SUBMISSION TO THE VICTORIAN ROYAL COMMISSION INTO MENTAL HEALTH

5th July 2019

ABOUT WIRE

WIRE stands for Women's Information and Referral Exchange Inc. WIRE is a not-for-profit organisation that provides a state-wide, free generalist information, support and referral service to women, nonbinary and gender-diverse people. WIRE was founded in 1983 by a group of women seeking to empower themselves and other women through a feminist framework.

Our Vision

A just and inclusive society where all people can thrive.

Our Mission

At WIRE we work with women, non- binary and gender diverse people to

- Address the issues they identify
- Assist them to make informed choices in their lives
- Advocate for structural change to bring about gender equity and social justice

Our Services

Direct Services

In 2018, WIRE received 14, 000 occasions of contact from women through its direct services. Of these, 3,984 women (25 %) identified family and sexual violence and 14 % directly related to mental health, of which 74 were suicide interventions. The majority of service users experienced some form of mental health problems.

	Number of Contacts
• Telephone, real time online and email support	5251
• Face-to-face walk-in support without appointment	3014
• Referrals to other services	6151
• Walk in Center (access computers and free Wi-Fi)	
• AMICA Club: Homeless and isolated women's lunch and activity	155
	1368 meals

Education and Information

• Information and Education seminars	41
• Financial support clinics	21
• Legal clinics	63
• Employment programs	
• Computer classes	35

Information Dissemination

- Resource website available 24/7
- Information booklets developed and written in plain English for women on issues such as family violence and stalking available for free
- Fortnightly e-bulletin delivered to over 3,000 email addresses

Research & Advocacy

WIRE has a history of advocacy in gender equity and prevention of family violence and conducts research into and advocacy on issues as they are identified — such as financial capability and economic security, work-life balance and gendered violence

- Financial abuse in the context of family violence
- Women's financial well-being programs that improve the level of knowledge and financial self-management skills with a focus on those affected by family violence and capacity building within relationships

Professional Training & Development

- Support Line volunteer training
- Professional Development training for the community sector
    - Identifying Financial abuse
    - Building financial capability in the family violence context
    - Dealing with difficult calls
    - Intersectionality in Practice

WIRE's submission to the Royal Commission into Mental Health

WIRE's submission to the Royal Commission focuses on the far-reaching mental health consequences women, gender diverse and non-binary people through the direct, indirect and structural disadvantages they face due to their gender. These disadvantages are compounded by the intersecting impacts of Indigeneity, race, culture, class, sexuality, age, migrancy and geographic location.

WIRE is a generalist gender-specific servicer that responds to 'any woman, any issue'. This enables us to recognize and respond to the inter-related economic, social, cultural and issues at the root of women's mental health needs. This stands in contrast with many government and community service models that are gender-neutral and designed to address singular issues, whose eligibility criteria often fail to reflect the realities of women's lives as they are lived, denying women's access to assistance when, how and where they need it.

Women often seek assistance at times of gross disempowerment, and WIRE'S feminist framework recognizes that women have considerable knowledge about their specific situation and what they need. We aim to empower women to make autonomous informed choices, build on their existing strengths and provide relevant referrals based on the needs and goals they identify.

WIRE's unique model of service delivery offers a non-stigmatising entry point into the Victorian service delivery system for women and by women.

As WIRE has only included gender diverse and gender non binary people as part of our eligibility criteria for the last 18 months the bulk of our knowledge and expertise relate to people who identify as being a woman. As a result, this submission will relate to our current experience as we continue to build expertise in working with the gender diverse and gender non- binary Victorian community.

WIRE's submission is focused at the intersection of mental health, family violence and financial precarity.

It has been prepared from contributions by WIRE's CEO, service delivery staff, project workers and data from our research. WIRE aims to amplify the voices of women who seek our services. Their comments in the submission illustrate how mental illness plays out in lived experience. We can consider that each woman tells a partial story and together their stories describe a broken, fragmented mental health system that further breaks apart their lives, families, finances and futures.

WIRE's submission calls for a gendered and intersectional lens in future reforms to improve access to prevention, early-intervention and long-term treatment and management of mental health disorders.

WIRE encourages practice models and strategies that have been shown to work and can authentically help women.

WIRE's contributions aim to provide insights to the Royal Commission's frames of reference through three main themes that we believe will raise distinct and critical issues that address specific intersections between women, mental health and family violence.

Main Themes

1. Gender Matters in Mental Health, Race Matters in Mental Health

There is an urgent need for better recognition of how gender cuts across all socio-economic indicators of risk factors for women's mental health; intersecting race, sex and gender discrimination, violence and abuse, financial inequity, under-employment and homelessness are key issues for many women in Victoria. These factors are inter-dependent and shift across a woman's life course, but at specific points in their lives, they are exposed and made more vulnerable to all forms of physical and non-physical domestic and family violence.

2. The mental health impacts of Domestic and Family Violence

Family violence impacts the mental health of women (and their children) before, during and long after the violence ends. There needs to be access and provision to effective mental health services across all phases of their family violence journeys.

3. Money matters in mental health

It is well established that a lack of money is one of the strongest barriers to women leaving a violent relationship and that victim-survivors, who are mostly women, endure ongoing financial hardship through un- or under-employment, debts, poor credit histories, reliance on income support, and homelessness. Poverty is a key social determinant of mental health, and distinct impacts of financial abuse in family violence and its compounding psychological and emotional impacts need to be recognized and responded to.

Definitions used in this submission

Family Violence refers to violence between family members, typically where the perpetrator exercises power and control over another person. The most common and pervasive instances occur in intimate (current or former) partner relationships and are usually referred to as domestic violence. Its use in this submission is inclusive of same-sex partners, elders, and 'familial' or 'family-like" relationships such as related or unrelated carers of people living with disability.

It refers to physical, sexual, emotional, financial and psychological abuses, which frequently overlap. The central element of family violence is an ongoing pattern of perpetration using violent, coercive and/or threatening behaviour where the perpetrator interweaves multiple strategies of physical and sexual violence with non-physical violence (e.g. intimidation, sexual degradation, isolation) as part of a range of tactics to exercise power and control over the victim survivor. The overwhelming majority of acts of domestic violence and sexual assault are perpetrated by men against women, with around 95% of all victims of violence in Australia reporting a male perpetrator.[1]

Feminist frameworks centre women's lived experiences and critically addresses power differentials that create complex, intersecting] entrenched gendered barriers that persistently and disproportionately economically disadvantage women in comparison to men. These barriers are structural, social and cultural and perpetuated through patriarchal beliefs and systems (which force gender into the binary categories "man" and woman" only and consider men inherently dominant or superior to women). These beliefs can be acted on by either women or men to entrench gender roles that are unjust and harmful to society.

Women, Gender Diverse and Non-Binary people (WGDNB): WIRE services are inclusive of LGBTIQ, non-binary and gender-diverse people who share experiences of oppression due to their gender identification. This reflects WIRE's intersectional framework. Gender also impacts risk factors specific to men, however, this submission refers to women, gender diverse and non-binary people who WIRE serves.

Intersectional Frameworks emerged through lived experiences of black and women-of-colour to explain how power shapes identity, and provides nuanced, contextualised analyses of how multiple forms of power operate intersect to compound existing structural oppression and domination according to race, class, age, sexual orientation, gender identification, faith, ability, Indigeneity, migrancy and other differences from the dominant social group. This makes certain groups of women more vulnerable to their health outcomes, and family violence where they face present specific barriers to their exit and recovery. In Australia, Aboriginal, Torres Strait women use intersectionality to contest their systematic oppression through settler colonialism, race, class and gender. Their structural financial exclusion and lack of access to legal rights, employment and economic empowerment have resulted in higher rates of prevalence and morbidity of violence against them (Djirra 2017; Young 2016).[2]

[1] Diemer K (2015) ABS Personal Safety Survey: Additional analysis on relationship and sex of perpetrator. Documents and working papers. Research on violence against women and children, University of Melbourne.
[2] Djirra 2017; Young A (2016) Indigenous Financial Inclusion: Good for Everyone, Investment Magazine March 21.

THEME 1: Gender Matters in Mental Health

There is an urgent need for greater recognition that gender matters in women's mental health research and practice.[3]

> Research on gender and mental health suggests that conceptions of masculinity and femininity affect major risk factors for internalizing and externalizing problems, including the stressors men and women are exposed to, the coping strategies they use, the social relationships they engage in, and the personal resources and vulnerabilities they develop
>
> Rosenfield & Mouzon (2013)[4]

A recent series of articles on women's mental health in The Lancet Psychiatry (2016)[5] found a significant lack of gender focused research. In spite of substantial and stable evidence of sex and gender differences in mental disorders regarding prevalence, symptomatology, risk factors and course,[6] mental health research is still gender neutral, or overtly sex-biased or gender-biased.[7]

WIRE has consistently found across all its services and research, that women's lives cannot be understood outside of the direct, indirect and systemic impacts of gender inequity. These impacts are compounded by discrimination and exclusion through the intersecting impacts of Indigeneity, institutional sexism and racism, ability, culture, class, sexuality, gender identification, age, migration status, and geographical location.

Naming and Framing Mental Health

Community understandings of mental illness and mental health are impacted by how we name and talk about mental illness, but also through the lens through which it is framed and contextualized—both impact the understanding and meanings people make from the messages they receive.

Gendered social norms and values impact mental illness and how it is understood and responded to in the community sector, society at large and in clinical practice.

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[3] See Fischer J (2017) Women and Mental Health , InPsych 2017, Vol 39 Issue 1 Available: https://www.psychology.org.au/inpsych/2017/february/fisher.

[4] Rosenfield S & Mouzon D (2013) Gender and Mental Health. In: Aneshensel C.S., Phelan J.C., Bierman A. (eds) https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30348-0/fulltext Handbook of the Sociology of Mental Health. Handbooks of Sociology and Social Research. Springer, Dordrecht.

[5] The series 'Women's Mental Health' s available at Lancet Psychiatry 2016.

[6] Riecher-Rössler A (2016) Sex and gender differences in mental disorders, The Lancet Psychiatry, Vol. 4, No. 1

[7] Howard, LM, Ehrlich AM, Gamlen F & Oram S (2016) Gender-neutral mental health research is sex and gender biased, The Lancet Psychiatry, Vol. 4, No. 1

Failure to take a gendered approach makes the far-reaching mental health consequences for women and their lived experiences and invisible and un-addressed.

- Part of the problem is the dominance of the bio-medical psychiatric model, which names mental illness according to diagnostic categories (e.g. DSM-5) that attribute labels which stigmatize people and prevent them from seeking help. The dominant discourse frames the overall discourse on mental health in ways that limit or confuse the community's understanding of what mental illness is and disconnect it from how it is experienced.

For women, a long history of disparaging myths and stereotypes around 'women and madness' have emerged through psychiatry that have fetishized their sexuality, labelled them as deviant and difficult,[8] and continue to subject women to deeply entrenched sexist attitudes when experiencing mental illness and seeking help. Added to the anti-feminist sentiment and misogyny that abounds, making a gender focus an urgent imperative in mental health, particularly where it intersects with family violence and financial abuse (see p. 22 of this submission).

A gender lens is important for members of the LGBTI communities who, as a whole, are at increased risk of suicidality and self-harm, and experiencing and being diagnosed with depression and anxiety and other mental disorders. Disaggregated data collection is needed to capture differences in mental health between lesbian and bisexual women and gay and bisexual men, and between LGBT people and trans and gender diverse people and those with intersexed variations.[9] Furthermore, research methodologies need to go beyond statistics, to centralize gender and lived experience and employ intersectional analyses to address the compounding impacts when gender and sexual orientation categories intersect with other social stratifications like race, culture, geographic locations, and disability. Notably, it is experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI that directly impact mental health outcomes for this group, that require sociocultural approaches to dismantle negative and exclusionary social attitudes and perceptions.

- A major issue is that bio-medical psychiatric discourse fails to adequately address the pervasive socioeconomic and structural causes of poor mental health. This perpetuates the notion that mental illness takes place in a vacuum, that it is primarily biological, and intrinsic to the individual. This framing fosters attitudes that having a mental disorder is a sign of weakness, or failure, and induces shame and fear that adds to stigmatization by others and self-stigmatization. The individualization of mental illness can also perpetuate victim-blaming,

[8] Ussher, JM (2011) The Madness of Women Myth and Experience, London: Routledge
[9] National LGBTI Health Alliance. Available at: https://lgbtihealth.org.au/statistics/

particularly when services and programs are designed to change the behaviour of the person rather than work to improve their external circumstances.

- It is vital to centralize socioeconomic factors in women's mental health, where the links between lower socioeconomic status and negative mental health outcomes are well established in Australia and internationally.[10] Women disproportionately experience poverty and socio-economic disadvantage due to the combined impacts of sex and gender discrimination, violence, unpaid domestic, caring and emotional labour, interrupted and substantially lower labour force participation rates, engagement in part-time, lower paid, insecure work, lower average wages then men (the gender pay gap is around 15% in Australia)[11], less superannuation, and underrepresentation in government and management. These social and cultural determinants of mental health are inter-dependent and accumulate throughout women's life course and worsen in times of social and economic decline.

- The bio-medical frame also favours pharmacological interventions which detracts from the development and provision of wholistic, healing, and culturally relevant models of mental health treatment and supports which women ask for.

> I wish there was somewhere I could go… like a sanctuary, where you could go in, even stay for a week or something and support people would be there if you needed to speak to someone. And no one pushed you. That type of place where you could get a lot of answers. People heal in different ways, and different types of meditation are also really useful.
>
> Chrissy, research participant

[10] World Health Organisation (2005), Gender in Mental Health Research, Department of Gender, Women and Health Family and Community Health, Geneva: WHO

What WIRE Staff Say

In their comments for this submission, workers and team leaders who staff WIRE's telephone and walk-in services stressed the limitations of a gender-blind approach to mental health care.

Their comments below speak to the burgeoning stresses of isolation, exclusion and alienation faced by service-users with mental illness, which they believe cannot be solved through a bio-medical pharmacological approach alone.

> "Almost every single caller would show signs of direct or indirect mental un-wellness. In the two and a half years I have worked at WIRE, only two callers did not have mental health issues"
>
> "The causes of mental health problems we see are due to structural oppressions that are not recognized or understood in mainstream mental health practice, which frames mental illness as an individual's issues, residing in the person-rather than the system."

- The existing system is difficult to navigate and vastly inadequate for those requiring inpatient care, formal counselling, and face-to-face support.

> "You often get service-users calling on behalf of themselves or someone else to get support about safety for a mentally ill person who has been admitted to a facility and discharged too quickly, too early."
>
> "The clinic system, and the services and programs for mental health are not integrated and connected. This makes it hard for someone who has mental illness to know where to go to for support. People often approach mental illness from trauma and abuse as being transient with the focus on pushing people to move forwards rather than healing and acknowledging trauma/experiences of abuse become part of a person's existence."
>
> "Face-to-face support is so important. Women come in and say, "I feel like I'm going crazy." If family violence is recognized and named, once they can see the dynamics of power and control, they are no longer in that state. The healing can begin if family violence is acknowledged and named."

- Lack of gender informed mental health practice members creates a serious gap in service-users from the LGBT community and those experiencing co-occurring conditions or accessing multiple services.

> "A service user I spoke to had tried to discuss their distress from homophobic attitudes they were experiencing, and the mental health practitioner tried to 'talk them out' of being gay. They totally invalidated her experience, and placed all the requirement to change onto her, to adapt to a hostile environment- this is victim-blaming and disempowering."

> "If a woman is using alcohol or drugs to cope with violence, counsellors will focus on the drug/alcohol use rather than the violence, which only further stigmatizes her as well as shuts her up about talking about the violence. The drug use becomes the cause of depression of anxiety for victim-survivor. On the other hand, if the perpetrator is using alcohol/drugs, the counsellor is likely to also focus on the drugs/alcohol as a reason to use violence, rather than seeing it as a choice he has made. The drug use becomes the cause of depression of anxiety for victim-survivor. and they are perpetrating."

WIRE staff also had ideas about what would improve conditions for people experiencing mental health problems, particularly in terms of reducing social isolation and building support within their own communities.

> "People are very re-assured by the Mental Health Care Plan, but it was reduced to 12, then 10 and now its 6 sessions, and you have to go back to the GP to get more. This is hard for some women, especially if they are on Newstart are can't afford to go or are so stressed out. Increasing it to 18-20 and making it easier to access would help more."

> "There need to be places in the community where people can go, meet, be with each other. Mental illness is very isolating, that is a huge problem. Places where there is tea and coffee free, information, books to read. Many people who are marginalized find strength from social justice spaces, are also interested in changing and transforming the systems that harm them, that harm everybody… like the environment, racism. Meeting others is supportive and can be empowering. And builds communities locally, provides a local response and more understanding in that community. The 'Man Walk' for example, is great… men walk, talk and support each other. This flips the coin, the deficit model, the negativity you hear in the media and can build awareness, purposeful connections."

- WIRE's AMICA Club a lunch and activity program for women and non – binary and gender diverse people who are experiencing homelessness and isolation has a high percentage of service user that have or are experiencing mental health issues. "A safe place to talk and be accepted" is commonly cited by AMICA Club participates as one of the most useful and life affirming aspects of the program. The seemingly simple act of accepting someone for who they are has benefits for people's confidence and mental health that are profound.
- The AMICA program includes art- based activities, Yoga, and dance, which service-users find empowering and healing.

Race Matters in Mental Health

Racism damages mental health via multiple pathways, directly and indirectly. The unconscionable barriers to access healthcare resulting from intergenerational trauma, loss, dispossession and systemic racism are yet to be addressed. The Victorian Government Report 'Racism in Victoria and what it means for the health of Victorians' (DHHS 2017) found race to be a key social determinant that significantly damages both the mental and physical health of Aboriginal Victorians and people speaking non-European languages. The study found

- people experiencing frequent institutional and interpersonal racism were almost five times more likely to have poor mental health that those who do not, and that
- racism more strongly impacted mental health than other risk factors such as smoking, obesity and mental ill-health.
- Greater socioeconomic status correlated with reduced experiences of racism.[12]

A study of racism experienced by Aboriginal Victorians in health settings (Paradise et al. 2014) found racism to be associated with very high levels of psychological distress and that racism in health setting may have a more negative impact than racism in other settings.[13]

Dugeon and Pickett (2000)[14] report reluctance to engage with psychology as a profession that has 'historically reflected and influenced mainstream Western scientific values that have perpetuated and excused racism, enlisted it to justify practices of assimilation and oppression … [and has been] complicit in the colonising process … [that] has objectified, dehumanised and devalued those from culturally different groups'.[15]

- The impact of racism as a mental health indicator needs to be high on the agenda of mental health reforms. At present, it remains difficult to name racism and to talk about it, especially for women. It is still the case that Aboriginal women who speak out against persisting

[12] DHSS (2017) Racism in Victoria and what it means for the health of Victorians, State Government of Victoria, Melbourne. ∗The ethnic groups most likely to experience racism are Eastern and Southern European, New Zealander and South Pacific Islanders, Aboriginal and Torres Strait, Islanders, Middle Eastern, Asian, Sub-Saharan African and Latin American.
[13] Kelaher MA, Ferdinand AS & Paradies Y (2014), Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities, Med J Aust 2014; 201 (1): 44-47.
[14] Dudgeon P, & Pickett H. (2000) Psychology and reconciliation: Australian perspectives. Australian Psychologist. 2000; 35(2):82-87.
[15] See Walker, R (2014), Introduction to National Standards for the Mental Health Workforce Chapters 11-15.

colonial structures and racism are subject to disparaging stereotypes in the media and represented as "angry black women".[16]

- Counselling, psychology and therapy practitioners need to be able to understand and address the dynamics of racism and sexism for women of colour, who do not fit into the available categories of "CALD" or "ATSI" but who nevertheless deal with the everyday institutional racism/sexism of a dominant heterosexual male privileged white society and workplace.

> "It's impossible to find a counsellor or psychologist who is across race and gender…you spend all the time trying to justify and explain the impacts of racism on you, on your kids…you're constantly having to educate them… so you're getting no help for yourself. It's exhausting."
>
> WIRE staff, woman of colour.

- It is important for Aboriginal and women of colour to access, but also be able to provide psychological support that is race/gender informed. However, the fields of psychology and counselling are currently dominated by Anglo/Euro Australians and 'impenetrable' for other ethnic communities to enter (personal communication, Primary Health Prevention organisation).[17]

[16] 'The Audacity of Anger', by Chelsea Bond, Indigenous X, January 29th, 2018.

[17] Personal communication, Primary Health organization.

RECOMMENDATIONS FOR GENDER /RACE INFORMED MENTAL HEALTH SERVICES

An intersectional approach

- Address the direct, indirect and structural/systemic impacts of gender inequity on women, LGBT, intersex and gender-diverse people.

- Develop an intersectional gendered approach in reforms to shift the paradigm of research and therapeutic approaches in order to develop effective psychosocial solutions to mental illness and health.

- Place a higher priority on race in intersectional approaches and create robust and effective anti-racism strategies in mental health care.

Funding for Workforce Education and Training

- Urgently increase funding, education and training for community controlled and self-determining mental health workers from Aboriginal and Torres Straits Islander communities.

- Invest in training on intersectionality and anti-racism to developed and developed by Aboriginal women, women from diverse ethnic and racial backgrounds, and gender-diverse people.

- Invest in recruitment and training of mental health professionals from First Peoples and culturally diverse backgrounds. This needs to include psychiatrists, psychologists, therapists, counsellors as well as nurses and support workers, where these groups are currently concentrated.

- Train and engage bi-cultural/bi-lingual mental health workers practitioners from culturally and linguistically diverse backgrounds and newly arrived communities.

- Educate health care professionals in race and racism at tertiary education preferably taught by racially/culturally/gender diverse educators.

Research and Data Collection

- Data collection that is inclusive of gender identity (women or men, cis- or transgendered, intersex or other identity), sexuality (inclusive of lesbian, gay bi-sexual or queer), race, culture and disability (physical, sensory, cognitive and intellectual disabilities).

- Facilitate more “joined up thinking” around gender and socioeconomic risk factors through qualitative research and authentic user-led methods.

- Develop more clarity and consistency need to be made regarding terminology and how we talk about mental illness, mental health and wellbeing across sectors and disciplines.

Programs, Services and Practice models

- Fund women-specific services and gender-sensitive mental health programs, which currently are provided through not-for-profit organisations or voluntarily, and are severely under-funded.

- Engage mental health peer support workers who not only share the experience of mental illness but also share experiences of being racialized and experiencing sexism.

- Develop and provide affordable access to race/gender/culturally aware counselling, therapy and healing programs developed by women from diverse ethnic and racial backgrounds including victim-survivors.

- Develop and implement programs using a feminist and intersectional lens that enable service users experiencing multiple oppressions to have a central place within the group.

- Build and maintain mental wellbeing, through funding for projects that create safe places for women, gender diverse and gender non- binary people experiencing isolation to socialize and be affirmed and validated. These safe places must provide a space for participants to forms friendships and share experiences within a strength-based approach.

THEME 2: Mental health and family violence have a two-way causal association.

The deleterious impacts of domestic and family violence on women's health, particularly mental health is well established globally.[18] Mental health and family violence have a two-way causal relationship: poor mental health increases the chance of victimization through family violence, and family violence significantly impacts victim survivors' mental health and that of children in their care.[19] Women experiencing family violence conditions commonly experience depression, anxiety, eating disorders, suicidal ideation, post -traumatic stress disorders, bi-polar disorders,substance abuse and alcohol-use disorders.

Australian research by the ANROWS (2016)[20] and the Australian Institute of Health and Welfare (2016)[21] on the burden of disease for women victim-survivors of domestic and family violence has shown that intimate partner violence in both cohabiting and non-cohabiting relationships and emotional abuse affects one in three women since the age of 15.

- Intimate partner violence contributes an estimated 5.1 percent to the disease burden in Australian women aged 18-44 years and 2.2% of the burden in women of all ages over 18.
- For women aged 18- 44 years, violence contributes more to the burden than any other well-known risk factors like tobacco use, high cholesterol or use of illicit drugs.
- Mental health conditions account for the largest proportion of the disease burden for women: depressive disorders account for 36 % and anxiety disorders for 33 %. Together they account for around 70% of the burden.
- IPV is estimated to contribute five times more to the burden of disease among Indigenous than non-Indigenous women.

[18] World Health Organization (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization. Quadara A (2015) Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper Sydney: ANROWS
[19] Oram S, Khalifeh H, & Howard LM (2017) Violence against women and mental health, Lancet Psychiatry, 4: 159-70.
[20] Webster, K. (2016) A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women. ANROWS Compass, 07/2016, Sydney, NSW: ANROWS
[21] Australian Institute of Health and Welfare. (2016*)* Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3, Canberra: AIHW

- Women associate the onset of mental disorders to experiences of control, abuse and violence and ending abusive relationship correlated with improved mental health.[22]

Lived Experience needs to be central to understanding and responding the impacts of family violence and mental health

WIRE's research (and other qualitative studies that focus on women's lived experience) of family violence understands the perpetration of family violence as a systemic pattern of violent behaviours that takes place along a continuum and occurs over time (rather than a single moment or event, although it may be a single incident that catalyses victims to seek formal help). The quotes below (and throughout the rest of the submission) are what Victorian victim-survivors have told WIRE in a recent research project examining the financial impacts of family violence (Fernando 2018).[23] They illustrate how family violence impacted their mental health at different phases of their journeys during violent relationships, at crisis and separation, and into the long-term, sometimes decades after separation. *All names and identifying information have been changed.

During Violent Relationships

- Family violence incurs constant emotional labour work that taxes victim-survivors' mental capacity. Victim-survivors are constantly 'switched on' and over-focused on pressing needs for safety and survival. They are flooded with internalised shame and guilt, terror, and isolation, resulting in a multilayered and complex state of emotional, cognitive and psychological trauma.

  I was going to drive off a bridge. I genuinely thought that I was the one that was wrong, I was the one that was going completely crazy. [redacted], 30s

  I made a serious suicide attempt during the abusive relationship and ended up in a psychiatric facility for three months. Survey respondent

  I woke up and I wanted to kill myself…Then I said, Wow I need help. So, this is when I made a phone call. That was that moment.

  [redacted], 30s

  I didn't identify it as domestic violence until I was suicidal. I was so broken one night I was going to go and throw myself under the train. I rang Lifeline. I said, 'please come and take my children because I can't go on anymore because of the abuse'. I had no money, I had no one, he had

[22] Laing L, Toivonen C, Irwin J, & Napier, L (2010) "They never asked me anything about that": The stories of women who experience domestic violence and mental health concerns/illness. Faculty of Education and Social Work, University of Sydney.

[23] Fernando N (2018) When's the right time to talk about money? Financial Teachable Moments for women affected by Family Violence, Melbourne: WIRE

completely isolated me, and I was exhausted, and I had a small baby and my son. She said, 'this is domestic violence' and it was the first time somebody put a label on it. I said, 'but he doesn't hit me' and she said, 'no this IS domestic violence' and put me through to a domestic violence agency.

([redacted], 40s)

- Physical, sexual, emotional and financial abuse often occur together, but emotional abuse can be as harmful, if not more so, than physical and sexual violence with a higher likelihood of victim survivors developing poor mental health.[24] The quotes below illustrate the continuum of violence women experienced, it's overlapping forms and the insidious nature of financial abuse that makes it difficult to identify by victim survivors themselves, as well as professionals, friends and family.

I experienced verbal abuse, isolation, financial, emotional spiritual and physical abuse.

Survey Respondent

I could count on my hand how many times he was seriously violent with me but the interrogation — every single day. He'd track me on his mobile phone … Ask the kids 'Who was she talking to? Did she stop?' Every few months he'd drink, or something would go wrong, and it would become physical. He left me with a $20 000 debt. The kids and I left barefoot. I was bleeding. It was not pretty. [redacted], 40s

I didn't have a whole lot of physical violence … a lot of it was more emotional and psychological … I was ripped off by both my ex-husbands. I knew I was in 'family violence' but I didn't quite realise it was financial abuse till after. [redacted], 50s

When people hear 'family violence' they think it's mostly physical… people have no idea of the mental, emotional, financial abuse. The physical violence is just the tip of the iceberg. I would prefer to be hit than half of the emotional abuse. The hurting is so much easier. You can hear it, name it, see it, instead of thinking 'Did he really say that'?

[redacted], 30s

- For Aboriginal and Torres Straits Islander women, higher rates of prevalence and morbidity of violence are directly related to structural financial exclusion, lack of access to legal rights, employment, housing, health care, higher rates of child removal, and incarceration. Aboriginal and Torres Strait Islander women represent 2% of Australia's female population but make up 34% of all women in prison, due to disproportionate levels of trauma and

[24] Webster, 2016

intersecting forms of discrimination which cut across lines of race, gender and socioeconomic status.

> There is a direct connection between the fact that 80% of Indigenous women in prison are mothers and the rapidly increasing rates of the removal of Indigenous children from families into out-of-home care.
>
> June Oscar, Aboriginal and Torres Strait Islander social justice commissioner 2019.[25]

- Mental health services and GP's can fail to recognize the connections between family violence and mental illness, which can place women at risk of further violence and compromise their mental health. WIRE Research participants [redacted], among others, wished that the GPs, psychiatrists and psychologists they consulted during and also after the relationship were trained to identify family violence for women presenting with depression and anxiety.

Instead of giving me drugs, if somebody identified [family violence] I may well have been able to do something. It would have been a bit late, but it would have been earlier than what it was. That would have helped me. [redacted], 60s

I was put on bipolar medication for a couple of years. I ballooned out to here (gestures to indicate she put on weight) which didn't help. I didn't have mental health issues… I had a relationship issue. [redacted], 60s

I was seeing a psychologist and he had been tracking my mood and thinking I was bipolar. I was about to start medication and a week after [the perpetrator] finally left, I went to my psychologist and said, 'I'm not bipolar, I'm just in a really crappy relationship'. [redacted] 30s

I was presenting to my local GP clinic with my injuries [broken bones] and disclosed that my partner caused this. The doctors treated the injuries, but completely minimised and ignored the family violence. I disclosed to various doctors — all men. None of them acknowledged it, or gave me a referral to a family violence specialist service. Having a medical professional completely disregard key information made me feel like a crazy person. I didn't know that family violence services existed. Had I been given a contact number I would have used it. ([redacted] 30s)

[25] Allam L , 29 June 2019, 'Hear us, see us' , The Guardian. See also Poole M, 29th June 2019, 'In Victoria's Prisons, women pay for men's violence', The Age.

- Likewise, domestic violence services can find it difficult to respond to complex mental health needs. Coupled with poor lack of access to financial and material services and supports, women are placed at greater risk of homelessness and poverty, and the development of entrenched mental health problems.[26] Women experiencing mental illness and florid symptoms may not be able to access women's refuges.

- A particularly worrying trend identified by WIRE is the lack of knowledge about the power and control dynamics of family violence in couples counselling.

  "Couples counselling is useless when there is emotional and financial power and control, and the practitioner does not identify these dynamics but treats it as gender-neutral. What happens is that the man who is angry, explosive is seen as the "fragile" one and they receive the protection, and he is excused and validated all over again. Counsellors who do not see it cannot challenge masculine entitlement and privilege and power. Maybe the counsellor themselves is fearful of the threat of male violence. If the female client discloses anxiety, depression, stress, what happens then is that all the attention is placed on her to 'help her cope', to tolerate it, to change. She becomes identified as the key player, the symptom-holder. This is only maintaining and replicating the power over her and the male does not get held accountable for his emotions. The message given is victim-blaming… "it's because you did this" that he explodes. Couples counsellors must be able to identify power and control."

  WIRE staff member

[26] Humphreys C & Thiara R (2003) Mental health and domestic violence: "I call it symptoms of abuse". British Journal of Social Work, 33: 209–226. Laing L, Irwin J & Toivonen C (2010) Women's stories of collaboration between domestic violence and mental health services. Communities Children and Families Australia, 5: 16–28.

RECOMMENDATIONS FOR RECOGNIZING THE INTERSECTION OF FAMILY VIOLENCE AND MENTAL HEALTH

- Build awareness across both mental health and family violence sectors around the intersection of mental health and family violence.
- Raise awareness in the community and among community services professionals about the causal two-way links between family violence and poor mental health outcomes.
- Family violence workers to receive specific training on recognising mental health issues.
- Specific training for counsellors, psychologist and psychiatrists around understanding family violence, its dynamics of power and control and its impact short and long term on mental health of victim survivors.
- Provide training and tools so that GPs and Child/Maternal services are better able to recognise and identify the early the red flags of family violence and financial abuse and make appropriate referrals to specialist services.
- Increase the number of sessions that an individual can access with a government subsidy in Mental Health Care Plans.
- Place a greater focus on the maintenance and building of mental health in family violence safety planning and recovery.
- Provide cross-sectoral education and training where drug and alcohol use co-occur with family violence, to ensure attention is paid to the violence.
- Increase availability of effective service models (such as Mc Auley Services for women) that provide medium term accommodation, meals and intensive and individualised case management support.[27]

[27] See http://www.mcauleycsw.org.au/.

THEME 3: Money Matters in the intersection between family violence and Mental Health

It is well established that a lack of money is one of the strongest barriers to women leaving a violent relationship.[28] Women and their children forced to flee violent relationships often sacrifice resources and assets in exchange for their safety. Fear of retaliation deters women from pursuing their full entitlements and they suffer financially for longer than male ex-partners, ending up with significantly reduced assets and resources post-separation.[29] Victim-survivors endure ongoing financial hardship through un- or under-employment, debts, poor credit histories, reliance on income support, and homelessness.[30]

For First Peoples of Australia, family violence and financial insecurity are rooted in settler colonial structures of genocide and dispossession. Historically, state-led financial abuses have been perpetrated though indentured labour, racial discrimination and stolen wages.[31] These grave and incommensurate socio-economic disadvantages have led to incomparable levels of violence inflicted on many Aboriginal and Torres Strait women, by perpetrators from all cultures. These abuses continue to be perpetuated through 'fiscal violences' that systematically disenfranchises First Peoples, as well as others made poor and marginalised through the erosion of the welfare state and economic, budgetary, revenue and tax policies. For example, the ParentsNext program, which requires people on parenting payment to undertake compulsory activities to keep their income support, disproportionately impacts Aboriginal mothers, especially those experiencing family violence, who are more likely to be cut off payments.[32]

Financial Abuse

Financial abuse is defined as a perpetrator's 'controlling and humiliating behaviours that constrain a women's ability to 'acquire, use and maintain [financial] resources, thus threatening her economic

[28] Cortis N & Bullen J (2015) Building effective policies and services to promote women's economic security following domestic violence, Sydney: ANROWS

[29] Cameron P (2014) Relationship Problems and Money: Women talk about financial abuse, Melbourne: WIRE. Smallwood E (2015) Stepping Stones: Legal barriers to economic equality after family violence, Melbourne: Women's Legal Services,

[30] Corrie T & Mc Guire M (2014) Economic Abuse: Searching for Solutions, North Collingwood (AUST): Good Shepherd Youth and Family Service and Kildonan Uniting Care. Fehlberg B & Millward C (2014) Family violence and financial outcomes after parental separation, Families, policy and the law: Selected essays on contemporary issues for Australia, Melbourne: Australian Institute of Family Studies, pp. 235-244

[31] Kidd R (1997) The way we civilize: Aboriginal affairs - the untold story, St Lucia, Queensland: University of Queensland Press.

[32] See article by Luke Henriques-Gomes, Parent's Next, The Guardian July 3rd 2019. Note: The insensitive title of this article has not been reproduced here.

security and potential for self-sufficiency' (Adams et al. 2008).[33] In Australia, 15.7% of Australian women and 7.1% of men have experienced financial abuse[34] and a staggering 80-99 percent of women seeking family violence services have experienced financial abuse.[35]

Financial abuse overlaps with other forms of abuse, and is perpetrated through:

> Financial control: Controlling day-to-day household finances and material well-being, for example denying access to money, bank accounts, hiding household income, monitoring spending.
>
> Financial exploitation: Stealing, forcing the abused person to give money, building up debts in both names, spending rent or bill money, manipulating credit and debt to the abused partner's disadvantage, refusing to work or contribute to household expenses, damaging possessions
>
> Financial sabotage: not allowing the woman to work or undertake education, denying access to means of transport or communication.

WIRE's research into financial impacts of family violence (Fernando 2018) found women experience a debilitating mix of emotional, psychological and financial abuse together, which create a toxic 'currency' that attacks the psyche, drilling to the core of the victim-survivor's identity, sense of self-worth and very existence. Money, used to reinforce those effects through deprivation, power and control, becomes infused with affective and cognitive meanings that dehumanise, degrade, silence and alienate the victim survivor, even from her own thoughts and feelings.

- An emerging body of international research has found a unique and significant correlation between depression, anxiety and financial abuse and emotional abuse. In the USA, research found economic abuse had a unique and significant correlation with depressive symptoms (less than psychological, physical or sexual abuse), suggesting that recent experiences of economic abuse contributed to a significant increase in depressive symptoms (Stylianou et al. 2018).[36]

[33] Adams AE, Sullivan CM, Bybee D & Greeson MR (2008), 'Development of the Scale of Economic Abuse' Violence against Women, 14 (5): pp. 563-588
[34] Kutin J, Russell R & Reid, M (2017) Economic abuse between intimate partners in Australia: Prevalence, health status, disability and financial stress, Australian and New Zealand Journal of Public Health, (41): 269-274
[35] Adam's et al, 2008.
[36] Stylianou, AM (2018) Economic Abuse Experiences and Depressive Symptoms among Victims of Intimate Partner Violence, American Journal of Family Violence, 33 (6): 381-392

- The highest depression scores and prevalence of suicidal ideation were found by Gibbs et al. (2018) among women experiencing combinations of emotional IPV or economic IPV with physical and/or sexual IPV.[37]

The impacts of financial abuse are unique; the additional financial hardship and prolonged psychological and social impacts on victim-survivors long after separation are not created by other forms of abuse, which may go some way towards explaining the strong relationship between financial abuse and depression.

- Victim-survivors of family violence navigate multiple agencies post-crisis and are pulled in several directions by multiple agencies. They struggle to maintain a roof over their heads and put food on the table while also caring for traumatised children, managing physical injuries, PTSD, trauma, anxiety and depression. Due to time-poverty, lack of money and loss of social supports, many healthcare and material needs often go un-met at the very time the most need it.

Involvement with the Courts [38]

After separating from violent relationships, many family violence victim-survivors face multiple legal processes in multiple legal systems (e.g. Family Law, Criminal Law, Child Protection, Victim of Crime Assistance Tribunal). Victim-survivors find the abuse continues to be perpetrated through the very institutions they seek support from.

- Women report the perpetration of post-separation financial abuse through a suite of tactics (joint loans/debts, hiding assets in property settlement procedures, delaying property settlements, repeatedly breaching court orders, noncompliance with child support payments, frequent changes, disputing parenting arrangements). However, these are rarely recognized in the courts.

  I had a lot of great support from my psychologist, services, my friends…there is a good understanding of non-physical abuse — until you get to court. You get to court, and all those

[37] Gibbs A, Dunkle K & Jewkes R (2018) Emotional and economic intimate partner violence as key drivers of depression and suicidal ideation: A cross-sectional study among young women in informal settlements in South Africa, PLoS ONE 13(4)
[38] See Women's Legal Services Victoria WLS (2018) Small Claims Large Battles, Achieving economic equality in the family law system, Melbourne: WLSV.

> things are not acknowledged … there's a huge gap... Initially you feel It's going to be OK. I thought everybody understands what this [emotional abuse] is now. I remember thinking about a year ago that he would get a conviction for hiding money and papers. It's laughable, now looking back on it. [redacted], 40s

- Legal bench books in many countries refer to tactics used to gain advantage, harass, intimidate, discredit or control the other party through courts as 'malicious, frivolous, vexatious, querulous, or abuse of process'.[39] However, just outcomes are rarely achieved for women in legal process with many moving parts, where lawyers, expert witnesses, judges, mediators do not have a strong, or a shared, understanding of the socio-psychological dynamics of terror and coercive control present in family violence.

Systems or Institutional abuse

Institutional or systems abuse relate to interference with benefits, or via legitimacy given to post-separation perpetrator abuse through actions by police, banks, welfare agencies and so on.[40] Few of these services are able to respond adequately to women experiencing family violence and mental illness.

- For women who have children, ex-partners continue to perpetrate emotional and financial abuse using Centrelink, Child Support, Child Protection and legal systems repeatedly to maintain control over victim-survivors through the children. Many mothers experiencing family violence have to fight child protection as well as their perpetrators. Ironically, mothers are expected to 'actively protect their children from abuse,' and yet in divorce cases mothers who bring up problems related to men's violence are likely to be considered 'uncooperative' and fear losing care of children (Eriksson and Hester, in Kaye et al. 2003).[41]

[redacted] a research participant, feared reporting abuse as she found herself increasingly being alienated from her by the perpetrator when he was granted primary care.

> When the perpetrator's still got your kids, actually reporting them is a really big deal— the kid might be led to think you made his father lose his job or whatever. [redacted], 40s

[39] See James Ptacek, Judicial Power and Control Wheel, Australian National Domestic and Family Violence Benchbook.
[40] Sharp-Jeffs N (2015) A Review of Research and Policy on Financial Abuse within Intimate partner Relationships, London: London Metropolitan University.
[41] Kaye M, Stubbs J & Tolmie J (2003) Domestic Violence and Child Contact Arrangements. Australian Journal of Family Law, 17: 93-133

- Mental illness is frequently weaponised by perpetrators of family violence through systems abuse, which proliferates in a broken and fragmented social services system. Women often cannot risk disclosing mental illness. [redacted], a research participant, was forced to exit her violent relationship and leave her children behind as she was unable to receive family violence services if she remained in the relationship. The perpetrator used mental illness to gain custody of her children, only to have them removed again and placed in out-of-home-care placements.

> One time [after assaulting me] he put the phone on speaker rang the police. He had it on speaker so that they could hear me screaming in the background, and he's like, "She's turned up here, she's off her head, she's gone nuts, you need to come and get her. The kids are here, she needs to go to a mental home"….Another time he contacted child protection and played the whole martyr father you know, "[redacted]'s mentally unwell, she's unstable, she's homeless she's doing this she's doing that" — which I was at the time; I was all over the shop. I didn't have my kids, I had nowhere to live. Child protection actually wrote a letter to Centrelink and I lost all payments, so I was back at square one. …They put the kids in out-of-home-care placements. I've been fighting the system since last year to get my children back [two years later]. I do have them now, finally. But it took a lot of work
>
> [redacted], 30s

Women who participated in WIRE's research recounted multiple instances where confronted with sexist attitudes when accessing services, where they were constructed as being biologically 'more emotional' 'neurotic, 'worry too much', 'not good with numbers, or 'not able to handle money'. They report being 'fobbed off' at banks, facing disbelief that a woman can be the primary earner, told their situation was 'too complex', by financial services who repeatedly allowed ex-partners to make withdrawals from mortgage accounts without a second signature but refused to alter conditions when women requested such a change.

Sexist attitudes prevail not only in perpetrators, but in the courts, GP's, lawyers, psychologists, counsellors, homeless services, Centrelink, real estate agents, social media, the workplace, job agencies, among family and friends. Systems and services set up to protect women that are laden with male-privileged assumptions and priorities is experienced by women as 'just more abuse' that reproduced the male power, dominance, and control they hoped to escape. It felt exhausting, draining and interminable.

Poverty, Debts, Financial precarity

- Depression and trauma for the WIRE survey respondent below, negatively impacted her ability to make major money decisions and got her into debt after separating.

> When I sold my house to pay out my ex-partner, I bought another house in dire need of renovation as it was the lowest mortgage loan I could get. I was in such a depressive state that I spent the left-over money meant for the renovations in a stupid and careless way and could not make clear decisions to organise the renovations and bills that I found myself deep in debt.
>
> Survey Respondent.

- Legal debts are also common to victim-survivors who has experienced financial abuse.

> I am in significant financial debt due to my relationship and now court costs to separate. I'm not working currently, so money is tighter. Plus, having a child meant I couldn't work at times, plus I owe over $150 000 of Family law debt thanks to the abuser.
>
> Survey Respondent

Post-separation

Money and emotions are very closely connected; when women unpack the connections between love and money, an overarching landscape of grief and abjection became visible.

- Grief and loss are mental health conditions that are not always addressed in family violence services or mental health services. Victim-survivors of family violence as women endure losses of all forms of capital — social, cultural and economic.

[redacted] a middle-class professional described her formal separation from family violence as one of 'disbelief after disbelief' and "loss after loss". Her financial losses over the course of a five-year family law settlement were compounded by the loss of care of, and eventually, all contact with her son, which shattered her faith in the legal system. Her story challenges the common assumptions that women get care of their children and that parental alienation happens mostly to fathers. It also highlights the profound loss and grief mothers often have to experience, despite having prioritised their children's well-being, 'playing fair', losing her home, and draining her remaining funds on legal fees to fight for access to her son.

> Since [losing care of child] I haven't really wanted to live. At the time of choking I actually thought you may as well kill me because I know you're taking my kid and the heartache of living without my kid […] I do understand that people suicide … it's unbearable.

- [redacted]s story below illustrates how unhealed trauma can create risks in new relationships and re-victimization without the right kind of emotional support. It also illustrates the inter-generational mental illness that can follow from children exposed to family violence.

> In my first (abusive relationship), I went 50/50 for settlement for the children's sake, thinking they would have a good life with him and with me. That was my first mistake — he ended up with another person who then abused my daughter psychologically and emotionally. I didn't think that [settlement] through; I was in PTSD because of abuse from my next partner. I had money in the bank from the first settlement; I didn't buy a house but had no debts. But in 2011, when my daughter started getting unwell [serious mental health, complex PTSD] I felt 'I just don't care anymore.' I started racking up debts. With everything else that was going on, I wanted to have some sort of life for us all while going through this hell. [redacted]

In the Long Term

Overwhelmingly, the feelings of grief, loss and betrayal by the men in their lives — often the fathers of their children — continue to hurt women decades after the violence ends, but they also felt betrayed by systems they had believed would protect them and deliver justice. These women received neither compensation nor recognition.

> Twenty years later, I have had a lot of breakdowns and mental health issues as a result of these crimes and no compensation for myself or children. All these years later and I still worry about the injustice and how I should [have] done things differently.
>
> Survey Respondent

Housing

Nowhere are the compounded impacts of gender, poverty, family violence and mental health more starkly visible than in the desperate state of the Victorian housing crisis.

The annual Anglicare 'Rental Affordability Snapshot' (2016) surveyed 75,410 rental properties and found that just 21 were affordable for a single person on Newstart and just 121 for a single person on Newstart with one child.[42] Older single women are the fastest growing cohort of people experiencing homelessness in Australia. [43]

A WIRE team leader commented that:

> "Housing calls are a minefield…Every worker in the phone room would find housing calls the most stressful- even more so than suicide calls- as there are simply no options."

[42] See 'Housing Availability Snapshot', Anglicare 2016.
[43] See 'Improving the outcomes for older women at risk of homelessness', Social Ventures Australia, May 29, 2019.

WHAT IS WORKING WELL

- Mental health and suicide lines with workers trained to identify and name family violence at the first call.

  For me in some way that was one call when I was suicidal and asked for help, I got straight away directed to the right person, so I started doing counselling. That's when I shifted most of the things. Then I did another recovery course through [family help for drug addiction service]. [redacted]

- A feminist framework that uses empowerment methods and recognizes agency as well as victimhood.

  Looking at it through the feminist lens you can see it clearly, but you can't work out why everyone else can't see it. Other people are buying into the financial abuse that is happening to you. They don't want to acknowledge that you're being abused or disempowered. The communities and institutions like your schools, the bankers are also buying into it, not just your individuals.' [redacted]

- Grassroots, community and holistic approaches are effective, but currently severely under-resourced and unable to compete with mainstream organisations for funding.

RECOMMENDATIONS TO ADDRESS MONEY MATTERS IN MENTAL HEALTH/FAMILY VIOLENCE

- GPs and mental health professionals screen for family violence and identify red flags for financial abuse to those presenting with depression, anxiety and financial stress.

- Urgently increase funding for Aboriginal Community Controlled family violence and legal services to provide culturally appropriate solutions focused at the nexus of family violence, child removal, and incarceration.[44]

- Urgently address the need for affordable, secure housing and in particular, opportunities for women to move along the housing continuum, through acting on solutions that have been put forward.[45]

- Provide education to health professions on recognising and responding to family violence that includes awareness of financial abuse.

- Train legal and court professionals on the socio-psychological dynamics of terror and coercive control present in family violence, particularly regarding financial abuses perpetrated through systems abuses.

- Screening for people seeking assistance for mental health issues for financial wellbeing and when appropriate, direct them to services that provide support for financial hardship and programs to build financial knowledge and confidence.

- Train and support financial counsellors to identify and respond to mental health issues that may be impacting their clients' financial wellbeing.

- Fund grassroots, community-based and innovative solutions by making specific funds available that do not require competing with mainstream organisations.

[44] Effective solutions and programs include those researched and implemented by **First Nations Foundation (**My Moola Program, Money Tips, My Super Day Out), Djirra (Sisters Day Out).
[45] See for example, 'New model for financing affordable housing' Social Ventures Australia, April 2016.

WIRE would like to thank the victim-survivors who contributed their stories that are reported in this submission for their generosity and insights, and honour their courage, integrity, agency and commitment to improving circumstances for others.

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