Yes. So Safe Pets Safe Families is a charity in Adelaide, and we support people and pets essentially through crisis.

MS ORR: Do you, as part of that, help clients and their pets who are experiencing or have experienced domestic family and sexual violence?

MS HOWARD: Yes.

MS ORR: Do you have any - are you able to tell us sort of how many of your clients are affected by domestic/family/sexual violence, approximately?

MS HOWARD: Yes. So I did write those down so I didn't forget. So since August 2016, we have been collecting data. And so we've had 297 clients that have had their pets in foster care. So far, we've had five in foster care this year, but we've had 44 intakes that we haven't been able to support with foster care. And we also provide some outreach services and other services to domestic violence clients and not just foster care.

MS ORR: You also have clients experiencing other sorts of crisis; is that correct?

MS HOWARD: Yes.

MS ORR: Like what?

MS HOWARD: Yes. So we also provide services to homelessness, mental health, medical and natural disasters, and things like that as well.

MS ORR: Could you - and I'm sorry if this is a question without notice. Could you give us an idea of the sort of proportion of your clients that are affected by violence, as opposed to those other things?

MS HOWARD: Yes. So the domestic violence clients are still sitting up over 50 per cent of our client intake.

MS ORR: You have mentioned - I'm going to ask you more about the services and programs you offer in a moment, but you've mentioned foster care. What other sorts of services are you providing in the domestic, family and sexual violence space?

MS HOWARD: Yes. Yes. So we provide an outreach service where if clients are in motel accommodation or accommodation where they can have their pets but there's barriers, so, like, for instance, if someone was in motel accommodation, they can't leave their pets behind when they need to go to appointments and things like that. So we just provide, like, a dog-sitting sort of daycare service, and we also have a community vet fund and a pet food bank and just simple services like transport. Just practical services.

MS ORR: And if you are happy to, could you just tell us a little bit about the background to Safe Pets Safe Families and how you came about setting it up?

MS HOWARD: Yes. So in my early - or, actually, my late twenties, I experienced domestic violence myself, and at the time I had two young children and two dogs and I had to leave my - the house that I was renting, and I went into a domestic violence shelter and I couldn't take my dogs with me, and I tried searching for all sorts of solutions and I couldn't find any solutions, and it - it really affected me badly, like, with my mental health and, I guess, like, it - it never really left me. So I guess after - when I was out of my DV relationship and I had stable housing again, and at the time I didn't have any pets of my own, so I just offered my services myself to Southern Domestic Violence at the time and another place called Eleanor, a place that's not around anymore, and I didn't really - when I first offered these services, I didn't really think much of it. I just thought, like, this is something I experienced, and if anyone else is experiencing this. I would love to be able to support them with their pets, and I literally got a phone call the next week, and it literally started as simple as that. Like, we just started a community around basically fostering pets, and - yes, and then it just grew so quickly and I didn't really know what the need was.

MS ORR: I don't want you to tell us more about how it's grown and what you're doing, but before we do, can you explain to us some more about the links between animal abuse, or animals in the context of domestic and family violence and how they fit into that picture?

MS HOWARD: Yes. So I guess in a household, like, when you think about it, around 69 per cent of Aussies actually own a pet, and so if you think about the percentage of - percentages of domestic violence that happens as well, like, in a household with pets, pets themselves are subjected to violence themselves, so they become, I guess, victims

of domestic violence in their own right, if they were - if pets were seen as a sentient being, but - and then pets are also used as coercive control, and I guess one of the important things as well is that there's a lot of research that shows that pet abuse can be an early indicator of other crimes, and, yes, I guess - and I guess, like, yes, pets are - they - because they're such an emotional tool, like, yes, back to the coercive control as well, like, it's a huge barrier for people.

MS ORR: And when you say - sorry, I will ask another question first.

MS HOWARD: Yes.

MS ORR: You said they are like an indicator of other crimes. What type of crimes? Crimes of violence?

MS HOWARD: Yes, yes. There's so much research that do show that when there is animal abuse present, that it's more likely for the perpetrator to go on and kill their partner. So it's a very early indicator of someone going on to kill their partner, rather than just experiencing domestic violence and - and yes. So it's - I guess it's more serious crimes when animal abuse is present.

MS ORR: And it's like a flag or an indicator, as you have said.

MS HOWARD: Yes.

MS ORR: Of something that might follow.

MS HOWARD: Yes.

MS ORR: You've also mentioned that pets can be used in the context of or as a form of coercive control. Can you give us some examples of that or explain how that might look?

MS HOWARD: Yes. So many clients of ours that - say they might have successfully escaped but without their animal, and if the animal is still at the address, the perpetrator can send threatening messages and things like that, that if they don't return home, this is what's going to happen to their animal, and so that - a lot of the times, that's what draws people back to the house. And they - I've even had some cases where - I won't, obviously, go into the details. It's really graphic. But where someone - they - a perpetrator has done stuff in front of the victim to the pet and said that, "You will be next if - like, if this doesn't happen," and so it's just a - it's just a means to control, because it's such an emotional - like, pets are, I guess - the human-animal bond, people are so connected, and I guess, like, it's - it's just like a child. Like, a pet is a part of the family and, yes, so, yes, I guess people find that as a tool, an easy tool to use to control people.

MS ORR: You've mentioned the bond. Does that present a barrier to leaving sometime?

MS HOWARD: Yes, it does. We get lots of inquiries and if we almost can't instantly take their pets, or if they can't find pet-friendly accommodation, then they refuse to leave.

MS ORR: You've mentioned previously that often, in your experience, people are ringing you or other animal organisations first before they ring anyone else because they're worried about their pets. Is that right?

MS HOWARD: Yes. Yes. I've actually had a phone call from somebody ringing about their pets, and in the background I could hear their partner sort of yelling, and - and everything was getting - like, was escalating, and I've actually had to call police on a number of occasions and - and, yes, so many people just - they worry about their pets that much, that their pet's safety is more important than their own.

MS ORR: And does that come back to that bond and them being a member of the family?

MS HOWARD: Yes. Yes, and especially - there is research that shows especially if someone has experienced trauma in their life, they actually bond - their bond to their pets are more than what a normal bond would be.

MS ORR: So against that background, how are the current domestic violence - domestic and family violence systems in South Australia set up to deal with pets? Are they well set up to deal with pets or not?

MS HOWARD: Yes, not - I think, like, we've - we've sort of - there's still a lot of gaps I feel in the - in the system, especially in - when - like, when domestic violence shelters are full, and only some domestic violence shelters do accept pets, but a lot of the time, victims of domestic violence do have to go to emergency accommodation first, and a lot of the emergency accommodation is not pet friendly, and, I guess, there's more of a need than we have shelters. I guess, like, there's more of a need than there is actually a solution, and, yes, it's just, I guess, some of the animals, especially when you think about farm animals and things like that, and that even there's a more risk with farm animals as well because some of the perpetrators of violence, when they live on a farm, do have access to firearms and things like that. So I guess it's - yes, at the moment there needs to be a lot more supports in not just making, like, shelters pet friendly but actual social services that do provide those services, to be able to remove people and pets at the same time.

MS ORR: You've spoken about pet-friendly shelters or accommodation. What else goes along with pets, other than actually a place to house them, that's not sort of being taken into account by the current system?

MS HOWARD: Yes. So even if a domestic violence shelter was pet friendly, we get - we frequently get phone calls from DV shelters and crisis services when the person needs to go to hospital, and, like, they might need to go to hospital for a pregnancy, they might need to go to hospital for injuries, they might need to go to hospital for mental health, but in all of these situations, the pets can't remain at the shelter by themselves, and - so that's one thing. They still - even if a DV shelter was pet-friendly, they would

still need solutions for, like, emergency boarding or fostering. And if anyone knows the cost of boarding pets, it's really expensive, and if you've got multiple pets, it's just so unaffordable for people, so there needs to be a discounted or free option. And I guess veterinary care as well, like, there's so much financial abuse that happens in a domestic violence relationship, and I know from my own personal experience as well, around, like, needing access to veterinary care, and some of these animals come in and they do need veterinary care that can be quite costly, which is unaffordable for the person. So there needs to be options of, like, payment plans and just access to veterinary care.

MS ORR: And what about transport of animals?

MS HOWARD: Yes. Transport is huge as well. So currently, government vehicles can't transport animals. So we do get called upon to provide transport sometimes for a victim and their pet to the shelter, or just the pet to the shelter.

MS ORR: We have in South Australia, and around Australia, I guess, normal animal welfare organisations. Is it the case that they're not suited to this kind of work?

MS HOWARD: Yes. So we've worked very closely with a lot of the animal shelters, and we actually get quite a lot of referrals from the animal shelters, and both of the, like, sort of two biggest animal shelters at the moment, they're both very limited with providing boarding, but I guess they're also limited in providing the emotional needs of the person as well. And sometimes, because the animals have, like, experienced trauma of their own, like, a shelter environment is just not the best environment for an animal either.

MS ORR: So I now want to ask you about what Safe Pets Safe Families is doing in relation to all the things (indistinct) in relation to domestic and family violence.

MS HOWARD: Yes.

MS ORR: You've mentioned foster programs. Should we start there?

MS HOWARD: Yes.

MS ORR: That's how you started, isn't it?

MS HOWARD: Yes. So the Safe Pets Foster Program was the original program that Safe Pets Safe Families built, and it has literally been a lifeline for so many people, and, I guess, even when some of the numbers of people experiencing homelessness, we have a higher number of women experiencing homelessness, and even though they're sort of presenting for a homeless reason, they've actually had domestic violence in their life as well. So they're going through, like, a secondary crisis, I guess, and, like, the foster program, I guess, relieves the shelters and things. So the idea of the foster program is to keep people - people's pets safe until they get stable housing and then their pets can go back to them. So we are heavily referral-based. Like, a lot of our clients all come from referrals. A lot of government and non-government agencies refer to us. I think if you can pretty much think of any support agency, like, human services or social services in Adelaide, they all refer to us. I don't think there's a place that hasn't referred to us. SA

Health is one of the biggest service referrers to us, and, yes, I guess the Safe Pets Foster Program has been running for a long time, since - I guess we have been collecting data since 2016. Then the second program that we started was Paws & Pals.

MS ORR: Can I - I do want to hear about that.

MS HOWARD: Yes.

MS ORR: But can I - is - are the foster carers generally volunteers?

MS HOWARD: Yes, all volunteers. Yes.

MS ORR: But you make the arrangements and organise the care; is that right?

MS HOWARD: Yes. So - yes. So we're - we've got a - I guess we've got around over 500 volunteers within our organisation, and we have, like, a separate group of volunteers and a separate group of foster carers. We don't allow - so we keep clients and foster carers anonymous to each other, so we have a volunteer caseworker that also provides all the coordination and the contact, so that's the go-to person for the client and the go-to person for the foster carer, and that person provides everything needed for the - the pet, the client and the foster carer, so it's quite - yes, quite substantial. And, yes, we do have other resources that support that foster program as well, like, a pet food bank, which is an independent program of its own, but when it first - I guess when we first established the foster program, we did have a - people were donating food and things like that for that program. Yes. And we have some emergency catios and things at our warehouse as well that we set up for - just so there's no waiting period for - for cats. We can't do dogs at the warehouse, but we can do cats.

MS ORR: Catios, did you say that?

MS HOWARD: Yes. Catios. Yes.

MS ORR: What's that?

MS HOWARD: Yes. So it's like a - about - sort of, like, a cat enclosure that we can - - -

MS ORR: Sorry.

MS HOWARD: Yes, that we can set up.

MS ORR: And, sorry, so you mentioned Paws & Pals. Can you tell us about that?

MS HOWARD: Yes. So Paws & Pals is a pop-up vet clinic. So I guess - that was the second program we started because we realised that access to veterinary care was a huge barrier for a lot of reasons for people, and so, I guess, like, we like to look at the - the Paws & Pals program as a bit of a gateway service as well, because a lot of the people - it's completely referral-based and it's completely volunteer. So we have

around 100 volunteer vets and vet nurses that give their time up on a Sunday, and we run about 20 clinics per year, and we run them across Metro Adelaide and also the Riverland, and we don't accept public - so just people - general public can't refer themselves. They actually need to be referred from service. And so a lot of human services and social services, like, refer their clients to us, and sometimes what we have found though that some of the people that are coming through homeless services, when we actually get talking to them they are experiencing domestic violence and other things, and so we - I guess we have an opportunity at those clinics to also then on-refer these clients to other services. And at the clinics, we basically offer a free general health check, free vaccinations, free microchips, grooming, flea and worming and our separate food support, and sometimes I do personal goodies for the person as well. But it's a good place that if someone - so we've sort of put out there like if someone's experiencing domestic violence, like, it's really important to have your pets vaccinated. So they can sort of discreetly come to the pop-up vet clinics and just get their pet vaccinated for free, and then prepare - yes, prepare themselves for leaving. So it's just a discreet thing that they can do, sort of without connecting to DV services as such. And there's - yes, so apart from - yes. So Paws & Pals, then we have got the pet food bank, and that's at our warehouse. So the pet food bank actually supplies food to most of the DV shelters and lots of other organisations like Salvation Army, Uniting Communities and Uniting SA, and a lot of other places that supply food, because, I guess, all of those places that supply human food, I guess a lot of people actually come and get human food and then feed their pets, and so this gives a good opportunity for people to be able to collect pet food and still be able to feed themselves. And with the - I guess, like, with the - so I will use the example as the Womens Safety Services for an example. They don't have, like, a lot of storage on - on site and things like that where they can't actually store food, so they get regular deliveries from us as well, and they can put individual orders. So it's not just - we've got a lot of community partners and then we have individual clients that access the pet food as well, and then our foster carers as well.

MS ORR: They access the food?

MS HOWARD: Yes. Yes.

MS ORR: You talked about Paws & Pals, in terms of the vet clinic. Is it correct that you also have loans available for vet care?

MS HOWARD: Yes. So we've got a community vet fund, and we've been - we've only been collecting data since 2020 on that, but it has been running a little bit longer. Basically, ever since we had a foster care program, we have provided vet care, but since 2020, we were just really, really lucky to actually be provided a really generous request from one of our clients a few years ago, and so I guess more money than anticipated sort of went into the community vet fund, but we've spent around 720,000 since 2020. I can't give the numbers of the - I didn't write that down, the numbers of the actual - how many vet appointments, but, yes, it has been - I guess, like, that's been a crucial part of our program, because I guess when you have pets, there - there is such a need for access to vet care. And at the moment, so we're averaging around 250,000 per year, but that - at that current rate, that's not sustainable for us to keep continuing at that rate, because it is a community circular fund, so,

like, basically, like, we will pay for someone's vet bill up front, and then they will pay it back on a payment plan slowly, so sometimes it takes a full year for someone to pay back their vet bill. So it's a - yes, it's something that is highly needed, and I guess we've surveyed some of the DV services, and that is one huge need of when pets are in DV shelters, and we had some comments of some of the DV workers saying that they've actually, out of their own pockets, have paid for people's vet bills and things because they just felt so sorry for the animal that needed the vet care, and that was the only way it was going to get vet care. And so I guess they were really - I guess they were really excited to know about the community vet fund, but at the same time, we need to find resources to obviously allow us do it at a bigger - a bigger rate.

MS ORR: And we've mentioned transport being a sort of hurdle. Is that something that Safe Pets helps with?

MS HOWARD: Yes. Transport is huge. Like, sometimes that might be the only service that we provide someone, but it actually could be an interstate transport as well. So sometimes there is really high risk DV cases that the person does need to move interstate, and so if they've got kids and animals in tow, it costs quite a lot of money to be able to, like, either fly the pets or - or transport them by road or - yes. And then even rural areas to metro areas, like, there's lots of long-distance transports, but then we also provide lots of short-distance transports as well, and there's - a lot of our clientele don't have cars themselves, so they have barriers of transporting. And then we - I think as an organisation we did try and - sorry, Uber Pets, but I'm going to - but with - we tried to use Uber Pet but some of their drivers actually just literally drive off and they would not pick someone up. They see - they see - they see an animal and are a bit intimidated by it, and - and then they just drive off. So you can't rely on things like that either. Plus though, I guess from a security and safety perspective, you wouldn't really want to be using a mainstream-type service that has lots of different types of workers and - either, so I guess services have become quite confident in our volunteers because all our volunteers are - have DHS clearances and they are all trained and have, like, privacy policies and things and - so I guess, like, our volunteers do make a good fit to transport, although since the cost of living, we have noticed, like, a drop in our volunteers being able to transport, so we did actually have to introduce a client contribution fee towards transports, which at first, like, a lot of - a lot of our volunteers and clients were like, "We don't want to charge the client, like, a transport fee," but unfortunately, I guess, like, with the cost of living and stuff, like, with volunteers actually using their own cars and petrol, we did have to introduce that, so - and that would - we - we calculated one month, we did 228 transports in one month, and that's not just domestic violence though. That's the whole - across the whole organisation. So that's huge.

MS ORR: Can you tell us about the Purina Purple Leash Project?

MS HOWARD: Yes. It's something I'm really excited about, because, I guess, ever since I started Safe Pets Safe Families, one of my goals was to make all DV shelters pet friendly, because, I guess, that's the barrier that - it's going to make me cry. It's the barrier that I had, and I couldn't take my pets with me. So - sorry.

MS ORR: No, it's okay.

MS HOWARD: So I guess when Purina - like, there's an organisation in America and they're called RedRover, and they're a similar organisation to us, and Purina had been doing a project there called the Purple Leash Project, and I guess the Australian team for Purina felt really passionate about this cause and they wanted to do something, and they - so they went on a search across Australia and they hired a third party to do research in Australia to find the perfect partner to be able to partner with to deliver these services, and so it took about four years or - I think, in their research, and then we had a few interviews with them and stuff and they eventually picked Safe Pets Safe Families as their national partner, and so they have partnered with us for three years. We've got a three-year contract with them, and it's around going out and visiting all the domestic violence shelters and basically helping them with resources. Like, it could be practical resources in fencing and gates or furniture, or it could be resources in, like - like, policies and procedures and training and referral pathways and things as well. Because we did a few, like, interviews with a lot of the DV shelters, and we asked them what their barriers were and things like that. So it's sort of - the project just entails the hire of - so we hired a project officer to complete the project, and, I guess - and we've already had some really great success in the project already, and it's already - news travels fast. It's already travelled interstate. So a lot of DV services interstate have already been reaching out for us to sort of go there as well. But it's a program that I guess is a long time coming. It's a pet food company that - that is supplying funding for us to be able to do this, and, like, I'm a little bit disappointed that it hasn't been done before this, and then it has taken a pet food company - I don't know why I'm crying again.

MS ORR: Purina is the pet food company that you're talking about?

MS HOWARD: Yes.

MS ORR: Yes.

MS HOWARD: Yes. So, like, I'm really excited for this though, but there's definitely so much more that could go into it though. It's not just about - I guess, like, Purina has made the first step into helping us be able to deliver these services and making shelters pet friendly, but having DV shelters pet friendly is not the only solution and there needs to be a multi-layered solution when we're having a response to the context of domestic violence and pets. Yes. So - yes.

MS ORR: And I want to ask you about the Youth & Pets Project.

MS HOWARD: Yes.

MS ORR: YAPP.

MS HOWARD: Yes. So we have got a program named YAPP. So there is two sides to the project. So one side is actually not - it's laying a little bit dormant at the moment because it needs a bit of funding into it and there's still a bit of research and resources, but the - that side of it that is laying dormant is a program - so we've actually put together a whole model, and it was based around - it's called the SHIP model, which is Strategic Humane Intervention Program, and basically, it's around teaching empathy to

children. So we based it around five to eight year olds that have witnessed domestic violence and animal abuse, because there is research that shows that children who witness domestic violence and animal abuse are five to eight times more likely to become future perpetrators themselves. And there has been really great success in this model that children that have been through this course - so it's like a program that actually is interactive with - with pets, so you can do it with guinea pigs, you can do it with like a mum cat and kittens, you can do it with, I guess, any small animals, and it's around, like, teaching, like, healthy attachments, it's around literacy, It's around getting children to open up and talk, watching, like, a mother and kittens and how - how you care for a cat and kittens.

Like, it's, like, a lot of - I guess it's around teaching empathy and getting the children to really engage. And so there was some success in actually - there was an Australian project in Victoria that did it with guinea pigs. They did, like, a model with guinea pigs, and there was a child at the end of that program that said that it took him much - like, much less time, like - sorry - much longer time to feel angry, so he's less angry. So it showed that over this period of time, the effect that this program had on the child was - was, like, really great benefits, and I guess there's lots of success in this program in America as well, and it's something we're really excited about. And the other side of the program though is working with children that come out of state care. So we are working with other - with youth organisations in South Australia, and because one of the first things, I guess, youths do when they get their own house and they become independent is they want to get a pet, and - because a pet is that emotional stability for them, it's a bond. They can tell their pet their deepest, darkest secrets. They can - they rely on their pet for so many things, and I guess the YAPP Program for them is all about just teaching responsible pet ownership, giving them access to vet care, giving them access to, like, animal training, mainly dog training, and I guess because when they become a responsible animal owner they also become a responsible tenant as well, so there's, like, some life skills in that. So we just have volunteers that work with youths for up to 12 months, just sort of interacting with this person and teaching them all sorts of things about responsible animal ownership, and just connecting them to other services and things as well. And I guess it is also around teaching empathy and educating them, and - and just so they've got support in a different way than just the normal supports, I guess.

MS ORR: The animal therapy that you were talking about before, is that - I know you said it's not running at the moment.

MS HOWARD: Mmm.

MS ORR: But is that sort of built or designed with counsellors or other therapists?

MS HOWARD: Yes. Yes. So we had - so I actually had - first off, it was actually a counselling student that built the project with me, like, as a part of a project for her studies, and then we've had - over time, we've had lots of volunteers that have given input. We've had an occupational therapist that has helped us put together - it's called, like, a box in a room, so basically we could set up this program anywhere and create a really safe space for learning. So - yes, so we've had counsellors, occupational therapists, we've had social workers, we've had some psychologists, but not a child

psychologist yet, but we are on the search for a child psychologist that can help give us the input as well. So I guess we just want to get it to a point where, yes, it's sort of - if we have a child psychologist, then we could obviously start putting it together better in a way that we can deliver it. But we've got the whole - like, everything's actually there, so the - the model is all there and the program's all there. We just, yes, haven't had a chance to actually deliver it yet.

MS ORR: And you mentioned before caseworkers. Can you tell us about that?

MS HOWARD: Yes. So, God, over the years, we have had caseworkers - our volunteer caseworkers are, like, the most amazing people ever. They just give so much time. We had - like, one of our original caseworkers that came on board, she was actually a midwife from Women's and Children's Hospital, and she actually retired, like, two years early. She was fortunate enough that she could. And she became - basically became a full-time volunteer with us, and she put so much time into it. But over the years, we've had, like, around 50 volunteer caseworkers, and the caseworkers - and we do give a little bit of in-house training and, like, we do, like, sort of mental health, first aid and other things as well, but our caseworkers do everything. So they're basically the point of call. So we have, like, a crisis intake worker that answers our phone, which currently she is - so we have only got one crisis intake worker and then myself as well. She has got a social work degree, and I guess she's the point of call for all the intakes and then for the case management team currently. And so our case management team is made up of all different people from all different professions. They don't have to be from community services.

We do have a lot of students, though, as well from TAFE and uni students, and I guess we have our own case management framework work that we built, and I guess the name that we actually give to it is Veterinary Social Services. So because we deliver a different kind of service, we help people through their pets, and I guess when you, yes, connect with someone through their pets, you can connect with people on a very different level. And, like, Veterinary Social Services goes a little bit beyond, I guess, normal case management, what you would see, because we sort of go, like, into the grief and loss, and it's around doing care plans for people's animals as well, like, contextualised care plans and stuff when people haven't got all the finances to provide for their pets, and - but it also includes, like, the foster programs and all sorts. So Veterinary Social Services is quite - yes, quite broad. But in the context of domestic violence, yes, it's around, I guess, when someone's in a crisis, so providing the emotional needs to a person through that - through that process and resources to be able to help their pets as well as them.

MS ORR: Are you able to say, in a general sense, when people connect with you or come to you, are they - do they tend to be linked in to domestic violence services already or not, or is it a mix?

MS HOWARD: A bit of a mix, yes. So I guess we get - we do get a lot of self-referrals as well, but we do try and connect people as fast as we can to services. But, yes, we do get a lot of self-referrals, like, people that will just phone up or email, or they just don't know where to start, I guess. And I think it's - they don't know where to start as well because they have a pet, so I guess, like, traditional services are - like, pets are a

barrier, so sometimes clients are told to re-home their pets or surrender their pets, or they get told that they will have better chances if they don't have their pets, and - so I guess - and, like, people can't - like, even just the thought of needing to re-home their pets is so traumatic and so they just completely refuse to engage if that's what - if that's what they're going to be told straight away. So I guess they come to us in a very desperate state a lot of the times, and they just don't even know where to start, and so we will help connect them and start, like, removing those barriers and say, "This is where you start," and - yes, so it's - and it's - we've got really good and close relationships with a lot of the DV services and stuff, so we can connect people pretty easy as well.

MS ORR: And so that case management role that you're talking about, is that taking place sometimes when there is no other DV service stepping in?

MS HOWARD: There - so just, like, recently, we had a case where - so there's some barriers to some people accessing services. So this person that experienced domestic violence, because she technically still owned a house, she wasn't eligible for some services. So what happened in her case, she - she sort of left, and then she ended up trying to get some services, but then she went into, like, a - a place where she was experiencing family violence, so she went from an interpersonal violence relationship to a family violence relationship, and then because she had a house, she couldn't - she wasn't accepted into a lot of the homeless or DV services, and so we were providing - for her, we were providing some motel accommodation, we were providing - we actually tracked down somewhere where she could, like, house share, and then basically when she was house sharing, we were providing services there. But we also got her connected to a lawyer and got her connected to some other outside finance DV-type services as well. So by the end of it, we actually connected to her for (indistinct) services, but that was a really intense, complex case management that we're not funded for. So it takes a lot of volunteer time and a lot of - a lot of - a lot of, I guess - yes, like, you have to be emotionally strong as well, dealing with some of this, and actually, like, without sort of giving too much away as such, like - like, because we're still working with that client, but we're actually helping her. She - her - finally, her court is finalised and we're actually helping her go back to her - where her perpetrator is to collect belongings, because that's an order of the court to go - and she has got no support systems to actually go do that. So she can get, like, a police standby, but, yes, she came straight to us and said like, "Are you guys able to help," and we did say yes, we could go and help her. So we're getting a van and going and helping her and picking up all her belongings. And - but it's sort of - it is - some people do say, like, "Is that your job? Like, are you meant to go do that stuff," and it's like, "Well, who else is going to do it?" Like, sometimes we feel like we're just left in positions where, well, there is no one else to do it, so we just can't leave someone in that situation to navigate that themselves, I guess. Yes.

MS ORR: On that note, you've talked about the kind of - all these different things that you're doing and kind of the evolution, I guess, of Safe Pets. Is it the case that you have just basically seen gaps and so tried to fill them?

MS HOWARD: Yes. Yes, we - that's - yes. We're definitely an organisation that's known for, I guess, that we just get things done, I guess, and, like - and we don't - we definitely don't try and duplicate any services, or we don't try and step on any toes, and

when we're working with - like, say if a client has been referred to us from, like, Womens Safety Services or something, if they've got case management happening, of course we're not going to provide case management where case management is being provided. But like I said, we can - we do complement the caseworkers though, because a lot of the times, even, like - even social workers, like, they get stuck sometimes in navigating certain issues, especially when it is around the pets, so they will come to us and ask us for advice on how to navigate something, or how to get resources. So we do - a lot of our referrals do come from social workers, and I guess - because I don't think - I don't think people realise the impact of that human-animal bond and what it means to support someone through their pets, I guess, and so there is a lot of - yes, there is a lot of gaps that are - that - yes, is because of the pets.

MS ORR: I want to ask you a couple of more practical things. You've spoken about referrals just from many, many sources. What about funding? How are you funded?

MS HOWARD: Yes. So we have no ongoing funding as such, apart from we've got, like, some sponsorships from some pet food companies and things, but most of our funding is just doing normal, like, fundraisers, like quiz nights or donations, or running sort of like small campaigns and things. So we just - like, it makes me laugh and it just made me think about some of our volunteers, like, we run off a smelly rag. An oily or smelly rag or something. That's what they always say. But - but, yes, so I guess over time, we're really fortunate that we've had a lot of community support, as in, like, a lot of volunteer power, and within our volunteers, we've had a lot of professional skills as well. So we do have, like, police officers and social workers and psychologists and, like, a lot of people that are passionate that want to get involved, and - and they just sort of come together, but there is, like - I've said it so many times. Like, I would really love to offer, like, yes, sort of veterinary social services or veterinary social work on a more formal level, because there is - there's a very huge need for that more complex sort of case management in the context of pets and people. And I guess then also, like, we're sort of, like, at the moment, even with one of our projects, even though we've got some referral pathways for the DV workers to be able to refer to us, we actually can't keep up with - like, can't keep up - keep up with the demand, I guess. Like, so it's sort of - like, yes, we've got solutions, but we don't quite have the capacity to fulfil the needs.

MS ORR: No government funding.

MS HOWARD: No government funding.

MS ORR: And capacity, which you've mentioned, I think you said you had approximately or over 500 volunteers?

MS HOWARD: Yes.

MS ORR: How many staff do you employ, or what's the FTE?

MS HOWARD: So at the moment - so I would have to add that up. We've got - - -

MS ORR: Approximately.

MS HOWARD: Yes. We've got seven staff, but some of them are casual and part time, so maybe equivalent to two/three full time, maybe, three full time. Yes, which is not - like, at the moment - so that might change next year if - like, if we don't find, like, funding, because some of our sponsorships through some of the pet food companies and stuff, like, that funding sort of runs out in July. So, like, our intake worker, for instance, that was funded by Petstock Foundation, so we've got - yes, so we have some, like, partnerships and we've got to, I guess, continually find funding to be able to fulfil these needs, I guess.

MS ORR: And just to finish off, I just wanted to come back to that sort of veterinary social work services and that unique nature of the work that you've described. Can you just explain a little bit more about that?

MS HOWARD: Yes. So veterinary social work, I guess it's the intersection of the human needs of pet welfare, I guess. So, like, when we think about, like - like, vet clinics, for instance, like, the vet industry has one of the highest suicide rates in Australia, and I guess, like, when people are presenting at a vet, they come with human problems as well. It's not just animal problems, and some of these people are experiencing domestic violence or they're experiencing mental health or other crises, and vets aren't trained to sort of deal with - with these sort of crises, and - and it's not just, like, financial issues. It's - it's social issues and things as well, and, I guess - I guess, like, the veterinary social work is to be in the middle between the vet industry and human or social services, so it means that they can be the go-between to be able to help veterinary - like, veterinarians and vet nurses be able to - things like grief and loss and conflict resolution and just be able to deal with those emotional needs. So, for instance, Safe Pets Safe Families, we have, like, 18 partner vet clinics across South Australia, and if there is a client that presents at a vet clinic and they are experiencing domestic violence, or they could be a complex person that lacks communication skills and things, then they phone Safe Pets Safe Families, and that means we can provide a volunteer caseworker that can help, basically, because there is a vet need still, but then there's this human need that - that isn't sort of dealt with. And so, yes, it's just - it basically is just at the intersection of the human-animal bond. And so we complement - like, I guess veterinary social workers complement other services. So, like, SA Health, for instance, has a whole team of social workers that will reach out to us. So they might have all their mental health needs and things covered, but then when it comes to the thing with - like, the thing with the pet, they're like, "Okay. Like, how do we deal with this, or how do we navigate this," and it's just dealing with those extra emotional needs that the normal - I guess normal - the normal system isn't at capacity - or not at capacity, sorry - doesn't have capacity to do right now, I guess.

MS ORR: Thank you, Commissioner. I have no further questions.

CMR DESPOJA: Thank you, Counsel Assisting. What fascinating evidence. I don't think there's anyone listening or sitting around who's not thinking about the bond with their pets right now. I wanted to start exactly where you were finishing. You answered the question I was going to ask, which is around veterinary surgeons actually making referrals to you and other services, because my concern was not only the pressure on them, but as you've identified, it's one of the - the most stressed professions. So there's that referral from veterinarians, and then you mentioned some of the other referrals, as

counsel assisting has done, but I just want to clarify. You're getting referrals from government agencies, but you don't get any government funding?

MS HOWARD: Yes, we're heavily - most of our referrals do come from government agencies.

CMR DESPOJA: Do you find that a bit strange.

MS HOWARD: We always do. We always do. And I guess we've just never known how to quite navigate it. Yes.

CMR DESPOJA: Gosh, I hope that after your evidence today that there will be a lot of people wanting to support you. When we talk about your funding, you said obviously community support, in-kind support, pro bono support, clearly some donors, philanthropists and pet food companies.

MS HOWARD: Yes. Yes.

CMR DESPOJA: Beyond that, any other private sector support?

MS HOWARD: So we have - so we have, like, applied for grants. So we have - we have no ongoing government funding as such, but we got, like, a - a grant for the - from the Office of Aging for a pilot program for our Paws With Friends Program, that I didn't mention, but that's supporting older people and pets.

CMR DESPOJA: Yes.

MS HOWARD: And we've had, like - like, the volunteer grants and things like that, but we haven't had, you know, sort of ongoing government funding. We did just - we were, like, just - like, we've only just received a grant from the Dog and Cat Management Board, and that's not in the context of domestic violence or, like - I guess it's - it's around supporting people and pets, but it's more around animal management, in helping people comply with - with animal management.

CMR DESPOJA: Got it. What about local government? Do you work with councils?

MS HOWARD: We're - we're starting to build relationships with councils. We do get - we're starting to get a lot of counsel referrals, especially with this new project that we've got at the moment. We've had, like, a few, like, small council grants, like, training and things like that, but no sort of ongoing funding or anything like that.

CMR DESPOJA: You mentioned, you know, obviously, your initial and ongoing concern about or interest in the number of shelters that allow pets. Do you have an idea or an overview of how many do or don't? And if that's an unfair question, I take it back, but I'm genuinely curious.

MS HOWARD: Yes. Yes. So I guess in South Australia, most of the shelters do have

some pet-friendly units now, but there is some capacity - like, capacity issues still. So some of the - like, for instance, if - say if a shelter was, like, a dormitory-style shelter, they're limited, like, to how many pets they could have in that type of environment. So even if they are pet friendly, they're not exactly pet friendly. So it's sort of - they're still limited in a lot of ways. So if someone had, like, I don't know, three big dogs, for instance, they potentially couldn't take three big dogs into that environment, or if they have farm animals, they couldn't, obviously, take farm animals.

CMR DESPOJA: Of course.

MS HOWARD: I wouldn't expect any DV shelter to host farm animals, but you never know. But - but - so there's still limitations, I guess. So, I guess, like, if I think about one shelter in particular, like, out of 12 units, they've got eight pet friendly, and you obviously have to keep some that are pet-free because of allergies and things like that.

CMR DESPOJA: Yes.

MS HOWARD: So - yes, so there's limitations with shelters. So even if they all became pet friendly, there's still limitations, and there's still the barrier of that victims don't go straight to a - straight to a shelter. They have to go to emergency accommodation first, and so then emergency accommodation could be a combination of different organisations or motels which are, like, hit and miss whether they're pet friendly or not, and so, yes, there's - yes. So I guess, like, it's a really hard question because how pet friendly are they?

CMR DESPOJA: Yes.

MS HOWARD: Like, even if they're pet friendly, how pet friendly are they?

CMR DESPOJA: All right. But things have changed, obviously.

MS HOWARD: Yes, definitely. It's definitely making a step - like, a step in the right direction, and I know that all the DV workers are very passionate about this area, and they all really want to be pet friendly, so it's something that is positive. I guess we just need the - the systematic changes to keep up with it.

CMR DESPOJA: And please don't think I'm, you know, taking out of this only - or in a simplified way the issue of, you know, management or caring for pets. I'm very conscious of the bond that you've talked about, but also, you know, the quite serious research and evidence that relates to injuries to pets, violence against animals as an indicator of violence that is to come.

MS HOWARD: Yes. Yes.

CMR DESPOJA: And also how pets are used. So you are really - you are really providing a public service. Can I ask just as a final question, are volunteers and your staff and pets safe? Do you ever fear any kind of security issues or reprisals as a

consequence of the work that you do?

MS HOWARD: Yes. There has definitely been times - we do utilise police standbys and stuff as needed, but there's definitely been times where - and I guess you get this - and you sort of - you get this in - like, in DV situations sometimes. It's - they say that sometimes it can take up to nine or 10 times for someone to leave. So I guess if a person has left but then gone back to their partner, but then brought their partner to, like, our warehouse sort of thing.

CMR DESPOJA: Yes.

MS HOWARD: That has happened before, and we've just - we've sort of, like, realised that this was the perpetrator of DV. Because you can just tell sometimes, and - and so, yes, there has been different situations. We've also been put in a situation where we were on site in-house feeding an animal, and some - well, the client was actually in hospital for mental health reasons, but then got released and my volunteer unfortunately walked in to the person that had taken their life. And, like, so we've sort have had to deal with, like, situations like that as well, where we've all come together as a team and supported our volunteer, and we provide counselling and stuff through students for our volunteers and fosters, but we have definitely had some unsafe and situations like that where our volunteers have been put in very vulnerable situations. But we always - always tell our volunteers though as well, like, "You need to put your safety first as well".

CMR DESPOJA: Yes.

MS HOWARD: "So if you rock up to somewhere to pick up a pet or something, that you need to sort of be vigilant and aware". And we always know where our volunteers are as well. We have like a check-in/check-out system, and so we've got - yes, we're always aware of where our volunteers are and - so as much as, like - and people voice as well, so we do - I feel like we - we manage it as best we can, but definitely a lot more could be done in, like, training and things like that.

CMR DESPOJA: All right. Well, thank you so much for your evidence today, but for everything you do. Counsel Assisting.

MS ORR: Thank you. Commissioner, I would ask the witness be excused.

CMR DESPOJA: Thank you, Ms Howard.

MS HOWARD: Thank you, Ms Howard.

CMR DEPOJA: You're free to go.

MS HOWARD: Thank you.

CMR DESPOJA: And that brings us to the end of public hearings on day 9 of the Royal Commission into Domestic, Family and Sexual Violence. We have hearings

tomorrow starting at the same time, at 9.30. That will be, I think, the last day of the public hearings as part of this Royal Commission. I do acknowledge that some of the evidence and information that you may have heard today could be traumatic and/or confronting. Also, that you may be interested in gaining support or assistance, in which case, as Counsel Assisting mentioned this morning, we direct you to our website for a list of services. That's royalcommissiondfsv@sa.gov.au. And we will close proceedings and see you tomorrow. Thank you, everyone.

MATTER ADJOURNED AT 4.31 pm UNTIL WEDNESDAY, 26 MARCH 2025