Final Report

Future-proofing Safety

COVID-19 and family violence in Victoria 2020–2021

Drummond Street Services
Centre For Family Research & Evaluation
RMIT UNIVERSITY | Centre for Innovative Justice
Australian Government
Australian Institute of Family Studies
AIFS

Acknowledgment of Country

The **Future-proofing Safety** consortium respectfully acknowledges the Kulin Nation as Traditional Owners of the land where we operate. We acknowledge Aboriginal and Torres Strait Islanders as the first peoples of Australia. Sovereignty was never ceded, and Aboriginal and Torres Strait Islanders remain strong in their connection to land, culture and in resisting colonisation.

Acknowledgment of support

The project was led by the Centre for Family Research and Evaluation (CFRE) at Drummond Street Services, the Centre for Innovative Justice and the Australian Institute of Family Studies, in collaboration with Sector Partners GenWest and Good Shepherd. We would like to thank the Supporting Organisations, who gave their time to support the case file review and the recruitment of service user participants and all members of our Advisory Group who generously gave their time throughout the life of the project.

We would like to acknowledge the commitment of practitioners and organisational leaders to this research project from across a broad range of sectors within the family violence and sexual assault service system, who gave up their time to participate in this research during Victoria's protracted lockdowns, ongoing surges in COVID-19 case numbers and heightened risk and need amongst service users. Thank you for sharing your insights and for generously giving your time to this project.

Finally, we would like to thank the service users who took the time to talk to the research team about their family violence experiences and service interactions during COVID-19. We would like to thank them for their time and generosity in sharing their experiences for the purposes of this research project.

Authors

There were several authors who contributed to this report through the various data collection points throughout the life of the project. Key authors are:

Lead authors

Beth McCann

Elena Campbell

Rachel Carson

Centre for Family Research and Evaluation, Drummond Street Services

Beth McCann
General Manager

Nina Logan
Research Officer

Hemei Fong
Senior Research Officer

Ellen Poyner
Senior Research Officer

Madeline Gibson
Senior Research Officer

Zeina Jamaleddine
Senior Research and Training Officer

Centre for Innovative Justice, RMIT University

Elena Campbell
Associate Director – Research, Advocacy and Policy

Riley Ellard
Manager – System Design and Evaluation

Matilda Simpson
Project Officer

Samara Young
Project Coordinator

Eliza Hew
Project Officer

Helen Forster
Senior Adviser

Australian Institute of Family Studies

Rachel Carson
Executive Manager – Family Law, Family Violence and Elder Abuse

John De Maio
Research Fellow – Family Law, Family Violence and Elder Abuse

Emily Stevens
Senior Research Officer – Family Law, Family Violence and Elder Abuse

Rae Kaspiew
Research Director – Systems and Services

Briony Horsfall
Senior Research Officer – Family Law, Family Violence and Elder Abuse

GenWest

Erin Soutter
Data Project Lead

Louise Falconer
Head of Evidence and Impact

Good Shepherd Australia New Zealand

Susan Maury
Senior Research and Evaluation Officer

Erin Price
Program Manager Family Violence Services

Livia La Rocca
General Manager Safety and Resilience

Zara Lasater
Head of Research and Advocacy

Suggested citation:

McCann, B. Campbell, E. Carson, R. Logan, N. Ellard, R. Simpson, M. Fong, H. Stevens, E. Poyner, E. Gibson, M. Young, S. Hew, E. De Maio, J. Jamaleddine, Z. Soutter, E. Maury, S. Price, E. Forster, H. Kaspiew, R. Horsfall, B. Falconer, L. La Rocca, L. Lasater, Z. (2023), *Future-proofing Safety: Surfacing inequality and building service capacity for crisis-ready responses* (research report, 09/2023). Family Safety Victoria.

Terms and abbreviations

Term	Definition
ACCO	Aboriginal Community Controlled Organisation
AFM	Affected family member
AIFS	Australian Institute of Family Studies
AOD	Alcohol and other drugs
AVITH	Adolescent violence in the home
CALD	Culturally and linguistically diverse
CFRE	Centre for Family Research and Evaluation at Drummond Street Services
CIJ	Centre for Innovative Justice at RMIT University
CLC	Community legal centre
Contact hours	Hours spent doing face-to-face client work (e.g., sessions)
COVID-19	Coronavirus disease which started in 2019 and led to large scale lockdowns in 2020. In keeping with how participants used the term, in this report we use COVID-19 to refer to the disease itself, the COVID-19 pandemic more broadly, and/or the pandemic response (e.g., lockdowns and restrictions). Within the organisational case studies component of this research Drummond Street, GenWest and Good Shepherd each looked client experiences, comparing a pre-COVID-19 and during COVID-19 timeframe (18 months between 2020 and 2021). The two time periods being compared are: • 1 April 2018 to 30 September 2019, referred to as “prior to COVID-19” • 1 April 2020 to 30 September 2021, referred to as “during COVID-19”.
CRM system	Client record management system
FDR	Family dispute resolution
FSP	Flexible Support Package
FVIO	Family Violence Intervention Order
GHB	Gamma hydroxybutyrate, a depressant drug often used recreationally or given to someone non-consensually
Holly	The CRM system used by Drummond Street Services during the research period

LGA	Local government area
LGBTIQA+	Lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning, agender and asexual We use this term broadly and inclusively, and acknowledge the diversity of sexualities, genders and sex characteristics. In some instances, we use "LGBQ+" to refer only to non-heterosexual clients.
MARAM	Family Violence Multi-Agency Risk Assessment and Management
MBCP	Men's Behaviour Change Program
Non-contact hours	Hours done outside of client sessions to support the work (e.g., case management)
OT	Occupational therapy
PAG	Planned Activity Group
PPE	Personal protective equipment
SHIP	Specialist Homelessness Information Platform
Victim-survivor	A person who has experienced domestic or family violence

Contents

Executive summary

This is the final report for the ***Future-proofing Safety: Surfacing inequality and building service capacity for crisis-ready responses*** **(Future-proofing Safety)** project, funded by Family Safety Victoria. The report highlights the significant challenges and specific opportunities for services and clients that emerged during COVID-19. These include elevated client risk and need, changed service responses, gaps and weaknesses within the family violence and sexual assault service system, and the impacts of COVID-19 on the workforce. The report finishes with a future focus by offering a framework for crisis readiness responses that aims to future-proof how Victoria responds to family violence during future crises.

Background

Led by the Centre for Family Research and Evaluation (CFRE) at Drummond Street Services, with support from research partners the Centre for Innovative Justice (CIJ) at RMIT University and the Australian Institute of Family Studies (AIFS), **Future-proofing Safety** purposefully took a system-wide view of service interactions for people who experienced or used family violence during COVID-19. The multi-faceted project design recognised that many conventional entry points to support and approaches to service delivery fell away during COVID-19. This occurred as practitioners contended with unprecedented challenges to support a population in crisis, while simultaneously adapting to the changes that the crisis brought about in their own lives.

Most importantly, **Future-proofing Safety** was about crisis readiness. It recognised that the unprecedented global disaster resulting from the COVID-19 pandemic will not be an isolated event, particularly as climate induced disasters increase over the coming years. Service systems must prepare for further events with population-wide impacts to support and promote family safety, particularly for those most urgently in need.

Project approach and methods

The project used a mixed methods approach that recognised the breadth and depth of data collection necessary to tell the complex and multi-layered story of family violence during COVID-19. Within this approach, a range of methodologies were used, with research components divided into three streams.

First, a **Sector Engagement** stream worked with organisations that provided support and services to people who experienced family violence or used family violence during COVID-19 in Victoria. These included specialist family violence, alcohol and other drugs (AOD), mental and physical health, maternal health, disability, legal, housing/ homelessness and community services, in addition to cohort-specific services such as Aboriginal Community Controlled Organisations (ACCOs), multicultural services and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual (LGBTIQ+) services.

This stream collected data through:

- a survey of sector professionals conducted by AIFS
- focus groups conducted by the CIJ with practitioners and managers from the range of services.

Second, a **Client Voice** stream was conducted by the CIJ that involved individual, semi-structured interviews with service users to support an understanding of how people experienced the spectrum of the service system in the context of COVID-19.

Third, a **Data Storytelling** stream involved:

- three detailed organisational data case studies, developed from data collected by three key Sector Partners (Drummond Street Services, Good Shepherd and GenWest)
- a targeted case file review of 70 case MARAM risk assessment tools and associated safety plans collected from participating organisations.

The project's **key research questions** were:

1. Have there been changes in drivers, needs, presentations, risk and intensity of family violence and sexual assault since the pandemic began? Has this been different for different cohorts?
2. How have services adapted to deliver different family violence service responses? What is the effectiveness and sustainability of these changes and innovations across different services and sectors?
3. What gaps and weaknesses within the family violence and sexual assault service system and broader sector have surfaced during COVID-19?
4. How do we respond to and recover from the current crisis? How can services address the gaps in the short, medium and long term?
5. How do we plan for future disasters/crises?

Findings

The findings of this research project encompass service user experiences, including shifting experiences relating to risks, needs and types of violence during COVID-19. While acknowledging the immense contribution of the workforce in addressing elevated and complex risks during this period, this project also highlights gaps and weaknesses that emerged in the service system and their impacts on service users.

These findings converge to highlight an indisputable need for crisis readiness responses that consider the impacts of large-scale disasters, as well as their associated policy responses, on those who use and experience family violence, particularly those who are already at the margins, and the service sector that support them.

Service user experiences

An increase in service demand and shifts in service user experiences during COVID-19 were highlighted across all data sources in the **Future-proofing Safety** project. Several key themes emerged surrounding:

- an increase in service demand and first-time presentations
- increased complexity relating to risk and co-occurring needs
- changes in the types of violence experienced and used during the COVID-19 pandemic.

Increased demand for services

A growing body of literature indicates that overall rates of domestic and family violence increased in frequency and severity, both in Australia (Boxall et al., 2020; Pfitzner et al., 2022; Usher et al., 2020) and internationally (Healy et al., 2022; Piquero et al., 2021; UN Women, 2021) during the COVID-19 pandemic. Documented factors linking large-scale disasters and family violence, particularly intimate partner violence (Parkinson & Zara, 2013) include "increased physical proximity to perpetrators, economic stress and unemployment, housing instability, trauma and grief" (McKibbin et al., 2021).

Findings from the Future-proofing Safety research add depth and breadth to these existing studies, highlighting the increased demand for services across a broad array of sectors beyond family violence-specific organisations, and in relation to a diversity of cohorts and communities. Within the **sector survey** results, for example, all respondents saw an increase in client inquiries relating to family violence and sexual assault, but to varying extents. This indicates substantial overflow and growth of family violence needs into services that did not see the same level of need in this area prior to COVID-19.

The **sector focus groups** identified an increase in service demand across all services and sectors. Practitioners described their sense of service system overwhelm during COVID-19 and the need to operate at surge capacity for extended periods of time. While some services saw an initial pause in service demand at the start of the pandemic, this was followed by a sharp increase in service demand, particularly as Victoria moved out of COVID-19 lockdowns. Some organisations felt that they were currently experiencing the peak of this demand at the time of their participation in the research during 2022, while others anticipated its continued acceleration.

Within the focus groups, many practitioners identified the increase in first-time presentations, including in:

- the Adolescent Violence in the Home (AVITH) space
- LGBTIQA+ specialist services
- AOD service provision, where practitioners noticed a spike in presentations following the easing of lockdown restrictions.

The **organisational case studies** reflected an increase in the number of clients overall accessing family violence services, across all three organisations. GenWest saw a 16% increase in family violence service access and Good Shepherd saw a 51% increase in clients receiving family violence case management. While the number of Drummond Street clients experiencing family violence remained consistent, the percentage of clients seeking assistance for personal and family safety increased by about 150%.

The **client interviews** revealed some experiences of first-time presentations, albeit where family violence had been present for some time but had been exacerbated significantly by the impacts of COVID-19. While the researchers did not ask participants specific questions relating to service demand, some participants volunteered that it was apparent that services were under strain or that access to their practitioner was limited, in relation to the types of support that they could provide during this time. Participants were unsurprised by the wait for services and the limitation of service responses, considering the ongoing crisis.

Complexity of presentations and co-occurring need

One of the most common findings across the streams of the Future-proofing Safety research was the increased risk, need and complexity[1] experienced by clients seeking services during COVID-19. This only escalated further for clients who were unable to access timely and responsive services.

Wider international research with practitioners from family violence support organisations has similarly found an increase in complexity and co-occurring needs of clients, evident in increased cases of lethality (Leigh et al., 2023).

Within this project, professionals across sectors increasingly reported that most of their clients who presented with family violence needs were also experiencing a broad range of other co-occurring needs. In the sector survey, the proportion of respondents reporting that most clients presented with two or more co-occurring issues increased from 69% prior to COVID-19 to 81% during COVID-19. Practitioners across all involved sectors reported that the primary cause for this increased complexity was the compounding impact of COVID-19 and its associated restrictions on an individual's pre-existing needs.

Within sector focus groups practitioners spoke about the ways in which individuals and families with pre-existing needs around mental health, financial stress, housing instability and AOD misuse experienced an exacerbation and escalation of these needs with issues such as heightened anxiety, isolation, loss of employment, intensified substance use and families living under increased strain. Just as importantly, practitioners emphasised that a lack of access to service supports over the course of the pandemic resulted in these needs becoming more acute and severe. Often needs had become significantly more varied and entrenched by the time that an individual or family were able to be seen by a service.

[1] Defined by multiple and intersecting needs which compound one another to accentuate risk.

Risk and complexity were particularly heightened for some clients either during, or as a result of, COVID-19. This was especially the case for those who:

- were fleeing family violence or seeking safety during COVID-19 related restrictions
- felt that they were not able to participate in the legal process fully
- had lost employment or whose partners had lost employment at the outset of the pandemic
- were experiencing additional difficulty finding safe and secure housing, as a result of rising rental costs, including in regional areas that had experienced an influx of 'tree changers' following lockdowns.

Analysis from the organisations that participated in case studies highlighted an increased intensity of risk, particularly with mental health needs. Drummond Street saw a particularly substantial increase in mental health risk, including suicidality risk and self-harm (70% increase), drug and alcohol abuse (38% increase), risk of homelessness (30% increase) and a higher need for intensive support. GenWest saw an increase in mental health needs and referrals from mental health services, from 12% prior to COVID-19 to 29% during COVID-19. Clients also experienced an increased risk of homelessness (23% increase). Demographic data demonstrated complex intersectional experiences of growing co-occurring needs associated with family violence for those belonging to marginalised groups.

Changes in the types of family violence during COVID

The findings from Future-proofing Safety contribute to – and broaden – a growing body of evidence that has highlighted the overall increase in rates of violence against women and children during the initial stages of the pandemic (Peterman & O'Donnell, 2020). More recent research has also signalled that particular forms of abuse appeared to escalate during the pandemic, being financial abuse, verbal abuse and threats, social restrictions, stalking and monitoring and reproductive coercion (Boxall & Morgan, 2021).

By extending the focus of inquiry, however, Future-proofing Safety was able to highlight how these behaviours impacted a broader diversity of Victorians across a breadth of different services. The research found that violence and abuse during COVID-19 escalated and took on novel forms, including the leveraging and weaponising of the virus itself, as well as the associated restrictions.

Respondents to the **sector survey** reported a marked growth in the frequency of many types of violence and abuse, with the most common being:

- insults with the intent to shame, belittle or humiliate (from 59% prior to COVID-19 to 73% during COVID-19)
- damage or destruction to property (from 46% prior to COVID-19 to 62% during COVID-19)

- preventing or attempting to prevent contact with family or friends (from 38% prior to COVID-19 to 56% during COVID-19).

Key examples seen across the three organisations involved in the **organisational case studies** included an increase in economic abuse; increases in isolation and controlling behaviour; technology-facilitated abuse; the weaponisation of COVID-19; and what practitioners described as the impacts of "pressure cooker" environments, where people were unable to escape the person using harm against them. This finding is reinforced by other Australian research into family violence services that showed that the weaponisation of COVID-19 was used to extend controlling behaviours including isolation, financial abuse and severe emotional and psychological abuse (Carrington et al., 2020).

While a concerning minority of **case files** (MARAM risk assessments) did not document risk factors or risk assessments for children in the household, those that did highlighted the elevated levels of AOD misuse by people using violence, an increase in jealous behaviour, mental health issues, and violence escalating in frequency and severity. Worryingly, the risk assessments analysed also depicted high rates of:

- threats to kill
- threats of self-harm or suicide
- threats to cause serious harm to victims and survivors
- financial abuse.

Focus groups and **client interviews** indicated that COVID-19 itself was weaponised as a means of family violence and coercive control, particularly during lockdowns, when managing needs and safety was much more difficult and complex. This included the leveraging of certain types of Government supported assistance, such as access to superannuation or the availability of JobKeeper payments. It also included manipulation around border or travel restrictions, as well as stay-at-home requirements. The disease itself was used as a threat or directly weaponised in a physical form by people using violence, including:

- exposing children to COVID-19 "hotspots" before returning them to another parent
- actively exposing people to the virus after testing positive for COVID-19
- using vaccination as a way to assert control, particularly over children.

System responses

As increasingly complex and interwoven client needs and risks resulted in several pressure points within services, the family violence and sexual assault service system came under strain. While many organisations were able to respond to changing needs through the provision of telehealth and increased brokerage spending; there were also

barriers to service provision, including for diverse cohorts and vulnerable people within the community, such as children and young people. The mixed benefits and barriers were particularly stark for telehealth service provision.

While telehealth allowed for flexible service provision and saw greater engagement with services, there were shortfalls when it was used as the sole mode of service delivery. Many respondents across sectors felt that it was not an appropriate form of service delivery for many of the most vulnerable in the community. Limitations included not being able to engage with some clients, particularly children and young people, those with disability or who were neurodivergent, or those who had lower levels of proficiency in English. There were often difficulties safely conducting risk assessments over the phone/videocalls with many incomplete or unable to be conducted because of safety concerns, with families locked down in close proximity.

Other Australian research has mirrored these findings to an extent, noting that, despite acknowledging significant challenges, practitioners reported a sense of achievement in their work and the work of their particular organisation during the pandemic (Baffsky et al., 2022) and felt that they had generally responded quickly and innovatively by making the leap to technology in only two weeks in a way that would otherwise have taken five to ten years (Worrell et al., 2022).

Research also highlights some limitations, with family violence practitioners in the early stages of the pandemic signalling concerns in general for the capacity to assess risk without face-to-face contact (Cortis et al., 2021; Worrell et al., 2022). Results from a national survey about the impact of the COVID-19 pandemic on Australian family violence services and their clients showed a consistent theme related to barriers to help-seeking and support via technology for clients (Carrington et al., 2020). While some overseas research has found that practitioners had a neutral to positive overall attitude to the expansion of online services, it has also highlighted concerns ranging from the limited capacity to develop emotional connections with clients online to challenges with the technology itself (Voth Schrag et al., 2023).

Barriers in responding to service demand

The Future-proofing Safety research highlights that there were several key challenges in responding to heightened demand across a broad range of sectors, such as long waitlists, reduced service capacity and a lag in response times. Reduced service delivery was particularly impactful where it related to child welfare agencies or statutory authorities such as Child Protection. The removal of face-to-face service provision and the withdrawal of key support services had an enormous impact on vulnerable clients. As services withdrew or reduced their capacity following the onset of the pandemic, the ability for families and individuals to seek or continue to engage with services was significantly compromised. With most sectors ceasing their delivery of face-to-face programs and moving to online service delivery, this created a multitude of systemic access barriers, which had direct consequences for clients.

For the services that did maintain outreach programs, practitioners explained that significant challenges still existed in engaging with clients and maintaining a lens on their safety during the first two years of the pandemic.

Practitioners described how this could obstruct their ability to get a proper sense of what was happening in the home, not only because of physical barriers, but also because of the individual or family being less relaxed and reluctant to engage.

The research also highlighted particularly stark examples of the withdrawal of certain vital services for victims and survivors more broadly, including forensic assessments for victims and survivors of sexual assault.

Workforce

Future-proofing Safety provides insights in relation to the impacts of COVID-19 on the workforce which provides services within the family violence and sexual assault service system and associated sectors. These impacts included:

- the high turnover in staff, which will likely continue to have broad reaching implications for the sector, particularly in relation to a loss of corporate knowledge and professional experience from critical community support services
- the pressure that this loss in workforce puts on remaining staff with knowledge and experience
- the inability to transfer knowledge to new graduates and any emerging workforce.

Critically, there were a number of findings relating to the way in which challenges in remote service delivery not only impacted on the ability of services to meet demand but also staff wellbeing, a finding echoed in other recent Victorian research (Worrell et al., 2022). Finding ways of supporting staff to continue to work safely is critical in future crises.

Crisis readiness responses

The victims and survivors was developed in response to the key findings and recommendations within this report. The framework was developed as a way to learn from Victoria's COVID-19 response – highlighting the ways in which services can better prepare for future crises by considering the overlapping cycle of preparation, response, aftermath and review to prepare more appropriately and effectively for future crises and to future-proof the family violence and sexual assault service system.

Crisis readiness principles

The principles for this Crisis Readiness Framework align with the **Future-proofing Safety** project's six foundations that support the consortium's approach and underlying principles. They are also based on the recommendations of the 2009 Victorian Bushfires Royal Commission and the resulting disaster preparedness work (Teague et al., 2010). These foundations include:

1. **Prioritising clients and being client centred.** This includes identifying and centring priority cohorts among those experiencing and using family violence, to acknowledge and account for intersectional experiences of marginalisation and disadvantage that are exacerbated during crises.
2. **Acknowledging that good crisis responses are local.** Local connections, coordination and communication are needed to enable strong coordinated responses across services, emergency management, local government and state government. Big picture coordination at the state level also needs to take place for accessible communication, responsive planning, funding and more.
3. **Ensuring that disaster responses are strengths-based.** This means that victims and survivors are empowered to make the best decisions for their particular context.
4. **Building capacity and integrating responses** across all relevant sectors, organisations and emergency responses, incorporating a system-wide examination and genuine commitment to support victims and survivors more effectively and respond to family violence during crises.
5. **Normalising crisis readiness and embedding it in a cycle of regular review** before, during and after immediate crises.

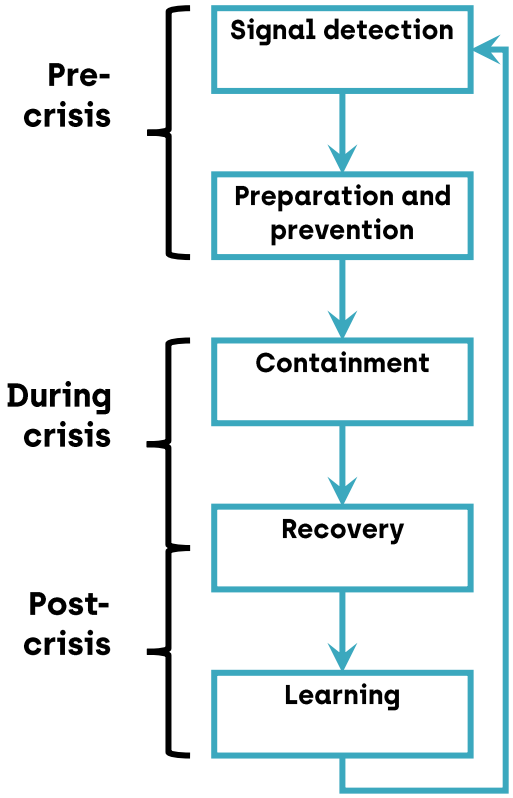
Why are crisis readiness and response so important?

Crises have often been regarded as outlier events, with organisations not always prioritising crisis readiness. Crisis preparation can become seen as a 'nice to have' rather than a 'need to have'.

Crisis readiness can help to mitigate some of the less obvious risks that surface during crises, particularly major crises. Failing or lacking to prepare for crises incurs major economic or social costs, as this project highlights. Many examples in this report speak to the myriad ways that a lack of crisis preparedness impacted some of the most vulnerable in the community. This was particularly the case in relation to children, as highlighted through the move to telehealth service provision, the withdrawal of Child Protection and an overall blindness to child risk and needs within the broader family violence and sexual assault service system.

What are the stages of a crisis?

Crises do not always unfold in a simple, linear way. Five common stages occur across the lifecycle of a crisis, however, and these generally overlap (see right, adapted from Crandall et al., 2009; Pearson & Mitroff, 1993).



1. **Signal detection**: Identifying and listening to warning signs among all the noise, and ensuring that signs can be reported and are taken seriously
2. **Preparation and prevention**: Comprehensively preparing and actively searching for and addressing risks factors
3. **Containment**: Limiting the impact of the crisis
4. **Recovery**: Resuming some operations (adapted or as normal) in the short-term and normal operations in the long-term[2]
5. **Learning**: Reflecting on lessons learned and what can be taken forward into the other stages in future crises.

Steps of readiness across levels of responsibility

This Crisis Readiness Framework provides five stages of readiness and then expands on each of these to provide reflective questions to consider across the local-to-state spectrum, including for:

- frontline service staff
- organisations
- peak bodies
- government.

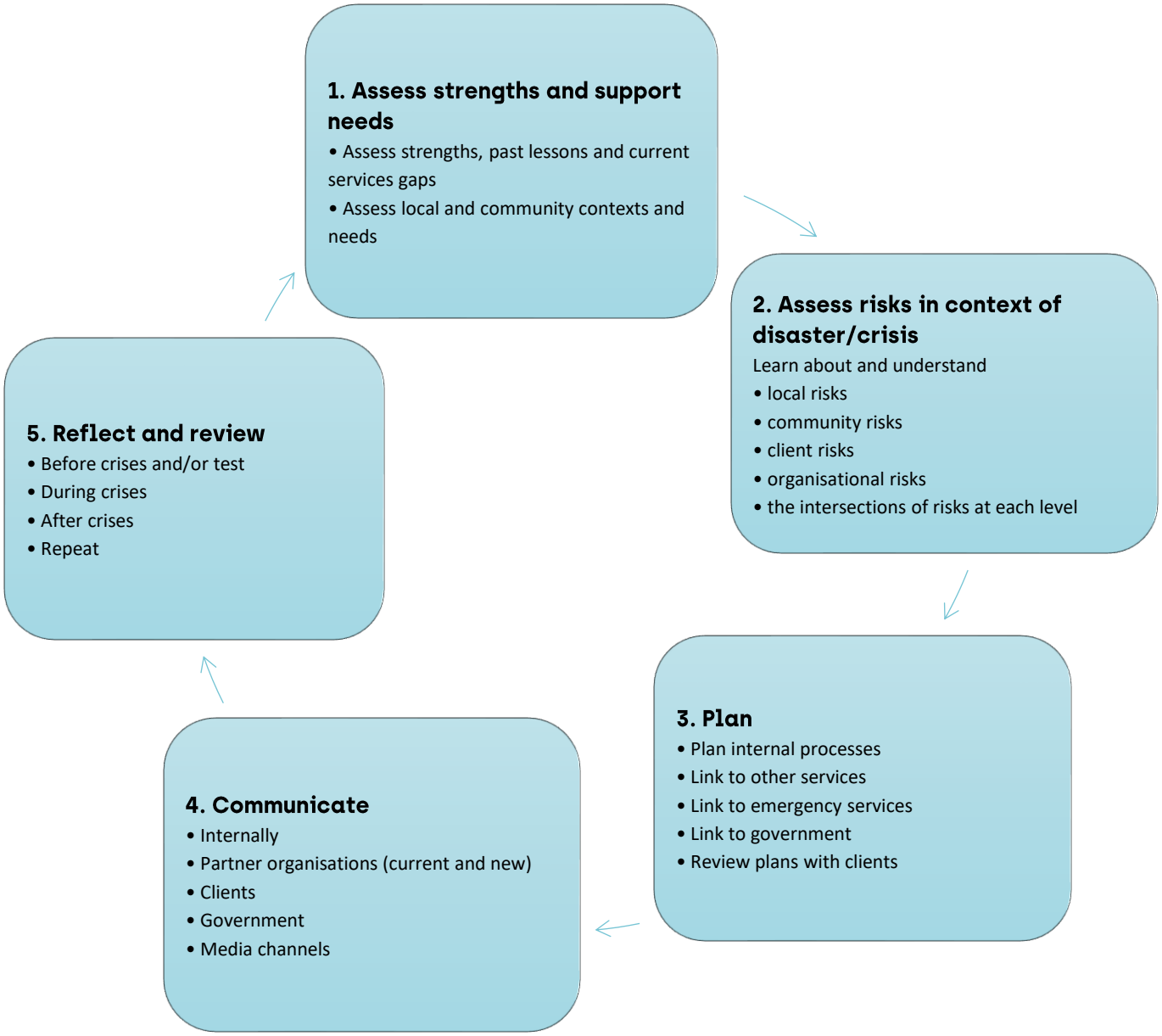
[2] Recovery can further be broken down into a series of phases (see Bushfire Recovery Victoria, 2020).

Crisis readiness and response are ongoing and iterative processes. Disasters or crises, like bushfires or floods, may have an initial devastating impact as well as many longer-term consequences. Others, like COVID-19, may have multiple 'peaks' of impacts that compound and extend the crisis over multiple years.

Aligning with the principles that guide this framework, the intention is to work through questions and actions in an integrated manner, collaborating with and across:

- clients (taking into account their specific needs)
- key staff (at the organisational level)
- networks, local governments, emergency services[3] and other service providers (at the sector level)
- key contacts through key agencies (at the Victorian Government level).

[3] While emergency services play an important role in crisis readiness and response, the Victorian Government already maintains and updates a family violence framework for the emergency management sector (State of Victoria, Department of Health and Human Services, 2019).


1. Assess strengths and support needs
• Assess strengths, past lessons and current services gaps
• Assess local and community contexts and needs
2. Assess risks in context of disaster/crisis
Learn about and understand
• local risks
• community risks
• client risks
• organisational risks
• the intersections of risks at each level
3. Plan
• Plan internal processes
• Link to other services
• Link to emergency services
• Link to government
• Review plans with clients
4. Communicate
• Internally
• Partner organisations (current and new)
• Clients
• Government
• Media channels
5. Reflect and review
• Before crises and/or test
• During crises
• After crises
• Repeat

Recommendations

The report explores and provides specific recommendations related to each section and key findings specific to each level including government, peak bodies and services. The broad overarching recommendations across all levels include:

- Developing and prioritising crisis response and readiness plans to prepare for future crises and disasters
- Coordinating and collaborating communication, planning and responses across all levels of government, peak bodies, services and at a community level (e.g., the engagement of key community leaders/groups)
- Adequately resourcing crisis readiness and response, whether that be through funding at the government level, support at the peak body level, or workforce capacity at the service level
- Capacity building across sectors (including housing, AOD, mental health, legal, family and relationships, and child safety, welfare and legal) in relation to family violence screening, assessment and responses, particularly during crises
- Utilising family violence knowledge from both research and the sector to inform crisis response policy that does not inadvertently escalate or enable family violence, including the abuse and exploitation of young people and children
- Invest in and enhance sector systems and infrastructure across services (including data capture, analysis, and implementation) in order to strengthen capacity and response, particularly to increased incidences, complexity and acuity of family violence during crises
- Ensure that Child Protection services are maintained and even expanded during crises and disasters to manage the increased level of risk that vulnerable children face and to ensure that children are not prevented from maintaining safe and supported contact with parents during this time, so that they may continue to work towards reunification, where relevant
- Adopt and integrate agility and flexibility across all levels of sectors and service systems to enable adequate crisis responses in environments that are rapidly changing (including increases in need at the same time as there are increases in staff shortages).

Part 1 – Introduction and context

This is the final report for the ***Future-proofing Safety: Surfacing inequality and building service capacity for crisis-ready responses*** (Future-proofing Safety) project, funded by Family Safety Victoria.

Led by the Centre for Family Research and Evaluation (CFRE) at Drummond Street Services working with the Centre for Innovative Justice at RMIT University (CIJ) and the Australian Institute of Family Studies (AIFS), **Future-proofing Safety** took a system-wide view of service interactions for people who experienced or used family violence during COVID-19. The project recognised the way in which conventional entry points to support and approaches to service delivery fell away during the COVID-19 period as practitioners contended with unprecedented challenges to support a population in crisis, while simultaneously adapting to the changes that the crisis brought about in their own lives.

The project aimed to understand the diversity and complexity of experiences relating to family violence across the Victorian population, as well as the ecosystem of services that supported those using and experiencing violence during COVID-19. It acknowledged and accounted for ongoing limitations on service providers' ability to collect data and participate in research, with the ultimate objective of building service capacity throughout the life of the project.

Most importantly, **Future-proofing Safety** was about crisis readiness. The project recognised that the unprecedented global disaster that was COVID-19 will not be an isolated event, particularly as climate induced disasters increase over the coming years. Service systems need to be prepared for further events with population-wide impacts to support and promote family safety, particularly for Victorians who are most urgently in need.

This final report highlights the significant challenges and specific opportunities that emerged during COVID-19. These include changes in client risk and need, services responses, service gaps and weaknesses, as well as the impacts of COVID-19 on the workforce. The report finishes with a future focus – looking at crisis readiness responses and making recommendations to future-proof Victoria's responses to family violence during any further crises.

Future-proofing Safety Foundations

The **Future-proofing Safety** project was built on six foundations or principles to support the consortium's approach to the research and inform the specific methodology used. These foundations directed the project to:

1. Explore priority cohorts among those experiencing and using family violence to acknowledge the unique and acute impacts of COVID-19 for communities who already experienced **marginalisation and disadvantage,** spotlighting both the deepening of existing fault lines as well as the creation of new ones during this period.

2. Explore how the **mainstream family violence system may not be accessible or appropriate** for many people from priority cohorts, who experience compounded inequality and disadvantage.

3. Track the experience of priority cohorts through a genuine interrogation of **intersectionality** that recognises that many individuals and families have multiple overlapping identities and experiences at the same time. This may lead them to engage with the service system through vastly different entry points.

4. Build service capacity to respond more effectively to family violence, recognising that **many services were not prepared to respond** to the family violence with which clients presented and therefore require support to be ready in the future.

5. Build service capacity **for adequate data collection** to ensure that **participation in research does not come at a cost to service delivery** and can protect client safety. Service providers need to be compensated for effective research participation.

6. Incorporate a **system-wide examination and genuine commitment to capacity-building** across the family violence and sexual assault service system and associated sectors, including specialist family violence, family services, legal services, mental and physical health services, disability, AOD and more, acknowledging the necessary system response to family violence in Victoria.

Project approach and methods

The approach of **Future-proofing Safety** was designed to strengthen the evidence base around family violence in the context of COVID-19 and to build on the wealth of knowledge and experience across **Sector Partners** and **Supporting Organisations**. Each **Research Partner** led the area of methodology suited to their strengths and capacity while also contributing and collaborating across all project areas.

The key research questions were:

1. Have there been changes in drivers, needs, presentations, risk and intensity of family violence and sexual assault since the pandemic began? Has this been different for different cohorts?

2. How have services adapted to deliver different family violence service responses? What is the effectiveness and sustainability of these changes and innovations across different services and sectors?

3. What gaps and weaknesses within the family violence and sexual assault service system and broader sector have surfaced during COVID-19?

4. How do we respond to and recover from the current crisis? How can services address the gaps in the short, medium and long-term?

5. How do we plan for future disasters/crises?

The **Future-proofing Safety** project used a mixed methods approach that recognised the breadth and depth of data necessary to tell the complex story of family violence during COVID-19. The range of methodologies explored the varied and limited availability of service data and account for the demands that research participation placed on organisations.

The components of this mixed methods approach were divided into three streams, as follows:

- The **Sector Engagement Stream** worked with organisations that provided support to people who experienced or used family violence during COVID-19 in Victoria. These included specialist family violence, alcohol and other drugs (AOD), mental and physical health, maternal health, disability, legal services, housing and homelessness and community services, in addition to cohort-specific services such as Aboriginal Community Controlled Organisations (ACCOs), multicultural services and LGBTIQA+ services. This stream collected data through:
    - A survey of sector professionals conducted by **AIFS** that aimed to elicit the breadth of experiences from both services and practitioners.
    - Focus group discussions conducted by the **CIJ** with practitioners and managers from the range of services and disciplines to elicit the depth of experiences regarding service delivery during COVID-19.
- A **Client Voice Stream** conducted by the **CIJ** that involved individual, semi-structured interviews with service users to explore their experiences of the service system during COVID-19.
- A **Data Storytelling Stream** involving:
    - three detailed organisational case studies based on data collected by three key **Sector Partners** (Drummond Street Services, Good Shepherd and GenWest), supported by **CFRE**. The case studies explored the presentation, needs and risk of each organisation's clients during COVID-19 and compared these aspects to the period prior to COVID-19
    - a case file review of 70 client records from participating organisations conducted by the **CIJ**, to examine client risk assessments and associated safety plans conducted prior to and during COVID-19.

The approach for each of these components is explained in more detail below.

Sector survey

Practitioners from across the family violence and sexual assault service system in Victoria were invited to participate in the survey on a voluntary basis. Information about the survey was distributed via email, social media, and newsletters.

The Australian Institute of Family Studies Human Research Ethics Committee granted ethical approval for this method of data collection.

Overall, 208 practitioners participated in the survey, providing 160 complete and 48 partial responses. Answers varied in sample sizes due to all questions being optional.

Demographic and service profiles of survey participants[4]

Table 1 shows the proportion of survey participants that worked in each sector category. Participants most commonly worked in family violence and sexual assault services (30%) and health, mental health and AOD services (24%).

Table 1: Distribution of respondents by sector

Sector category	n	%
Family violence (including sexual assault services)	63	30
Health, mental health, and AOD services	50	24
Legal, FDR, parenting and family relationship services	34	16
Education, housing, and other services	34	16
Child safety and family welfare services	26	13
Missing	1	1
Total	**208**	**100.0**

Survey participants were generally older women, with 57% aged over 45 years and 80% identifying as women. Most participants worked in suburban (46%) or regional areas (38%). For more information about the demographics of survey participants see Appendix A.

Sector focus groups

Practitioners participating in focus groups were recruited through peak bodies and service providers across the family violence and sexual assault service system. Recruitment materials outlined the scope and purpose of the project, the nature of practitioner participation and an online opt-in consent process was developed.

[4] Percentages in this section may not total exactly to 100.0% due to rounding.

Two streams were offered, being **sector-specific** focus groups with practitioners within the same discipline, and **place-based** focus groups comprising practitioners within the same local government area (LGA) or region. Most practitioners elected to participate in sector-specific focus groups. Most focus groups were conducted between May and August 2022.

The Justice Human Research and Ethics Committee (JHREC) granted ethical approval for the components of the research led by the CIJ, being these sector focus groups, the client interviews and the case file review (JHREC CF/21/14098). The focus groups were recorded and transcribed using Microsoft Teams and then coded and analysed thematically (Braun & Clarke, 2006). The focus groups involved engagement with a breadth of services depicted in Table 2.

Table 2: Number of focus group participants by service type or role

Service	Representation
Cohort-specific services such as Culturally and Linguistically Diverse services, LGBTQIA+ services and ACCOs	34
Publicly funded legal services	24
Specialist women's family violence services, including refuges	14
AOD services	10
Sexual assault services	8
Financial counselling services	7
Family services	6
Elder abuse services	6
Representatives from peak bodies or Senior Managers	6
Housing services	4
Specialist programs working with adolescent violence in the home	4
Men's Behaviour Change Programs (MBCPs)	4
Community and crisis mental health service	3
Early parenting services	2
Total	**132**

Ethical considerations

It is well understood that practitioners who work with traumatised clients can experience vicarious trauma as a consequence of empathetic labour (Cohen & Collens, 2013; Monash Gender and Family Violence Prevention Centre, Domestic Violence Victoria & Domestic Violence Resource Centre Victoria, 2021). The research team recognised that this experience may have been particularly heightened in the context of COVID-19, where practitioners were also often managing its impacts on their own lives, including increased care-giving or child-caring responsibilities, loss of employment or income of other family members, social isolation and the absence of informal debriefing and support from colleagues as services pivoted to deliver a significant proportion of their practice remotely.

The research team minimised the potential for focus group participation to impact practitioners who may have experienced vicarious trauma by:

- ensuring that focus group questions did not direct or encourage practitioners to recount specific incidents or histories of trauma
- redirecting the discussion in instances where a particular question or topic may have caused distress, including by reframing the discussion to focus on client strengths and factors contributing to positive client outcomes
- using other techniques as required, such as taking a short break or inviting other practitioners to share their own reflections to provide validation and support.

The research team also identified that some participants would have personal histories of trauma or experiences of family violence. It was anticipated that, where this was the case, the nature of their practice roles meant that practitioners with lived experience had developed tools and skills to self-manage their trauma experiences, including in the context of applying their lived experience knowledge to practice. When researchers observed that a participant may require follow-up support, they checked in confidentially to ask if they had supports that they could engage, or if they would like the research team to arrange for supports.

Reflecting on the safety of this method, at the conclusion of each focus group many participants highlighted how they appreciated the opportunity to be asked about and to share their experiences, including with other practitioners working in the same discipline. Some volunteered that they found the experience therapeutic. Similarly, practitioners appreciated the opportunity to contribute to efforts that may 'future-proof' their capacity to protect their clients' safety, address inequality and ensure that sectors were ready to respond to any further large-scale crises that may arise in the years to come.

Client interviews

Participants were recruited for the client interviews through the range of partner agencies who supported the research from the outset of the project. This established a lens over the support needs of participants to ensure that their involvement in the research was positive and supported. Research design workshops were conducted with participating organisations to identify issues relevant to specific cohorts and organisational needs. Insights in this initial design workshop informed the application for ethical approval from the JHREC, including accompanying data collection tools.

Recruitment was undertaken across a number of organisations to ensure that a diverse group of clients were sampled and that the burden of recruitment was dispersed across services.

Following JHREC approval, a Recruitment Guide and Participant Information and Consent Forms were provided to practitioners, supported by the offer of recruitment briefing sessions. Clients were considered eligible if they had been engaged by the service at any point since the onset of COVID-19, with a diversity of past and current clients recruited. With respect to people using violence, this meant that services were only likely to recruit recently engaged clients.

Interviews were conducted with participants by phone, online and in-person. Participants were drawn from regional and metropolitan areas, with the research team travelling to both for in-person interviews where required. Participants were recruited through services delivering specialist family violence services, including those supporting people from LGBTIQA+ communities; Men's Behaviour Change Programs (MBCPs) and programs supporting people who experience elder abuse.

Interviews were recorded and transcribed, then analysed thematically using NVivo in accordance with *a priori* themes which were then tested and refined by the research team.

Organisational case studies

The organisational case studies examined the de-identified, aggregate service data from three Sector Partners (Drummond Street Services, Good Shepherd and GenWest) to provide case study examples of client needs and organisational responses during COVID-19.

Each organisation exported their own de-identified data from their client record management (CRM) systems. No data was shared between any of the organisations. Aggregate data was examined for different cohorts (by demographics, time period, and program) to explore the experiences of client groups prior to and during COVID-19.

Within the organisational case studies component of this research Drummond Street, GenWest and Good Shepherd each looked client experiences, comparing a pre-COVID-19 and during COVID-19 timeframe (18 months between 2020 and 2021). The two time periods being compared are:

- 1 April 2018 to 30 September 2019, referred to as "prior to COVID-19"
- 1 April 2020 to 30 September 2021, referred to as "during COVID-19".

Following quantitative data analysis, each Sector Partner consulted with practitioners to inform the organisational responses component of their case study. Partners were provided with a small number of questions to guide them in this process. Key questions were:

- What have been the challenges of service delivery in the context of COVID-19?
- How has your organisation responded to COVID-19?
- What key learnings would your organisation like to take into the future?

Both GenWest and Good Shepherd used the Specialist Homelessness Information Platform (SHIP). This is the client management system used by services that receive government funding for certain programs, including family violence programs. SHIP is used to document client and service data such as:

- client needs
- the type(s) and length of support received

- family violence risk and safety planning
- demographic information.

Drummond Street used an in-house CRM system, Holly, to document client and service data and files. For each client, Holly records:

- a broad range of a client's presenting needs
- risks and risk alerts
- demographics
- information about the session (e.g., service type, contact and non-contact hours, referrals).

Case file review

The CIJ conducted a case file review of MARAM risk assessments from 70 case files, which involved targeted quantitative and qualitative analysis of file data provided to the research team. Case file data was drawn from five of the project's Supporting Organisations, offering a broad range of programs to people experiencing and using violence.

In the context of the application for ethical approval from JHREC, the research team sought and received a waiver of consent for the case file review, where clients had not already provided consent for their data to be used for the purposes of research. A waiver was sought on the basis that the research team limited the types of data used to include only MARAM or MARAM aligned risk assessments and safety plans, as well as on the basis that contacting clients to seek retrospective consent would be potentially retraumatising for clients and impractical for the participating organisations. Accordingly, the review involved examining completed risk assessment tools (including Screen and Identification, Brief and Intermediate and Comprehensive MARAM tools) and safety plan documents.

File Eligibility

The CIJ supported participating organisations to understand the eligibility criteria for the contribution of case files to the review. Any program delivered by a participating organisation was able to contribute files, though eligible files were restricted to MARAM-aligned family violence risk assessments completed for relevant clients.

There was no age limit on eligibility to participate in the file review, provided the client had a risk assessment completed in their own right. Where risk assessments and/or safety planning had been conducted jointly for family members (i.e., for a protective parent and child), participating organisations were informed that all assessments relating to the family should be provided as a single case file to provide a complete picture of risk and need for the family.

Participating organisations identified files that met certain eligibility criteria, using available reporting systems (i.e., by filtering files by dates of engagement or through a manual identification process). Files were then randomly selected.

Transfer of data

Participating organisations ensured that key identifying information was removed from file data before it was provided to the research team. This included, for example, removing all names from the file; replacing birth dates with age or birth years; and replacing addresses with a suburb or LGA.

Review process

Once received, the research team reviewed the case files by completing qualitative and quantitative data collection tools. Qualitative tools prompted the reviewing researcher to pull and input the relevant data into a specifically designed Case File Review Tool, which had been reviewed by JHREC. The researcher additionally recorded relevant quantitative case file data in an Excel tool, which was designed specifically for quantitative review and analysis. The emerging findings from the case file data were then tested with practitioners from participating organisations in a Data-Testing Workshop. This workshop involved practitioners who had either recorded the information in the case files or were involved in the relevant program of each service, during the time at which the files were completed.

Data testing and triangulation

In addition to ongoing meetings throughout the life of the project where the Research Partners discussed key findings emerging from each data collection method, there were also a number of data triangulation workshops held in November 2022 to discuss the project's key findings and recommendations. Key findings and recommendations were then tested and discussed in a series of workshops with the project Advisory Group and a number of practitioners who participated in the sector focus groups.

Limitations

The project involved a number of limitations. In particular, the ongoing nature of the COVID-19 pandemic created numerous barriers for practitioners from across sectors to engage in key research activities. Stakeholders, organisations and peak bodies reported that professionals in the broader service system were experiencing significantly increased and complex workloads, together with research participation fatigue. These challenges with recruitment limited the research team's ability to recruit participants from certain professional groups and made recruitment across all areas of research challenging.

Sector survey

The sector survey was based on a voluntary, opt-in sample, and as such cannot be characterised as representative of professionals providing services to people who experienced or used family violence during the COVID-19 pandemic. Given the small size of samples of particular professional groups (e.g., participants working in 'child safety and welfare services'), it is important to exercise caution when interpreting the data.

It is also important to note that the vast majority of survey responses were from women (80.2%), meaning that there was limited representation from people of other genders. These figures are likely reflective of the sector, with the Workplace Gender Equality Agency reporting that women account for 79% of the 'health care and social assistance' workforce (Workplace Gender Equality Agency, 2022).

Sector focus groups

During the focus group recruitment process, the research team encountered several key challenges. This included attempting to recruit practitioners from state-wide and location specific services to participate in the place-based focus group stream, which ultimately only involved two focus groups. Challenges also included recruiting practitioners from certain sectors, noting the particular demands on the ACCO sector over the last two years, which meant that participation of practitioners working with First Nations clients was relatively limited.

More broadly, challenges also included very low uptake from practitioners in the early stages of the research. This was largely because project timeframes meant that the initial attempts to recruit for the sector focus groups were falling right at the end of Victoria's extended sixth lockdown, when practitioners were exhausted and looking forward to some much-needed leave over the summer period. For this reason, a decision was made to delay the focus groups until early 2022.

At this point, however, Victorian workforces were in the midst of rolling waves of the 'Omicron' variant and skyrocketing case numbers. As a result, further challenges and other COVID-19 related impacts continued to be encountered as the focus groups began to be scheduled. Given that the majority of focus groups were ultimately conducted during May – August 2022, this coincided with a spike in COVID-19 infections and influenza in Victoria, which affected many practitioners and their services more broadly, as well as their capacity to participate in the research. Frequently between 1 – 4 practitioners were unable to attend their allocated focus group, as a result of illness.

Overall, this meant that the CIJ conducted a greater number of focus groups (29) than was in the project's budget and design but ultimately spoke with 132 practitioners from across a wide range of services. This was achieved by extending the timeframes of the focus group period and providing multiple opportunities for practitioners to participate, where they may not have been able to attend their original allocated session.

Client interviews

Ultimately, 18 participants were recruited through six of the participating organisations. This sample was considerably lower than the original target sample of 70 clients, with similar challenges as those encountered in relation to the sector focus groups. As a result, of the challenges described above, practitioners were not able to turn their minds to recruitment until later in 2022, despite the fact that recruitment and interviews needed to conclude in November 2022, in time to inform data triangulation, analysis and reporting. Limitations of this sample size, albeit a substantial sample in the context of qualitative research more broadly, should therefore be kept in mind.

A further limitation is the fact that this later period of recruitment impacted the extent to which participants recruited through MBCPs were impacted by online interaction with services and systems. This is because it was important for MBCPs to recruit clients with whom they had recently been engaged or who were still engaged in services. As a result, participants had generally been involved with an in-person MBCP or equivalent service in mid-2022 but, where relevant, had been engaged with the court system earlier in the year when appearances were still occurring online.

Organisational case studies

A major limitation for interpreting the results of the organisational case studies relate to the constraints of the data. Given that the primary purpose of a client record management system is for keeping a record of clients who access the service and not primarily for research or reporting, there was a large variation in how each organisation's staff recorded data and what data fields were prioritised. This in turn impacted the ability of the research team to make direct comparisons between organisations.

The data captured reflects what was *recorded* for all clients, not necessarily what all clients *experienced*. Individual practitioners make different choices about how to enter data. This should be kept in mind when considering the variations in the data presented here. The research team has noted where data integrity clearly influenced the analysis. However, there are likely further limitations in the data presented. It is expected that most fields analysed as part of each organisational case study underestimated the breadth of presenting issues, where rates of co-occurring needs are ascertained from client record management systems (rather than by surveying clients' needs).

Case file review

During the data collection phase of the case file review process, it became clear to the research team that inconsistencies of data capture within the MARAM-aligned tools limited the researchers' ability to reflect how risk presentations, complexity and needs changed over time for clients and their families in a quantitative way. Many services were only able to provide a single risk assessment per client; rather than multiple risk assessments which tracked dynamic changes in risk over time. In addition, many risk assessments were not fully completed.

Worryingly, of the 70 risk assessments that were assessed as part of the Client File Audit, only two related to children. This was despite the fact that at least 57 had at least one child attached to the case. In almost all of these cases, the children were living in the home with the client. While the children were specifically listed in the 'Children' section in most risk assessments, some did not specifically list the children at all but described them in other parts of the assessment as living in the family home. As a result, there is very little data in the case file review pertaining to child risk and gaps in relation to treating children and young people as victims and survivors in their own right.

The research team held a Data Testing Workshop with practitioners from across participating organisations to test emerging findings and to explore the range of factors that may be impacting practitioners' data collection practices. During the Data Testing Workshop, practitioners confirmed that, where client referrals were from the Orange Door, the risk assessments completed by the Orange Door practitioners are often used by the receiving service. While that practitioner at the receiving service will continually assess risk for the client and will incorporate relevant updated risk information into the client's case notes, updated MARAM-aligned risk assessments will not necessarily be completed because of time constraints. These practitioners also identified that there were often limitations in assessing or managing child risk during COVID-19, given the escalation in risk and needs of the protective parent.

Practitioners in the testing workshop reflected on the increased service demand during COVID-19 and the challenges for staff in balancing increasing caseloads with working from home effectively. Practitioners described time constraints impacting their ability to complete risk assessment tools in a comprehensive way, at the same time as reflecting risk through case notes.

Data used from the case file review for this report has been contained to qualitative data that describes the client's risk presentations and needs at a point in time. This includes use of the data to demonstrate the type and level of risk, as well as thematic analysis of the identified risk factors that were present on the first risk assessment provided for each case file.

Part 2 – Service user experiences

Shifts in service user experiences during COVID-19 were captured across all data sources. Several key themes were identified around an increase in service demand and first-time presentations; increased complexity relating to risk and co-occurring needs; and changes in the types of violence experienced and used during the COVID-19 pandemic.

Increase in service demand

All relevant data sources illustrated an increase in family violence and sexual assault service demand during COVID-19. While some service sectors saw more of an increase than others, practitioners across all sectors involved in the study reported increases in demand. This elevated demand was driven by an increase in first-time presentations and significantly increased complexity of risk and need, which will likely continue to impact family violence service provision into the future. These findings extend upon other emerging research focussing specifically on women in the context of intimate partner violence, highlighting that the pandemic coincided with first-time presentations and an escalation of violence for a significant proportion of women (Boxall & Morgan, 2021).

Key findings

Survey respondents across all sectors saw an increase in demand for services regarding client inquiries relating to family violence and sexual assault, but to varying extents. This indicates a substantial overflow and growth of family violence service demand within a broad range of sectors, including in services that did not see the same level of need in this area prior to COVID-19. These findings reinforce and extend upon other Australian research about women's experiences of family violence during the initial stages of the pandemic (Boxall et al., 2020) as well as early insights into the impact of the pandemic from Victorian practitioners, showing an increase in frequency and severity of violence against women (Pfitzner et al., 2022).

The **sector focus groups** identified an increase in service demand across all services and sectors. Practitioners described their sense of service system overwhelm during COVID-19 and the need to operate at surge capacity for extended periods of time. While some services saw an initial pause in service demand at the start of the pandemic, this was followed by a sharp increase in demand when COVID-19 lockdowns were eased. At the time of the focus groups, some organisations felt that they were currently experiencing the peak of this demand, while others anticipated its continued acceleration.

Within the focus groups, many practitioners identified the increase in first-time presentations, including in the AVITH field; in LGBTIQA+ specialist services; and in AOD service provision, where practitioners noticed a spike in presentations following the easing of lockdown restrictions. In first-time presentations where controlling behaviours may have been present prior to COVID-19, practitioners described how the individuals experiencing violence were able to recognise violent and abusive behaviours during COVID-19.

Aged care practitioners echoed this narrative, working with older people that identified intimate partner violence for the first time when activities were taken away and lockdown restrictions confined them at home with the person using violence. In line with these findings is an identification in the wider literature of a "parallel outbreak of ageism" (Ayalon et al., 2021; Parkinson et al., 2020) during the pandemic. Here, social isolation and discrimination were compounded during COVID to worsen elder abuse (Evans et al., 2020).

Important to note, in some regional areas, the increase in first-time presentations accompanied the shift to online service delivery and the option for people to engage in services for the first time without having to travel large distances.

Practitioners across a range of sectors described the immediate spike in demand relating to material need. At the time of data collection, they also highlighted that this need was rising again for many, with increasing cost of living pressures, including housing costs, the withdrawal of government support and a lifting of moratoriums.

The **organisational case studies** reflected a surge in demand across all three organisations, with an increase in the number of clients overall accessing family violence services. GenWest saw a 16% increase in family violence service access and Good Shepherd saw a 51% increase in clients receiving family violence case management. While the number of Drummond Street clients experiencing family violence remained consistent, the percentage of clients seeking assistance for personal and family safety increased by approximately 150%. The organisational case studies illustrated how the complexity of cases also increased, with clients engaged for longer or for more hours during COVID-19. Good Shepherd saw an increase in contact hours[5] – from 48 to 72 hours – and Drummond Street's non-contact hours[6] almost doubled.

While the researchers did not ask participants specific questions relating to service demand within the **client interviews**, some participants volunteered that it was apparent that services were under strain or that their practitioner was limited in the types of support that they could provide during this time. Participants were unsurprised by the wait for services and the limitation within service responses, considering the ongoing crisis.

Increase in people seeking advice and support

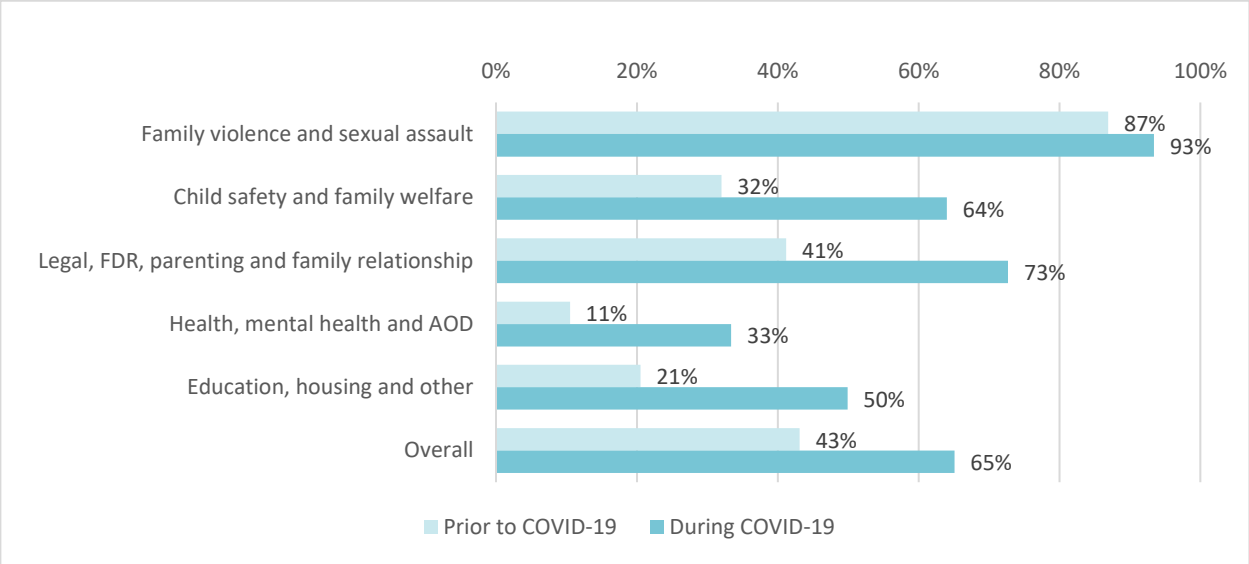
The sector survey indicated that the frequency of clients seeking advice or support in relation to family violence and/or sexual assault increased during the COVID-19 pandemic.

Prior to COVID-19, 87% of respondents in the family violence and sexual assault sector described the majority (more than 50%) of their client enquiries as relating to family violence and/or sexual assault. This was considerably higher than the proportion reported by respondents in other sectors that did not specialise in family violence.

[5] Hours spent doing face-to-face client work (e.g., sessions).
[6] Hours done outside of client sessions to support the work (e.g., case management).

During COVID-19, the proportion of respondents in the family violence and sexual assault sector for whom the majority of client enquiries related to family violence and sexual assault grew marginally (from 87% to 93%). More saliently, this period was characterised by marked increases in the proportion of respondents from sectors that did not specialise in family violence and sexual assault, for whom the majority of client inquiries related to this need (Figure 1).

Figure 1: Proportion of respondents for whom the majority (>50%) of client enquiries related to family violence and/or sexual assault prior to and during COVID-19[7]



During COVID-19, the proportion of respondents for whom the majority of client enquiries related to family violence and sexual assault:

- **doubled** in the child safety and family welfare sector (32% cf. 64%)
- **almost doubled** in the legal, FDR, parenting and family relationship sectors (41% cf. 73%)
- **tripled** in the health, mental health and AOD sectors (11% cf. 33%)
- **more than doubled** in the education, housing and other sectors (21% cf. 50%).

In line with the findings from other data sources, the survey results suggest a substantial overflow and growth of family violence needs during COVID-19 into services that did not see the same level of need in this area prior to this period. To view the tabular data used for this analysis, see Appendix B.

Increases in first-time presentations

Within the sector focus groups, practitioners working with victims and survivors saw an increase in clients who disclosed their experience of family violence for the first time. Practitioners reported an increase in first-time client presentations seeking family violence support, although it was the increase in the intensity and complexity of client presentations and risk profiles that was emphasised.

Practitioners working with victims and survivors described many clients disclosing their experience of family violence for the first time, despite this experience pre-dating or existing at the outbreak of the pandemic.

> "Where there was less access for the women to seek support through alternative services, the referrals from that side dropped off quite significantly … what we did see in police referrals is there were a lot more of those and there were a lot more severe incidents happening … women can be quite hesitant to contact police in the first place and they would only call when it was really that high-risk, quite a serious incident."
>
> **Practitioner 32**

Practitioners working in the specialist family violence sector observed a particularly marked spike in first-time client presentations during COVID-19, when lockdown restrictions were eased.

> "It went weirdly quiet at the start of the pandemic. The first lockdown, I spoke to friends from Safe Steps, who said the same thing. And that was actually really scary for us because we knew perpetrators were at home stopping women from calling crisis services. I was in intake at the time and it was ridiculous how quickly we caught up on our waitlist because people weren't answering and then it kind of slowly came back. And then all of a sudden it was like an avalanche. Once the lockdowns ended and everything kind of went back to normal, it was like everybody called all at once."
>
> **Practitioner 73**

Some practitioners, including those working with people using violence in relation to co-occurring needs, suggested that the immense spike in family violence presentations was partially attributable to some clients not

recognising the behaviour of the perpetrator as family violence, until it escalated in intensity and frequency during COVID-19.

> "[P]rior to COVID, there were people or families who had issues, there were difficulties and stresses in their lives and what's happened during COVID … was those increased amount of stressors and the increased amount of time at home has really led to … victim-survivors being able to identify 'this is moving beyond just I guess a dysfunctional relationship to a family violence incident'."

Practitioner 10

Practitioners, including those working with people using violence, were at pains to emphasise that the apparent escalations in abuse were often the result of a person using violence leveraging the pandemic as an excuse.

> "One example that comes to my mind was the Dad who'd been highly manipulative in a previous relationship, had full custody of children, used the court to completely … further this coercive control …. he was using the pandemic …to manipulate us to see that, yes, in the past he had used violence … but now the pandemic had come along and he wasn't working. He was, you know, having opportunities to have a drink every day. And that wasn't normal … and, you know, just the stress of not being able to earn money. … When we sort of dug a bit deeper and we spoke to his current partner, he was very controlling, very manipulative. His attitudes and beliefs around her were very much …he was that patriarchal person in the family, his way or the highway. I highly suspect that, without the pandemic, the violence would have been the same."

Practitioner 121

A number of examples also emerged within the client file review, where practitioners identified that people using or experiencing violence used COVID-19 pressures as a means of justifying violent or abusive behaviours. In one case file example involving a MBCP participant, the practitioner describes the client as "mutualising" and justifying his behaviour as a result of a build-up of stress of being isolated and home-schooling the children. In another case file example of a MBCP participant, the practitioner describes the client justifying his behaviour by blaming his family for not respecting him and interrupting him while he worked from home. Consistent with wider patterns of family violence, examples also emerged of victims and survivors feeling that they needed to justify or excuse the perpetrator's behaviour in the context of the pandemic, including in one case example where the client returned

to reside with the perpetrator two months after a strangulation attempt, describing the perpetrator as “not a violent person, but under stress after losing his job due to COVID-19”.

Notably, many of the reasons for complex first-time presentations were also associated with the impacts of COVID-19 on individuals and families. These factors included an increase in substance use, experiences of mental ill-health, financial stress and loss of employment, additional childcare responsibilities and what practitioners described as the “pressure cooker” environment that could exist for individuals and families living in close contact for extended periods.

> “And I think we're still seeing that now currently, when people's, I guess, reliance on drug and alcohol use has increased a lot during lockdowns, and then as a way to, I guess, continue coping with the stress.”
>
> **Practitioner 10**

Practitioners working in the AVITH sector saw a significant increase in young people and their families seeking primary consultations resulting from what one practitioner described as a period of, “unchartered turbulence for families” (Practitioner 89). This “turbulence” was particularly felt by young people who were required to participate in remote learning and were not able to engage common protective measures for de-escalating heightened situations, such as seeing their friends, playing sport or having other forms of respite or relief from the dynamic in the family home.

> “I know that the adolescent alcohol and other drug services noticed a significant increase in the perpetration of adolescents using family violence when they hadn't previously.”
>
> **Practitioner 8**

> “In the … AVITH space in particular, there has been a significant amount of first-time service users. … I know that with lockdown, you know, not being able to go to school and not having that connection for young people, we've seen younger clients as well”.
>
> **Practitioner 10**

Practitioners explained that ‘first’ presentations were still occurring well into 2022 for support needs that were present during the midst of the lockdown periods – but which had not received support due to overwhelming demand on the sector.

> "You know, we've had in the last couple of weeks … two families that we've been allocated and they've kind of said 'we first reached out for help in July last year and we've been waiting and actually, you know, we needed it back then and now it's too late'."

Practitioner 75

Practitioners supporting LGBTIQA+ communities reported that the rise in first-time client presentations was, for many, associated with young clients experiencing homophobia or transphobia from family members with whom they were having to spend more time at home.

> "Some of them reach out to us when they're only 14 or 15 … because they really don't feel safe at home because there's also homophobia, transphobia at home ... But that was also difficult when people needed to do the homeschooling."

Practitioner 59

Housing practitioners identified an increase in young people experiencing, or at risk of, homelessness as the result of escalations in familial conflict at home. These young people were part of the broader increase reported by housing services in first-time client presentations.

> "A lot of the kids that we have [were] couch surfing because of family violence, because they were worried about them being super spreaders, they actually housed them for a while. … it was the first time they had a clean bed and food, you know, and of course at the end of the period, they were terrified about what was going to happen to them."

Practitioner 11

Practitioners working in elder abuse services described an increase in first-time presentations of clients seeking support via the national elder abuse helpline. Many of these were aged care residents who were:

- concerned about being exposed to COVID-19
- experiencing increased isolation and loneliness as a result of visitor restrictions to aged care facilities
- experiencing elder abuse from family members, particularly adult children who had moved in with them during COVID-19.

Practitioners described the escalation in risk of violence for older people during this time.

> "We had a lot of clients … [where] they might have been tolerating a family violence situation or, you know, some difficulties with the relationship with an adult child or a partner at home. And previously they coped with it because they had that outlet where they could go to the [Planned Activity Group] or the luncheons or the gardening group and then, all of a sudden, they were stuck at home all the time."

Practitioner 23

This was also a particular theme in client interviews, where participants who had been involved in Planned Activity Groups [PAGs], which provided a vital outlet for them in the context of their experience of abuse, had been suspended.

> "[The PAGs] made me feel wanted and needed. All of a sudden, they were gone."

Participant 10

Insights from the sector survey further described the changing service needs of clients and echoed narratives of increased service demand.

> "Demand for services and for secondary consultations dramatically increased during COVID; more clients who were in higher states of anxiety and distress."

Family and relationship service, suburban area

> "Acute presentations to emergency departments have increased to (un)sustainable levels during the pandemic mostly because there were restriction(s) with access to community service providers funded to do this work."

AOD service, regional area

> "The core of the work never changed, it was more the number of referrals received and some higher need in regard to financial advice."

Family violence service, regional area

The organisational case studies also demonstrated an increase in demand for and access to family violence services.During COVID-19, GenWest saw a 16% increase in family violence service access and Good Shepherd saw a 51% increase in clients receiving family violence case management. While the proportion of Drummond Street

clients experiencing family violence remained consistent, the percentage of clients seeking assistance for personal and family safety increased by 150%.

The case studies highlighted that the complexity of cases also increased, with clients engaged for longer or for more hours during COVID-19. Good Shepherd saw an increase in contact hours – the average amount of contact hours per Good Shepherd client rose from 48 to 72 hours – and Drummond Street's hours almost doubled, with a substantial increase in both contact hours (46%) and non-contact hours (70%).

Consistent with some of the reflections from practitioners in the sector focus groups, some victim-survivor participants in client interviews reflected on how COVID-19 had exacerbated their feelings of risk to the point at which they had sought family violence specific support for the first time.

> "I think the catalyst was really COVID and lockdown for us because the kids couldn't go [to contact visits with parent using violence], we agreed they wouldn't go on [public transport]. So, him not having that access for that longer time and the kids not seeing him was what broke the camel's back [in terms of escalation of risk]. So, I don't think, like, if COVID hadn't appeared then maybe we would still be going [and not have sought assistance]."
>
> **Participant 7**

> "… since 2020 and COVID started, that's when I started to take it seriously and I realised I had to do something about it."
>
> **Participant 8**

> "…my ex-partner …wasn't an essential worker, so when he was working, I was fine, I was safe. [Then] the monster was home with me 24/7 and the abuse rose so high. … It got to a point where he had beaten me to a pulp, I'd waited a week for everything to heal and I had to call the police to remove him. … I told the police what happened, and they weren't interested in listening to me because they were transphobic, they're uncomfortable in my presence …. So, I was home with a monster 24/7 and the abuser 24/7. And then when Stage 4 hit, it was like 'Yeah, eventually he's gonna kill me. No doubt in my mind'."
>
> **Participant 3**

Recommendations

The Future-proofing Safety project identified the increase in demand for family violence and sexual assault service responses during COVID-19. It underscored how an initial drop off in people seeking support, followed by a sharp spike in presentations, may be characteristic of service demand during crises and disasters. During COVID-19 this was particularly the case for specialist family violence and sexual assault services.

The research uncovered a spike in family violence presentations across the broader service system, including housing, AOD, mental health, legal, family and relationships, as well as child safety, welfare and legal services. This highlights the need to upskill the workforce across the service system so that all service entry points are able to respond to and manage family violence risk. It also highlights the need to improve collaboration and coordination between sectors to enable more effective service provision during crises.

Government, peak bodies and organisations	• Develop Crisis Readiness Response plans to prepare for future crises and disasters. Part 3 of the Future Proofing Safety project provides a Crisis Readiness Framework to inform this planning.
Government	• Adequately fund all services that have seen an increase in family violence enquiries and presentations during the COVID-19 pandemic. This is urgently needed both to respond to the current surge in demand and to support the system's readiness to respond to future disasters. • Fund family violence and sexual assault training for a diverse range of services so that practitioners from different disciplines are able to embed a family violence lens within all their work. • Support coordination and collaboration across sectors, including providing funding to services to provide secondary consultation for family violence and sexual assault service responses. • Consider the development of a centralised website or database that allows services to provide regular updates on service offerings, demand, wait times and service capacity. This will enable services to provide warm referrals to appropriate supports and enable collaboration of care.
Peak bodies	• Support collaboration and communication between services and sectors. • Provide specialist support and resources to other sectors to support capacity building.

Services	• Develop communications plans in a broad range of languages and modes of communication (e.g., audio, visual, electronic, hardcopy) during crises and disasters to: ○ support clients to access the appropriate supports to meet their needs ○ support other service providers across the sector to support adjacent sectors to keep up to date with availability, waitlists, and other support options for clients. • Audit the skills and experience of staff to support the specialist transfer of skills and knowledge within services during crises. Develop the internal processes needed to support these processes. • Build and improve networks between services and sectors to enable effective cross-sector collaboration and capacity-building. These mechanisms will be critical for developing better organisational practices and the strong foundations needed for multisector support during crises.

Complexity of presentations and co-occurring need

One of the most common findings across all data sources was the increased need and complexity of clients seeking services during COVID-19. Numerous examples of the ways in which the increased need and complexity played out for clients were identified, particularly as many clients were unable to access timely and responsive services.

Key findings

The **sector survey** data showed an increase in the frequency of respondents reporting that most clients with family violence and/or sexual assault enquiries were presenting with a broad range of co-occurring needs during COVID-19. Importantly, it highlighted the proportion of survey respondents reporting that most of these clients presented with two or more issues, rising (12% increase) from 69% prior to COVID-19 to 81% during COVID-19.

Across the **sector focus groups**, the increased complexity of client presentations in terms of both risk and needs was one of the strongest themes. Practitioners across all sectors involved reported that the primary cause for increased complexity was the compounding impacts of COVID-19 and its associated restrictions on people's pre-existing needs. They recognised that individuals and families with pre-existing needs around mental health, financial stress, housing instability and AOD misuse experienced an exacerbation and escalation of these needs with heightened anxiety, isolation and loss of employment. Just as importantly, practitioners emphasised that a lack of access to service supports over the course of the COVID-19 pandemic resulted in these needs becoming

more acute and severe. The research team heard that, by the time an individual or family reached services for support, their needs were more varied and entrenched.

International research has similarly found that the pandemic has "reinforced important truths: inequities related to social determinants of health are magnified during a crisis" and that the experience of violence at this time "has had a disproportionate effect on communities of colour and other marginalised groups" (Evans et al., 2020).

The **case file review** provided concrete examples of the ways in which risk and complexity increased during COVID-19 across the facets of people's lives. These included particularly salient examples relating to increased mental health distress, economic pressure including through job losses, increased substance abuse and families living under increased strain.

The **client interviews** provided insights into the ways in which risk and complexity had heightened for some clients either during COVID-19 or as a result of the pandemic. This was particularly the case for those who were fleeing family violence or seeking safety during COVID-19 related restrictions; who felt that they were not able to participate in the legal process fully; who had lost employment or whose partners had lost employment at the outset of the pandemic; or who were now experiencing additional difficulty finding safe and secure housing as a result of rising rental costs, particularly in regional areas where an influx of 'tree changers' accompanied COVID-19 lockdowns.

The **organisational case studies** described how co-occurring needs increased in client bases. Analysis showed an increased intensity of risk, particularly with mental health needs. Drummond Street saw a particularly substantial increase in mental health risk, including suicidality risk and self-harm (70% increase), drug and alcohol abuse (38% increase), risk of homelessness (30% increase) and a higher rate of intensive support provided. GenWest saw an increase in mental health needs and referrals from mental health services, from 12% prior to COVID-19 to 29% during COVID-19. Clients also experienced an increased risk of homelessness (23% increase). While Good Shepherd saw a decrease in recorded co-occurring need, they saw an increase in the amount of time that clients were engaged with the service and the number of sessions provided, indicating that recorded co-occurring needs likely did not reflect the reality at this time.

Demographic data within the organisational case studies demonstrated complex intersectional experiences of growing co-occurring needs associated with family violence for those belonging to marginalised groups. For example, clients who were from non-English speaking backgrounds had a higher risk of homelessness and higher incidence of financial insecurity. This was similar for single parented households (and higher still if clients who were from non-English speaking backgrounds and single parented households).

Risk, complexity and co-occurring needs

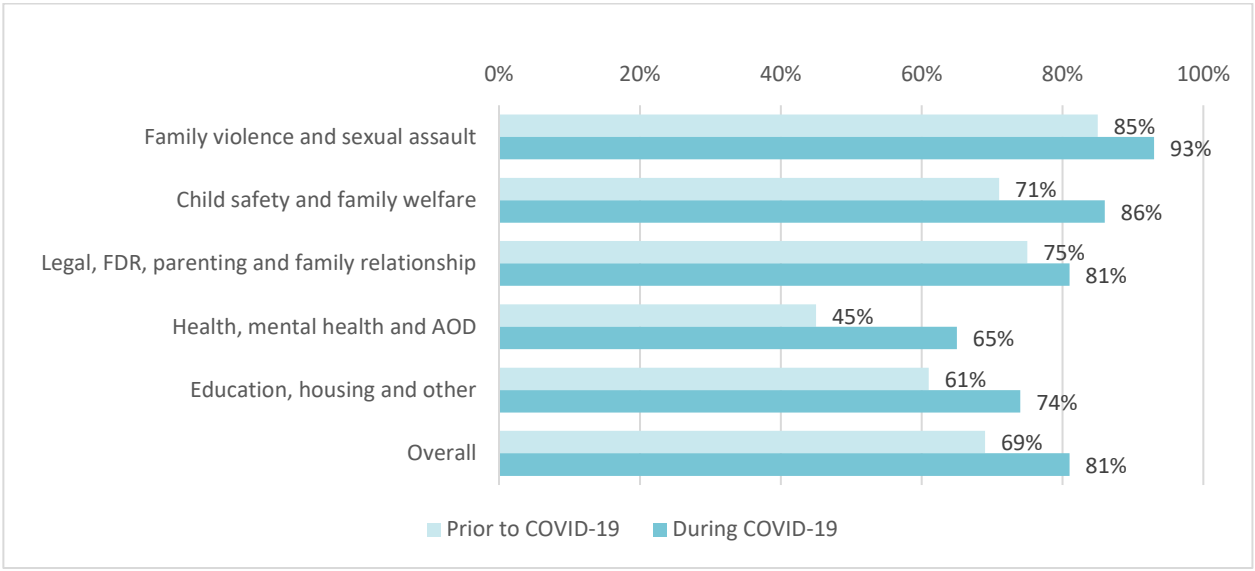
The sector survey saw increasing complexity in the experiences of clients who presented with family violence and sexual assault needs during COVID-19. Further analysis emphasised how this complexity was driven by an increase in client risk and co-occurring needs.

Multiple co-occurring needs

Across all sectors, the proportion of survey respondents reporting that the majority of their clients also presented with two or more co-occurring needs grew during COVID-19 from 69% to 81% (Figure 2). This growth was particularly marked in the health, mental health and AOD sectors which saw this proportion rise from 45% to 65%.

Overall, the rise in the frequency of clients with multiple co-occurring needs indicates an increased complexity of client experiences during COVID-19. This was evident in sectors that did not usually see this complexity of need with their clients experiencing family violence, such as the health, mental health and AOD sectors.

Figure 2: Proportion of respondents reporting that the majority (>50%) of clients with family violence and/or sexual assault needs also presented with two or more co-occurring needs prior to and during COVID-19



Prior to COVID-19, the co-occurring needs most frequently reported by respondents, as seen in the majority of clients, were:

- emotional abuse or anger issues (64%)
- mental health issues (60%)
- relationship breakdown (59%)

- financial stress or hardship (58%).

The distribution of co-occurring needs varied considerably between sectors. To view a tabular comparison of co-occurring needs by sector prior to and during COVID-19, see Appendix C.

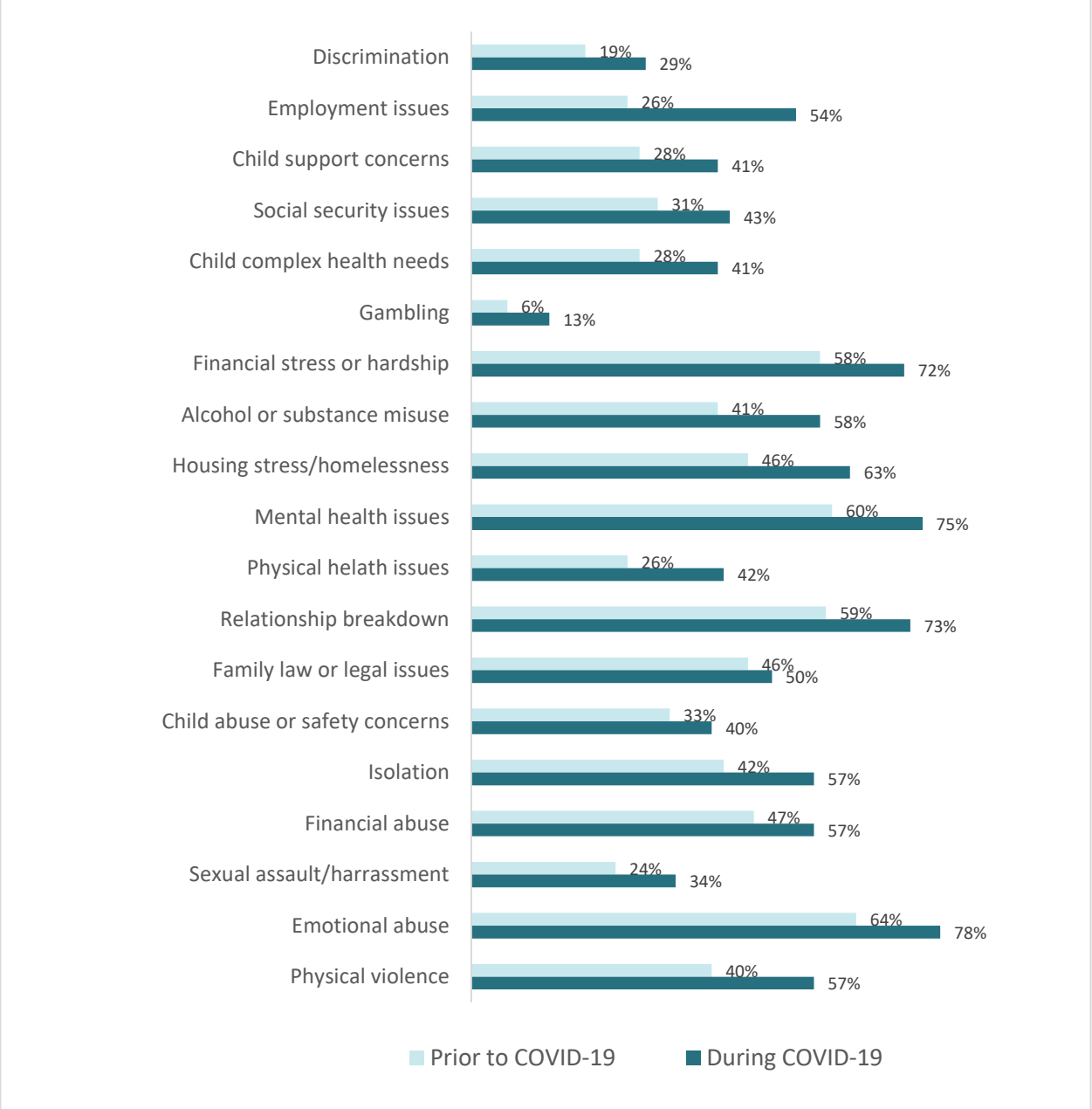
Prior to COVID-19, markedly greater proportions of respondents working in the family violence and sexual assault sector, compared to other sectors, saw the majority of clients present with needs around:

- physical violence (82% cf. 40% all services)
- emotional abuse or anger issues (89% cf. 64% all services)
- sexual assault and/or harassment (50% cf. 24% all services)
- financial abuse (including attempted/prevention of knowledge of or access to family money) (74% cf. 47% all services)
- isolation (including attempted/prevention of contact with family or friends and and/or attempted/prevention of the use of telephone or car) (70% cf. 42% all services)
- mental health issues (72% cf. 60% all services)
- child support issues or concerns (46% cf. 28% all services).

The proportion of survey respondents across sectors reporting that the majority of clients presented with co-occurring needs increased during COVID-19 across all categories of need (Figure 3). The most marked growth occurred in the following areas:

- Employment issues more than doubled (26% prior to cf. 54% during COVID-19)
- Gambling issues more than doubled (6% prior to cf. 13% during COVID-19)
- Housing stress or homelessness grew 1.4-fold (140%) (46% prior to cf. 63% during COVID-19)
- Alcohol or substance misuse grew 1.4-fold (140%) (41% prior to cf. 58% during COVID-19)
- Physical violence grew 1.4-fold (140%) (40% prior to cf. 57% during COVID-19).

Figure 3: Proportion of respondents reporting that the majority (>50%) of clients with family violence and/or sexual assault needs also presented with the listed co-occurring needs



Co-occurring needs

High proportions of survey respondents reported the following co-occurring needs for clients presenting for support relating to the experience and use of family violence and/or sexual assault during COVID-19:

- multiple issues and needs being present (80%)
- increase in mental ill-health (84%)

- increase in financial stress and hardship (79%)
- higher levels of risk or harm relating to family violence (67%)

The majority of the occurrences listed were most frequently reported by respondents in the family violence and sexual assault sectors with some notable exceptions:

- The highest proportion of respondents reporting a decreased visibility of child safety concerns worked in the child safety and family welfare sector (64%)
- The highest proportion of respondents reporting needs relating to housing or living arrangements worked in the child safety and family welfare sector, of equal proportion to those working in the family violence and sexual assault sector (72%).

Table 3: Proportion of respondents reporting the following occurrences "almost always" or "often" being present for clients experiencing or using family violence and/or sexual assault during COVID-19

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Increase in mental ill-health	91.2	80.0	87.6	78.3	80.7	84.3
Increase in clients characterised by multiple issues	93.0	84.0	71.9	73.9	67.8	79.6
Increase in financial stress/hardship	94.8	80.0	75.0	68.9	67.7	79.1
Higher level of risk or harm relating to family violence	89.7	72.0	54.9	52.2	53.4	66.8
Changes in housing/living arrangements	72.0	72.0	65.6	50.0	51.6	62.3
Changes in issues clients are experiencing in addition to family	73.2	70.8	61.3	55.6	40.0	61.3

violence (Please specify)						
Increase in clients seeking support for family violence who have not previously sought support	69.0	48.0	40.7	43.5	53.3	52.9
Decrease in visibility of child safety concerns	60.3	64.0	54.9	37.7	29.0	49.5
Changes in child safety concerns, including an increase in risk or harm to children (Please specify)	67.9	56.0	54.9	27.3	22.6	47.1
Changes in the client base seeking support for family violence	52.6	44.0	40.6	26.7	42.0	41.6
Other (Please specify)	20.0	16.6	18.2	12.5	11.8	15.2
n	**58**	**25**	**31**	**46**	**30**	**190**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Service and support needs of clients

Prior to COVID-19, the most common services or supports required by clients related to:

- counselling or other therapeutic support (65%)
- referrals to other services (60%)
- financial support or assistance (59%)
- safety planning (57%)
- legal advice or representation in relation to family violence, such as intervention orders (51%).

Some of these needs varied between sectors, with the following needs being significantly different across sector types:

- Safety planning was more frequently needed by clients engaged in family violence and sexual assault services (83%) and child safety and family welfare services (62%)

- Counselling or other therapeutic support was more frequently needed by clients engaged in family violence and sexual assault services (80%) and child safety and family welfare services (76%)
- Assistance with housing was more frequently needed by clients engaged in family violence and sexual assault services (65%)
- Legal advice and representation in relation to family law matters was more frequently needed by clients engaged in legal, FDR, parenting and family relationship services (59%) and family violence and sexual assault services (54%)
- Legal advice and representation in relation to Child Protection was more frequently needed by clients engaged in family violence and sexual assault services (43%)
- Legal advice and representation in relation to family violence was more frequently needed by clients engaged in family violence and sexual assault services (67%) and legal, FDR, parenting and family relationship services (67%).

Table 4: Proportion of respondents reporting that the majority (>50%) of clients required the following services and supports, by sector, prior to COVID-19

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Counselling or other therapeutic support	79.6	76.2	48.1	58.6	53.4	64.8
Referrals to other services/supports (Please specify)	66.7	55.0	48.0	57.5	65.4	60.1
Financial support or assistance	70.3	71.4	44.4	47.5	60.0	59.4
Safety planning	83.4	61.9	48.1	38.0	41.4	57.2
Legal advice/representation in relation to family violence (e.g., Intervention orders)	66.7	57.1	66.6	22.5	43.3	51.2
Assistance with housing	64.8	38.1	25.9	40.0	40.1	45.4
Legal advice/representation in relation to family law matters	53.7	42.8	59.2	17.9	33.4	41.6

(including children and/or property/financial matters)						
Legal advice/representation in relation to Child Protection	42.7	28.6	29.6	20.0	16.7	29.0
Legal advice/representation in relation to other matters (Please specify)	20.7	15.0	22.7	7.8	17.2	16.7
n	**54**	**20**	**25**	**40**	**29**	**168**

Notes: Percentages may not total exactly to 100.0% due to rounding.

During COVID-19, the proportion of respondents reporting that most clients required certain services or supports increased for all listed services and supports (Figure 4). This growth was particularly marked for:

- assistance with housing (61% during COVID-19 cf. 45% prior to COVID-19)
- safety planning (66% during COVID-19 cf. 57% prior to COVID-19)
- legal support (other) (25% during COVID-19 cf. 17% prior to COVID-19).

Figure 4: Proportions of respondents reporting that the majority (>50%) of clients required the following services and supports, prior to and during COVID-19

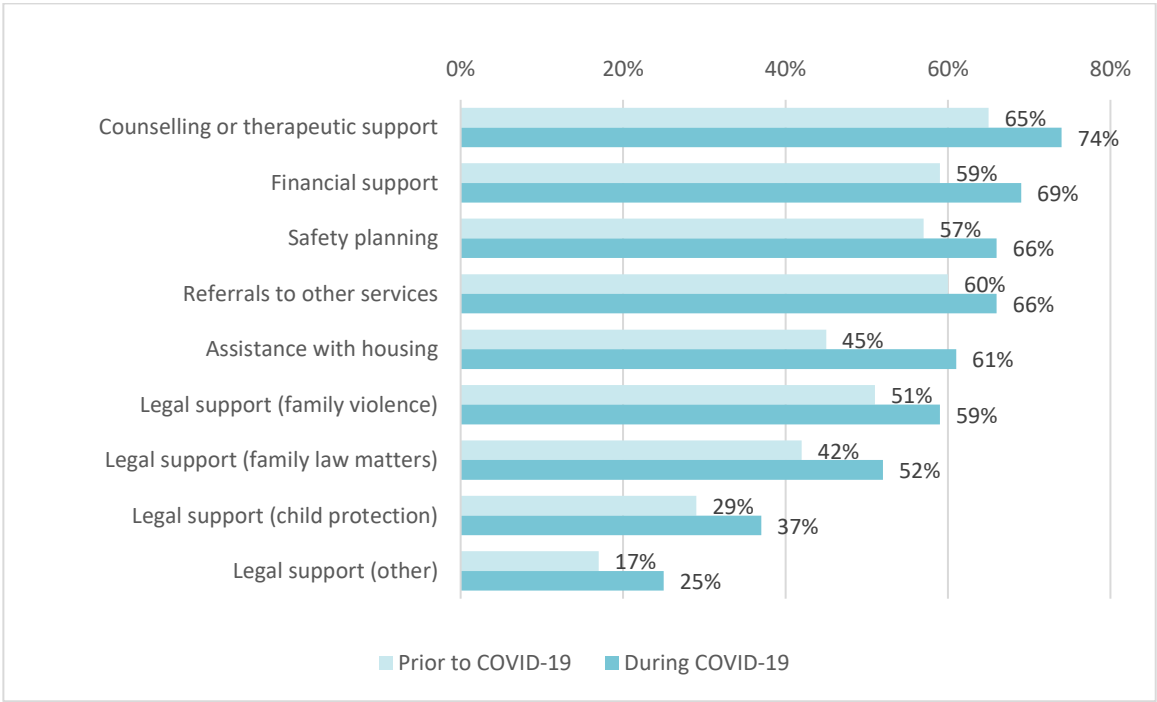


Table 5: During COVID-19, more than half of clients experiencing or using family violence and/or sexual assault required the following services and supports

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Counselling or other therapeutic support	92.8	76.2	70.3	61.0	62.0	74.5
Financial support or assistance	89.1	76.2	62.9	41.5	72.4	69.4
Safety planning	92.7	71.4	59.2	47.5	44.8	66.3
Referrals to other services/supports (Please specify)	75.0	60.0	72.0	56.5	63.0	66.3
Assistance with housing	80.0	66.7	37.0	45.0	65.5	61.1
Legal advice/representation in relation to family violence (e.g., Intervention orders)	80.0	57.1	74.0	27.5	48.2	58.7
Legal advice/representation in relation to family law matters (including children and/or property/financial matters)	71.0	42.9	62.9	23.1	48.2	51.5
Legal advice/representation in relation to Child Protection	49.1	33.3	38.4	27.5	27.5	36.8
Legal advice/representation in relation to other matters (Please specify)	25.9	20.0	37.5	13.1	33.3	25.1
n	**52**	**20**	**25**	**39**	**27**	**163**

Notes: Percentages may not total exactly to 100.0% due to rounding.

The **organisational case studies** also highlighted the rise in complex co-occurring needs. While the level of these needs is likely to be substantially underestimated, Drummond Street Services saw a very high level of co-occurring needs and risk presentations for clients experiencing family violence. These are described below.

- 94% of clients had co-occurring mental health needs (e.g., depression, anxiety, stress, mental illness)

- 45% of clients were experiencing financial insecurity (including economic deprivation and finance-related needs)
- 22% of clients were at risk of homelessness
- 51% of clients were experiencing social isolation
- 15% of clients had presenting needs related to AOD misuse (e.g., past or present substance abuse).

Financial needs were exacerbated for clients with disabilities, single-parented households, people who spoke a language other than English at home and First Nations clients. LGBQ+ clients had a much higher risk of homelessness than heterosexual clients.

When comparing the period prior to COVID-19 to the period during COVID-19, Drummond Street Services recorded the following changes in co-occurring needs for clients experiencing or using family violence:

- risk of homelessness increased by 30.2 percentage points, from 16.9% (n=353) to 22% (n=444)
- financial insecurity increased by 2.5 percentage points, from 44.1% (n=919) to 45.2% (n=914)
- mental health needs increased by 2.4 percentage points, from 91.5% (n=1906) to 93.7% (n=1895)
- AOD-related needs slightly increased as a percentage, from 15.1% (n=314) to 15.2% (n=308)
- social isolation increased by 12.4 percentage points, from 45.2% (n=941) to 50.8% (n=1027).

In addition:

- suicide risk alerts increased by 67.2 percentage points, from 6.7% (n=139) to 11.2% (n=227)
- self-harm risk alerts increased by 72.5 percentage points, from 4% (n=84) to 6.9% (n=140)
- AOD abuse risk alerts increased by 37.5 percentage points, from 2.4% (n=51) to 3.3% (n=66)
- at-risk youth risk alerts increased by 38.5 percentage points, from 6.5% (n=134) to 9% (n=181)

While

- Child Protection involvement risk alerts decreased by 20.2 percentage points, from 8.4% (n=174) to 6.7% (n=136)
- at-risk children risk alerts decreased by 14.9 percentage points, from 7.4% (n=154) to 6.3% (n=127)

The decrease in child need and Child Protection involvement, accompanied by an escalation of other risks and needs, indicates that child needs were likely falling through the gaps during the COVID-19 period, resulting in reduced referrals and interventions for at-risk children.

GenWest's data highlighted how the most significant negative impact of the pandemic related to clients' mental health. During the period prior to COVID-19, 11.8% (n=121) of clients reported compromised mental health. During COVID-19, this increased by 143.7 percentage points to 28.8% (n=346). Financial insecurity and homelessness were also common needs at GenWest during the pandemic, although this was tempered by greater support from federal and state governments. As a result of this support, the proportion of clients who reported financial insecurity reduced by 57.0 percentage points, from 65.9% (n=675) to 28.4% (n=341). This contrasted with the proportion of clients who reported risk of homelessness which grew by 22.6 percentage points, from 16.9% (n=173) to 20.7% (n=249).

During COVID-19, 1,203 clients started receiving outreach case management support, GenWest's longer-term support program. Of these clients:

- 20.7% (n=249) reported risk of homelessness
- 28.4% (n=341) reported financial insecurity
- 28.8% (n=346) reported compromised mental health.

Homelessness, financial insecurity and compromised mental health were common among clients seeking family violence support. These needs are likely to be underrepresented within the dataset, however, because of data capture methods at GenWest.

Meanwhile, of clients who received case management at Good Shepherd during the COVID-19 period (n=1,129), 1,046 had a contact history and 931 had a safety plan put in place. Of these:

- 33.7% reported risk of homelessness (n=353)
- 44.8% reported financial insecurity (n=469)
- 26.2% reported mental health needs (n=275).

Risk of homelessness, financial insecurity and mental health needs are always consistently high amongst family violence clients.

Interestingly at Good Shepherd, the core reason for seeking support did not change, with close to 100% of all clients seeking assistance for experiences of domestic and family violence – 98.5% of clients prior to COVID-19 and 99.9% during COVID-19-19. Other reasons for seeking assistance all reduced, however, between the periods prior to and during COVID-19. These included:

- financial difficulties – 24% decrease
- relationship or family breakdown – 17% decrease
- mental health issues – 31% decrease

- housing affordability stress – 37.2% decrease
- lack of family or community support – 47% decrease.

Identified co-occurring needs also dropped between the periods prior to and during COVID-19. The risk of homelessness had only a small decline of 7%, while financial insecurity dropped 19% and mental health needs dropped 26%.

The downward trend of co-occurring needs may indicate that practitioners (and possibly clients) were focused on the most critical issue, setting aside other pressing needs within the greater context of uncertainty and such dramatic changes in service provision. This is suggested by the strong reduction in the number of clients with co-occurring needs recorded, which decreased by 70% between the periods prior to and during COVID-19.

The most unexpected change in the data was a 26% reduction in mental health needs, from 35% of clients prior to COVID-19 to 26% during COVID-19. At a time when the Victorian population overall reported worsening mental health, it seems unlikely that people experiencing family violence would not also experience compromised mental health.

Despite declining co-occurring needs, the average length of support increased for clients by 50%, from an average of 48 contact hours per client prior to COVID-19 to an average of 72 contact hours during COVID-19. Referrals to most other support services also increased for most categories, including:

- material aid or brokerage – 167% increase
- specialist counselling service – 142% increase
- advocacy or liaison services – 243% increase
- housing services – 50% increase
- financial information – 44% increase
- assistance for trauma – 14% increase.

Taken together, the increases in contact hours and the referral patterns indicate that the reduction in need captured in the data was not commensurate with the types of support provided during this time.

Across the **sector focus groups**, one of the strongest themes that emerged also related to the increased complexity of client presentations in terms of both risk and needs. As noted above, practitioners working across related sectors attributed the increased complexity to the compounding impacts of COVID-19 and associated restrictions on an individual's pre-existing needs and experiences of inequality. Practitioners recognised that individuals and families with pre-existing needs around mental health, financial stress, housing instability and AOD misuse all experienced an exacerbation and escalation of these needs, associated with heightened anxiety, isolation, and loss of employment.

Just as importantly, practitioners emphasised that a lack of access to service support over the previous two years had resulted in client needs becoming more acute and severe.

> "I think the clients' needs are becoming more complex, like during COVID, the deterioration of mental health and also the increased use of AOD, so when the clients present to us for family violence, it's actually first much more about their other needs."
>
> **Practitioner 59**

> "So, we were the only service who was physically allowed to go to them, because that was part of their [mental health] treatment orders. Other services, particularly things like NDIS providers, who they might have had in the home previously, they weren't able to come. And so, we saw this increase in complexity where isolation just kept on increasing, the mental health impacts were increasing and the family violence severity was getting worse."
>
> **Practitioner 28**

> "I found that we were holding like family violence and mental health and AOD and homelessness and everything a lot more because of that kind of increased demand for all services across the board."
>
> **Practitioner 33**

Increased risk and complexity of need also meant that practitioners were remaining engaged with clients over a longer period of time, increasing their own caseloads and the level of risk that they were holding.

> "Normally our support is up to 13 weeks, sometimes 26 weeks. But I found that we were holding clients for far longer. I had clients that I was holding for up to 12 months."
>
> **Practitioner 33**

For many practitioners, the increased complexity and a lack of regular supports created situations where practitioners who did not have the relevant expertise were having to identify and respond to family violence without being adequately equipped to do so.

> "… because of the external services' inability to be able to provide support. […] it felt like our clinicians were really the ones that had to handle the family violence

> aspect of it. However, they're really not family violence specialists [and that] was, yeah, really tough on the staff … because they really felt frustrated about not being able to help keep a woman and their child safe."
>
> **Practitioner 27**

This trend did not abate during 2022, despite the absence of lockdown restrictions.

> "Services that are not specialised in family violence are holding family violence work because the waitlists are so long at specialised family violence services. And then likewise, like, we're holding mental health work and everyone's like a stopgap. Like, we're all holding each other's work because it's just the way that the system works at the moment and the demand that's through the roof."
>
> **Practitioner 32**

Professionals in the focus groups also identified a range of specific issues pertaining to co-occurring needs, including mental health, substance misuse, financial distress and safe and secure housing, which many practitioners described as people living in a "pressure cooker" environment.

Similarly, participants in client interviews described the way in which COVID-19 exacerbated existing safety risks, through isolation and an inability to see friends, which made their situation worse (Participant 13).

> "… he was still living close by, so you're just hypervigilant all the time, you're listening out for that car engine, looking behind your shoulder, it's fight, flight or freeze all the time. You're in survival mode. It's a very debilitating, traumatic experience, probably amplified because you're in lockdown … because I was at home alone, everything was amplified, I felt very isolated. I mean victims feel isolated regardless, but this exacerbated my experience of the isolation and going through this on my own … If you're going to throw funding somewhere, that needs to be looked at, to create those opportunities to not be so isolated."
>
> **Participant 1**

> "Stressful, very stressful. Mainly because I was working during COVID while living in and dealing with an abusive marriage ... because you're trying to leave an abusive marriage and protect your kids …"
>
> **Participant 4**

> "I was under huge pressure. [Working in tertiary education] we lost most of our experienced colleagues … So huge pressure to cover all sorts of things and students were stressed … So, they were going through financial and living arrangements crises and just the stress of them having to do of all their learning online and we had to adapt all of our teaching. … So that's what I mean about the whole thing about COVID being compounding. It wasn't just one area of your life that affected. And then you throw family violence in the mix and it just feels completely overwhelming."
>
> **Participant 14**

Participants in the client interviews described the direct impacts of COVID-19 on their immediate safety.

> "I didn't have any excuse to sort of go out anywhere … because, like, everything was locked down, so I can't say, 'oh, I just have to go do this' to get out of a situation. Yeah, and sometimes it was a bit hard just to drive out, wondering if you're going to get in trouble by police, like if I had to leave the house or there was an issue."
>
> **Participant 2**

Mental health needs

The increased incidence and severity of the mental health needs of clients was a recurrent theme across the focus groups. Across all sectors, practitioners reported a rise in clients presenting with mental health needs, particularly depression, anxiety and loneliness that were either caused or exacerbated by the impacts of the pandemic and meant that "thresholds to deal with … crap just lowered" (Practitioner 88).

Key impacts raised during the sector focus groups included the isolation that individuals and families experienced during the state's multiple, extended lockdown periods. These not only increased rates of loneliness and depression but could simultaneously increase risk for a person either using or experiencing family violence, as contact with support networks, including friends and family as well as services, was limited to online engagement or ceased entirely.

In particular, practitioners in relevant service areas reported that young people using violence in the home with general diagnoses of mental ill health, such as anxiety and depression, were often found to have used violence following episodes of acute mental ill health.

> "At some points in our inpatient units, we had in excess of … 50 to 60% of persons with mental health that were persons who use family violence."
>
> **Practitioner 27**

> "… a lot of clients presenting with family violence and drug and alcohol were informing me of an increased sense of social isolation, which was exacerbated during COVID lockdowns. But that sense of isolation really worsened their sense of mental health, their … capabilities and sense of being able to not only seek services, but to be able to change their future outcomes."
>
> **Practitioner 10**

> "… a large majority of our young people are suffering significant mental health issues and not wanting to go back to school, not wanting to engage with friends in the same way that they did prior to COVID … for some young people who already struggled with a lot of social anxiety that was quite convenient to not have to go and do those things anymore. And then it's actually just exacerbated it all, because now it's really difficult for them to get back into that space."
>
> **Practitioner 77**

Practitioners working with young people identified common pandemic-related factors that initiated or aggravated mental health needs, including the restriction of face-to-face schooling and related challenges. These challenges included the stress of remote learning, particularly for those students who needed more intensive support from teaching staff. Challenges also included isolation from friends and peers, increased social media and technology usage – including participating in or experiencing harmful or high-risk online behaviour – as well as the inability to engage in protective measures such as playing sport, seeing friends and having appropriate time away from the family home.

Practitioners described their concerns about the links between the time that young people spent online during COVID-19 and the severe and acute mental health issues with which they were presenting.

> "Self-harm and mental health is another big one that seems to have ramped up through the COVID period, and accessing public services, the wait list is just horrendous, so being able to link them in with private psychs has been a priority for us. I think they're probably some of the biggest changes we're noticing."
>
> **Practitioner 53**

> "… we've had that … kind of like a suicide cluster which the ripple effects of those deaths, which were young people that were very connected on social media … what a lot of young people have been exposed to was really, really graphic, self-harming, suicidal kind of posts. … So, just the overwhelming nature of not being able to actually know what young people are seeing, the level of really high-risk materials that they're getting exposed to, that it's kind of all invisible and underground."
>
> **Practitioner 75**

Practitioners described an over-exposure to the online environment as being harmful to young people in other ways, increasing a broad range of risks and co-occurring needs.

> "… use of online bullying is impacting on how they're able to connect again and they're having more conflict at school … clients have [had] people go to their house and throw paint on their parents' cars and yeah, really ramping up the use of attacks from what they're saying to each other on social media to what they're then actually doing in reality as well."
>
> **Practitioner 77**

Practitioners working in the elder abuse sector also identified how the mental health needs of elderly clients' adult children could heighten their risk of experiencing family violence from their child.

> "We talked to people who … had adult children who were behaving really badly … you know, with mental health issues, perhaps even drug issues. And they were really frightened people because I know in one particular case the adult son was going out breaching the COVID rules which upset the parents, but also, they were really scared that he was going to bring COVID home to them. But there was also this reluctance, even in those extreme situations, to apply for intervention orders because they were scared of what would happen to the [adult] child with, you know, on the streets given COVID and everything that was happening so they would more likely tolerate that situation, even though it was really terrifying for them."
>
> **Practitioner 23**

> "Some families, you know, found people went into further conspiracy theory behaviours […] I remember a few parents found themselves living with an adult child who turned, you know, quite down that pathway and was therefore, you know, really trying to direct them to what they could, couldn't, should. And then the vaccine then brought up the whole other in fact, that was the really big, like, schism in some families."
>
> **Practitioner 22**

The **case file review** also revealed how mental health risks, particularly social isolation and loneliness, were exacerbated for those seeking support during the pandemic. This data source highlighted instances where victims and survivors were isolated from their community supports and connections as a result of COVID-19 and the negative impact of this isolation on their mental health. One file documented how a client moved to a new area immediately prior to COVID-19 but, because of lockdowns, she had not been able to engage with social workers or supports such as mothers' groups, play groups or self-help groups (GS5).

Examples of the mental health impacts of COVID-19 on children were also uncovered. In one, lockdowns exacerbated a young person's already waning school attendance, intensifying their withdrawal, isolation and limited contact with peers while also occurring in the context of their use of violence in the home (DS19). Cases documented the needs of children to be outside, at the park, playing with other children and going to a shopping centre, as well as documenting the boredom that they experienced at home. Similarly, case examples documented how some children struggled to adapt to changes in restrictions because of their high sensitivity levels and emotional adjustment difficulties (DS18).

Participants in client interviews described significant escalations in mental health issues – either in relation to themselves or their children, or in relation to the person using violence against them. They also described the impact of long wait times for appropriate support, whether for mental health or other needs, with the absence of service support overall compounding each need, both separately and in combination.

> "And his mental health deteriorated, I guess that was perhaps the catalyst for this escalating behaviour."
>
> **Participant 1**

> "During COVID, my daughter, especially her mental health, declined significantly … You know, she's always had things there, but it was definitely 10 times worse [She started self-harming] … And now … you know she's questioning her [gender] now she feels like should have been born a boy. … But again, we're

having trouble to be able to tap into [appropriate] services because COVID has made ... the wait … ridiculous ..."

Participant 12

"I don't know if I was mentally impaired at the time, that's something for my lawyers to deal with because I have medication I take, but part of it also involves family violence because the anger I was having at Victoria Police was so, you know, extensive because they've kind of never taken the emotional and psychological violence I've experienced seriously [and I was involuntarily admitted] during the lockdowns once."

Participant 8

Substance misuse

Previous research looking at the first months of the pandemic in Australia found an increase in the co-occurring issues of alcohol consumption and severe symptoms of depression or anxiety (Tran et al., 2020). Research analysing changes in alcohol consumption in Australia also suggests an increase in alcohol consumption since the COVID-19 pandemic began (Biddle et al., 2020).

Echoing this, elevated substance misuse was identified as a common presenting need in clients across sectors and was generally compounded in incidence and severity by a range of pandemic-related factors. Practitioners not only found that problematic substance use escalated in clients with a history of substance misuse, but also noticed a rise in first-time presenting cohorts such as those from professional backgrounds, men in younger age brackets (30 to 40 years old) and in mothers with primary child-care responsibilities.

"We're certainly still seeing the after-effects of it. Though it's still a lot of presentations from people that wouldn't typically present to an AOD service. They're returning to work and realised that the alcohol use and benzo use or whatever has some, you know, or opioids has increased in it, and they're not in control anymore. The last time we saw this was the Black Saturday bushfires – it was the similar sort of crisis in Victoria … you get people presenting in the years after saying that that had been the event … We noticed people who had

> previously done years of abstinence [or] … never had treatment in the AOD sector, had suddenly lost their job, started to drink heavily."
>
> **Practitioner 7**

> "You know when we're trying to adapt to our post-COVID world, those strategies have continued and have become habits and behaviours … And I do have a suspicion that it might get worse, given the amount of increase in costs and all the stressors that's happening at the moment, like the rise in the cost of living and such."
>
> **Practitioner 10**

Legal practitioners also reflected on the rise in substance misuse in their clients, identifying an increase in children being removed as a result of parental substance misuse and its contribution to family violence risk in the home.

Practitioners also identified a correlation between clients' substance misuse needs and their risk of either using or experiencing family violence. Several factors underlying this correlation were highlighted. Many related indirectly to COVID-19 specific measures, such as the relationship of border restrictions to an increase in clients using more illicit, higher-risk and poorer quality substances for the first time because of the reduced availability and increased cost of their usual substances.

Practitioners working for in-patient AOD facilities also reflected on how COVID-19 presented unique challenges and opportunities alike. For certain clients, including those in mother and baby detox facilities, lockdown periods and the restriction on visitors created an opportunity for victims and survivors of family violence to have emotional and physical respite from a violent intimate partner and, in some cases, to recognise the nature of their partner's behaviour as family violence.

> "… for the previous four to five years, the vast majority of referrals to our facility had already had family violence identified because they'd been picked up in specialist maternity programs … so we already knew about very high rates of family violence, which was consistent with the literature around possession, obsession and the power shift in dynamic that happens around pregnancy … So, what COVID did differently, I guess in some ways by not allowing visitors anymore, some of the women got more space."
>
> **Practitioner 7**

Increased substance misuse was also found within the client file review, particularly instances of increased substance misuse by the person using violence, leading to increased risk to victims and survivors. In one case example, the perpetrator's increase in substance use during COVID-19 was identified as directly contributing to their use of violence (GS2).

The case file review also reflected the direct impact of COVID-19 economic measures on increased drug use. In one case example, the perpetrator accessed his superannuation according to the government policy, and subsequently used this money for the purchase of drugs (GS5). In another, a young person received JobKeeper as a result of being unemployed, and he used the money to purchase drugs and alcohol, which caused concern for his mother (the client in this case).

Practitioners in the sector focus groups also described increases in harmful rates of substance use by the young people with whom they were working.

> "I've been seeing drug use in young people who might be, you know, smoking a lot of marijuana and got a bit caught up in that during COVID, being isolated and using … then that being part of their mood and rages and violence as well. But also, these pressures on the family system, so that parents are really under stress because of, you know, losing a job or losing finances, or having everyone home for a year, multiple children in the family, you know, [and] just couldn't have the time to focus on addressing what was going on for the young person."
>
> **Practitioner 52**

> "I'm noticing a lot of young people are then doing drugs. So, they're bringing their … paraphernalia back to the house, so then younger kids are being, you know, impacted by that. Parents are concerned about that, then they're going into their rooms … they'll then connect in with more high-risk social networks to get that approval and that connection and stop … feeling like the problem."
>
> **Practitioner 76**

Some participants in the client interviews also referred to the increased use of alcohol on the part of people using violence – although, notably, it was not as substantial a theme volunteered by participants as were mental health issues.

> "I think it definitely contributed to the family violence because he started drinking again so he started stressing financially and things like that."
>
> **Participant 1**

Financial distress

The sector focus groups pointed to the significant economic impact of the pandemic and the contribution of ongoing, extended lockdown periods on the rise in clients presenting to services in financial stress. The most common causes of financial stress related to the loss of employment or income, which often put pressure on families and contributed to heightened tension, particularly as it compounded the likelihood that people were at home together. Practitioners participating in the sector survey explained that financial pressures could mean that clients simply did not have any credit on their phone to be able to engage in services.

This was similarly highlighted in the qualitative responses of the sector survey, with practitioners describing the financial security needs of their clients during the pandemic.

> "Due to job losses and financial impacts of COVID, more clients seemed to be experiencing financial struggles or housing needs due to the perpetrator being home more."
>
> **Family violence service, suburban area**

> "People were more focused on immediate material aid and support, such as financial support, food, housing etc. It was hard to engage in therapeutic work when basic needs were not being met."
>
> **Family and relationship service, CBD**

Examples within the sector focus groups explored the frequent intersection between financial stress and family violence risk, as victims and survivors who had lost their employment or source of income were unable to manage their financial needs and moved back in with the person using violence.

Other examples of the way in which financial stress could escalate family violence risk involved people using violence having to sleep in their car after losing their employment and stable accommodation, which could lead them to return to the family home to seek food, a shower and somewhere to sleep, regardless of whether this was a breach of a Family Violence Intervention Order (FVIO).

Many practitioners described the impact of financial distress and job losses on all facets of life.

"… parties are all at home together, schooling from home, working from home or one or both parents have lost jobs or been stood down. So, there's financial pressures on the family and, you know, increased substance use or alcohol in the house or whatever it might be. It seems that they all followed a pretty standard trajectory in a lot of those applications (for FVIOs). So, I think there's definitely something to be said of the additional pressures that placed on families."

Practitioner 63

"People didn't have credit on their phone, like, we had quite a lot of clients … who would drop off the radar and … some of them, it genuinely was because they just didn't have the money to have credit on their phone. And so, unless you called at a time that they could answer, they had no way of calling you back."

Practitioner 88

"… we were already seeing [increased family violence and complexity]. And then COVID came and then obviously with all the lockdowns, with people becoming financially strapped with people losing employment. Particularly out in those areas where there's huge mortgage stress … where people had really extended themselves financially, that became a huge stress for them …"

Practitioner 98

Participants in client interviews described the impacts of financial distress on their living situations during COVID-19. This was illustrated by the experience of one participant (Participant 13) who lost her employment and became more dependent on her violent partner, who remained employed. Others described the challenges of seeking financial support, particularly in the early stages of the pandemic.

"I couldn't work at the time, I'd just moved house and couldn't get Centrelink … because everyone was going through COVID so they couldn't even process what I'd put in for like 12 weeks or something."

Participant 14

"… the organisation wasn't sure exactly, you know, financially how they were going to cope. You know, thinking that … it's all doom and gloom and people are

not going to spend. So, they cut back on their budgets … I'm a contractor and so contractors are the first ones to go."

Participant 16

"I know the government … introduced this family violence scheme so female victims … could get up to $5000 … so with that they could set up themselves in accommodation or all sorts of safety measures, but I wasn't eligible because it was only for intimate partner violence for women."

Participant 8

"He was still working throughout the whole thing … [but my industry] completely shut down in July. I wasn't able to work … no income, he had that financial burden on me which I really couldn't do anything about and that just became the most controlling part of that with COVID."

Participant 6

"I had to spend over 12 months with a financial counsellor because debt had been created in my name … Just, uh, essential services, but you know, new furniture because he took it all, he pretty much took everything from me. You know, I'd saved in his account because he controlled the finances. He stole [thousands of dollars] and there was nothing I could do about it … It was a really tough two years. More financial support would've been great."

Participant 3

The case file review presented key examples of the impact of unemployment and COVID-19 related job loss on the emergence or escalation of violence. There were multiple case examples where the perpetrators' recent unemployment as a result of COVID-19 had exacerbated their use of violence within the family. In one instance, the perpetrator was described as out of work and home with "little to do", which resulted in an overall escalation and increase in the client's exposure to violence (GS13). Another case file documented how a perpetrator who lost his job because of COVID-19 started using financial abuse towards the client. While the detailed nature of this financial abuse was not provided on file, it described the perpetrator's unemployment precipitating arguments about his gambling habits, in one instance resulting in him strangling the client for approximately 15 seconds (IT9).

Narratives in the case file review relayed the limited job opportunities and financial distress experienced by victims and survivors as a result of COVID-19 and its related lockdowns. In one case example, the client had recently

relocated to a private rental in a new area after a stint in crisis accommodation at a women's refuge, but then had no success in securing a job because of COVID-19 related business closures (IT5). Another case file highlighted the difficulty in securing employment after family violence incidents for victims and survivors on precarious work visas or those who had never before worked in Australia (IT10).

Within the sector focus groups, practitioners acknowledged the positive impacts that measures introduced by the federal and state governments, such as increased welfare benefits, as well as rent and debt collection moratoria, had on people at risk of family violence. For victims and survivors, the increase in Centrelink payments enabled many to escape family violence as they were able to afford to live independently and support themselves and their children, without relying financially on the perpetrator. In these instances, not only was the physical safety of the victim-survivor protected but this alleviation of financial stress and the creation of financial independence had positive flow-on effects, such as improved mental health and increased capacity to care for children.

While the loss of employment in the early waves of COVID-19 was a significant factor during 2020, the withdrawal of COVID-19 supplements in 2021 was actually volunteered more frequently by practitioners as impacting significantly on their client base.

> "I did a lot of intakes … and I'd say as an indirect factor … so people who had never used violence before, using violence for the first time … when there was the loss of the COVID supplement, like JobKeeper and then … the coronavirus supplement for JobSeeker … that was like incredibly evident in 2021 of that financial stress and burden."
>
> **Practitioner 42**

> "The COVID supplements for Centrelink made a huge, huge difference to clients, what they could do, what they could afford, their level of just life standard in general, and also homelessness knowing that your clients, if they were homeless would be put in a hotel but now they're not … I mean, they've suddenly gone back to these ridiculous incomes that they can't live on, they can't afford housing. Especially like, where I am in the legal service, like that's petty crimes leading to that drug use."
>
> **Practitioner 47**

Qualitative responses within the sector survey also identified the effects of the winding back of economic measures on the lives of victims and survivors.

> "Initially, clients who received crisis Centrelink payments and an increase in their unemployment benefits to match the minimum wage, were able to move out of their usual crisis mode and engage meaningfully in parenting psychoeducation. I experienced some significant changes for the first time for many of my clients and could see the possibility of truly breaking the intergenerational cycle of poverty and violence for these families. Then, when these payments were dropped, I watched clients return to a constant state of urgent need requiring crisis support, where engaging in parenting psychoeducation became more difficult as clients needed to be focussed on the daily push to survive and seek food vouchers, free food from support centres, again experiencing deteriorating mental health for themselves as well as their children and a return to family violence in the home."

Parenting program, suburban area

Within sector focus groups, financial counsellors told of how financial distress was created for clients who had used "buy now/pay later" services during the pandemic and were unable to meet these repayments on their reduced income. While moratoria by governments, banks and other agencies on rent and debt collection alleviated financial stress, financial counsellors described how the financial relief that they provided was only temporary and often not properly communicated to clients. In some cases, this lack of communication about the nature of the moratoria on debt collection resulted in unexpected and dire financial outcomes.

> "ATO and Centrelink stopped all kind of … collection activity during COVID and the banks were giving automatic, you know, blanket hardship out, just tick a box basically to everybody. All the Councils stopped collections, so now they're all starting to ramp up the collection activity … It was almost creating problems because there wasn't the understanding out there in the general population … of what the three months or six-month holiday means … that the debt then was going to be accrued at the end of the hardship.''

Practitioner 40

> "Likewise with utility bills. I mean there were no disconnections. So, it's not uncommon now to see utility bills of $5,000 or $7,000 that are still connected.

> And you can imagine how that affects the client themselves to see the bill come in and they think 'How the hell am I going to find $5,000 to pay this?'"

Practitioner 35

Practitioners explained that this was more likely to occur in instances where banks and other agencies had automatically granted clients' 'hardship considerations' without properly examining the circumstances of clients to assess whether they were eligible. The lack of oversight resulted in inappropriate decision-making and did not properly inform clients about their financial obligations when the moratoria lifted.

> "I think those banks, government departments, what have you, they went with a process that was quick and easier, checked the box because they couldn't ramp up their support areas to provide the same sort of oversight of these requests that they would normally do in normal situations. So, that was the only way they could deal with the volume, was to have a very arbitrary tick the box and take the word of the person requesting the assistance. And whilst there might have been letters that might have then gone to the client or whatever, once again the way that those letters are often written, for the basic man in the street sort of thing doesn't really understand the true consequence."

Practitioner 34

These decisions had flow-on effects, with victims and survivors not knowing that their partner had been granted a moratorium on their rent or utility bills, nor that they were liable to repay the debt when it was lifted. This meant that financial counsellors were using an increasing amount of their time advocating for waivers for clients who were victims and survivors of family violence.

> "Creditors were responding with a COVID look at things, as opposed to family violence. It was like a hardship [lens] … And we were always trying to advocate that it was different to a hardship lens or hardship approach, and it was a family violence lens that they needed and it was really frustrating. So, we were saying 'we need to get a waiver', and instead it was 'oh we'll give you a moratorium under hardship', you know".

Practitioner 36

> "I had that recently with a car loan and they were treating it as hardship because they wanted all of her pay slips and everything, and it wasn't relevant at all. We

> wanted to get her name removed from the car loan. He had the car, he [had claimed hardship] and was missing payments … they kept harassing her for the debt and because he kept making these late payments and I had to jump through hoops to get her removed from the loan."

Practitioner 38

The lack of capacity to understand family violence, as opposed to financial hardship, was one of many examples of service system problems that pre-dated, but had been compounded by, COVID-19.

> "My client had escaped family violence … her car was her remaining asset, albeit that she owed more than the car was actually worth. But they were wanting, you know, her to surrender the vehicle. …. I just couldn't get it through to them that 'do you realise she's walked away and left any sort of assets or anything that she had, and this vehicle is the only thing that is giving her some sense of independence and safety?'. And you know that concept was very, very hard to get across to the male hardship person at this organisation."

Practitioner 34

While the decision to allow superannuation withdrawal alleviated financial stress for some, practitioners across financial counselling, legal and specialist family violence sectors unilaterally agreed that this decision would continue to have long-lasting, negative effects for victims and survivors of family violence.

> "I had pretty much every single one of my clients access their super early. And, you know, that is going to leave them in a lot of financial hardship later on in life. And I honestly think it was almost every single one of my victim-survivors in 2021, accessed their super early and, like, just thinking about those really long-term impacts … It's really scary".

Practitioner 32

Practitioners working in financial counselling services identified a spike in first-time users of their services, including asylum seeker families who were unable to access government support payments during the pandemic and were more at risk of not knowing or understanding the conditions of the moratoria. Also raised was the lack of access to other social supports that women on temporary visas faced.

> "The big issues for women on temporary visas were, for example, the lack of recognition that women on temporary visas would be here and had no access to social supports. Women on temporary visas experiencing family violence is an entirely different kettle of fish to a person who might be able to access Medicare services, Centrelink, the payments JobKeeper, JobSeeker."

Practitioner 72

Practitioners across services spoke about other ways in which women on precarious visas were impacted. Many who had applied for partner visas, which would then make them eligible to access Medicare, often had to remain with their violent partner or face a prolonged process of trying to prove their experience of family violence.

> "People who have applied for partner visas who can be eligible to access the family violence provisions, you have to … either give them a final family law order … a final intervention order, or … get your social worker to write a letter of support, but they have to actually do a statutory declaration … and then you'd have to get like your GP to do something, and it's all of these processes … and you have to pay for those … And also, the definition of what family violence is in migration is … physical injury or you have to show evidence of a mental health plan … and whatever mental health condition you have has to be linked to the family violence. So, it's really specific and … there's no explicit mention of any other types of family violence. It's physical or mental, but they don't really go into what mental could be like."

Practitioner 71

Practitioners recalled a case in which a woman who had experienced sexual violence from her partner was not successful in arguing eligibility for family violence provisions because it was not deemed to be a physical injury.

Participants in client interviews also described varied access to COVID-related financial assistance, with some finding additional support particularly helpful in the context of their experiences of family violence.

> "I got a government grant during the lockdowns, so I bought a car and it's paid off now. And I found the Uni Lodge was offering a room which was quite affordable … and they haven't raised rents on me yet."

Participant 8

> "I think we got like $750 or was it $250 or something from the government as like a few times that you got payouts and then … when I wasn't working, I had to claim something each fortnight."
>
> **Participant 2**

> "My daughter stayed in day-care, and I accessed 12 weeks of government funding, so I didn't have to pay for 12 weeks of childcare fees, which was a huge help … And because I was an essential worker, even though I was off work, they just were like … 'we get the situation you're in' … I've been at that day-care since I returned back to work … So, they were like, 'you're fine'. And, you know, I think without them as well, like, the childcare staff was so supportive. They knew what was going on. They had photos of him up at the daycare. They still do. So, they know, you know, to never hand her over."
>
> **Participant 5**

Other clients, however, were excluded from accessing support or had accessed it but later found themselves in significant debt when they had applied for it incorrectly.

> "… everybody was getting that extra COVID payment. But I didn't get that because I'm on Carer's payments not parenting payments, so it was quite frustrating to have my friends get it and, you know, still whinge about the prices of things … it's hard enough as it is being a carer because you've got to be able to pay for all the therapy and all the devices … I feel like it put me more in debt, to be honest, COVID did."
>
> **Participant 12**

> "[I received], JobKeeper, or whatever [it] was called and then realised, because I was self-employed, I should have been paying three times what I [was] paying … and when it came time to do my tax which was nearly 12 months late, and I did it and went 'oh shit'. Like, I didn't realise that. I was still putting away and here am I thinking, 'right'. Yeah, because it was not explained to me properly."
>
> **Participant 6**

Safe and secure housing

Access to safe and secure housing during the pandemic was another foundational need reflected across the focus groups. At both a pragmatic and policy level, COVID-19 created challenges to accessing secure accommodation. For example, many clients experiencing family violence no longer had access to informal accommodation options through extended family, which was a significant factor for some.

> "Even when we weren't in harsh lockdown, just people … being really reluctant to have additional people in their house, but also then that internalised worry for the victim-survivor of not wanting to … have that conversation or put anyone under that pressure to have to kind of take them on in their home environment."
>
> **Practitioner 42**

Services working with young people in the context of housing and homelessness echoed the loss of opportunities for clients to 'couch surf' with friends and escape family violence at home. This, combined with restricted access to school and face-to-face services, led to fewer eyes on potentially escalating violent situations.

> "Our young people don't have credit, or they don't have internet at home. So, that was a massive barrier to finding out [about their risk profile] straight away. So, it was then days or weeks before we could get on to our young people and have heard like, what's been going on, and being able to help and support. Whereas now we're back on site, if something was to happen the night before, that morning, we see them that day, they come to the school to seek that support. It's a hard one, that one."
>
> **Practitioner 41**

At a policy level, the initial provision and subsequent withdrawal of crisis and longer-term housing during the pandemic had both positive and negative impacts for clients with housing needs. Government initiatives such as the Homelessness to Home (H2H) program and the use of otherwise unoccupied hotels as crisis accommodation were generally described by practitioners as being based on "good principles". Practitioners also noted, however, that these initiatives could pose significant challenges and safety risks for clients either experiencing or using family violence as a result of what was described as the "chronic lack of awareness within the housing sector about family violence risk and how to mitigate it" (Practitioner 127).

Victims and survivors who had voluntarily left the home were, in many cases, considered ineligible for specialist family violence support, instead being deemed to be part of the general homeless population. Practitioners spoke of the need to ensure that people using and experiencing violence were allocated crisis accommodation in

different suburbs, as well as keeping clients with complex AOD and mental health needs separate from victims and survivors who were living in crisis accommodation with their children.

> "We tried to manage the hotels for different needs ... But there's also that really, like, that harsh reality of demand … it got to the point where we've got these people that are living with such complexities and such trauma and backgrounds, … and also potential perpetrators of violence with victims and survivors in the same hotel."
>
> **Practitioner 43**

The nature of the accommodation was a primary concern for practitioners working in housing during the pandemic, because of the "appalling conditions" of some of the crisis accommodation hotels. These were described as budget spaces that had inadequate facilities and were not built to maintain individual safety. As the practitioner quoted above went on to explain.

> "… it was great that we always knew where all these like really hard to reach, really vulnerable clients were for the first time but at the same time we knew that there were just a couple of doors down from their ex potential perpetrator, like people that they like went to jail with, someone that bashed them at their old house. Like all these kinds of histories just kind of percolating altogether … and the people that work there aren't trauma informed and … also the drop of a hat they're calling the cops … Some hotels [were] having cops every single day. So, you've got like, vulnerable women and children trying to escape violence and trauma at these hotels where there's cops there every day and violence there every day. … I think the way that the system works, where victims and survivors of domestic violence initially start off in Safe Steps or the Orange Door and their accommodation, and then they get transferred to generalised homelessness, I think, yeah, it's terrible."
>
> **Practitioner 43**

Services explained that some hotels were now refusing to accept their clients, including those escaping family violence, because of negative experiences managing hotel residents during COVID-19. This resulted in fewer available short-term and emergency accommodation options in 2022, with practitioners explaining that:

> "… if you're ringing from an organisation, it's been completely tarnished, regardless of whether the person you're putting in there is a Mum with three kids, you know who has mental health issues or AOD issues. They just don't want to know."

Practitioner 98

One housing practitioner shared an example in which a person experiencing violence was accused of causing property damage to her hotel room and was subsequently asked to leave the hotel. The practitioner explained that this damage had occurred when she was being assaulted by her ex-partner from whom she had been in the process of escaping.

> "… we had one client, I was trying to get in touch with her, and she wasn't there and, like, two weeks later, someone at the hotel was like, 'Oh yeah, … you know, she was covered in bruises.' And I said, 'But why didn't you tell me?' And it's like, 'Oh, we didn't think it was relevant …. My last job was like a plumber or a builder or something and I don't know about family violence.''

Practitioner 127

Another government-initiated housing response during COVID-19 that had both immediate and longer-term impacts for clients was the re-location of large families in public housing towers to private rentals across the outer suburbs of Melbourne. Not only did this have immediate impacts on the families themselves, but also on the other residents who remained in the public housing. This was because, in some cases, members of the general homeless population who had acute AOD and mental health needs had been moved in, causing significant angst and safety concerns for other public housing residents, including young families.

The relocation of large families out of the towers and into private rentals had some benefits during the pandemic, giving them more space and improved amenities. These benefits for many have proven to be short-lived, however, with the rise in demand for rental properties resulting in private landlords increasing rent and the tenants,, therefore, being relocated again to cheaper accommodation, often in suburbs where they had no established connections or support networks.

Housing practitioners also described the increase in Child Protection notifications for the children of women fleeing family violence, where the victim-survivor had no accommodation options other than hotel crisis accommodation and was therefore considered by practitioners to be exposing her children to unacceptable levels of risk and harm. These notifications generally came from housing practitioners themselves, or from police after attending incidents at the hotel. Practitioners who participated in the sector focus groups observed instances of "mothers being punished for their inability to manage the risk posed to them by the perpetrator" (Practitioner

127), despite their ability to protect their children already being compromised by the level of risk that existed in crisis accommodation.

Participants in client interviews also described significant issues accessing safe and secure housing during COVID, as well as in the aftermath of the pandemic which saw rental shortages in 2022, particularly in regional areas.

> "I got assessed by Safe Steps as being at risk of family violence and they offered me short term accommodation … but what about after? … I called them a second time a few days later and they tried to deter me from going to the crisis accommodation … because a lot of them apparently had problems with stealing, drug use, and suggested it was better that I stay home …"
>
> **Participant 8**

> "I did want to leave the house that we all lived through that for – I didn't think the girls were coping too well with that. Yeah, but there were no houses available. They were more expensive than where we live now. So, we moved back in."
>
> **Participant 6**

> "I had two weeks to move. So, I literally had to take the first and only thing that that was offered. Like you, you weren't even getting on the list, basically because there was such a shortage … And so that's why I accepted something that's not in the right location, that's not in my budget – because we have a house … it means I now have to spend two hours a day travelling to keep [the kids] at the same school."
>
> **Participant 15**

> "I'm on the waiting list now to be transferred and we're on priority because as soon as I can move to [regional location], it's in new court orders that I actually get more time with my [child]. But COVID has pushed out the waitlists … And now the floods have just made it worse again. … in society I'm classed as a 'houso' and low income. So, you get put into this bracket automatically and you are looked down upon and then the government choosing their little groups that

they wanted to help didn't help that situation at all. It probably isolated housing commission people even more."

Participant 12

Families living in 'pressure cooker' environments

Wider research has reported that the impact of the COVID-19 pandemic on family life included increased stress and tension in the home and "more conflict between family members" (Fogarty et al., 2021). Echoing this, and in addition to the immediate material support needs described above, practitioners participating in the Future-proofing Safety research described an increase in clients seeking parenting support, as they struggled to manage additional childcare responsibilities and remote learning as well as their own needs, such as mental health, employment loss and substance misuse.

Notably school closures were identified as having both positive and negative impacts for clients with family violence needs. Some examples of the positive impacts for some families emerged across the research, with the presence of children and young people in the home acting as a protective factor for victims and survivors, where violence was not enacted when the children were home. In some cases, the closure of schools was also said to reduce and alleviate risk and tension between young people and their parents, particularly in cases where school refusal was previously a source of significant conflict.

More commonly, however, the closure of schools also created or compounded family violence risk. This was in part because it reduced the ability for victims and survivors to have time away from the perpetrator during school pick-ups and drop-offs and limited the oversight of the school on the wellbeing and physical presentation of families, where family violence was present. School closures could also restrict opportunities for young people to disclose their experiences of family violence, with services observing an increase in family violence disclosures when schools returned to on-site learning.

While children and young people were permitted to attend school for on-site learning during the first two years of the pandemic if they were 'at-risk', examples were provided of eligible children being kept home because the perpetrator refused to disclose the family's vulnerability to the school.

Practitioners reported that some Aboriginal families and families from CALD backgrounds faced unique challenges in managing the COVID-19-related impacts on work and schooling arrangements, often as the result of entrenched disadvantage, systemic barriers accessing culturally specific support and having low literacy in English. Many also had limited access to technology and thus struggled to support children to engage in school.

The impacts for some families were exacerbated by the over-crowding of their living conditions, particularly in public housing, with some clients living with multiple children and several adults in a two-bedroom unit. During this time commentators described these lockdowns as "disproportionate and extreme … [with] the more than 3000 residents publicly humiliated and dehumanised" (Tu, 2020). These commentators more specifically reflected

on the "disproportionate levels by which migrant women have been affected by the pandemic, with job losses, higher levels of domestic duties and family support work … [noting that they] are at higher risk of family violence and social isolation, yet are less likely to have access to the information, support and services they need."

Practitioners similarly commented that the impacts of this overcrowding often fell disproportionately on women and girls, where safety was compromised or where families defaulted to gendered stereotypes about work distribution.

> "It was a human rights issue … the biggest flat on those high rises, is three bedrooms … why would you assign people, … 9 or 10 or 12 people in a 3-bedroom flat? It's the same politics and it's the same decision, you know, with no intersectional lenses in that space when they made this decision for the hard lockdown."
>
> **Practitioner 49**

> "[Sometimes it was] 'We've got all these people in the house now; you need to pull your weight and be cooking and cleaning' and all of that."
>
> **Practitioner 30**

> "We were really concerned about women being trapped in those towers with no support, trapped with perpetrators, you know, all sorts of issues."
>
> **Practitioner 18**

Practitioners described some families experiencing acute fear and anxiety following the government and police response to a COVID-19 outbreak at the public housing towers in inner Melbourne. Many practitioners described the experience as being "triggering" and "traumatising" for their client base, including children, with one reporting that her clients were frightened even if they were not immediately affected.

> "Some people were really scared. They were worried, especially when there was a lockdown at North Melbourne. I have some clients who lives in Carlton high-rise and one day around 11:00 PM one of my clients, she called me, and she said 'I can't sleep' … she just told me she stands next to the window, and I asked her 'why you have to stand next to the window?', she said. 'Oh, maybe if the police come to lock us down like the North Melbourne and Flemington.'"
>
> **Practitioner 92**

"… the high-rise housing towers and their hard lockdowns, that had … hugely traumatic impacts on the folks there, that sort of in our Child Youth and Family services was pretty challenging, and it hasn't stopped. The impacts are just continuing to roll on for families."

Practitioner 98

"We had more young people having clashes with their parents and other people in the house, siblings because they have to stay in so much, especially in the high-rise towers and lots of Mums very worried about, umm, you know, young men and their dads or stepdads fighting … We had a lot of trouble closing cases, maybe we still do because so many of the workers would just say 'I can't, I can't leave her in COVID. No, I'm just going to keep it open'. … we're meant to have maybe six sessions with a new parent … and a lot of them have been with us for 18 months."

Practitioner 30

Practitioners also raised concerns around the dynamics in separated families, as the impact of COVID-19 led to an escalation of family violence risk when separated parents were unable to see their children, which was often interpreted as further evidence of how "the system" was working against them. This included situations where access to supervised custody was limited or completely unavailable.

"… the men really feel like this already when they come to us, they feel the system is against them, and then you've got these additional things that 'oh, I don't get to see my children and there's no one to supervise'. You know, they feel that the system is even more against them … [so then] they've got less to lose, like they feel like 'I'm not seeing them anyway, I might go and see them' or 'It's my right'."

Practitioner 58

"Not having access to potential for supervised contact with children … combined with the restrictions meant that there were families not seeing their children,

respondents not seeing their children when actually the AFM wanted that to happen".

Practitioner 62

Participants in client interviews described different impacts of living in this pressure cooker environment. Some emphasised that it gave them time to reconnect with their families or that they valued the quiet. The majority described a particular concern about the impacts on children and managing the challenges of remote learning.

"… Gosh, they were just home bound. They didn't even want to go outside and play. It was taking its toll on them … Adults, we can kind of accept it, but the kids couldn't. They were still struggling to accept the fact that they couldn't get in the car and go to the shops, or we couldn't go to a different park, and it wasn't around the corner … When I did get to that stage of knowing that I could get the [kids] back into school, which was after [the person using violence] had left, that was so beneficial for them …."

Participant 6

"So, the two kids I have in my full-time care, they've both got ADHD and then one has got autism and as well. So, we do have to run a very strict routine and structure. So, it was really hard for them to go from 'you're going to school' to 'no, you're not, your home schooling' to 'you're going to school', 'no, you're not, you're home schooling' [and then it was] … 'we are moving again'. So yeah, it's mentally for them it's not been very good at all. There's been no stability at all."

Participant 12

"… because of COVID, [my mother was] saying 'I can't bear these lockdowns' and that's sort of what brought her to … go mad. But before, she's never been supportive … of my wish to transition to female. But now, ever since COVID started it's just gotten worse, she's become even more insulting and it's clear that she won't support me … For my mum it was mainly being locked down in the house, she didn't obey the laws anyway."

Participant 8

Some participants described making use of the exception to stay-at-home orders for people experiencing family violence, including one participant who left home within hours of an FVIO being issued and, upon showing the FVIO to police at a state border, was able to reach extended family in safety. More broadly, participants described the impacts of the lack of access to their usual supports that had been compounded by the stay-at-home restrictions.

> "I couldn't have that, the bubble thing, because he was still living here. I couldn't have my friend, obviously … So, I could only do the people within that 5km, which were my parents thankfully. If not for that, I would have been so close to just getting in the car and driving and just thinking 'you know what, I don't care anymore'. I didn't, I did the right thing, but if it wasn't for my family, I wouldn't. And that isn't to say I wanted to break the law or anything but … you do need people."
>
> **Participant 6**

> "I had to get family violence letters to say I could cross certain borders, the family violence people said they will create a letter for me to say that I need to get out of those zones for family violence reasons in case I do get pulled over by police … I also needed a letter from the [crisis accommodation] … because they know that I'm coming from a restricted area into a sort of an open zone … I also had to keep getting a re-updated letter as time went on or new restrictions, I guess as rules changed or things change then I might need like a different letter just to specify … So, the Orange Door were really good in supplying all those for me."
>
> **Participant 2**

Across the research, participants also described the impact of the withdrawal of certain activities, such as sporting teams, as well as the initiative that they took to keep themselves busy and engaged. Examples included re-engaging with church congregations through online platforms and taking up employment delivering pamphlets that meant that they could get out and get exercise within their 5km zone.

Reduced visibility of child risk

Findings from across the various data sources in the research, including in the sector focus groups, pointed to a significant reduction in the visibility of the risk to children, including children who may not have previously been on the radar of the Child Protection or family violence systems.

> "… children and young people, … even how they are visible or seen in family violence as victims in their own right and things too, I think is just massive, and I think COVID's really kind of made them more invisible."

Practitioner 98

> "I think we're quite a way away from having a kind of a sort of strong systemic response for children and young people and COVID did us no favours other than perhaps maybe highlighting a problem."

Practitioner 4

Some practitioners described creative use of certain mechanisms of the Department of Education to maintain a lens on vulnerable young people, or even involve statutory authorities where they had no other means of checking on a young person's safety.

> "… because we had that vulnerable student list … they had to fit a really strict criteria to be able to go on site … if they were higher risk or if we believe that they were at risk, we could add them to that list even if they weren't, I guess, on there originally, which was good. I think the other thing is that, because of the limited amount of outreach we could do, we use [and] involve welfare checks with VicPol more, which is something we hate doing but …"

Practitioner 41

Practitioners reflected on the way in which the isolation and stresses being felt by parents could have downstream impacts on children and young people.

> "I think kids have been less 'reached' if that's a word, through this time, because I'm not sure how the parents have been reached to be honest … parents have had to become teachers in most spaces as well …. And if parents are already, you know, struggling and not capable of parenting the way that children need then, you know, it's just been more overwhelmed … what I've noticed over this period, is that kids have actually isolated themselves more from their parents. And I think that's had a lot to do with technology, you know, and being in their rooms all the time. So … we need to hear from the kids at the end of the day..."

Practitioner 76

"… there were a lot of children we couldn't engage online and because parents were presenting with more challenges, more difficulties, more acute mental health symptoms, the holding of parents was pivotal to keeping children safe."

Practitioner 31

A crucial mitigating factor in the isolation of children and young people was the umbrella of the school environment, with negative consequences arising once this was no longer available. These findings build on research conducted during the early months of COVID-10 in which practitioners expressed concern for children and young people given that schools were an important source of referral (Cullen et al., 2021).

"… one of the big impacts has also been that young people and children are much less visible because they're not at school, and they're not seeing other services. And, you know, previously you might have a young person coming through a service and they're sort of those incidental opportunities to have conversations, if not a full risk assessment."

Practitioner 4

"So young people living with a parent with mental health issues or with a family member, schools were really important places for them to be identified but also for them to have time out. You know, so that was a place where their lives could be in a different space and demands might be different and they lost that. And I think that has not yet been fully examined."

Practitioner 3

"In the past, for example, we always got referrals from the school counsellors, and also some students go to the school to send emails to us. To say 'I don't feel safe at home', those things. And … we could go to the school and directly liaise with the school counsellor to book the room at school to have the counselling session with the young people … But then during COVID, it was really difficult because then how could they, like, have a reason to say that, 'OK, I will not be at home and I will be out'…"

Practitioner 59

> "… we've now got a crisis in our schools with teachers and shortages and classes being mixed, classes being cancelled, different teachers all the time. So, you know, the place that was once … this place where kids could go and it was regular, it was routine, it was consistent … And now they're going back, and it's all supposed to be normal. And the schools are in disarray, you know, and they can't provide any consistency. That's a double whammy."
>
> **Practitioner 76**

As a result of fewer opportunities to have eyes on and engage with children and young people, practitioners had to hold a lens on young people's safety, albeit in a reduced fashion.

> "… we were sort of the holding space to engage with young people over Zoom while they were in a train station or in a park or, like, needing to get out headphones, like, gift cards so young people could purchase data so they could contact us, touching base by Instagram, text, Zoom, things that were accessible to them and that will be safer for them …"
>
> **Practitioner 83**

As noted earlier, services working specifically with young LGBTIQA+ people described particular concerns about young people's safety.

> "… lots of kids who kind of [in] early adolescence were being stuck at home with parents who maybe were not particularly supportive of their identities, experiencing lots of kind of violence in that sense. And it was pretty difficult to try and provide support to them, very difficult for them to find a private space to speak to people."
>
> **Practitioner 99**

As noted throughout this report, what practitioners described as the "pressure cooker" environment of lockdowns and other COVID-19-related restrictions contributed to heightened risk for young people and their families, particularly those who were already at risk of contact with the justice system or disengaged from protective factors such as school.

"… the kids [who] were experiencing [family violence] would breach, you know, the lockdowns and they were getting arrested every five minutes, you know. And I mean, we're dealing with clients who don't tend to follow the rules anyway".

Practitioner 11

"… the online remote schooling I think also became an issue with the young kids, particularly because they were trying to remain engaged and connected with their friends, and that was often through gaming. And so, there were conversations that I had, in particular with single parent families because they were extremely concerned about the withdrawal behaviour when the kids got off their laptops and PlayStation … it was the regular use of that for long periods of time that brought out behaviours that probably weren't there before. So, … the emotional climate was a lot more heightened because of that."

Practitioner 91

Practitioners were particularly concerned about the compounded impacts of these issues on families from refugee or migrant populations or those who were otherwise marginalised. This included describing "young people being targeted, mostly the African and Pacific Island young people in the towers".

"And then trying to get the parents of these children that were given activities by the school and English is their second language. Trying to get them to teach and help their children through that whole process. I mean, it's cruel. It was just outright cruel. I don't have a second language and I found it hard."

Practitioner 93

"Most people who live in a high-rise, two-story bedroom houses, they have overcrowded families. The oldest ones, they need their own room when they there's online study. They can't do it. So, it was. It was really, really hard."

Practitioner 92

"… sometimes they'd have earphones, and they'd have four other people in the room. So, when they were asked to talk, they couldn't. And this is in spaces

> where they were in housing and it was overcrowded, and it was their reality. But this was their reality 24/7."
>
> **Practitioner 93**

Within the organisational case studies, the needs of children were not well represented, with data largely focused on the needs of the parent seeking support, with children 'attached' to a family case. This highlighted how data capture systems across services are not nuanced enough to view children as victims and survivors in their own right.

The Drummond Street case study, for example, saw a reduction in most child issues, but an increase in age-appropriate development as a primary reason for seeking assistance was highlighted. This aligns with what the research team heard anecdotally from its intake team and practitioners, including that a number of families presented with a 'child of concern' as a primary reason for seeking assistance. During the early contact with the client, however, it became evident that many were actually experiencing and seeking support for family violence related needs. Many of these clients felt that accessing a specialist family violence service would have been too high a risk for them and their families during lockdowns, whereas accessing a service to support the needs of their child was one way that they could safely engage with the service system.

Notably, of the 70 risk assessments that were assessed as part of the Case File Review, only two related to children. This was despite the fact that at least 57 had at least one child attached to the case. In almost all of these cases, the children were living in the home with the client. While the children were specifically listed in the 'Children' section in most risk assessments, some did not specifically list the children at all but described them in other parts of the assessment as living in the family home.

Within the Data Testing Workshop, practitioners described children being added quickly onto their mother's risk assessment, as many felt that they did not have the time, particularly during the pandemic to 'double up' with a second child-specific assessment. Others spoke about the challenges of not being able to ascertain sufficient information about children during telehealth appointments to complete their risk assessments. In cases where risk assessments were completed by the Orange Door intake team prior to referral, practitioners explained that services did not complete another risk assessment and instead updated risk in case notes as needed to monitor dynamic risk. Practitioners who took part in the multiple findings testing workshops acknowledged that, while this was not best practice, there were many constraints to working in a COVID-19 environment.

Participants in client interviews talked about the challenges that they had experienced trying to get support for their children during COVID, with particular examples nominated by participants feeling that there was not always an appreciation of their children's learning needs or the risk that they might have been experiencing by the schools that they were attending.

> "I said 'this is really hard … we can't do any schoolwork. We're getting pressure from the school to get schoolwork done … There's a family violence situation. They ended up referring [child] to get assessed for his learning and everything which happened like a year later. But … [child's] teachers were just hopeless. After speaking to the Vice Principal, he took it seriously and he allowed [child] to go to school for on school learning … But I just had no support from the teachers."
>
> **Participant 2**

> "… [the school has] known about that assault, some different things have happened and there's never been an intentional checking in of 'how's things going for your family' and you know, it's always had been me having to communicate, 'hey, just letting you know, we're moving house again. The kids might be tired'. 'Hey, this is happened'. You know if ... or if the kids are getting separation anxiety, you know it's always been up to me, so yeah, that does feel a bit frustrating."
>
> **Participant 14**

Participants expressed concern about the lack of eyes on children from police in the context of family violence callouts or FVIO applications.

> "I do get the sense they were really busy, but things were not followed up and really unhelpful decisions were made. You weren't getting the advocacy that you needed, so one example being that the children's names didn't end up on a family violence safety notice. Because they didn't follow up and advocate as they needed to, because the children were at the incident."
>
> **Participant 14**

Legal and justice service system interactions

While the research was limited by an absence of direct engagement with Victoria Police, Corrections Victoria or court employees, discussions with a wide cross-section of community and public legal assistance practitioners highlighted specific examples of how interactions with legal and justice systems had impacted their clients. Important to note, practitioners sought to highlight the particular impacts on victims and survivors where the

demand on police during the COVID-19 restrictions had taken them away from general or family violence duties or meant that they had less capacity to engage around the conditions of orders or to negotiate outcomes.

> "I guess it was quite disappointing or worrying to be talking about safety planning with victim-survivors and/or use of statutory responses that you knew wouldn't come if they need that … even just ambulances not being able to attend if there were serious injuries ⋯ So, it felt almost false, you know, what I was suggesting could be part of their safety plan …. And it felt, you know, risky, even sort of telling them that they could move around to seek safety..."
>
> **Practitioner 16**

> "… we didn't have police because they were all at the border … they took policing out of family violence, or the family violence units were heavily hit with workforce being diverted to go COVID hotels etc … they needed to have police officers but they didn't want to take it from the members who are out on the divvy van because the community would observably see the disappearance … I'm not saying that their decisions were wrong, but everything had a roll-on effect."
>
> **Practitioner 2**

Legal practitioners also noted that police were not available to support safety in mental health crisis responses.

> "There were less police around to come out so there was a real kind of attitude about managing this crisis within the family, that was the message. Basically, unless the person's sort of in a pool of blood and I'm not being facetious, then you know maybe do something, but other sorts of things you manage in-house."
>
> **Practitioner 3**

Practitioners also noted, however, that some Victoria Police initiatives worked well, such as checking on risk in families through the justification of checking on compliance with COVID-19 related restrictions. As one practitioner commented "the story is never one way or the other, it's always both" (Practitioner 2).

Contrasting with this concern about perceived police absence from a family violence or mental health response, practitioners also sought to highlight the way in which the disadvantaged communities with which they worked

had been disproportionately targeted by police, given that these communities were potentially more visible than other cohorts.

> "… the youth team where I was based, my office was in [area of Melbourne], where a lot of the kids didn't follow any of the rules. So, it's pretty easy to find a bunch of teenage boys running from the police and now the army so that was interesting, you know, asking me if they can hide in my boot and drive them to the other side of town. Like, 'no, you can't'."
>
> **Practitioner 15**

> "[I saw] a lot of young people being sort of fearful and concerned about interactions with police … even if they were to do things that were legitimate … they didn't trust that their reasons [to leave] would be listened to because of the way that they looked or their hair, or their piercings or tattoos or whatever. They were just kind of looking at me like 'you're crazy, you know, I'm not going to have a positive interaction with the police.'"
>
> **Practitioner 14**

> "I have been clearing people's fines that they got during COVID … like the DWB, 'driving while black' … their cars were identifiably Aboriginal as in stickers and shit on them and my clients were getting pulled over if there was more than one of them in the car and they would all have to show their ID. Now if one of them had a different address on their ID, they got fined for being with somebody that was not from their household. And … even when my clients were saying 'I can't go home, I can't go home' and the police were like, 'well, you know, you've got an opportunity to, like, challenge that in the court.'"
>
> **Practitioner 127**

The impacts of interaction with police in the context of enforcing restrictions was described as particularly acute in relation to communities in the public housing towers that experienced "hard" lockdown in July 2020. Many practitioners described the ongoing impacts of what they saw as very palpable systemic racism.

> "[A client of ours went down to the shop at the bottom of the public housing tower] to get milk for his children and he wants to go back. They don't let him go

> … So, it was really, really the worst way of handling it. He said, 'my kids are inside, and the Mum is not there. I want to go back'. They said no. So, it was a huge fighting. And it scares people … Unless you see it, you don't believe it."

Practitioner 92

> "A lot of people, they were thinking that the police are soldiers. That they are not police … So, during COVID-19 there came a lot of racism, a lot of kids from, you know, non-English speaking background who were living in the Housing Commission. They are still angry. We need time to recover. We need money to actually speak about openly putting it there. Speak about racism. We can't afford to not say the word racism."

Practitioner 90

Practitioners described challenges where police were the only statutory authority in their client's lives and no aspects of the system were supporting a proper inquiry into women and children's circumstances.

> "… there'd be a family violence callout, the police would attend, our clients might get verbally aggressive and that then starts off a chain reaction. [Police] then seek family violence safety notices, which will then prohibit all contacts [including] any children there. There's absolutely nobody with eyes on the children, other than the police at that initial contact …"

Practitioner 88

Participants in client interviews highlighted particular challenges with police and the legal system during COVID-19 – including in the context of experiencing ongoing systems abuse from their current or former partners. These were systemic issues pre-dating COVID, particularly around the tension between the Child Protection and Family Law systems, as well as perpetrator tactics in terms of 'conflicting out' victims and survivors from accessing certain legal assistance. Some of these experiences are shared in the next section of this report.

Recommendations

The Future-proofing Safety project highlighted the heightened and diverse range of health and wellbeing needs of clients seeking support for family violence and sexual assault during COVID-19. For many, the ongoing lack of access to services and supports induced by COVID-19 restrictions, and its impacts on the sector, has led to these

needs becoming more acute, severe and entrenched. Practitioners participating in the research were strongly of the view that the intensified risk and complexity of client need would continue to have an impact into the future, representing an ongoing surge in demand. A concerning gap that this project highlighted was the blindness of many services to the needs of children and young people during COVID-19, putting many of the most vulnerable in the community at risk. The research also highlighted the ways in which some communities faced additional layers of disadvantage, due to the way that systems and structures impacted some communities more severely than others. The impact of racism and how it played out in relation to COVID-19 restrictions was particularly salient for people from First Nations, multicultural and multifaith communities.	
Government, peak bodies and organisations	• Develop immediate plans to respond to the current and acute needs within the community that are not being adequately met following the return to ostensible "COVID normal" service provision. • Develop Crisis Readiness Plans to improve responses to future crises and disasters which consider and address the needs of communities who have historically experienced disadvantage. • Prioritise the needs of children and young people during a crisis. This should consider targeted ways to support children, respond to needs and manage risks.
Government	• Further invest in the development of cross sector intersectional practice to break down some of the structural barriers that continue to disadvantage specific communities. • Address the long-term impacts of crises and the ways in which crisis-induced service demand and complexity of client needs can continue to spike well after the crisis is considered over. • Support the response to the current crisis through greater funding to increase the service capacity of family violence, sexual assault, mental health, AOD, housing, family support, child and youth service system to meet and support system-wide recovery across a broad range of complex client needs. • Lead co-ordination and collaboration between sectors to enable knowledge-sharing and wrap-around service delivery for clients with complex and co-occurring needs. • Consider how mental health reforms review the escalation of family violence, sexual assault and co-occurring client needs that occurred during COVID-19. The reform agenda must enable collaboration and integration of the service system as

	a whole, to enable effective support for clients whose needs often exist across sector boundaries. • Consider how data capture processes can be reviewed and refined, with greater consistent data capture across organisations to better inform planning and recovery responses. • Prioritise responses to the needs of children and young people. Funding should be allocated to services to provide specific holistic supports to children and young people to support recovery. • Invest in emergency accommodation and public housing so that there are safe accommodation options for people fleeing violence, particularly during crises. • Consider the safety and risk of victims and survivors when implementing housing policies or measures. This could be codified through agreed-upon principles, such as victims and survivors not being housed, even temporarily, in the same hotels as their perpetrators. • Review the MARAM practice guidance and tools related to children to identify how child risk might be better captured and managed as part of current legislative risk assessment and management processes. • Support the service system to improve how risks to children are captured in family violence risk assessments within the MARAM framework and expand training across multiple sectors should centre the importance of capturing and managing child risk in the assessment and management of risk.
Peak bodies	• Work with government to support better coordination and collaboration within and between sectors. Enable knowledge-sharing to support wrap-around services delivery for clients with complex and co-occurring needs. • Support member organisations to centre the needs of children and young people, including child specific risk and needs, working with the sector to identify possible improvements in this area.
Services	• Establish partnerships and foster collaboration with a broad range of other organisations across sectors. • Consider the ways in which services can be made more accessible to those who experience intersectional barriers to safe service access. • Consider how data capture can both improve client responses and facilitate better-informed organisational responses and decision-making processes during crises. • Consider the needs of children and young people as victims and survivors in their own right to improve service responses for children and young people.

- Develop and optimise support for children and young people across a broad range of health and wellbeing needs. This may be through specific services, partnerships with other services or through providing training and greater support to staff.
- Support staff to improve risk screening for children and young people, as part of the MARAM framework. Where staff are not completing child risk assessments, this should be explored and remedied. Where necessary and needed by staff, training should be provided to build their capacity in this area.
- Services should support staff to capture client risk within risk assessments rather than in case notes. Staff should update MARAM assessments when client risk changes and keep up to date notes which is particularly important in times of crisis, so that up-to-date information about risk can be easily found in the event of staff absence or turnover.

Changes in the types of family violence during COVID-19

Changes in the types of violence and abuse experienced and used during COVID-19 was something explored in the sector survey, sector focus groups, case file review and, to a lesser extent, the organisational case studies. The various sources either identified the types of violence that were commonly used during the COVID-19 period or highlighted the ways in which new forms of violence emerged, with people using violence leveraging and weaponising COVID-19 and the associated restrictions.

New forms of family violence developed in the context of the pandemic have also been found in overseas research (Lyons & Brewer, 2021). People using the virus and health as an additional tool for control within a relationship; for example, hiding insurance information, denying access to masks, and threatening to get family members sick on purpose (Leigh et al., 2023).

Key findings

Sector survey respondents described growth in the frequency of all listed types of violence and abuse, with the most common being: insults with the intent to shame, belittle or humiliate (from 59% prior to COVID-19, to 73% during COVID-19); damage or destruction to property (from 46% prior to COVID-19, to 62% during COVID-19); and preventing or attempting to prevent contact with family or friends (from 38% prior to COVID-19 to 56% during COVID-19).

The **case file review** highlighted some of the more common forms of abuse during the pandemic. Of the 70 case files examined, 14 had no risk factors ticked – this included two child risk assessments which were blank. The remaining 56 examined highlighted the high levels of AOD misuse by people using violence, an increase in jealous

behaviour, mental health issues, and violence escalating in frequency and severity. Worryingly, the risk assessments also highlighted high rates of threats to kill, threats to self-harm or suicide, causing serious harm to victims and survivors, and high rates of financial abuse.

Practitioners who participated across all **sector focus groups** highlighted some of the ways in which COVID-19 itself was weaponised as a means of family violence. During COVID-19, particularly during lockdowns, managing needs and safety was much more difficult and complex, which in turn made it easier for people using violence to cause harm. This included the leveraging of certain types of Government supported assistance, such as the access to superannuation or the availability of JobKeeper payments. Just as crucially, it included manipulation around border or travel restrictions, as well as stay-at-home requirements. COVID-19 itself was used as a threat or was directly weaponised in a physical form by people using violence as a form of coercive control used against family members, including exposing children to COVID-19 "hotspots"; knowingly trying to infect family members when COVID-positive; and using vaccination as a way to assert control, particularly over children.

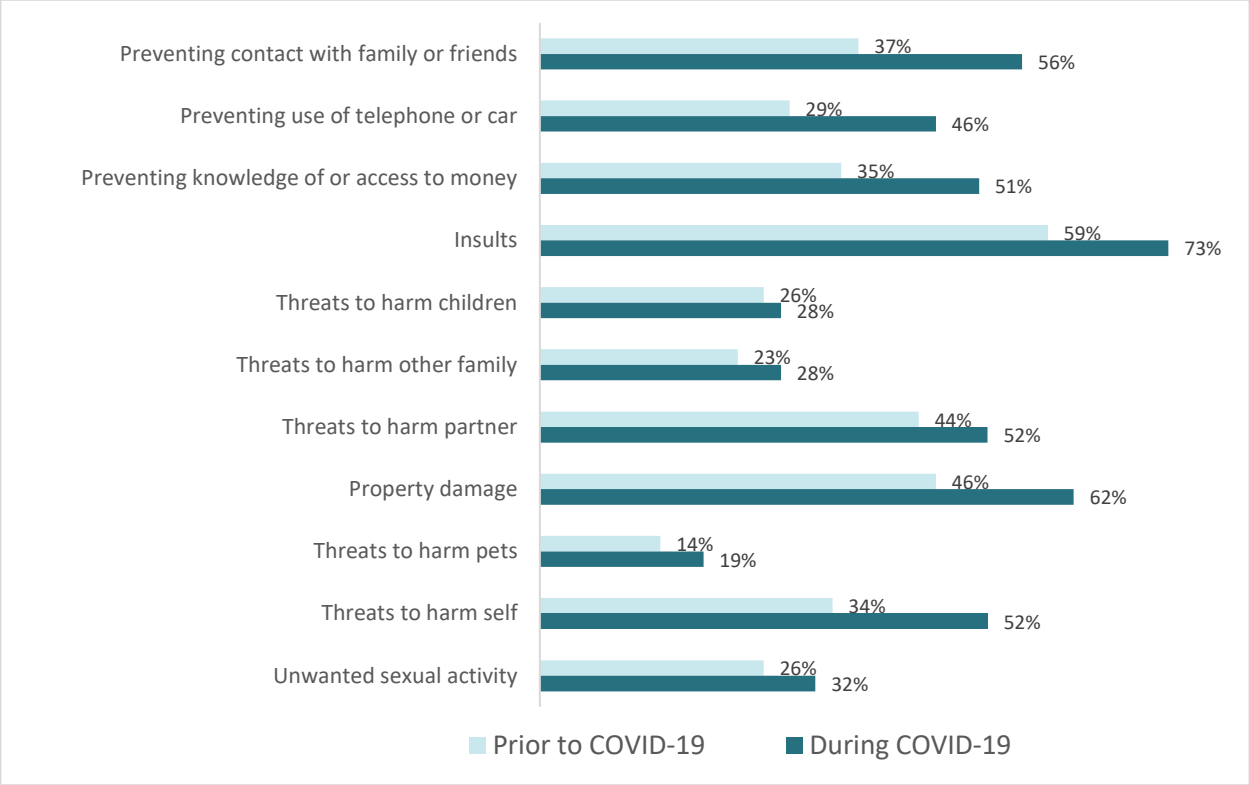
While the **organisational case studies** did not examine changing forms of violence directly, there were key themes that arose in each of the case studies relating to changes in the use of violence. Key examples seen across the three organisations included an increase in economic abuse, increases in isolation and controlling behaviour, technology facilitated abuse, pressure cooker environments where people were unable to escape harm, and the weaponisation of COVID-19.

Types of violence and abuse

The sector survey highlighted some of the ways that reported violence changed during the pandemic. During COVID-19, the highest proportions of reported types of violence and abuse were:

- insults with the intent to shame, belittle or humiliate (73%, cf. 59% prior to COVID-19)
- damage or destruction to property (62%, cf. 46% prior to COVID-19)
- preventing or attempting to prevent contact with family or friends (56% cf. 38% prior to COVID-19).

Figure 5: The proportion of respondents indicating that the majority (more than 50%) of their clients experienced the following types of violence and abuse



To view the tabular data used for this analysis, see Appendix C.

The **case file review** also highlighted the types of violence that were commonly experienced during the pandemic, in addition to highlighting some specific ways in which the pandemic and related measures either mitigated or escalated risk for people engaged in service delivery. While the limited number of risk assessments collected during the pandemic limited the ability of the research team to assess the types of violence that increased, the review was able to highlight the most common forms of abuse that were prevalent within the 56 case files (of 70 case files) where this information was available.

The results of the case file review align with other findings throughout this project, including the high rates of drug and alcohol use amongst people using violence (57%); mental ill health of the person using violence (50%); an increase in the severity and frequency of violence (45%); high rates of unemployment amongst those using violence (43%); and high rates of economic abuse (43%). Worryingly, other high-risk issues were present in a number of the risk assessments examined, including the person using violence threatening to kill victims and survivors (39%) and people using violence threatening or attempting suicide or self-harm (39%).

Table 6: Risk factors and appearances in risk assessments

Identified risk factor	Frequency of appearance in risk assessments (n = 56)[8]	Percentage of appearance in risk assessments
Perpetrator has recently misused drugs, alcohol or other substances	32	57%
Perpetrator has recently been obsessively jealous towards client	29	52%
Perpetrator has recently shown signs of a mental health condition	28	50%
Violence has recently increased in severity or frequency	25	45%
Perpetrator is currently unemployed	24	43%
Perpetrator has controlled access to money or had a negative impact on client's financial situation	24	43%
Perpetrator has seriously harmed Client	23	41%
Client has recently separated from partner	23	41%
Perpetrator has threatened to kill client	22	39%
Perpetrator has recently threatened or attempted suicide or self-harm	22	39%
Perpetrator has been reported to police by client or another for family violence	20	36%
Perpetrator has recently followed, repeatedly harassed or messaged/emailed client	18	32%
Perpetrator has forced the client to participate in sexual acts against their will	18	32%
Perpetrator has tried to choke or strangle client	18	32%
Perpetrator has breached or broken the conditions of an Intervention Order	17	30%
Perpetrator has committed a crime	17	30%
Client believes it is possible that the perpetrator could kill or seriously harm client	16	29%
Perpetrator has used controlling behaviours	16	29%
Perpetrator has threatened or used a weapon against the client	15	27%
Perpetrator has access to weapons	15	27%
Perpetrator has a history of being violent to previous partners, other family members or non-family members	13	23%

[8] Of the 70 files, 14 had no risk factors ticked – this included two child risk assessments which were blank.

Perpetrator has been arrested for violent or other related behaviour	11	20%
Perpetrator has assaulted client whilst pregnant	11	20%
Perpetrator has been to court or been convicted of a violent crime or other related behaviour	10	18%
Client has immediate concerns about the safety of their children or someone in their family	9	16%
Client has immediate concerns about the safety of her children or someone else in the family	9	16%
Client has pending family court matters	6	11%
Perpetrator is using stalking or harassing behaviour	4	7%
Perpetrator is about to be or has been recently released from jail or another facility	4	7%

The sector focus groups highlighted a number of key areas where practitioners across various sectors reported an increase in risk or the emergence of new types of violence or abuse. Worryingly, this included an increase in child sexual abuse and exploitation; increased sexual assaults related to drug use; the weaponisation of COVID-19 and associated measures; and increases in economic abuse, including economic abuse directly relating to COVID-19 economic measures.

Increase in child sexual abuse and exploitation

Recent research notes that an area receiving little attention during the COVID-19 pandemic was that of physical and emotional sibling violence (Perkins et al., 2021). Examining the increase to family stress during the pandemic and the potential for increased risk for physical and emotional sibling violence, this research also discusses the connection between other forms of family violence, including intimate partner violence and parent-to-child abuse. The findings from Future-proofing Safety help to contribute further to this discussion.

Linked to the lack of visibility or supervision of children, practitioners working in the sexual assault sector reported a noticeable increase in referrals for sibling sexual abuse, child exploitation, grooming and increased sexual assaults.

> "… we saw a big increase in COVID in the sibling sexual abuse in our [harmful sexual behaviours] program and a big increase in online behaviours. So, whether that was in relation to pornography or online grooming and things that I suspect during COVID and lockdowns, parents trying to work and be busy weren't as

across their children's use of online devices and things, and then a lot of them have discovered after the fact what had happened."

Practitioner 56

"So the one thing that's really stood out for me is sibling sexual abuse. And it was probably more late 2020, early 2021 [that] we started to see those referrals come through."

Practitioner 54

"We've also heard a lot from teenagers, under 18s, you know 13- to 18-year-olds calling us. There's been an increased calling us about concerns about sexual assault perpetrated on them or a friend, someone that they're concerned about."

Practitioner 57

"We actually found that we had an overrepresented section of young people between the ages of 12 and 15 … disclosing sexual abuse and that was particularly during that time of COVID where they were at home and often the perpetrator … was in the family and with a lot of the families, often the kids release would be going to school or going to friends' houses or when Dad was away or whatever. But everyone was stuck at home."

Practitioner 96

Increase in sexual assault related to drug use

Notably, practitioners working across several AOD services reported a link between clients (all of whom were identified as women) using GHB for the first time during COVID-19 and experiencing sexual assault from their intimate partner. Many of these practitioners described how this was often influenced by a significant increase in the use of cheaper and more readily available substances during COVID, such as GHB.

"So, we have started having more discussions with women about sexual assault from the intimate partner, under the influence of GHB and I don't think the sector is up to speed with that."

Practitioner 7

> "I have a client currently in the AOD sector who he's injecting her with ICE, but he's also putting GHB in her alcohol, she's lethargic all the time, passing out and then waking up to sexual abuse and strangulation. So yeah, hand in hand, GHB and sexual abuse."
>
> **Practitioner 8**

Financial abuse

Financial abuse relating to the COVID-19 financial measures implemented by the Federal Government was also highlighted in the sector focus groups. Many practitioners spoke about women being forced to withdraw their superannuation early by people using violence and the long-term impacts that this type of economic abuse was likely to have on women and children.

> "We did hear of women who were persuaded to withdraw their super … it didn't seem to be a very sensible policy. And it certainly really was not thinking of women in that."
>
> **Practitioner 69**

> "When we're asking how much super you've got, and they'll say 'none, because he forced me to take it out during COVID' because anyone could just apply, and it would go through with no checks or whatever … that was a big one that is quite common when people say they've got none left."
>
> **Practitioner 39**

Early withdrawal of superannuation by men was also described by legal practitioners as having a negative impact on women in the context of separation, as the early withdrawal of superannuation was often used as a tool to reduce assets.

> "We had a problem where men had accessed their own super, which effectively reduced the property pool that might have been available to our clients … because they would have spent it on lifestyle or a depreciating asset … it's frequently really just the male partner who's got the superannuation. So, we saw that money being withdrawn simply because people like the opportunity to get a bit of cash."
>
> **Practitioner 69**

Further examples of the financial impacts of COVID-19 were also identified in the elder abuse sector. Practitioners reported that older clients faced barriers to accessing or having control over their finances as a result of the closure of in-person banking services, while their lack of confidence with online banking services and the subsequent reliance on family members to manage their finances elevated their vulnerability to experiencing financial abuse.

> "We're having people call us and say 'I've just looked at my bank account. Somehow my son set up internet banking and, you know, I didn't authorise these transactions'... the older person couldn't get to the bank [in-person] and had to rely on other ways to do their banking or get help that they hadn't previously. I think we're just starting to see the trickle or maybe of those kinds of matters coming through …"
>
> **Practitioner 23**

Within the organisational case studies, Good Shepherd practitioners, in particular, highlighted the increase in economic abuse, with 90% of financial services practitioners indicating that they were seeing economic abuse in casework, while 67% of family violence practitioners indicated seeing an increase in economic abuse. Specific examples included victims and survivors being coerced into taking out loan guarantees; using the identification or fraud to access online credit; and perpetrators opening multiple 'buy now, pay later' accounts in the victim-survivor's name. Family services practitioners specifically mentioned cases where parents who were separating had to remain in the same home as a result of lockdown orders, with the perpetrator refusing to meet rent or mortgage payments.

The weaponisation of COVID-19

A growing body of literature explores the ways in which perpetrators of violence leveraged COVID-19 as a tactic in their abuse. These studies found that, in addition to violence increasing in complexity and severity during COVID-19, the social isolation and financial vulnerability of victims and survivors was exploited in the context of new and intensified behaviours by people using violence, which saw a weaponising of COVID-19 and a rise in intimate terrorism (Warren et al., 2022).

This was certainly echoed in the Future-proofing Safety findings. Within the sector focus groups, practitioners spoke about some of the ways in which COVID-19 and the associated restrictions were weaponised as a means of control. This included manipulation around border or travel restrictions, as well as stay-at-home requirements.

> "… when the NSW and Victoria border was closing, we had patients in our inpatient areas and perpetrators were putting pressure on them and feeding them with misinformation using the border closures strategically as a way to kind

> of pressure them to come back out … They just take that, any sort of stuff that's happening around government and those border closures, and they really exploit it. But the reality was, we couldn't necessarily get clear communication about the border closures either. So, you can't actually alleviate people's concerns if you know, 'well, when could I go back?' and 'how does that work?' And you're like,' good question'."

Practitioner 28

This was also a feature of the case file review, with examples of how travel restrictions impacted people's ability to keep themselves safe. In one case example, the client expressed a desire to travel to a different suburb area with her children to avoid stalking from the perpetrator's accomplices, yet felt that they were unable to do so, because of the 5km radius restriction (GS6). While the 5km travel restrictions temporarily improved safety for another client and her child - given that the perpetrator lived outside the 5km radius and did not want to breach restrictions - the perpetrator continued threatening to attend the client's house once restrictions were lifted (GS5).

Practitioners in the sector focus groups highlighted how people using violence also used the government's stay-at-home orders and confusion over what was and was not permitted in order to wield control.

> "We found a lot of perpetrators were using that confusion from the government with stay-at-home orders; 'You're not allowed to go out', 'You can't leave this house', 'You can't do anything other than what I tell you to', 'the shops are too dangerous', so women weren't even able to make a choice whether they could even seek support for family violence,.'"

Practitioner 32

There were also examples of how the stay-at-home orders limited people's ability to keep themselves safe if violence did escalate, because of the additional levels of control imposed by the state. Practitioners highlighted, for example, the impact of restrictions on members of marginalised communities, including LGBTIQA+ communities, who feared not being believed by police if they were stopped leaving their house as a result of family violence.

> "… people who are using violence will kind of use whatever is around to, you know, to control people. And so, when you've got like a higher level of control that's coming from government and police, then you know that is going to impact on young people and on the queer community more broadly. So, not just young queer people experiencing family violence, but others too … and we know there was exceptions on restrictions for being able to leave due to family

> violence. But you know, there was a lot of fear around who would be believed. Well, I suppose for young queer people in particular who are experiencing violence in the home that's coming from family, those kids often not seen as experiencing family violence."

Practitioner 99

The restrictions also led to innovative and new ways of people wielding control. One example was provided by practitioners working in AOD inpatient facilities, who spoke about the ways in which restrictions on visitors led people using violence to use different methods to stalk and harass people receiving treatment in these facilities. They described instances of perpetrators standing across the road of the facility all day, calling the facility's reception and pretending to be other family members, by using a different name each time or leaving a teddy bear or flowers outside the facility each day. Practitioners explained that this could have the effect of women being "stalked to exhaustion" and could result in them leaving the facility only days into their two-week stay.

The COVID-19 virus itself was also used as a threat or directly weaponised in a physical form by people using violence and coercive control against family members, including by exposing children to COVID-19 "hotspots" before returning them to another parent after contact visits.

> "I had one woman in particular who, she'd gone out to go to the shops, and the perpetrator located her, he had driven past, spat on her, and said 'get COVID'. She shortly [afterwards] tested positive. So, it was also kind of used as a bit of a weapon in that sense as well as she had to isolate with him for 14 days after that."

Practitioner 32

In some cases, it was also used as an excuse to cause further harm to children and families.

> "I also had one client who – and this has always stuck in my mind … the perpetrator would wash the children's hands in boiling water to say that he was, you know, getting rid of COVID and getting rid of the infection, but it was clearly a tactic to harm the children and the mother."

Practitioner 33

> "And more chronic, coercive control and gaslighting … a lot of partners were using COVID as a way of actually causing harm … So, for example, sending a kid

> back from a placement or time knowing that they were COVID positive with the hope that if they would infect everybody else."

Practitioner 75

The prospect of children contracting COVID-19 was also a source of tension in the context of family law proceedings or contact negotiations.

> "Often the perpetrator used the children and threats of going back to Family Court … because maybe the perpetrators were still working and the Mums … wanted to keep the children safe so … they didn't want the children to go from one house to another. And there were lots of threats by the perpetrator of taking the mother to court. And, you know, threats not to return children and so they really used the children during this time as leverage."

Practitioner 29

The case file review highlighted that exposure to COVID-19 created a range of additional risks for people experiencing violence. This included in relation to people using violence not adhering to COVID-19 regulations or spreading misinformation to children. In one case example, the person using violence shared anti-lockdown and anti-government rhetoric with the client's child and refused to follow mask wearing mandates, which created confusion for the children, who felt that they were receiving 'mixed messages' from their caregivers (DS6). In another example, the client expressed concern regarding the increased risk to her child during COVID-19 because of the perpetrator's failure to adhere to government regulations. The perpetrator was described as spreading misinformation about COVID-19 to her child, including telling the child that COVID-19 was not a virus and that face masks were not protective (GS10).

Within the organisational case studies, Drummond Street practitioners also shared examples of COVID-19 being used as a controlling mechanism in some family violence cases, with many people using it to isolate victims and survivors further from their support networks, including using vaccine mandates to assert further control over children.

The use of vaccine mandates to wield control was also highlighted in the sector focus groups, with practitioners describing vaccination as a particular source of tension and further opportunity for people using violence to wield control, including limiting movements and the opportunities for women and children to seek support.

> "… when vaccination came into question, that became a big means of control in families. It became a big point of conflict that would then obviously lead to family violence as well, or would be used as a reason by perpetrators, but really

kind of that differing opinion and telling women or children that they shouldn't, they couldn't get vaccinated, which would then limit their movements further."

Practitioner 31

"And we continue to see that as well … they can't go on camps or whatever because they're not vaccinated because the men using violence are refusing to let the children."

Practitioner 29

"… [we saw examples of] men not letting women get vaccinated because it limits their chances of going into accommodation or getting support. Or you have a client who couldn't even go into the library to set up her mobile phone to get access to it MyGov because she wasn't vaccinated."

Practitioner 127

"I can think of a couple of cases of people who are incarcerated where their partners have actively chosen not to have their children vaccinated. And the prisons have a rule which is out of sync with community guidelines, where if children are to visit they have to be vaccinated. So, it means they've had no contact in-person contact with their children even though they can now."

Practitioner 83

Participants in client interviews also offered examples of the way in which COVID-19 had been leveraged or weaponised by the person using violence against them.

"[Former partner] actually became more controlling through the lockdowns and things. You know, he was planting things in my son's head, giving him the impression that I would be the one to give him COVID. And that I would be the one to break rules … So, we were all in limbo like, 'OK, well, do we still do custody arrangements?' And him being controlling as he is, he was like, 'whoa, what are you and your family doing? And what rules do you have in place and where are you going and what are you doing?' Yeah. He was out breaking the rules continuously. And it was, 'well, you're not picking him up today and they

would go to school in the middle of the day and make my son do a COVID test two hours before I had to go and pick him up."

Participant 12

Recommendations

Future-proofing Safety underlines both the intensification of existing, and the development of new, types of violence and abuse during COVID-19. The project revealed new areas of need that must be addressed across sectors and at a policy level to respond to the changed risk and need within the community.

In particular, the research identifies a worrying increase in child sexual abuse and exploitation and emphasises how the needs of these children and young people must be considered in recovery and crisis planning. These plans must also consider how government, sectors and organisations can collaborate to identify risk and protect children from sexual assault and exploitation more effectively in future disasters or crises.

The needs of people who experienced financial abuse were also highlighted as stark and will likely have long-term implications, particularly in cases where victims and survivors were forced to withdraw their superannuation early. This example highlights the need for all levels of government to consider family violence when implementing policy measures in future crises, in addition to considering the ways that they can support those who experienced this type of economic abuse during COVID-19.

Government	• Increase funding to services that support the recovery of children and young people who experienced child abuse and exploitation during COVID-19. • Consider ways to screen all children and to better support at-risk children more appropriately and effectively during crises and disasters. This could be through increasing the capacity of entities that support children to continue some face-to-face service delivery and support, including maternal child health, childcare centres, kinder programs, early childhood education, schools and support services. It also includes the increased provision of Child Protection services during crises and a commitment to continue to deliver these essential services face-to-face. • Design a crisis policy that considers the ways that policy changes may be leveraged by those using family violence. Legislation should be developed with a family violence lens that supports the needs of victims and survivors and commits to reducing risk during times of crisis and disaster. Any crisis policy development or legislative change should be assessed against a Domestic, Family and Sexual

	Violence Impact Statement as well as a wider Gender Impact Assessment in accordance with recent initiatives announced at a Commonwealth level.
Peak bodies	• Support member organisations to identify and manage new and emerging areas of abuse and violence during crises. • Help member organisations to capture changing risks and to advocate to government in relation to changing client needs.
Services	• Support all staff to be able to conduct nuanced and intersectional risk assessments, which consider new and emerging risks during crises. • Support the development of communities of practice and other group supervision practices to unpack and support practitioners to manage new and emerging risks during crises. • Support practitioners to be able to better screen for and identify risks to children and young people.

Part 3 – System responses

As highlighted in the section above, the complex and interwoven client needs resulted in a number of pressure points within services and throughout the service system. As client need increased in risk and complexity, however, the family violence services system came under strain. Many participants in the research were able to identify strengths in the way that their organisations were able to respond to changing needs as the pandemic unfolded, including through the provision of telehealth and increased brokerage spending to respond to rising material need in their client base. They also identified a number of barriers to this new service provision, including for diverse cohorts and vulnerable people within the community, such as children and young people.

More commonly, practitioners contributing to the research identified shortcomings within the family violence and sexual assault service system. They identified a number of gaps, particularly in relation to service system responses, including barriers to service provision, long waitlists and the withdrawal of key services.

Organisational responses to the service demand

Across data sources, the ways in which organisations responded was explored. While many felt that their organisation was able to respond well to changing client risk and experiences, practitioners highlighted weaknesses within the broader service system which impacted the ability of services to provide holistic support to clients with complex needs. Across all data sources, participants (including service users) highlighted some of the benefits and barriers of telehealth service provision and the increased support for material needs.

Key findings

Sector survey respondents across all service types indicated that their organisations 'almost always' or 'often' responded to the demand for services and supports by changing the mode of delivery of their services, transitioning to the delivery of services online or by telephone (88%).

The **sector focus groups** explored some of the benefits and barriers to telehealth service provision, highlighting that, while it allowed for flexible service provision in some cases, shortfalls occurred when it was used as the sole mode of service delivery, with it not being an appropriate form of service delivery for many of the most vulnerable in the community. The focus groups pointed to other ways in which service delivery had changed during the pandemic, including that many services introduced initiatives and programs to respond to the immediate material needs of clients. This included delivering food packages, mobile phone data and self-care support packages.

The **organisational case studies** highlighted some of the ways that session type and structure had shifted with the provision of telehealth services, including through the delivery of shorter, more regular online or

telephone sessions. The case studies also drew attention to the ways in which the three organisations spent brokerage funding and responded to client material needs during the pandemic.

While the **case file review** did not reveal a great deal about telehealth service provision, there were some examples of how telehealth allowed for greater levels of service engagement. Case files also illustrated limitations, including not being able to engage with some clients, particularly children and young people, and case examples where risk assessments were incomplete or unable to be completed because of safety concerns, with families locked down in close proximity.

The **client interviews** highlighted the advantages of telehealth or other forms of remote service provision to some extent, but also explored the ways in which people experiencing and using violence often obtained greater benefit and value from in-person, face-to-face interaction – particularly where they may already have complex needs.

Responding to changing need

Most surveyed respondents (88%) across all sectors indicated that their organisation adapted their services during COVID-19 by shifting the mode of delivery to online or by telephone (Table 7).

This was seen most frequently by respondents in the legal, FDR, parenting and family relationship sector (93%); and the family violence and sexual assault sector (92%). Additionally, half of all respondents (50%) saw their organisations increase financial support during this period. This was most common in the child safety and family welfare sector (61%); and the family violence and sexual assault sector (76%).

Table 7: Proportion of respondents reporting that their organisation "almost always" or "often" responded to demand during COVID-19, by taking the following actions

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Change in mode of delivery of support/services (move to online or telephone)	92.2	88.9	92.6	81.4	82.7	87.5
Increase in financial support provided	75.5	61.1	26.9	25.0	57.2	50.3
Development and/or maintenance of connections between your organisation and other relevant services	50.0	33.4	61.6	35.7	51.7	46.6
Change in organisational structure	49.0	38.9	50.0	38.0	37.9	43.4
Increase in housing support provided	58.4	33.3	23.1	27.5	46.5	40.1
Increase in staffing	20.0	22.3	23.0	20.0	27.6	22.1
Other changes in form of services and supports provided (Please Specify)	21.4	23.6	56.5	25.6	34.7	30.5
n	**50**	**18**	**26**	**42**	**29**	**165**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Nearly one-third (31%) of all respondents described other changes in the services and supports provided during this period. These included transitioning to remote and online service delivery and implementing other more flexible means of engaging with clients and delivering the required support.

Telehealth service provision

The sector survey underscored the agility and timely adaptation to telehealth service provision in response to the changing circumstances.

> "Our service adapted very quickly. We were all given IT support to work from home. Clients were checked up on more frequently."
>
> **Family violence service, rural area**

> "I believe we provided the same high level of service provision to our clients as we always have, with just changes to the way we delivered it in terms of it no longer being face-to-face."
>
> **Family violence service, rural area**

> "Took on the overflow with closed books of other services [and] moved to telehealth and now that is a standard service option."
>
> **Health service, suburban area**

Some participants in the client interviews had reflections about the benefits of accessing services remotely, where they may have found engaging with services in person too much of a step outside their comfort zone.

> "I think it would have been difficult for me to go in, rather than first initially talk over the phone, if that makes sense … I felt like a lost cause type of thing at the start and if I was to go into places straight off the bat, I don't think I would have been able to do it."
>
> **Participant 6**

The ability for people from regional areas to engage with a broader range of services was also raised. For some metropolitan based services, the broadening of geographical regions led to a huge increase in service demand.

> "… because we could service the regions, we were suddenly not just doing the metro courts and some regional courts, we were just doing all regional courts … I felt like we were servicing a lot more clients in the regions and our workload increased like exponentially."
>
> **Practitioner 88**

When discussing telehealth, however, most participants within both the sector survey and the sector focus groups described challenges and shortfalls associated with the effectiveness of telehealth service provision. Challenges and shortfalls included the unsuitability of remote engagement for a broad range of clients.

> "Our services, for the most vulnerable children and families in the community… For the most part, especially in 2020, we did not provide this service and I think we let these children and families down."
>
> **Parenting program, suburban area**

> "Remote client contact is not always the most appropriate process for clients going through traumatic situations."
>
> **Legal service, suburban**

> "During the pandemic there were times that [telehealth] delivery really wasn't appropriate for clients, and yet this was all we were able to offer."
>
> **Sexual assault service, regional area**

Within the sector focus groups, participants noted the lack of opportunities available to clients to engage with services safely and privately. COVID-19 related measures inevitably created fundamental barriers for clients to engage in remote service delivery and could introduce new risk factors, particularly for clients who were still living with the person using violence or who had children in their full-time care and therefore had limited safe opportunities to speak to services via phone or video call.

> "I think especially when we are providing some therapeutic work, like their home environment is not safe and they never feel safe in that room, but they need to do therapeutic work in that room, rather than they come to the counselling room …"
>
> **Practitioner 59**

Practitioners across a breadth of services spoke of how this prevented many clients from providing the "full story" or from disclosing episodes of family violence. This included older clients, who did not disclose experiencing family violence from their adult child as they were often present in the home, as well as young people – including from the LGBTIQA+ community – who were experiencing family violence from a parent and/or sibling who was unsupportive of their gender identity or sexuality.

As a consequence of the myriad barriers to accessing services during the first two years of the pandemic, including the restriction and complete withdrawal of some services and the default to online engagement, practitioners spoke of the entrenched isolation and disconnection that occurred between clients and their usual social and service networks. This was a theme that emerged in all sectors, with practitioners describing how the extended

lockdowns and restrictions on movement and social contact further pushed already vulnerable individuals to the margins.

Practitioners working with Aboriginal clients in specialist family violence and legal contexts described their clients as being at greater risk of isolation, reporting low levels of engagement as the result of a preference for engaging with services face-to-face; a lack of access to suitable devices and/or credit; as well as a reluctance to accept phone calls from 'unknown numbers', which practitioners often used when contacting them. This was particularly understandable in the context of systemic and structural harm experienced by Aboriginal communities, including the disproportionate intrusion of statutory authorities in their lives.

> "Often the clients don't answer from a no call ID, and they miss the opportunity … and same with police, you know, they're calling to, you know, do risk assessments or various things and calling from a no caller ID. I think when everyone's just calling on the phone and you're not putting faces to names, I think the clients that were really distrustful of the system and quite often, understandably so, it was 'who are you. Are you with the Department? Are you with police?' 'No I'm your lawyer', but they never, you know, they haven't actually seen you and met you and … I think that became really confusing ..."
>
> **Practitioner 64**

It was noted across both the sector survey and sector focus groups that online service delivery was not an ideal way to engage children and young people and families.

> "Most clients could not do video telehealth as it was cost prohibitive. Telephone counselling was used 90 per cent of the time, which was an inferior method of delivery as the client was often caring for children, distracted in other ways and at times driving!"
>
> **Psychology/counselling service, suburban area**

> "A lot of our assessments were done by phone due to COVID policies. This made it very difficult to engage with very traumatised young people who could not get face-to-face service delivery."
>
> **Housing service, suburban area**

> "It's really hard sometimes for people, especially for young people, who have some disability and for some people with autism, it's hard for them to look at the

> screen for one hour just to talk to you … they have to pause it until face-to-face is available."
>
> **Practitioner 59**

Building on these findings, the case file review illustrated the limitations of engaging children and young people in telehealth. In one case example a young person using violence within the home struggled to stay engaged with his NDIS supports, including OT and behavioural management supports, as a result of solely having online contact (DS5). In another case featuring multidirectional violence within the home between the client and her three children, one child refused to engage with supports over Zoom (DS1).

Within the sector focus groups, specialist family violence practitioners spoke of the potential for remote engagement to create additional risk factors for clients, particularly where perpetrators were spending most of their time in the home following loss of employment or working from home. This created situations where victims and survivors were having to engage with services while hiding somewhere quiet in the house, or by leaving the house at night in breach of the state-wide curfew. Further examples were provided of perpetrators answering the victim-survivor's phone or making their presence known during the victim-survivor's counselling sessions with a service.

> "I'm thinking of a client … where every [therapy] session her partner would open the door and come in and say 'hi' to the therapist. And it was almost this, this aspect of 'I'm here, I'm lingering' and he would have to make his presence known each and every session and we would reflect on that and put it to the client, and she would say, 'Oh no, no, I'm safe and things are fine now', even though there was this really long history of family violence. So, I think we can underestimate the impacts of having people tell their stories in their homes."
>
> **Practitioner 31**

Examples of the difficulty in completing risk assessments when others were able to overhear the session were apparent in the case file review. In one case example, significant portions of the risk assessment were unable to be completed because of the client being in close proximity to her son during calls. This client felt unable to disclose or share relevant family violence risk information while the young person was 'within hearing distance' of the conversation, which compromised the practitioner's ability to assess the level of risk in the home. No risk factors had been ticked for this risk assessment, likely for this reason (DS17).

In response to the move to telehealth service provision, practitioners who participated in the sector focus groups spoke of 'upskilling' in safe technology use; employing strategies such as asking first if a client was alone when engaging with them remotely; and not asking them questions that could create risks to their safety until the client

was alone. Practitioners also described taking greater care and thinking of creative approaches when engaging with clients, where they felt that remote service delivery posed too great a risk to their safety.

> "…We'd often safety plan that if it's not a good time for you to talk, just say it's a wrong number. Say we're [a] different service, whatever it might be, just so that they could hang up and we know that it wasn't a safe time for them in that moment to speak."
>
> **Practitioner 32**

Other strategies described by practitioners included going to pick up a client and take them to the pharmacy to collect medication or meeting them at a supermarket to conduct a risk assessment.

Additionally, services described overcoming some of the access barriers to telehealth by using crisis brokerage to provide clients with phones and credit. Many practitioners reported that their engagement with clients was often better over the phone, with one practitioner describing a 90% success rate in reaching people compared with face-to-face engagement. Engagement over the phone was noted as being particularly beneficial for forensic clients and clients who were said to have previously felt a sense of failure for not attending in-person appointments, as a result of the often chaotic and transient nature of their lives.

Across the client interviews, participants in general spoke about their wish for greater face-to-face contact – or at the very least online service provision, where the focus had been on telephone service provision.

> "I still haven't actually met [practitioner] in person or even seen her online. I've got no idea. I could walk past her in the street, and I've had so many really personal, really detailed conversations with her and I would not know what she looks like. So, and she's been involved, really for a couple of years … I just feel like you get to know people a lot better when you can actually see their expression … [although with a different provider] there was an opportunity that I could have done my counselling on Zoom or some kind of platform, but then the difficulty was that I had three kids running around the house and my space, like, where I had good Internet, was in the kitchen lounge room area. So, it's like, couldn't talk about anything or if I had my phone and it'd be patchy service, and I'd be out in the garage or something and it would just be trying to get a private space because we're in a fairly little house … Yeah, so phone just ended up being

the way to go and sometimes, you know, we'd walk the dog, and the kids would be right up ahead, so they weren't listening."

Participant 14

Men's Behaviour Change Programs (MBCPs) telehealth considerations

While online engagement contributed to risk for clients using and experiencing family violence, practitioners working with people who used violence specifically described how the flexibility offered by remote engagement, via phone or video calls could, in some cases, mitigate and alleviate family violence risk by increasing engagement in relevant programs. This included where clients working in essential services could attend online appointments during their lunch break or while they were away from the home and other family members, meaning that engagement in services such as MBCPs could increase for certain cohorts.

"… working online really offers flexibility, particularly for the men we work with, … a lot of them are like truck drivers or Uber drivers. And so, all they're on shift work and so ... it's not feasible. But for them, they can just nick to the car, we can do the assessment online. I mean, there are things that are missing from that … the other thing is normally our programs were only in [certain area of Melbourne], so they delivered face-to-face in that area. But because of this program and being online, we could actually, like, support men in in like other areas ..."

Practitioner 58

This same practitioner reflected on the benefits to the workforce of conducting sessions with people using violence online.

"… trying to see a male client face-to-face is really, really difficult because you can't go to our office in case there might be some connection to the woman. And then there aren't other spaces that want to give it to us because we're working with men who use violence, and then you might then you're putting yourself at risk because you might have to go and meet them at the library or something."

Practitioner 58

While greater participation was noted, services working with MBCP service users also echoed how remote service delivery also created specific risk factors relating to their use of violence. Practitioners expressed their concerns for

an individual's behaviour escalating when participating in a MBCP or therapeutic work when the victim-survivor was often also in the home. Identifying this risk in the first place was said to be challenging, as practitioners generally were only made aware of the victim-survivor's presence in the house via their support person, rather than from the MBCP participant themselves.

Other limitations of remote engagement that could contribute to risk and was reported by practitioners working with clients across all sectors, was the inability to pick up on a client's physical presentation and body language, including their reactions to certain questions/subject matters. For some practitioners, this inability to monitor risk meant that they were unable to challenge particular behaviours in the same way as they would in a face-to-face session.

> "I can't observe them as well because I can't watch their body language. And also, I'm typing so, you know, there's all of that that can be missed. And those are key to kind of like their reactions … to the questions I ask."
>
> **Practitioner 58**

> "… it's really difficult to have a challenging conversation with someone who's using violence, where they can just hang up on you. It's a much more delicate conversation I have found myself [having] over the last two years or so, challenging people who are using violence less for that reason because it's like, 'I need to keep them engaged, not collude, but challenge them in such a delicate way that they're going to stay engaged enough for me to keep an eye on safety."
>
> **Practitioner 12**

The case file review highlighted the limited effectiveness of online remote service delivery in establishing trust and rapport with clients. In one case example, a MBCP participant stated that, prior to meeting his practitioner face-to-face, he thought he was "talking to a 21-year-old" but that, after he met the practitioner, he trusted him and his advice (U8). Participants in client interviews who had been involved in M BCPs or Caring Dads programs were all recruited for the research in 2022, meaning that their participation in the relevant programs had all been in-person, or had at least finished in-person despite starting online. In this context, participants volunteered reflections on the benefits of in-person engagement and what the comparison with online attendance was or might be, including comparing with their experience of other relevant programs, where applicable. All of these participants also had experience of working online during COVID-19 or of being involved in other programs online. Overwhelmingly, they were of the view that programs that engaged with this kind of content should prioritise in-person participation, where possible.

"I just found that I engaged and got to know the boys or the men much better face-to-face and … online everyone was a bit more, not controlled, but a bit more, like it just didn't flow as naturally."

Participant 16

"We connect with the people in the group. Some people don't socialise as much and then we have a break and some then, you know, they go out for smokos, and you know they have a chat that way … that's part of when you build a rapport amongst each other, and it actually helps with the discussion during the session."

Participant 17

"Because of the delicate nature of what it is, yeah, I prefer in person. I just think you can better gauge sincerity. You can better gauge one's empathy towards one's unique set of circumstances … I mean, having dealt with video conferences through work, it's not as effective. And, you know, you maybe with a bit of luck, you'll have everyone on camera. But a lot of a lot of times you don't. 'Oh, I'm having technical difficulties' … I'm a firm believer you're on borrowed time, so make the most of that time. We've got 20 weeks. Yeah, I want to feel good about going ... to walk out after the two hours and say, you know, I've got something out of it."

Participant 19

Participants also reflected on the importance of in-person interaction in relation to the work of the program facilitators and how they might be able to engage the group.

"… the lead facilitator, she was fantastic … and I think her skills you know, were shown by having that done in person and I think yeah, you know she would not have been as effective, I feel, if it was done online … You got to keep the connection going because, if you lose your audience, you've lost it. So, if I start to lose confidence in [facilitator], for argument's sake, then I'm going to check the ticket. I'm not going to say much anymore …"

Participant 18

Court experiences of online technology

A substantial number of findings related to the move to online court during the pandemic. As well as a range of benefits to online courts, participants identified key barriers, including for people accessing online court, as well as for legal practitioners.

Benefits of online court

As with clients seeking community-based services and support more broadly, some court users were described by legal practitioners as experiencing increased access to justice because of the ability to join hearings online. A clear benefit acknowledged related to the increased safety for victim and survivors, given that they did not need to attend court in-person and be in physical proximity to the person using violence. At the same time, practitioners described the online environment as a "double-edged sword", particularly where the technology was too challenging and the attendance did not come with appropriate support.

> "I think it's a difficult thing to work out how to get a balance because of course there are those things of safety that are increased because the AFM's not theoretically exposed to the respondent."
>
> **Practitioner 62**

> "I think now maybe a bit of the hybrid where respondents are required to attend, but AFMs have that flexibility is probably a good way of going about it. But every court is operating a little bit differently and it's not necessarily working the same way across them all. So that creates issues …"
>
> **Practitioner 64**

To that end, some practitioners observed that the current expectation that respondents appear in-person did not take into account the safety challenges where victims and survivors had been misidentified as respondents or where respondents had a disability or health condition that precluded them from attending court.

Some participants in client interviews appreciated the opportunities that participating via online technology had for their feelings of safety in the context of FVIO applications.

> "… one of the beneficial reforms or initiatives was that I didn't have to attend court, to obtain an IVO, it was all done on the phone and that was very beneficial for me because I didn't have to face the perpetrator in a court setting and it was all done very efficiently and it was the registrar who took my statement and it

> was very timely. I was granted that IVO quite quickly and I didn't find it as stressful as I had previously when attending."
>
> **Participant 1**

The majority of participants in client interviews, however, volunteered that they had found the experience of appearing online very challenging and had felt that they were excluded from the process, as discussed below.

Challenges of online court

Legal practitioners described their concerns about the impacts of online court environments for their clients. This included a lack of ability to develop trust and rapport between practitioners and clients, with practitioners describing the importance of face-to-face interaction, particularly in terms of being able to support clients with planning or decision-making around safety.

> "… that moment of interaction with a client over the telephone as opposed to face-to-face, there's a whole trust issue that is a really, really significant in the work we do as duty lawyers at courts that means that the moment to capture further referral, further support to get to the core of things and assist in that way beyond just the legal matters was compromised."
>
> **Practitioner 62**

> "… I've found not meeting my clients and knowing them face-to-face has made our relationship quite different and there's things I probably could have done to keep them safe if I'd known more about them, [things] I would have found out if I'd seen them [in person] more often."
>
> **Practitioner 47**

This was particularly the case for clients from vulnerable cohorts in the community.

> "… for kids, often I am worried about their level of understanding of getting instructions on the phone or even trying to organise a Zoom with them in terms of being able to build that connection and particularly with clients and finding during the pandemic with the under-14s."
>
> **Practitioner 67**

> "… I had big concerns in practice for clients who are from a culturally or linguistically diverse background, how they were engaging with the system and the availability of interpreters and of appropriate materials online and all of that sort of stuff. Same goes for people with disability who might usually want to attend courts in-person because they've got a hearing, vision, physical, some other impairment that stops them, you know, from engaging fully in the online experience."

Practitioner 63

> "I had a new client, who attended their court hearing from a video link from [custody] and found it incredibly stressful … She obviously hadn't been given her correct medication that was up to date and found the whole thing very distressing and it happened very quickly … Yeah, she had no idea what was going on, and nobody took the time to explain to her, and then she was just gone. And I don't think she even knew that we were there in the room to help, you know, be there for her ..."

Practitioner 83

The online court environment was described as involving similar concerns as online therapeutic or other service support environments in terms of privacy and safety. For example, practitioners related occasions on which a victim-survivor appeared in an online hearing and agreed to a limited 'safe contact' order for it to emerge later that the respondent had been in the same room with her, off camera.

> "Often we didn't know who else was there in remote telephone conversations, in remote hearings … the court has tended to be reluctant to hand out a link to another person, be it a worker or a support person, during the time that we were working remotely. So, I would expect that most people, unless they had somebody sitting nearby who wasn't visible were, you know, fairly isolated."

Practitioner 45

While acknowledging the importance of victims and survivors being able to appear from a safe remote location, practitioners explained that, when parties attended court in-person, this had a range of benefits.

"… the sort of reality of being in a courtroom and having comments made from the bench and realising that, if you're not willing to move or address your behaviour, then this other person's going to make a decision for you. And the power of that is really lost in doing things online … in a Child Protection matter, parents have been working hard and things are just being adjourned on the papers. You really lose that opportunity for them to be commended or any comments to be made."

Practitioner 64

"… some of my clients are ringing … at work, you know, and they're behind the counter when they take the call, if they're not appearing. And I appreciate the people have to, they have to survive, and they have to go to work. But there's just something incredibly incongruous and sometimes just not right about [an intervention order] just being something you acquire."

Practitioner 62

"… there's something pretty powerful about being in the courtroom when the Magistrates deliver a pretty scathing summation of what's going on in a matter or when they speak really powerfully about how impressed they are with the work that parties have done between hearing dates."

Practitioner 63

Practitioners explained that the benefits of attending court in-person did not just extend to the courtroom itself, but to the connection with wider services that attendance at the court building often facilitated, the impacts of which were still being seen in 2022.

"… at the moment, we're having a lot of clients breaching those eligibility counselling orders because they just haven't even rocked up for the initial assessment because they just didn't understand that they had to … and no one's ever told them … 'Go to a Men's Behaviour Change Program, this is what it is. That's what you have got to do, expect a call.'"

Practitioner 68

Remote service delivery also brought other practical challenges identified with respondents having access to a copy of the order.

> "… because they were appearing remotely, they weren't getting hard copies of the orders so … if the oral explanation was given [in court], then it was considered served and [some] courts weren't posting out hard copies."
>
> **Practitioner 66**

As flagged above, many participants in client interviews found the experience of attending court online disempowering and felt that it contributed to a lack of information being presented to the court and poorer outcomes as a result. Some had a strong perception that in person attendance improved the ultimate result.

> "I was in [particular court location] … but with no place to be able to go inside, like a meeting room or whatever because they were completely closed to the public. And so, I had to sit somewhere outside on a bench on the street … and have that hearing. And I made that clear to the Magistrate that, you know, this is ridiculous that they don't even let people into the court room because family violence can be just as serious as the effects of COVID."
>
> **Participant 8**

> "… my ex-partner is incredibly clever at using systems and you know, turning things around on to me … [to look] like I was the person that was committing violence, and they couldn't even see me to see, you know, 'this person's a [professional], hey looks after their children really well. you know, they speak well.' Nothing … So, your solicitor or your lawyer, your legal representative will have their camera on, and will speak on your behalf … like you have literally no voice in it, it's like you're not even there. So, I'm there texting away to the lawyer and I'm not the fastest texter in the world. And the Magistrate would be there demanding this information and then I'm trying to quickly say, 'yes, the children are this old' or 'yes, you know this much' … and there's not really space as there would be if you were sitting next to your lawyer in the courtroom to say 'please

can you follow up about this' or you know 'that's not correct' or those little whispers that you normally have."

Participant 15

"I actually found it really empowering to be able to walk in and confront the person that had done all of this and say 'I'm still sitting there' and 'OK, you know, and I'm not giving in to this rubbish'. So, for me [in person attendance] was, yeah, incredibly empowering. And I felt really safe because there is security everywhere and I was always with, you know, my lawyer, the [volunteer support] … You get a much better outcome than I feel like the way that you know the Magistrate has addressed the issues raised and it's a different tone that they use if they can actually see you."

Participant 11

Participants also found the online process very confusing, sometimes meaning that they missed out on attending their hearings altogether.

"… they wouldn't allow people to go to court and you had to do tele-link. But then the information that they gave to go to tele-link and all this, it was, yeah, it was really confusing. So, I actually missed some court dates because it wasn't, the information wasn't given to me correctly … I'm used to going to court and you just rock up and that's it. But yeah, they changed it … I think I might have got a small text or an e-mail or there was like a small, tiny piece of information which made me think, well, what's going on …"

Participant 12

"… it was just hard to get through to them because everything was online, so it was hard to get through to their call centre. Everyone was calling like, what do we do? … Everyone sort of did what they could … but they were a bit like … given a piece of information and too bad if you don't know what that means or what to do, like their lines were just packed and yeah. So, I feel a bit let down by the court."

Participant 2

One example of a participant experiencing sustained elder abuse described the disempowering experience of service users interacting with legal processes in different jurisdictions and the lifelong implications of not being able to have a genuine voice in the proceedings when she lost all her assets to her adult child.

> "VCAT online, well there's a disaster ... I could have cut my wrists after that if I was suicidal, VCAT shouldn't have an online … I had the [support person and lawyer] and the barrister online, but the Member who it's called in there, he kept popping in, but I was never in the picture with [the other participants] so I don't know what they were saying. I couldn't hear anything. So, then he'd pop in and the barrister would talk to me and then the Member would pop out and then he'd pop in again. It was awful and I ended up with nothing and I never heard what [adult child seeking property] told the Member."
>
> **Participant 10**

Here the research team notes that participants experienced these court interactions at a time when service delivery was continuing to evolve in 2022 and that none of the participants had benefited from the opportunity to participate in an FVIO hearing via the Magistrates' Court of Victoria's Remote Hearing Support Service, which enables victims and survivors to be supported during an appearance from a remote location by a dedicated practitioner who also engages with them before and after the hearing.

Benefits and disadvantages for legal practice

Legal practitioners described benefits of the online environment – including efficiencies gained – for their own practice that they would have liked to retain.

> "… the change fatigue has been massive, but you know it was a real blessing to not have to attend courts in-person to inspect subpoenas and to be able to have documents sent to you via email … So, I think that sort of streamlining of process has been really awesome and I wish that, yeah, we could go back to [that]…"
>
> **Practitioner 63**

At the same time, practitioners explained that an entirely online environment was frequently more time consuming than an in-person environment. With a move to a 'hybrid' environment of partially online and partially in-person, as noted above, this made the demand even more significant.

> "We sit in completely different parts of the court and a lot of the court day, we don't see each other until we're sitting together at the bar table because there's

just that expectation that everything tends to happen via the chat or via e-mail. We truly have so many platforms open while we are working every day, it is madness."

Practitioner 63

"As a practitioner, you now have a screen even at court, where there are messages coming into you via chat, via e-mail … there's an impetus to stay on top of while you've got a client in front of you engaging in some of the most intimate discussions that that person may ever have about what they've experienced … I don't think it's possible to provide the same level of service at the same volume … on this multi-platform engagement …"

Practitioner 62

Benefits for the court versus benefits for the court user

Practitioners were concerned that the use of technology was going to be retained or prioritised for reasons other than improvements in safety. Particular concerns were voiced about the centralisation of court registry and administration functions.

"… the organisational bureaucracy … has seen how the technology can work and is now trumpeting it – and you know there are safety benefits, but actually it's beneficial for reasons that have nothing to do with the quality of service and representation and safety and the rhetoric around family violence. It's efficient, it's cost-saving. We can centralise registries without really addressing what that means for clients … it's rare that the end user really gets a voice in whether it's working or not."

Practitioner 62

Practitioners were very clear that decisions around how people attended or participated in a hearing needed to be led by AFMs or people otherwise impacted by family violence and related issues such as Child Protection involvement, rather than by the needs of the system.

"… if the principle was online as an option where it's more efficient and aids participation is a choice, if that was the principle, the guiding principle, that

> would be great. But that's not how the decisions are being made and there needs to be state-wide consistent practice directions about this."

Practitioner 60

> "I think courts, what they generally tend to do, and that is to kind of build a system around what suits them rather than what suits the [AFMs] … I think one of the things we've learned during the pandemic is that perhaps a mix of options are the way to go, to be able to best suit the AFM. And as long as that's to suit the AFM rather than to suit the system …"

Practitioner 45

Practitioner concerns were that the priority on the experience of court users – and the transparency of the court process – needed to be a central consideration in the future.

> "Magistrates are not accountable. They are not as accountable as they are when we are at the Court and we're in there and out of there. We're watching them not only in our matters, engaging in our matters but in other matters … in my view, it's really significant …"

Practitioner 62

Practitioners were equally concerned about the differentiation in experience for different court users, depending on the approach of their local court, with some regional courts no longer allowing remote or online appearances which was having a significant impact on access to justice for some clients.

> "… we've had this great sort of increase in access to representation in a lot of matters because we've been able to have people beam in. But now with every court sort of having their own Children's Court Practice Direction and they're making local rules and, you know … it's to stop someone being unrepresented in a really important decision."

Practitioner 60

Supporting material need

Practitioners within the sector focus groups highlighted that the scope of some services expanded in an attempt to address and manage unmet and escalating needs. Across the focus groups, practitioners from a range of sectors

explained that this was generally out of necessity, as clients were unable to access support where relevant services had extensive waitlists. Practitioners described initiatives and programs that were brought in to respond to the immediate material needs of clients. Examples were provided of services developing food box programs, facilitating provision of culturally appropriate groceries and pre-prepared meals for clients. These boxes were generally delivered by practitioners themselves (and in one instance, the CEO of a service), which was in addition to their usual workload or in the context of a volunteer roster.

> "How are we supposed to do the therapeutic work when people can't eat?"
>
> **Practitioner 98**

> "[Our program staff] go around to people's houses and help them adjust to parenting, give them practical help to assist with their mental health, and they were just saying 'we just feel like social workers because the demand for the basics is so big' … so we really just concentrated on providing food and [phone and internet] data, and things like that, which hadn't really been our role previously."
>
> **Practitioner 30**

> "So, we actually did a massive food shop … And then we went into the hotels and I'd say, 'Where are your Aboriginal [residents]? Can you tell me who have got kids? We're gonna take them all food.' But the problem was, it might have to be microwaved. And the hotels were saying, 'Our power doesn't allow for people to have microwaves in their rooms.' So, people still couldn't like eat it, so then they were going to the 7-Eleven … but people had to make sure that they worked around the curfews."
>
> **Practitioner 127**

Family and AVITH services spoke of how they sent 'care packages' containing art supplies and activities and coordinated with other services to provide families experiencing financial stress with laptops and other devices so that children could participate in remote learning.

Practitioners explained that this support, including technology and data packs, was often provided to families from newly arrived or refugee families, some of whom may not have previously used technology. Many services, including community legal centres (CLCs) provided clients with mobile phones and data. Although some had also done this prior to COVID-19, it was explained that this need skyrocketed as clients not only required a device to

engage in remote court appearances, but also to engage with other services remotely as part of Community Corrections Orders or Child Protection access arrangements.

In addition to providing mobile phones and data, some CLCs provided food vouchers, funding for accommodation and other fundamental provisions to address the immediate material needs of their clients. Lawyers working within these CLCs explained that, prior to COVID-19, these needs would have been addressed by referring clients to specialist services, with legal services now having to meet urgent requirements that these other services could not because they were too stretched.

Examples were also provided of how services used the extra brokerage that they received during the pandemic to provide e-vouchers for supermarkets and other essential services that could be sent directly to a client's phone or email, as well as mobile phone data packages so that clients could send text messages and use internet on their phone. This enabled them to have greater access to and engagement with services, such as remote court appearances and videocalls during access visits with their children. Crisis brokerage was also used to respond to the immediate material needs of clients at risk of experiencing family violence, such as having a client's car fixed and the locks on their residence changed.

Many practitioners described the distress of not being able to address their clients' safety needs adequately, with individual practitioners taking it upon themselves to drop food around to clients' houses as way of these practitioners reassuring themselves that they were doing what they could, while reassuring clients that somebody cared.

> "I think a lot of it, sometimes around family violence and safety planning and COVID and stuff, was just about accepting you couldn't do anything, which is a horrible thing to have to tell your client as well. Or it was more, you were working around safety planning, like placating the perpetrator, I guess, instead of looking at ways to get out or ways to be safe."
>
> **Practitioner 47**

The demand on the health system also meant that family violence risk was de-prioritised when victims and survivors elected to provide their partners with urgent, pragmatic support.

> "I had a family where the [person using violence] was dying over lockdown … So, it just felt like the only thing I could do would be to rock up every now and again and drop off groceries and roast chickens because it was just such a powerless time of just watching … so many systems and medical systems, just fail these

> people. So, they ended up having him back in the home where he was delirious, abusive and dying."
>
> **Practitioner 14**

The organisational case studies shed light on some of the ways in which increased brokerage spending was allocated to address client needs and safety across a range of areas. Across all three organisations, there were dramatic increases in the amount of money spent on basic supplies including food, technology and data to support people during the pandemic.

Drummond Street provided brokerage and essential supplies to clients from across a broad range of programs, with the majority of funds spent on the organisation's Food Outreach Operations at Drummond Street (FOODS) program, developed in response to the pandemic to provide food and essential material goods to clients. The second most common area was accommodation, including support with rent, establishing or maintaining a long-term tenancy and short-term and emergency accommodation relief. Drummond Street practitioners also supported clients experiencing family violence to access flexible support packages through other organisations.

GenWest indicated that, during COVID-19, the amount of financial support available for clients increased substantially, as did the permitted amount that could be spent on each client. The majority of brokerage was spent on essential supplies, including food, clothes, appliances, phones, computers, office supplies and other household items. This was followed by spending on domestic and personal safety measures and accommodation support.

At Good Shepherd, the total amount of brokerage funding spent increased by 85% during COVID-19. The largest increases in spending related to essential supplies, including food, clothes, phones or computers. This was followed by an increase in spending relating to 'other brokerage', accommodation and personal safety measures.

Participants in client interviews also highlighted the kinds of support that services had been able to provide them during COVID.

> "I'd mention things and she would provide, you know, a Bunnings voucher, I needed a new phone, because my ex was abusing me on my old phone, so I needed a new number, so with the JB Hi-Fi voucher, I managed to get a cheap phone and a SIM card. And I didn't even know there was any of this support available, I never asked for anything, [service] were just like, 'well we need to help you', and it was just amazing. Little things like that you don't think of, you know, because you're just trying to pay rent, or for petrol and food and then it's things like, even Orange Door, I told them I was on a pension and that my boys had just eaten $70 worth of food and they said they could give me vouchers, and

I was just like 'thank you!' Little things like that just make you feel human and help you survive."

Participant 4

"I accessed the local community and got food parcels. So, I'd go down and pick up, you know, some night nappies for her, and you know some cereal … they also gave me a parcel of clothes for my little one … I think at the start I'd sort of they said, what do you really need? … something for my daughter to sleep in because sleeping in the car and stuff is not working … So, yeah, they gave us a swag … [and] her and I just made that her adventure swag, so I when we roll that out, we're having an adventure night …One of the other things they gave us, which was really, really good was an iPad voucher for JB's … So that iPad was just a lifesaver because it sorts of gave her the TV without giving her a TV."

Participant 5

Reflections on the effectiveness of service delivery

When reflecting on the effectiveness of service delivery by both their organisation and the broader service system (Table 8), most respondents 'strongly agreed' or 'agreed' that their organisation had been able to adapt to clients' increased and/or changing needs (78%) and had been innovative in the modes of service delivery (76%). Almost two-thirds of respondents 'strongly agreed' or 'agreed' that their organisation had been effective in meeting clients' needs (64%).

On the other hand, responses suggested that a significant minority of organisations still had a range of gaps in their services delivery, especially for cohorts who already experienced marginalisation. One quarter of participants reported that their organisation had not been sufficiently accessible to most clients (25%) or to Aboriginal and Torres Strait Islander clients (24%), culturally and linguistically diverse clients (26%) or LGBTIQA+ clients (18%). Respondents working in health, mental health and AOD services were more likely to report that they 'strongly agreed' or 'agreed' that the services in their organisation had not been sufficiently accessible to most clients (41% cf. 25% all services).

Table 8: Views on their organisation, proportion reporting "strongly agree" or "agree" in response to each item

	Family violence (including sexual assault services) (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
My organisation has been able to adapt to clients increased and/or changing needs	86.3	82.3	92.3	69.0	62.0	78.2
My organisation has been innovative in modes of service delivery	72.5	82.4	96.2	73.8	63.4	75.9
The changes made in my organisation have been effective in meeting clients' needs	70.0	70.6	84.6	42.8	63.3	64.2
That services in my organisation have not been sufficiently accessible to most clients	25.5	17.6	8.0	40.5	20.0	24.9
That services in my organisation have not been sufficiently accessible to Aboriginal and Torres Strait Islander clients	25.5	6.3	23.0	30.0	23.3	24.0
That services in my organisation have not been sufficiently accessible to culturally and linguistically diverse clients	25.5	5.9	23.1	36.6	23.3	25.5
That services in my organisation have not been sufficiently accessible to LGBTIQA+ clients	25.5	5.9	7.7	23.8	10.0	17.5
The changes made in my organisation are not sustainable in the longer term	19.6	11.8	7.7	28.5	26.7	20.5
n	**51**	**17**	**26**	**42**	**29**	**165**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Other challenges and shortfalls identified by survey respondents, with respect to the effectiveness of service provision by their organisation, related to issues associated with resourcing and funding of services and the inability to meet the demand.

> "The waitlist for clients has been out to 5/6 months due to increase in demand through COVID, and while staff had time availability to meet this, there was insufficient funding to enable the extra day or two of work that needed funding to meet this increased demand. More frontline workers were needed."
>
> **Family violence service, suburban area**

> "Demand for psychology services was/is very high meaning most parents and children were not able to access this even when able to pay. Parents particularly distressed about not being able to access therapeutic supports for their children's developmental and emotional needs."
>
> **Health service, suburban area**

Respondents were much more favourable towards their own organisation with many feeling that the broader service system was unable to respond appropriately (Table 9). Less than half of respondents (49%) 'strongly agreed' or 'agreed' that the wider service system had been able to adapt to clients' increased and/or changing needs (cf. 78% on organisational level) and 58% reported that the wider service system had been innovative in the modes of service delivery (cf. 76% on organisational level).

Only 37% of respondents 'strongly agreed' or 'agreed' that the wider service system had been effective in meeting clients' needs (cf. 64% on organisational level).

More than one third of respondents reported that the wider service system had not been sufficiently accessible to most clients (41%) or to Aboriginal and Torres Strait Islander clients (39%), and close to one-third of respondents reported that the wider service system had not been sufficiently accessible to culturally and linguistically diverse clients (30%) or LGBTIQA+ clients (30%).

Table 9: Views of the wider service system, proportion who reported "strongly agree" or "agree" in response to each item

	Family violence (including	Child safety and family	Legal, FDR, parenting, and family	Health, mental health, and	Education, housing,	All services (%)

	sexual assault services) [%]	welfare services [%]	relationship services [%]	AOD services [%]	and other services [%]	
The broader service system has been able to adapt to clients increased and/or changing needs	54.0	58.8	69.2	36.8	29.2	49.0
The broader service system has been innovative in modes of service delivery	56.0	70.6	76.9	50.0	45.8	58.0
The changes made in the broader service system have been effective in meeting clients' needs	38.0	41.2	57.7	34.2	16.7	37.4
That services have not been sufficiently accessible to most clients	44.0	41.2	15.3	50.0	50.0	41.3
That services have not been sufficiently accessible to Aboriginal and Torres Strait Islander clients	36.0	37.6	34.6	39.5	47.8	38.5
That services have not been sufficiently accessible to culturally and linguistically diverse clients	36.0	41.2	34.6	44.7	41.7	39.3
That services have not been sufficiently accessible to LGBTIQA+ clients	36.0	35.3	19.2	28.9	29.1	30.3
The changes made in the broader service system are not sustainable in the longer terms	20.0	35.3	19.2	37.8	40.9	29.0
n	**50**	**17**	**26**	**37**	**22**	**152**

Further insight from open text responses from respondents illustrates the mixed response of the broader service system.

> "I think it is hard to talk to the system as a whole, some services have done an amazing job of responding to clients' needs, however in some cases/regions

> referrals were not being accepted at all and people were left with no support at all."
>
> **Family violence service, regional area**

Inadequacies in staff resourcing and funding were nominated in relation to the response of the system as a whole.

> "There is not adequate funding or resources in the tertiary healthcare sector to provide holistic care to consumers presenting with a chronic community-based issue in a situational crisis."
>
> **AOD service, regional area**

> "[Services are] struggling to hire sufficient staff numbers to meet the increased demand for service support."
>
> **Family and relationship service, suburban area**

Some participants in client interviews volunteered that they were aware that practitioners and services were experiencing significant demand issues, noting visible practitioner fatigue.

> "… you could just tell … that staff were a bit stressed and had really big caseloads and sometimes, even when you know a critical event had happened and you'd call them and, you'd say 'I need to talk to someone' like, they'd get back to you as soon as they could but sometimes that was still days later, because they're just responding to yeah, so many things."
>
> **Participant 15**

> "I found a couple of the workers were fatigued and they were just going through the motions. But others were brilliant … I didn't have a change of workers at any stage, but [there was] worker fatigue that I felt from some of the counsellors … I see it when I look for jobs, there's always jobs for 1800 Respect and yeah, I just know in working in the sector, the changes, I think there's a high burnout rate, especially when you're dealing with trauma all the time … and there's no light at the end of the tunnel."
>
> **Participant 1**

There were a number of reflections made within the sector focus groups relating to system level barriers to responding to service need, risk and complexity. Although participating practitioners felt that, overall, their organisations had responded as effectively as possible in the circumstances, this was not necessarily supported at a system level. Further, practitioners described the complete withdrawal of some services, long waitlists and waitlist triaging for others and, in particular, the reduced capacity of services to respond to the acute and complex needs of clients, including children and young people.

Recommendations

Future-proofing Safety highlights that, while organisations found ways of responding to client needs during COVID-19, including through the rollout of material needs like basic supplies and communication tools, there were a number of communities for whom, telehealth and online service provision was not appropriate. Additionally, many respondents were critical of the broader service system's ability to respond to client needs. Future crises should consider the need for face-to-face service options to remain available for vulnerable members of the community. In addition, government should support the continued provision of face-to-face service delivery of essential services. Material support and additional brokerage spending provided clients with critical basic supplies and supports during COVID-19, with many services filling a critical service gap in responding to basic needs. Continued brokerage to support the immediate and ongoing material support needs of clients, should be considered.	
Government, peak bodies and organisations	Consider the need for hybrid service models to enable face-to-face service delivery to continue during crises and disasters, where possible.
Government	Support services and sectors providing front line family violence service provision to continue to offer face-to-face service provision. Provide ongoing brokerage support for those who are still in need of basic supplies.
Peak bodies	Support services providing face-to-face service delivery in how to do this safely, including through the provision of PPE.
Services	Identify and implement mechanisms to support staff through the provision of face-to-face service delivery. Identify and implement agile methods to respond to client needs as they change and evolve as we move into crisis recovery. Integrate learnings from COVID-19 service delivery. Hybrid working arrangements should not undermine face-to-face work. Communications should be developed to

support staff to navigate the return to face-to-face service delivery, so that they do not feel the need to be both online and in-person at the same time.

Barriers in responding to service demand

A number of barriers that limited service capacities to respond to demand were identified. While some were experienced across the range of organisations, others were more service-specific such as long waitlists, reduced service capacity and delayed response times. Some, such as reduced service delivery by Child Protection, were system-specific, yet impacted across the service system.

The sector focus groups identified the move to face-to-face service provision and withdrawal of key support services as having an enormous impact on vulnerable clients. As services withdrew or reduced their capacity following the onset of the pandemic, the ability for families and individuals to seek or continue to engage with services was significantly compromised. With most sectors ceasing their delivery of face-to-face programs and moving to online service delivery, a multitude of systemic access barriers emerged, to have direct consequences for clients who were experiencing or using family violence.

For those that did maintain outreach programs, significant challenges still existed when engaging with clients and maintaining a lens on their safety during the first two years of the pandemic. These challenges generally resulted from the surface-level nature of the engagement that practitioners had with their clients because of COVID-19-related restrictions, with outreach to a client's home involving a practitioner remaining in the client's front garden in full Personal Protective Equipment (PPE). Practitioners described how this could obstruct their ability to have an adequate sense of what was happening in the home due to both the physical barriers themselves, as well as the individual or family being less relaxed or reluctant to engage.

Within the sector survey, respondents also underscored the barriers most frequently encountered when responding to the demand for services and supports during COVID-19. Across all services, respondents were most likely to report that barriers for their own services 'almost always' or 'often' involved insufficient accommodation options to meet client demand (65%), issues with clients' access to technology (60%), insufficient resources relating to staff or funding (59%) and a lack of appropriate options for client referrals (59%).

Differences also existed across services. Of note, and consistent with findings that emerged from the sector focus groups, case file review and organisational case studies, child safety and family welfare services highlighted elevated issues with screening- including issues with assessing safety to participate in service remotely (64.7%), the online mode of delivery not appropriate/consistent with best outcomes for client (70.6%) and client preference for face-to-face service delivery (76.5%), as outlined in Table 10 below.

Table 10: Barriers that organisation encountered in response to the demand for services-proportion reporting "almost always" or "often" in response to each item

	Family violence (including sexual assault services) (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Issues with screening (including issues with assessing safety to participate in service remotely)	52.9	64.7	36.0	45.0	30.0	45.4
Issues with service's access to technology	45.1	53.0	23.1	22.5	16.6	31.7
Issues with client's access to technology	62.0	64.7	61.6	57.5	53.4	59.5
Online mode of delivery not appropriate/consistent with best outcomes for client	51.0	70.6	38.4	55.0	43.4	50.6
Client preference for face-to-face service delivery	47.1	76.5	50.0	52.5	40.0	50.6
Language or cultural issues	17.6	23.5	24.0	14.6	20.7	19.0
Insufficient funds to meet the demand for financial assistance	46.0	56.3	32.0	48.7	51.7	46.6
Insufficient accommodation options to meet client demand	72.0	70.6	57.7	60.0	60.0	64.5
Insufficient resources (staff or funding)	66.0	58.8	50.0	65.0	46.7	58.9
Inadequate staff training to meet clients' needs	45.1	11.8	12.0	40.0	23.4	31.3
Lack of appropriate options for client referral/s	64.0	52.9	46.2	68.2	53.3	59.1
Insufficient support for staff to adapt to changes in service provision/increased demand	44.0	29.4	16.0	50.0	40.0	38.9

Other (Please specify)	33.4	0.0	9.1	22.7	12.5	18.4
n	**50**	**17**	**25**	**40**	**30**	**162**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Across all services, survey respondents were most likely to report that service system barriers during the COVID-19 pandemic 'almost always' or 'often' involved three issues- insufficient accommodation options to meet client demand (68%), insufficient resources relating to staff or funding (58%) and a lack of appropriate options for client referrals (57%), as outlined in Table 11 below.

Table 11: Barriers that exist in relation to broader service system in response to the demand for services - proportion reporting "almost always" or "often" in response to each item

	Family violence (including sexual assault services) (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Issues with screening (including issues with assessing safety to participate in service remotely)	53.1	62.5	32.0	63.2	50.0	52.7
Issues with service's access to technology	36.7	47.1	24.0	37.8	25.0	34.2
Issues with clients' access to technology	44.9	70.6	46.1	56.7	54.1	52.3
Online mode of delivery not appropriate/consistent with best outcomes for client	44.8	53.0	38.5	45.9	54.2	46.4
Client preference for face-to-face service delivery	46.9	64.7	50.0	62.1	33.3	51.0
Language or cultural issues	22.4	17.6	28.0	39.4	20.8	26.8
Insufficient funds to meet the demand for financial assistance	49.0	58.8	41.7	51.3	66.7	52.3

Insufficient accommodation options to meet client demand	73.4	70.6	61.6	64.9	65.2	67.8
Insufficient resources (staff or funding)	63.2	58.8	46.1	71.0	39.1	58.1
Inadequate staff training to meet clients' needs	42.9	29.4	16.0	43.2	22.7	34.0
Lack of appropriate options for client referral/s	61.2	52.9	44.0	68.4	47.8	57.2
Insufficient support for staff to adapt to changes in service provision/increased demand	44.9	43.8	32.0	48.6	39.1	42.7
Other (Please Specify)	0.0	10.0	7.7	6.3	18.2	7.7
n	**49**	**16**	**25**	**37**	**23**	**150**

The research highlighted particularly stark examples of the withdrawal of certain vital services for victims and survivors more broadly, including the reduced capacity of the Child Protection system, the withdrawal of the majority of forensic examinations available to sexual assault victims and other barriers to accessing services such as long waitlists and extensive confusion over COVID-19 restrictions.

Reduced capacity of the Child Protection system

Perhaps one of the most significant themes across the sector focus groups related to the reduced capacity of the Child Protection system, with the subsequent impacts limiting the visibility of vulnerable children and restricting access between parents and their children in care.

The reduced visibility of children was a key concern highlighted by practitioners, as services described receiving fewer notifications for Protection Applications as a result of fewer Child Protection workers "being on the ground". Specialist family violence services noted that the reduced capacity of Child Protection had practical impacts on their workloads, with some support needs being pushed from the more intense end of statutory intervention to the community services sector.

As well as holding and supporting clients, a significant theme across the focus groups was therefore the way in which the community service sector was 'holding' risk that was particularly severe, with referrals back to statutory intervention often not being accepted. This echoed the extent to which the risk 'threshold' had shifted during the pandemic, as noted above.

> "So, you'd speak to Child Protection about concerns, and they'll say, 'no, that's not at the high-risk threshold', even though that could be debated many times

and they'd say, 'refer to Child First' but Child First would not be accepting referrals and would not give any reason as to why, they would not tell us when they would open the wait list again."

Practitioner 33

"… what we just kept on seeing was really bizarre things, like young babies being with perpetrators with really high-risk histories and, you know, people being in the house who were known sex offenders … if this made the paper, it's just really obvious risk … And the children and the child-focused lens was just not there. You know, it's bizarre if an adult mental health service is the ones who are going, 'I think you're meant to do something with the kids like, umm, seems like that's your job' … we had weird meetings with protection workers who they literally would be flat out and just say bluntly, 'No. I've been brought into close this case', and I'm like 'at least it's transparent, I guess".

Practitioner 28

"… it's something I hadn't seen to that extent, like cases where we would most definitely ask Child Protection to intervene and at least investigate, but those cases weren't crossing that threshold, they were being closed at intake and the expectation was that the service involved that was potentially making the report would be the one that continues to hold that risk because it wasn't sufficient."

Practitioner 31

"… we continued to do some levels of face-to-face, but there was no Child Protection. But then there was pressure from Child Protection because you were the one service system that was sort of saying 'we'll always remain open' … you might not get exactly what you got last year, but you'll get something … so there was a pressure on the service system, you know especially the refuges. That was the only space that could have a lens on children, but for practitioners, although

we have a legislated responsibility, we are not Child Protection … a practitioner and a refuge is not Child Protection. “

Practitioner 2

“I distinctly remember having a very heated discussion with a Child Protection worker … saying, ‘but you work in an essential service, you really should just wear PPE and allow this to occur’ – as in the visits – and they disagreed with me and said ‘no, we need to put the protection of our employees first’ and I was like ‘that's great, but doctors also need to put the protection of their employees first and yet they're still out there doing work. You're in not the exact same field, but it's an essential service that you're providing.’ And they just stopped providing that service.”

Practitioner 88

Practitioners also described a default to an overly punitive response where Child Protection was involved with families.

“I felt like I was dealing with Child Protection like, from 10-15 years ago type stuff … We had some really concerning attitudinal stuff that was happening where we had, again, like Mums with mental health issues who previously, you know, there might almost be more pressure put on mental health to kind of, you know, ‘you fix that, that will be your problem, that is your job’, almost this really conservative viewpoint. ‘No, Mum's the risk here’. So, Dad, who we know is a perpetrator, the kids are going to go with him ...”

Practitioner 28

“… the impact is still being felt today about what happened during the lockdowns … we have a client who was actually misidentified as a person using violence and Child Protection are still banging on about why I wasn’t able to take photos of her bruises at the time …. she took them herself because there was no second person there to take them … if we weren’t in lockdown, we would have been there with her. What happened during lockdown and how police interpreted the

> situation is still being used as a reason not to return Aboriginal children to their mothers."
>
> **Practitioner 127**

Situations were also described where children identifying as LGBTIQA+ were returned by Child Protection to homes that practitioners considered unsafe because of the behaviour and attitude of parents towards their child's gender or sexuality.

Practitioners also described other shortfalls that related to the withdrawal of supervised visits facilitated by Child Protection. This included the general suspension of in-person contact at the outbreak of the pandemic, which was said to be the case even where a child was in the care of a family member who was willing to facilitate in-person contact, or where children were under the age of 5 and for whom video calling was not a useful form of contact.

Practitioners reported that, even though the Department with responsibility for Child Protection authority did re-open several offices soon after the pandemic began, these remained difficult to use for in-person access visits between parents and their children and was identified as one of "many roadblocks" that existed for parents to spend time in-person with their children. Further "roadblocks" that were identified by practitioners involved the carers of children not being appropriately informed by Child Protection about their obligations to continue facilitating children's access to their parents via remote technology.

Although the consensus from practitioners was that the reduced capacity of the Child Protection system during COVID-19 generally had adverse impacts on parents and their children, some practitioners also identified unintended benefits, reporting that, in some cases, it allowed services the opportunity to work with families to address their needs and avoid Child Protection involvement, resulting in some cases being closed which allowed for "breathing room" for families to build trust and rapport with services.

Sexual assault services and refuges

In the sexual assault service sector, practitioners described how state-wide forensic assessment services were restricted to three sites in metropolitan Melbourne, with others withdrawn at the outset of the pandemic. Practitioners explained that, as a result, some clients were unable to be forensically assessed immediately following a sexual assault and, in some cases where the assault occurred at night, were told to "hold evidence" and sleep in the clothes in which they had been assaulted.

> "Many women didn't get [Forensic Medical Examinations] through that period … women would just be told to go home and hold evidence till the next day. No

survivor is going to do that …the loss of that opportunity for forensic evidence also means lower evidence and lower support for the client if they go to court."

Practitioner 97

A further access barrier that was identified was the closure of many refuges to accepting new clients, particularly during the first six months of the pandemic. Practitioners working in refuges explained that, in some cases, closures were introduced not because of a lack of capacity in the refuges but, rather, to protect the individuals and families who were living there from being exposed to COVID-19.

"… we went through a stage in early COVID where even the refuges that I was used to working with would say we don't really want new people coming in. Yes, I could fit them, but I've got 12 other families here and I can't put them at risk. So that was a real conundrum. And people who were in short term refuges and normally would have been moved on into weeks were sort of there for up to 8 weeks and longer… it was just like a freezing of 'we don't want this to get anywhere, so let's just keep all our women and children in the one spot … And [youth refuge] usually have a much higher turnover, and you can just go there for a night or two nights, but everyone just stopped and went 'we don't really know. So, we're just going to not do anything', which is understandable."

Practitioner 30

Long waitlists for services

Within sector focus groups, practitioners explored the impact of prolonged waitlists for services, including mental health services - highlighting that, by the time that clients were engaged in the service, they were often acutely unwell.

"… by the time they get to us, they're extremely ill, you know, we're stretched as a service anyway … there's generally a two to three week wait before they can get into see a clinician, but during COVID that stretched out at one point to 18 weeks before someone could even see anybody. So, I don't think they've really looked at the impacts of what that might look like … the impact that's had is obviously the extended case management in relation to the family violence is that they weren't getting the appropriate services … and the family violence sort

> of fell by the wayside because that was considered in our industry – well in the mental health industry at that point in time, was relatively new in the system."

Practitioner 27

This was also the case for practitioners in the family services and AVITH sector who found that mental health symptomology was commonly severe by the time that they had contact with families and young people and was often a cause of significant distress and tension within the broader family unit. Practitioners described the impact of clients being unable to access timely community-based mental health support because of extensive waitlists. Many felt that risk was more difficult to manage, while these particular support needs remained unmet.

> "… there's such an overwhelm in the mental health services space that we're then carrying that load of trying to work within that – parents are wanting a diagnosis of whether it is a mental health condition or whether it is just them using violence in the home and yeah, so it's kind of it seems like a whirlwind space at the moment. A lot more complexity, that's for sure."

Practitioner 77

Examples were similarly shared by specialist family violence services of victims and survivors experiencing severe mental health presentations which, left untreated, resulted in their inability to care for their children or meant that they were more vulnerable to an abusive partner's control.

> "… by the time they were making contact with our mental health service system, they were really acutely unwell. That's not new because we are at the acute part, but just the frequency of it. And whereas other services might have picked up, they might have had a phone call from, you know, into our triage earlier from somebody who might have been concerned about them or even family and friends might have been visiting them."

Practitioner 28

The rise in substance misuse also put significant demand on the AOD sector. Practitioners described the system as being overwhelmed and unable to meet demand, with many AOD services having waitlists of up to 12 months. This demand was also experienced for residential-rehabilitation bed facilities. Many of these restricted their intake because of concerns about exposing existing patients to COVID-19 or as the result of government mandated restrictions on people's movement around the state.

> "… the fact that we couldn't get substance misuse dealt with by the people using violence actually impacted on our ability to keep our clients safe because we needed those centres to stay open."
>
> **Practitioner 10**

Although AOD services described quickly adapting to remote service delivery to maintain their provision of support, this presented a barrier for some clients to engage, such as those without access to a suitable device or credit to engage in telehealth or video calls. In some cases, practitioners spoke about maintaining in-person engagement with clients (in line with COVID-safe practices) explaining that they did not want to isolate their clients further when they were already very isolated. This was echoed by other practitioners who shared that some clients had told them that COVID-19 had not had much impact on their day-to-day lives because they felt that, as a substance dependent person, they often lived alone and were isolated from society anyway.

Legal practitioners spoke of the challenges for clients to undergo the regular drug screens that were conditions of parenting orders, as these were conducted at pathology clinics which clients often had to catch multiple forms of public transport to attend, at times accompanied by their children, thereby increasing their chances of exposure to COVID-19. Practitioners similarly noted the challenge of pathology labs being preoccupied with doing COVID testing rather than drug and alcohol screens.

The impact of a lack of access to services and supports had negative implications on court processes, particularly when accessing services is part of the conditions of an order for people using violence. This included supervised contact with children, or attendance at mandated programs, such as MBCPs.

> "… the availability of services, be that counselling, drug and alcohol, Men's Behaviour Change, you know, Child Protection engagements, it's pretty difficult to come back to a hearing and say, 'well, unfortunately my client's been able to do nothing in the last three months because nothing's been available' … [plus] … the wait lists for government supervision services blew out quite significantly at points as well. I'm talking like a 12 or 18 months' wait list time for clients to get into those services and then feeling the pressure to agree to alternate supervisors … which was not nice."
>
> **Practitioner 63**

> "… probably the biggest issue that we had during COVID, and the Magistrates just can't sort of get a grasp of now, is all these breaches are coming through for failing to comply with counselling orders and eligibility assessments … because

> there could be 3-4-5 months between when a final order is made and when the eligibility assessment was being done … So, there's been a lot of delay in putting off that treatment of respondents, which then obviously flows onto them coming back into court fairly quickly for the criminal offending or further orders, restrictions increasing because they're not getting the help they might have got when they walked in the court physically on that day."
>
> **Practitioner 68**

The research team heard that variations in approaches from different organisations were also having impacts on clients.

> "… the service sector is hard to navigate in the best of times let alone within the pandemic, you know. So, yeah, I think a lot of the service sector scratching their heads and then the deadline for people who are trying to access service."
>
> **Practitioner 19**

Participants in client interviews also reflected on waitlists and the impact that this had on their support needs.

> "… it was nearly impossible to get any kind of support from anywhere, to be honest. Everywhere was like, 'oh, we're too inundated' or 'you don't fit our criteria to get our support'."
>
> **Participant 12**

> "I know that the police were under a lot of pressure during COVID, but when you've got an old person at risk the way I was, on a daily basis. Every day I woke up not knowing what was going to happen that day. It was awful."
>
> **Participant 10**

> "You couldn't get into psychologists, the waitlists were so long, they were trying to do Zooms, this was with private psychology, and that's why it didn't work out, and I didn't have that support that I needed."
>
> **Participant 4**

Referral pathways into services

Practitioners working in specialist family violence services described managing the unprecedented demand by introducing 'waitlist triaging', which involved clients who had self-referred being prioritised over clients referred by other services, as the latter were considered to have a service engaged as another source of support already. Practitioners also noted that referrals from other services, such as universal services, were often not possible in an online environment during 2020 and 2021, leading to increased risk and entrenched disadvantage over the longer term.

> "You might get a referral from someone like maternal health nurse or something like that, [who] are a safe space to talk … if you call them when normally the husband's out at work or out, then you could speak freely. But you can't if they're there all the time."
>
> **Practitioner 58**

Another way in which referral pathways changed was articulated by practitioners working in the AVITH sector, who explained that unless "mayhem" was occurring, families were not getting support, meaning that referrals from services such as The Orange Door and Child Protection would generally involve individuals and families with more acute needs and presentations of risk. Practitioners also described how the quality of referrals was often compromised by the overwhelming demand on services, resulting in the risk and needs of clients being inaccurately identified.

Specialist family violence services further described changes to the scope of referral pathways, as services in some areas of the state were so inundated with demand that practitioners started to see referrals "bleed" to other regions, with services making exceptions and accepting clients from outside their regular catchment areas.

Examples were also provided of the way in which clients were referred to services where there was availability, even if it was not the clients most pressing need. This was described as occurring so frequently in the AOD sector that they considered their service to be a "gap" service that was expected to pick up clients who often had more urgent needs than substance misuse, yet their service held that client and worked with them as they faced a waitlist of up to 12-months for any other service that they required.

At the same time, practitioners noted that some clients who would generally be referred to their service had not received support because some pathways had not been functioning as they previously had.

> "We generally get lots of referrals from the hospital, especially when they have, like someone who identifies a male, no matter trans male or cis male, then it's really hard for them to get access to the mainstream service like the Safe Steps or the Orange Door, so they will try to reach out to us when they want to

> discharge the client and client is not safe to return home … [but] during COVID, not that many people were going to hospital."
>
> **Practitioner 59**

Even where people *were* going to hospital, practitioners working in certain sectors such as elder abuse reported that the focus of the hospital environment was, understandably, elsewhere. This meant that family violence risk would often get missed.

> "So, the pressure that staff, nurses, doctors, etc. discharge planners are under in relation to having people come in and out of hospital means that they're kind of focused on the more functional stuff and the medical stuff that they need to do, so they're not necessarily looking for anything that's going to complicate either a longer stay patient or an issue. So that means that a lot of things get missed or they're noticed, and they don't get asked … It's like, 'Oh no, it'll be OK. Someone else can manage it when it gets home' … So, people were being discharged into situations that put others at risk and that, you know, I'm thinking specifically about the intimate partner stuff. I'm also thinking about, you know, older people who are discharged home to a perpetrating son or daughter. And the son or daughter says, 'No, no, everything's fine, I've got this all handled.' And everyone goes 'Yeah, yeah. OK, fine. We can't see any other issues, or the issues seem to be managed.'"
>
> **Practitioner 26**

Confusion accessing services due to COVID-19 restrictions

In addition to the impacts of COVID-19 changing and eroding conventional referral pathways, the focus groups also revealed several key barriers to clients accessing services. A key systemic barrier to support identified by the research involved the lack of suitable health information made widely available and accessible in languages other than English.

Practitioners working in specialist multicultural family violence services explained how some victims and survivors did not access services, including specialist family violence services, as they were unaware that this was a legitimate exception to COVID-19 movement restrictions. Practitioners also spoke of the challenges in providing

clients with accurate information about COVID-19 restrictions, with the advice frequently changing so that practitioners found it hard to provide information that was up to date.

> "So, I think the government completely failed to consider that even women … who might be citizens, that does not mean that their level of English is at a relevant level to understand that you can leave the house for family violence. Many people come to Australia and understand that it is a country that runs off a lot of regulations and rules and that you simply follow the regulations and rules. So, if I was a woman who was fairly illiterate and just saw a quick ad in English that said you can't leave the house unless you go into the doctor or going shopping for your one hour or walking for one hour, I would say, 'That doesn't sound like I can go to the police station. That doesn't sound like I can go to my friend's house to avoid family violence.'"
>
> **Practitioner 71**

Barriers to service access related to clients needing in-person support to be able to apply for certain supports or means of protection, whether because of language needs or because of disability.

> "The element of not being able to visit families and clients through outreach became significantly challenging, I think, particularly for our families where they were going through crisis, where there was potentially family violence present, having them, our CALD community, for example, complete forms, access services, understand how to go through entry points. We couldn't just be there with them to take them through the online application process or to complete their [Flexible Support Package] or to help them find housing if that's what was required and so that then becomes an extremely anxiety provoking stressful situation that has women say, 'It's too hard, it's too much and I can't do this.'"
>
> **Practitioner 31**

The restriction on movement was also raised as a barrier to clients accessing some services, with examples provided of clients not being able to access food boxes or other goods as part of their FSP if the service providing the FSP was located outside of their permitted radius. Ultimately in this scenario, many services arranged couriers to ensure that clients still had access to this critical support.

Practitioners also spoke more broadly about the challenges in providing clients with accurate information about COVID-19 restrictions, with the advice frequently changing so that practitioners found it hard to provide information that was up to date. This was particularly the case for clients in inpatient mental health and detox facilities who often had no access to their own mobile phones, so relied on practitioners for information about the pandemic, such as current restrictions, COVID-19 case numbers and information regarding vaccines.

Practitioners described how ensuring that the information needs of these clients were properly met was made more challenging in instances where clients were victims and survivors of family violence and those using violence against them would intentionally misinform them about vaccines or restrictions such as border closures. Examples were provided of this resulting in clients being told that they would not be permitted to leave the facility or, if they did, would not be allowed to see their children, as well as clients 'going down the rabbit hole' and developing extreme, paranoid or conspiratorial views about the pandemic and the government's response to it.

As with some other COVID-19-related measures, examples were provided throughout the focus groups of the way in which restrictions could mitigate family violence risk. This included where border restrictions protected victims and survivors from perpetrators who were in other states. In some cases, the curfews also mitigated the risk posed by the perpetrator at night.

In other cases, practitioners described how border restrictions could restrict clients from accessing appropriate services, particularly in regional areas where access to services was often already limited and was further compounded by border closures. Other victims and survivors reported to practitioners that, because of the curfew, they felt they had no way to explain their reason for leaving the home at night, which restricted their ability to seek safety.

Initial impacts of changes to family violence court processes

Echoing the absence of proper inquiry from courts in the early stages of the pandemic, legal and other practitioners described an initial rush of adjournments, which they saw as still having a downstream impact two years later.

> "… in the Magistrates' Court and in the Family Court as well, matters were just sort of being automatically adjourned if there was no way that an agreement could be reached on the day and I think that's probably contributed to the significant backlog that a lot of the courts, particularly for intervention orders, have been dealing with this year … there was basically a form that clients were filling out and it was like, 'well, do you consent to this order, yes or no?' And if

they were saying 'no', the matter would be automatically adjourned. So, there was no real space for there to be discussions or advice or negotiations."

Practitioner 63

As well as a backlog for courts, practitioners explained that this was leading to an observed impact on police capacity, as well as a potential impact on client safety.

"… in the beginning they adjourned a lot of matters, and then now we're seeing the backlog that we see in terms of the flow-on effect for the police. It just meant that the police availability to negotiate matters … it wasn't there, so it was much harder to keep moving matters forward … And then that can have a real effect on safety, because it means that matters are in the court longer so there's more of an opportunity for … conflict to occur. And also, it slows down. I think it's had an impact potentially on the service of [FVIOs] … it can mean that that the order is not necessarily effective ..."

Practitioner 1

As with other areas, legal practitioners described an initial drop in referrals for legal advice, as well as matters being processed in the courts. Conversely, they also described an increase in AFMs seeking legal advice where they did not feel that police had been prepared to take their preferences into account.

"What definitely happened … in 2020 particularly, was that, because not everyone was coming to court, and … legal services were very reliant on police for referring matters. That wasn't necessarily happening across the board, and so there was decreased access to legal services in [FVIOs] in particular at the beginning."

Practitioner 1

"… we did seem to have an uptake in AFMs on police applications who felt as though the police weren't listening to what they wanted. So often, if … a few months have passed, possibly there's a full interim and they're wanting to vary the order down. We found that, from what we were being told, police weren't

> interested in engaging with that and probably just said 'you need to make your own application to vary or call legal help'…"

Practitioner 66

Impacts of changes in custodial measures

Practitioners working with women who were victims and survivors of family violence spoke about the disproportionate impact of measures in custodial environments. While practitioners who worked with criminalised women – and who were invariably victims and survivors of family violence – were pleased that bail was more readily granted in the initial stages of the pandemic, they highlighted some inadvertent consequences of the fact that the 'exceptional circumstances' provisions of the Bail Act were being used more readily by courts. This was because these decisions to grant bail did not appear to be taking family violence risk into consideration, nor facilitating the supports that people needed to be able to succeed on bail.

> "… lots of people were getting bailed, but they were also bailing people … who use really serious violence. … We were just there going. 'Are you kidding me? They got bail?' And then to try to tell our clients that they did the right thing. Like we'd say to our clients. 'OK, we know you don't trust the police, OK? You don't trust the justice system. We're asking you to trust us. Trust us, use the police this time. What's happened is really serious. You need to use the police. We need to trust in the police and the justice system that are gonna do the right thing.' And then these people would get bail. And then our clients would look at us and … it was like breaking our rapport with clients … how do we then get them to trust the police, to use the police the next time around because they're like, 'but we did that, we made the statement and they got bail after what they did' and we were like, 'I honestly don't know.'"

Practitioner 127

Within the case file review, there were also examples of the ways in which changes to the bail laws impacted the safety of victims and survivors. In one example, the perpetrator's prison release date was brought forward because of changes in prison policies related to COVID-19 Emergency Management. The risk assessment stated that "risk is currently mitigated whilst perpetrator is in prison however once released, risk will increase". To respond to the increasing risk, the client took additional safety measures, including installing a CCTV camera and obtaining a personal safety watch/device (GS15).

Conversely, practitioners explained that it was very difficult to obtain court agreement for alternatives to prison for some of their clients.

> "… [practitioners] were finding it very difficult to get people they were supporting into Forensicare as opposed to prison … So that was another area where violence was occurring, but the boundaries between mental health and violent behaviour was still, you know, it was difficult for families to navigate and to get support and understanding … "

Practitioner 3

Where clients were in custody, practitioners described the experiences as likely to have been especially damaging longer term, beyond the existing negative impacts of carceral environments. Practitioners described the challenges of trying to deliver therapeutic support to clients in custodial environments, including relying on online platforms which were sometimes accessed by Corrections staff. In addition, the lack of capacity to attend in-person meant that legal practitioners had to rely on phone appointments with clients, which they found frequently got missed or miscommunicated.

> "It's really hard to do it on Zoom, to have group therapy with people who are in prison."

Practitioner 59

As highlighted in earlier sections of the report in relation to Child Protection, the impact on criminalised women's contact with their children during COVID-19 was particularly profound.

> "[Child Protection and Corrections] seemed to be using COVID as an excuse not to get women like photos of their kids or video calls, like, 'oh no, COVID' 'Oh no, your kid's got home school on' or 'we don't have enough staff' …"

Practitioner 127

> "… contact for clients that are in custody, if it happens, it's by Zoom and that's just impossible with a child … and no visits- face-to-face visits … [can lead to] just the disruption in relationships, particularly with children … and yeah, inability to be able to build those attachments and maintain family relationships for when

> they get out and having to kind of start from scratch and rebuild a relationship after maybe two years of not having seen someone face-to-face …"
>
> **Practitioner 128**

> "[Child Protection] weren't facilitating face-to-face visits in the beginning. They still have not been able to reinstate those face-to-face visits now, and that does not even take into consideration the video, phone calls or the just basic phone calls in which women are not able to access at all."
>
> **Practitioner 126**

> "It might just be like [kids have] a cold or, but even if they're cancelling face-to-face, why were they not then replacing that with virtual access? … they haven't replaced any of it. And they were the ones cancelling it, not facilitating it … I think there's a combination, I don't wanna say all of this is Child Protection because there was certainly Corrections not allowing it and Corrections are still not allowing it."
>
> **Practitioner 127**

Additionally damaging were the conditions in custody in terms of particular restrictions introduced to contain the spread of COVID-19 in a closed environment. While practitioners acknowledged that the risks were high and that vulnerable populations needed to be protected, they also described the profoundly damaging experiences for prisoners who had to endure 14 days of quarantine every time they entered the prison environment. For women charged with low-level offences but with no support in the community, this was often a revolving door occurrence.

In particular, practitioners described the impact of 14 days of isolation on a client base that had invariably experienced trauma – with 'sitting with nothing but your thoughts' for 14 days being a significant trigger for people who have experienced sexual abuse and family violence. More acute still, practitioners described clients being given permission to leave prison to see a dying relative or attend a funeral and then having to return to prison for 14 days in isolation immediately afterwards, with no emotional or psychological support.

Considerations around clients' release into the community were also flagged as a real concern. This was in part because services did not have access to clients to conduct risk assessments or to ensure that people were linked with necessary supports upon release.

"… we couldn't get phone calls to do risk assessments for women who are about to leave prison. [So I said we] need to do … a risk assessment. I need to safety plan. I got a reply back saying, 'We will do it'. And I was like, 'How can you do it? You're not trained in this!'"

Practitioner 127

"We were having people leaving prison with no Centrelink benefits, which is meant to be organised …"

Practitioner 128

"… we actually had one that got out of prison during the middle of bloody lockdown, no clothes other than her prison gear, no money, after 8pm in the middle of the bloody curfew. Just 'here you go, good luck'. Women were running the gauntlet of the curfew and the public transport system to find somewhere safe."

Practitioner 132

Recommendations

Future-proofing Safety highlights a number of service system failings in relation to family violence and sexual assault service provision. The withdrawal of key services, including the closing of Child Protection offices and/or facilitation of access visits, as well as the withdrawal of forensic examinations for sexual assault victims and survivors, will have wide-reaching and long-term implications for children and adult victims and survivors of sexual assault.

The lack of service system coordination and collaboration during COVID-19 failed clients seeking support, while practitioners spent extensive time finding support pathways for clients to address compounding needs and risk issues, across a service system that was struggling to keep up with demand and was largely operating in silos. Better service collaboration, including through the development of new systems to support collaboration, could mean that people are able to access the support they need in future crises.

Government, peak bodies and organisations	• Find ways to enhance communication and collaboration across sectors during crises and disasters.
Government	• Enable Child Protection services to be maintained and even expanded during crises and disasters to manage the increased level of risk that vulnerable children face. The need for protecting the Child Protection workforce should not come at the expense of protecting vulnerable children when there are ways of keeping workers safe, including through the use of PPE. • Support coordination and collaboration across sectors, including funding services to provide secondary consults for family violence and sexual assault service responses, • Consider the development of a website or database where services can provide regular updates on service offerings, service demand, wait times and service capacity. This could then be used to guide the sector about where and when appropriate supports might be available. • Enable forensic assessments for sexual assault victims and survivors to be re-established across Victoria. These services should be classified as an essential service that is never withdrawn during crises. • Invest more in family violence emergency accommodation and other safe accommodation pathways for victims and survivors so that they are able to access safe and timely accommodation support. • Ensure that, during crises and disasters, government provides up-to-date and timely advice and communications in a range of community languages and methods. All communications during crises and disasters should include information about family violence provisions so that people are aware that they are allowed to leave in family violence situations.
Peak bodies	• Support collaboration and communication between services and sectors. • Provide specialist support and resources to other sectors to support capacity building.
Services	• Develop communications plans during crises and disasters to support clients to know what other services are available and how they can access support. • Develop communications plans for other services to support the broader sector to know what services are available, what the waitlists for services are like and how clients can access support.

- Prioritise the development of multidisciplinary teams where possible to provide internal support and specialist expertise which can be utilised within organisations during a crisis.
- Improve networks with other services and sectors. Cross sector collaboration and capacity building could be used to support and improve practice and would form a strong foundation for support during crises.
- Find ways to provide ongoing support for sexual assault victims and survivors, particularly given the barriers to accessing forensic assessments and the impact that this will have on their lives.

Impacts on the workforce

While the wellbeing of frontline healthcare professionals during the pandemic was increasingly recognised, the wellbeing of practitioners working in broader community-based services received less attention by comparison. Early insights from online surveys with family violence practitioners in Queensland and Victoria focussed on the repercussions of remote service delivery and its impact on workers' wellbeing (Pfitzner et al., 2022). The survey data results from this wider research found that working from home "during the COVID-19 restrictions had a detrimental impact on the wellbeing of many practitioners".

Other studies found that increased workloads were shown to "create stress, risk of exposure to COVID-19, longer and more shifts, and the need for immediate and round the clock outreach" (Baffsky et al., 2022). Recent research in Victoria has echoed these findings to an extent in the context of family violence services for members of the LGBTIQ+ community (Worrell et al., 2022).

Because of its system-wide focus, Future-proofing Safety was able to examine the impacts of service delivery on a broader range of community-based practitioners, including AOD, mental health, financial counselling, parenting and family services. sexual assault and legal practitioners. Across the sector focus groups, for example, practitioners described a range of impacts. Some of these were positive and represented shifts that they were seeking to adopt, as permanent in the way that they worked and delivered services. These primarily involved the increased flexibility in their roles provided by use of technology.

> "The IT side of things, the use of Zoom just as a worker I think has been revolutionary."
>
> **Practitioner 101**

> "So, I have actually enjoyed working from home and hope to continue working from home and my clients have been very, very supportive."

Practitioner 6

That said, the nature of the work that most practitioners were undertaking – supporting people who had increasingly complex needs while also experiencing or posing significant risk – meant that the isolation and absence of boundaries involved in working from home often undermined the benefits of this flexibility.

> "Rolling out of bed and over to the desk that is in your bedroom and then suddenly inviting it into your room. Where are the boundaries here? "

Practitioner 14

> "… the support absolutely depended on this phone work and not the practitioner sitting in a room by themselves at home, trying to manage three other children and all the things in their lives. It was actually built around the idea of that you're in a supporting environment with other people who you're sharing your work with and decision making and all that sort of thing in the space."

Practitioner 2

> "I'm blessed that I have a spare room to have as my office. I know a lot of people who were doing it from their bedrooms, like doing family violence risk assessments in the space where … they're supposed to be able to go to switch off ..."

Practitioner 48

Practitioners spoke about the acute stress of trying to support clients with complex needs while also trying to supervise their own children in remote learning and otherwise cover the additional domestic workload that resulted from everyone being constantly at home.

> "And it's a very female dominated industry and women have, like we did the caring responsibilities we did, the teaching, the parenting, the everything … And I've had workers who were doing serious high risk family violence work with two kids from home like home schooling. And it's just like primary school aged young children …, like you can't do that."

Practitioner 48

> "Women were … on the front line and also the primary caregivers and that needs to be recognised ongoing."

Practitioner 17

Many practitioners spoke about the challenges of COVID-19 in their own lives and the disproportionate impact that the virus had on many communities, including workers from those communities who were experiencing the impacts, while also trying to support others.

> "[Our organisation has] such a diverse staff coming from different backgrounds and … the country and the families that they have connection with are overseas and still impacted by COVID differently and somehow that's really hard to be acknowledged in work settings … it feels like you are tackling the COVID here, but you're also kind of tackling the COVID in your families and your loved ones that are still experiencing it. I think that's also had a huge impact on the workforce."

Practitioner 82

> "Aboriginal staff have pages or their own Instagram pages that all the Aboriginal women know who work here, who are connected, but it's family or community, are messaging our staff outside of hours with those, you know, with concerns. Yeah, it's sometimes it's information: 'when's the next workshops?' … and our team don't ignore those messages … that's outside of nine to five as well, like, it kind of doesn't stop."

Practitioner 18

Practitioners across the focus groups described the community services and legal sectors as frontline sectors that they felt had largely gone unacknowledged and unsupported in the same way that other frontline services had.

> "I mean from a staff perspective, we were sending staff in, in a really unsafe situation at the beginning because DFFH was sending their lawyers in. So, it's kind of the same as … with, you know, police being there, and we just had to do it because things were just happening, and you had to physically be there to

actually safeguard against things being happening without your client being heard".

Practitioner 60

"The risk is too high for anyone to go in because the harm is too great … So, there are lower levels of risk that more skilled practitioners would be able to manage. But there are also some really pointy end, nasty end people who are verbally aggressive. It's not safe for someone to attend ..."

Practitioner 26

Across the focus groups, the research team heard that the combination of frontline pressures had resulted in significant workforce stress and burnout.

"… it's overloaded and it's certainly not an efficient or effective or professional way to run a service and to provide, you know, the best care to these families. And get the best staff and get, you know, staff to be committed and stay and not to be suffering with their own anxiety and worry along the way of whether they're going to have a job in three months' time."

Practitioner 76

"Yeah, I had a lot of people around me saying that they felt like they were doing a shit job at everything because they were trying to do everything at once, at the same time."

Practitioner 100

Some practitioners described the stressful impacts of practices that were adopted by some of their employing organisations when the shift to working from home first occurred. This included some services requiring practitioners to complete timesheets to account for how they were using their time, given that they were not visible to management.

"… [the timesheet] was so stressful. Like, I don't get stressed at work and this thing was just stressing me out so much, like you would just be thinking about everything you were doing. 'Did that take too long?' You know, like if you did go for a walk at lunch and you were like 5 minutes late, you know, like 'oh, I've got to make sure I answer my phone, and make sure to do a message this time so

> that I can show that I was back on time' … Yeah, there was no way that I was slacking off ... Like just the amount of work that they were getting out of us".
>
> **Practitioner 47**

There were also changes in the expectations of the workforce in the initial stages of the pandemic, including the provision of more meetings and additional work, which took them away from client work and increased the pressure that many individuals were already under. This was noted as a shift that had been sustained following the pandemic.

> "I think what's happened is there's so many meetings. I think that's probably been the shift that it takes away from actually working [on] cases."
>
> **Practitioner 58**

Stemming from this was an impact on services and practitioners which lead to downstream effects on services' ability to support clients.

> "Our staffing group as a whole was sort of decimated and it felt like I was looking at a staffing group that just had absolutely nothing else left in them. I've never experienced … such … widespread loss and grief and you know, they were also scared and burdened. I feel like I'm using a lot of really negative language. But they were so impacted, the workforce and still are so impacted by that. So, I definitely agree with the idea of this kind of collective PTSD from that experience that has not yet ended or given them a moment's breath."
>
> **Practitioner 16**

The impact on the workforce was compounded by the rolling waves of COVID-19 when organisations and practitioners had been pacing themselves for a shift back to in-person practice and support from colleagues.

> "… we thought [COVID] was going to end and it didn't … I mean, we were hearing people who rarely got off their seat to go to the toilet because normally when you travel to meetings or there's kind of inherent breaks … And all of a sudden people were doing back-to-back, you know, in front of a screen for hours on end …. We just gave them additional leave and … we sent out a, a wellness pack … but we felt anything we were doing was kind of inadequate really … in the office … you've got your colleagues to debrief with. At home, you just, it's mounting

> from screen session to screen session and there's no real debriefing or, you know, kind of humanising element …".

Practitioner 11

Practitioners demonstrated a considerable feeling of loss and grief across the focus groups. Some worried that the exhaustion and overwhelm they continued to experience may have a lasting impact on the social services sector.

> "… I feel like COVID was a risk too big to ask for the community service sector to bear as a workforce. You tolerate a lot, have a high tolerance for a lot of things. You have a lot of resilience and because I think for a lot of the risks you can sort of contain that … for the workplace. And take that barrier away from the home that with COVID, I mean, you know when you put yourself on the frontline to be exposed, then obviously it has an impact on your home … I wouldn't be surprised if there's a lot of workers that have worked for a long time that this is, COVID is being their straw that's broken the camel's back."

Practitioner 19

Turnover in the workforce was already a feature of organisational environments which meant that a lot of staff were commencing roles in the online environment without any previous experience of this complex practice prior to COVID-19.

> "… given the high rates of staff turnover in the community sector, there were a lot of people who started this kind of work during lockdown and not just in our organisation, but particularly Child Protection. So, a lot of the work that we were doing was helping people be acquainted with their job and know what they had to do and know what to look out for … And it felt like there was not enough support built into their organisations."

Practitioner 48

> "All of the things that I relied on to be able to do this job and to do this job well and to refill your cup … A lot of them didn't exist anymore or weren't available to you … So, I think that that's definitely something to be thought about. I've definitely had a lot of colleagues leave the profession … [but] it's felt across all

industries. It's not just ours … I think it's something that we're going to continue to see the ripple effects of probably for a while to come."

Practitioner 63

Consistent with their commitment to their clients, practitioners reflected on the downstream impacts of this turnover on people who needed their support.

"I've got clients … they're such vulnerable women who don't trust and have got so many previous problems that have happened that it's a big deal for them to keep having workers change, and all of them just drop off when they've lost these certain workers."

Practitioner 47

"… we have regularly got staff not coming into the office; outreaches need to be cancelled. So, that's a disruption for not only the service we provide, but the intervention and the potency I suppose of how that intervention can be delivered."

Practitioner 53

Participants in sector focus groups described concerns about the fact that workforce turnover meant that they were increasingly looking to inexperienced staff to carry caseloads.

"I guess we've found ourselves employing counsellor advocates who we probably wouldn't have employed in the past that are kind of more junior or less experienced in their career … and without having some support around how we can … develop these workers, it's kind of not really meeting our demand or need."

Practitioner 55

"… most of the [new practitioners] that have graduated, have graduated without ever doing a face-to-face placement over the past two years. So, they've done research and policy placements because of COVID, so … we have got quite a few new graduates on my team because it's that or nobody."

Practitioner 56

> "I think it was extremely stressful, and we see that now when we're advertising for positions and no one bites – like, across the service sector, I wonder where the professionals have gone – probably to careers that are being interior designers or florists as we usually daydream about, but I think burnout was seen consistently and it almost became trivial discussing burnout because it started, I know from the management or as a supervisor, you feel helpless in knowing how to support your staff any further."
>
> **Practitioner 31**

More than the impact of workload, however, practitioners described the distress and long-term effects of feeling helpless in being able to provide appropriate and sufficient support to clients. Several practitioners described this separately as a "moral injury".

> "… you know what [clients] need. And actually, you can't respond and nobody else can respond. And so, you're left with moral injury and that's devastating and that's what's going to burn a lot of practitioners out. And then you've got a whole lot of new staff that actually are just going to be burnt out because they don't have the skill and support from all this experience, and so you're just not going to have people wanting to come into the sector."
>
> **Practitioner 75**

> "So, it's just wild to me, the way that they kind of ask us to do this, this life changing work in such a short period. Practitioners burn out and, you know, they're wanting to keep going with their clients, they're not allowed to. They get the moral injury stuff and then they end up moving on to something else where … they're not under so much pressure and people's lives … you feel like your clients' lives are in your hands sometimes in this work … And particularly for queer clients who don't have trust in other services, so you can't send them to [Emergency Departments] … when they're feeling suicidal. The risk really feels like it sits with you … So, practitioners are really doing a really big thing."
>
> **Practitioner 99**

> “So, you know, while at the same time self-care became something that was talked about, but it was all individually related and systemically the system has actually become quite abusive … these systems that were set up for really complex clients, they all just failed. So, I was really resentful that I'd spend so much time filling out huge forms for specialist consults that were going to magically open portals to extra supports, only to find that it all failed. And I was just left holding it all anyway. … So, it definitely felt like none of the system was working.”
>
> **Practitioner 14**

Some of these practitioners described sometimes taking matters into their own hands and bending the rules so that client could have some sort of support.

> “I really did just sort of throw out some of the rules at times and just did what I felt had to be done. I just didn't wear PPE, I just ticked that I did on the forms, and just did it … I tried to manage the risk as best as I could, but sometimes I just couldn't deal with it and just have to do what I felt like a good human would do.”
>
> **Practitioner 14**

Practitioners urged that the impacts of this period be taken into account in future planning for service provision.

> “… if you're anxious, if you're stressed out, if you're feeling vulnerable, if you're feeling traumatised, if you're feeling those sorts of things, that has a direct impact on the clients you're working with, and I think that's one of the missing components is that we're delivering services to people who are traumatised and are in crisis. And sometimes so is the staff member! I think that's one of the things we have to sort of reflect on.”
>
> **Practitioner 2**

> “So, my daughter is 16. Her school counsellor identified that she was experiencing vicarious trauma as a result of listening to some of those conversations that I did have [with clients], although the door was closed, and she was in another room.”
>
> **Practitioner 51**

> "I had my phone turned on at night. And I felt because some of those [clients] didn't have other supports, so I was there for them to reach out to. The downside of that was I'm also a single parent and I have my [child] here. So, my [child] was exposed to some of those support conversations and the worries. When I'd walk out and not, you know, not be sure whether the Mum would make it to the next day or not."

Practitioner 91

Insights relating to the impacts on the workforce were also a key theme to emerge from the sector survey. Participants spoke specifically about how some of the challenges in remote service delivery not only impacted the ability of services to meet demand but also staff wellbeing.

> "There was a huge increase of work, complexity and demand on the organisation. There was less staff and most staff members taking on additional roles to help with staffing demands across the whole organisation."

Health service, regional area

> "Connections to other teams within the service was poor as was external service relationships, I don't believe this was primarily because of work from home but the belief that we had to "get through" for a little bit and then we would get back to working as per normal, as we got further into the pandemic it became apparent that this was going to be longer than expected. Numbers of referrals increased and there was no increase in staffing and staff wellbeing was not prioritized. As a result, service provision was impacted, the capacity to do quality work was overshadowed by sheer quantity and staff stress, numerous positions were vacated (including mine) as the demand was overwhelming and support not appropriate. I believe the quality of service provision to clients was significantly affected by the experience of staff."

Family violence service, regional area

> "A lot of staff were starting to display stress and anxiety and/or were coping with their own health issues or health/caring issues with family members."

Family and relationship service, suburban area

Recommendations

Future-proofing Safety provides insights in relation to the impacts of COVID-19 on the workforce who provide services within the family violence and sexual assault service system. The enormous turnover in staff will continue to have broad reaching implications across sectors, particularly in relation to a loss of corporate knowledge and professional expertise from critical community support services; the pressure the loss in workforce has on remaining staff with knowledge and experience; and the inability to transfer knowledge to the new graduates and the emerging workforce.

Critically, a number of findings related to challenges of remote service delivery that not only impacted on the ability of services to meet demand but also to manage staff wellbeing. It is critical to find ways of supporting staff to continue to work safely in future crises.

Government, peak bodies and organisations	• Support the remaining workforce through the provision of further support and training in key areas of identified need.
Government	• Urgently respond to staff shortages through the provision of training and other support to the sector. • Advocate for incorporation of specialist family violence training into all social work degrees – including training and placements in support managing complex risk and need so that new graduates can more easily respond to the increased need within the community. • Consider more flexibility with hybrid working arrangements in future crises, including thinking about what services should maintain face-to-face offerings. Government should offer support across sectors to manage this change in policy safely.
Peak bodies	• Consult with member organisations experiencing staff shortages to identify needs and provide ongoing advocacy and support.
Services	• Implement wellbeing measures for staff that are well-communicated, planned and staff centred. • Undertake regular audits to understand the needs of staff and the ways in which crises would impact capacity to continue to deliver services, in particular face-to-face supports, safely.

- Explore ways to embed additional support for staff members from within the marginalised communities they support – often they will face additional requests and expectations from community and therefore may need additional support.
- Enhance the use of PPE and other protective measures to enable staff to continue to safely deliver face-to-face services to vulnerable members of the community, including children and young people.

Part 4 – Ongoing impacts and lessons for crisis readiness responses

The findings of **Future-proofing Safety** highlight many of the ways in which the family violence and sexual assault service system faltered during the COVID-19 pandemic. In particular, the system level gaps discussed above describe the many ways that the move to telephone and online service delivery alone, as well as the withdrawal of key services, left many of the most vulnerable in the community at risk. This occurred at the same time as there was an escalation in family violence risk and co-occurring needs, hindering the surge capability of the sector.

In order to future-proof safety for Victorians, we must respond to the current crisis, in addition to improving our planning and responses to future crises.

Key findings

The **sector focus groups** highlight the need to respond to the current crisis, highlighting how a 'snap back' to prior COVID-19 service delivery is not possible with the huge current demand on services. In particular, practitioners highlighted that the complexity that had increased in their client base across 2020, 2021 and 2022 was now entrenched and would likely require much greater attention for at least five years or more. They also emphasised that this entrenched complexity was often as a result of the most marginalised or disadvantaged members of the population not having been prioritised in the initial crisis response. Some participants in **client interviews** also volunteered this perspective.

The **Crisis Readiness Framework** presents the ways in which services can better prepare for future crises, by considering the overlapping cycle of preparation, response, aftermath and review to prepare more effectively for future crises and to future-proof the family violence and sexual assault service system to improve future responses. The Framework draws on the key findings and recommendations of this report to improve responses to future crises, across all levels of the service system.

Responding to the current crisis

The sector focus groups highlighted the need for recovery from the current crisis to be foundational to any future disaster planning. Practitioners emphasised that the concept of a 'snap back' to pre-pandemic conditions was vastly unrealistic. Rather, practitioners stressed that the impacts of the previous two years on their caseloads and their workforce needed to be recognised and accommodated, as did the impacts on the increased complexity and support needs of their clients.

"So, I think there's still so much work and we're really seeing that recovery is going to take a long time for families and society. It's like where everyone snapped back. Well, it's not true."

Practitioner 52

"So, you were just in a holding pattern and so the complexity was increasing, the need to work longer was increasing and demand pressures were increasing all at once. So it was, excuse my expression, but it was kind of a clusterfuck, you know, like there's no better way of saying it. And actually, I think we're still in it. So, more and more people are actually less and less able to deal with the chronic nature of conditions and with the systems that are pressuring you to fix things that are actually more overwhelming."

Practitioner 75

Practitioners consistently volunteered that they could see the impacts of COVID-19 continuing to be felt over a period of five years. Many who participated in the sector focus groups felt that, in order to future- proof the family violence services system, there is and will continue to be the need to address what had unfolded.

"Yeah, I think that we're going to be overwhelmed for the next five years. Easy. Yeah, like the level of just the reduction of resilience and flexibility and kind of space to even think to get out of a fight, flight, freeze response, umm on multiple levels for multiple people in the household is just huge and … we've got multiple systems that are actually not functioning and not able to actually respond. So, we're just going to have more suicides. We're going to have more deaths. We're going to have slower change."

Practitioner 75

"I would say that we would still see these people present for treatment over the next couple of years. It could be too early for a whole lot of people. They're in the acute phases of their substance use."

Practitioner 7

"We know stress has a physical impact on the body. So, I think when people are left in a state for a long period of time without being able to access the

appropriate support in the timely manner that ideally they need, like there's delays with all systems, there's delays with our, you know, general public health system as well, but without having that it can exacerbate things ..."

Practitioner 56

"COVID … made it so incredibly visible that we couldn't look past it. We don't have houses for our clients."

Practitioner 8

Practitioners were particularly concerned about the long-term impacts on children and young people and what they described as an 'unravelling' of the supports that had previously been provided that would in turn mean demand on the service sector in years to come. This was in relation to the impacts on children and young people's learning, as well as their behaviour and wider experiences of trauma.

"I think that is another big part of this, is [young people's] learning … And then you add people in with learning difficulties and all of those things. I wonder what impact that's going to have on their mental health, on their engagement, on their ability to manage to, you know, to be resilient, to know what to do."

Practitioner 76

"… I've got teachers who are just saying, you know, the behaviour – … like the kids, their language that they're using, the violence towards the teachers, like their behaviour has just really escalated. And then you kind of think, well, what were they witnessing at home 24/7 … and that's really impacted on their behaviour and the way in which they're now acting in the world".

Practitioner 98

"… we work with a lot of queer people, and we just saw the level of kind of isolation skyrocket. Wait times for gender affirmation surgeries, access to HRT, all of those things are still months, you know, possibly months away. So, like in my mind, often it's like … we're still deep in COVID, like we're still here and we're still feeling the impacts and the ripples, and I imagine we will see those for years to come".

Practitioner 103

> "A lot of contacts weren't going ahead so families were missing out on that time with their children. And I don't think I had any successful reunifications during COVID."

Practitioner 86

Overall, practitioners felt that a significant injection of resources was needed to support vulnerable communities to recover from the pandemic, as well as to prepare for any future crisis.

> "… it's going to take I think years to actually, you know, work through the backlog of people, and all their experiences. I think we've seen an increase, you know, in forms of coercive control, financial abuse, and you know, before they weren't identified, but I think it's happening right now … we are just not going to reach the people that really need services."

Practitioner 29

The impacts on the workforce described throughout this section were something that practitioners thought needed to be a focus of government planning – not just in terms of addressing workforce burnout and turnover but in changing the way that practice was delivered and services were funded.

> "… we have these people that potentially have never really engaged with the client at all, despite their four years of university … they might go and work in another job before they consider coming to the pointy end of social work, or sexual assault or family violence. That's very daunting for these new graduates that have never sat with a client before."

Practitioner 56

> "… even prior to COVID we used to rely on a lot of people that were coming over from overseas to, I guess, backfill our sector … But how do you help your current pool of staff to be more resilient when the resources that you would normally offer them like, you know, extra clinical supervision or, you know, time off to kind of refill their cups and things like that to do some self-care, those things aren't available either."

Practitioner 55

The theme of staff wellbeing and burnout was also reflected in the sector survey responses.

"Staff wellbeing – we cannot provide adequate client care if we ignore it, higher referrals, higher mental health issues in clients on top of people's own experience of the isolation and fear associated with the past two years has left people burnt out and leaving the workforce … burnout is a HUGE problem and I am yet to see anyone actually look at this being the reason for staff turnover/poor practice."

Family violence service, regional area

"Support for staff working in family violence work from home and how this isolation mixed with work stress can impact their mental health and welfare."

Family violence service, suburban area

Practitioners emphasised the need to recognise and resource client-facing services on a more equitable basis across sectors, particularly to address short-term funding models and address practitioner pay levels.

"I recognised the stigmatisation of our sector through COVID when the government was able to access an enormous amount of money to support not only people on Job Keeper and Job Seeker, but also to increase their funding available to our health sector and just how limited we are in the AOD sector. And so, I think if the government is able to identify funding when they need it, then we need to hold them accountable in identifying funding now, because we need it now."

Practitioner 8

"I don't think anybody would disagree that the investment in family violence is fantastic. The investment in sexual assault services and harmful sexual behaviour services particularly need - and it's not just about an increase, but acknowledgement. This is not short-term work."

Practitioner 54

"The casualisation and short-term nature of funding cycles that's been around in the last 10 years and also funding models of the community sector have been

> nothing but destabilising and really unhelpful and a sense that all of us, you know, it's kind of a rush to the bottom ..."

Practitioner 75

> "… people have reflected on their life and kind of gone, 'do I really want to do this work for this money?' … like we get these pay increases and all those sorts of things, but we don't get a lot of easing of targets and things. So, you're trying to still do the same amount of work with less staff because you're paying staff more, which is what they deserve to be paid … I think government really needs to think about, well when there are pay increases like 4.5%, which is well deserved … if that doesn't get passed onto us … that just, you know, continues to put more pressure on staff because then they end up having to [meet] targets for less staff hours on the ground."

Practitioner 98

Practitioners highlighted the need for appropriate supports such as clinical supervision and adequate training, which they noted was still not sufficient, or where the benefits had been lost when trained practitioners moved on and new ones were not brought up to speed. In addition, they noted that many new practitioners had not had the chance to learn from their more experienced colleagues while their workforce was delivering services remotely. This was particularly important, one practitioner explained, in developing "a cultural understanding and respect for the clients they are working with" (Practitioner 62).

> "…. supervision is something that we need to talk about more often because that is how you work … and if we don't have that built into the system for you on the front line, that's a very dangerous situation for you ongoing."

Practitioner 51

Just as crucially, practitioners highlighted the urgent need for resourcing for early intervention and prevention – both in terms of recovery from the current crisis and preparedness for the next.

> "… what I would really like to see all across the board, but particularly from government departments is more resourcing for early intervention and prevention and for that to be consistent … There are silos not only between different … sectors drug and alcohol, and domestic and family violence and

whoever else. But even in between the governments themselves, it doesn't seem like the different portfolios are talking to each other or willing to collaborate …"

Practitioner 10

"… how can we plan moving forward to protect our community, protect our women and children, our vulnerable people? … I haven't got a magic answer but I think yeah, prevention as well as … response really needs to be addressed ..."

Practitioner 57

Practitioners emphasised the importance of a strong foundation for the community service sector, rather than *ad hoc* additional funding. In particular, they explained that it was especially challenging to try and use the sudden injections of funding that some services had received during COVID-19 without an adequate workforce to provide the additional services.

"… all of a sudden, there were these short-term, you know, pilot projects and money being thrown out … It was like actually, you know, we needed the money years ago and not right now we're in survival [mode] … we can't find staff, you know, and or actually it's going to take me six months to train somebody up to do this work. So actually, it created more stress and expectation … I've never seen it as bad. And I'm pretty skilled and sometimes you're kind of going, 'I don't know what to do here, like, there's actually no effective way'."

Practitioner 75

Practitioners had a number of reflections about what they had learned to value about their work or appreciate about the way in which their workforce had managed to respond as best they could, including in the context of wider and substantial sector change in response to recent Royal Commissions. Some of these reflections, such as the benefits of an accelerated move towards the use of technology that would otherwise have taken five to ten years are echoed in other recent Victorian research (Worrell et al., 2022).

"I think we've probably saved five years, if not 10 years of systems becoming aware of certain practices … we're all better at Zoom and all this sort of stuff that in itself is also going to make differences about how we do our practice, how we train, how we do everything … I'll never, ever underestimate the importance of belonging to a team ever again and that sort of thing in being in open

> workspaces where, if I notice, or my colleague notices that I'm having a difficult conversation with the client, and you know the little things makes the difference, like if they walked past me and just tapped me on the shoulder like 'I'm here' and yet online we miss all that sort of stuff. I hope we don't forget that."
>
> **Practitioner 2**

> "… whatever decisions are made needs to be focused on what's best for the clients, so we don't abandon what we had with face-to-face. If that is better for the client then that is what the client needs, and the victim-survivor needs. But we shouldn't abandon online because that's also better for some people as well. It's often more suitable and we need to be guided by victim-survivors' wishes and that voice needs to not be lost in the charge for efficiency …."
>
> **Practitioner 1**

Most importantly, practitioners across the sector focus groups emphasised the need to remember the most vulnerable members of the community in any crisis response.

> "I would love to see minorities to be a part of the decision-making … have an intersectional lens. Invite them to that table."
>
> **Practitioner 49**

> "Crisis readiness is a social equity problem across the board all the time."
>
> **Practitioner 83**

> "Going through COVID just really showed how shit and just … understaffed, under resourced, underfunded, under everything the housing system in general was and just how inhumane it was. I think it really put a spotlight on the policy neglect …"
>
> **Practitioner 43**

This was also reflected in the sector survey, looking at how better service and sector collaboration could potentially elevate the voices of diverse community members.

> "Need to have better interagency connections, between family violence specialist services and mental health/community health organisations that involve workers who provide direct care & support as well as the service users and those with personal lived experiences across all ages and backgrounds. Having intersectional partnerships and grassroots style community consultations and collaborations where diverse voices are truly heard."

Mental health service, regional area

As reflected in the earlier observations about Aboriginal practitioners' community obligations, practitioner concerns included flagging the need to recognise and understand that a wide range of practitioners themselves were often members of particular communities and had their own responsibilities This is also echoed in other recent Victorian research involving insights from practitioners working in LGBTIQ+ support services who were themselves members of the LGBTIQ+ community (Worrell et al., 2022), and was particularly reflected in the Future-proofing Safety research by practitioners from culturally and linguistically diverse communities.

> "I think we could have plan better … I have to have seven days a week and 24/7. I have to have my phone because I live within the community. I work for the community, and I speak a couple of languages in the community … It was very hard also to say no because … they think I will solve their problems. That's why they call me … because we didn't plan. So, we all struggle."

Practitioner 92

Participants in client interviews themselves also volunteered that they thought it was crucial to remember and centre the needs of the most vulnerable or disadvantaged in any future crisis response.

> "What was missing was the lifting of restrictions for people going through that stuff … restrictions should never have been put in place for vulnerable people"

Participant 8

> "I class myself as pushing poverty … you know, I'm struggling every day. So I think more focus definitely on the lower end of the community because they're already struggling, so to add something like COVID or something similar on top of that … There needs to be some immediate support to know that we're still not being left behind and left alone. The government does need to step up. You know, get people out there door knocking, physically checking in on families to

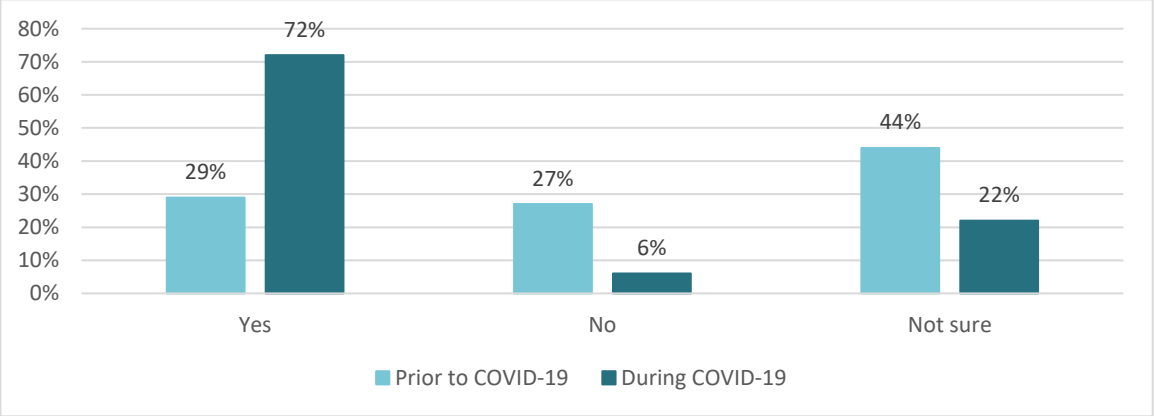
make sure they're OK, cause over the phone, it's easy to say 'Yeah, I'm fine'. But we're not."

Participant 12

Crisis readiness planning for COVID-19

The sector survey explored whether organisations had crisis response or readiness plans at the outset of the pandemic. While to the pandemic, few respondents were aware of their organisation having crisis response measures in place. Less than one-third (29%) of respondents reported that their service had a policy, response plan or other arrangement in place. Since the emergence of COVID-19, most respondents (72%) said their service had implemented a crisis response policy or plan. These proportions are compared further in Figure 6.

Figure 6: Proportion of respondents who had a crisis response policy or plan in place prior to and during COVID-19



Where respondents identified the existence of a current policy, response plan or arrangement that guided effective service delivery during disasters or crises, they were asked about the key elements of the policy, response plan or arrangement. This varied across service type as outlined in Table 12 below.

Table 12: Existence of a policy, response plan or other arrangement that guided effective service delivery during disasters or crises

	Family violence (including sexual assault services) (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)

Did your service have a policy, response plan or other arrangement that guided effective service delivery during disasters or crises BEFORE the COVID-19 pandemic (before 1 April 2020)?						
Yes	28.6	41.2	23.1	32.5	23.1	29.1
No	18.4	23.5	46.2	32.5	19.2	27.2
Not sure	53.1	35.3	30.8	35.0	57.7	43.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Does your service have a policy, response plan or other arrangement that guides effective service delivery during disasters or crises such as the COVID-19 pandemic (since 1 April 2020)?						
Yes	69.4	75.0	73.1	72.5	73.1	72.0
No	4.1	0.0	7.7	10.0	3.8	5.7
Not sure	26.5	25.0	19.2	17.5	23.1	22.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
n	**49**	**16**	**26**	**40**	**26**	**157**

Note: Percentages may not total exactly to 100.0% due to rounding.

Where respondents did work in an organisation with a current policy, response plan or arrangement that guided effective service delivery during disasters or crises, they were asked about the key elements of the policy, response plan or arrangement. Table 13 below shows that, overall, more than three quarters of survey participants reported that the key elements included assessing the most effective mode of delivery to ensure that clients' needs are met (85%), ensuring client safety when services are delivered remotely (82%) and assessing client needs when intake occurs remotely (77%).

Two-thirds of respondents identified the assessment and identification of any gaps in service delivery as a key element of the policy, response plan or arrangement (66%). There were no statistically significant differences between the service types of respondents.

Table 13: Key elements of current policy or response plan or arrangement

	Family violence (including sexual assault	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)

	services) [%]					
Assessing the most effective mode of delivery to ensure client needs are met	79.4	83.3	100.0	79.3	89.5	85.0
Ensuring client safety when services are delivered remotely	82.4	91.7	94.7	72.4	78.9	82.3
Assessing client needs when intake occurs remotely	79.4	58.3	89.5	72.4	78.9	77.0
Assessing and identifying any gaps in service delivery	61.8	66.7	73.7	58.6	78.9	66.4
Other (Please specify)	2.9	0.0	10.5	3.4	0.0	3.5
n	**34**	**12**	**19**	**29**	**19**	**113**

Note: Multiple responses so percentages may not sum to 100.0%

Where respondents did identify the existence of a current policy, response plan or arrangement, they were asked whether they thought that it was effective in meeting client needs. Overall, most respondents reported that their organisation's policy, plan or arrangement was effective (67%) or very effective (24%) in meeting client needs. There were no statistically significant differences between respondents from different service types.

Table 14: How effective is the COVID-19 service delivery policy in meeting client needs?

	Family violence (including sexual assault services) [%]	Child safety and family welfare services [%]	Legal, FDR, parenting, and family relationship services [%]	Health, mental health, and AOD services [%]	Education, housing, and other services [%]	All services [%]
Very effective	33.3	33.3	21.1	11.1	21.1	23.6
Effective	60.6	66.7	78.9	66.7	68.4	67.3
Not very effective	6.1	0.0	0.0	18.5	10.5	8.2
Not at all effective	0.0	0.0	0.0	3.7	0.0	0.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

n	**34**	**12**	**19**	**29**	**19**	**113**

Note: Percentages may not total exactly to 100.0% due to rounding.

Improving crisis readiness responses

Crises and disasters are becoming increasingly common both internationally and locally. Crises are not always one-off events – many are ongoing and intersecting. Crisis readiness and response considers the overlapping cycle of preparation, response, aftermath and review so that we can better prepare for further crises and future-proof the family violence and sexual assault service system to improve future responses.

The framework draws on the findings of the Future-proofing Safety project and is designed to complement existing policies, frameworks and tools that are already in place. Most notably, this includes the Victorian Government's social services sector emergency management policy and resources. These apply to services funded, delivered or regulated by the Victorian Department of Families, Fairness and Housing. Existing resources also include:

- a family violence framework for emergency management focused on the Victorian Government and emergency management sector
- a vulnerable people in emergencies policy.

Crisis readiness principles

The principles for this Crisis Readiness Framework align with the **Future-proofing Safety** project's six foundations that support the consortium's approach and underlying principles. They are also based on the recommendations of the 2009 Victorian Bushfires Royal Commission and the resulting disaster preparedness work (Teague et al., 2010). These foundations include:

1. **Prioritising clients and being client-centred**. This includes identifying, planning for and centring priority cohorts among those experiencing and using family violence, to acknowledge and account for intersectional experiences of marginalisation and disadvantage that are exacerbated during crises.
2. **Acknowledging that good crisis responses are local**. Local connections, coordination, and communication are needed to enable strong coordinated responses across services, emergency management, local government and state government. Big picture coordination at the state level also needs to take place for accessible communication, responsive planning, funding, and more.
3. **Ensuring that disaster responses are strengths-based**. This means that victims and survivors are empowered to make the best decisions for their particular context.

4. **Building capacity and integrating responses** across all relevant sectors, organisations and emergency responses, incorporating a system-wide examination and genuine commitment to better support victims and survivors and respond to family violence during crises.
5. **Normalising crisis readiness and embedding it in a cycle of regular review** before, during, and after immediate crises.

Why are crisis readiness and response so important?

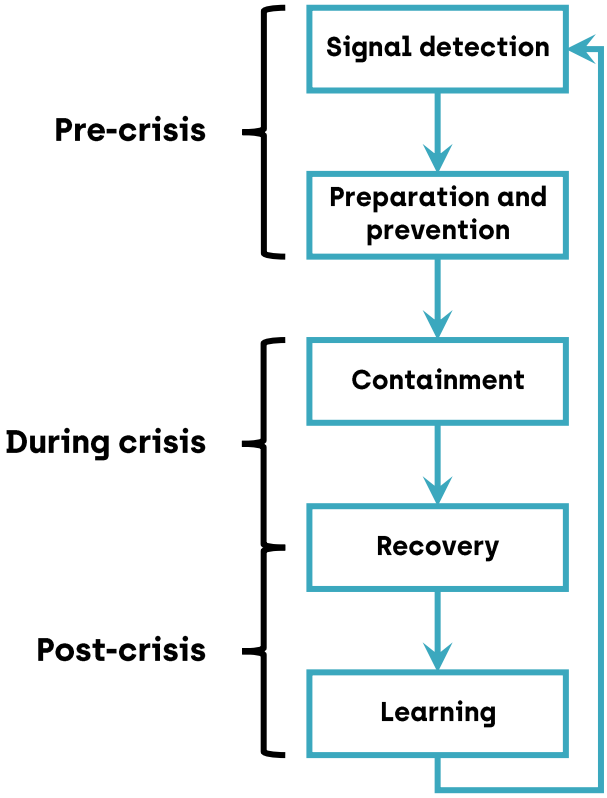
Crises have often been regarded as outlier events, with organisations not always prioritising crisis readiness. Crisis preparation can become seen as a 'nice to have' rather than a 'need to have'. As the observation below suggests, however, it is less effective to develop a response in the middle of a crisis than it is to have a plan in advance.

> "There should be no complacency that [contingency planning and stress-testing] can be 'workshopped' in real time."
>
> **Australian Institute of Company Directors and the Governance Institute of Australia (AICD & GIA, 2020, p. 7.)**

Crisis readiness can help to mitigate some of the less obvious risks that surface during crises, particularly major crises. Failing or lacking to prepare for crises incurs substantial costs – whether economic, social or both – as this project highlights. Multiple examples in this report speak to the myriad ways that a lack of crisis preparedness impacted some of the most vulnerable in the community. This includes children and young people, in particular, whether through the move to telehealth service provision, the withdrawal of Child Protection, and a blindness to child risk and need within the broader family violence and sexual assault service system.

What are the stages of a crisis?

Crises do not always unfold in a simple, linear way. Five common stages across the lifecycle of a crisis, however, and these generally overlap (see right, adapted from Crandall et al., 2009; Pearson & Mitroff, 1993).



1. **Signal detection**: Identifying and listening to warning signs among all the noise and ensuring that signs can be reported and are taken seriously.
2. **Preparation and prevention**: Comprehensively preparing and actively searching for and addressing risk factors.
3. **Containment**: Limiting the impact of the crisis.
4. **Recovery**: Resuming some operations (adapted or as normal) in the short-term and normal operations in the long-term
5. **Learning**: Reflecting on lessons learned and what can be taken forward into the other stages in future crises.

Steps of readiness across levels of responsibility

This section provides five stages of readiness and then expands on each of these to provide reflective questions to guide actions across four levels of the local-to-state spectrum, including:

- frontline service staff
- organisations
- peak bodies
- government

While emergency services are not discussed in the steps below, the broad level questions across each step are still applicable. Further, all levels of responsibility should consider coordination, communication, and planning with emergency services, particularly in contingency planning.

Crisis readiness and response are ongoing and iterative processes. Disasters or crises, like bushfires or floods, may have an initial devastating impact as well as many longer-term consequences. Others, like COVID-19, may have multiple 'peaks' of impacts that compound and extend the crisis over multiple years.

Aligning with the principles that guide this framework, the intention is to work through questions and actions in an integrated manner, collaborating with and across:

- clients, taking into account their specific needs
- key staff (at the organisational level)
- networks, local governments, emergency services[9] and other service providers (at the sector level)
- key contacts through key agencies (at the Victorian Government level)

[9] While emergency services play an important role in crisis readiness and response, the Victorian Government already maintains and updates a family violence framework for the emergency management sector (State of Victoria, Department of Health and Human Services, 2019).

It is important to work through these proactively and, where possible, in non-crisis environments. To note, the questions provided are not a comprehensive list of all considerations for each level during a crisis. Rather, they are a starting point, based on the findings from **Future-proofing Safety** and other crisis readiness and disaster preparedness frameworks. Further questions will likely need to be considered at each level, based on local factors and specific contexts. The best crisis responses, however, are never workshopped in the moment. Workshopping these questions and actions ahead of time, in collaboration across levels and with a range of scenarios in mind, can assist responses at all levels to be better prepared and to respond more appropriately.

Step 1: Assess strengths and gaps

Initial crisis readiness planning should assess and review current organisational readiness and reflect on lessons learned from previous crises. This review process should map internal, local, regional, sector and network landscapes. Network maps developed ahead of time are crucial to ensuring that connection within and between organisations, communities and individuals does not break down during times of crisis and emergency.

Crisis readiness planning should also assess and understand communication and relationships with clients, other services in the sector or region, and emergency services, These partnerships can be formalised through agreements such as a memorandum of understanding (MOU) to both strengthen connections and improve collaborative response to crises.

The following table summarises actions and considerations across the different levels of responsibility in Step 1:

	Frontline staff	Organisations	Sector peak bodies	Government
What are strengths that can be leveraged during crisis?	• What are our clients' strengths and protective factors? How can these be leveraged to support them in a crisis? • What are our clients' support, accessibility and communication needs? How can we ensure that these are met? • What should family violence safety plans consider during crisis? What additional provisions can we include in risk assessments and safety plans in the event of a crisis?	• What are our organisation's strengths? Are there strengths in certain teams or in our internal communication channels? • How can different strengths be deployed across different areas to ensure continuity of service delivery to meet client needs? • What strengths are there across our partnerships with other organisations? • How can our partnerships strengthen responses to crises to support complex client needs?	• What strengths can be leveraged to support member organisations and the broader sector? • What resources can we leverage to support organisations and government in responses to crises? • How can the collaboration and connection between member organisations be leveraged to support increasing complexity of client needs that often accompany times of crisis?	• What are our strengths within and across departments and agencies? • What connections and resources can we leverage or deploy quickly in the event of a crisis? • How can we support a multi-sectoral response to a crisis to ensure that increased risk and complexity of need can be addressed for clients who may need services from multiple sectors? • How can we support practitioners outside of specialist family violence sectors to leverage skills outside of their normal area of work to support clients experiencing or using family violence during crisis?
What is the local and community context? What considerations are specific to these?	• What are our clients' context-specific needs? How will this impact them in a crisis? • What community resources can clients leverage during disasters? • How will we leverage community strengths and existing grassroots organisations to	• What local resources, networks or partnerships exist? How can we participate in or leverage them? • Who are our key contacts and connections in our region and/or sector?	• What is the local and community landscape for our member organisations? • How can we support member organisations to build and maintain local connections and partnerships?	• What infrastructure is in place and what resources are available within and across geographical areas of the state? • How can resources be deployed effectively and rapidly to meet specific local community needs?

	support clients during crises more effectively? • What other aspects of our clients' lives could magnify or add complexity to their experiences or use of family violence? What would be the impact of a crisis on these factors? What aspects of their lives are protective in times of crisis?	• Are there existing arrangements in place around local area coordination during crises or disasters? • What pockets of local knowledge, connections and networks exist in our organisation?		• How can we work with and leverage the existing strengths of community (such as grassroots community organisations) to report back during crises and support messaging?
What are some past lessons during crises that can be applied to future planning?	• What alternative or complementary service options might there be for clients during crises? • What worked well for each client during previous crises or emergencies? What could have been done differently?	• What temporary or permanent adaptations have worked (e.g., remote service delivery)? • What information and communication technology needs have emerged? • What would have helped us respond to the changes we encountered in previous crises (e.g., resources, networks or partnerships)? • How can any additional demand or complexity be dispersed or shared across the workforce, rather than carried by particular individuals or teams? • How has service demand changed in past crises and what characteristics of those periods lead to these shifts?	• What would have helped us support our member organisations (e.g., around coordination, communication, advocacy, resources)? • What were the needs of member organisations during past crises?	• What have we heard from clients, local communities, broader communities, organisations, and peak bodies? How can we respond to this feedback? • How can resources be more effectively and rapidly deployed? • How can cross-sector and cross-departmental recommendations be adopted to support clients seeking services across the family violence and sexual assault service system as a whole? • How can we support organisations to respond to growth in service demand that often occurs during crises? • Given that most crises see rates of family violence increase, how can we support organisations and individuals to prevent family violence and support those experiencing it?
What are some current or past crisis-related gaps?	• What service gaps have we noticed during past crises or emergencies? (These could be in the team, in the organisation or elsewhere in the service system.)	• What service gaps have emerged during crises or emergencies?	• What gaps have emerged during crises or emergencies in our sector?	• What gaps have emerged during crises or emergencies across the service system?

	• What existing gaps might be exacerbated by crisis? How can we support clients around these issues?	• How strong are our relationships with other organisations and agencies (e.g., emergency services, police)? • What existing gaps might be exacerbated by crisis? How can we advocate for these gaps or barriers to be addressed? • How can staff and practitioners who work outside of the specialist family violence space be trained to respond to elevated demand for family violence services and increased presentations from clients experiencing or using family violence during crises?	• What gaps have emerged in relation to communication with other sectors and how might these be addressed? • What existing gaps might be exacerbated by crisis? How do we support the sector to advocate for these gaps or barriers to be addressed?	• How can gaps be addressed to better support people seeking family violence and sexual assault support in future crises? • What existing gaps might be exacerbated by crisis? How can we overcome these gaps or barriers? What supports should be put in place early? • How can organisations that do not specialise in family violence be supported to accommodate any crisis-driven increases in demand for family violence services or from clients using or experiencing family violence?

Step 2: Assess risks

Familiarity with the risk landscape is crucial to crisis readiness planning. Risks can exist at and across multiple levels including individual, community, local and sector-wide. As well as identifying, reporting and proactively addressing risk, organisations should foster environments that enable these actions.

The following table summarises what each level of responsibility should consider in Step 2 when learning about and understanding risk profiles:

	Frontline staff	Organisations	Sector peak bodies	Government
What are the risks that exist across the different contexts and levels? What are the intersections of risks?	• What specific risks and needs are in our clients' lives? How might these be exacerbated in a crisis or emergency (e.g., safety, material security, etc.)? • What are the safety, wellbeing or other risks we might face as staff? How can these be addressed? • What are the risks to effective and ongoing communication with clients (particularly if there are phone, internet, transport or power disruptions)? • What are the risks related to partnerships or local coordination? How will we communicate with other organisations and sectors to better support complex client risks and needs? • What are the risks relevant to our own context (e.g., natural disasters)?	• What are the risks to the organisation (e.g., funding, staff safety and wellbeing)? • What are the risks to service delivery (e.g., capacity, continuity, disruptions or cessation, increased demand)? • Are there changes to service demand (e.g., increased complexity or intensity of presenting needs or risk factors among existing and/or new clients)? How does this impact organisational risk? • What are the risks related to partnerships or local coordination? • What are the risks to effective and ongoing communication with clients and staff (particularly if there are phone, internet, transport or power disruptions)? • What are the risks in our local area or relevant to our context (e.g., natural disasters, funding and support environments)?	• What are the risks to member organisations and partnerships? • What are the sector-wide impacts of risks to organisations and their service delivery? • What are the risks to effective communication and coordination within and between sectors to streamline client responses? • How do these risks interact and overlap?	• What are the risks to the overall service system capacity? • What are the risks to infrastructure and access to essential services, homes, offices, and places of safety? • What are the risks to effective communication with, and coordination of peak bodies, organisations and communities? • What are the risks of economic or financial impacts on communities and government-funded organisations? • How coordinated and collaborative is our signal detection work around new, emerging and potential risks? • How do these risks interact and overlap?
How can we foster and reinforce a culture and environment that is aware of and sensitive to risks?	• How do we communicate risk with colleagues and with clients? • What are our practices around risk assessment and safety planning? Are there additional risks that need to be considered during crises? How will these risks be recorded?	• How can we encourage and enable strong risk identification and management processes (e.g., training, regular check-ins)? • Do we have processes in place to monitor risks and issues such as risk registers and issues logs? • How will we respond to risk at an organisational level? How will we capture risks that are emerging on the	• Do we have processes in place to collaborate with member organisations and government around risks and issues? • How can we drive sector-wide risk assessments and management strategies that respond to emerging needs and best practice?	• How can we resource and prioritise risk assessment and management that is responsive to emerging needs and best practice? • How can we leverage existing consultation groups and networks to get timely updates

	• What opportunities are there for collaborative and reflective practice opportunities with our colleagues (both within our organisation and within and across sectors) around risk?	ground? How do we do these in ways that centre clients within organisational decision-making?	• How can we capture risks emerging at the client and member organisation level? How can we communicate these back to government in a timely and coordinated way?	about changes in risk and need at the service level? • How can we ensure that lived experiences and client voices are empowered and heard during crises to inform client-centred responses? • How can we support the service sector in response to changing risks and needs during crises? • How can we fill current service gaps to better support organisation's surge capacity during crises? How can this be done collaboratively across departments and agencies?
How can we establish a risk profile?	• What tools do we use to analyse risk? • How can we learn with colleagues about identifying risks and the likelihood of their impacts? (These can go beyond family violence risk or client risk to look at workplace risks that might get exacerbated during a crisis.)	• What areas of concern, pressure or need emerged among clients during previous crises or emergencies (e.g., wellbeing, safety, material security)? • What areas of concern, pressure or need already exist that may be exacerbated during crises? • What areas of concern, pressure or need emerged among staff during previous crises or emergencies (e.g., burnout, moral injury)? • What risks might there be in how our organisation responds to crises or emergencies?	• What areas of concern, pressure, or needs have emerged among member organisations? • What risks are involved in how we respond to crises? • How do we support member organisations and staff within these organisations to respond to emerging risks in a timely manner (e.g., the development of timely guidance materials for managing new risks)?	• What areas of concern, pressure, or need have emerged among clients, organisations and peak bodies during previous crises? Is this pressure or need felt disproportionately by some groups, communities, organisations or sectors? • How can government support the recovery from the current crisis and address emerging risk issues in order to future-proof the family violence and sexual assault service system? • What can be done to better support the family violence and sexual assault service system and associated sectors to better collaborate and coordinate? • How can we support the establishment of collaborative networks to support future crisis readiness responses?

How can we assess and address complexity among diverse clients, particularly intersectional and marginalised?	• What are some specific risks, particularly in relation to structural barriers, that clients face that are unique to their individual circumstances, identity, and contexts? • How can we work with clients and their whole-of-identity to assess and manage risk? • How can we work with established community groups and build trust with people from diverse communities to facilitate timely service responses and enhanced help-seeking during crises? • How does a crisis impact the risks and needs of children and how can we support them as victims and survivors in their own right?	• What are the service experiences of people from marginalised and intersectional cohorts? Are there specific risks or needs that should be addressed? • How can we effectively engage clients and people with lived experience, in shaping risk assessment and management tools to be appropriate and meet the needs of diverse and intersectional cohorts during crises? • How can we support and advocate for clients who face structural forms of discrimination and barriers to support? • How do our services and programs support and protect children as well as their needs and risks, particularly when they diverge from those of their other family members and carers?	• How can we support organisations and clients to assess and manage risk across intersectional and marginalised cohorts? • How can we support member organisations to leverage best practice and intersectional service responses to support the needs of people from diverse communities more effectively?	• What are some specific risks that clients face that are unique to their individual circumstances, identity, and contexts? • How have multiple and complex intersecting needs been considered in the context of this risk? • How can government effectively engage organisations, peak bodies, and community groups (including grassroots organisations and service users across marginalised and intersectional cohorts) in effective risk assessment and management?

How can we address common barriers to service access, particularly during increased demand from existing and/or new clients?	• What are the unique barriers that our clients face? What are the common barriers that they face?
	• How can we work with clients to help them access our service? How can our practice shape and impact client service experiences?
	• How can we support clients to access other services that they might need as part of their support/care plan?
	• How can changing accessibility of other services during crisis impact the risk profile of our clients?
		• What barriers, challenges or issues exist relating to:
		  ○ client access to technology
		  ○ online mode of delivery not appropriate/consistent with best outcomes for client
		  ○ client preference for face-to-face service delivery
		  ○ insufficient accommodation options to meet client demand
		  ○ insufficient resources (staff or funding)
		  ○ lack of appropriate options for client referral/s
		• How can we support clients to seek help during crises when conventional pathways to services break down?
			• How can we support organisations to remove barriers to service access during increased demand or complexity? What resources can we mobilise to support member organisations with this task?	• What resources are available to respond quickly and effectively to increases in demand? How can we support organisations and local responses?
				• Have we identified and mapped barriers to service engagement among priority cohorts that may prevent emergency measures from being effective?
				• How could legislative, legal and policy changes during crises increase family violence risk, support the emergence of new forms of violence or inhibit or prevent help-seeking? What considerations are needed to prevent this?

Step 3: Plan for readiness

With an assessment of both resources, risk and barriers to crisis readiness complete, organisations should develop plans for emergencies that outline strategies for responding to new or different crises, including the impacts of the risks identified in Step 2, and how to leverage the local and organisational or sector networks identified in Step 1.

A summary of questions to consider during Step 3 are distinguished across the different levels of responsibility in the table below:

	Frontline staff	Organisations	Sector peak bodies	Government

What are the risk mitigation strategies, plans, and processes in place? What gaps are there? Are we considering all the risks identified in Step 2?	• What processes are in place to discuss and document crisis-focused safety plans with clients? (This includes how to maintain contact, ensure safety, and deliver services during crises.)
	• What needs and risk factors are in clients' lives that might need planning or actioning during a crisis?
	• How can we support clients to develop a set of questions for disaster preparation as part of risk assessment processes?
	• What additional questions do we need to ask? How do we make sure that client risks are also highlighted?
	• What risk mitigation strategies are there within and across our colleagues and teams? How do we monitor and manage these?
	• How would a crisis change the predominant forms of violence experienced by my clients? What should I be anticipating in the wake of a crisis?
		• What processes are in place to discuss and document crisis-focused safety and wellbeing plans across the whole organisation (including clients and staff where appropriate)?
		• How will we manage and document delegation and responsibility for actions across the organisation and locations (if applicable)?
		• How can we explore and set up referral pathways or agreements with other organisations?
		• How can we explore and implement knowledge sharing and case coordination/consultation across teams and partnerships?
		• How can we assess the strength of our relationships with other organisations and agencies (including police)? How can we strengthen these?
		• What is our family violence capacity and knowledge? How equipped are we to respond to an increase in family violence presentations?
		• How would we respond if there was an increased demand, severity, or complexity?
		• How can we adapt and plan for contingencies around:
		  ○ other services ceasing or withdrawing
			• What processes are in place to support coordination responses to crises across the sector?
			• Where are the process and planning gaps? What needs to be created?
			• How will we manage and document delegation and responsibilities?
			• How equipped is the sector to respond to an increase in family violence presentations during a crisis?
			• How can we support member organisations' contingency planning around:
			  ○ other services ceasing or withdrawing
			  ○ other services becoming overburdened (e.g., similar service providers, health services, emergency services)
			• How would an organisation, sector or local area adapt if a particular emergency service or service system was suddenly overburdened? Are there contingencies in place?
				• How can government support coordination of crisis planning resources and training across the service system? (This includes funding, resourcing, coordination, and surge capacity.)
				• How can government collect real-time data to support responsive funding allocation sensitive to changes in service demand?
				• How can we support organisations to provide prevention-focused services early on during a crisis?
				• Can we allocate and formalise roles and responsibilities across departments and agencies around family violence during crises?
				• How would we respond and adapt, allocate and deploy resources in the event of sudden service system breakdown or overburden? Are there contingencies in place?
				• How can government responsively alleviate increasing acuity, severity, and complexity of service access needs?
				• How can we monitor services in real-time to check for emerging service gaps and needs in order to maintain service continuity with an aim for earlier intervention?

		○ other services becoming overburdened or withdrawing (e.g., similar service providers, health services, emergency services) ○ elevated levels of family violence risk, including serious and/or lethal violence for clients ○ Increased potential for empathy fatigue, vicarious trauma and burnout in our staff		• How can we increase resources, where needed, in a timely and coordinated way?
How can we create plans and responses with input from clients, local communities, partners, and government?	• What works best for us and our clients in terms of maintaining connection and delivering services? • How might we keep in touch with our clients and ensure safety if there are outages (e.g., phone, internet, power, roads)? • How do we centre client voice and ensure that there are avenues for clients and local communities to shape our responses?	• How can we ensure that services continue in ways that are accessible and tailored to clients' needs? • How can we centre client and community voices and ensure that these feed into our organisational policies and responses to meet the needs of the most marginalised? • How can we support staff, who are also from community and may be responding to the crisis in their own lives?	• How can we support coordination of crisis planning, resources and training for member organisations? • How can we collaborate with other peaks to support referrals between organisations and real-time data to support sector-level coordination and advocacy?	• How can we empower, build knowledge and support cross-sector and cross-region coordination and collaboration? • How can we centre lived experience voices and consider inequalities and intersections in planning, funding and resource allocations, and responses? • How can we support the most marginalised communities or people during crises? Have we fully identified and understood who these communities are and what their needs are likely to be?

Step 4: Communicate plans

This step builds on the importance of coordination and communication, whether that is internally, locally, with networks, or within the sector. Effective communication and coordination are critical to ensuring service continuity, identification, and appropriate responses to emerging and ongoing needs.

The following table summarises actions and considerations distinguished across the different levels of responsibility during Step 4:

	Frontline staff	Organisations	Sector peak bodies	Government
What channels of communication across the internal organisation, partner organisations, clients, and government exist? What needs to be created?	• What are the channels within teams and between staff and leadership? What needs to be created? • What are the channels to communicate with clients about their crisis or emergency plans and how we can support this or draw inspiration into our own planning? • Where are the communication gaps and where can we create new channels or protocols?	• What communication channels are in place across all levels both internally and externally? What needs to be created? • How do we communicate service continuity and crisis readiness/management plans early and across all levels? • How can we ensure client voice representation in communication across levels?	• What channels are available across all levels? What needs to be created? • How can we provide communication resources and guidance to member organisations? • How can we support member organisations to collaborate on and coordinate their plans?	• What communication channels are in place across all levels (including local communities, service organisations, and statutory authorities)? What needs to be created? • How can we create pathways and processes to respond to needs across contexts and communicate response across levels? • How can we centre lived experience voices to plan communication and coordination strategies with a focus on culturally-responsive, intersectional and accessible communication across a range of languages?
What media outlets or channels can be leveraged for communication across local and community contexts?	• What connections and networks with local community can we leverage to support clients during crisis? What new connections can we make? • What organisations and sectors do we already engage with in our everyday work? How can we strengthen communication channels and coordination with these services?	• How can we identify and leverage channels (e.g., media outlets) to communicate across all levels (internal, clients, external partners, and local/community)? • How can we leverage local knowledge, connections, and networks? • What are the areas of need? What are unique communication challenges that exist within the local context? How can these be addressed?	• Where have our communication channels with member organisations and other peak bodies worked well previously? • What processes exist to identify needs and meet these among organisations and local communities?	• What is the state of information and communication technology access for service providers and communities across Victoria? How can we support improvements to access and reliability? • How can government identify both strong communication channels and gaps in communication and leverage or deploy resources?
How will we collaborate with other organisations (whether they're local or elsewhere) in order to streamline communication and responses?	• How is our organisation communicating service responses and needs during crises or disasters? How can we further communicate	• What mechanisms exist within the organisation to facilitate collaboration between teams and leverage off the existing networks of practitioners?	• How can we strengthen communication channels across member organisations to respond to emerging needs?	• How can the Victorian Government improve and strengthen communication channels with emergency services, peak bodies, organisations and communities?

	these responses to clients and other organisations?	• What collaborative networks or partnerships is the organisation already engaged in? • Are there new partnerships to explore to streamline and enhance communication across sectors and services? • How can we ensure that communication plans are responsive to emerging needs?	• How can we take a leadership role and support collaboration with other sectors to support family violence service collaboration and coordination?	• What allocation of funding will be allocated to organisations to establish collaborative partnerships to improve service provision for vulnerable clients, particularly during crises?

Step 5: Reflect and review

Ongoing crises and overlapping or co-occurring crises provide opportunities to test, reflect, iterate and refine to improve future responses and respond to emerging needs. Similarly, plans and ideas should be constantly appraised by all levels from staff to government. Following the implementation of any aspect of a crisis readiness plan, entities across these levels should reflect purposefully and consciously to understand what worked well, what could be improved, and what to try next.

The table below summarises actions and considerations distinguished across the different levels of responsibility during Step 5:

	Frontline staff	Organisations	Sector peak bodies	Government
What can we learn from previous crises that can inform how we prepare for future crises?	• What processes are in place to review crisis readiness and response with clients and apply feedback to future plans? • What processes are in place to review within and across teams to continue centring client voice? • What processes are in place to review crisis readiness plans with practitioners across different sectors?	• What processes are in place to review and reflect on our whole-of-organisation response, including client voice? What are the lessons which can be incorporated into future plans? • What processes are in place to review and reflect across levels (including with other organisations and government) to learn from past responses and improve future ones?	• What processes are in place to review and reflect across the organisation? • How can we facilitate learning from across member organisations? • How can we learn from our experiences during COVID-19 to support communication and collaboration in future crises?	• What processes and channels are in place to support the integration of lessons from COVID-19 at all levels (including client, community, organisation, peak body and emergency services)? • What processes are in place to integrate feedback and lessons to future plans and resourcing? • What funding and time have been allocated for service providers to be able to reflect, learn and better collaborate?
What processes, plans, and processes worked? What did not? What can we put in place before the next crisis?	• What were the common things that worked for clients? What were the common things that did not? • What needs to be put in place for the next crisis? • What were common things that worked for you or your colleagues? How do we support our own wellbeing during crises so that we can better support our clients?	• What were successful temporary adaptations and successful permanent adaptations (whether for staff or clients)? • What would have helped us respond to the changes we encountered in previous crises? (Think about resources, networks or partnerships, particularly in your area.) • What do we need to put in place before the next crisis?	• What worked during the last crisis? What did not? How can we learn from this? • How can we ensure that lessons reflect feedback from across levels including client voice? • What do we need to put in place before the next crisis?	• What worked during the last crisis? What did not? How can we learn from this? • How can we ensure that lessons reflect feedback from across levels including client voice? • What do we need to put in place before the next crisis? • What resources do we need to make available?
How can we better respond during crises? What do we need to consider further?	• What gaps and strengths did we identify? • What can we do, what processes can we adopt, what plans do we need to put in place, and	• What gaps and strengths did we identify? • What can we do better and what processes, partnerships, plans and actions do we need to	• What gaps and strengths did we identify? • What can we do better and what processes, plans and actions do we need to put in place to respond more effectively to the next crisis?	• What gaps and strengths did we identify? • What can we do better and what strategies do we need to put in place to respond better to the next crisis?

	what advocacy and communication needs to take place to respond better to the next crisis? • Did anything emerge that cannot be resolved at this level? What needs to be escalated? Who needs to be involved?	put in place to respond better to the next crisis? • What unexpected issues, risks or strengths emerged? How can we learn from these? • Were there unexpected increases or decreases in demand? • What needs to be escalated? What advocacy needs to take place? What do we need to communicate to peak bodies and government?	• What unexpected issues, risks, or strengths emerged? How can we learn from these?	• How can we better allocate and deploy resources to enhance responses?
How can we build in iterative processes and ensure that reflection and review are always taking place?	• How can we ensure that these crisis readiness steps become normalised within practice?	• How can we ensure that crisis readiness is normalised and built into our organisational culture and operations?	• How can we ensure that crisis readiness is normalised and built into sector best practice?	• How can we ensure that crisis readiness is normalised and built into government plans and resource allocation?
How can this step help us to respond better to complex and diverse needs and specific challenges and barriers before, during, and after a crisis?	• How can we ensure that we are identifying unique barriers and challenges and identifying unique needs of intersectional and marginalised clients?	• How can we use an intersectional lens to ensure that we adopt best practice into our organisational policies, processes and practice to better meet the needs of diverse clients?	• How can we ensure that we are engaging and incorporating diverse, lived experience, and marginalised voices and feedback from across levels into sector best practice?	• How can we ensure that we are engaging and incorporating diverse, lived experience, and marginalised voices and feedback from across levels into government crisis readiness responses, plans, and resource allocation?

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Appendix A

Demographics of participants in the sector survey

	Family violence (including sexual assault services) (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Age						
Under 25 years	1.6	0.0	2.9	2.0	0.0	1.4
25 - 34 years	25.4	30.8	11.8	16.0	11.8	19.3
35 - 44 years	19.0	19.2	29.4	16.0	20.6	20.3
45 - 54 years	30.2	34.6	29.4	26.0	44.1	31.9
55 years or older	20.6	11.5	26.5	36.0	23.5	24.6
Prefer not to say	3.2	3.8	0.0	4.0	0.0	2.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Are you:						
Man or male	7.9	7.7	11.8	20.0	14.7	12.6
Woman or female	90.5	80.8	79.4	70.0	76.5	80.2
Non-binary	0.0	7.7	8.8	8.0	5.9	5.3
Other/I use a different term	1.6	0.0	0.0	0.0	0.0	0.5
Prefer not to say	0.0	3.8	0.0	2.0	2.9	1.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Identify as Aboriginal and/or Torres Strait Islander						
Yes, Aboriginal	1.6	3.8	0.0	4.0	2.9	2.4
No	96.7	92.3	94.1	96.0	94.1	95.1

Prefer not to say	1.6	3.8	5.9	0.0	2.9	2.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Speak any languages other than English						
Yes	12.7	20.0	17.6	14.3	24.2	16.7
No	84.1	76.0	79.4	83.7	72.7	80.4
Prefer not to say	3.2	4.0	2.9	2.0	3.0	2.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Geographical area of work						
Melbourne Central Business District (CBD)	3.2	3.8	17.6	8.0	0.0	6.3
Suburban area	44.4	34.6	41.2	52.0	55.9	46.4
Regional area	39.7	42.3	29.4	36.0	41.2	37.7
Rural area	9.5	19.2	11.8	4.0	0.0	8.2
Other (please specify)	3.2	0.0	0.0	0.0	2.9	1.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Less than one year	7.9	7.7	11.8	4.0	5.9	7.2
1-5 years	57.1	50.0	35.3	48.0	47.1	48.8
6-10 years	15.9	23.1	32.4	14.0	14.7	18.8
11-15 years	12.7	7.7	11.8	6.0	17.6	11.1
15+ years	4.8	11.5	8.8	28.0	14.7	13.5
Prefer not to say	1.6	0.0	0.0	0.0	0.0	0.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
n	**63**	**26**	**34**	**50**	**34**	**207**

Table note: n=1 missing response for type of service.

Appendix B

Estimated percentage of client enquires relating to family violence and/or sexual assault during COVID-19, by sector

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
More than three-quarters of enquires	88.5	28.0	33.3	8.9	23.5	42.4
About three-quarters of enquiries	3.3	20.0	21.2	6.7	8.8	10.1
More than half but less than three-quarters of enquiries	1.6	16.0	18.2	17.8	17.6	12.6
About half of enquiries	1.6	16.0	3.0	8.9	11.8	7.1
More than one-quarter but less than a half of enquiries	0.0	4.0	12.1	6.7	14.7	6.6
Less than one-quarter of enquiries	1.6	8.0	6.1	33.3	8.8	11.6
No enquires	3.3	8.0	6.1	17.8	14.7	9.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
n	**61**	**25**	**33**	**45**	**34**	**198**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Appendix C

Proportion of respondents reporting that the majority of clients (>50%) experienced the following types of violence and abuse, prior to COVID-19

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Trying to/preventing contact with family or friends	70.7	25.0	26.7	22.2	17.8	37.5
Trying to/preventing use of the telephone or car	54.9	20.0	17.2	17.2	14.3	28.8
Trying to/preventing knowledge of or access to family money	62.8	20.0	33.3	11.2	28.5	35.1
Insults with intent to shame, belittle or humiliate	84.3	40.0	66.6	35.1	46.5	58.5
Threatening to harm the child/children	43.1	20.0	19.9	17.2	17.9	26.2
Threatening to harm other family members	39.2	10.0	17.2	17.2	14.2	22.7

Threatening to harm partner/spouse	72.5	25.0	46.6	25.0	25.0	43.7
Damage to or destruction of property	68.0	45.0	48.2	25.8	32.1	46.3
Threatening to harm or harm pets	19.7	10.0	6.8	8.6	17.9	13.5
Threatening to harm themselves	51.0	30.0	30.0	28.6	17.8	34.1
Trying to force partner into any unwanted sexual activity	45.0	15.9	13.3	11.2	17.8	23.8
n	**51**	**20**	**30**	**35**	**28**	**164**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Proportion of respondents reporting that the majority of clients (more than 50%) experienced the following types of violence and abuse, during COVID-19

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Trying to/preventing contact with family or friends	84.6	61.8	46.6	29.1	37.0	55.8
Trying to/preventing use of the telephone or car	79.2	57.1	20.0	19.4	29.6	45.6
Trying to/preventing knowledge of or access to family money	75.4	57.1	42.0	12.9	51.8	51.0

Insults with intent to shame, belittle or humiliate	94.3	66.6	74.2	56.3	55.5	73.2
Threatening to harm the child/children	43.4	28.6	29.1	16.1	11.1	28.2
Threatening to harm other family members	40.4	33.3	20.0	25.9	11.5	28.1
Threatening to harm partner/spouse	77.3	38.1	53.3	28.2	37.0	51.5
Damage to or destruction of property	88.6	61.9	54.8	42.0	40.7	61.9
Threatening to harm or harm pets	30.8	19.1	6.6	9.9	18.5	18.7
Threatening to harm themselves	71.7	42.9	46.6	45.1	33.3	51.9
Trying to force partner into any unwanted sexual activity	58.5	19.1	20.0	9.9	25.9	31.7
n	**53**	**21**	**30**	**30**	**27**	**161**

Notes: Percentages may not total exactly to 100.0% due to rounding.

Appendix D

Proportion of respondents reporting that the majority (>50%) of clients presenting with family violence and/or sexual assault needs also presented with the following issues prior to COVID-19, by service type

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Physical violence	81.5	28.6	15.6	16.2	28.5	40.0
Emotional abuse or anger issues	88.6	55.0	65.7	35.9	60.7	64.0
Experience(s) of sexual assault and/or harassment	50.0	10.5	6.2	16.7	14.3	24.0
Financial abuse (including attempted/prevention of knowledge of or access to family money	74.1	36.8	40.7	24.3	39.3	47.1
Isolation (including attempted/prevention of contact with family or friends and and/or attempted/prevention of use of telephone or car	70.4	30.0	32.3	29.7	25.0	42.4
Child abuse or child safety concerns	46.3	57.2	28.2	15.4	17.9	32.8
Family law or other legal issues	64.2	28.6	68.8	21.1	32.1	46.0
Relationship breakdown	75.9	47.5	75.1	26.3	57.1	58.5
Physical health issues	44.5	19.0	12.9	24.3	14.3	26.3
Mental health issues	72.2	61.9	50.0	54.0	55.5	60.2
Housing stress/homelessness	66.0	42.8	29.0	31.6	50.0	46.2
Alcohol or substance misuse	49.1	33.4	38.7	44.7	32.1	41.4
Financial stress/hardship	74.1	61.9	56.2	39.5	53.6	58.4

Gambling	13.4	9.5	0.0	2.7	0.0	5.9
Child/children with complex health or other needs	35.2	50.0	18.8	15.4	28.6	28.2
Social security issues	50.0	33.3	6.3	24.3	28.6	30.8
Child support issues or concerns	46.4	23.8	29.1	5.4	21.4	27.5
Employment issues or concerns	37.7	14.4	9.4	23.7	35.7	26.2
Experience(s) of discrimination	26.4	14.3	12.5	21.1	14.3	19.2
Other issues or safety concerns (please specify)	39.6	16.7	10.7	16.2	19.2	23.3
Clients presenting with two or more of the above issues	85.2	71.4	75.0	44.7	60.7	68.8
n	**54**	**21**	**32**	**37**	**28**	**172**

Notes: Percentages may not total exactly to 100.0% due to rounding.

	Family violence and sexual assault services (%)	Child safety and family welfare services (%)	Legal, FDR, parenting, and family relationship services (%)	Health, mental health, and AOD services (%)	Education, housing, and other services (%)	All services (%)
Physical violence	87.1	63.6	38.8	23.5	53.9	56.9
Emotional abuse or anger issues	96.4	90.9	74.2	45.7	77.7	78.2
Experience(s) of sexual assault and/or harassment	56.4	36.3	22.6	17.7	22.2	34.3
Financial abuse (including attempted/prevention of knowledge of or access to family money	83.6	77.2	42.0	20.6	51.8	57.4
Isolation (including attempted/prevention of contact with family or friends and and/or attempted/prevention of use of telephone or car	81.9	72.7	46.6	29.3	40.7	57.2
Child abuse or child safety concerns	54.6	63.7	38.8	22.9	14.8	40.0
Family law or other legal issues	65.4	45.4	61.4	26.5	40.7	50.2
Relationship breakdown	85.4	86.4	80.7	44.1	66.7	73.4
Physical health issues	52.7	40.9	29.0	39.4	37.0	41.7
Mental health issues	85.5	81.8	64.5	68.6	70.3	75.3
Housing stress/homelessness	74.5	72.7	51.6	44.1	66.6	62.7
Alcohol or substance misuse	61.8	63.6	60.0	60.7	40.7	58.1
Financial stress/hardship	89.1	77.2	61.2	49.9	70.4	71.6
Gambling	16.7	13.6	6.7	9.1	18.5	13.2
Child/children with complex health or other needs	52.8	68.2	38.7	14.3	29.6	40.6
Social security issues	57.4	54.5	30.0	24.3	44.4	43.4
Child support issues or concerns	56.3	40.8	44.7	15.2	37.0	40.9

Employment issues or concerns	65.5	49.9	36.6	43.7	62.9	53.6
Experience(s) of discrimination	40.0	36.4	10.0	28.2	19.2	28.5
Other issues or safety concerns (please specify)	32.5	20.0	20.0	10.3	25.0	23.0
Clients presenting with two or more of the above issues	92.5	85.8	80.7	64.6	74.1	80.8
n	**53**	**21**	**31**	**34**	**27**	**166**

Notes: Percentages may not total exactly to 100.0% due to rounding.