Research report

Stephanie Lusby
Gene Lim
Marina Carman
Suzanne Fraser
Matthew Parsons
Jackson Fairchild
Adam Bourne

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Opening Doors:
Ensuring LGBTIQ-inclusive family, domestic and sexual violence services

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Copies of this report or any other publications from this project may be obtained by contacting:

Australian Research Centre in Sex, Health and Society (ARCSHS)
Building NR6, La Trobe University, Victoria 3086 Australia

T (03) 9479 8700

E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

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Glossary of key terms

Cisnormativity: a suite of cultural, legal and institutional practices based on the assumption that people's gender identity matches the biological sex assigned to them at birth and that the only 'normal' and 'natural' bodies and gender identities are 'male' and 'female'. These ideas underpin transphobic and intersexphobic social and political structures, attitudes and behaviours.

Coercive control: an overarching term for patterns of behaviour where different abusive tactics are used by a perpetrator to manipulate, coerce and cause fear in the person being victimised. Coercive control may be perpetrated alongside physical and/or sexual abuse but the term is more commonly used to describe cumulative patterns of non-physical forms of family and domestic violence.

Domestic violence: (see family violence) a term used as a synonym for all forms of family violence or to refer particularly to intimate partner violence (IPV) as a form of family violence.

Emotional abuse: a form of abuse used to undermine the mental wellbeing and sense of self confidence of the person being victimised, often as part of a broader pattern of efforts to control, coerce and create fear.

Family violence: an overarching term for violence and patterns of abusive behaviour perpetrated by someone who shares a home and/or is in a familial or intimate relationship with those that they victimise. This might include current or former intimate partners, parents, siblings or other members of a family of origin; extended family members; chosen family; or housemates.

Financial abuse: a form of abuse focussing on finances and assets; this can include withholding money, stealing money (including by fraud and deception), controlling the spending of a victim-survivor, or refusing to include a victim-survivor in financial decisions.

Gaslighting: an aspect of emotional abuse where the person being victimised is led to doubt their capacity to comprehend what is happening to or around them. This can include a person using violence denying that their behaviour is abusive and attributing accusations of abusive behaviour to the victim-survivor's poor mental health.

Heteronormativity: a suite of cultural, legal and institutional practices that work to explicitly privilege relationships between 'men' and 'women' as traditionally defined as the only 'normal' and 'natural' form of relationship. Heteronormativity underpins homophobic, biphobic and queerphobic attitudes, and has been criticised as central to women's oppression in patriarchal societies.

LGBTIQ community-controlled organisation: an organisation set up by and for LGBTIQ people and communities. These are configured and governed in different ways, have different scope of services and activities, and may focus on the needs of a particular demographic (e.g. trans and gender diverse people or people with intersex variation); however, they share a central focus on addressing the particular concerns of LGBTIQ communities.

LGBTIQ-targeted abuse: a form of abuse where family, domestic and sexual violence (FDSV) is targeted at a victim-survivor's gender identity, sexual orientation or intersex variations. This can include revealing or threatening to reveal the sexual or gender identity or birth-assigned sex of a partner, or revealing or threatening to reveal the HIV status of a partner. For trans and gender diverse people this can also include withholding of finances for medical services or items for expressing gender identity; focussing on features associated with an individual's birth-assigned sex, and denying trans people are 'real' women or men; or targeting gendered body features during violence.

Sexual violence: any sex act or attempt to obtain a sex act that is coerced or unwanted. Sexual violence can occur in the context of family and domestic violence, and can be perpetrated by someone who does not have a prior relationship with the victim-survivor or by someone with whom the victim-survivor has a casual or more distanced relationship.

Specialist family/domestic violence service: a service established to provide crisis response and care to people experiencing family violence. This may include counselling, case management, housing support and legal support.

Specialist sexual assault service: a service established to provide crisis response support to people who have recently experienced sexual assault, as well as to provide ongoing counselling to people recovering from sexual assault.

Systems abuse: a form of abuse where the person using violence manipulates and uses biases in legal, bureaucratic or administrative systems to coerce, control, harass or cause fear to the person experiencing violence.

Contents

Case studies

Concise case studies of promising practice accompany Chapter 6 to illustrate strategies for developing LGBTIQ-inclusive practice:

Expanded case studies of promising practice are accessible on the project website.

Guide for practitioners

This research report is accompanied by a practice guide, which aims to draw out key insights from the project in informing policy and practice to improve LGBTIQ-inclusive FDSV services nationally.

You can access the practice guide on the project website.

Executive summary

Background

- Opening Doors: Ensuring LGBTIQ-inclusive family, domestic and sexual violence services (Opening Doors) details findings from a multi-phase, mixed method study that considers how to improve family, domestic and sexual violence (FDSV) service accessibility and safety for lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) people in Australia.
- FDSV is a significant issue experienced by LGBTIQ populations yet engagement with support services following family violence is low among this group, indicating there are barriers to this. Analysis of data from the largest LGBTIQ health and wellbeing study in Australia, Private Lives 3 (1) found that:
  - 60.7% of participants reported experiencing some form of intimate partner violence (IPV)
  - 43.2% reported experiencing some form of FOV
  - 48.6% of participants reported having experienced sexual assault, and the majority of these assaults were perpetrated in the context of family violence (IPV and FOV)
  - Only 25.9% of participants who indicated they had experienced family violence in their lifetime reported their most recent experience of FDSV to service providers. Of these, only 2.3% made reports to specialist FDSV services and 5.9% to police.
- Although accessibility is of critical concern, there are a number of promising examples of LGBTIQ-inclusive FDSV initiatives from around Australia that demonstrate that the challenges described here are far from insurmountable.
- Against this background, Opening Doors investigates current challenges faced by LGBTIQ people in Australia when seeking help after experiencing FDSV, as well as promising moves towards safe and affirming service provision in different sectors and organisations.

Project aims

1. To explore expert opinion as to how FDSV services can appropriately support LGBTIQ communities
2. To understand needs and experiences of LGBTIQ people accessing FDSV services
3. To identify and describe principles of promising practice within the FDSV sector in understanding and meeting needs of LGBTIQ people
4. To inform capacity development among FDSV service providers to better meet the needs of LGBTIQ communities

Method

The report draws on three phases of qualitative data collection and analysis undertaken in 2020-2022:

Phase 1. Key stakeholder interviews with representatives from women's, general population and LGBTIQ community-controlled specialist FDSV services

- This phase involved interviewing 21 key stakeholders from LGBTIQ community-controlled organisations providing FDSV services, women's or specialist family violence services, and LGBTIQ FDSV response interagency groups from across Australia.
- Interviews sought to build new knowledge about good models of inclusive practice for LGBTIQ communities, enablers to service access and barriers to providing inclusive services.

Phase 2. Qualitative interviews with LGBTQ people who have experienced FDSV

- This phase of work was designed to build new knowledge about LGBTIQ people's experiences of FDSV services.
- Thirty qualitative interviews were conducted over Zoom or via phone calls with LGBTQ adults from around Australia. Participants represent a diverse range of experiences in terms of their gender and sexual identities, age, geographic location, experience of disability, and cultural backgrounds.

Phase 3. Case study examples of 'promising practice' in inclusive service delivery

- This phase comprised case studies of six organisations (two LGBTIQ community-controlled, three specialist FDSV services, one LGBTIQ FV support program in a community organisation) that provide FDSV services tailored for LGBTIQ communities or have modified their FDSV services to be more gender inclusive and affirming for LGBTIQ people.
- We sought to identify how principles of promising practice for LGBTIQ-inclusive FDSV service provision are being applied in different operational environments around Australia and understand the systemic, relational, operational and organisational factors that enable or impede application of promising practice principles.

Findings

Opening Doors considers the sociocultural, systemic and service-level factors that shape whether and how LGBTIQ victim-survivors are able to seek help after experiencing FDSV.

Naming and recognising FDSV

In interviews with LGBTQ people who had experienced violence (Phase 2), challenges in naming and recognising FDSV emerged as a significant barrier to seeking and receiving support. This was true for victim-survivors being able to see themselves as people who were experiencing violence (and, in most cases, that someone they loved had harmed them), and for service providers that they encountered who found it difficult to understand FDSV outside of typical framings that emphasise heterosexual and/or cisgender experiences.

Many participants had also assumed 'violence' to mean physical or sexual violence, meaning that non-physical abusive tactics used to coerce, control or cause fear in patterns of family and domestic violence were downplayed. The relationship between the person using and experiencing violence could also make it difficult for participants to name and recognise FDSV. Some participants who talked about FOV, or violence perpetrated by extended family or housemates, described their challenges in understanding whether or not this 'counted' as family violence, as it occurred outside of an intimate relationship.

These challenges were reflected in some participants accounts of their encounters with service providers. Some participants reported not feeling like their complaints of IPV were taken seriously by police, counsellors or specialist family or sexual violence services because their violence in their relationship was not perpetrated in line with cisgender and heteronormative framings. In same-gender relationships, several participants described how they worried that service providers might try

to impose a heteronormative framework on their relationship when trying to determine the primary aggressor, such as determining who was more masculine and therefore the more likely perpetrator based on relative physical size and assumed strength or their presumed assigned sex at birth. For example, James felt unable to reach out to the police for help when his partner, an Aboriginal woman, physically assaulted him.

> *I didn't want to call the police because that's not how I roll. Yeah, it was, because we were both Aboriginal, it probably wouldn't be a safe experience, and she lived in housing commission, so the police would be all over it. Like, it'd just be messy and not good for any of us; it could actually even get uglier for me because I'm the man.*
>
> *(James, trans man, queer, early 20s)*

This complicated the necessary nuanced investigations into how power and control was being misused in the relationship.

Structural and systematic barriers

Key informant interview (Phase 1) participants explained how political support, policy visibility and resourcing are all crucial to ensuring that LGBTIQ people can have reliable access to inclusive support after experiencing FDSV.

At the political and policy level, participants described the welcome shifts that have been made in recent years that have seen LGBTIQ people acknowledged in most state, territory and Australian Government plans regarding FDSV. They pointed out, however, that there is considerable variation in how such statements are framed and thus how resourcing decisions are made. This translates to uneven and uncertain access to safe and affirming care for LGBTIQ people in different parts of Australia.

Some participants described their frustration at government calls for evidence. Although emphatically supporting the idea that more and better research into FDSV experienced by LGBTIQ people is needed, they reflected that such calls for more evidence before taking action on service improvement are out of sequence, particularly as inclusive services need to be made available and used in order to collect data about community uptake and demand.

> *The data stuff is really hard isn't it … that's what the mainstream wants from us, from us as a specialist sector, is they want us to tell them the data of harm caused to people before they act on something […] I mean, I don't know, I find that such an offensive idea. But I think that they want—it's, like, 'Show us the bodies', that's what they want us to do: 'Show us the bodies and we will act differently'.*
>
> *(Ava, practice manager, LGBTIQ community-controlled family violence response program)*

Participants from LGBTIQ community-controlled organisations discussed a long legacy of working to meet the needs of FDSV victim-survivors in their communities, even where dedicated funding was not provided from government funders. They described the agility and resourcefulness required to do good work in these circumstances, even where it felt like 'robbing Peter to pay Paul' where funds needed to be redirected from other areas of work. Where LGBTIQ community-controlled organisations were operating FDSV programs in supportive policy and resourcing environments, and thus able to greatly expand the scope of their work, participants described continued high community demand and waitlists, demonstrating the necessity of existing and expanded resourcing support.

Some LGBTIQ community-controlled organisations also provide capability-building support to other organisations to help them to develop safer and more inclusive services for LGBTIQ people. Where there is adequate resourcing and support from organisational leadership, this can be done in robust ways that embed principles of LGBTIQ cultural safety in every aspect of service delivery and organisational management. However, some participants from LGBTIQ community-controlled organisations described limited organisational budgets and government support for this kind of professional development. This, alongside the fact that it is often viewed as optional rather than essential, means that it is difficult to provide sufficient training to services to empower them to provide culturally safe care to LGBTIQ people.

Navigating safe care

Together, the challenges in recognising FDSV among LGBTIQ people, and the structural barriers discussed above, have created terrain that has proved difficult to navigate for many LGBTQ participants with lived experience of family violence.

A commonly described challenge was needing to educate practitioners about their LGBTQ identity and relationships before being able to access help. Participants described the effort of this and the frustration of having to use limited consultation time to build practitioner cultural competency and knowledge. This could include being asked invasive questions that participants felt were more motivated by curiosity than related to providing them help, and it was often experienced as discrimination. Anticipating needing to expend this kind of effort acted as a deterrent to seeking further help for some.

Disclosure of sexuality or gender diversity acts as a risk event for many LGBTIQ people, given the possibility of discrimination, hence many are selective about when they do so. For trans and gender diverse people, choosing whether to disclose can be especially fraught, as it might mean not correcting someone misgendering them or misgendering themselves. Participants talked about, when approaching services, weighing up their anticipated risk of discrimination or exclusion from a service – should they share their gender or correct a service provider who misgendered them – against the risks of further violence in their home or relationship. These considerations were made more complex when overlaid with anticipated risk of racism or discrimination on the basis of disability that was experienced by some participants.

Conversely, participants also described what it felt like to receive affirming, supportive care from general population or LGBTIQ community-controlled services. This could mean use of correct pronouns, acceptance and affirmation of a client's gender and sexuality, including not asking invasive questions about or making them feel pressured to defend their identities, gender presentation or intimate or social relationships. It also meant believing LGBTIQ clients' accounts of FDSV and validating their need for care and support.

Promising practice

The six case studies investigated in Phase 3 looked at how LGBTIQ-inclusive FDSV practice is being attempted across different organisational, policy and resourcing settings. These studies revealed six key themes that combined can help to build a culture of LGBTIQ-inclusive practice in organisations, develop better referral networks and systems, and support safer service encounters for LGBTIQ victim-survivors.

1. Whole-of-organisation support for inclusive practice
2. Building and honouring LGBTIQ community trust
3. Adaptability and responsiveness to LGBTIQ communities' needs
4. Building strong cross-sector and interagency networks
5. Establishing cultures of reflective practice, attentive to LGBTIQ inclusion
6. Managing client safety and resistance to LGBTIQ inclusion

Summary and implications

Policy-level or structural-level implications

1. There is a need for a national policy framework for primary prevention of LGBTIQ experiences of family violence to:
    a. Raise awareness and recognition of FDSV among LGBTIQ people, the FDSV service sector and the general population.
    b. Promote social inclusion and equality, working against pathologisation of LGBTIQ identities, bodies or relationships.
    c. Promote social connection and community as protective and responsive for LGBTIQ people experiencing violence, including raising awareness of social isolation as a tactic of perpetration.
    d. Address stigma around reporting experiences of violence, and encourage help-seeking by challenging the ideas of victim-survivors being 'weak' or needing to 'protect' perpetrators.
2. Increased resourcing of family violence services nationally will mitigate competition for funding between groups in significant need.
3. Increased visibility of LGBTIQ people in all jurisdictional FDSV strategies and action plans will help normalise and embed inclusive practice design and resourcing for LGBTIQ inclusivity.
4. Improvements in routine data collection to ensure inclusion and representation of LGBTIQ people within all family violence and sexual violence data collection systems will help to ensure accurate assessment of community need, including:
    a. A review of all available routine data sources, including intake and referral documentation and reporting to funders, to identify opportunities to capture LGBTIQ-relevant information.
    b. The adoption of the 2021 Australian Bureau of Statistics (ABS) Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables for all routine data collection instruments.
    c. The inclusion of the aforementioned ABS standard in the Personal Safety and Crime Victimisation surveys, and disaggregation and reporting of LGBTIQ experiences documented in these surveys.

Implications for service-level intervention

5. A national plan, with resourcing, to support the delivery of LGBTIQ-inclusive family violence services will help to coordinate, normalise and systemise these supports. Such a plan might include:
    a. Establishing or strengthening formal referral pathways between LGBTIQ-expert/specialist services and other providers.
    b. Mechanisms to support the revision of practice frameworks to take account of gender diversity and specific needs of LGBTIQ people.
    c. Recognition of the diverse forms of violence that can impact LGBTIQ people
    d. Recognition that some victim-survivors will require population-specific services to feel safe (i.e. trans-specific services or women's services).
    e. Recognition of suicidality as significant impact of LGBTIQ FDSV, and better integrate mental health and FDSV prevention and response efforts.
    f. Recognition of the ongoing importance of LGBTIQ community–led responses and community trust in the success of any interventions, and resource the participation of a diverse range of representatives from these communities in consultation and review processes.
6. Scaling up of resources to enable LGBTIQ community-controlled organisations to advance their provision of FDSV services will foster development of tailored, fit-for-purpose interventions and new approaches to responding to FDSV that can be shared across general population and LGBTIQ sectors.
7. There is conspicuous need to develop interventions that recognise and respond to FOV among LGBTIQ people.

Implications for community-level intervention

8. There is a need for community awareness campaigns that raise awareness of FDSV among LGBTIQ communities and how it can present in ways that may be difficult to recognise.
9. Community-level interventions aimed at disrupting negative stereotypes about victims of FDSV and about the 'kind of people' who need to seek help will help to challenge shame and stigma that stops some victim-survivors from accessing services.

Implications for future research

There is a need for further research which:

10. Explores the factors and forces that contribute to the perpetration of family violence.
11. Is peer-led and considers the experience and presentation of FDSV among people with intersex variation.
12. Is focussed, peer-led research among Aboriginal and Torres Strait Islander LGBTQA+ people.
13. Seeks to better understand how perpetration of FDSV against LGBTIQ people can be informed by ablism.
14. Is conducted among young people to explore how they experience and frame hostility from members of their family of origin.
15. Examines how sexual consent is understood and practised in different LGBTIQ communities, including:
    a. How experiences of transphobia and homophobia might act as barriers to practising sexual agency.
    b. How conversations about sex positivity and consent are navigated by people from different LGBTIQ communities, with a view to sharing lessons with people who are recently out or exploring their sexuality.
16. Works with staff and clients in specialist women's family violence services to understand how each group are engaging on issues of LGBTIQ inclusion and cultural safety in services.
17. Facilitates periodic monitoring. Ongoing funding is required to enable surveys that can track LGBTIQ experiences of FDSV over time, including the intersectional communities most impacted, service engagement experiences and associations with broader aspects of health and wellbeing.

Structure of this report

This report considers:

- Key factors that shape service engagement (and non-engagement) by LGBTIQ people experiencing family violence
- Barriers to and gaps in inclusive service provision and access
- What inclusive, safe and affirming practice looks like for service users
- The factors that have helped organisations demonstrating promising practice approaches to develop more inclusive services.

Chapter 1: Introduction sets out the aims of this study and the methods used across the three phases of data collection and analysis. It also provides a background to FDSV service provision in Australia and the prevalence and experience of FDSV among LGBTIQ populations, and defines key concepts and frameworks used throughout the report.

Chapter 2: Method details the data collection methods and analytic approaches used across three phases of research:

- **Phase 1.** Key stakeholder interviews with representatives from women's, general population and LGBTIQ community-controlled specialist FDSV services
- **Phase 2.** Qualitative interviews with LGBTQ people who have experienced FDSV
- **Phase 3.** Case study examples of 'promising practice' in inclusive service delivery

Chapter 3: Naming and recognition of FDSV in LGBTIQ communities draws predominantly on qualitative lived experience interview data (Phase 2) to examine issues related to what is often a crucial first step in seeking help: naming and recognising that violence has occurred.

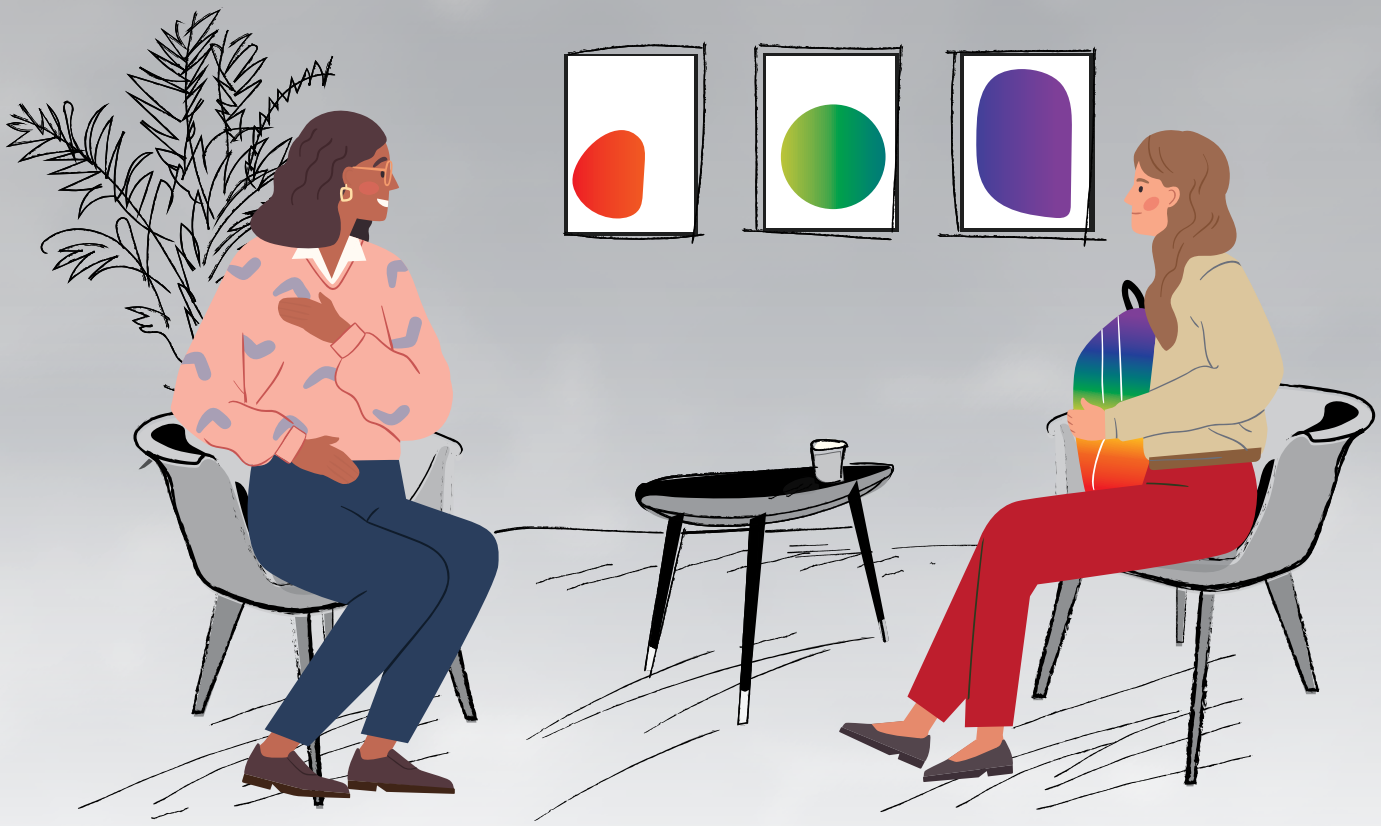
Chapter 4: Mapping barriers and enablers to inclusive service provision considers the structural and systemic issues that impede more comprehensive development of LGBTIQ-inclusive FDSV services.

Chapter 5: Navigating support after experiences of FDSV returns focus to lived experiences of LGBTIQ victim-survivors attempting to access help.

Chapter 6: Strategies for developing LGBTIQ-inclusive practice provides a counterpoint to the challenges discussed elsewhere in this report. It discusses examples of LGBTQ participants' lived experiences of affirming, supportive service encounters. This chapter then provide key lessons from the six case studies of promising practice, demonstrating different approaches to embedding and enacting culturally safe and trauma-informed practice for LGBTIQ people experiencing violence.

The report concludes in ***Chapter 7: Summary of findings and research implications***, which brings together findings from this study and considers how they might inform future research, policy and practice development and implementation.

A practice guide and expanded set of promising practice case studies can be found on the project website.



1 Introduction

Opening Doors: Ensuring LGBTIQ-inclusive family, domestic and sexual violence services (Opening Doors) details findings from a multi-phase, mixed method study that considers how to improve family, domestic and sexual violence (FDSV) service accessibility and safety for lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) people in Australia.

In this chapter, we provide an overview of the research and its aims, key concepts used throughout the report, and background to the study. We define family, domestic and sexual violence, discussing the ways that the meanings and applications of these terms have evolved over time in service delivery, policy and legislation, and public understanding. We use this to discuss the context of FDSV for LGBTIQ communities in Australia, considering prevalence, presentation and what we know from current evidence and research literature.

The chapter then looks more closely at FDSV services. We provide an overview of:

- Categories of services in Australia
- Social and political influences that have shaped development of services over time
- Service differences across both state and territory jurisdictions, and between metropolitan and rural/regional parts of the country
- This provides important contextual information when considering access and capacity of mainstream FDSV services for LGBTIQ communities.

We follow this with a discussion of key concepts that characterise 'inclusive' FDSV service delivery: trauma-informed care (1) and culturally safe practice (2,3). These concepts are widely used in practice literature and by services themselves to inform frameworks for affirming, safe and effective care. They are used throughout the report as a means of understanding gaps in LGBTIQ-inclusive service delivery and what might be done to address them, as well as to identify existing examples of promising practice demonstrated in different service and geographic settings across Australia.

1.1 Research overview

Opening Doors aims to inform and improve the capacity of family, domestic and sexual violence (FDSV) service providers to understand and address the needs of lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) communities. The project has been undertaken with a series of five overlapping objectives:

1. To explore expert opinion as to how FDSV services can appropriately support LGBTIQ communities
2. To understand the needs and experiences of LGBTQ people accessing FDSV services
3. To identify and describe principles of promising practice within the FDSV sector in understanding and meeting the needs of LGBTIQ people
4. To raise awareness and understanding of the study findings
5. To increase the capacity of FDSV service providers to meet the needs of LGBTIQ communities

Throughout the report, LGBTIQ is used as an umbrella term to describe a set of both distinct and overlapping communities. This term is widely recognisable in Australia as a political and social category of people who are underserved by many service sectors and is commonly used by government and service providers when considering capability development to better serve these communities.

While the aim of this research is to support the development of comprehensively LGBTIQ-inclusive services, some parts of the research did not specifically include people with an intersex variation.[1] Despite attempts to recruit participants with an intersex variation, none of the participants in the interviews looking at accounts of lived experience (Phase 2) disclosed having an intersex variation. So the report uses 'LGBTQ' in this section, as our data unfortunately do not describe the lived experience of people with an intersex variation who are victim-survivors of FDSV. As discussed in greater detail later in Chapter 7, people with intersex variation face a unique set of issues and concerns that may best be considered in an individual project with meaningful community involvement.

1.2 Defining family, domestic and sexual violence

Family and domestic violence overlaps with sexual violence and often occurs concurrently, with similarities in terms of how they are perpetrated and the social drivers of violence (2,3). However, there are distinct service responses and needs related to different types of violence. There are also different legal and practice definitions of family and domestic violence and sexual violence in use across different Australian jurisdictions.

This section outlines the principles that are used by mainstream or LGBTIQ community-controlled specialist services providing assistance to someone who has experienced violence, whether or not they seek legal redress. That is, this section does not detail definitional differences across various pieces of legislation but describes general, common use understandings of family and domestic violence, and then sexual violence.

1.2.1 Family and domestic violence

'Family violence' and 'domestic violence' are terms used together and sometimes interchangeably across federal, state and territory jurisdictions to describe violence perpetrated by someone who shares a home and/or is in a familial or intimate relationship with those that they victimise (4). This might include current or former intimate partners; parents, siblings or other members of a family of origin; extended family members; or housemates (5,6). Family violence is the preferred term used by many Aboriginal Australians to describe experiences of violence in familial, intimate partner and domestic settings, as it encompasses a range of different familial and kinship relations where violence may occur (7). This phrasing has been adopted in many Australian policy and practice settings as a result (8). 'Domestic violence' may be used to refer particularly to IPV as well as being used as a synonym for family violence.

In the context of LGBTIQ family and domestic violence, some service providers and practitioners also include violence perpetrated by a member of one's chosen family (9). This reflects the critical importance of close social networks in the lives of many LGBTIQ people particularly as a source of support in the face of homophobia and transphobia, including that which might come from one's family of origin (10).

Regardless of the relationship between the person using violence and the person or people being abused, there are common factors that determine whether unhealthy behaviours in a domestic or family setting have become abusive. Crucially, family and domestic violence is understood to consist of patterns of behaviour where the cumulative impact of tactics of abuse are to coerce, control or make the victim feel fear, whether or not single reportable incidents of, for example, criminal assault are part of those patterns (6,11).This means that tactics used to perpetrate family and domestic violence can take many forms, including emotional, verbal, psychological, financial, technological and social abuses, as well as physical assault, property damage and threats to cause harm.

1.2.2 Sexual violence and abuse

Sexual violence and abuse is defined by the World report on violence and health as:

> *Any sexual act, attempts to obtain a sexual act, or acts to traffic for sexual purposes, directed against a person using coercion, and unwanted sexual comments, harassment or advances made by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (12).*

Sexual abuse can occur in the context of family and domestic violence, be perpetrated by someone who does not have a prior relationship with the victim-survivor, or be perpetrated by someone with whom the victim-survivor has a casual or more distanced relationship. It can include acts such as 'stealthing' (removal of a condom where consent for sex was predicated on using protection). It includes where sexual acts or advances are continued after someone has withdrawn their consent, even if they had previously agreed to an act or encounter; and where someone is not able to give their consent because they are intoxicated.

1 'Intersex' describes people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies and can manifest at birth or in later life (1). People whose innate sex characteristics fit normative medical or social ideas for female or male bodies are described as 'endosex'.

People understand sexual assault and sexual violence in a multitude of ways (13) and there are variations in the way it is defined in legislation in Australia (14). However, the principles set out in the World report on violence and health are broadly reflected in Australian law and in practice definitions used by specialist sexual assault response services.

All Australian legislation recognises that sexual violence can be perpetrated against people of any gender by people of any gender; this is also reflected in the service scope of most sexual assault and rape crisis services, which are generally mixed-gender services. However, public conversations about sexual assault and sexual violence predominately focus on cisgender women victimised by cisgender men, and child sexual assault (15). This reflects available whole-of-population data on prevalence rates; however, it is notable that these data are only disaggregated across binary gender categories and therefore does not provide information as to prevalence among trans and gender diverse populations.

1.3 Context of FDSV for LGBTIQ communities

Family, domestic and sexual violence is a significant issue experienced by LGBTIQ populations. Some studies indicate that prevalence rates of victimisation are similar to those found in the general population and even higher for some groups (1,14-18). Despite this, there remain considerable barriers that impede LGBTIQ people experiencing violence from accessing help from services such as specialist family violence response providers or refuges, specialist sexual assault services (including telephone hotlines), police, courts, and healthcare providers (1,17,19-21). There is a growing body of literature that highlights the pressing need for services that are safe, inclusive and responsive to the particularities of LGBTIQ people's varied experiences of violence and their impacts (2,24).

Research relating to engagement with supportive FDSV services by LGBTIQ people who have experienced violence is limited, in Australia and overseas. Little is known about the extent to which those who have experienced violence seek or take up supportive services, where they might go for help, or their experience of doing so. Analysis of data from the largest LGBTIQ health and wellbeing study in Australia, Private Lives 3 (1) found that only 25.9% of participants who indicated they had experienced family violence in their lifetime reported their most recent experience of abuse to service providers. Of these, only 2.3% made reports to specialist FDSV services and 5.9% to police. This aligns with similar findings from the UK and US (23,25).

1.3.1 Prevalence of FDSV among LGBTIQ populations

There is limited population-level data recording prevalence and presentation of FDSV in LGBTIQ communities. Widespread under-reporting and a tendency for existing population-level surveys about FDSV to use binary frameworks for data collection on gender and sexuality contribute to these gaps (issues that are explored in greater detail in Chapter 2).

Private Lives 3 provides insight into the scale of FDSV among LGBTIQ populations. Survey respondents were asked about their experiences of IPV and FOV in two ways (1). First, they were asked questions aimed at gauging respondents' capacity to name the broader patterns of abuse: 'Have you ever felt you were abused in some way by a family member(s)?' and 'Have you ever been in an intimate relationship where you felt you were abused in some way by your partner(s)?'

Second, the survey asked whether respondents had experienced specific categories of abuse tactics perpetrated by an intimate partner, or by a family member. Response options were 10 forms of violence: physical abuse, emotional abuse, social isolation, sexual abuse, stalking, verbal abuse, property damage, threats of self-harm or suicide, financial abuse, and LGBTIQ-related abuse (e.g. being shamed for being LGBTIQ, threatening to 'out' them or their HIV status, withholding hormones or medication). Respondents who had experienced any of these forms of IPV or FOV were also asked if they felt they were targeted for the abuse because of their sexual orientation, gender identity, gender expression or intersex variation(s).

Of the respondents, 41.7% reported that they had ever experienced IPV, and 30.9% stated that they had experienced FOV when asked directly. When asked to identify individual categories of abuse, this increased to 64.7% stating that they had every experienced family violence, while 60.7% stated that they had experienced IPV and 43.2% stated that they had experienced FOV (1,26).[2]

Secondary analysis of these data undertaken for the current study found that cisgender women, trans men and non-binary participants were the most likely to report experiencing both FOV and IPV (22). This analysis also found that people with disability were also more likely to have reported experiencing some form of family violence.

In contrast, the 2016 Personal Safety Survey conducted by the Australian Bureau of Statistics found 23% of women and 16% of men reported ever having experienced emotional abuse by a partner, and 17% of women and 6% of men reported every having experienced physical or sexual violence perpetrated by a partner (27). While not directly comparable due to the different questions asked in each survey, these data indicate that family violence is a significant issue for LGBTIQ people. Further, that responding to and reducing family violence experienced by these populations should command similar attention to the critical issue of responding to violence experienced by women.

Numerous international studies indicate a high incidence of sexual assault experienced by LGBTIQ people, and suggest that some LGBTQ victim-survivors felt that they were targeted for the assault because of their gender or sexuality (13,28). Similarly, 48.6% of *Private Lives 3* participants reported that they had been sexually assaulted in response to the question, '[Has] anyone ever coerced or forced you into sexual acts you did not want to engage in?' Again, while there are limitations to comparing results across different studies, it is notable that the Personal Safety Survey found 18.4% of women and 4.7% of men indicated that they had ever been sexually assaulted (since the age of 15), as reported in Sexual assault in Australia (15).

Private Lives 3 participants were also asked about their relationship to the person who perpetrated the most recent sexual assault. Responses indicated that most of these assaults might be classified as family and domestic violence, with 21.9% perpetrated by former intimate partners, 19.4% by intimate partners, 4.1% by family members, 3.2% by family-like relations, 2.7% by a parent or guardian, and 2.3% by a sibling.

2 This issue of how readily LGBTIQ people experiencing violence are able to name what is happening to them, and implications for accessing services for support, is explored in greater detail in Chapter 2.

A further 19.4% were perpetrated by friends, which may also include relational categories – such as housemates or chosen family – that are considered as family violence in some jurisdictions or by some services.

1.3.2 Common dynamics and drivers

FDSV is perpetrated to cause fear and facilitate control. People who use violence draw on the personal vulnerabilities of those being victimised and the ways that those vulnerabilities are shaped by structural inequalities (21,29,30). These often include discriminatory gender dynamics, which represent key drivers of violence perpetrated by cisgender men against cisgender women (3). Recent research suggests that the same gender norms are layered with cisnormativity and heteronormativity in violence perpetrated against LGBTIQ people (2).

The ways that structural inequalities inform perpetration of FDSV plays out differently depending on the identities and relationships of those using and experiencing violence. For example, IPV between two cisgender men may still draw on rigid patriarchal norms of men being prone to physical violence, with the implication that the person experiencing violence should just 'be a man' and fight back (29-31). Gender diverse young people may experience violence perpetrated by their family of origin because they are not conforming to assigned gender roles (34). Equally, people who use violence can draw on any combination of racism, ableism, precarious migration status, financial insecurity or ageism as well as gender or sexuality-based discrimination to maintain control in their relationship with the person they are victimising (33-37). These factors shape how FDSV might be perpetrated and its effects. They also play a role in determining whether and how people identify the harms they are experiencing as violence (see 26), which services they feel safe and able to approach for help, and their experiences of engaging with different services and navigating across service systems.

1.4 Family, domestic and sexual violence services

1.4.1 Service categories

Throughout the report, the term 'LGBTIQ community-controlled services' is used to describe supports designed and implemented for and by LGBTIQ communities. These might include specialist family violence or sexual violence supports, as well as broader health, wellbeing, and social support programs.

The nature of this research is to understand LGBTIQ inclusion in service supports. When referring to LGBTIQ community-controlled programs, services or organisations, we distinguish them as such. All other programs, services or organisations are either referred to by service type or with the umbrella term 'FDSV services'. These may include services for the general public, which might be mixed-gender specialist family or sexual violence services, police, courts, health service providers and other social services, as well as specialist women's health and/or family violence services.

Specialist family and domestic violence services provide crisis responses and case management to people who have experienced violence, often referred to as victim-survivors. They may also provide behaviour change support and early intervention services for people who use or are at risk of using violence. Many services that support victim-survivors are women-only services or have women's programs within a mixed-gender service; and most behaviour-change and early intervention programs target only men (and predominately cisgender and heterosexually presenting men). Specialist sexual violence services are more commonly mixed-gender services and provide counselling and case management support for people of any gender who have experienced sexual assault (including in the context of family violence). There are several LGBTIQ community-controlled specialist family and/or sexual violence services in Australia. However, the majority of sexual violence services are general population services and the majority of family and domestic violence services are targeted towards women who experience violence from male partners and limit their client eligibility to only provide victims services to women and perpetrators programs to men.

FDSV AMONG LGBTIQ POPULATIONS IN AUSTRALIA AT A GLANCE

AMONG RESPONDENTS OF PRIVATE LIVES 3 (THE LARGEST EVER SURVEY OF LGBTIQ PEOPLE IN AUSTRALIA) (1,16,26):

60.7%
REPORTED EXPERIENCING SOME FORM OF IPV

43.2%
REPORTED EXPERIENCING SOME FORM OF FOV

CISGENDER WOMEN, TRANS MEN AND NON-BINARY PARTICIPANTS WERE **THE MOST LIKELY** TO REPORT HAVING EXPERIENCED FOV AND/OR IPV

LGBTQ PEOPLE WITH DISABILITY WERE **1.5 TIMES MORE LIKELY** TO HAVE EXPERIENCED FOV AND ALSO MORE LIKELY TO HAVE EXPERIENCED IPV

48.6%
REPORTED HAVING EXPERIENCED SEXUAL ASSAULT

THE MAJORITY
OF THE SEXUAL ASSAULTS EXPERIENCED WERE PERPETRATED IN THE CONTEXT OF FAMILY VIOLENCE (IPV AND FOV)

1.4.2 Background to FDSV services in Australia

Feminist activism, in particular, the women's liberation movement of the 1970s, provided the foundations of current scholarship, legislation, policy and action around FDSV in contemporary Australia (40–42). This activism, advocacy and service delivery was centred upon responding to high levels of IPV, domestic violence and sexual assault experienced by heterosexually presenting, presumptively cisgender women and their children, perpetrated by heterosexually presenting, presumptively cisgender men.

The community activism that drove contemporary family and sexual violence response reform in Australia came in response to the urgent problem of violence against women; an issue of continued, considerable need. This early focus on heterosexual women and their children, and an emphasis on physical assault in discussion of family violence, reflected in early terms such as 'wife battering' (5) was successful in bringing to public attention a vast epidemic of otherwise unrecognised violence in Australian communities. For decades feminist practitioners and advocates working with and for victim-survivors have understood the multifaceted ways that family violence is perpetrated (6). However, these broad early framings of family violence, simplified in order to capture attention of policymakers and the general public, formed the 'public story' of how family violence is thought of in wider Australian society, inadvertently limiting understanding of the range of people experiencing violence and their service needs.

There have been considerable shifts over the decades, and public conversations about FDSV are now more nuanced. For example, the 2017 National Community Attitudes Towards Violence Against Women Survey (NCAS) found that more Australians were able to identify that family violence is more than physical abuse than in 2013 or 2009 (43). However, many FDSV issues continue to require further public education and advocacy. For example, victim-blaming narratives around sexual assault persist, and recognition of sexual abuse perpetrated in intimate and family relationships also needs improvement. The 2017 NCAS found that, although there have been some shifts, concerning attitudes continue to be found in the Australian community: for example, one in five people were not aware that non-consensual sex in marriage is against the law (15).

It was in the 1980s that Australian activists and service providers working to support people who had experienced FDSV helped to broaden legal definitions of family violence away from just incidences of physical assault (6). However, the broader category of 'violence against women' which describes discrimination, harassment, violence and abuse experienced by women, including but not limited to family violence, became shorthand for discussions of IPV, and sexual assault and harassment (44). This shaped key pieces of policy and service infrastructure nationally, including the National Plan to Reduce Violence Against Women and Their Children (45), which focuses predominantly on IPV and sexual assault perpetrated by men against women.

This focus has been enshrined in policy frameworks, funding and service agreements for FDSV support providers and community understandings of FDSV in Australia. While addressing violence against women remains of critical importance, the framing of FDSV as 'violence against women' has obscured LGBTIQ experiences of violence and created barriers to help-seeking for LGBTIQ people experiencing or using violence. The historical framing of FDSV can make it difficult to identify abusive behaviour in LGBTIQ relationships or used against LGBTIQ people as family or domestic violence. Practically, it can also make it challenging for services to provide support to people experiencing violence who do not identify as women, for example, where a contract with government or other funders stipulates that funding address violence against women (discussed in more detail in Chapter 3).

In recent years there has been more widespread consideration of how FDSV plays out in different ways according to the different experiences, relationships and identities of perpetrators and victim survivors, including what FDSV looks like in LGBTIQ communities and relationships. This was reflected in submissions to the Victorian Royal Commission into Family Violence in 2016 and its report which provided 227 recommendations to improve prevention and responses to family and domestic violence, including for LGBTIQ communities. More recently, after extensive community consultations in 2021, the draft version of the National Plan to End Violence against Women and Children 2022-2032 provided for public review in January 2022 included more comprehensive consideration of violence experienced by LGBTIQ people than its predecessor published in 2011 (45). It includes mention of the role of heteronormativity and cisnormativity in driving violence for these communities. The draft National Plan 2022-2032 gives the following definition of gender-based violence:

In recent years there has been more widespread consideration of how FDSV plays out in different ways according to the different experiences, relationships and identities of perpetrators and victim survivors, including what FDSV looks like in LGBTIQ communities and relationships

> ***Gender-based violence*** *refers to violence that is used against someone because of their gender. It describes violence rooted in gender-based power inequalities and gender-based discrimination. While people of all genders can experience gender-based violence, the term is most often used to describe violence against women and girls, because the majority of cases of gender-based violence are perpetrated by men against women, because they are women. Gender-based violence can include female genital mutilation, trafficking of girls, forced marriage, and dowry abuse. Violence experienced by LGBTIQA+ people of all genders is also gender-based violence (8).*

This last line, and its explicit mention of violence experienced by LGBTIQA+ people, marks significant national policy recognition that violence against LGBTIQA+ people is intertwined with violence against women in terms of both its drivers and its remedies. There is also growing recognition of the separate but overlapping issues of 'family violence, family and domestic violence, domestic violence and sexual violence' and 'violence against women' in policy documents and awareness campaigns published by government and community sector agencies across Australia.

This can perhaps be best understood as a slow and uneven redefinition of understandings of FDSV, which is occurring alongside other moves towards acknowledging patterns of coercive control (11,18) and non-physical forms of abuse in domestic policy and law (6).

Acknowledgement of LGBTIQ experiences of FDSV in public discourse and service provision is relatively recent. In Australia, while there have been significant moves towards inclusivity in government policies and practice frameworks, public discussion of violence in LGBTIQ families and relationships remains largely separate. That is, it is often a discrete issue considered in addition to, rather than as intertwined with, violence faced by cisgender women and their children (2). This may also influence the extent to which many LGBTIQ people trust in a service's ability or willingness to provide support that is safe or, indeed, whether supports exist for them at all. These issues are discussed in detail in subsequent chapters.

1.4.3 Australian service systems

The make-up, resourcing and referral networks within FDSV service systems vary across states and territories. Within this, there are also considerable differences in service availability between rural, regional and metropolitan areas. There are multiple points of entry into service systems where victim-survivors may be referred on to more specialised services as appropriate. A range of non-FDSV-specific LGBTIQ community-controlled service program areas serve as common entry points (such as mental health, sexual health and alcohol and other drug services, and counselling phone lines) as well as services that target the general population (such as GPs, hospital physicians and clinical staff, mental health professionals, mental health and FDSV counselling and advice phone lines, social workers, homelessness services, and alcohol and other drug services, and police, courts and legal services) (1).

People experiencing FDSV may subsequently be referred on to specialist support services, which assist with a variety of needs. They may also approach these services directly. This includes crisis intervention, crisis accommodation, counselling, and therapy (both long- and short-term), and assistance with accessing legal protections or advice. These functions are often dispersed across multiple organisations, which may coordinate care and service provision through either established interagency partnerships, or through ad hoc collaboration.

There are several LGBTIQ organisations that provide community-controlled support to LGBTIQ-identified people who have experienced FDSV. Some of these organisations have developed effective, tailored, community-informed responses to FDSV and are providing workforce capability building to other services and organisations. Two of these are profiled in the case studies of promising practice discussed in Chapter 5. However, the majority of LGBTIQ community-controlled specialist family violence services are concentrated in Sydney and Melbourne (although several organisations in these and in other metropolitan centres provide regional outreach or national phone and web-based help), which means that accessibility for LGBTIQ people in much of Australia is challenging.

A small but growing number of general and specialist services, including sexual violence services, have undertaken comprehensive organisation-wide capacity building efforts to ensure that they can provide safe, inclusive services for LGBTIQ people (such as the four services that make up the remainder of the promising practice case studies in this report).[3] However, as demonstrated throughout the report, in other services, the intent to provide inclusive services may not be supported with adequate understanding of the safety and service needs of LGBTIQ clients, or there may be different degrees of knowledge or biased attitudes held by staff in an organisation. For example, a service may start to include LGBTIQ community flags in their promotional material without having comprehensively considered whether they would be able to support all LGBTIQ people who might approach them for help. Encountering and even anticipating discriminatory attitudes can be a significant deterrent to accessing help (47). Research participants indicated that many specialist family violence services that have historically been women-only services and do not have clear policies on inclusion of trans women or non-binary people. They may still exclude GBT men from accessing victim-survivor services, including crisis accommodation for people escaping violence, even while indicating in promotional or informational materials that they are LGBTIQ inclusive. Service providers and stakeholders interviewed for this study also identified a significant gap in behaviour change programs for people who have used violence who are not cisgender, heterosexually presenting men, and that only a handful of LGBTIQ-inclusive programs open to people of all genders are available across the country.

As pointed out by a participant who had worked across women's, general population and LGBTIQ organisations in a number of states, the LGBTIQ community is diverse: some people will want to attend an inclusive general population service, others a larger LGBTIQ organisation and others may not feel comfortable in either, for a range of reasons both personal and structural (1,23,25,48). Progressive policy conversations that look at entire systems and how to ensure opportunities for safe disclosure and help-seeking for FDSV, including with people with the power to effect change within government, are therefore critical.

3 The most well-established of these is the Rainbow Tick accreditation model (46). This was developed by Rainbow Health Australia for use in different health and service settings but is most widely implemented in the Victorian specialist family violence sector as a result of the LGBTIQ Family Violence Capacity Building Initiative 2018-2020, funded by Family Safety Victoria.

1.5 Practice frameworks

There are common principles that scholarly and practice literature indicate are foundational to providing FDSV services in a safe and inclusive manner for LGBTIQ populations (2,46,49,50).

Broadly speaking, application of these principles is intended to ensure that LGBTIQ people who need support can:

- Find the support that they need when they need it
- Trust the support services that are available to them
- Have culturally safe and inclusive experiences when accessing a service
- Experience a positive change to their safety and wellbeing as a result of seeking help

These key elements of safe and inclusive service experiences for LGBTIQ people inform analysis throughout this report.

Overall, the two most important practice principles that participants identified as key to creating inclusive supports for LGBTIQ communities accessing their services were: cultural safety and trauma-informed practice.

1.5.1 Cultural safety

Culturally safe practice means creating environments where people's identities and experiences are not assaulted, challenged or denied. It refers to practice that is centred upon shared respect, deep listening, and co-creation of knowledge and meaning between practitioners and clients (49,51,52). The Rainbow Tick Standards guide explains the origins of this framework and how it came to be used in LGBTIQ communities:

The concept of 'cultural safety' was originally developed to apply to health service delivery for Māori communities, with the hope it would be further developed to benefit other marginalised populations as part of a shared responsibility to create a more equal society. This concept and term have been adopted for use by First Nations peoples, including by Aboriginal and Torres Strait Islander communities. Over time, the concept has been expanded to apply to inclusive and affirmative health and community service delivery for other groups, including LGBTIQ communities (46).

Culturally safe service interactions were usually recognisable to LGBTQ research participants who had experienced violence, even if they did not necessarily articulate or qualify it within those terms. Often this was experienced as an affirmation of their status or identity, for instance, through the use of the correct pronouns. It also meant services had changed their universal culture, so the participants did not feel pressured to explain, defend themselves or educate a service worker about their gender expression or relationship/s in ways that felt invasive or surplus to improving their care or support.

1.5.2 Trauma-informed care

Trauma-informed care is based on the assumption that most people coming into a service (whether clients or staff) are likely to have experienced trauma of some kind. Service operations, practice protocols and care are therefore structured to avoid retraumatisation or reinscribing past harms. Ideally, this approach is integrated into all levels of operation so that efforts toward trauma-informed care in practitioner–client interactions are well supported.

There are different frameworks and approaches used to explain and scaffold trauma-informed approaches to care (50). In a review of approaches used in the context of domestic violence, Wilson and co-authors identified six key themes that emerged as fundamental to understanding and implementing trauma-informed approaches:

a. Establishing emotional safety

b. Restoring choice and control

c. Facilitating connection

d. Supporting coping

e. Responding to identity and context

f. Building strengths

From these principles, it is apparent that trauma-informed care means working with clients to understand what makes them feel safe (or unsafe), allowing them autonomy over decisions and actions, and building trust. Principle 5, 'Responding to identity and context', describes the importance of recognising that experiences of discrimination, however subtle or unwitting, can be retraumatising. Therefore, culturally safe practice can be viewed as a crucial aspect of trauma-informed care.

Embedding these practice protocols and building organisational and workforce capability in providing trauma-informed and culturally safe care requires ongoing attention and effort. This is particularly true where new cultural competencies and knowledge need to be developed, as is the case for many women's or general population services providing services for LGBTIQ populations.

2 **Method**

The research was conducted via three phases of data collection with participants from across Australia, including:

- Nineteen interviews with key stakeholders across the LGBTIQ and mainstream specialist FDSV sectors
- Thirty qualitative interviews with LGBTQ people with experience of FDSV
- Six qualitative case studies of promising practice in inclusive FDSV service provision

This chapter starts by explaining these methods in detail.

2.1 Phase 1: Key stakeholder interviews

This phase involved interviewing key stakeholders in both mainstream and LGBTIQ organisations providing FDSV services to build new knowledge about:

- Good models of inclusive practice for LGBTIQ communities
- Enablers to service access
- Barriers to accessing and providing inclusive services

This phase examined a range of service contexts across Australia. These include services delivered by LGBTIQ community-controlled organisations and other specialist family violence services. Participants were recruited by directly approaching FDSV service organisations for interviews. Invitations were made based on recommendations made by FDSV and LGBTIQ sector leaders across the country. At the end of their interview, participants were asked whether there were other key stakeholders in their local context who we should invite for interview.

Nineteen interviews were conducted with 21 participants. Some participants worked – or had worked – across both sectors, some were part of the LGBTIQ community and working in women's or general population services, and some were interviewed in their capacity as representatives on interagency or cross-sector bodies looking at FDSV experienced by LGBTIQ communities. Of those working in women's or general population specialist family violence services, some described organisations that had made significant progress towards developing LGBTIQ-inclusive practice and others described organisations where this work was nascent or not yet in scope for their service.

Table 1: Organisational affiliations

Type of organisation	Number of participants
Women's/general population specialist family and domestic violence services[4]	11
LGBTIQ community-controlled organisations	12
Cross-sector advisory or convening organisations	8

Table 2: Participant location

State/territory	Number of participants
Northern Territory	3
Australian Capital Territory	1
Tasmania	2
South Australia	4
Western Australia	3
Queensland	1
Victoria	3
New South Wales	3

Participants were asked to discuss provision of support and referrals for LGBTIQ people who had experienced FDSV. Interview participants had experience in a range of different service types including:

- Refuge accommodation and case management
- Specialist counselling and group support services for LGBTIQ people experiencing or using violence in relationships or families
- Sector coordination and advocacy agencies
- Specialist services and LGBTIQ-focussed FDSV sector forums (e.g. statewide interagency groups)
- Primary prevention initiatives
- Services for people experiencing homelessness
- Support for LGBTIQ people using alcohol or other drugs, and
- Mental health support

Interviews were between 25 and 60 minutes in length. Audio recordings of interviews were transcribed and analysed thematically (53) with the assistance of qualitative research analysis software (NVivo).

4 Some participants had recently changed sectors to or did locum and consulting work in women's or general population services so are recorded against both.

2.2 Phase 2: Qualitative interviews with LGBTQ people who have experienced FDSV

This phase of work was designed to build new knowledge about LGBTIQ people's experiences of FDSV services. By interviewing LGBTIQ people who have experienced FDSV, we set out to understand:

- The factors that encourage people to seek support
- Practice approaches that facilitate positive client experiences
- Barriers that prevent LGBTIQ people from accessing help

Thirty qualitative interviews were conducted over Zoom or via phone calls with LGBTQ adults (aged 18+) from around Australia. Participants were recruited from a database composed of Private Lives 3 participants (1) who had consented to be contacted about future studies. An email was sent to the email address nominated by individuals, explaining:

1. The goals of the project
2. What participation in the project entailed
3. Eligibility criteria

Interested parties were directed to complete an online screening questionnaire designed to further determine the respondent's eligibility; this captured basic demographic information such as:

- Race/ethnicity
- Age
- Sexuality
- Gender identity
- State of residence
- Recency of last FDSV-related incident
- Use/non-use of formal support services

In order to ensure the equitable representation of various demographic characteristics and lived experiences within the study, purposive sampling was used to obtain a participant sample from among the eligible respondents with an even distribution of these demographic characteristics.

The interviews were structured as a narrative or life history that centred on accounts of a recent experience (within 2 years) of FDSV, and how and why support was sought or not sought. Many participants also discussed previous experiences of FDSV, and/or encounters with different services, that shaped whether and how they sought help in the past 2 years. Most recent experiences of FDSV related to IPV. Other accounts related to sexual violence experienced in the context of casual or dating encounters, violence perpetrated by a housemate, and violence within a participant's family of origin, either as an adult or a minor.

Interviews were between 45 and 90 minutes long. Audio recordings were transcribed and analysed thematically with the assistance of qualitative research analysis software (NVivo). An overview of demographics in the participant cohort is provided below. No participants identified themselves as having an intersex variation in the initial screening survey, and therefore there are no data on lived experiences of support seeking after FDSV from people with an intersex variation. Participant ages ranged from 20 to 79 years of age, with half (n = 15) listing their age as between 25 and 44 years old.

Diversity within the sample meant that participants were able to speak about their experience of disability; navigating care of children and custody arrangements in the context of family violence; and interactions with institutions and services including police, courts, national helplines, LGBTIQ community organisations, other FDSV services, GPs, psychologists and counselling services, migration agencies, hospitals and social workers. There was also considerable variety in how participants attempted to access support, whether these attempts resulted in improvements in their safety or wellbeing, and the reasons why people chose not to approach formal services for help.

Table 3: Demographic overview

Demographic characteristics	Number of participants
Cisgender participants	16
Trans and gender diverse participants (trans women, trans men, non-binary and other gender diverse participants)	14
Number of sexual identities represented	7
Queensland, Victoria, New South Wales (some participants moved between states and are counted twice)	26
Northern Territory, Australian Capital Territory, Tasmania, South Australia, Western Australia	7
Number of ethnicities represented	10

2.3 Phase 3: Case study examples of 'promising practice' in inclusive service delivery

The aims of this phase of research were to:

- Identify principles of promising practice for LGBTIQ-inclusive FDSV service provision and examine how they are being applied in different operational environments around Australia
- Understand the systemic, relational, operational and organisational factors that enable or impede application of promising practice principles
- Identify transferable lessons from different settings as to how the application and implementation of promising practice principles can be better supported

We conducted case studies of six organisations that:

- Provide FDSV services tailored for LGBTIQ communities
- Have modified their FDSV services to be more gender-inclusive and affirming for LGBTIQ people

These case studies allow exploration of the factors that help facilitate 'promising practice' in inclusive FDSV support for LGBTIQ people (use of the term 'promising practice' as opposed to 'best practice' is explained in detail in section 6.1, as are the principles of promising practice used to select case study participants.

Case studies were selected to best enable understanding of how implementation of good practice is enabled or constrained across different contexts. These are shaped by various factors including:

- Different policy and funding arrangements across state jurisdictions
- Rural, regional and metropolitan contexts
- Available resourcing for LGBTIQ community-controlled FDSV services or for capacity building towards LGBTIQ-inclusive practice in women's or general population services

Purposive sampling was used to identify organisations that allowed us to explore these different contextual factors and environments. Drawing on the professional networks of the project team, organisations were included that allowed the study to meet the following criteria:

Table 4: Minimum representative criteria for case studies

Key	Minimum representation across n = 6 case studies (non-exclusive categories)
Located in Northern Territory/Western Australia/Australian Capital Territory/ Tasmania/South Australia	2
Located in metro Sydney/Melbourne/ Brisbane	2
Located in a rural or regional centre	3
Specialist sexual violence service	1
LGBTIQ+ community organisation	2
Expertise in working with Aboriginal and/ or Torres Strait Islander and or culturally and linguistically diverse populations	1

Interviews were conducted remotely via Zoom and recorded, transcribed and analysed alongside website copy, annual reports, research outputs, strategic plans and media reports from each organisation. Review of these materials allowed us to verify time lines (this was particularly important where there had been staff turnover or change in leadership during the process of adjusting service scope or practice governance) and understand how inclusive practice had been articulated or scaffolded in vision and mission statements and whole-of-organisation planning.

The research team sought perspectives on the organisational trajectory towards embedding LGBTIQ-inclusive FDSV practice and also on what it meant to implement principles of inclusive practice in day-to-day operations. Depending on the size of the organisation and its progress towards implementing changes, one to three interviews were conducted for each case study.

Findings from each phase of data collection are integrated across all chapters of this report. This allows lived experience accounts to be placed in conversation with perspectives from LGBTIQ community-controlled service providers and other FDSV services, and analysis of survey data.

2.4 Attribution of qualitative data in this report

Participants in research Phases 1 and 2 contributed to the study on condition of anonymity. Where data are attributed to Phase 1 participants, these participants have been assigned a pseudonym and the state where they live and work is not mentioned. This further mitigates the likelihood of participants being identified, allowing them to speak freely and make critiques of the policy and practice contexts if they wanted. In order to indicate their expertise and perspective, participants are identified by their relationship to FDSV work or role in their organisation, and whether they work with a women's or general population specialist family violence service; an LGBTIQ community-controlled service; or, if it is their most pertinent role in relation to this study, participate in a working group related to FDSV in LGBTIQ communities.

Care has been taken to remove details that might make lived experience participants identifiable, in order to protect their privacy and safety. The details removed include the state where they live (or lived while experiencing FDSV), their name or the name of the person who used violence against them, details about their work, or precise descriptions of ethnicity and age. Where FDSV was perpetrated in ways unique enough to render it potentially recognisable to people in the social circles of the participant or the person who perpetrated violence against them, those details are not included. Participants have been assigned a pseudonym and attributions include their gender, sexual identity and an approximate age. Details related to whether they are a person with disability, are Aboriginal and/or Torres Strait Islander, their cultural background or ethnicity, or if they live in metropolitan, regional or rural Australia are discussed in text where relevant. In some cases, if different aspects of a participant's account were to be read together it might allow someone with close knowledge of their experience to identify them, multiple pseudonyms have been assigned and used at random throughout the report.

Participants in Phase 3 are identifiable by their organisational affiliation, as case study organisations are named; however, individual participants are not named and, in some cases, they have been assigned a pseudonym. Participants were advised when seeking their consent to participate in the study that this may render them identifiable within their workplace or by people in their social and professional networks.

2.5 Ethics

Detailed research plans for Phases 1 to 3 were submitted for review and approval by the La Trobe University Human Research Ethics Committee (reference codes: HEC20360; HEC21051; HEC21334)

Phase 2 (interviews with LGBTIQ people who have experienced FDSV) were also submitted for review and approval by ACON Research Ethics Review Committee (reference number: 202111) and Thorne Harbour Health (reference code: Approval THH/CREP 21-008).

3 Naming and recognition of FDSV in LGBTIQ communities

As described in Chapter 1, findings from Private Lives 3 suggest that many LGBTQ people find it difficult to name what is happening to them as family or domestic violence, even if they are able to identify the tactics of abuse used against them (i.e., physical, verbal, emotional etc.). This chapter provides complementary narratives to these data through reporting on the qualitative lived experience interview data (Phase 2). It considers the different factors that can impede or facilitate recognition of FDSV experienced by LGBTQ people: by people experiencing abuse and service providers.

Difficulties in LGBTIQ victim-survivors recognising what is happening to them as violence or abuse can present significant barriers to accessing support. Existing literature has suggested a number of reasons why victim-survivors in general may struggle to name what is being done to them as abuse. Someone experiencing FDSV may not want to name the person who is abusing them as a 'perpetrator'. This could be because they may love, are attracted to or share a familial relationship with that person (45,49,50). People experiencing violence might also not want to take on the label of 'victim,' with the vulnerabilities, stigma or shame that the term can connote (41). It might be difficult to describe individual incidents that they feel are 'serious enough' to be recognised by others as self-evidently abusive, even while experiencing considerable psychological and emotional harm from sustained patterns of controlling behaviour (26,44).

These factors have been reported in studies of victim-survivors who do not identify as LGBTIQ, and are particularly well reported with regard to presumptively cisgender women

abused by presumptively cisgender men (50-52). It is likely that these, and additional complexities, impact on LGBTIQ communities because of the challenges of recognising oneself in common narratives about FDSV: who perpetrates it, who experiences it and how it is carried out. This study added significantly to the picture of challenges in how participants were able to see themselves in the 'public story' of family and domestic violence (22), regardless of their relationship to the person using violence.

The chapter explores the challenges that participants, and the service providers they encountered, experienced in naming and recognising FDSV.

3.1 The effects of heteronormative and cisnormative framings of violence

It has been suggested that heteronormative and cisnormative understandings about who perpetrates and experiences violence affects the recognition and naming of violence for LGBTIQ people (26,47,54). Because the 'public story' of FDSV genders people who use violence as male and people who experience violence as female, it can be difficult for people in same-gender relationships or in other relationships where a woman or non-binary person was the primary aggressor to understand that what was happening to them was abusive. There are also indications that LGBTIQ people can feel less secure in telling others about their experiences of violence because they are not sure whether others would take their accounts seriously (23,47,48).

In this study, participants reported experiences that suggested that the dominant heteronormative and cisnormative scripts had impeded their ability to name and recognise their experiences as FDSV, and the ability of service providers to effectively name and respond to FDSV.

There were two key factors that we found to be influential in how or whether participants seek help for FDSV:

- How victim-survivors defined FDSV and positioned their experience against those definitions
- How service providers that they encountered defined FDSV and who experiences it, and how participants anticipated that service providers would define FDSV and who experiences it.

We consider each of these in turn here.

3.1.1 Understanding of FDSV among LGBTQ participants

When asked how they would have defined FDSV prior to identifying their own experience as violence or 'abusive', most lived experience participants described physical violence perpetrated by a cisgender, heterosexual man against a cisgender woman, usually in an intimate relationship. This was reflected by many participants regardless of their age, gender, sexuality, ethnicity or whether they had lived in mostly rural, regional or metropolitan settings.

> *I would say that I very much thought about it through a heterosexual lens, and for me it was very difficult to recognise myself as a victim of IPV … I would talk about it in terms of gender-based violence, I would talk about it in terms of power disparity between men and women, and something that battered wives experience. And I would have, I guess, some vague knowledge that it occurs within same-sex relationships and amongst the queer community as well. But it would be quite confusing in my head to try and transfer the concept to my own relationships or to the relationships of friends I have who have same-sex partners.*
>
> *(Vincent, cisgender man, gay, mid-20s)*

Several participants discussed the ways that heteronormative and cisnormative preconceptions about what 'counted' as family and domestic violence prolonged the time it took for them to understand their experience as violence. This often worked in combination with other factors such as believing family and domestic violence referred only to physical violence (discussed later in section 3.2).

Although the gender dynamics within an individual relationship might not reflect binary gender power disparities, the person using violence may still instrumentalise systemic sources of oppression to control or cause fear that are rooted in patriarchy, including heteronormativity and cisnormativity (2,11). For lived experience research participants, this was especially apparent in accounts where emotional abuse, gaslighting and LGBTIQ-related abuse were central tactics of control. In these situations, sexist, homophobic and transphobic tropes about, for example, cis and trans women's and gay men's irrationality or propensity to 'hysteria' might be used by the person using violence to deny or belittle a victim-survivors' experiences of being made fearful or feeling controlled or coerced. As will be described below, discriminatory stereotypes about people of different ethnicities or people with disability can be used to similarly undermine participants' sense of credibility or confidence in their ability to correctly assess their experiences.

Participants reported perpetrators used these ideas to discourage them from seeking help, implying that they would not be believed by loved ones or service providers. These experiences could combine with a victim-survivor's own negative past experiences of discrimination and anticipation of service providers' discriminatory beliefs to inform a choice not to reach out for help.[5]

For men in same-gender relationships, normalisation of physical violence as part of how men relate to each other shaped how family and domestic violence was perceived by those experiencing or using violence, by friends and family, and by service providers (32,47,55). This was confirmed in the lived experience interviews conducted for this study. For example, Bo described his uncertainty around what might be legitimately termed family and domestic violence when asked whether he had encountered it prior to the experiences that prompted him to nominate for our study:

> *[He would] punch me but he's so much smaller so, you know, whether that was domestic violence or not [I don't know].*
>
> *(Bo, cisgender man, gay, mid-20s)*

Bo also expressed that he had previously understood violence as something that occurred in heterosexual couples, and that this was something that he had experienced as a child in ways that were both damaging and normalised. The fact that his former partner was smaller (which in Bo's eyes meant he represented less risk of significant physical harm), combined with this formative understanding, meant that Bo was not sure

5 Experiences of racial and gender discrimination are discussed in greater detail in Chapter 5.

whether he could credibly claim to have been victimised in intimate partner relationships. Ultimately, it was only through understanding that the sense of entrapment, fear and loss of autonomy in a later relationship constituted IPV that he was able to interrogate where those same dynamics had been present in that previous relationship.

3.1.2 Experiences of service provider understandings of FDSV

Participants also talked about their experiences of service provider perspectives on FDSV, indicating that where service providers demonstrated low levels of knowledge about FDSV among LBGTIQ people, participant confidence in naming their experience was undermined. Even when participants reached a point where they were clear that they needed assistance, some described encounters with service providers where their experience was minimised.

Summarising this tendency, a key informant who had worked across family violence and LGBTIQ community sector responses shared:

> *There is still the heterosexual authority over the way we understand relationships, and whose relationships get valued, and whose safety is most valued, and who gets held to account for their harms. I think it's still largely a space that's dominated by straight people and heterosexual relationships, and the reproduction and preservation of the heterosexual relationships.*
>
> *(Hiram, senior family violence counsellor, LGBTIQ community-controlled organisation)*

The experiences of many participants demonstrated that heteronormative framings were also projected onto LGBTQ people and relationships, in ways that affirmed gender stereotypes. Asking people in same-gender relationships 'who is the man' or 'who is the woman' in the relationship has increasingly been understood as misconceived and offensive, not least because it implies that the only legitimate way of understanding a relationship is through a heterosexual lens (56,57). However, participants described ways that they felt service providers coded traits such as physical size or aesthetic choices as either feminine or masculine, making heterosexist projections onto same gender relationships. These experiences influenced how much victim-survivors felt that they could trust services to understand and affirm their experiences as FDSV. This was particularly pronounced in accounts of IPV, but also apparent in some accounts of FOV. Gender stereotypes were particularly disruptive to feelings of acceptance and being believed in situations where someone presenting as butch or masculine was victimised or if someone with a more slight build, who is a woman or whose presentation is coded as more feminine was using violence.

This was the case for Louise, who attempted to get a protection order from police when, after many years of escalating abusive behaviour, her ex-partner attempted a serious physical assault. Louise described herself as tall and strong and her ex-partner, also a cisgender woman, as short. Although police seemed to take the matter seriously when they attended at Louise's home after the assault, Louise described how she felt that senior officers and detectives were resistant to seeing her as a legitimate victim in the lead up to and during court hearings:

> *[The police] weren't interested. I had to keep pressing them to do their job. So, because – I think for several reasons: one, you know, a gay couple; two, they're thinking, 'No, [ex-partner is] not that much of a danger.' They were just judging all of that. You know, she'd hit me with a car – somehow, she was not a danger to me. It was too hard […] I do think, though, that when you're in a same-sex relationship, and it's a woman that's your partner, they still have the same views, like the general population, which is that you can't possibly be in as much danger, because it's another woman that is your abuser.*
>
> *(Louise, cisgender woman, lesbian, early 60s)*

A number of participants of different genders also talked about how their experiences of FDSV were not taken seriously because the person victimising them was a cisgender woman (or was perceived as a cisgender woman by service providers). In some accounts, participant reports of harm or violence was minimised by service providers both because it was perpetrated by a woman and because of poor recognition of non-physical abuse tactics as family and domestic violence. However, even when physical violence or threats of violence were used, participants felt that the risk they were in was perceived as less significant.

It took a long time for Vincent to recognise his experiences as IPV, but an especially aggressive physical attack meant that he needed to get treatment at a hospital. He was referred to a social worker who was mandated to make a report to police because of the nature of Vincent's injuries. Vincent described his reluctance about going to the police because of concerns about how he would encounter stereotypes as a Black, gay man, and because he had previously experienced discrimination by police. He also reflected on self-stigmatising beliefs about how he should have responded as a man:

> *My kind of understanding of the police was that they're really homophobic, and they'll probably either be actively homophobic towards me, as I reported my case, or they'd be dismissive of it. And then, you know, there was that added level of humiliation around I'm male, you know, I'm not a battered woman. I should, as far as masculine standards go […] I should have the capability to fight back, and I didn't.*
>
> *(Vincent, cisgender man, gay, mid-20s)*

When the social worker made her report and the police followed up with Vincent, his fears of dismissive treatment were realised:

> *I got a call from a constable who was investigating, and he basically asked me, he said, 'I hear you've been having some trouble with you and your housemate'… And I thought to myself, This guy who's phoned up has no idea, it's not at all been framed to him as this is domestic violence that has occurred in a same-sex couple. You know, somehow in his brief, whatever was reported to him was that, you know, it's some little kerfuffle between two guys over something.*
>
> *(Vincent, cisgender man, gay, mid-20s)*

This account demonstrates that stereotypes about masculinity can exacerbate challenges in naming and recognising FDSV experienced by men. Normalisation of physical violence between men, the belief that men can only perpetrate and not experience IPV, and the belief that even during a controlling and abusive relationship, a man 'should'

be able to fight back against a physical attack all combined to limit the help that Vincent sought and was able to receive.

Heteronormative and cisnormative framings of FDSV also impacted upon trans and gender diverse participants. Several described instances where the violence that they experienced was minimised or disregarded. Noah felt that the transphobic nature of violence that was perpetrated by a housemate, and the fact that he was able to physically defend himself against his cisgender male housemate, contributed to police refusing to take action to help him.

A trans man in his early 30s, Noah, described a situation where he experienced violence perpetrated by a housemate. Although this is not recognised under law as family violence in all states and territories, specialist family violence services and LGBTIQ community organisations acknowledge that being made to feel unsafe by someone who shares your house can be frightening and destabilising even where there is no intimate or traditionally recognised familial relationship (58). After a letter arrived using his deadname,[6] Noah's housemate 'put two and two together' and directed significant transphobic verbal abuse at him.

Shaken, Noah and his other housemates called the police, but they were unwilling to intervene.

> *The police came and they didn't do anything. They're like, 'Oh it's really your word against his', and I was like … 'It's happened in my room and I've got two witnesses. And they're like, 'Well, they'd have to come to court and they probably wouldn't do that', and I'm like, 'You haven't even asked them'. They didn't write anything down, didn't do anything, and meanwhile the other guy is still downstairs yelling and carrying on. I was like, this is a joke … they didn't do anything to him. Once they left, I locked my door and again barricaded myself in and he was whispering weird stuff in front of the door.*
>
> *(Noah, trans man, bisexual, mid-30s)*

3.2 Recognition of non-physical forms of abuse

Where tactics used to coerce, control or cause fear in the context of family violence did not involve physical or sexual abuse, it was more difficult for participants to name what they had experienced as family or domestic violence.

The harms of non-physical family and domestic violence are well recorded and demonstrated in growing calls for better recognition of coercive control tactics other than physical threats or assault in family and domestic violence responses (11,30,47,59). However, as discussed in the introduction, the idea appears to remain pervasive that damaging behaviour can only legitimately be considered family violence if it includes instances of physical abuse. Lived experience study participants described remembering feeling unsafe, diminished and scared, but did not consistently categorise this as abuse. Further, some talked about not having these harms recognised by service providers (the effects of this on participants' service experiences are explored in more detail in Chapter 4).

For example, Jia Hao is a cisgender gay man in his mid-20s who lived in a regional town. During the first months of the COVID pandemic, he had limited opportunities to work and became dependent on his older, white partner for accommodation. He described his romantic attachment as making him deeply invested in the relationship, and his precarious financial, visa and living situations as rendering him dependent on his partner. The partner, also a cisgender man, was still exploring his sexuality and Jia Hao described him as having historically maintained a macho, heterosexual public presentation. This led to some ambivalence and fear about his relationship with Jia Hao early on, and what it might mean for his social and professional relationships if they were more open about being together. Within this context, Jia Hao often felt the relationship to be tenuous or at risk, which meant that he felt he needed to please his partner so that the partner wouldn't ask him to leave.

> *I was more afraid because I wanted the relationship to work so it was like, I was really keen to save the relationship or to just stick in a difficult situation.*
>
> *(Jia Hao, cisgender man, gay, mid-20s)*

Jia Hao's partner was prone to physical aggression when he was angry. Jia Hao described situations where his partner had punched a hole through a wall, or where he had pushed or shoved Jia Hao. He spoke about feeling 'trapped and [partner] being in control and [Jia Hao] not having options and stuff', but he came into the interview unsure about whether his experience could legitimately be classified as family and domestic violence.

> *You can have a hard line to say you have to physically abuse someone, and then there's people that sort of say control and coercion and the verbal … you know, there's a whole spectrum, so it's very hard to, sort of, know. I guess I'm happy to talk about [my experiences], but there's always that fear that maybe I wasn't really in a DV relationship and I'm wasting your time.*
>
> *(Jia Hao, cisgender man, gay, mid-20s)*

Similarly, Isla described how despite years in a manipulative and emotionally abusive relationship with another cisgender woman, it took an attempt at getting an intervention order post-separation to realise that it was family and domestic violence. Isla described her past understanding of family and domestic violence as binary gender and anchored in perpetration of physical violence.

> *Definitely physical violence, yeah, I think also more, I guess I thought victims of domestic violence and family violence kind of, they knew that they were victims … I didn't think that the victim may not necessarily know that they're a victim.*
>
> *(Isla, cisgender woman, lesbian, mid-30s)*

Isla's ex-partner continued to harass her after the relationship ended, including sending emails with sensitive information about Isla to her workplace. Isla sought an intervention order to stop contact and needed to attend court. While waiting for information about her case, she was approached by a women's domestic violence court advocacy representative:

> *They're like, 'OK, well you're eligible for this service' – I'm like, 'I am?' They're like, 'Yeah, we're going to find out what's happening for you' and then I had to fill out, like, a questionnaire for their application form to use their service, and it was only then that I realised that I was – when I started answering the questions that I realised that I was in a domestic violence relationship.*
>
> *(Isla, cisgender woman, lesbian, mid-30s)*

6 The name used by some trans people before they affirmed their gender.

Isla's experience of active intervention from a service contrasts with that of Gerald, for whom it was exposure to public messaging that prompted him to see his relationship as abusive. Gerald, a gay, cisgender man in his 70s, described how a recent relationship with a younger man became abusive. The relationship was romantic and sexual, but also involved a degree of disability assistance as Gerald has a degenerative condition. This became a focus point for increasingly controlling behaviour, which included financial and emotional abuse.

> *Looking back on it, there was also an element of control, and I was not comfortable. I wasn't comfortable; I was just a little bit sort of, I don't know what's going on, I can't put my finger on it.*
>
> *(Gerald, cisgender man, gay, late 70s)*

Six months into the relationship, Gerald heard a radio program about gaslighting as a tactic of abuse, which helped him to name what was happening in his relationship:

> *All these things came out in this gaslighting radio program … I thought that I could handle all this, I've done some very important jobs in the past, I had lots of responsibilities, there was no reason why I shouldn't handle this properly, and I'd be able to deal with a character like this, no problem at all. Then I heard this program, and I thought, 'No, hang on, perhaps I can't, perhaps I'm vulnerable'.*
>
> *(Gerald, cisgender man, gay, late 70s)*

Other participants also described how hearing others' experiences described as family violence helped them to name and understand what was happening and seek help. For Alicia, a trans woman in her late 40s, assisting with a grant proposal at work pertaining to LGBTIQ family and domestic violence incidentally allowed her to identify what she had gone through as abuse. She described her shock at so many of the descriptions of abuse matching her own recent relationship and post-separation dynamic:

> *I just had this moment of going, 'Oh my gosh, everything is me, everything that is being described here is me' … I hadn't put together that the totality of the violence and abuse that she was exerting on me, and the control that she was trying to place on me, I hadn't realised the connection. And I had never used the label, you know, 'domestic violence' to describe my experience, or even recognise that I was a survivor of it, until that moment.*
>
> *(Alicia, trans woman, bisexual/queer, late 40s)*

A key aspect of the abuse Alicia was subjected to was emotional, including gaslighting, with her former partner using societal cisnormativity and transphobia to perpetrate harm. This included threatening to 'out' Alicia as trans to her former employer when she was relatively early in her process of gender affirmation. Post-separation and when Alicia had socially transitioned, her former partner tried to limit her access to their child on the basis that it would be damaging to them to see Alicia as a woman. Alicia described attempts by her ex-partner to use Alicia's gender as a means to get more from a financial settlement:

> *The financial settlement took forever, and it was all predicated upon the money that I had spent on my medical care to transition while we were in a relationship belonged to her. And I needed to pay it all back to her, because that was a waste of resources and that was all a waste. And so, she basically tried to litigate that I was trans as a factor in court.*
>
> *(Alicia, trans woman, bisexual/queer, late 40s)*

Several other participants also discussed emotional abuse as forms of control that were hard to name or recognise as violence until after a period of distance. Ying Chan talked about how she had been controlled and experienced emotional abuse in a 5-year relationship that had recently ended, the first same-gender relationship for her and her former partner:

> *There was a lot of gaslighting in that relationship, and I didn't know at the time that it was happening to me. And yeah, it didn't kind of click until quite early this year that, 'Oh, this relationship's actually quite unhealthy, it's quite toxic and I never kind of spoke to anyone about it'.*
>
> *(Ying Chan, cisgender woman, queer, late 20s)*

Ying Chan described how, early in the relationship, she had difficulty naming what was happening to her or asking for help, due to her conservative upbringing, having few people in her life who affirmed or understood her sexuality and identity as a queer woman, and having limited relationship experience.

3.3 Identifying social isolation as FDSV

For several participants, this sense of not knowing where to go for help was exacerbated because social isolation was also used as a tactic of coercive control in the context of family and domestic violence. This section explores the different forms that this can take, as well as the ways it can intersect with racial bias and discrimination, and with discrimination against people with disability.

Social isolation is a well-recognised tactic of FDSV, and is included in legal definitions of family and domestic violence across Australia (60). It may include controlling who a victim-survivor talks to or spends time with, in-person or online. This means that people experiencing violence have fewer social supports to understand damaging relationship behaviours as family violence and encourage them to seek help (23). This can play out in uniquely damaging ways for LGBTIQ people.

As rejection (often by a family of origin) and social isolation are common experiences for LGBTIQ people, the negative impacts of losing social networks – or needing to rebuild or find new social networks after experiences of abuse – were significant. This was particularly so where participants had been portrayed as 'toxic' or abusive themselves, resulting in people siding with their abuser against them. While this experience is also common for cisgender women abused by cisgender men (61), accounts from lived experience participants in this study provide evidence that this also occurs in uniquely complicated ways for LGBTIQ people.

Social isolation was, for example, also described as an element of FOV where young people are stopped from spending time with friends and peers who affirm their gender, gender expression or sexuality. Even as an adult this can cause harm, as in the case of Zelda who came out to her family as trans in her 20s. Her parents provided her with an ultimatum, insisting that she cut ties with her friends and social supports in order to be accepted by her family:

> *A couple of months later I was like, 'Hey, I'm trans; just letting you know'. And then they sent me another abusive email about that just like, you know, their usual, 'You'll*

For several participants, this sense of not knowing where to go for help was exacerbated because social isolation was also used as a tactic of coercive control in the context of family and domestic violence.

> *never be a woman, you can't make this decision, you've been influenced by bad people, you need to cut off all of your friends and come back to us.'*
>
> *(Zelda, trans woman, lesbian/gay/queer, mid-20s)*

Despite describing ongoing pressure from her family, Zelda was able to draw extensively on peer networks and friends to help navigate the distress caused by these interactions. She described these networks as being cultivated and nurtured over a long period of time by providing reciprocal support. Where there are gaps in support and assistance from formal services for LGBTIQ people, informal community support and connection, friends and 'chosen family' can be especially important for wellbeing (10). Denying access to these networks can itself cause harm.

In the context of IPV, social isolation by the person using violence was described as a tactic of control. Minna described how her partner, also a cisgender woman, regularly corroded her relationships with friends and family.

> *[Name] would have very strong opinions about people, and so if one of my friends, if she decided she didn't like one of my friends, then she would make it very difficult for me to see that person, and any sort of mention I made of them would be met with these sort of nasty comments, then I realised, like, I couldn't really bring that person into the fold or the group. […] She would also convince me that some of my friends, you know, like, say someone cancelled on me or something like that, that was a sign that they didn't appreciate me, and they didn't care about me, but she did.*
>
> *(Minna, cisgender woman, lesbian, late 30s)*

Some participants spoke about having their social media, phone messages and social interactions monitored by an abusive partner. Others described changing 'rules' set by their partner about what was and was not acceptable in terms of socialising.

> *[It was] like a test to see what I might do, and then him getting sometimes explosively angry after when I had decided to just socially hang out with somebody who wasn't him, even though we hadn't made any concrete arrangements. That was a kind of pattern of monitoring and control.*
>
> *(Edward, cisgender man, gay, late 20s)*

For people in open or polyamorous relationships, this extended to who was allowed to have romantic or sexual encounters outside of the relationship and who was not. Even in instances where participants felt that initially they had a clear and consensual agreement, they reported their partner changing these rules constantly. This included abusive partners prohibiting or penalising them for being intimate with others, while at the same time continuing to have relationships or hook-ups, including in ways that transgressed the established rules of their relationship. Participants talked about feeling disrespected and experiencing this as a significant breach of trust. For some, this also led to concerns about sexual health, where they felt they could not trust their partner to observe agreements about managing risk of sexually transmissible infections, including HIV.

In other cases, people who used violence weaponised widely held discriminatory views to justify their efforts at controlling a victim-survivor's social relationships. For Coen, a trans man whose partner, a heterosexual cisgender woman, had previously only been with cisgender men before, attempts to isolate him from his social networks were framed in homophobic and transphobic stereotyping about promiscuity:

> *We were a happy family, I was being, like, a father figure to her son, and, you know, things were going alright. And then I wanted to hang out with my friends, and I couldn't hang out with my friends, because she accused me or was accusing me of hooking up with them … she doesn't want me seeing these people because, you know, I'm going to cheat on her with them and whatnot, and getting fucked by them, and just really gross queerphobic things.*
>
> *(Coen, trans man, queer, mid-20s)*

Coen's former partner tried to keep him isolated from what he described as his 'intentional family' because of her fears that those relationships might undermine the nuclear family that she was seeking to create with him. These fears, Coen felt, were informed by homophobic and transphobic stereotypes.

Some participants with disability said that their intimate partners positioned themselves as 'carer,' even where this was not what was required or requested. In these accounts, they demonstrated that this was difficult to see as abuse at the time, as it was control couched in the language of care. Those participants described this as feeling as though their partner positioned them as helpless or incapable of stating their own care needs and capabilities. Further, that this played into and reproduced discriminatory stereotypes about disabled people in wider society (62). In doing so, abusive partners assumed additional power and encouraged increased dependence from their partner, including through socially isolating them.

> *I had no sense of agency in the home. I was not allowed to feed the cats or do the washing or cook or do anything, because they said it would exacerbate my chronic fatigue, so my physical health conditions, which – I actually do all those tasks now independently. They made me feel like I was unable to do things, and I also felt unable to go out somewhere without them, and I became very dependent on them.*
>
> *(Margie, non-binary, queer, late 30s)*

Some victim-survivors with disability described their difficulty accessing support through social networks. Levi, a participant who had acquired a neurological disability, identified his disability as a significant source of disruption to his social networks, stating that:

> *All the connections that I made in the community over the last 18 years have all evaporated, every single one of them, and this is the problem with being disabled.*
>
> *(Levi, cisgender man, gay, late 50s)*

Levi's disability caused him difficulty with mobility and communication. He therefore found himself less able to cultivate and maintain the kinds of friendships that had been so crucial to his recovery from an earlier relationship where he experienced IPV. Further, while perpetrating abuse, his former partner had portrayed himself to others as an attentive and caring partner to his disabled spouse. Indeed, it took time for Levi to comprehend the cumulative impact of his abuse and what he had lost in terms of financial stability, social relationships and autonomy in his relationship. Levi felt that this meant that friends found his accounts of experiencing IPV after the relationship ended less credible and that former mutual friends were conflicted about who to believe. Levi felt that these were contributing factors to the atrophying of these friendships.

Margie described a similar dynamic where friends distanced themselves from them because they saw the relationship as 'toxic' and didn't know who to believe. For both Margie and Levi, this was partly attributable to the fact that their violence did not occur within heteronormative frameworks: Levi is a cis male victim and Margie experienced violence perpetrated by a cisgender woman. Without a normative, gendered script to help identify likely victim or abuser, there was a suggestion from those who walked away from their friendship that they suspected mutualised violence rather than identifying that one party was being controlled, harmed or made fearful in an abusive relationship. Margie recounted a conversation with friends that had drifted away during this period after reconnecting with them some months later:

> *[My friends] said to me, 'Yeah, we were worried because of the way they would patronise you in front of others, we were worried about that, and our child witnessing that, and we weren't sure what to do with the friendship. And secondly, we weren't sure what to do with the friendship when you two broke up; whether we walk away from both of you or one of you, or what to do.' So that occurred.*
>
> *(Margie, non-binary, queer, late 30s)*

3.4 Relationship to perpetrator and the impact on abuse recognition

The majority of participants nominated themselves to participate in the study because of recent experiences of IPV. However, a significant number also described experiences of abuse perpetrated by family members, both when they were minors and as adults. Those who were abused as minors, including as a result of witnessing abuse of others in their family, generally had a cogent narrative about those experiences where they were confident to name it as FDSV. This may have been because of the time that had elapsed and because of therapy and other interventions since the abuse took place. Recognising their experiences as FDSV became more complicated in relation to abuse that was related to their gender or sexuality, however, and even more so when homophobic, biphobic or transphobic abuse carried on into adulthood.

Simon, a bisexual cisgender man in his 30s, talked about being abused verbally and emotionally by his stepfather growing up, to the extent that he developed serious mental illness as a result. He was matter of fact in recognising this as harmful and unacceptable behaviour towards a child, as well as in describing the consequences of the abuse. However, he was less certain in talking about biphobic abuse he had experienced from family as an adult. Simon described how his sister would periodically use his bisexuality and his disability to make him feel vulnerable or unstable when she was angry with him. However, he also talked about how he was unsure of which behaviours from family members he could legitimately name as abusive:

> *The general consensus, unless there's actually physical harm going on, if you're not in a relationship, if it's family, you tend to be just a lot more forgiving … you go, Well, that was bad, but you know, it was due to the circumstance, it was due to this or due to that. You know, going through the process of seeking help for [impacts of his sister's behaviour], just seems a bit weird and like, 'I don't count' kind of thing. Even though there's been a number of things that probably would count, it's like the general consensus is, 'Oh, you've had a fight with your family', and yeah, OK, you move on.*
>
> *(Simon, cisgender man, bisexual, early 30s)*

Several of those participants who had been treated poorly or abused by family members in ways that were related to their gender or sexuality were hesitant to name this as family and domestic violence. This aligns with analysis of Private Lives 3 data that found those who identified experiences constituting abuse from a family member targeting or weaponising their gender identity, expression or sexuality were less likely to identify this as abuse (26). Existing research has suggested this may be related to normalisation of 'coming out' narratives that include experiences of rejection or abuse (63,64) and the difficulty of moving from those accounts of personal histories to acknowledge experiences as family and domestic violence (65). Case worker and counselling staff working with LGBTIQ community organisations reaffirmed seeing this within their client base:

> *So many in our communities are experiencing this violence, and they don't know to call it family violence; they don't recognise it, they think that it's a part of being queer.*
>
> *(Ava, practice manager, LGBTIQ community-controlled family violence response program)*

This points to an acute need for increased consideration of what FOV looks like for LGBTIQ people in both research and practice.

3.5 Shame and stigma related to being a 'victim'

A small number of lived experience participants at the time of the study were working, or previously had worked, in the family violence sector, LGBTIQ community-controlled organisations, or other social service–oriented roles. These participants had a sound understanding of how FDSV is experienced and talked about in LGBTIQ relationships and communities, as well as the specific tactics and patterns of abuse. It was striking, though, that they also talked about the difficulties they faced in naming

or recognising their experiences as violence, particularly in the context of IPV, demonstrating that challenges of FDSV recognition are more complex than just lack of awareness.

For some, challenges of naming their situation as abusive was related to not wanting to identify as a 'victim'. Alongside the normative ideas of family and domestic violence as only cis men using physical violence against cis women, another dimension of the historic sexist narrative is the (feminised) passive victim who was too weak or unknowledgeable to recognise red flags in a relationship or remove herself from an abusive situation (32,47,55). This is reflected in common questions targeted towards cisgender, heterosexual women victim-survivors asking why they didn't 'just leave' an abusive relationship or home (66). Similar ideas that reflect victim-blaming and shifting of responsibility for abuse were reported by participants in this study. For example, Goldie had worked in a number of different capacities in the family and domestic violence and gender equality sectors while in an abusive relationship with another cisgender woman. She had struggled to fully cut ties with her abusive partner even after recognising that she was experiencing abuse, largely because of the love she still felt for her. At several points in her interview, Goldie raised her discomfort with the fact that she had been abused, and found it so hard to leave the relationship, despite her professional experience:

> *I am an educated, articulate woman who's worked in this field, and I think [that was] the shame that I felt through that period, to not be able to talk to anyone about it, because I should've known better.*
>
> *(Goldie, cisgender woman, lesbian, late 30s)*

More broadly, participants of different genders and in various geographic settings also described their uncertainty about recognising what was happening to them as IPV, in part because they did not want to identify or be seen as a victim. Although more pronounced in situations where the abuse was primarily non-physical, self-doubt persisted even in instances of physical and sexual violence. While receiving out-patient mental health care after a period of hospitalisation, Jasper recognised that part of what had triggered a recent mental health crisis was the fact that he had been emotionally and sexually abused in a recent relationship. He described his feelings about coming to that realisation:

> *it was first a lot of shame, because it wasn't even just, like, shame with him and, like, how disappointed I was with him for the lies and manipulation and all that, but also, like, shame within myself, because I felt like I should have also known a little bit better, and it was a lot of regret, of course.*
>
> *(Jasper, cisgender man, gay, early 20s)*

Some participants still struggled to name what was happening despite being physically abused and having a prior understanding of coercive control. Some only recognised what was happening to them when the abuse severely escalated. For others, they were able to understand their experience as family and domestic violence after attempts (sometimes multiple) from friends, family or other supports to get them to leave their relationship and seek help.

3.6 Naming sexual violence and assault

Most lived experience interview participants whose most recent sexual assault had occurred in the past 2 years reported this happening in the context of an intimate relationship, with one person talking about their experience of assault on a first date. However, several other participants discussed earlier histories of being assaulted or raped by strangers, human traffickers, work colleagues, sex work clients, immediate family members (including as minors), or former partners. In some instances, rape was overtly motivated by homophobia and/or transphobia:

> *It did get classified as a hate crime because the person was talking about, as they sexually assaulted me, wanting to teach me, essentially being corrective with their rape.*
>
> *(Kristian, trans man, bisexual, mid-30s)*

Where participants were asked to reflect upon historic experiences of violence and abuse, most people who had histories of sexual violence were able to name it as sexual assault, abuse, or sex that they were coerced or forced into[7] When discussing more recent experiences of sexual abuse, a number of people discussed how they had identified their experience as assault at the time it happened. Most sought support from friends and or services as soon as they were able, or they confronted the person who hurt them, if they knew them. This was particularly true of people who had been assaulted outside of an intimate partner relationship.

For other participants, there was a longer process involved in being able to name that they had been assaulted. Gray is non-binary and asexual, and in their early 20s. Gray had been subjected to a sexual assault by a boyfriend when they were in their teens, which resulted in injury and ongoing trauma. This impacted upon the ways that they liked to be intimate, which they had shared with a new partner who was a cisgender woman.

One night, the partner held Gray down and kept touching them after they had asked her to stop. They eventually faked orgasm in order to end the assault. The two talked about what had happened, with Gray telling their partner it was 'terrifying'. The partner apologised and Gray tried to minimise what had happened and move on. However, a reminder of the assault prompted a panic attack several months later:

> *They're like, 'I feel super bad about it, I'm sorry, I don't know what I can do', and I'm like, 'Well, you could've just listened in the first place for one; and two, promise me you'll never do that to anyone, anyone else.' But yeah, I realised it was a problem … because I had a song that they would often have playing in the car, played, and I had a full-on anxiety attack.*
>
> *(Gray, non-binary, bisexual, early 20s)*

Experiencing the anxiety attack led Gray to recognise and name what had happened as assault and start to seek help. They described not being able to receive the support they had hoped for, due to long wait periods at services, most of which were only providing remote care due to COVID health measures, and, they suspect, because their case was not considered urgent. Gray's impression was that services were more inclined to address the symptoms of their anxiety attacks rather than take the assault seriously. In turn, this made Gray reluctant or apprehensive when it came to describing what had happened as sexual violence, as they felt unsure of the legitimacy of that claim. Gray wondered whether their presentation of anxiety, service provider perceptions of

7 At the same time, several described the challenges of recognising sexual assaults that occurred when they were children or young people, and of accessing help from adults in their lives or from service providers. These experiences are worth noting; however, they are outside of the scope of this study.

the assault as not violent, and the fact that their partner was a cisgender woman, all contributed to how they were treated by service providers. They described their experience going to a GP and then trying to access a remote counselling service:

> *I'd gone to a walk-in clinic, like walk-in doctor's clinic, about it, and […] they couldn't do exactly much, so they just basically, I had somebody there for like 10 to 20 minutes and then they would just leave me alone in the room until I calmed down, and then they were like, 'Great, you seem better; you can go'. And then I left […] [At the counselling service] I felt like it was a dismissal as well as like a play down of my own fear, and like trying to almost to a point going like, 'Hey, it's not as bad as some other people', trying to trim down what had happened to me, comparing it to somebody else who's had it worse.*
>
> *(Gray, non-binary, bisexual, early 20s)*

Some participants who had been sexually assaulted in the context of broader patterns of family violence talked about occasions where they did not feel able to refuse sex, or particular kinds of sex, because of the power dynamics at play in the relationship. Goldie described how this played out for her in a relationship she had recently ended:

> *There's definitely things she's done that have been, like, physically intimidating, and you know, sexually, I think, like, she's quite dominant sexually, and so there's been line calls on consent, and that's not to me the problem, like, that to me is, like, not anything in comparison to the way she psychologically fucked my head.*
>
> *(Goldie, cisgender woman, lesbian, late 30s)*

Other participants described similar situations, where boundaries of what had been conditionally consensual sexual dynamics were breached in the context of increasingly abusive relationships. Vincent, a cisgender gay man living in a major city, was forced into penetrative sex without a condom several times by a man with whom he then entered into a relationship. Even though the assaults left Vincent feeling violated, he continued in the relationship, because the abuse was situated in the midst of attraction and affection. This contributed to difficulties he experienced in naming and confronting what had happened.

Aaron spoke about a situation where he had consented to taking a submissive role in a sexual relationship because he and his partner, both trans men, enjoyed that kind of play. However, his partner manipulated that dynamic as part of increasingly abusive pattern of behaviour. The sexual assaults perpetrated by Aaron's partner occurred at the same time as the relationship as a whole was becoming more controlling. Similarly, there was still attraction and care, which hindered his ability to allow himself to countenance that he had been assaulted.

Other participants described sex that they did not actively consent to but that they were not sure constituted sexual assault. Jacob, a gay, trans participant in his early 30s described struggling throughout his process of gender affirmation in his late teens. Describing struggles with low self-esteem and poor mental health, he participated in sex that he didn't want but didn't know how to say 'no' to or stop. In some instances, this was related to feeling apologetic for his body and wanting to please partners, despite his own feelings of discomfort. He also discussed being fetishised as a trans man and feeling pressured into sex that compounded negative feelings about his body.

> *How do you navigate as a trans guy? How do you navigate these online apps? Like, I didn't know whether I should put I was trans on the profile or not. I initially did. And then I got fetishised, and guys would meet up and it was really dangerous meet-ups … I was secretive about it, didn't actually tell people where I was going, didn't know people's status, HIV status, risky stuff. But the thing is, they all just wanted to fuck me in the front. And I didn't even know what I wanted. I didn't even know if I wanted that.*
>
> *(Jacob, trans man, gay, mid-30s)*

Jacob did not necessarily want to ascribe malicious intent to his past sexual partners, stating that some of them might not have known how uncomfortable he was. Jacob's experience suggests a need for more widespread, robust conversations about seeking and giving active consent in an ongoing way within LGBTIQ sexual relationships, particularly in the context of casual sexual encounters. It also points to the ways structural power dynamics, including transphobia and unwelcome fetishisation of trans bodies, can shape the degree to which people are able to voice their dissent to continuing a sexual encounter to which they initially consented (67). Further, 'consent' is something negotiated between people in the context of broader experiences of mental health, self-worth, and the way that different people's personhood and bodies are valued.

3.7 Summary

The accounts in this chapter demonstrate the complex factors that can inhibit LGBTQ victim-survivors and those around them, including service providers, from naming and recognising their experiences as FDSV. These have a significant and detrimental impact on people's ability to effectively seek help, and on service providers ability to provide it. Improving public awareness of violence perpetrated in ways that diverge from the established 'public story' (54), of physically violent IPV perpetrated by cisgender men against cisgender women, may help to improve the capacity of people to understand their experiences.

However, our findings suggest that even people with high levels of awareness about FDSV in LGBTIQ communities – including as a result of working within these sectors – could also struggle to name what was happening to them. This suggests that there is critical and shared work to be done for all victim-survivors addressing the stigma associated with identifying as someone who is experiencing violence, including the ways this stigma is reinforced by gender stereotypes.

Issues of naming and recognition form one aspect of barriers to LGBTIQ people seeking help from services. The next chapter maps challenges faced by services seeking to provide more inclusive services. Together these chapters establish the terrain that LGBTIQ people experiencing violence must navigate to seek and obtain safe and appropriate support.

4 Mapping barriers and enablers to inclusive service provision

Developing LGBTIQ-inclusive FDSV services in Australia requires action at system-wide and organisational levels, as well as capacity building for different workforces that support people who have experienced and used violence.

Key stakeholders from LGBTIQ peer–led and mainstream specialist FDSV services identified particularly the need for strong systems to support the development and quality of individual services, including political and policy recognition, resourcing, and developing functional referral pathways with mainstream services.

This chapter investigates three key aspects of strengthening enabling environments for inclusive FDSV service provision for LGBTIQ people in Australia. It considers:

- Political will, visibility and commitments to LGBTIQ communities in FDSV policy. This includes the degree to which LGBTIQ communities are mentioned and planned for in government strategies, and how and why decision-makers view calls for LGBTIQ FDSV service improvements as credible and what this tells us about the political dimensions of data and evidence.
- Resourcing for LGBTIQ-inclusive FDSV services. This includes infrastructural and capacity needs for mainstream FDSV services to expand their scope of service, as well as for LGBTIQ peer–led organisations looking to provide specialist assistance for people seeking FDSV-related support. We also look at workforce capability building to support inclusive practice in mainstream services, and how this might be approached for sustainable, sector-wide knowledge and capacity development.
- Factors that contribute to resistance to full LGBTIQ inclusion within the mainstream FDSV sectors. These include political concerns among some in women's specialist family violence services who may worry about losing or diluting focus on the gendered drivers of FDSV, as well as concern about how to expand already overstretched services to meet the needs of a broader section of the community.

We present existing barriers and progress towards inclusion as discussed by study participants engaged as key informants (Phase 1), as LGBTIQ people with lived experience of FDSV (Phase 2), and as part of case study research (Phase 3).

4.1 Political will and LGBTIQ visibility in FDSV policy

This section draws upon Phase 1 (key informant interview) data to consider the role of political and policy support for LGBTIQ-inclusive FDSV services (or its absence) in the development of more affirming and accessible services. It provides an overview of recent moves towards LGBTIQ inclusion in FDSV policy and then describes the effects of actionable frameworks that are in place in various parts of the country. Relatedly, it considers the understanding and use of 'violence against women' as a proxy term for FDSV in policy and government funding investments. Key informant interview participants describe the ways that this can confuse efforts to develop LGBTIQ-inclusive services and avert a broadened understanding of the gendered dimensions of violence to include examination of heteronormativity and cisnormativity.

Other key barriers to developing the enabling environment and resourcing for LGBTIQ-inclusive services are considered, specifically resistance to change, and a relative lack of data and evidence specific to LGBTIQ experiences.

4.1.1 Overview of LGBTIQ inclusion in FDSV policy

Professional stakeholder participants from LGBTIQ community-controlled organisations, specialist family violence services and sexual violence services all commented on the pivotal role of government policy in facilitating inclusive practice development and implementation across their sectors. Community advocates and practitioners have worked for years to highlight the importance of ensuring LGBTIQ people have access to affirming support in addressing FDSV:

> *I think it's about bringing it back to everybody has the right to live free from violence, everybody has the right to accessing services; and we need to understand how each person comes to us in the context of the world in which they live and how their identities over generations have impacted their ability to seek help.*
>
> *(Erin, LGBTIQ family violence consultant, multiple LGBTIQ community-controlled and other specialist family violence organisations)*

Participants from LGBTIQ and other specialist FDSV workforces talked about how this sentiment needed to be reflected in the policies that frame sector funding and development. Furthermore, that this needs to include specific mention of LGBTIQ communities in order to allow for the full complexity of understanding about who experiences and perpetrates FDSV. Many participants working in FDSV-related roles argued that understandings of family and domestic violence, and to a lesser degree sexual violence, are still widely limited to violence against cisgender women perpetrated by cisgender men. Naming and addressing LGBTIQ communities within FDSV policy is a relatively new phenomenon, despite broader social and legal changes towards inclusion.

> *I do think that there is growing awareness of violence in LGBTIQ communities, and there's a growing acceptance of the community as a whole, so I think since marriage equality, it's not OK now to discriminate or to not be on the bandwagon of acceptance.*
>
> *(Erin, LGBTIQ family violence consultant, multiple LGBTIQ community-controlled and other specialist family violence organisations)*

There are also indications that government attitudes have started to shift in line with community understanding and expectations, including a greater turn towards using intersectionality as a key principle of social policy design (68-72). Some participants mentioned the importance of strong community advocates and allies working within government in facilitating this change. These individuals were able to help drive change by keeping the rights and needs of LGBTIQ communities on state and national agendas.

> *It's individual really good bureaucrats – I can say that with the knowledge of a couple of people within the system, yeah – and that's the only reason we have this on the National Plan agenda and why we have managed to get [changes in government policy].*
>
> *(Jade, LGBTIQ community-controlled and women's/ general population family violence service manager)*

However, the pivotal role of individuals – alongside issues of resourcing and political will – means that change has been uneven. Research participants pointed out that this is apparent both in terms of differing degrees of policy and resourcing focus in different jurisdictions, and applied to particular groups and intersections contained within the umbrella term of 'LGBTIQ'. Across state and territory policies there is also considerable variation in actionable frameworks for LGBTIQ inclusion. Some states have fully articulated LGBTIQ-focussed plans (71,72), whereas others note that supports need to be developed (73,74).

In moving towards more inclusive practice in FDSV services, participants spoke about how insufficient guidance in policy frameworks played out in service implementation. For example, in some jurisdictions, participants described major gaps in attention and resources for supporting LGBTIQ people experiencing FOV:

> *Now when you talk around family of origin, the whole system falls flat on its face. Because that is not considered intimate partner violence, domestic violence, and the only time that family violence will be taken into consideration is with First Nations people. We have flagged that issue with several people, you know, to say the homophobia, transphobia, biphobia that occurs within birth families is often a reason that people then also become homeless. We haven't quite got traction on that, because the homelessness service will then quite clearly sort of go, 'Sorry, but family violence is only for Aboriginal people, and this person wasn't an Aboriginal person so therefore' … yeah. And so it falls flat. So if someone is experiencing violence in their relationship, they return home because they've got nowhere else to go, they then experience violence from the family, the system starts breaking down rapidly.*
>
> *(Deb, senior manager, specialist family violence response service)*

There are multiple issues raised by Deb in this quote. It is important that tailored and culturally safe services are accessible for Aboriginal people experiencing violence (75,76). However, there is a historic legacy of punitive interventions

against Aboriginal families, including those that facilitated removal of children who became the Stolen Generations (77). These are predicated on the implied expectation that there will be violence and abuse in Aboriginal families (78). Deb is arguing that by centring policies about FOV exclusively around Aboriginal people, contemporary policy ignores the ways that similar kinds of violence play out for LGBTIQ communities.

Other notable gaps are the needs of people with an intersex variation, and how these needs are considered in family violence sector and practice development. People with an intersex variation may face unique forms of abuse that stem from lack of respect for their bodily autonomy (79). Parents and guardians may be complicit in allowing or facilitating medical interventions to make an intersex person appear more male or female. However, these choices may be situated in contexts where parents are not provided with sufficient information and/or agency to refuse medical advice. This complicates categorisation as FDV, because these abuses perpetrated against people with an intersex variation are embedded in broader issues of how their human rights and bodies are treated in medical systems and wider society, which can impact the informed decision-making capabilities of parents and the intersex person. As noted in Chapter 1, there is currently very little research that considers the ways that people with an intersex variation experience intimate partner or sexual violence and the ways this may differ from other victim-survivors. Further, many intersex people do not identify as LGBT or Q (80). While broader advocacy for LGBTIQ inclusion in FDSV services is important, there is a need for more specific understanding of the actual needs and experiences of people with an intersex variation and how these might be addressed.

Even while frustrated about the pace of policy change in many parts of Australia, participants described how naming the issue in policy creates an anchor point for further advocacy and discussions about programmatic and systemic changes.

> *Certainly there's been some progress in the policy and legislative environment in [state] ... Does it go far enough? No, but it's a kind of signal.*
>
> *(Michael, senior manager, LGBTIQ community-controlled health organisation)*

At the same time, the degree to which naming the issues in policy has translated to defined plans, programs and resourcing to improve outcomes varies greatly between states and territories, and across rural and urban areas. Even where LGBTIQ communities are named as populations 'at risk' or where phrases such as 'violence against women and LGBTIQ people' are used, research participants expressed concern that policymakers have not fully considered the changes that are needed to cater for all victim survivors.

> *It tries to do both, but the LGBTIQ+ stuff it sounds tokenistic, because a true understanding of inclusion would need to change the heteronormative language, and I think that's just reflective of how governments are trying to process this stuff as well, you know [...] [LGBTIQ+] looks like it's been inserted into the original document.*
>
> *(Janu, manager, women's refuge and LGBTIQ family violence interagency group coordinator)*

Evolution of LGBTIQ visibility in FDSV policy

Government policy change towards greater LGBTIQ inclusion has happened at a different pace across various jurisdictions. Most states and territories now include in FDSV policy frameworks mention of the fact that LGBTIQ communities are affected by violence, even if these policy frameworks are not all accompanied by actionable plans (66,68,69,76-78). In addition, each successive action plan associated with the National Plan to Reduce Violence Against Women since 2011 has contained more comprehensive discussion and measures to prevent and support LGBTIQ people experiencing violence (43,79-81). These shifts have resulted from sustained advocacy from LGBTIQ community organisations and experts, as well as public servants and elected officials working from within mechanisms of government to create institutional change.

4.1.2 Positioning LGBTIQ inclusion in FDSV policy and practice frameworks

Participants were attuned and in most cases sympathetic to the imperative not to lose a hard-won gendered understanding of FDSV and to the ongoing need to address violence against women.

At the same time, some participants pointed to concerns about the dilution of focus on violence against women; they expressed frustration about those concerns and argued that they lose sight of the gendered nature of violence against LGBTIQ people as well (as articulated in the draft National Plan cited in Chapter 1) (2,8). Participants argued that framing LGBTIQ community needs as separate from the needs of cisgender, heterosexual women reinforces their exclusion and disregards the benefits of policy and program innovations that stem from thinking holistically about inclusive services. For instance, some felt that expanding understanding of how to better support members of all communities affected by violence can precipitate generalised service improvements for victim-survivors.

One participant from an LGBTIQ community-controlled service spoke about the ongoing relational work involved in addressing concerns among FDSV services about their work being diluted or co-opted by broadening their focus.

> *In fact, the feminist system and the response that they have to family violence is only strengthened by the addition of inclusion and diversity into that kind of narrative, not diluted. But, you actually have to spend the time and the energy to sit with people who might feel really reactive or really hostile or really defensive about that change.*
>
> *(Genevieve, senior manager, LGBTIQ community-controlled health organisation)*

One example where improving access for LGBTIQ people coincided with benefits to all victim-survivors is with regard to inclusive crisis accommodation for people experiencing FDSV. Overall, LGBTIQ people have minimal access to safe accommodation when in crisis, or refuge support when fleeing and hiding from family violence. This is particularly true for those who are not cisgender women, and this is a critical issue for family violence sectors across the country. This largely stems from many FDSV services not providing services

for gay, bisexual+ and trans (GBT) men and non-binary people, and inconsistent approaches to providing accommodation or refuge for trans women. One participant described how dire the situation was in her state, particularly for men.

> *Over a third, even maybe half of the people who accessed our after-hours service were gay, bi, queer, trans men fleeing family violence, and there was nowhere for them to go. The only response that we could offer them was a homelessness response with [name] crisis service; none of the – there were no family violence services that would offer accommodation. That's a problem.*
>
> *(Ava, practice manager, LGBTIQ community-controlled family violence response program)*

Several participants in our study discussed these issues as particularly acute or problematic in communal refuges, where clients may need to share sleeping, kitchen or ablution facilities with other people. As well as the access issues for GBT men, participants described how issues of safety within refuges take on a unique dimension for trans women and gender diverse people.

> *I think the thing that is apparent where there is absolutely no problem solved is where we have trans clients and there is no safe refuge space available, and none of the current services can do it because of all their existing rules but also that their client groups cannot always guaranteed to be safe people. That's meant that when we've had trans clients who are needing accommodation, it's meant that we've basically had to offer that accommodation via hotel because there are very few options.*
>
> *(Sophia, crisis services manager, specialist family violence service)*

Moving to alternative models of crisis accommodation (where people using the service are afforded private amenities within managed accommodation units) is an important point of advocacy for LGBTIQ organisations. As this participant points out, existing models are exclusionary or create risks for many LGBTIQ people. Moreover, the Victorian Royal Commission into Family Violence (39) found that these models are also experienced as unsafe or a source of stress and anxiety for people with disability, women with children, women with adolescent male dependents (who are excluded from some refuges) and women who are not able to access beds within many services because they do not have children. As a result of these findings, all refuge accommodation in the state will be changed to cluster models of accommodation, a project planned to be completed by the end of 2022 (81). This is one of several areas where encouraging re-examination of longstanding family and domestic policy and infrastructure to improve LGBTIQ accessibility has been part of prompting changes that benefit many other victim-survivors.

4.1.3 Political dimensions of data and evidence

Participants described policy discussions about data and evidence pertaining to LGBTIQ FDSV as one of the more frustrating impediments to more comprehensive policy recognition. They reported a sense that conversations about evidence-backed service expansion were sequenced in what they perceived as the wrong order. Several spoke about being in policy spaces where they were told that in order to justify funding, the LGBTIQ sector needed better or more convincing data about community need and the scale of the problem. There are several issues with this threshold, related to the current capacity of FDSV and LGBTIQ community–run services to collect data. There is currently insufficient coverage by inclusive services across most areas of Australia, and moreover, insufficient services that people trust in ways that mean they would share information about their gender and sexual identities or intersex status. This combined with poor general recognition of FDSV among LGBTIQ populations means that people are not able to access help, and may therefore be lost to data collection, not counted in evidence of community demand. One participant described the trajectory of these issues in her state:

> *I think the first thing is always data; if you're not in the data you don't exist. So [there are] issues about whether, you know, any of the services providing those sorts of things actually collect that data – and we know that [police reports] are pretty woeful at picking up LGBTIQ violence and that court systems are often the slowest in terms of cultural change … So I think there's definitely data collection challenges; there is recognition or lack of recognition around the violence existing, whether it's sort of seen as mutualised violence or housemates or whatever else might be that it's not seen.*
>
> *(Genevieve, senior manager, LGBTIQ community-controlled health organisation)*

Further, Genevieve went on to point out that many women's and general population services are not providing people with the opportunity to tell them they are LGBTIQ:

> *I think perhaps a lot of the time people are not asked about sexuality or gender, and that might be because people don't think it's relevant or that they don't see it as relevant, or people are not given the opportunity; and maybe the experience has got nothing to do with any of those things, but people are not necessarily given the opportunity to ask, and that comes back to that data stuff.*
>
> *(Genevieve, senior manager, LGBTIQ community-controlled health organisation)*

This situation is mirrored in whole-of-system or population data gathering mechanisms. For example, the ABS Personal Safety survey and Crime Victimisation survey do not adequately capture the LGBTIQ identities and relationships where violence can occur (82). Despite the lack of population-level data in Australia, Private Lives 3 (1) and other Australian research such as the 2018 Australian Trans and Gender Diverse Sexual Health Survey (83) tells us that LGBTIQ experiences of FDSV are significant and require concerted attention and service responses.

In many states, data reporting systems do not require or provide the option for service providers to record the sexuality of clients or provide options to record diverse gender identities. FDSV workforce participants reported that where GBT men and non-binary people are referred to homelessness services by specialist family violence services that only cater to women, they will likely not be asked about their gender, sexuality or whether experiences of FDSV have contributed to their need for emergency accommodation. In each of these scenarios, there are missed opportunities to gather data about the scale of FDSV among different cohorts of LGBTIQ people. In turn, this can limit the advocacy tools available for LGBTIQ services and allies in appealing for resourcing and support that is commensurate with community need.

You know, there's no clear stats and evidence base around DFV [domestic and family violence] within this cohort. We all take some pretty good guesses, and you know, we think that it probably works out about the same, but then we don't actually have any evidence that we can say, here's where we need to improve this service or even have this service.

(Diane, senior manager, specialist family violence service)

Participants indicated that there is enough existing evidence available from community and service experience to legitimise more comprehensive consideration of how to support expansion of LGBTIQ-inclusive services in policy. Some pointed to examples from Victoria and New South Wales where improved service provision has given services and government the ability to collect more and better data, which are then used to inform and refine systemic and organisational practice approaches. This expansion also demonstrates the degree of community need. Even where there is better availability of supports for LGBTIQ victim-survivors and people who use violence, there remain considerable waitlists.

It is that sort of cliche around 'build it and they will come'. And we certainly have never struggled for clients into the service. Indeed, we have waiting lists for programs, and […] the significant investment does continue to need to grow, in order to meet the demand and the expectations that people now rightfully have about receiving an appropriate response when they reach out for support.

(Genevieve, senior manager, LGBTIQ community-controlled health organisation)

Several participants expressed their frustration that the onus for providing more and better proof of LGBTIQ community need for FDSV services remained on their shoulders.

The data stuff is really hard, isn't it, because that's exactly, you know, that's what the mainstream wants from us, from us as a specialist sector, is they want us to tell them the data of harm caused to people before they act on something. You know, it's like we have to remind ourselves that the Royal Commission into Family Violence in Victoria was built on the murder of Luke Batty; it was prompted by his murder. And if we, do we have to wait for that to happen? I mean, I don't know, I find that such an offensive idea. But I think that they want – it's like, show us the bodies. That's what they want us to do; show us the bodies and we will act differently. So yeah, we need accurate data from coroners; we need, around suicide, around homicide, around, you know, all of those things, absolutely we need data that tells a story.

(Ava, practice manager, LGBTIQ community-controlled family violence response program)

4.2 Resourcing for inclusive service development

Service adaptation and expansion requires resourcing, which stems directly from recognition of LGBTIQ FDSV in policy frameworks. There are two key areas that Phase 1 (key informant interviews) and Phase 3 (case study participants) described as requiring increased focus and development.

The first is adapting service-level and system-wide FDSV supports so that they are more inclusive. Participants stressed the need for investment and resourcing in capacity building, as well as the need for improvements in infrastructure and service availability, to ensure that people can get help when and where it is needed. In discussing how these have been attempted to date, this section also provides lived experience accounts that reinforce the need for sufficient consideration of sector-wide FDSV workforce and systemic capacity building.

The second area of focus for this section is resourcing for existing LGBTIQ community-controlled health and community organisations to help them to provide more comprehensive, specialist FDSV programs. It considers the adaptability and agility that is necessitated by insufficient resourcing for LGBTIQ community-controlled services and the impacts that this has on service capacity to meet the needs of LGBTIQ people affected by FDSV.

4.2.1 Capacity building and infrastructural support in FDSV services

This section discusses the ways that infrastructural and resourcing investment to allow services to meet community need for services, and workforce capacity building (i.e. developing the knowledge, skills and practice needed for LGBTIQ-inclusive practice development, as well as the organisational and systemic enablers to inclusive practice) have been approached in women's and general population FDSV services. It considers key gaps and challenges, as described by research participants from LGBTIQ peer–led, women's services and general population FDSV workforces.

4.2.1.1 Challenges to improving the scope and reach of FDSV services

Several participants highlighted how conversations about increasing resourcing to improve FDSV services for LGBTIQ communities take place against a backdrop of widespread funding and service capacity shortfalls in all services across the country. This varies from state to state, and between rural and urban areas, but even participants from parts of the country with comparatively greater resourcing for FDSV services spoke of the acute need for more. This is especially visible with regard to specialist family violence services, including safe accommodation and refuge supports. Fluctuation in core funding grants from federal government and many state governments over the past decade, and shorter-term funding agreements, have created widespread issues. These include problems with staff retention, long client waitlists and lack of capacity to provide comprehensive case work and counselling support within public systems. Particular barriers were identified for people on low incomes and in rural and regional areas, as travel costs or the time required to travel to find services may be prohibitive. These pre-existing issues have been compounded in more recent times as services have reported facing significant increase in demand resulting from the social impacts of the COVID-19 pandemic. Lived experience participants and those in the FDSV workforce discussed how finding affirming and inclusive help is particularly challenging for LGBTIQ people, and made even more so for people who face intersecting forms of discrimination such as people with disability, those who are Aboriginal or Torres Strait Islander, those who are migrants or refugees, those who speak languages other than English, or those who are otherwise subject to racialised discrimination.

Several participants reported that despite intention or desire within their organisations to provide more inclusive services, this was made difficult because they understood their funding agreements stipulated that they were to provide supports to women and/or women with dependent children.

Many participants acknowledged that seeking and receiving adequate help is uniquely difficult for LGBTIQ people, and even more difficult for those with additional intersecting experiences of stigma and disadvantage.

> *No matter who you are and where you're coming into the system, and in particular if you've got loads of intersecting things that make it difficult for you – whether that's sexuality, gender, you know, drug use, disability, Aboriginality, you know – it doesn't really matter what the layers of complexity are, you put any complexity on top of […] mainstream, heterosexual cisgender experience – and we all know that's difficult enough for victim-survivors.*
>
> *(Jade, LGBTIQ community-controlled and women's/general population family violence service manager)*

Several participants reported that despite intention or desire within their organisations to provide more inclusive services, this was made difficult because they understood their funding agreements stipulated that they were to provide supports to women and/or women with dependent children.

> *[Specialist family violence service] is definitely, probably being the most proactive in terms of, yeah, their crisis line is open for anyone, but their contractual obligation is for women and their children, in their actual support services.*
>
> *(Chloe, LGBTIQ+ project officer, non-government social services organisation)*
>
> *The funding itself is gender identified, so we support women and their children moving on after family violence, and that includes case management and security upgrades in order to establish that safe life.*
>
> *(Sophia, crisis services manager, specialist family violence service)*

In some states, service agreements from government funders have for some time stipulated that organisations are to support victim-survivors and their children, while allowing each service the choice of which subsection of that group they choose to focus upon. However, organisations in other parts of the country described how they were now required by their funding agency to provide mixed-gender services. They explained how they were able to use these changes as an opportunity to explore how to provide more inclusive services. For example, a participant from a family violence counselling service explained how they received a request from the state government funding agency to expand their service to provide support to men who had experienced violence as well as women. This provided a useful catalyst to begin a review of organisational operations to ensure that people of any gender or sexuality would feel affirmed and supported within the service.

> *Very interestingly there with the new funding … there was a requirement within that, that we aren't just a family violence counselling service for women, that we had to be a family violence counselling service for people. So that was, like, lots of internal thinking and reconfiguring how we appear externally as well.*
>
> *(Grace, senior leader, specialist family violence service)*

In addition, most specialist sexual assault services have provided mixed-gender services for many years. This does not necessarily mean that services or all members of the workforce are equipped to provide safe, affirming care for all LGBTIQ people and communities, and there have been movements towards addressing those capability gaps in recent years in many services. However, key informants and participants in case study interviews suggested that it can mean that the policy, contracting and resourcing context for providing gender-inclusive sexual assault services is potentially more enabling.

Many specialist FDSV organisations reported working to review existing practice frameworks and policies to facilitate better support for LGBTIQ populations and that they were aware of others doing the same. Further examples of other approaches to whole-of-organisation capability development and expansion of service scope are provided in Chapter 5, which presents accounts from case studies of promising practice in LGBTIQ-inclusive service delivery.

4.2.1.2 Capacity building around LGBTIQ-inclusive practice for FDSV workforces

While resourcing has not yet been made available for comprehensive organisational and sector-wide changes to support cultural safety (outside of Victoria),[8] government funding bodies have nonetheless increasingly included provision for some workforce capacity development in LGBTIQ inclusion. This has largely taken the form of training for members of the FDSV workforces, often provided by LGBTIQ community-controlled organisations or those expert in this subject matter.

There was almost unanimous support from all qualitative study participants (those engaged as people with lived experience of FDSV or as members of FDSV workforces) for a diverse range

8 Recommendation 167 of the State Government of Victoria Royal Commission into Family Violence stipulated that all funded family violence services need to achieve Rainbow Tick accreditation. All service providers have progressed through workforce training and 31 organisations will achieve accreditation by 2022 (39,84).

of support options for LGBTIQ people affected by FDSV; that is, well-resourced and functioning programs in LGBTIQ community-controlled organisations, and safe and affirming care in other specialist FDSV services and related services such as police or health clinics. This echoes findings from Private Lives 3, in which all participants were asked where they would prefer to access support if they experienced FDSV in the future. In the study, 35.1% indicated that they would approach 'a mainstream domestic violence service that is LBTIQ-inclusive' and 20.6% said 'from a domestic violence service that caters only to lesbian, gay, bisexual, transgender and/or intersex people'[9], an option that had a higher figure for trans and gender diverse participants of the study (1). This also demonstrates the desire for both inclusive general population services and community-controlled services.

Capacity building support for non-LGBTIQ community-controlled services is a crucial aspect of realising systems where all LGBTIQ people can get the support that they need. Participants described significant limitations to current approaches to FDSV service capacity building, however.

Participants working with LGBTIQ community-controlled organisations in some states said that often the limited amount of funding available to them for FDSV-related programs was predominately for them to train other organisations in LGBTIQ inclusivity, not for them to develop in-house FDSV services. While welcoming the opportunity to help build the inclusivity of the sector as a whole, they pointed out that the 'either/or' approach presented by this distribution of funding neglected the value of ensuring FDSV supports were available in organisations that are already trusted by LGBTIQ communities.

Further, some participants mentioned the limitations placed on much of this capacity training due to insufficient resourcing and investment of staff professional development time by organisations. As discussed throughout this chapter, moving towards LGBTIQ-inclusive practice requires fundamental political and structural shifts for many FDSV organisations. This is not by any means insurmountable, and as demonstrated in Chapter 5, there are examples from across the country where this has been achieved by organisations of different sizes and with different resourcing capacity for organisational change. However, as case study respondents reflected, it does take time, effort and, ideally, resourcing to address the many component parts related to holistic, sustainable organisational change.

There are capability building programs available that comprehensively address these wide-ranging issues, and a growing number of specialist FDSV services, health services and organisations from other, aligned sectors are participating in them (46,85). However, unlike some other pieces of training and accreditation, these are not positioned as core or fundamental professional development requirements in government policy or by professional associations. It is therefore largely left to individual organisations to opt into these programs and to enable them to happen through allocating funding as well as staff time.

Where there is government funding for training in FDSV services, participants described it as insufficient for more than short, one-off training sessions (half-day to 1 day). This is generally only enough time to address the basics of LGBTIQ identities, forms of discrimination and distinct presentations of FDSV among different communities. That is, participants might learn new information but not have the opportunity to build practice-based skills or tools to facilitate the organisation and practise changes necessary to appropriately apply the new information. Owen described his frustration at how workforce development was approached in his state:

> *The government only really gave, I'm going off the top of my head here, I think it was about $260,000 total to train the entirety of [state], and that was left up to one person at [LGBTIQ community-controlled organisation] to organise facilitation for an entire state, which is just absurd. And when you look at that, it wasn't even training people to train other people, it was literally just training individuals. So once that person moved on from a service, and that sort of thing, you've lost them and, yeah. And there's no capacity to train more people that come into a new organisation or that move […] So there are places that are trained, but in the grand scheme of things, when you look at how many organisations there are, and how many towns there are, they've really only just scratched the surface […] when you're looking at developing something for a state of, I don't know how many, five point something million, you can't really rely on one organisation and $260,000 to train every DV organisation in how to be inclusive and recognise, like, the barriers that might be present for their services and things to people accessing them.*
>
> *(Owen, FDSV service worker and LGBTIQ family violence interagency group member)*

Several other participants discussed the difficulty of staff attrition generally across the FDSV sectors. This is for a variety of reasons, including burnout due to large workloads and the challenging nature of the work, limited career progression opportunities especially in small and mid-size organisations, and short-term employment contracts that are tied to project-based funding (86). As pointed out by Owen, if workforce development is just short training courses for individuals, there is insufficient capacity for organisations to build better practice capability in their systems and structures, or even to retain knowledge if those individuals move on.

Deb, a senior manager of a large, specialist family violence response organisation, drew parallels between expanding services for LGBTIQ people and the crucial work of attending to other forms of cultural safety and inclusion across the sector. She discussed the unintended harm of inclusivity training being used as a proxy for capability development, when it is not backed by comprehensive efforts towards organisational change.

> *We talk about the microaggressions that people experience on a daily basis; like, you know, you have to have at least your 101 understanding of … how one is participating with homophobia, biphobia or transphobia, understanding the privileges of heterosexuality. So, you know, that needs to sit in the mix if you look at safety. Because, you know, people, and people – with no necessary[il]y ill intent – but [they] will just throw things like, 'Oh God, I'll be so glad when this training is over; we're about to do training for LGBTQ', and say this happily to me, and I go, 'Oh, OK, will my life stop after that?' […] It's just, people sit very much in their very cisgender space, firmly anchored, and it's a stretch; yeah, it's a stretch. So to have safety there, to have a framework that builds around that and have that safety there, it would need to be, you know, you need to step out of, you have to address privilege. You have to address race; you have to address a whole lot of things.*
>
> *(Deb, senior manager, specialist family violence service)*

9 Of the Private Lives 3 participants, 21.3% said that they 'did not know' and 17.6% had 'no preference'

Several participants with lived experience of FDSV talked about the harm they experienced where organisations were not aware of the gaps in their capacity around providing a safe and inclusive service. Study participants who had sought help from services talked about looking out for indications like a rainbow flag displayed in offices or on websites and saw this as assurance that they would not be discriminated against within these services. However, some participants felt that these indicators were sometimes only 'lip service', and that they were used by services that lacked any true capability to provide appropriate support to LGBTIQ people experiencing violence. This could be hazardous and result in discriminatory or unhelpful practices that, even when inadvertent, could harm victim-survivors. Wendy, a lived experience participant who also worked in the FDSV sector explained that:

> *Mainstream services [need] to get beyond that kind of superficial [allyship and inclusion], and actually kind of think about what is uniquely required around the dynamics of queer violence.*
>
> *(Wendy, cisgender woman, lesbian, late 30s)*

This issue also extended to other parts of the service ecosystem, with participants such as Levi noting that there was often a stark divide between service organisations' official stances and policies regarding LGBTIQ clients, and how LGBTIQ clients experienced these services.

> *Well, it's like most of these organisations, even the family court, they produce these marvellous websites and these beautiful brochures that give you lots of information, but once you actually try and action any of that stuff, you come up at a brick wall.*
>
> *(Levi, cisgender man, gay, late 50s)*

4.2.2 Resourcing FDSV capacity building in LGBTIQ community-controlled services

Many contemporary LGBTIQ community health organisations in Australia were formed in response to the HIV and AIDS epidemic, and adapted to provide sexual health services, therapeutic interventions for those who use alcohol and other drugs, homelessness services, and counselling and wellbeing support. Participants described how there was history of people who had experienced FDSV to present to services through seeking help for attendant issues (for example, alcohol and other drug issues, mental distress, homelessness or sexual health concerns). They spoke of how LGBTIQ community-controlled FDSV services are a critical element of the broader FDSV service systems, not least they can assist LGBTIQ victim-survivors who may attend their organisation primarily because they are seeking help for other issues and who may have struggled to name their experiences as abuse.

Further, whether seeking help directly for FDSV or for attendant problems, LGBTIQ community members have a degree of existing trust in LGBTIQ community-controlled services that they will provide safe, affirming care. This is important, as there is a portion of LGBTIQ communities for whom a service led by their LGBTIQ peers is the only service they trust. This may be due to their own past experiences of discrimination or poor treatment when accessing services, or a perception this will happen, based on the experiences of others in their communities (as further explored in section 4.3) (87).

Despite this, relatively few LGBTIQ community-controlled services receive funding for FDSV programs. Many LGBTIQ community-controlled organisations that provide counselling and case management services try to meet community need related to FDSV by allocating existing staff time and other organisational resources. Several participants described how this created budgeting tensions. Services do not want to leave demand for FDSV services completely unmet but are aware that, without dedicated funding, they are not able to provide the degree of support that is needed. Further, other areas of funding normally have minimal (if any) underspend available to be reallocated, so moving or sharing resources to cater to the needs of people experiencing FDSV makes it difficult for those existing programs to reach their full potential. Lastly, services do not want to give funders the impression that they are able to do all that is needed with limited or no direct resourcing when increased and longer-term funding is very much needed. As a participant from an organisation with no funded FDSV program stated:

> *There's a bit of robbing Peter to pay Paul, you know; it addresses immediate need, but it's problematic in that it doesn't kind of allow real funding needs to kind of rise up. It's patchy, you know, and you want to kind of meet the community need, but you don't want a funder to think that that need is being fully satisfied or fully addressed, because you've got part of a solution over here with this.*
>
> *(Michael, senior manager, LGBTIQ community-controlled health organisation)*

Michael's quote illustrates the agility and resourcefulness of LGBTIQ community-controlled organisations, and indeed, there are similar dynamics present across FDSV and community service sectors where organisations are reliant on short term, project-based funding (88,89). Here, Michael also highlights the deficits in funding and lack of attention to to the need for specialist services that in large part stem from inadequate policy consideration about what appropriate LGBTIQ service provision entails. This piecemeal approach to resourcing is not part of a strategic approach that also seeks to grow the evidence base and sector capacity about LGBTIQ FDSV discussed earlier in this chapter. It makes it difficult to collect information about experiences of FDSV in a uniform way, or effectively evaluate supports that are integrated into and across multiple programs. Erin described this issue in the context of recording clients so that they could be visible in funded program monitoring and evaluations in a larger LGBTIQ community-controlled health organisation when there was no FDSV funding:

> *I don't know long we'd been doing [FDSV support] before, because we just have been recording them as HIV or, you know, yeah, sexuality, just so that we can see them; does that make sense? So it's only in the last couple of years I'll ask to properly record and to take case studies so we can put a case together to say, 'This is the work we're doing for free – pay us.' Sometimes funders go, 'Well, you're doing it for free; why would we pay you?'*
>
> *(Erin, LGBTIQ family violence consultant, multiple LGBTIQ community-controlled and women's/general population specialist family violence organisations)*

This dynamic also makes it difficult to cultivate and retain in-house specialist skills and knowledge related to FDSV supports, grow organisational knowledge, or develop relationships and safe referral networks with specialist family and sexual violence services and related sectors.

There are identified capacity gaps in some LGBTIQ community-controlled services with regard to meeting the needs of people

with intersex variation. A participant from a smaller LGBTIQ FDSV program spoke about her discomfort with being funded to provide services to intersex people and not having the community connections or staff knowledge to feel that they were acting on this in a way that meets their needs:

> *[Advocacy groups for people with intersex variation], they're saying, 'Actually, don't include us unless you're including us'. And so, so well, we have to, because we're funded, so how do we do that? We can't just go, 'What? Actually, we're not really including those people.' So, it's better to take the 'I' out? We can't do that, because we're funded to do it. So how do we do meaningful work for intersex people, because we're funded to do it and because it's the right thing to do as well?*
>
> *(Krista, practitioner, LGBTIQ FDSV program)*

These same issues also arise in the context of other FDSV services attempting to improve LGBTIQ inclusivity. As Krista points out, in either setting, more funding should be given to organisations set up to cater directly to the needs of people with intersex variation 'who are already doing this work'. She and others had concerns, however:

> *Even if we weren't funded, it's no guarantee that that funding then would be given to the appropriate people anyway … It's just, it's quite an ethical dilemma, actually, because you want to be doing best by marginalised people and, you know, marginalised within even the marginalised group at times.*
>
> *(Krista, practitioner, LGBTIQ FDSV program)*

In some jurisdictions, the context is even more challenging, with participants stating that there was very little funding statewide for any LGBTIQ programs, let alone those that focussed on FDSV or the needs of the more marginalised populations. This means that substantial staff and organisational resources are necessarily directed towards income generation, which limits capacity to advocate for better FDSV supports:

> *When I talked about lack of LGBTI-specific funding in [state], that also means that the work that I do here is not funded; we have to run fee-for-service training just to even keep our couple of staff employed. So trying to even just be available to sit on those advisory groups or to do any kind of advocacy, get the voice heard, is itself difficult.*
>
> *(Hazel, senior manager, LGBTIQ community-controlled organisation)*

Where there are resources allocated, participants described how funding was often program-focussed and short-term, often labelled as a 'pilot' or as 'innovation'. By contrast, ongoing and sustainable core funding would allow for supports to be embedded and practice knowledge and community trust developed over time. Erin, who had worked across LGBTIQ and other FDSV programs and engaged in advocacy at national and state level expressed her frustration at this continuing issue.

> *Funding needs to be [a] long-term political investment. The awareness is there, but it's still like we're still tacked on as that 'other' box, you know? It's, like, 'Men's violence against women is a really serious issue and we really, really care about it' – which I do believe that they do – 'Oh, and then there's LGBTIQ communities', so they don't quite know how to integrate that within the core frame of thinking. It's still like, 'Oh, and then we better give $100,000 in innovation funding to the queer organisation, yeah.' I find nobody told them that we make up, like, 15% of the population; I just feel like, yeah, we're still that box and that parade once a year.*
>
> *(Erin, LGBTIQ family violence consultant, multiple LGBTIQ community-controlled and women's/general population specialist family violence organisations)*

The problem of piecemeal program resourcing for LGBTIQ community-controlled FDSV programs is magnified for smaller community organisations that may have limited or no ongoing funding. Some participants said that funders may allow for a limited administrative fee to be claimed by the organisation, which may make the cost of running the program untenable. Rebecca, the leader of one such organisation, which provides a variety of supports for her local LGBTIQ communities, said that this was a barrier to her organisation seeking to expand further into FDSV-focussed operations:

> *If we took on anything more, we'd have to also have enough money to expand some of the operational sides of the organisation, you know, in terms of admin support or compliance support or finance support, whatever it is. Because those things, if they exist at all, are sort of maxed out. So sometimes people think, just give you a bit more money and it's fine – well, it would need to be more than just program money; there'd need to be some substantial money for the organisation as well. So, I mean, in that environment we'd be hesitant to take anything on … you know, sometimes if you've got a lot of staff where you could say, 'OK, that person has got capacity, we can add to that', we don't even have that at the moment. We've got staff that are all sort of pretty chockers – either with the job they're doing for us, or with another commitment, including other jobs.*
>
> *(Rebecca, CEO, LGBTIQ community-controlled organisation)*

4.3 Experiencing exclusion and mitigating resistance to change

Our research participants reflected a perception that at government, sector and organisational levels, there remains some resistance to making the comprehensive changes necessary to improve service inclusivity for LGBTIQ people, particularly in the specialist family violence sector. Much of this aligns with the policy challenges outlined above, where trepidation around undermining decades of work from feminist family and domestic violence advocates has contributed to slowed progress for LGBTIQ service development (23,47,82,90). While participants often identified this as the cause, and it is a contributing factor, it is important to note that all forms of resistance to LGBTIQ inclusion and change towards equality are in fact part of broader social exclusion of LGBTIQ people – which is reflected in a lack of research, policy and programmatic inclusion for LGBTIQ people in general.

As discussed in Chapters 3 and 5 of this report, when victim-survivors anticipate experiencing exclusion or where they actually encounter it, it can be a significant barrier to accessing help.

4.3.1 Expressions of exclusion in FDSV services

Several participants described anticipation of transphobic and exclusionary attitudes as a key deterrent to them approaching FDSV services. This was especially noticeable in the context of trans women seeking to access help and crisis accommodation.

Women's services can apply for exemption under the equal opportunity legislation in their state or territory, which allows them to employ and provide services only to women. They are nonetheless legally required to support both transgender and cisgender women according to the Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013. However, many specialist family violence services have not yet undertaken the capacity building work required to adequately address the safety needs of trans women. Non-binary people most often exist in a legal limbo because they are not acknowledged in relevant legislation or there is conflicting language between the way that federal and state anti-discrimination legislation use sex (assigned at birth) rather than gender. This ambiguity can then be interpreted as it being up to each service to define whether trans women and gender diverse people are eligible for services.

Trudie described her experience of trying to provide supports to other trans women in a community sector role in the early 2000s, prior to the relationship where she experienced abuse.

> *So it's like the women's shelters wouldn't take them, because the other women were threatened by them, because they were, you know, men, to some of them. And they didn't want to go to the men's shelters, that's if the men's shelters would even take them. So it was like, sorry, too hard basket, no-one will take you trans women.*
>
> *(Trudie, trans woman, bisexual, mid-50s)*

Much like how LGBTIQ people may recommend certain services to other LGBTIQ people, the victim-survivors interviewed in this study also attempted to steer others away from those services that they had experienced as unsafe. As one participant put it, this was a form of mutual care between LGBTIQ people that was intended to help others avoid services that were 'unsafe':

> *Yeah, I try to, because it is, there's been times where I haven't been careful enough [with vetting a service], so I'd much rather not make the mistake again, and if I can help others not have to deal with that mistake, take that little extra time when doing stuff so that they don't get a bad experience, I'll happily show my experience.*
>
> *(Gray, non-binary, bisexual, early 20s)*

Concerns about encountering transphobic attitudes from FDSV service providers are situated within wider contexts of transphobia that have gained renewed attention in public discourse in recent years. This has been apparent in conservative commentary and legislative efforts to exclude and continue to discriminate against people on the basis of diverse genders and sexuality, which have been coupled in Australia and overseas with efforts to repeal women's reproductive rights and rights of same-gender couples (91). This has overlapped with a rise in 'gender critical feminists,' sometimes referred to as TERFs (trans-exclusionary radical feminists) (92). Broadly, this cohort understand gender as being unequivocally tied to biological sex and the ways that women and men experience discrimination and inequality. Within this framework, transwomen (or non-binary people assigned male at birth) are viewed as men, and therefore more likely to be potential and actual perpetrators rather than victim-survivors (93). Adjacent to this is a perception from some people that violence between men should be treated as a separate issue to violence against women. This can mean that GBT men, and trans women (whose gender is not recognised by some service providers), are not adequately considered 'legitimate' victim-survivors of FDV. Further, some express concern that allowing men (and trans women) to access victim-survivor services poses a threat to women's safety and comfort (94).

Some participants in our study offered accounts that indicate there are people who hold these views in FDSV sectors. Josie, the leader of a specialist family violence organisation described the criticism they received from sector colleagues and some in the community when they changed the name of the organisation and their scope of services from being exclusively for women to a mixed-gender service with a focus on LGBTIQ inclusion.

> *There was a little backlash […] people going that we were being, you know, selling out women's services by changing our name […]*
>
> *(Josie, leader, specialist family violence response service)*

Ava described how part of her role was to refer LGBTIQ clients who called a crisis line coordinated by her organisation to support services, including helping some of them to find crisis accommodation. She talked about her frustration about the ongoing exclusionary policies and attitudes that she encountered in her work:

> *The transphobia that exists within women's refuge services is a huge barrier for trans women and non-binary people to access service.*
>
> *(Ava, practice manager, LGBTIQ community-controlled family violence response program)*

These themes were also reflected in accounts from lived experience interviews. Trans women, particularly those who were abused in same-gender relationships with cisgender women, described what they experienced as the transphobic reluctance of some service providers to see trans women as women. This dovetailed with their perceived unwillingness to countenance the possibility that cisgender women might use violence in intimate relationships.

Several trans women participants described their frustration at being subjected to unique forms of emotional and social abuse because they were trans, but then also experienced some service providers relating to them as though they were cisgender men. By extension, they felt that because they were in relationships with women, they were seen as likely perpetrators rather than victims. Zelda explained how this came to mean that she started avoiding specialist family violence services as a result:

> *The way these domestic violence services work, it's implicitly transphobic […] [they are] like, men are like this, and women are like this. And then, because, you know, trans people lived part of their life out as a different gender. So even if [services are] like, 'Oh no, like, I accept trans women or women,' it's like, you're still going to, if you're like, 'all men are bad', then it's like, well, you know, while you were living as a man, you were, like, a bad man. And so, like, there's just that kind of implicit transphobia in that; I just don't think you can get around it.*
>
> *(Zelda, trans woman, lesbian/gay/queer, mid-20s)*

There clearly remains an acute need for work to address heteronormativity and cisnormativity within FDSV services. However, some research participants working across both LGBTIQ community-controlled organisations and other specialist FDSV sectors suggested that attitudes towards LGBTIQ people have improved. A training practitioner and advocate from an LGBTIQ community organisation, who had worked in several east coast states, recalled her time conducting capacity development programs across New South Wales:

> *I found them really open to it, which was interesting because I think the women's sector prior to that had a reputation for just not being interested in working with anything other than [cisgender] women, and that I think was probably quite unfounded on – or maybe founded on stuff that had happened a long, long, long time ago.*
>
> *(Jade, LGBTIQ community-controlled and women's/ general population family violence service manager)*

Being 'open' to change is a promising start. However, given the issues of insufficient support for capacity building in many parts of the country described earlier in this chapter, it was apparent from the study that much of the specialist family and domestic violence sector in particular had not been afforded the opportunity to access it. Organisations might see the need for change, and even have members of staff and leadership advocating for greater inclusion. However, understanding how to implement change, what change might mean for their practice and client base (both existing and potential), and navigating that through system-wide attitudinal, political and resourcing barriers contributed to their slowness to move.

4.3.2 Pathways towards inclusion

The two major concerns for FDSV services in broadening their work to include LGBTIQ communities were identified by participants:

- Losing a focus on gender drivers and impacts of violence, when violence against women remains a widespread and pressing issue
- Worrying about service reach and the ability to meet additional client needs, when many services struggle to assist their existing cohort

This section looks at emerging ways of addressing these concerns:

- Broadening thinking about the ways that FDSV is gendered, to encompass heteronormativity and cisnormativity as drivers of violence intrinsically related to the rigid gender norms that drive violence against women
- Providing robust support for collaborative approaches to LGBTIQ inclusion between LGBTIQ community-controlled services and other specialist FDSV services
- Addressing resourcing shortages across LGBTIQ peer–led and other FDSV services

4.3.2.1 Broadening thinking about gender and FDSV

With regard to the concerns about loss of a 'gender lens' as the result of expanded services, participants identified this as a political issue.

> *I think it's an intractable issue, because you're talking a cultural and philosophical difference, and it's, you know, very deeply held, and I think there are women out there who feel like women have fought incredibly hard to get to the place where they have to provide services for women, and feel really threatened by changing that, that that somehow dilutes the work that's happened or that the safe space has been created for women on the back of patriarchal violence.*
>
> *(Genevieve, senior manager, LGBTIQ community-controlled health organisation)*

Participants who are LGBTIQ-identified and/or who worked with LGBTIQ community-controlled organisations were clear that there needs to be a continued, and better resourced, focus on gendered responses to FDSV, and on addressing men's violence against women more broadly. All participants from FDSV-aligned workforces were respectful of the challenges of adjusting service scope across the sector, particularly in light of continued broader social resistance to women's equality measures and resourcing gaps for existing family violence services. However, they were firm that prevention and response efforts and advocacy is improved and enriched, rather than depleted, by consideration of how to address FDSV in LGBTIQ communities.

This was the case for Centre Against Violence (CAV), a specialist family and sexual violence service that provides one of the case studies of promising practice detailed in Chapter 5. Staff described how, since undertaking the comprehensive, initial work of changing their family violence service from one focussed on women to a mixed-gender, LGBTIQ-inclusive service, it was now difficult to imagine that the service had operated any other way. They talked about how this had benefits for some clients who, because they presented in a way that they were assumed to be cisgender women with intimate relationships read as heterosexual, were now able to get better help because they felt safe to share their sexuality or more accurately describe their gender. One staff member from CAV shared with us how a bisexual client had strategically presented herself as heterosexual at first. Subsequent to a review of data collection, documentation and client interview policies as part of Rainbow Tick accreditation,[10] this client 'came out' to service workers at CAV and was able to open up about her partner's uses of identity abuse against her. As this staff member stated:

> *We were missing her as a whole person … I am able to manage risk a lot better in that way now that we are asking those questions, but it's not something that I predicted.*
>
> *(Bronwyn, family violence crisis and recovery a dvocate, CAV)*

In spite of these kinds of potential, unexpected practice improvements, research participants from LGBTIQ peer–led organisations observed continued trepidation from colleagues working with general population and women's family violence services. These fears were described as anchored in fears of reduced attention on the still-urgent issue of men's violence against women:

> *To understand the pivoting away from cis women and children, and that's 50 years of work of the women's, the feminist women's movement that's – it's really threatening. It's threatening to ask them to pivot away from that. But, I mean, what we're asking them to do is expand their service delivery, not [dilute], expand their service delivery.*
>
> *(Ava, practice manager, LGBTIQ community-controlled family violence response program)*

10 An LGBTIQ cultural safety and inclusion accreditation created by Rainbow Health Australia (46).

Moving through these deeply held feelings of protectiveness for the work of the FDSV sector is a challenging and time-consuming process. Nonetheless, other participants shared that they have been part of successful efforts to help colleagues in women's services and specialist FDSV organisations shift attitudes through an empathetic, gradual, reflexive conversation.

> *My experience on the ground has been when you can provide people on both sides the opportunity to facilitate those discussions and sit in the discomfort of what those tensions bring up for us – you can actually get to the other side of it.*
>
> *(Genevieve, senior manager, LGBTIQ community-controlled health organisation)*

4.3.2.2 Support for collaborative solutions

The reflections and experiences of members of LGBTIQ community-controlled and specialist FDSV workforces shared in this study suggest that, when provided the resources to reflect and problem solve, they have the capacity to deliver innovative and pragmatic solutions. This is particularly so when, as in Genevieve's account, LGBTIQ community-controlled and other services are able to collaborate and think together.

For example, both LGBTIQ community-controlled and mixed-gender FDSV services are especially concerned with accurately identifying primary aggressor in family and domestic violence (as opposed to people who are being abused and who use violence reactively or defensively as well as people who would be assessed as primary aggressor falsely claiming victimhood when presenting to services). This is particularly apparent in cases where women are accused of using violence or men report experiencing FDSV, even in the context of same-gender relationships. Navigating how to make assessments about who is the primary aggressor in reports of family and domestic violence , can be further complicated by so-called 'men's rights activists' (95). These are usually (heterosexually presenting, cisgender) men who perpetrate FDSV but who may claim to be victims, blame women if they face consequences for that abuse, and/or who disavow gendered frameworks for understanding FDSV and violence against women more broadly.

Efforts from within FDSV services to not reinforce these narratives can make it difficult for male victim survivors to seek help (or for people of any gender whose abuser is a cisgender woman). Hiram, a practitioner working with an LGBTIQ community-controlled organisation shared this concern:

> *One of the things I worry about for queer men who are victims of family violence is that we get tangled up in the straight men's rights activism […] I think that there is something around the term 'male victims', which does, in fact, legitimately happen unfortunately for queer men and trans men and, you know, non-binary people whose sex assigned at birth was male […] I think that there is – just as there are anxieties for trans women to access mainstream women's services for support – there is nowhere to go; in fact, there's probably even less spaces to go for queer male victims because of the rhetoric around straight men being victims of female abuse.*
>
> *(Hiram, senior family violence counsellor, LGBTIQ community-controlled organisation)*

That these views are encountered and feared by victim-survivors who are not cisgender women speaks to the need for broader prevention efforts required to address violence against LGBTIQ people in all its forms. This work builds on and furthers the decades long legacy of feminist movements to counter gender inequality, including rigid gender norms, which research shows is a shared driver of violence against women as well as LGBTIQ people (2).[11] In addition, LGBTIQ community-controlled specialist family violence services, and several organisations that have expanded their services to providing LGBTIQ-inclusive services for all genders, have successfully developed protocols to screen for people who misrepresent themselves as victims to services.

Staff from several specialist family violence organisations described cases where some people have misrepresented themselves to services as victims, and described the protocols they had put in place to screen for attempts by perpetrators of violence to misreport their partner as the primary aggressor of family violence. These were developed after the organisations moved to providing mixed-gender services. One staff member told us:

> *We do a lot of cool things, but one of them is we've got a working with [perpetrators] tool, like a kind of a screening tool … what I know from research and practice is that male perpetrators can present as victims. They'll ring up and say, you know, [about] the victim, 'My partner has been horrible to me. She's hurt me, she's hit me. She's taken my kids,' … some, you know, 'She's got a family violence order against her because I called the police after she attacked me.' And then with our little tool, our screening tool, we've got a series of questions to work through to identify whether that person is actually the primary aggressor … And if they are, they get referred somewhere else.*
>
> *(Grace, senior leader, specialist family violence service)*

This corresponds with work that has been done by LGBTIQ community-controlled specialist FDSV organisations which have co-developed sophisticated screening processes to mitigate risk of misidentifying the primary aggressor in reports to their service. The internal processes developed in these organisations also form the basis of advocacy and knowledge sharing with other LGBTIQ community-controlled services and FDSV services, including police who may receive reports of, for example, IPV in a same-gender couple and struggle to accurately identify the primary aggressor. These are supported by sector-wide initiatives in several states, such as the Victorian Family Violence Information Sharing scheme, which allows services to talk to each other to validate risk information. A staff member from one of the case study examples used in this study, Thorne Harbour Health, told us that:

> *We always do our own assessments about that, and a more sort of culturally nuanced assessment. Because we recognise that what presents may or may not be necessarily at the facts of the matter; it's not as clear cut. We also do a whole lot of really direct work with the Orange Doors [a network of information, screening and referral hubs established by the Victorian Government as localised domestic and family violence service entry points]. And we do a whole lot of work specifically with VicPol around referrals, and L17 teams and the way in which that that's happened. So we're involved in kind of*

11 Strategies for approaching prevention of violence against LGBTIQ people are set out in the Pride in Prevention messaging guide (96), which was also used to inform approaches in the updated national primary prevention framework, 'Change the story' (3).

sector reform pieces of advocacy, as well as in this place training component, and then also at the individual level, with stations or with organisations that might be referral pathways into our service.

(Chris, senior manager, Thorne Harbour Health)

These accounts illustrate that collaborative practice, and support to consider solutions to complex considerations of safety for different victim-survivors, are key to addressing resistance to LGBTIQ-inclusive practice. Further examples of promising efforts to undertake the comprehensive, ongoing reflexive capacity building required to address these issues are provided in Chapter 5.

4.3.2.3 Addressing resourcing shortages

Participants also discussed a second common rationale for lack of progress: resourcing. More specifically, they identified concerns about exacerbating service shortages for cisgender women and children as a result of expanding access to more LGBTIQ people. As expressed by Janu, a manager of a women's refuge in a smaller state capital:

It's the kind of thing of, 'We can't meet the existing need; why would we go out looking for more?'

(Janu, manager, women's refuge and LGBTIQ family violence interagency group coordinator)

The following three quotes from Ava, Chloe and Owen provide a sense of the ways that insufficient resourcing for FDSV services generally present a major barrier to provision of inclusive support for LGBTIQ people across the country. They and Janu all live in different states and work in different parts of the FDSV sector (i.e. women's, general population and LGBTIQ peer–led programs). However, they are unanimous in the significance of this issue in impeding progress towards shifting inaction and moving towards inclusive service provision.

I think it's a scarcity model as well, because why they are reluctant is because they don't have enough, they don't have enough to service their main cohorts, and so the idea that they're going to have to deal with more people is difficult, that there hasn't been – I mean, let's not even talk about prevention in the response to family violence – there is not enough resources.

(Ava, practice manager, LGBTIQ family violence response program)

Funding in general is a big issue across the domestic and family violence sector in [less populous state]. So, trying to advocate for organisations to do more to support LGBTIQ people when there's, you know, they're having funding cuts just to their core service delivery anyway, that's a challenge too.

(Chloe, LGBTIQ+ project officer, social services non-government organisation)

I think it's because [specialist family violence services] are just focussing purely on what the biggest issue is, which is obviously [presumptively] heterosexual women are at the greatest risk and – well actually, yeah, when you look at LGBTIQ relationships, they're not really the one[s] with the greatest risks, but obviously the biggest problem considering the [larger percentage of the population who are presumptively heterosexual women] […] So they're fiercely sort of advocating for their cause, rightly so, but I think are scared that if the attention is taken away from them that they'll, I'm not sure whether they'll lose funding or what they're scared of, but they think that by including others they'll miss out somehow.

(Owen, FDSV service worker and LGBTIQ family violence interagency group member)

Throughout the study, several general population services provided accounts that demonstrate the considerable resourcefulness and tenacity they apply in seeking to serve a greater proportion of their communities despite these challenges (see Chapter 5). However, in order to mitigate resource shortages, there needs to be increased attention to collaboratively advocating for a capacity expansion in government policy and budgetary decisions.

4.4 Summary

Participants from mainstream and LGBTIQ community-controlled services commented that policy, resourcing and exclusion or resistance to change present mutually reinforcing barriers. Political will can impede or encourage changes at sector and organisational levels in mainstream sectors, as well as legitimise or curtail the effectiveness of LGBTIQ community-controlled services. Resourcing for LGBTIQ community-controlled services can embed expertise, practise leadership and allow choice; resourcing for FDSV service capacity building and service expansion means that there is 'no wrong door' for survivors and allows for more robust and effective referral networks and pathways. Study participants were clear that when systems and services are better functioning, there is less avoidance of services by victim-survivors. Better functioning systems mean collaborative and creative solutions to meet client needs, warm referrals as needed to other affirming, appropriate services, and choice of community-specific and whole-of-population services. Where these systems are present, services and the sectors as a whole are able to capture data about community need that can be used to evidence investment in ongoing development and maintenance of the sector as critical social services.

As described here, however, gaps in policy frameworks and resourcing coincide with a slow pace of service expansion, particularly in the broader family violence sectors and organisations. The next chapter describes how this, and the issues of naming and recognition of LGBTIQ FDSV described in the previous chapter, play out for victim-survivors as they attempt to navigate services and seek help.

5 Navigating support after experiences of FDSV

Using data from lived experience interviews (Phase 2), this chapter considers the strategies and effort required by LGBTQ victim-survivors to mitigate experiences of discrimination and its harms when seeking help for FDSV.

Often, the experience of seeking support through services is not simple. Even after a victim-survivor has been able to recognise that they need help, and name what has happened or is happening as FDSV, it can be difficult to know where to go, what kind of assistance is available, what help to ask for, and what to expect from services. The resourcing challenges faced by service providers described in Chapter 4 can mean long waitlists and issues with accessibility that may be compounded for people with intersecting experiences of discrimination and inequality.

LGBTIQ people often face additional and unique challenges and are often required to expend additional effort to receive support. The chapter explores how this was experienced by study participants by examining the following themes:

- The ways that LGBTIQ people may need to educate service workers about their lives and relationships in order to receive support
- Navigation of intersecting sources of marginalisation within systems
- Navigation of unrecognised or obfuscated consequences of systemic heteronormativity and cisnormativity within services and service systems
- Efforts to protect the broader LGBTIQ community and LGBTIQ people who use violence from discriminatory consequence of reporting abuse
- The tactics participants use to manage anticipated or actual discrimination from service providers
- Systems-based solutions to providing inclusive FDSV services for LGBTIQ people

5.1 Educating service workers

As discussed in Chapters 3 and 4, there is a substantial need for more capacity building within services to meet the needs of LGBTIQ populations. This is reflected in the experiences of many participants, who discussed challenges related to 'educating' service providers on LGBTIQ-related issues and topics before they were capable of providing them with adequate or appropriate kinds of support. For instance, a participant who is experiencing LGBTIQ-specific abuse may need to explain to a service worker why 'outing' them non-consensually or threating to do so to exact greater control are forms of abuse. Lived experience participants described how service workers sometimes had to be educated on even relatively well-documented topics (e.g. relationship styles and identity labels) that could be easily researched or could be part of standardised workforce training. Several participants noted that it was unreasonable that the burden of educating these service workers should be placed on LGBTIQ people experiencing violence. As one participant noted:

> *You're there to try and get help for something; you don't want to have to educate them on gender.*
>
> *(Sam, gender diverse, queer, mid-30s)*

This form of self-advocacy could be emotionally and mentally taxing, particularly if participants were required to interact with, and therefore educate, multiple service workers throughout the course of efforts to seek support. An example of this was relayed to us by one participant who had to repeatedly explain their sexuality to their family physician. In a discussion that took place while the participant was attempting to seek support after experiencing sexual violence perpetrated by a male partner, they explain:

> *She was giving me a lecture; she was like, 'You need to always have condoms with you' blah blah blah, and I was like, 'Oh, I'm not usually sleeping with men, and I didn't expect this to happen' and she was like, 'Oh shit, oops sorry', like realising that it hadn't been a consenting experience. She's like, 'Oh, but you know, OK, this is just normal advice then, in your everyday life, you always need to have condoms with you', and I was like – I feel like my queerness has definitely been dismissed right now, because I had said to her a couple of times, I was like, 'I don't usually sleep with men', like, 'I don't want to sleep with men', and she was, like, ignoring that […] It was definitely a shock to me to have to continually state and restate and restate to my old GP that I was … that I usually have sex with AFAB [assigned female at birth] people; like, it was weird to be standing up for myself while I was trying to receive help.*
>
> *(Finley, non-binary, bisexual, early 20s)*

The trauma of their experience of violence was therefore compounded by the exasperation they felt toward their GP's obtuseness, and this undermined the trust they felt towards their GP. Recent findings suggest that health providers such as GPs are an important avenue through which victim-survivors report experiences of FDSV. In Private Lives 3, Hill and colleagues (2021) found that among a sample of 4,731 LGBTIQ+ people experiencing violence, the majority first disclosed their experiences of violence to their GP. Moreover, secondary analysis of these data found that those who had a strong relationship with their GP were more likely to feel supported while seeking help for FDSV (22). This was reflected in participant experiences in this study, as a significant number of participants highlighted the crucial role that GPs played in facilitating their access to support.

In qualitative lived experience interviews, the majority of participants who sought help for FDSV evaluated service interactions with their GPs positively and stated that GPs were often instrumental in referring participants on to appropriate population-specific services. For instance, one trans participant spoke about how her GP had insisted on referring her onto a psychologist who specialised in working with trans clients. Despite her objections to being treated any differently from his cisgender clients, the participant conceded that the psychologist's expertise was a relevant component of the positive service interactions she subsequently experienced with this psychologist. Hence, experiences like Finley's point to the ways in which a lack of professional education can deprive people experiencing violence of an important opportunity for disclosing their experiences of violence, as well as denying them linkages to other forms of service provision.

Some participants described being attentive to the fact that some professionals in the FDSV sector and related sectors may not respond positively to being educated and may perceive this as a challenge to their authority. For example, Quinn, who is non-binary and was abused by their trans masc ex-partner, described choosing not to correct a police officer who misgendered them as a woman and who assumed that their partner was a cisgender man at the time Quinn made a report:

> *It wasn't the time or the place for me to [correct them] which I know also helps perpetuate things, but I didn't have the spoons[12] to do that. And you know, when you correct somebody, you put them offside and they get defensive; and cops, like I said, they're often in flight or fight mode, they're really ready to get defensive very quickly, so you sort of have to keep them calm.*
>
> *(Quinn, gender diverse, queer, mid-30s)*

However, even when it felt safe for participants to educate service workers on LGBTIQ-specific terminology and concepts, becoming an information resource was not without issue. Participants felt that they needed to justify to that service worker that the kinds of abuse they experienced, particularly emotional abuse or abuse targeting their LGBTQ identities, are legitimately harmful and to be taken seriously. One participant expressed their frustrations with such interactions:

> *It's invalidating [because] you have to go through and open up to ongoing trauma, or ongoing invalidation, in the hopes that they'll come around, just to prove to somebody that you're just not overreacting.*
>
> *(Jia Hao, cisgender man, gay, mid-20s)*

Although likely largely unintentional, this transfer of the responsibility to educate undermines principles of trauma-informed care, as it creates a context where victim-survivors start from a place of not feeling believed or having their experiences validated.

Having to educate service workers could also take a significant amount of time from time-restricted service interactions (e.g. counselling sessions that are typically limited to 60 to 90 minutes). This had implications for getting help in the ways participants needed, as well as financial implications

12 'Spoon theory' is a concept used by many people with disability to describe their emotional capacity to manage tasks or interactions at different points (97).

if they were paying for counselling or a visit with a GP. Jia Hao elaborates by stating:

> *They don't get it, and you spend a lot of time just managing them [rather] than actually getting help, because you're sort of sitting there going, 'OK, I can't talk to them about this, I can't talk to them about that' or 'Is this worthwhile for me to educate them about this?'*
>
> *(Jia Hao, cisgender man, gay, mid-20s)*

A subcategory of experiences under this banner also related to service workers who requested to be educated on components of LGBTIQ peoples' identities or lived experiences that had little to do with the needs that they were experiencing. One participant spoke about several service interactions with workers who were inappropriately inquisitive about his gender identity and sexuality, fixating on these even when neither was greatly relevant to the needs he was experiencing:

> *And then people don't really focus on what is actually happening to you now. They're trying to, but it's all about this journey of how you get there. And it's about, 'Oh, wow' – they sort of appreciate that, how you've got that; I think they're focussing more on the journey of trans and trying to get their head around you being with a guy now, and all that sort of stuff.*
>
> *(Jacob, trans man, gay, mid-30s)*

In these examples, educating service providers 'on the job' often did not actually enable them to better support these individuals' needs during the service interaction itself. Rather, it appeared to place an unreasonable burden of self-advocacy upon individuals who often were already in a state of distress.

5.2 Navigating intersections of sexuality, gender and race

The challenges of navigating service systems can be amplified by direct barriers to service access that result from racial discrimination, as well as from other structural factors that are associated with decreased access to services (e.g. poverty) that are more pronounced for LGBTIQ people from some cultural backgrounds (98). Research from the United States has documented that LGBTIQ people who are also Black, Southeast Asian, South Asian, Middle Eastern, Indigenous or Pacific Islander may be more likely to experience both IPV and FOV than their peers (99), and some may have narrower sources of social support (100). Pressures from both the LGBTIQ community and their cultural community often mean that LGBTIQ people who are Black, Aboriginal or Torres Strait Islander, Middle Eastern or Asian are forced to compartmentalise their identities (101), meaning that holistic support is often unavailable to these individuals. This is notable because LGBTIQ people belonging to these cultural groups face unique forms of racial discrimination within the LGBTIQ community. These range from racism within the community and discrimination in their intimate lives to heterosexism within their cultural communities (101). As a consequence, some services may lack relevant culturally appropriate and LGBTIQ-appropriate expertise to holistically meet their needs. One of the most common examples of this raised by participants is the way in which racism was perceived as limiting the services that individuals experiencing violence could safely access. Several participants described how white-centric bias inherent in the practice approaches of many service providers impacted the help that they were able to receive, and how past experiences of racist interactions made them wary of some services. There were additional layers to this for people whose first language was not English or whose migration or visa status was precarious.

Aboriginal people experience similar kinds of discrimination in distinct but related ways. This was illustrated by James' account. As an Aboriginal man, James felt unable to reach out to the police for help when his partner, an Aboriginal woman, physically assaulted him.

> *I didn't want to call the police because that's not how I roll. Yeah, it was, because we were both Aboriginal, it probably wouldn't be a safe experience, and she lived in housing commission, so the police would be all over it. Like, it'd just be messy and not good for any of us; it could actually even get uglier for me because I'm the man.*
>
> *(James, trans man, queer, early 20s)*

James spoke of his perceptions and distrust of police, noting that Aboriginal and Torres Strait Islander people he knew regularly experienced discriminatory interactions with police. James was as such unwilling to put his then partner and himself through what was likely to be a traumatic experience. His knowledge of other Aboriginal people's encounters with police also made him concerned that, as a man, he was more likely to be misidentified by the police as the perpetrator of abuse.

Risk of significant harm when accessing services for these interview participants was created by service providers' insufficient knowledge about how intersecting sources of discrimination can shape violence. This was demonstrated in Yazid's experiences of FOV. An international student from a socially conservative and religious country, Yazid was 'outed' to his family by a colleague who had been both assaulting and blackmailing him for several months. Subsequently, Yazid's family reported him to the religious authorities in their country, where homosexuality is subject to capital punishment, and cut off financial support to him. This culminated in a period of homelessness, a suicide attempt and then hospitalisation. While in hospital, Yazid's doctors put his family in contact with him against his wishes, and they nearly succeeded in having him repatriated so Yazid could be handed over to the religious authorities. Because his doctors did not listen to Yazid's accounts of both the circumstances surrounding his cultural context and sexual identity (these were initially characterised as psychotic delusions), they were not attentive to the potential trauma and harm to which they were exposing Yazid.

Another barrier that LGBTIQ people who experienced racism face was reflected in interviews with service workers. Many of the staff working with LGBTIQ community-controlled services that were interviewed as part of this study described their awareness of concerns that clients who were Aboriginal and/or Torres Strait Islander or from multicultural backgrounds may have about encountering racial discrimination and their plans for addressing them. Two lived experience participants described having worked with an LGBTIQ community-controlled service to help make it safer and more accessible for people from their cultural communities. Nonetheless, as Erin, a practitioner and policy consultant who had worked across LGBTIQ community-controlled and other FDSV services reflected, the problem of safety for intersectionally marginalised groups of LGBTIQ people had manifested over the years:

> *Queer people of colour are not accessing queer services, they're not accessing domestic violence services, they're not accessing particular cultural services, and so I think*

where we might see big improvements for probably white, middle-class queer people being able to access support, we're still doing a disservice to so much of our community.

(Erin, LGBTIQ family violence consultant, multiple LGBTIQ community-controlled and other specialist family violence organisations)

As alluded to in this quote from Erin, for some LGBTIQ people, their cultural community and families of origin are crucial sources of support, particularly where they experience racialised discrimination or lack of cultural understanding in LGBTIQ community spaces (102). However, a lack of cultural acceptance for LGBTIQ people may also be present within those settings, and this means that their connections to these communities are contingent upon the continued concealment of their sexual and gender identities. Some stakeholders felt that this could mean LGBTIQ people who were part of these cultural communities might prioritise anonymity and confidentiality in accessing support services:

Because they have that double whammy of can't come out in community, that would just be the death of them, all of that. So there are some [targeted supports] that occur, but they are quiet, they're discreet, and they need to be discreet because otherwise no-one comes, and then you know like – so it's still a bit sort of underground.

(Viv, senior manager, specialist family violence response service)

Although not articulated in detail in our qualitative data, similar issues have been found in other studies that examine the experiences of LGBTIQ people with disability seeking to access basic healthcare and support, including from LGBTIQ community-controlled organisations. As with people who are likely to experience racism, O'Shea and colleagues (103) describe how at times people with disability who are LGBTIQ need to select whether they are better equipped to manage homophobia or transphobia, or ableism when seeking the care that they need. As with our participants, the effort of navigating and seeking to find the lesser evil during periods of stress was described by their community research participants as exhausting.

5.3 Navigating systemic heteronormativity and cisnormativity

Legal, bureaucratic and service systems in Australia have, in the main, historically been designed to cater to a normative ideas of a white, able-bodied, cisgender, heterosexual majority (104-106). There has been significant progress towards creating systems that better reflect the reality of diversities within contemporary Australian society, although there is more to be made. Further, many of these changes are iterative and the result of advocacy by people who are affected by exclusionary policies in ways that may not be visible to those who do not have lived experience or comprehensive understanding of the impacts of this normative framing. As described in Chapter 3, this can present barriers to service provision and access within FDSV services for LGBTIQ people. There may also be unintended exclusionary consequences that result from heteronormative and cisnormative assumptions in legal, bureaucratic and service systems and settings. For LGBTIQ people, this can provide additional challenges to navigate in finding help. These can also be manipulated as part of patterns of coercive control, in a tactic known as 'systems abuse'. This is where discriminatory principles in policy, law or service frameworks are used to cause harm or exert control by a perpetrator. This might include drawing on discriminatory treatment of Aboriginal people in legal systems to have a victim-survivor misidentified as a perpetrator or using a victim-survivor's history of mental illness to make service providers complicit in a perpetrator's gaslighting (61,107,108). It can also mean using someone's gender, sexuality or the nature of an intimate relationship to facilitate unfair treatment in different systems.

One of the more striking examples of this was seen in the account of one participant, Patricia, a cisgender woman, whose ex-partner, also a cisgender woman, had excluded her from contact with their child post separation. While attempting to regain access to her child through formal avenues, Patricia repeatedly encountered both bureaucratic and legal difficulties that stemmed from the way many of these systems had been designed solely with the children of heterosexual and cisgender couples in mind. As the non-birth parent, Patricia felt she was positioned as the 'man' by service workers with whom she came into contact. Patricia's experiences spoke to the fact that service infrastructures often could not accommodate relationships outside the usual configuration (i.e. involving a cisgender man and woman). Consequently, individuals within same-sex relationships are often assigned a 'male' and 'female' role within these contexts. Attendant to this, Patricia was viewed as more likely to perpetrate violence and her partner more likely to be victimised. For example, prenatal and postpartum risk assessments for IPV were only done with birth mothers, and not their partners; while Patricia states that her then partner's use of violence began during this period.

Despite being viewed as analogous to the 'man' in her relationship, the structural privileges accessible by cisgender, heterosexual men within these systems were not extended to Patricia. Being the non-biological parent of their child, Patricia had few rights; as she pointed out, in some instances, fewer than a biological father who had been found to have used violence against his child's mother would have. For example, Patricia found it was possible for her ex-partner to remove her from their child's birth certificate by paying an administrative fee, without requiring either Patricia's knowledge or consent; were she the birth father, this process would have required a court order.[13]

Another way that the cisnormative and heteronormative preconceptions of service providers could result in systems abuses was specific to lesbian, bisexual and trans women. These participants sometimes reported that their experiences of abuse were not regarded with the appropriate gravity when the individual using violence was a cisgender woman. For example, one participant, Justine, spoke to us about how her then partner had repeatedly threatened harm to her and her pets, and had attempted to carry out this threat. She shared that she made a police report after her partner attempted a serious assault, but neither the ongoing threats nor the attempted harm resulted in police protections beyond the duration stipulated by an interim protection order. Although police attended at the property after the attempted assault and seemed to regard it as worthy of pursuing charges, Justine felt that there were several factors that meant that the risk to her and the scale of the abuse were subsequently

13 In the 2 years since this happened to Patricia, processes have been improved, and such changes to a birth certificate now have more rigorous requirements in Patricia's state, the same as for removing a biological parent.

We spend a lot of time defending ourselves and our choices to [cisgender and heterosexual people]. We don't want them to know that we're not perfect, because we're already battling [against the idea that LGBTIQ relationships are pathological]. So we need to present this front to them that we're great. So going to them and saying, you know, 'I'm in this queer relationship where people are fucked' can be difficult.

(SAM, GENDER DIVERSE, QUEER, MID-30S)

downplayed. First, the person using violence was a cisgender woman who was also physically smaller than Justine. Second, Justine's then partner had professional knowledge of police processes and, Justine suspected, of the biases and knowledge gaps of some senior officers. She was able to use this information to minimise what had happened and offer suggestions for a swifter resolution to the matter. On hearing about this action second-hand, Justine experienced it as a further attempt to control and exert power over her by her former partner, as well as an indication that she could not expect the protection that she hoped for from existing law and justice mechanisms.

5.4 Efforts to protect the reputation of LGBTIQ communities and of the person using violence

Another challenge to accessing support described by study participants was the tendency of some victim-survivors' to 'shield' their abusive partners from the punitive consequences of their actions by refraining from accessing either police or legal services. Due to the discrimination faced by the LGBTIQ community at large (1), LGBTIQ participants who had experienced violence described deciding not to seek out specialist FDSV or general population services, as they did not want to add to existing negative external perceptions of LGBTIQ people or relationships. As one participant explained:

> *We spend a lot of time defending ourselves and our choices to [cisgender and heterosexual people]. We don't want them to know that we're not perfect, because we're already battling [against the idea that LGBTIQ relationships are pathological]. So we need to present this front to them that we're great. So going to them and saying, you know, 'I'm in this queer relationship where people are fucked' [can be difficult].*
>
> *(Sam, gender diverse, queer, mid-30s)*

In other instances, 'shielding' behaviours seemed to stem from lingering or existing attachments that victim-survivors felt towards the individual using violence. These attempts to 'shield' people using violence from negative consequences of legal interventions in particular are also documented in relation to violence perpetrated by cisgender men against cisgender women (109). Participants explained the added dimensions of this for LGBTIQ people, as there may also be a sense of solidarity borne out of experiences of marginalisation or discrimination common to both parties. This may also be reflected in different ways across intersecting identities and sources of experiences of marginalisation. This rationale is exemplified in one participant's account, where Edward describes their reluctance to press any charges against their partner:

> *I was fearful for what might happen to him. I thought to myself, if I go to the police over this, I destroy his career, he probably would lose his [professional accreditation], at worst he'd get a criminal charge, there'd probably be some sort of AVO that would come against him; and I wasn't ready to do any of that to him.*
>
> *(Lance, cisgender man, gay, mid-20s)*

Where victim-survivors experienced non-physical forms of abuse, the possibility of disproportionate harm coming to the individual using violence was weighed up by participants, who felt that no benefit would eventuate from reaching out to these services:

> *Even if it did happen, in Australia the cops aren't going to believe me, they're not going to take it seriously, there's no proof. Like, what's the point; it's just going to hurt him.*
>
> *(Sam, gender diverse, queer, mid-30s)*

Relatedly, participants who experienced either IPV or FOV sometimes abstained from seeking help through social networks, particularly if these social networks were shared with the individual using violence. This too is something that has been documented among cisgender, heterosexual women who are victim-survivors (109). As described in Chapter 2, the crucial importance of social networks as an indicator of better mental health among LGBTIQ people (1,63) and the relatively smaller size of LGBTIQ peer communities can contribute to a perceived imperative to protect perpetrators. For participants, this could stem from an awareness that divulging the details of one's abuse to others within these social networks could negatively affect their view of, and hence relationship with,

the individual using violence. This was more often seen in instances where these social networks were important sources of support for the individual using violence. Individuals experiencing violence often did this with the intention of preserving these connections and relationships as viable avenues of support for the individual using violence.

5.5 Managing risk and harm from discrimination from service providers

This section examines different tactics that participants used to mitigate risk or experiences of discrimination from service providers. People experiencing violence typically access support services while in a compromised emotional and/or psychological state. In this context, forms of discrimination they may otherwise feel equipped to confront could feel amplified, more consequential, or beyond their ability to cope with in the circumstances. For instance, an individual might normally be able to disregard inadvertently derogatory or ignorant assumptions about their sexual or gender identity. However, the same slights or insults could be greatly magnified by the circumstances that prompt victim-survivors to seek help, due to the fact disempowering and betraying nature they take on when they originate from a service worker one expects to be helpful. As discussed in the previous section, this kind of discrimination often caused victim-survivors to forgo the use of support services all together. Depending on the severity of need, however, this was not always a viable option. Participants like the one quoted below often had to put up with discriminatory treatment in order to access the support they needed:

> *I'm familiar with people being homophobic, so I do have my guard up about that, so it's not necessarily that I didn't really expect it. I was just so desperate that I was willing to do anything for them to help me. In retrospect, I would have liked someone to have listened to me and not judge my story.*
>
> *(Minna, cisgender woman, lesbian, mid-30s)*

Service interactions like these typically came at a tangible 'cost' to the psychological wellbeing of the victim-survivor. To safeguard their psychological and emotional safety, participants used a range of strategies which better allowed them to navigate experiences of discrimination within the service system. These include:

- Not disclosing their sexual and/or gender identity (where possible)
- Assessing the likelihood of a service being able to provide safe and affirming support
- Strategically moving between practitioners or services to mitigate risk of (further) discrimination
- Drawing on 'informal' sources of support to meet gaps in formal service assistance

5.5.1 Non-disclosure of sexual and/or gender identity

Some victim-survivors chose not to reveal their gender or sexual identities to service providers. This strategy was not equally available to all participants. On the one hand, for example, same-gender couples might be 'outed' by partner contact service models. Whether or not a trans individual could successfully 'pass' as cisgender in a service interaction could hinge on many factors, some of which may be outside their control. On the other hand, for some individuals, like Simon, 'going back into the closet' was a little easier, as he was sometimes able to lie by omission about his sexuality:

> *And, like, it does cross my mind from time to time is, like, is it really a good idea saying that I'm bi in today's world? Because people react differently and stuff, and you can just get away with just saying, 'Oh, I'm just hetero, yeah. Yeah, I just like girls'. You know, get away with it.*
>
> *(Simon, cisgender man, bisexual, mid-30s)*

Participants sometimes defaulted to these strategies while attempting to ascertain a service worker's stance towards LGBTIQ people, only 'coming out' to a service worker once they were satisfied that they would not experience any overt discrimination from said service worker. This could be a complicated process, particularly if victim-survivors interacted with multiple workers over the course of a service interaction.

On a more practical level, the use of these strategies made it difficult for participants to articulate and access support for LGBTQ-specific needs and issues. Examples of these include victim-survivors experiencing FDSV directly related to their gender or sexual identity, or who are concerned about being housed in refuge-style crisis accommodations, due the elevated risk of discrimination within these settings. In such instances, LGBTIQ victim-survivors often have the unenviable choice between having their safety needs related to their ongoing FDSV situation going unmet and potentially experiencing discrimination targeted at their sexual or gender identities within services.

Moreover, for some trans and gender diverse victim-survivors, the nondisclosure of their gender identities made it likely that they would be unintentionally misgendered by service workers. Misgendering is form of discrimination specific to trans people; it is often experienced as the negation of a trans or gender diverse individual's own designations of their gender and body, and it can have very distressing or (re)traumatising impacts (110). One participant summarised this dilemma as follows:

> *I can walk in there and pretend that I'm not trans, or just not correct them, and allow them to misgender me, but you know, that's causing me harm at a time when I'm already vulnerable and hurting.*
>
> *(Sam, gender diverse, queer, mid-30s)*

5.5.2 Forecasting the risk of negative service interactions

When afforded the opportunity, many participants described being selective in the services that they chose. Where there was a variety of service options available, victim-survivors attempted to determine a service organisation's public stance toward LGBTIQ individuals before reaching out to these organisations for support. To determine whether a service organisation was safe for their use, participants typically drew upon any combination of:

- Explicit information available publicly
- Contextual evidence gleaned from news and social media items regarding the service organisation
- The use of signifiers like rainbow flags or other similar iconography
- Hearsay from other LGBTIQ peers

The participant below described the 'vetting' processes she undertook to determine the 'suitability' of a service organisation to her needs:

> *I guess if I look into their bio, I'd look at how they would provide their services, any kind of keywords that might pop up as well, and how they engage with the community, so I know that they are a lot of pride events that happen throughout the months, like this month and next month, so seeing whether they get involved or are engaging in that.*
>
> *(Ying Chan, cisgender woman, queer, late 20s)*

Trans participants, and trans women in particular, were keenly aware that they were navigating a service environment where there has been significant public debate over whether services that predominantly support (cisgender) women experiencing violence ought to extend that support to trans women. As described in Chapter 3, there remains opposition to including trans women in some women's family violence services. Participants noted that service organisations typically did not specify whether their services were intended exclusively for cisgender women, or if trans women would also be accommodated. Likewise, it was possible that a service organisation might be willing to support (cisgender) lesbian or bisexual women, while simultaneously declining to render services to trans women, despite this being prohibited by Commonwealth law (111). As one trans participant who worked in the FDSV sector emphasised:

> *Trans women are experiencing so much violence in the world, and then to expect them to go and talk with cis[gender] people that are […] working in gendered women's services that are potentially quite [exclusionary], many of them are … to, like, expect them to be able to access that and get appropriate support and safe services [is unreasonable].*
>
> *(Jaz, trans masc and non-binary, queer, late 30s)*

5.5.3 Strategically moving between services

Another way that participants attempted to minimise harmful service interactions while getting their needs met was by strategically moving between services. This often involved drawing upon several services either sequentially or simultaneously, and sometimes required participants to partition or portion out their needs so they could be met by each individual service. Additionally, the need for participants to pivot between services was sometimes due to a lack of wraparound services within the service system.

It was common for participants to move between services in response to any perceived compromises to their emotional or psychological safety. An example of this could be seen in Jaz's interactions[14] with several sexual assault support service organisations in attempting to find inclusive support. Below, they describe how their queerness was invalided within these contexts and dismissed, as a result of the psychological trauma of the sexual violence they had experienced:

> *I did access a few services and I found all of them very [homophobic], like, a lot of things like, 'Of course you think you're a lesbian or you're queer now, because of what happened to you; that will probably change'.*
>
> *(Jaz, trans masc and non-binary, queer, late 30s)*

14 The experiences described here by the participant took place when they had previously identified as a lesbian woman.

Experiences like Jaz's suggest that, in many instances, even pivoting across to different services was no guarantee that people experiencing violence would eventually have their needs met. Seen here, people experiencing violence can exercise significant agency in avoiding and managing negative service interactions. However, the extent to which skilfully navigating a service environment where LGBTIQ-specific expertise is considered 'niche' will result in them accessing appropriate forms of care is ultimately restricted by the availability of such expertise. This could be exacerbated for people in areas with fewer services, including in rural and remote settings, and for people on lower incomes who cannot access private practitioners or travel to access LGBTIQ community-controlled services.

Moreover, having to pivot between services in this manner meant that people experiencing violence might be only intermittently engaged with services, particularly in service environments where there was poor interagency cooperation or information sharing. Participants sometimes also experienced these interruptions to their care as setbacks and talked about subsequently avoiding services altogether. For example, Jasper, a non-binary queer person in their early 20s, described how their struggles with anxiety and depression could make it difficult to manage the administration around appointments. In their experience, some services could impose penalties for non-attendance. For Jasper, anticipating that they would miss an appointment and invite a penalty could sometimes mean that, if they were at a particularly low ebb, they would just not contact support services at all.

5.5.4 Drawing on informal sources of support

Attendant to this, where participants were not able to access adequate support from formal services, or where they chose not to engage with services, some talked about turning to 'informal' sources of support. These typically comprised networkers of peers, loved ones and even community members and co-workers who were sources of support that were drawn on in lieu of a 'formal' support service. Existing research demonstrates that informal supports provide critical assistance to people experiencing violence (109) and that this has particular salience for LGBTIQ people (23).

There were several noticeable benefits to drawing on these sources of support. For instance, the individuals making up these support networks were likely appraised of both the victim-survivor's sexual and gender identities, and – in the case of IPV or FOV – might be at least partially aware of the abusive dynamics that had led the victim-survivor to reach out. This usually eliminated the need for participants to 'come out' to a service worker, and also reduced the need for participants to relive or revisit some of the traumatic details of their abuse.

- Support sought from these avenues typically pertained to needs that were ordinarily fulfilled by:
- Crisis accommodation services (i.e. sleeping on a friend or family member's couch)
- Psychological counselling services (talking through problems)
- Support with navigating bureaucratic and administrative processes (seeking advice or having a friend provide moral support)

Very few participants replaced the use of 'formal' services entirely with these 'informal' sources of support, but rather, utilised these sources of support strategically in order to avoid overtaxing them (see 112).

As discussed in section 3.3 in relation to social isolation as a tactic of abuse, these supports were not available to everyone, however. As past research shows, LGBTIQ people may have smaller social support networks than their heterosexual and cisgender counterparts, and these may be constrained further for people who are migrants, refugees or who have experienced or are concerned about encountering racism in spaces that are predominately and/or culturally white (100). They may also have experienced family rejection or other forms of FOV, precluding access to informal supports that are crucial for other victim-survivors. This both limits the extent to which LGBTIQ people experiencing violence are able to tap into their social connections, as well as the sustainability of these networks when placed under such demands. As one participant noted:

> *Everybody just assumes that you have a supportive friendship that is sustainable and there would be very, very clear times when it's not, or when you are struggling with it and nobody wants to touch [the topic of IPV], even in the LGBTIQ groups you know, and that makes it very, very frustrating.*
>
> *(Jia Hao, cisgender man, gay, mid-20s)*

Social support networks are often disrupted by migration and natural attrition. Victim-survivors who are newly arrived in Australia and/or who are older may find it difficult to maintain a sufficiently robust social network to tap into as improvised sources of support. Yvonne, a participant who had settled in Australia several years ago, spoke to us about how she found the Australian LGBTIQ 'scene' uninviting to new additions. Similarly, she found little success in befriending her neighbours and members of the local community:

> *My age has something to do with it, so when you're [almost 40] and you're arriving back and everyone's got quite strong relationships and quite strong networks, it's not always easy to break into those [...] but it's taken me 9 years. So it literally took me 5 [years] to have a business network and 7 [years] to have some kind of social network.*
>
> *(Yvonne, cisgender woman, lesbian, early 40s)*

This kind of social isolation can often be doubly disadvantageous, as it not only makes individuals like Yvonne more vulnerable to abuse, but also causes them to be largely reliant upon 'formal' services for support, which may be inaccessible or unsafe.

Additionally, LGBTIQ people experiencing IPV may have significant portions of their social support network in common with the individual using violence. For participants, this sometimes resulted in a scenario where a victim-survivor could only rely on a fraction of their social network for support.

5.6 Summary

This chapter has detailed the many layers of labour and effort required of LGBTIQ people when they enter FDSV service systems seeking help to address or recover from abuse. These are additional dimensions to the effort required from any victim-survivor seeking help.

These accounts and analysis demonstrate the difficulties experienced by LGBTIQ victim-survivors where inclusive service providers are difficult to identify or access, and where service providers have insufficiently nuanced interpretations of safety and inclusivity for different LGBTIQ communities and people. Lived experience participants described needing to educate service workers about their sexual and gender identities, relationships and the context for particular kinds of harms they experience before being able to access care. They told us of how wearing and time-consuming this could be – especially if they were required to do this with multiple people across different services – to the extent that it could deter victim-survivors from seeking help if they were not assured of affirming care and a basic level of practitioner knowledge about LGBTIQ experiences.

Networks are often disrupted by migration and natural attrition. Victim-survivors who are newly arrived in Australia and/or who are older may find it difficult to maintain a sufficiently robust social network to tap into as improvised sources of support.

The chapter further explored how heteronormativity and cisnormativity are inscribed into bureaucratic and legislative systems in ways that require careful examination to displace and that are often most visible only to those who are negatively impacted, because they live outside of those norms. Finally, the chapter discussed the different tactics to avoid or minimise harm of discrimination from service providers shared by participants. These included hiding aspects of their identity or personal experience until services had proved they were safe for LGBTIQ people, researching the credibility of an organisations claims to 'allyship', and strategically moving between services and selectively disclosing parts of their experience depending on how the participant assessed each service's safety.

The next chapter seeks to provide a counterpoint to the questions and issues raised here, by considering what LGBTIQ-inclusive FDSV services might look like.

6 Strategies for developing LGBTIQ-inclusive practice

Despite the numerous challenges described throughout this report thus far, there are nonetheless many practitioners and services currently providing safe and affirming services to LGBTIQ people experiencing FDSV.

Secondary analysis of Private Lives 3 data found that only 25.9% of participants who had experienced IPV or FOV indicated that they reported their most recent experience of IPV or FOV to an individual or service. However, of those, 84.6% felt supported when they reported this experience (21). This chapter explores what inclusive, safe and affirming FDSV services look like in practice, and key strategies and considerations for organisations seeking to improve service supports for LGBTIQ people.

The first section of the chapter considers accounts from lived experience interviews (Phase 2) that describe what affirming care looks and feels like from service user perspectives. These are placed in conversation with service provider accounts from key informants (Phase 1) and case study interviews (Phase 3) that describe how services approach establishing culturally safe and trauma-informed practice for LGBTIQ people who have experienced FDSV.

The second section presents six themes related to inclusive practice development drawn from the interview data:

1. Whole-of-organisation support for inclusive practice
2. Building and honouring LGBTIQ community trust
3. Adaptability and responsiveness to LGBTIQ communities' needs
4. Building strong cross-sector and interagency networks
5. Establishing cultures of reflective practice attentive to LGBTIQ inclusion
6. Managing resistance and client safety

6.1 Organisational case studies

Six organisations were selected as case studies in order to illustrate transferrable lessons in efforts towards embedding safe and affirming care for LGBTIQ people:

- **Centre Against Violence (CAV):** combined specialist family violence service and centre against sexual assault, regional Victoria
- **Thorne Harbour Health:** LGBTIQ+ community organisation, metropolitan Melbourne (with clinical outreach to regional Victoria and statewide/national advocacy networks
- **ACON:** LGBTQ+ community organisation, metropolitan Sydney (with service outreach to regional New South Wales and statewide/national advocacy and training networks)
- **Safe Connections, Lifeline Darling Downs:** LGBTIQ+ family violence support project within a mid-size mixed social services NGO, regional Queensland
- **YWCA Australia (Domestic and Family Violence Centre, Darwin):** specialist family violence crisis and counselling services within a mid-size mixed social services NGO, greater Darwin area
- **Engender Equality:** specialist family violence counselling services, metropolitan/regional/rural Tasmania

The six inclusive practice themes listed above resulted from analysis of data from across the case study investigations. They are also informed by the principles of promising practice used to select case study participant organisations. These principles were drawn from the Rainbow Tick accreditation standards and adopted to guide participant recruitment. As set out in the guiding document, Rainbow Tick Standards: A framework for LGBTIQ cultural safety: 'the Rainbow Tick Standards serve as a useful framework to guide best practice in LGBTIQ inclusion at any stage of the change process' (46). This guidance was applied to help identify where organisations, networks and coalitions are making progress towards meeting any of the six accreditation standards as part of improving cultural safety of FDSV services for LGBTIQ populations.

The Rainbow Tick Standards are particularly applicable for considering progress towards better cultural safety for LGBTIQ people in FDSV services and broader referral networks. The standards and the ways they were used to identifying promising practice are set out Table 6.

The term 'promising practice' is purposefully used rather than 'good practice', as the case studies are not evaluative but an exercise in highlighting strengths, successes and transferrable lessons from existing inclusive service development. This chapter also seeks to avoid suggesting that there is a hierarchy of inclusive services and that the small number of organisations able to be included in this sample are the only 'good' services in Australia. Lastly, recognising that given the different resourcing and policy conditions around the country and concomitant support for inclusive FDSV services, it is important to give attention to what is being built and attempted as well as what has already been tested and established.

Before considering these organisational development perspectives, this chapter first turns to lived experience and service provider accounts of what inclusive care looks like in practice.

Table 6: Rainbow Tick LGBTIQ-inclusive practice standards

Rainbow Tick Standard	
Organisational capacity	The organisation embeds LGBTIQ-inclusive practice across its systems and continuously seeks opportunities for improvements
Workforce development	Staff and volunteers understand their responsibilities to LGBTIQ service users and are trained and able to deliver LGBTIQ-inclusive services
Consumer participation	LGBTIQ service users are consulted about and participate in the planning, development and review of the service
Welcome and accessible organisation	LGBTIQ service users can easily and confidently access services because the physical and virtual environments, including information, structures, resources and processes, are welcoming
Disclosure and documentation	LGBTIQ service users, staff and volunteers feel safe to provide personal information, including their sexual orientation, gender identity and/or intersex status, because they know information will be treated respectfully and that systems are in place to ensure their privacy
Culturally safe and acceptable services	Services and programs identify, assess, analyse and manage risks to ensure the cultural safety of LGBTIQ service users

6.2 Cultural safety and trauma-informed care in practice

This section considers how culturally safe and trauma-informed care were both experienced by LGBITQ people accessing services and configured and implemented by service providers. It provides examples of affirming care shared by lived experience interview participants, which demonstrate the positive effects and encounters that result from trusting and feeling safer in FDSV services. The discussion then turns to service provider perspectives, considering what they prioritise in order to create culturally safe and trauma-informed practice environments and service experiences for LGBTIQ people. Lastly, this section explores what it means to create tailored service approaches for each client. Commonly articulated by research participants from FDSV workforces as 'meeting people where they are', this describes applying knowledge of structural sources of harm and discrimination to understand and accommodate the needs of individual LGBTIQ victim-survivors.

Lived experience interview participants described service interactions that might be categorised as culturally safe practice, even if they did not use the term. This could mean use of correct pronouns, and acceptance and affirmation of a client's gender and sexuality, including not asking invasive questions about or making them feel pressured to defend

their identities, gender presentation or intimate or social relationships. It also meant believing LGBTIQ clients' accounts of FDSV and validating their need for care and support.

An example of this was shared by Finley, a bisexual participant who, although sometimes sexually attracted to cisgender men, had predominately only had intimate partners who were cisgender women and non-binary people assigned female at birth. They wanted to explore their sexuality and had gone on a date with a cis man who then sexually assaulted them. This perceived 'inconsistency' in their dating history sparked several invalidating comments about their sexuality from some service providers and people in their personal support networks. In contrast, their regular GP appeared unfazed by this fact, in ways that Finley described as reassuring:

> *And he didn't sort of question why I'd gone on a date with a guy, because, like, that was one of the other first things that my parents asked. They were like, 'Why are you out here dating men? Like, what's happened?' and it's, like, 'Nothing, sexuality is fluid'.*
>
> *(Finley, non-binary, bisexual, early 20s)*

Another instance where a service worker's familiarity with an LGBTQ client's needs facilitated positive service interactions, and ultimately a positive client–therapist relationship, was related to us by Helena. Having disclosed her experience of emotional abuse to her GP, Helena subsequently received a warm referral to a psychologist who specialised in working with trans clients. Throughout her interview for this study, Helena described her frustration when, at various points, people misattributed the mental and emotional distress she experienced as a consequence of family violence to the fact that she was trans.

> *I'm not a trans statistic; I'm a DV statistic. It's an abuse statistic. I don't want to be a trans statistic; I had a successful transition.*
>
> *(Helena, trans woman, bisexual, mid-50s)*

As a result, Helena bristled at first when she was recommended a psychologist who specialised in working with trans people. However, after discussing it with her GP, she agreed to try their suggestion. She found that this psychologist's knowledge and lived experience of family violence was complemented by her knowledge about trans needs and experiences in ways that greatly aided Helena's recovery. She stated:

> *She's a cis woman but she's very diversity-friendly, works with trans people. I almost felt a little bit patronised that my doctor put me on to her when she specialises in that, because I'm going, 'You know, you don't need to treat me different because I'm trans', but […] she gave me someone who totally got where I was coming from, who had been through emotional abuse herself. So that was like the jackpot.*
>
> *(Helena, trans woman, bisexual, mid-50s)*

Helena's account demonstrates that culturally safe practice can be expressed as complementary forms of knowledge and expertise by different service workers. These are mutually necessary to ensure safety at all points on the continuum of care. For Helena's GP, cultural safety is demonstrated through the recognition of her trans patients' unique needs, and her recommendation of a psychologist who specialises in trans clients. Cultural safety is ensured by Helena's psychologist through a thorough technical understanding of the therapeutic needs of trans people experiencing coercive control in the context of IPV. In conjunction, both forms of culturally safe practice translate into highly productive therapeutic relationships and positive outcomes for Helena.

Service stakeholders' statements also pointed to the necessity of interrogating existing assumptions about cultural safety. They reflected nuanced understandings of cultural safety that framed it as being wholly distinct from cultural competence. As past research suggests, while both concepts are often seen as interchangeable, cultural safety pertains to a systemic approach to service provision that aims to challenge service workers' biases, attitudes and assumptions towards clients from marginalised communities. In contrast, cultural competency relates to the acquired knowledge, skills and attitudes that enable productive service interactions (113). A key informant participant argued that the kinds of critical self-awareness encompassed by cultural safety ought to premise all service interactions, even ones that were brief or casual, citing the example that:

> *It's the really basic things. Like, you know, if there is a woman in front of you saying that she's experienced domestic violence, you don't say, 'Oh, how long has your husband been doing this?' You know to avoid that gender language, so it's the very, very basic stuff.*
>
> *(Jaime, senior manager, LGBTIQ community-controlled organisation)*

Service workers' ability to tailor service responses to the needs of LGBTIQ clients, as opposed to presupposing or pre-empting these individuals' needs, was identified as another important aspect of inclusive practice. LGBTIQ people experiencing FDSV may experience shared circumstances that relate to factors such as discrimination, cisnormativity or heteronormativity. However, a range of factors such as age, socioeconomic status, cultural background, geographical location, race, specific sexual and gender identities and the ways that these intersect can determine the situational relevance of these shared circumstances to individuals. For instance, a trans woman who is a middle or higher-income earner and resides in a socially progressive area of a metropolitan city may have improved access to medically assisted gender affirmation (if she desires it) as well as make-up and clothes that help her to express her gender. All these factors combined make her less likely to experience similar vulnerabilities to transphobic violence as a trans woman with a lower income living in a rural location, though the possibility of such violence is nevertheless ever-present in the lives of both women. In a similar way, the needs of each LGBTIQ individual experiencing violence are unique to their particular circumstances.

This is a key tenet of trauma-informed and culturally safe care. Case study participants emphasised repeatedly that these kinds of bespoke responses involve more than the use of the appropriate terminologies and pronouns; they also relate to understanding why these signals of respect and affirmation are important. As one case study participant from ACON described:

> *Inclusive practice isn't [just about] pronouns […] affirming someone is much deeper than just getting their pronouns right, or getting their relationship structures right, or getting their history right […] One of the things I think that really set[s] our clinicians apart is that many of them are from our community. And they have lived experience of being part of the community in whatever way and have a deep commitment to meeting the client where they're at.*
>
> *(Micah, senior manager, ACON)*

The ability to 'meet someone where they're at' – a phrase which many service workers used to refer to tailoring service responses to the needs of the individual experiencing violence – was also identified by lived experience participants as an indispensable component of positive service interactions and outcomes.

Seth related how service providers helped him to navigate a difficult home context when he was receiving telephone counselling. Intrusive family members made it difficult for him to speak frankly with counselling staff and case workers who were calling to check in with him. After raising this issue with staff, they collaborated to devise a workaround. This enabled him to remain within these services without the risk of his family members prying into the specifics of the interactions:

> *I don't like my family knowing, because they do judge a bit, [and so what I asked] was: 'If you could just please say, "Hey, it's blah blah, just wondering how you're travelling?" – that's it – like, don't actually say where you're from or anything like that.'*
>
> *(Seth, cisgender man, gay, early 20s)*

Taking a tailored approach to services could also mean ensuring people were referred to appropriate care providers both within services and within service systems. This might be at the recommendation of service staff or according to the preferences and safety needs of a client. As put by a staff member at Thorne Harbour Health:

> *I think [the] best practice in this sector is [enabling] choice, so that a person – depending on who they are, how they identify, where they live – gets a choice of service, and it might be a mainstream family violence service or it might be a specialist service that meets particular identified needs of theirs, be it their sexuality, their gender expression or experience, their indigeneity, their culturally and linguistically diverse background, their disability.*
>
> *(Chris, senior manager, Thorne Harbour Health)*

6.3 Principles and case studies of promising practice in inclusive service delivery

This section considers inclusive practice themes drawn from the case studies and the ways they were used by a diverse range of services to build and maintain safe an affirming FDSV practice. It provides a short overview of each of principle and then illustrates what it can look like in practice by providing a case study example from each of the six organisations that participated in this study.[15]

6.3.1 Whole-of-organisation support for inclusive practice

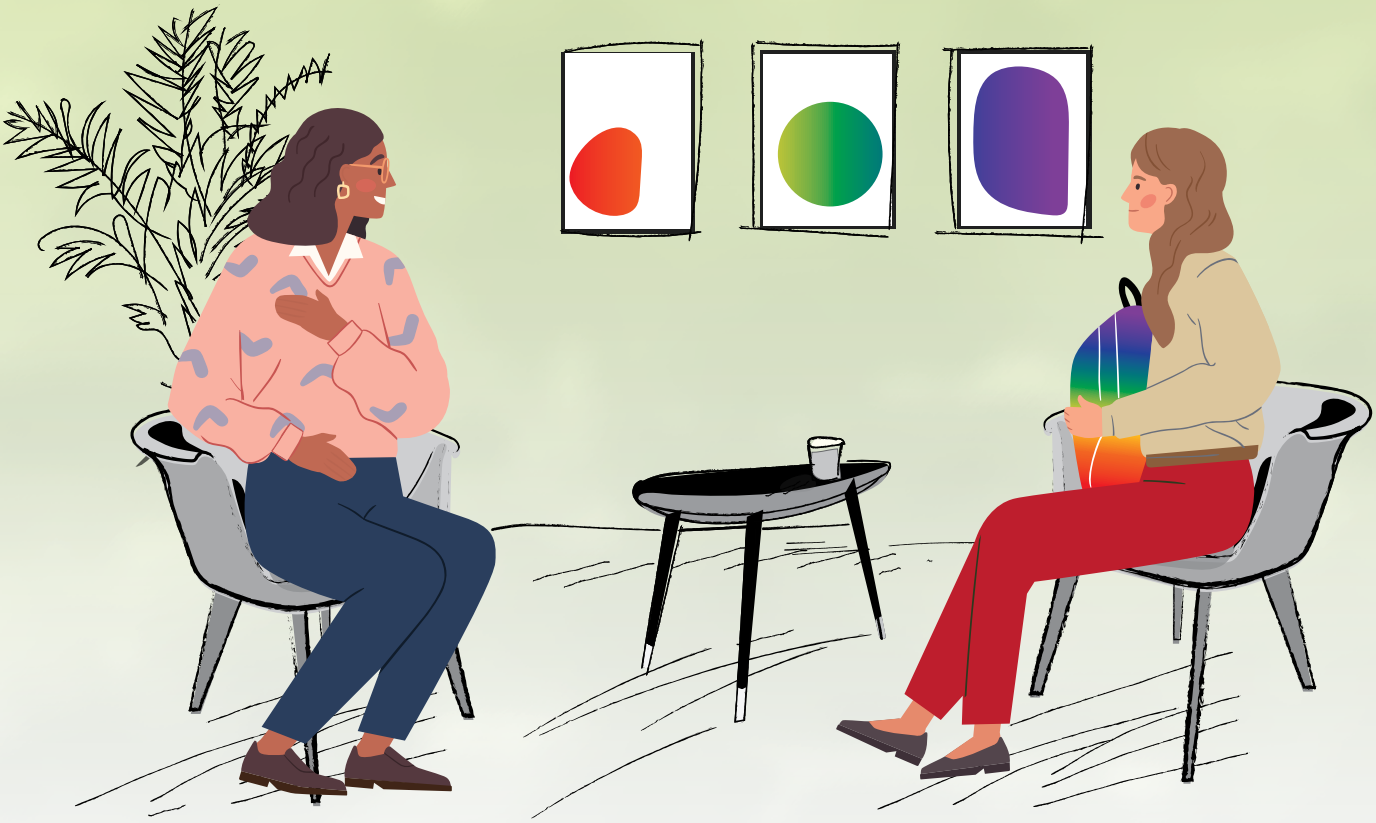
The importance of fostering an organisational culture defined by a commitment to the principles of inclusive practice was a unifying thread throughout all six case studies. An indispensable component of fostering such cultures involves formal capability development. This is not only for client-facing staff but for everyone in the organisation, from board members and leaders to ancillary staff. It also involves capacity building in organisational systems and structures to create an enable environment for LGBTIQ cultural safety within these. As will be illustrated in the case study example from CAV, a specialist family and sexual violence service in rural Victoria, this type of thorough approach means that catering to LGBTIQ clients is less likely to be viewed as 'niche' work. Instead, ensuring that every client who comes through the door is treated with respect and provided with the trauma-informed and culturally safe support they need, including in relation to their gender or sexuality, becomes core to everyday operations in all parts of the organisation.

For example, at YWCA Darwin, staff from all areas of operations participated in 3 days of capacity development training provided by ACON. This included cleaning and housekeeping staff, many of whom are engaged on a casual basis, as the organisation recognised that these staff were likely to interact with LGBTIQ people staying in crisis accommodation or in incidental encounters at YWCA Darwin. As the training included an online, self-directed component and there were variable degrees of computer literacy among this group of staff, this meant that YWCA Darwin invested additional time from other staff to make sure that needed support was available for them to progress through the training. As well as ensuring a strong baseline level of knowledge about LGBTIQ-inclusive practice, the signalling by board and leadership that this is an area of development that is worth investing in, and approaching wholeheartedly, demonstrates that it needs to be taken seriously by everyone in the organisation.

This kind of formalised investment in training takes resources. Particularly for smaller organisations, it may take time to work with funders to make that kind of investment possible. Engender Equality described the ways that it has made changes to better support LGBTIQ clients by seeking help and advice from LGBTIQ organisations through professional and local networks, and by using publicly available resources. Staff working with the Safe Connections LGBTIQ family violence support project with Lifeline Darling Downs (LLDD) approached its board and provided a tailored version of a training package about working with LGBTIQ people. This is part of ongoing efforts to raise the profile of the importance of creating more inclusive service environments across the organisation.

All case study organisations stressed the importance of creating work and service environments where staff members adopt a critical eye for assumptions about gender, sexuality and relationship types in existing work processes, or even in their own interactions with clients. In addition, this meant creating work cultures where staff members could comfortably engage in mutual capability building and knowledge sharing about what it means to provide a safe service for LGBTIQ people (and indeed, other marginalised groups). These processes were identified as crucially important to scaffold, embed and grow capacity development even after formalised training had been provided.

15 Expanded case studies are available on the Opening Doors project website [insert URL here].



CASE STUDY 1: WHOLE-OF-ORGANISATION DEVELOPMENT

Centre Against Violence (CAV) in the rural and regional Ovens Murray region of northern Victoria is one of 14 sexual violence response services known as centres against sexual assault (CASAs) in the state. It is also a specialist family violence service.

CAV started exploring LGBTIQ-inclusive practice development in 2019, after it was identified as a priority by its then CEO. With comprehensive support from Rainbow Health Australia staff, CAV initially focussed on changing language on intake forms (particularly those related to family violence) and reviewing the language and framing used in internal policies to reflect greater gender inclusivity. Building buy-in from the board was critical as it meant that the considerable investment of organisational resources (staff time, board time and financial resources) was supported and understood as important for CAV's ability to serve the whole community. This provided the enabling environment to attempt other changes in day-to-day operation and practice, and to embed safe, affirming care for LGBTIQ+ clients as central to the ethos of CAV.

Several participants reflected on how there was resistance from some staff to the proposed changes, more than from members of the board, particularly with regard to making language and family violence supports more gender inclusive. This was especially regarding to changing the family violence supports to a mixed-gender rather than women-only service, which was a significant practice change. It took time for some staff to appreciate the importance of wearing pronoun badges on their work lanyards (done with a view to normalise pronoun sharing and therefore encourage gender diverse clients or other staff to feel comfortable nominating their pronouns to avoid being misgendered); and avoiding gendered stereotypes or assumptions in conversations with clients and staff.

As a result of supportive professional development efforts accessed from the LGBTIQ family violence team at Rainbow Health Australia and LGBTIQ community-controlled reflective practice initiatives, the culture of the organisation has shifted in the intervening period. An LGBTIQ+ working group made up of staff from sexual assault, family violence and ancillary services teams was established, which assisted with regular Rainbow Tick[16] progress updates in team meetings. Some staff began using pronoun badges to identify themselves as being of a different gender than their colleagues had assumed them to be, which 'made it quite real for [colleagues], like, "OK, there are people in our organisation that I need to be respectful of" […] It was very brave of them.'

Seeing the ways that the concepts and adjustments being implemented through Rainbow Tick were not abstract or simply about compliance but had direct and immediate benefits for other staff helped to embed enthusiasm for the changes, which in turn made it easier for LGBTIQ+ staff to be open about their gender or sexuality at work. This education work with existing staff, management and board members was also supported by changes in staff recruitment and induction practices that result in new workers or graduate placements beginning work with a firm understanding of what LGBTIQ-inclusive and safe practice and workplace culture mean at CAV.

16 An inclusive practice professional accreditation, administered by Rainbow Health Australia.

6.3.2 Building and honouring LGBTIQ community trust

Throughout all phases of this study, participants of all kinds observed that communities need to trust that services will provide affirming and supportive care when approached for help. LGBTIQ people keep each other safe by sharing information about which FDSV organisations are safer to engage with, and which ones to avoid. Similarly, community advocates and LGBTIQ community-controlled organisations that might be in high demand as community advisers or partner organisations are judicious about which organisations they partner with. LGBTIQ community-controlled organisations need to ensure their communities keep trust in them by mitigating risk of reputational damage by association with an entity or person who has a reputation for discriminatory views or behaviour. They also need to protect staff time and ensure they keep focus on their core work for their communities by minimising risk of an overly burdensome partnership with an organisation that is not doing the robust, internally driven capacity-building work described above or that is not prepared to resource the labour it takes for LGBTIQ people and organisations to provide ongoing advice and capacity building.

Building community trust takes time and commitment. This was described in different ways by FDSV services that were developing more inclusive practice and by LGBTIQ community-controlled FDSV services that stressed that they saw trust as a practice, not a fixed achievement that they could take for granted. For specialist family violence services that, until recently, had solely provided services for (presumptively cisgender and heterosexual) women experiencing violence, community trust formed a significant barrier to service uptake by LGBTIQ people experiencing violence. Service stakeholders discussed several ways in which organisations attempted to signal their expanded capabilities to potential LGBTIQ clients. These included relatively passive demonstrations of support, such as the incorporation of LGBTIQ pride flags in advertisements and in office displays, and through social media engagement (e.g. spotlighting community events and commemorating events such as Pride Month). Where appropriate, this also encompassed more overt signalling such as raising awareness of LGBTIQ experiences of violence or discrimination, advocacy efforts at the local or state level, and involvement in LGBTIQ community events. These efforts do not exclusively function to build rapport with LGBTIQ communities. They are also important demonstrations of solidarity, increasing visibility and recognition for LGBTIQ people, while also contributing to the normalisation of LGBTIQ people and identities to members of the broader community.

Importantly, these organisations also reached out to members of their local LGBTIQ communities, contacting LGBTIQ community-controlled organisations and community groups to seek advice about how to make their services as useful and safe as possible. Safe Connections staff in LLDD focussed almost exclusively on community trust and rapport building in the inception phase of its project. In an organisational and geographical context where there have historically been few direct supports for LGBTIQ people, building trust and showing that the program wanted to be responsive to community needs has been key to building uptake of the services it was funded to offer.

The service scope of ACON and Thorne Harbour Health, the two LGBTIQ community-controlled organisations included as case studies, has shifted to more explicitly cater to all people across LGBTQ+/LGBTIQ+ communities over the decades (as opposed to its primary focus on the sexual health of gay men when first formed in response to the HIV/AIDS epidemic). They have worked to telegraph and build service inclusivity through advocacy efforts, and by ensuring that their governance structures, advisory committees and workforces are representative of all the communities they serve, as illustrated in the case study example of Thorne Harbour Health below.

Establishment of community trust and rapport could sometimes be a protracted process that spanned a duration of months or even years. Service organisations that embarked on capacity-building efforts oriented toward LGBTIQ clients often found that the developing the technical capabilities for providing appropriate and adequate support to LGBTIQ people was relatively straightforward. However, the uptake of these expanded services by LGBTIQ people did not necessarily directly follow these capacity-building efforts. Without community knowledge of or trust in the safety and scope of accessible FDSV services, they may not be seen as an option. This knowledge and trust can only be built over time, ideally reinforced with word-of-mouth validation from trusted peers, whether individuals or organisations.

Building community trust takes time and commitment. This was described in different ways by FDSV services that were developing more inclusive practice and by LGBTIQ community controlled FDSV services that stressed that they saw trust as a practice, not a fixed achievement that they could take for granted.

CASE STUDY 2: COMMUNITY TRUST

Thorne Harbour Health is an LGBTIQ+ community-controlled health organisation that works to improve the health and wellbeing of LGBTIQ+ populations in Victoria.

It also houses specialist family violence services, including counselling and crisis support for people experiencing FDSV, and a behaviour change program for GBT men who use violence. These services are housed within a broader therapeutic services team, which means that people seeking help can be referred in and across supports, ensuring 'wraparound' care. For example, someone who approaches the service because they are experiencing homelessness might disclose that this is because of family violence; appropriate care and support will then be coordinated with the client across teams. Thorne Harbour Health also play a key role in state and national advocacy about improving FDSV supports for LGBTIQ+ communities.

As an LGBTIQ+ community-controlled health organisation, ensuring cultural safety for both clients and community has always been central to its organisational ethos and practice governance. Case study participants described how this meant there was a baseline of community trust that meant prospective clients were more likely to feel that they will be safe, understood and treated with respect. This has contributed to the fact that the organisation's family violence programs have been oversubscribed since they were instituted, even as they have expanded with increased state government funding in recent years.

Accountability to LGBTIQ+ communities, and marginalised groups within those communities, is also built into the organisation's governance frameworks. They have established community advisory groups as a central governance mechanism. As one staff member stated, this functioned as an invaluable 'point of dialogue':

> *Between the community members, for example, like the women's community, the trans community, the Aboriginal community, [the] HIV-positive population … [they] can provide input and guidance and support and expertise, I suppose, around what's happening in the community and current issues, and we have accountability back to the things that we're doing, so that there's this mutual space.*
>
> *(Chris, senior manager, Thorne Harbour Health)*

Advice from communities also informs how the organisation engages in networked operations across the family violence sector, as well as in advocacy to governments and various consultative and advisory bodies. Other key sources of expertise that it brings into these spaces include internal practice experience and findings from various research projects that it partners on.

As a result of the community trust and expertise that it brings into consultation, it is sought after as a partner and source of advice. Staff reflected that they value opportunities to contribute to these important discussions, and members of the leadership team usually take time from their other duties to participate in community and government forums.

Many LGBTIQ community-controlled service organisations typically operate in service environments where they constitute either the sole, or one of a small number of providers of population-specific wellbeing and support services. However, many of these organisations have risen to meet community need in this area and worked to develop ways to assist members of their community experiencing FDSV.

6.3.3 Adaptability and responsiveness to LGBTIQ community need[17]

Many LGBTIQ community-controlled service organisations typically operate in service environments where they constitute either the sole, or one of a small number of providers of population-specific wellbeing and support services. However, many of these organisations have risen to meet community need in this area and worked to develop ways to assist members of their community experiencing FDSV, even where, as described in Chapter 3, there is limited or no dedicated resourcing for such programs.

These challenges present a substantial and ongoing strain on organisational capacity to meet LGBTIQ community need. However, organisations, as well as service workers, have built cultures of adaptability and resourcefulness that mean when more appropriate funding is made available, they are able to maximise these investments by expanding existing, innovative approaches to FDSV response. Staff from ACON and Thorne Harbour Health described approaching available funding to look at how they could achieve the greatest service reach, and how they could share knowledge and resources within the LGBTIQ community sector and into specialist FDSV sectors. They each demonstrated nimbleness in proactively expanding organisational capacity to meet identified gaps in the service environment.[18] Examples of this include pioneering work done by both organisations in developing LGBTIQ-specific behavioural change programs and by ACON in developing a nationwide online service database of LGBTIQ-friendly services and practitioners.

This ethos of adaptability extends to internal work processes and informs ongoing approaches towards prosecuting emotional and cultural safety for individuals experiencing violence. Large LGBTIQ community-controlled organisations have a significant profile within and hold close social and professional ties to the broader LGBTIQ community. This can create potential or perceived risks for people considering accessing a service. Some lived experience interview participants described their trepidation at using LGBTIQ community-controlled services. The LGBTIQ community can be small and tight-knit, and these participants talked about worrying that if they were seen attending the service by someone they knew, the person who harmed them might find out. Staff from LGBTIQ community-controlled services described the responsive protocols they have developed to mitigate such risks and concerns. These might include identifying service workers by name to clients prior to a service interaction, to let them assess whether there was a conflict of interest, or coordinating the appointments of clients to minimise risk of accidental contact between people experiencing and using violence within these services. In this way, staff and organisations worked to ensure that the safety of clients, and their agency, was affirmed at all points of engagement with the service.

It is important to highlight that there are limits to the extent to which service organisations and workers could successfully meet these challenges through sheer resourcefulness. For instance, case study participants spoke about how, even with current, comparatively greater funding for LGBTIQ community-controlled specialist services, services were still oversubscribed. Adaptability and nimbleness are crucial enablers of an organisation's ability to respond to gaps within the service environment in a timely manner, and even allowing service workers to temporarily work beyond resourcing constraints. However, these approaches are ultimately unviable in the long term, and should constitute neither the exclusive nor indefinite basis of an organisation's service capabilities. Rather, as case study participants emphasised, they should be considered evidence of the potentially significant positive impact, reach and responsiveness that might result from further, enhanced investment in LGBTIQ FDSV services that corresponds to community demand.

17 Both LGBTIQ community-controlled and other FDSV services described innovative programs that they developed to meet the needs of LGBTIQ communities they served, even in the face of considerable resourcing constraints. This section focuses particularly on LGBTIQ peer–led services, but further examples of innovations from CAV, Engender Equality, YWCA Darwin and LLDD can be found in the expanded case studies on the Opening Doors project website [insert URL].

18 Similarly, CAV and Engender Equality demonstrated a different expression of 'nimbleness' in taking steps to review internal policies and make their services more LGBTIQ inclusive prior to receiving dedicated funding for these efforts.

CASE STUDY 3: ADAPTING SERVICES TO MEET COMMUNITY NEED

ACON provides a range of services broadly relating to LGBTQ+ health and wellbeing. This includes support and counselling for needs relating to drug and alcohol use, sexual health and mental health, as well as FDSV. It has played a pivotal role in developing programs addressing prevention of family violence in LGBTIQ communities.

ACON also provides training and consultancy to other organisations looking to better meet the needs of LGBTQ+ clients, and lobbies for LGBTQ+ issues within government, cross-sector and policy settings.

Originally an organisation formed to mount a community-centred response to the HIV/AIDS epidemic, ACON has iteratively taken up many of the roles it currently plays within the service environment. For instance, the decision to provide specialised FDSV support services was made in response to conspicuous community need. Interview participants noted that victim-survivors were frequently presenting to ACON's other services even back when the organisation lacked the capacity to provide specialised support. A higher-level example of this relates to how ACON has stepped into advisory and advocacy roles in both state and federal FDSV policy spheres over the last decade.

In combination, these shifts have led to development of significant in-house practice expertise relating to LGBTQ+ family violence over the last decade. It both supports and draws on its frontline service delivery with its work in primary prevention, advocacy for more inclusive referral systems and for increased support to community-run specialised services, and capacity building to help other organisations build services that are safer for LGBTQ+ people. This affords ACON a holistic approach to FDSV, working across the continuum from primary prevention to crisis response and recovery.

Likewise, many of ACON's proactively undertaken initiatives and projects have dilated in scope from the state level to the federal level and have been accordingly funded to accommodate this expansion of service provision. One example of this is the Say It Out Loud campaign; while initially New South Wales–focussed, this has since been expanded nationwide.

ACON leadership has often taken an expansive view towards policy and mission directives in service provision, and it has quickly stepped into service environments where gaps have been identified. This
has allowed it to both consolidate and share practice, research and advocacy knowledge derived from other LGBTIQ health and wellbeing programs as well as from community stakeholders working in FDSV service domains.

6.3.4 Building strong cross-sector and interagency networks

Interagency partnerships and collegial relationships are critical to ensuring service continuity and to matching clients to the services and service organisations most appropriate to their needs. For instance, collegial relationships between LGBTIQ community-controlled service organisations and FDSV and other health and community services were vital for ensuring that clients could receive warm referrals if the service they presented to was unable to provide adequate support. This also meant that wraparound or holistic service provision could be achieved for LGBTIQ clients through brokering partnered care with between LGBTIQ community-controlled and other specialist FDSV services and different sectors, for example, health or homelessness organisations.

Some case study participants were part of formalised partnerships or interagency networks. However, the majority of collaborative efforts were brokered by staff as part of their day-to-day work and were predicated upon interpersonal relationships between individual service workers. These collegial relationships were a valuable means of capacity building, and case study participants described ties between individual service workers from different organisations as an important mechanism for knowledge transfer and sharing.

These individuated collaborative relationships could be disrupted due to staff movements, reflecting the need for organisational-level investment and alignment rather than relying predominately or solely on key individuals to advance LGBTIQ issues. Case study and service worker participants recounted instances of such collegial relationships being abruptly terminated or petering out when a counterpart in another service organisation left their role. However, through making conscious efforts to introduce trusted individuals to others in their service, some case study participants described how these networks could, over time, become knowledge that was owned by the organisation. For example, ACON staff spoke about an informal directory of psychologists and other mental health professionals (many of whom were former ACON counsellors) who they knew would provide affirming care for existing clients of ACON's service. This eventually became the inspiration for the nationwide Say It Out Loud online service directory, now hosted by ACON. This example also demonstrates the importance of fostering strong intra-organisation relationships, including through developing cultures of reflexive practice (discussed in Case Study 5).

These partnerships could be invaluable for mediating LGBTIQ peoples' engagement with services or systems that clients might perceive as being biased or exclusionary, based on reputation and/or past history of interactions with LGBTIQ communities. For example, service workers may draw upon pre-established professional ties to individual police officers when assisting LGBTIQ people in navigating these services. As previously discussed, many LGBTIQ people may hesitate to reach out to police due to the expectation that they will experience discrimination or prejudice. Given that LGBTIQ liaison officers are not appointed in all states and are only intermittently available depending on both jurisdiction and working hours, service stakeholders spoken to for this study cited the working relationships they had developed with local police as particularly meaningful for fostering clients' confidence in these services.

Some case study participants were part of formalised partnerships or interagency networks. However, the majority of collaborative efforts were brokered by staff as part of their day-to-day work and were predicated upon interpersonal relationships between individual service workers [...] These individuated collaborative relationships could be disrupted due to staff movements, reflecting the need for organisational-level investment and alignment rather than relying predominately or solely on key individuals to advance LGBTIQ issues.

CASE STUDY 4: BUILDING STRONG NETWORKS

Lifeline Darling Downs (LLDD) services the southern third of Queensland, around 480,000 square kilometres. This includes the largest city in the Darling Downs South West region, Toowoomba.

In 2020, it actively sought out and successfully applied for funding from the Australian Government Department of Social Services to develop and pilot an LGBTIQ+ family violence support initiative, Safe Connections, centred in Toowoomba (it also does some outreach to other communities). The organisation does not currently have any other LGBTIQ+-focussed programs.

Building relationships with the LGBTIQ+ community and with other services to offer support for capacity building and referrals was a critical part of establishing Safe Connections. There are few LGBTIQ+ groups with conspicuous public profiles in the area. Staff used their own networks and word of mouth to approach smaller social groups or communities to ask what they thought was needed in their local area. Many of those that they spoke to said that education and awareness of how to work respectfully with LGBTIQ+ people was a critical gap, as was lack of visibility of safe services for LGBTIQ+ people or recognition of LGBTIQ+ people and their needs.

To address lack of awareness and education gaps, they began their relationship building and promotion of their program by providing an education package to various service and community stakeholders. The two case coordination staff completed an LGBTIQ+ inclusion and a train-the-trainer program with ACON Pride Training to prepare them to deliver workshops. They commissioned a 1-day training package including basic concepts such as explaining different gender and sexual identities and terminology, as well as discussion of the prevalence and impact of FDSV among LGBTIQ+ populations and service responses and gaps. These components also offered a means to introduce the support services for LGBTIQ+ people experiencing family violence offered through Safe Connections.

Training was advertised locally, particularly among local NGO networks, and later participants heard about the training through word of mouth. This helped to broker relationships with key actors in sectors such as housing, as well as lay groundwork to help make referrals to those services safer, particularly for trans or gender diverse clients. A number of training requests came from education providers, including senior classes at public high schools, a local TAFE and a private school.

6.3.5 Establishing cultures of reflective practice to support LGBTIQ capacity development

Participants from all six case study organisations described the importance of collectively and individually interrogating and challenging their own inherent biases and knowledge gaps in order to ensure that their service provided safe and affirming care for those who need it. For LGBTIQ community-controlled organisations, this meant ensuring that practice approaches were informed by advice from marginalised groups and people with intersecting marginalised identities, as described in Case Study 2. For other services, similar efforts were accompanied by considerable focus on addressing heteronormativity and cisnormativity in existing or foundational operational and practice approaches.

Many specialist FDSV and social services organisations provide reflective practice sessions for staff as a regular aspect of professional development. These provide a mechanism for ongoing capacity development and peer-to-peer knowledge development about a variety of subjects, as well as collaborative case management. Staff from specialist FDSV services included in our study described how they used existing cultures of reflective practice to strengthen and embed LGBTIQ-inclusive practice development.

Creating cultures of mutual learning that accept that embedding new concepts and practices can take time, and that assume everyone is trying their best in good faith, were described as critical to embedding inclusive practice. As will be described in Case Study 6, some people may have philosophical reservations that need to be managed differently. That said, in the accounts related to us from YWCA, CAV and Engender Equality, the three specialist FDSV services that had changed from women's services to mixed-gender services, most staff wanted to be part of making an LGBTIQ-inclusive service. For each, this included practices such as integrating conversations about LGBTIQ inclusion into regular team and staff meetings, matter-of-factly correcting one another for missteps with language (e.g. using the wrong pronouns or deadnaming someone) and committing to responding openly when corrected. As described by participants, baseline cultures that were supportive and collegial, and that encouraged curiosity, humour and shared practice development, made it much easier to integrate LGBTIQ inclusivity into reflective practice.

These mechanisms were important to embed and foster culturally safe services for all case study participants. They played a particularly critical role for Engender Equality, which had not yet been able to access formal capacity building to support LGBTIQ-inclusive practice. Staff described their commitment to continuing to develop their shared capacity to assist LGBTIQ people in their communities, and the knowledge and networks they brought together to help each other, both from past work and their own lived experience. Although a senior staff member stated that she would appreciate the reassurance of formal capacity building support and the ways that it would address any knowledge gaps they had not considered as a team, she also did not want to wait for such training if it would mean LGBTIQ victim-survivors might miss out on support. As a proxy solution, community-controlled reflective practice, as well as the local networks and self-guided learning described in Case Study 1, meant that Engender Equality was nonetheless about to make promising developments in expanding culturally safe services.

Creating cultures of mutual learning that accept that embedding new concepts and practices can take time, and that assume everyone is trying their best in good faith, were described as critical to embedding inclusive practice.

CASE STUDY 5: CULTURES OF REFLECTIVE PRACTICE

YWCA provides several social services to the greater Darwin area. Its Domestic and Family Violence Centre provides crisis accommodation, safety planning, safe referrals and support to people with children affected by family violence.

It also has a counselling service for people who have experienced violence and a Keeping Women Safe in their Homes program that provides security upgrades to accommodation for women affected by violence.

Historically, YWCA's family violence services has catered to presumptively cisgender women and their children. Since 2020, with the support of Australian Government Department of Social Services, the family violence team have been exploring the steps they need to take to make their services better able to cater to LGBTIQ people who are experiencing family violence.

To support consistent approaches to inclusive practice across the whole organisation, all staff and management participated in ACON training. Reflecting on how staff and managers supported each other post training, one staff member said:

> *We have a, I guess, a role in being really mindful that if you hear a staff member not using the correct language, to be able to have the time to go, 'Now hang on a second', you know … that's one of the important things, for staff to learn … It's just treating people with respect and acknowledging that you don't know; you're not walking in their shoes.*
>
> *(Freya, senior manager, YWCA Australia Domestic and Family Violence Centre, Darwin)*

In the family violence unit, staff spent a lot of time reflecting with each other too, examining their own reactions and biases. This was described as especially important because individual staff came into the LGBTIQ training with different levels of knowledge about people from these communities, what FDSV might look like for them, and what safe or unsafe practice as a service provider might look like. A culture of reciprocity, care and curiosity within the team was described as critical to the success of these conversations:

> *[It takes] really, really open, honest conversations, without judgement, you know? It's accepting that we all have bias … I think it was that real reflective practice, about, you know, Why did I feel like this? And why was it uncomfortable? […] I guess we're really lucky that as a team, we all feel quite secure to be vulnerable. And to ask a question, without feeling that people are going to laugh at you; we'll laugh with each other […] And that's the type of culture that we've really promoted.*
>
> *(Freya, senior manager, YWCA Australia Domestic and Family Violence Centre, Darwin)*

YWCA hopes to provide 'refresher' training on a regular basis to support this ongoing community-controlled learning and to embed LGBTIQ-inclusive practice as a key aspect of professional development.

Some services that operated within community contexts characterised by a high level of social conservatism described community resistance or backlash against expanding service provision to include LGBTIQ people [...] All staff from services that were not LGBTIQ community controlled were matter of fact in describing the ways that they continued to progress their efforts towards improving LGBTIQ access to FDSV supports in spite of this kind of resistance.

6.3.6 Managing community resistance and client safety

Some services that operated within community contexts characterised by a high level of social conservatism described community resistance or backlash against expanding service provision to include LGBTIQ people. As explored in the discussion of exclusion and barriers to service changes in Chapter 3, this was particularly the case for organisations that had historically catered solely or predominately to victim-survivors who were presumed to be cisgender women. This could overlap with a more generalised discomfort with organisational change, which might appear in any workplace setting when there are significant shifts in an organisation's direction, public profile or leadership.

All staff from services that were not LGBTIQ community controlled were matter of fact in describing the ways that they continued to progress their efforts towards improving LGBTIQ access to FDSV supports in spite of this kind of resistance.[19] Case Studies 1 and 5 presented some of the ways that whole-of-organisation support for inclusive practice development and reflective practice supported efforts to address reservations within organisations, and the ways that networks and outreach can help to address community-based resistance are demonstrated in Case Study 4. A more detailed example from Engender Equality is provided below.

In addition, CAV staff described an example of addressing practice or client safety–focussed resistance. An often-repeated reason for excluding trans women or men from services that cater predominately to women victim-survivors is to protect cisgender women's comfort. That is, that the presence of men in a waiting room, or women who appear masculine, might trigger a trauma response for some cisgender women. Notably few studies have been published that have asked cisgender women accessing family violence services whether they would feel uncomfortable or unsafe if trans women also accessed those services. In one study from northern England, Pain and colleagues spoke to trans and cis women clients and staff at six mixed-gender or women-only specialist family violence services. They found that 'while the issue of trans access to abuse support services is largely discussed in public debates as a potential threat to cis women survivors, most services and cis women service users are welcoming of trans women' (114). They also found that both trans and cis women staff and clients were emphatic about the importance of women-only programs, including initiatives within mixed-gender services.

Staff working with CAV talked about how they managed clients' safety and comfort during intake. As they pointed out, very few people want to see or talk to anyone unexpectedly, regardless of gender, when distressed and accessing help for FDSV. This is particularly the case in a small community where you might be worried about being seen or gossiped about, or worse, having your location disclosed to the person who has perpetrated the violence. As a CASA, CAV had already provided mixed-gender services even before making its family violence supports gender-inclusive or undergoing Rainbow Tick accreditation. It has protocols in place to make sure that no client spends more than a few minutes in their waiting area. This is the case even if clients arrive early or their assigned service worker is delayed, as administrative staff are trained to move clients into a private consultation room as quickly as possible to wait for their appointment. Further, as in the other organisations included in the study mentioned above, CAV continues to provide psychosocial support groups for women who are victim-survivors (although it has had no trans women seeking to join the group yet, staff indicated they would be able to access this group). This recognises that different groups of victim-survivors will provide support to each other because of shared experiences; in this case, experiences of sexism and misogyny that drive violence (and that are also experienced by trans women survivors of violence).

19 It is important to note that LGBTIQ peer–led organisations manage resistance to LGBTIQ inclusion regularly, as part of and as advocates for their communities. This takes the form of generalised heteronormativity and cisnormativity, as well as more egregious displays of transphobia, homophobia, biphobia and intersexphobia. The ways that this has affected service development and accessibility are addressed particularly in Chapter 3 but underpin all the findings of this study.

CASE STUDY 6: MANAGING EXCLUSION AND RESISTANCE

Engender Equality is a not-for-profit organisation working across Tasmania, providing long-term therapeutic support for people affected by family violence. The organisation also actively contributes to advocacy for improved resourcing and supports for people affected by family violence, as well as providing training about family violence prevention and response, and bystander training for workplaces and other groups.

The organisation was established in 1987 as SHE (Support, Help and Empowerment) by the volunteer-run Domestic Violence Action Group, a collective of women who were concerned at the lack of services available in Tasmania for women experiencing domestic and family violence. Initially community-funded, it then received support from the Tasmanian state government and has since become a key actor in the local family violence system. In 2018, the organisation changed its name to Engender Equality, reflecting a desire to provide supports to anyone affected by family violence in Tasmania, regardless of gender.

There are several factors contributed to Engender Equality working towards more inclusive service delivery. The first was an increase in funding and attention to addressing family violence after the high-profile murder of 11-year-old Luke Batty by his father in 2014, which precipitated powerful anti-violence advocacy by Luke's mother, family violence survivor Rosie Batty. In Tasmania, as in other parts of the country, the elevated public conversation about family violence resulted in more funding for specialist family violence services, allowing Engender Equality to expand its staff and reach. Some of the new funding was tied to expanding service provision beyond presumptively cisgender women who had experienced violence. As a result, the organisation revisited its strategy and how it framed its scope of services. This was an opportunity to examine whether the focus on violence against women perpetrated by men (and the implication that both survivors and perpetrators were cisgender) was still appropriate. Further, that if it wanted to provide a service that anyone experiencing family violence could access, whether the feminine name 'SHE' might discourage people who were not cisgender women from contacting it for help.

Case study participants perceived that some in the community disagreed with the changes that Engender Equality was making to its name and service scope. The name change took place at the same time as Tasmania was introducing legislation that allows people to ensure that their birth certificate accurately reflects their gender if it is different from that they were assigned at birth. There was already opposition in the community to this legislation, which included discriminatory discourse targeting trans and gender diverse people. Some of that became directed at Engender Equality as well, as a result of the name change. Some in the women's movement also expressed concern around the organisation accepting that, given that violence emerges and persists through asymmetrical power relations, men can experience family violence, as the organisation signalled by making its services gender inclusive. Rather than viewing this as a challenge for the organisation, Engender Equality used this as an opportunity to talk about why it was important to stand against transphobia and its harms.

Since then, the organisation has continued to grow, and it is a key part of family violence infrastructure in Tasmania. The majority of the clients it supports are still cisgender women, and the staff that we spoke to are committed to continuing to grow their practice knowledge and supports for LGBTIQ communities.

6.4 Summary

This chapter has provided the opportunity to profile progress being made towards more inclusive service delivery across Australia. It demonstrates the transformative effects that affirming service experiences can have for LGBTIQ people experiencing violence. These could be as simple as consistent affirmation of their sexuality and gender through use of pronouns, or basic displays of respect in asking questions relevant to client care that are not intrusive or primarily motivated by satisfying service provider curiosity. This was supported by service providers and staff building (or sourcing, when doing intake for a client belonging to a gender or sexual minority) foundational knowledge of common experiences of discrimination or abuse for LGBTIQ people and taking steps to reassure their safety in service encounters. Service providers also talked about prioritising care that 'meets people where they are at', tailoring approaches to safety to ensure that they mitigate intersecting potential sources of discrimination or risk to cultural safety. A fundamental aspect of this is promoting choice and agency for clients, ensuring that they can ask for and be assisted to find the right care for them, within services and across service systems. These trauma-informed approaches have long been fundamental to service provision in many women's and general-population FDSV services. However, when practised in tandem with LGBTIQ culturally safe approaches, there is greater potential for providers to ensure clients feel safe enough to name issues of unsafety or discomfort particular to their identity and experiences of FDSV and related trauma.

This chapter also considered the different strategies, partnerships and innovations that LGBTIQ peer–led and other FDSV services have developed to better serve LGBTIQ communities, illustrated through six case study examples. These overlapping themes are:

1. Whole-of-organisation support for inclusive practice and LGBTIQ cultural safety
2. Building and honouring LGBTIQ community trust
3. Adaptability and responsiveness to LGBTIQ c ommunities' needs
4. Building strong cross-sector and interagency networks
5. Establishing cultures of reflective practice attentive to LGBTIQ inclusion
6. Managing resistance and client safety

Each reinforces and facilitates the other: organisations are able to respond to community needs where there is whole-of-organisation support for inclusive practice. Where there are high levels of community trust, this will help to build stronger cross-sector networks as well as inform practices of accountability and reflection as part of ongoing professional and organisational development. As several of these case studies illustrate, as well as being important in and of itself to improve safety and support for LGBTIQ communities, developing more inclusive FDSV services can result in organisations taking a more nuanced and thoughtful approach to configuring their policies and services, benefiting all clients and staff.

The final chapter of this report consolidates these findings and considers their implications for continued and expanded development of and access to LGBTIQ-inclusive FDSV services.

7 Summary of findings and research implications

This report has detailed the needs and lived experiences of LGBTQ people accessing FDSV services in Australia; the challenges faced by mainstream and LGBTIQ peer–led services in meeting these needs; and promising examples of adaptive, LGBTIQ-inclusive practice that indicate strategies for moving past such challenges. These findings are based on a combined analysis of existing research, stakeholder perspectives and service user experiences, drawing these resources together to identify future directions for research and practice development.

The following conclusions and suggestions for further work are organised to reflect the various levels at which actions should be taken, including for specific sections of the LGBTIQ community where particular attention is warranted. We anticipate these suggestions will be of use of use to federal, state and territory policymakers working within government; those commissioning, designing or delivering family violence services; and the broader LGBTIQ community who are involved in grassroots efforts to advance support for peers experiencing FDSV.

7.1 Policy-level or structural-level implications

Findings detailed throughout this report point to a need to reshape the policy and structural environment surrounding family violence to be more inclusive of LGBTIQ, and to ensure that all those in need can feel safe and supported. This environment includes the FDSV strategies and policies, at all jurisdictional levels, that guide funding decisions and service design. As described in this report, many of these are currently insufficiently attentive to LGBTIQ concerns or provide insufficient clarity as to whether and how LGBTIQ people fall within their scope. This environment also includes the specialist family and sexual violence response sectors that can, inadvertently, operate in ways that render LGBTIQ people less visible. This negatively impacts data collection about LGBTIQ community service demand and need, which then shapes government resourcing decisions. The study findings point to the following strategies to help address these issues:

1. **Creation of a national policy framework for primary prevention of LGBTIQ experiences of family violence.**

This should clearly define the drivers of violence and essential actions to reduce violence, and must include a focus on equality, recognition, respect and celebration of LGBTIQ bodies, identities and relationships. Such a policy framework would serve to address the major shortcomings in existing practice frameworks outlined in Chapter 4, as well as the challenges inherent in recognising and naming violence that were described in Chapter 3.

Rainbow Health Australia's Pride in Prevention (2) clearly articulated the shared drivers of violence for LGBTIQ people and for women. Subsequently, Our Watch carefully integrated intersectionality, and the shared drivers of LGBTIQ experiences of family violence, into the latest iteration of 'Change the story' (3). However, a specific national primary prevention framework for violence experienced by LGBTIQ communities is needed, to ensure coordinated, strategic and mutually reinforcing prevention efforts. A national framework of this kind, sitting alongside 'Change the story', would lay a solid foundation for much-needed community awareness campaigns and initiatives to:

   a. Raise awareness and recognition of FDSV among LGBTIQ people, the FDSV service sector and the general population.
   b. Promote social inclusion and equality, working against pathologisation of LGBTIQ identities, bodies or relationships.
   c. Promote social connection and community as protective and responsive for LGBTIQ people experiencing violence, including raising awareness of social isolation as a tactic of perpetration.
   d. Address stigma around reporting experiences of violence, and encourage help-seeking by challenging the ideas of victim-survivors being 'weak' or needing to 'protect' perpetrators.

2. **Increased resourcing of family violence services nationally to avoid competition for funding between groups in significant need.**

Family violence is a serious issue that impacts many populations across Australia and the extent of service support need is considerable. The findings described in this report indicate a need for further investment to ensure LGBTIQ people can choose between an LGBTIQ-specific service and a mainstream service that is LGBTIQ culturally safe. This requires significantly scaled-up funding for both LGBTIQ-specific services as well as robust organisational and sector capacity-building support to ensure access to at least one LGBTIQ culturally safe family violence service in each local government area. It is critical, however, that these sector-wide improvements do not come at the cost of reduced fundings for other impacted populations. This would undermine crucial collaboration and referral pathways between services and different community-led sectors, which, when functioning well, serve to benefit all victim-survivors and their communities.

3. **Increased visibility of LGBTIQ people in all jurisdictional FDSV strategies and action plans.**

Many such strategies and plans are framed, or even titled, solely in terms of reducing violence against women and girls. This issue also extends to the framing of funding schemes in response to family violence, which significantly limits resourcing of LGBTIQ-related services. It is essential that new strategies and plans utilise inclusive language to guide funding, commissioning and service design. This should not be confused with a call for obscuring or avoiding discussion of gendered drivers of many forms of FDSV, and the disproportionate rates experienced by women in heterosexual relationships. Rather, it should pay express attention to the ways binary gender norms (and their constituent elements, heteronormativity and cisnormativity) create contexts in which violence occurs. These frameworks also need to acknowledge the unique forms of violence that can occur for LGBTIQ people, including FOV for this community.

4. **Improvements in routine data collection to ensure inclusion and representation of LGBTIQ people within all family violence and sexual violence data collection systems.**

Many routine data collection systems and surveys within the family violence sector do not currently capture data on sexuality, sex characteristics or gender diversity in a sufficiently inclusive manner. Even when such data are collected, they are not always disaggregated or reported, limiting opportunities to better understand LGBTIQ community engagement and needs. We suggest:

   a. A review of all available routine data sources, including intake and referral documentation and reporting to funders, to identify opportunities to capture LGBTIQ-relevant information.
   b. The adoption of the 2021 Australian Bureau of Statistics (ABS) Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables for all routine data collection instruments.
   c. The inclusion of the aforementioned ABS standard in the Personal Safety Survey and Crime Victimisation Survey, and disaggregation and reporting of LGBTIQ experiences documented in these surveys.

7.2 Implications for service-level intervention

This study has identified areas of promising practice, where organisations are working with LGBTIQ communities in safe and affirming ways that respect their gender identity or sexuality. However, it has also identified a significant capacity shortfall in the specialist family violence and sexual violence sectors, evidenced by numerous experiences of discriminatory practice, felt or enacted stigma, insufficient understanding of LGBTIQ lives, or lost opportunities to identify and respond to FDSV and its consequences. Enabled by a reformulated policy and structural environment (see section 7.1), next steps should be taken to secure the following:

5. **A national plan, with resourcing, to support the delivery of LGBTIQ-inclusive family violence services** in all states and territories, including both LGBTIQ community-controlled services and other services that have been through recognised programs and processes to become LGBTIQ inclusive. This plan should seek to embed minimum standards of LGBTIQ-inclusive family violence service delivery nationally and share lessons and best practice to drive further change within the sector to improve inclusion. Such a plan will also serve to:
   a. Establish or strengthen formal referral pathways between LGBTIQ-expert/specialist services and other providers.
   b. Support the revision of practice frameworks to take account of gender diversity and specific needs of LGBTIQ people.
   c. Recognise and reflect diverse forms of violence that can impact LGBTIQ people.
   d. Recognise that some victim-survivors will require population-specific services to feel safe (i.e. trans-specific services or women's services).
   e. Recognise suicidality as significant impact of LGBTIQ FDSV, and better integrate mental health and FDSV prevention and response efforts.
   f. Recognise the ongoing importance of LGBTIQ community–led responses and community trust in the success of any interventions, and resource the participation of a diverse range of representatives from these communities in consultation and review processes.
6. **Scaling up of resources to enable LGBTIQ community-controlled organisations to advance their provision of FDSV services.** While the services are currently modest in scale and confined to only two states, considerable evidence points to the valued and central role that LGBTIQ community-controlled organisations play in this sector as expert sources of community knowledge and of innovative practice and policy leadership in the specialist family and sexual violence sectors more broadly. While, like any sector, LGBTIQ community-controlled organisations need to advance work with further marginalised populations (such as those with disability, those from multicultural backgrounds, Indigenous communities, trans and gender diverse people, and people with an intersex variation), our findings suggest those LGBTIQ community-controlled organisations providing FDSV services were trusted to understand and respond to their needs. Further resourcing is required to scale up their service offering, and to ensure integration into the broader FDSV referral network. Such funding needs to be specific to LGBTIQ communities and to be longer term, rather than short-term or one-off 'innovation'-style project funding, in order to embed practice knowledge, grow the workforce and ensure effective developments are made sustainable.
7. **Development of interventions that recognise and respond to FOV among LGBTIQ people.** Phase 1 interviews were not able to identify any interventions design to provide support for LGBTIQ people facing FOV. This is despite reported rates of 40.4% experiencing FOV at some point in their lives (1,26). Awareness of the extent and nature of this issue needs to be raised among the family violence sector workforce, and consideration must be given as to how services can be structured, funded and delivered to provide support.

7.3 Implications for community-level intervention

Chapter 3 of this report describes how many within the LGBTQ community, and those working in the family violence sector, can struggle to recognise when and how violence or abuse is being enacted by intimate partners or family members. Partly this may arise from a much greater public awareness of IPV as enacted by presumptively cisgender men against presumptively cisgender women. While understandable in the context of population size and extent of harm, the findings of this study make clear that the lack of broader awareness can limit individual ability to recognise or name experiences as violent or abusive. Not only does this complicate or delay support seeking by those experiencing violence, but it can also hamper the ability of family violence sector staff to recognise or respond to the needs of LGBTIQ communities. At the same time, stigma associated with being a victim of FDSV (often unconsciously underpinned by sexist stereotypes that see women, the normative idea of a victim-survivor, as weak), or a desire to reject being labelled as a victim-survivor, also complicates or delays help-seeking. With such issues in mind, there is a need for:

8. **Community awareness campaigns that raise awareness of FDSV among LGBTIQ communities and how it can present in ways that may be difficult to recognise.** Such campaigns need to highlight the prevalence and nature of such experiences among LGBTIQ people. Any campaign should include direction to LGBTIQ-affirming family violence support services for those in need, assuming such services have been adequately resourced (see recommendations above). It is critical to recognise that without service improvements to ensure that people have services to approach, such campaigns risk causing harm to LGBTIQ victim-survivors and must therefore be undertaken as joint rather than standalone efforts.
9. **Community-level interventions aimed at disrupting negative stereotypes about victims of FDSV and the 'kind of people' who need to seek help.** Such interventions, aimed at addressing stigma around help-seeking, should emphasise that people can be strong and resilient and also victim-survivors of FDSV. These interventions might include increased national and local profiling of LGBTIQ victim-survivor advocates who represent the diversity in these communities, including positive stories of recovery from violence. It is also critical that such campaigns are properly tested and evaluated to ensure they are effective.

7.4 Implications for future research

Opening Doors has contributed significant new knowledge on experiences of FDSV among LGBTIQ communities. However, no single project could ever hope to answer every question, nor could it do justice to all the groups that make up the rich and diverse LGBTIQ population. While both feature in the report to some extent, there is a particular need to further examine experiences of – and responses to – sexual violence and of abuse perpetrated by families of origin; the multifaceted and complex nature of this warrants focussed attention. The calls for future research that follow should be considered by all state, territory and federal governments and associated funding bodies. There is a particular need for:

10. **Research that explores the factors and forces that contribute to the perpetration of family violence.** In order to inform primary prevention efforts, it is essential to resource research that examines the perpetration of violence within intimate partner relationships, and from families of origin. Such research among LGBTIQ people is severely lacking globally, and especially in Australia, but is needed to better understand the drivers, cultural forces and social norms that may shape the experience of FDSV.
11. **Peer-led research considering the experience and presentation of FDSV among people with intersex variation.** This should include consideration of how and whether people with intersex variation view medical abuse (i.e. medical interventions as minors, including hormonal treatment and surgeries, to 'normalise' bodies, assigning a sex and instilling a sense of binary gender on intersex individuals) in the context of FOV.
12. **Focussed, peer-led research among Aboriginal and Torres Strait Islander LGBTQA+ people.** Attaining a holistic understanding of experiences of Aboriginal and Torres Strait Islander LGBTQA+ people requires specific, culturally situated research to explore their experiences relating to wellbeing, violence and abuse. This research should be led by Aboriginal and Torres Strait Islander researchers and organisations, and it should also include an examination of how all organisations, regardless of their LGBTIQ expertise, can better meet the needs of Aboriginal and Torres Strait Islander people experiencing FDSV.
13. **Research to better understand how perpetration of FDSV against LGBTIQ people can be informed by ablism.** This research should include the ways this intersects with homophobia/transphobia; gaslighting, emotional abuse and denial of agency; risk of physical violence, neglect, or the withholding or obstruction of medical treatment. People with disability must be meaningfully involved in the design and delivery of such research.
14. **Research among young people to explore how they experience and frame hostility from members of their family of origin.** Findings from Phase 2 suggest that it is more commonly in later life that LGBTIQ people come to frame their experiences in ways that denote FOV, while findings from Phases 1 and 3 of this study indicate that few, if any, services exist to support people experiencing abuse from families of origin. The forces that shape the experience, framing and response to such violence requires further examination.
15. **Further research about how sexual consent is understood and practised in different LGBTIQ communities.** This should include:
    a. How experiences of transphobia and homophobia might act as barriers to practising sexual agency.
    b. How conversations about sex positivity and consent are navigated by people from different LGBTIQ communities, with a view to sharing lessons with people who are recently out or exploring their sexuality.
16. Research with staff and clients in specialist women's family violence services. This should seek to understand how each group is engaging on issues of LGBTIQ inclusion and cultural safety in services.
17. Periodic monitoring. Ongoing funding is required to enable surveys that can track LGBTIQ experiences of FDSV over time, including the intersectional communities most impacted, service engagement experiences and associations with broader aspects of health and wellbeing.

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La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (Aquila audax) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where ARCSHS is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

Contact

ARCSHS
Australian Research Centre
in Sex, Health and Society
Building NR6
Bundoora VIC 3086
Australia

General enquiries
T +61 3 9479 8700
E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

facebook.com/latrobe.arcshs
twitter.com/LTU_Sex_Health