Evaluation of Family and Relationship Services and Specialised Family Violence Services

25 September 2025

ALLEN + CLARKE CONSULTING

Thank you

Allen + Clarke has had the extraordinary privilege of learning about the impact of FaRS and SFVS through the support of service providers and service users. To mitigate risk and support trauma-informed engagement, the evaluation recruited service users only through their existing service providers. It is through the deep generosity of service providers who supported recruitment, over and above their existing workloads, as well as the many service users who spoke about their experiences accessing SFVS and FaRS funded services, that we have been able to draw the data for this report. We take this opportunity to thank them for giving us their time and their insights.

The photos used in the section breaks of this report were captured during site visits. Many of the photos highlight the care and attention that service providers gave to ensuring a safe, welcoming and warm environment for service users. Permission has been provided by relevant service providers for the use of these photos. The artists whose work appears in these images include: Executive Summary: Artist unknown; Context: Painted as part of an activity at a multicultural festival where people added their thumbprint as a show of unity and community; Efficiency section/Effectiveness: Marli Macumba, Pitjantjatjara, Yankunytjatjara, Arrernte, Gurindji and Warlpiri; Appropriateness: Marvyn McKenzie, Adnyamathanha Mathari Yura law man with ties to the Luritja, Ngarrindjeri, Irish and Scottish people.

Contents

Note on terminology

In this report, the term family violence is used as an inclusive term to encompass various forms of violence that occur within familial and domestic settings. This includes terms such as domestic violence, family and domestic violence, intimate partner violence and other similar variations found across the literature. The choice of family violence reflects a holistic approach to examining violence within family relationships, recognising the diversity of contexts in which such violence can occur. This term is intended to unify discussions across studies and maintain consistency while acknowledging that specific terminology may vary depending on the context and focus of individual research sources. In specific instances, other terms such as intimate partner violence are used to reflect their usage in the literature or because analysis is focused on a particular form of violence, such as child or adolescent violence against parents.

Some terms which recur throughout the document have been standardised for consistency and readability. For example, the term 'single parent' has been used throughout, including where a source uses the term 'sole parent' or 'one parent'. In all other cases, we have retained terminology used in each individual source.

Services are funded to provide a mixture of Family and Relationship Services (FaRS), Specialised Family Violence Services (SFVS), Men's Behaviour Change Programs (MBCP), and/or Child Specific Counselling (CSC) programs. Specific terminology is used to differentiate each:

- FaRS service provider – refers to findings on the delivery of FaRS specifically
- SFVS service provider – refers to findings on the delivery of SFVS specifically
- Dual FaRS SFVS service providers – refers to findings on the delivery of both FaRS and SFVS
- CSC service providers – refers to findings on the delivery of CSC specifically
- MBCP service providers – refers to findings on the delivery of MBCP specifically.

Note on quantitative data

All Data Exchange (DEX), Grant Payment System (GPS), and funding data used in this report are accurate as of July 2024.

Executive Summary

Executive Summary

Family and Relationship Services (FaRS) and Specialised Family Violence Service (SFVS) programs are funded by the Department of Social Services (the Department) under the Families and Children (FaC) activity. Collectively, these programs aim to strengthen family relationships, prevent family breakdown, increase participation in communities, and ensure that the wellbeing and safety of children is maintained (Australian Institute of Family Studies, 2024a).

Whilst understandings of contemporary Australian families have evolved since marriage counselling and family services were first funded several decades ago, the need for FaRS, and now SFVS, remains clear. Families are more diverse, and the social and economic context of family life has changed. Notably, the prevalence of family violence and the need for family violence services have significantly increased since the inception of the FaRS program.

In recent years, the Australian Government has made a significant investment in the FaRS and SFVS programs. As of July 2024, 81 organisations across Australia receive funding through FaRS programs. 38 organisations are funded to deliver SFVS programs. From 2021-22 to 2025-26, Australian Government funding for the FaRS program totalled $400,345,040.

This evaluation

Allen + Clarke Consulting was commissioned by the Department to conduct an independent evaluation of FaRS and SFVS programs. This evaluation has assessed the efficiency, effectiveness, and appropriateness of these programs to inform ongoing service delivery, design, and future policy. This evaluation adopted a staged, sequential, mixed-method approach between July 2024 and September 2025 and is framed around efficiency, effectiveness and appropriateness.[1] Data sources for this evaluation are summarised below, and a detailed overview of the methodology including the Key Evaluation Questions can be found at **Section 3.**

Figure 1: Data sources for the evaluation

[1] Note that modelling is being undertaken during the next phase of the evaluation to better understand demand for FaRS and SFVS services and service configuration.

This evaluation draws on robust data to inform findings and opportunities. Data limitations are outlined at **Section 3.8**. The evaluation team was guided by a set of standards, ethical considerations, trauma-informed approaches, culturally safe, and 'Do No Harm' principles. Ethics approval was received from three Human Research Ethics Committees (HRECs). More information is provided in **Section 3.2**.

Findings

Efficiency	
1	**FaRS and SFVS provide value for money** Benefit Cost Ratios for FaRS and SFVS are high. FaRS and SFVS convert funding into a high volume of services and positive outcomes. This output relative to investment is efficient. The result is a cost per service well below comparable intensive interventions.

Effectiveness	
2	**FaRS and SFVS are effective in improving outcomes in personal and family safety, mental health and wellbeing and relationships for many Australians** Overall, people who use FaRS and SFVS services experience improvements across the short and medium-term outcomes in the Program Logics. These outcomes include improved knowledge and skills relating to personal and family safety, respectful relationships and conflict resolution, resilience, wellbeing and mental health.
3	**The flexibility of the program guidelines is a key factor contributing to the effectiveness of FaRS and SFVS** The FaRS and SFVS Operational Guidelines grant service providers latitude to tailor service provision to the needs of their communities and individual service users. Service providers are using this flexibility to shape their service offerings and modes of delivery (including the use of virtual platforms) in ways that enhance outcomes. While this flexibility is a key strength of the programs, there is evidence that the program guidelines are sometimes applied inconsistently. Further research is needed to understand how this impacts equitable access to services.
4	**Changes in Australian society, service systems and the workforce are placing FaRS and SFVS under pressure** There is increasing complexity in service user presentations and needs. Service users are presenting with higher rates of family violence, mental ill health, neurodiversity and intersecting disadvantages. At the same time, service providers report challenges referring service users into a service system which is under strain. While a key enabler of the success of the FaRS

	and SFVS programs is the expertise and dedication of service providers, some feel inadequately trained or equipped to meet the increasingly complex needs of many service users. These trends are increasing the demand for services, requiring more intensive and integrated service responses, and impacting providers' capacity to respond to these demands.
5	**FaRS and SFVS are filling key gaps in the public health and social services system** FaRS is intended to be primarily a prevention and early intervention program. Increasing client complexity mean FaRS and SFVS services are often providing services across the intervention spectrum, including crisis response. Many service providers are delivering these services without adequate training and resources. There is evidence that a minority of FaRS service users are seeking support through the FaRS program because clinical mental health services are unavailable or inaccessible.

Appropriateness	
6	**FaRS and SFVS are largely meeting the needs of most priority cohorts, although there remains scope for improvement** There is evidence that FaRS and SFVS are successfully reaching Aboriginal and Torres Strait Islander people and communities and people who identify as culturally and linguistically diverse (CALD) and are achieving positive outcomes for these cohorts. Rates of participation in FaRS and SFVS by people with disability are lower than is expected based on population and family violence data. However, outcomes for people with disability are consistent with outcomes for the general population. Evidence on reach and outcomes for the LGBTQIA+ community is limited as Data Exchange (DEX) data does not fully capture LGBTQIA+ status.
7	**Aboriginal Community Controlled Organisations (ACCOs) are designing and implementing culturally appropriate, community-controlled services, but are reliant on other funding sources to meet client and community needs** Some ACCOs have successfully leveraged their existing relationships and trust with their communities to lay firm foundations for ACCO-led SFVS programs. SFVS program guidelines have enabled ACCOs to co-design flexible, trauma-informed and integrated approaches, which embed community ownership. Current SFVS funding arrangements are insufficient to support full implementation of these approaches which currently rely on other support to operate.

8	**Child-Specific Counselling (CSC) services are achieving positive outcomes for children** Services delivered to children are supporting positive outcomes for children and play an important role in ensuring children and young people feel seen, heard, and recognised. Data suggests that there is significant unmet need for support for children who have experienced or been exposed to family violence. The key challenge to scaling CSC is securing counsellors with specialist skills and experience to work with children.
9	**There is demand for more programs directed at changing the behaviour of men who use violence, and scope to clarify the roles such programs play in SFVS** Whilst it was not possible for this evaluation to assess the extent to which the Men's Behaviour Change Programs (MBCPs) have led to behaviour change for participants, interviews with a small number of MBCP participants demonstrated these individuals had very positive experiences with the programs. A range of stakeholders described a lack of services directed towards men who use or are at risk of using violence and identified this as a barrier to offering an integrated response to family violence and family violence risk.
10	**The current mix of face-to-face and virtual service delivery is effective and appropriate, but there is scope to increase virtual service delivery in the right circumstances** Nearly 20% of FaRS and SFVS services were delivered virtually from January to June 2024. Virtual service delivery has increased accessibility – particularly for people living in rural and remote areas, some people with disability, and people with caring responsibilities – and offers service providers greater flexibility and efficiency. While virtual FaRS and SFVS services achieve outcomes for service users broadly comparable to face-to-face services, many service users and providers prefer face-to-face delivery of counselling services. Considerations such as safety, building trust and rapport and privacy inform assessments of whether virtual delivery is appropriate. There is particular scope for expansion of virtual delivery of education programs (such as parenting programs) and hybrid delivery of counselling services.

Opportunities

The evaluation has identified 8 opportunities to build on the efficiency, effectiveness and appropriateness of service delivery for FaRS and SFVS services.

Opportunities	
1	Continue to fund FaRS and SFVS to support its focus on early intervention and prevention. Enhance funding to ensure that providers can successfully deliver work across the intervention spectrum by: • expanding the early intervention and prevention focus, whilst also increasing funding to support case management and brokerage • expanding capacity and capability to respond to family violence risk. This should include expanding SFVS as well as increasing specialised family violence capability in the FaRS workforce, with a focus on locations where access to other specialist family violence services is limited.
2	Identify levers to encourage better coordination in local service systems so that service provision is efficient, referrals are more seamless and effective, and people have access to the services they need. Consider: • promoting local level service system mapping by service providers • including outputs relating to partnerships and coordination for service providers in Activity Work Plans • establishing communities of practice to support collaboration, innovation, and continuous improvement across service providers.
3	Expand and enhance virtual service delivery to complement face-to-face service delivery, where appropriate and preferred through: • the design of a framework for best-practice, trauma-informed virtual service delivery which includes guidance for transitioning service users from face-to-face delivery to virtual delivery, where preferred and appropriate • transitioning a higher proportion of education programs (such as parenting programs) to virtual modes of delivery • digital upgrades and supporting increased digital literacy for providers where the potential for increasing access is greatest (for example in regional, rural and remote areas).
4	Invest in upskilling of the FaRS and SFVS workforce to meet key trends in community and service user needs. Areas of focus should include: • for the FaRS workforce, working with victim survivors of family violence • best practices in working with people with disability, neurodiverse people, and people experiencing complex mental health challenges • working directly with children.

5	Increase services for children and young people through the expansion of the CSC program and initiatives to upskill the FaRS and SFVS workforce (where needed) to work directly with children.
6	Consider how SFVS can contribute to meeting the demand for programs to support behaviour change in men who use violence as part of an integrated response to family violence and family violence risk. Any approach should take into account evidence on the effectiveness of MBCPs and other intervention models, as well as evidence on the systemic and structural factors influencing program effectiveness. Any approach should also consider delivery of community-led, place-based delivery of MBCP services by ACCOs.
7	Fund more ACCOs to provide SFVS services to Aboriginal and Torres Strait Islander communities. Funding settings should support ACCOs to co-design and deliver integrated, whole-of-community approaches. They should also support ACCOs to onboard and develop teams which are able to provide culturally appropriate services and address common barriers including transport.
8	Improve data collection, reporting and monitoring by: • ensuring appropriate data is collected in DEX to understand the reach and outcomes of the programs for all priority cohorts, including collecting enhanced data on LGBTQIA+ status and improving consistency of data on CALD status • working with service providers to refine reporting requirements so that they align with the complexity of service delivery; support cultural safety and capture all activities undertaken by service providers under the programs • exploring opportunities to use linked data to track service user progress and inform future monitoring and evaluation processes.

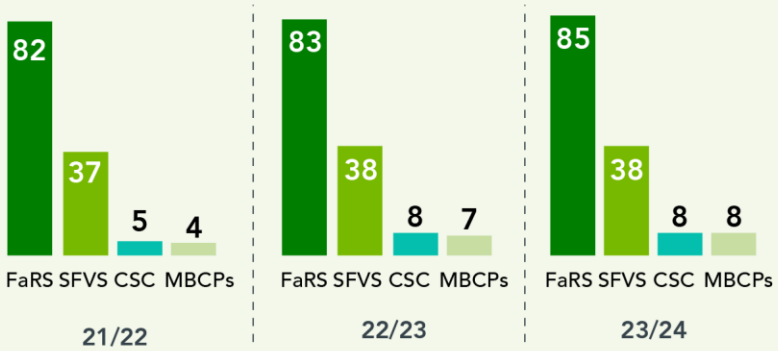
FaRS + SFVS evaluation snapshot

What are FaRS and SFVS?

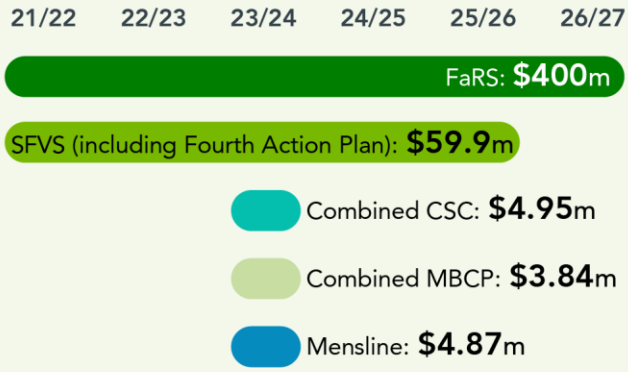
FaRS provides early intervention and prevention activities targeted at supporting families during significant life changes. SFVS was established in 2001 as a sub-activity of FaRS to offer tailored services to individuals and families experiencing, or at risk of, family and domestic violence.

How many organisations receive funding?

Many FaRS service providers also deliver SFVS services.



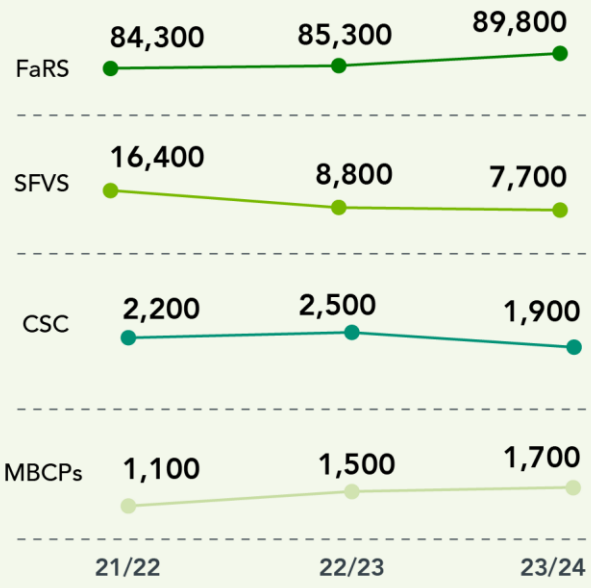
How much funding is provided to FaRS and SFVS?



Note: 'Combined' refers to SFVS funding that may partially support CSC or MBCPs rather than dedicated CSC or MBCP funding pools.

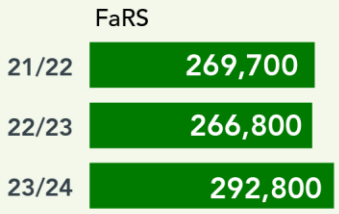
Who is accessing FaRS and SFVS?

Number of individual service users served *(adjusted to nearest 100 users).*

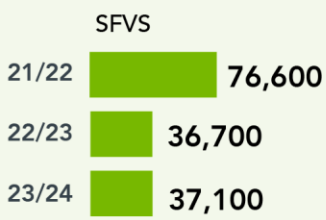


What services did service users receive?

Number of sessions delivered *(adjusted to nearest 100 users).*

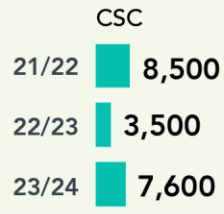


Counselling made up the majority of sessions annually.

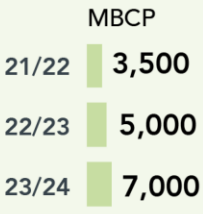


On average, SFVS service users received multiple sessions across counselling, advocacy, child therapy, and education.

Number of sessions received fell from 21/22 to 23/24, likely because the program shifted from shorter interventions or group sessions to more intensive case work.



The total sessions delivered for CSC were substantial given the intensive work.



These include all types of sessions recorded by those activities.

How are services being accessed?

Between July 2021 – June 2024

47.4% face-to-face

20.7% virtually

Source: GPS-DEX Extract

What was the demographic profile of service users?

Source: Unit Record DEX data

FaRS
46% female

9.7%
5.4%
36.7%

Proportions stayed steady from 2021–22 to 2023–24, showing FaRS reached a broad cross-section of the community.

SFVS
71.6% female

11.4%
12.5%
22.8%

Key:
- reported a disability
- from CALD backgrounds
- identify as Aboriginal and Torres Strait Islander people

Why are people accessing services?

Source: Evaluation Survey Data.

79.9% (n=127)
Relationship issues
(most commonly selected)

39% (n=62)
Mental health
(second most commonly selected)

Do people pay fees?

Source: Evaluation Survey Data

FaRS
80.7% (n=134)
paid for service

82.8% (n=111)
agreed or **strongly agreed**

5.2% (n=6)
disagreed or **strongly disagreed**

How much did users pay?

$31-60:
35.7%
(n=50)

$61-90:
34.3%
(n=48)

Are the services achieving outcomes for users?

Source: DEX-SCORE, July 2021 – June 2024. All changes are statistically significant (p<.001).

FaRS

54.9% (n=36,522)
improved their family functioning

55.5% (n=33,940)
improved their mental health, wellbeing and self-care

42.6% (n=17,913)
improved their personal and family safety

SFVS

54.9% (n=2,911)
improved their family functioning

56.0% (n=3,092)
improved their mental health, wellbeing and self-care

57.0% (n=3,585)
improved their personal and family safety

Are people satisfied with the services?

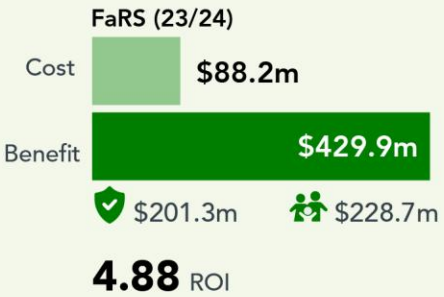
Source: DEX-SCORE, July 2021 – June 2024. Mean latest score for Satisfaction Domain: I am satisfied with the services I have received.

On average service users scored their satisfaction with the services they received:

FaRS
4.7/5 (n=16,679)

SFVS
4.7/5 (n=1,837)

Are the services offering value for money?



4.88 ROI

5.54 ROI

Key:
- Personal and family safety
- Family functioning

Note: Cost only includes funding contributions by the Department

Background

1. Background

Family and Relationship Services (FaRS) and Specialised Family Violence Service (SFVS) programs are funded by the Department of Social Services (the Department) under the Families and Children (FaC) activity. Collectively, these programs aim to strengthen family relationships, prevent family breakdown, increase participation in communities and ensure that the wellbeing and safety of children is maintained (Australian Institute of Family Studies, 2024a).

The genesis of the FaRS program can be found in marriage counselling, which the Australian Government started funding in 1959. Over decades, FaRS has expanded and evolved in response to a growing recognition of the complexity and nuance of family and relationship service needs and best practice service delivery. Services delivered under FaRS were initially funded under the Family Relationship Services Program (FRSP) through a dual arrangement between the Attorney General's Department and the Department of Social Services (the Department). The FRSP program and the FaRS and SFVS programs became more distinct following a gradual change in funding arrangements, wherein the Attorney General's Department funded the FRSP, and the Department funded the FaRS and SVFS programs.

As a result of shared history, there are consistent elements between the FRSP and FaRS and SFVS (Australian Institute of Family Studies, 2024b), including similarities in the providers funded to provide services under the programs, the population served, and the services delivered under the programs. There are multiple providers delivering both FRSP and FaRS and SVFS services. Relationships Australia is a principal provider under all programs (Australian Institute of Family Studies, 2024b) and the FRSP, and FaRS and SFVS are also delivered by a range of Christian faith-based organisations, Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCO) and other community based non-government organisations (NGO).

FaRS and SFVS focus on families and couples experiencing risk or harms associated with social issues, including separating families. FRSP focuses on supporting families to resolve interpersonal disputes on parenting and property, with a greater focus on dispute resolution, family law and legal frameworks (Colmar Brunton Social Research, 2004). Both FaRS and SFVS and FRSP provide intake screening and assessment, referral to other services, counselling services and education. Where relevant, service users of FaRS and SFVS are referred to services delivered under FRSP and vice versa. However, the programs are now distinct. Both FaRS and SFVS and FRSP provide intake screening and assessment, referral to other services, counselling services and education.

1.1. Overview of the FaRS Program and its objectives

The focus of FaRS is on providing early intervention and prevention activities targeted at supporting families during significant life changes such as formation, extension, or separation, with an emphasis on at-risk families and those facing disadvantage or experiencing vulnerability (Department of Social Services, 2021a). The long-term aims of FaRS are for families and children to experience:

- improved family safety and security,
- family functioning including modelling healthy respectful relationships and positive parenting practices, and
- improved wellbeing and resilience during family transitions.

Services provided through FaRS include information and referrals, support, education and skills training, counselling, outreach and community capability building and development. FaRS also funds MensLine Australia Services – a national telephone and online support, information and referral service for men with emotional health and relationship concerns.

FaRS-funded service providers have significant latitude in what services they spend their funding on, with Activity Work Plans (AWP) and associated key performance indicators agreed with the Department as part of five-year funding cycles. Operational Guidelines published by the Department assist FaRS providers to work in a nationally consistent way (Department of Social Services, 2021a).

FaRS is a universal service for at-risk families, including families at risk of breakdown, families with children at risk of abuse or neglect, and families experiencing disadvantage or vulnerability. Priority cohorts for FaRS services are:

- couples forming long-term relationships,
- families at risk of breakdown or experiencing relationship issues,
- families with children at risk of experiencing abuse of neglect,
- families experiencing disadvantage or vulnerability, and
- individuals, couples, children, and families who are experiencing or at risk of family violence.

The Department's Operational Guidelines and Grant Agreements do not impose any limit on the number of sessions an individual service user may access under FaRS. Service providers are responsible for ensuring service provision is effective, efficient, and appropriately targeted to meet responsibilities and accountabilities under state, territory, and Commonwealth legislation and regulations. FaRS service providers have flexibility in how they provide their services, including managing the number of sessions per service user. Service providers set targets for service user numbers and demographics in agreement with the Department as part of the development of AWPs. Adjustments to session duration and amounts are determined internally to meet agreed goals and outcomes with an expectation to monitor and adjust services to meet the changing demands (Department of Social Services, 2021a).

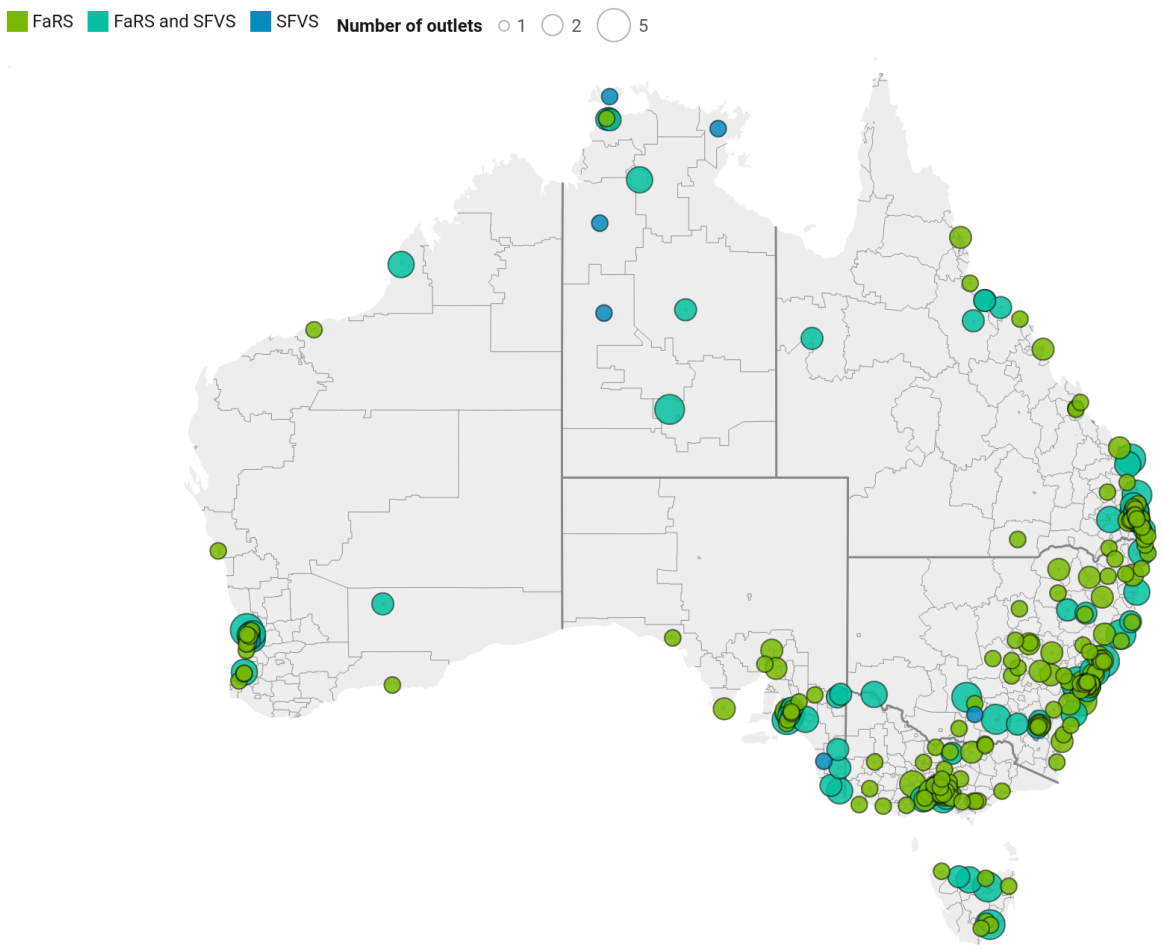
FaRS performance measures, as outlined in draft grant agreement material, include:

- number of service users assisted
- number of events / service instances delivered
- percentage of participants from priority target groups
- percentage of service users achieving individual goals related to independence, participation, and well-being
- percentage of service users achieving improved independence, participation, and well-being, and
- AWP activities completed according to scope, quality, timeframes, and budget.

As of July 2024, 81 organisations across Australia receive funding under FaRS. In 2022-23, over 83,000 individual service users received a FaRS-funded service.

Figure 2 below shows the distribution of FaRS and SFVS service provider outlets across Australia.

Figure 2: FaRS and SFVS outlets, by SA2



Source: FaRS and SFVS service provider SA2 location. Data supplied by the Department

FaRS service providers may charge fees for services on a sliding scale depending on service user income. However, service users must not be refused services or referred to other organisations if they cannot pay a fee. Application of the sliding scale is left at the discretion of service providers. FaRS services can be delivered face-to-face or via telephone or other modes of virtual delivery.

1.2. Overview of the SFVS Program and its objectives

SFVS was established in 2001 as a sub-activity of FaRS to be a universal service for families, communities, and individuals experiencing or at-risk of experiencing the impacts of family violence. SFVS uses a whole-of-family approach to strengthen family and community functioning and improve personal and family safety by providing support to individuals, couples, children, and families who are experiencing, or at-risk of experiencing, family violence (Department of Social Services, 2021b). SFVS aims to provide support to families to improve the wellbeing of children and young people to enhance family and community functioning and increase participation in the community. SFVS contributes to the strategic vision of the *National Plan to Reduce Violence against Women and their Children 2022-2032* and its action plans.

The Department publishes specific Operational Guidelines for the SFVS program (Department of Social Services, 2021b). SFVS service offerings include individual or couple broad-based counselling and dispute resolution services, tailored in-home supports and family capacity building and education sessions and workshops. SFVS funding also includes specific funding for:

- support for children who experience or witness family or domestic violence to support them as victim survivors in their own right through Child Specific Counselling (CSC)
- Men's Behaviour Change Programs (MBCP) that support users of violence to address and change their behaviour
- delivery of culturally safe services in the Northern Territory (NT) by Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCOs).

SFVS programs can be delivered face-to-face, via telephone, or through other modes of virtual delivery.

Priority cohorts for SFVS are:

- people who identify as Aboriginal and Torres Strait Islander
- people from culturally and linguistically diverse backgrounds
- people with disability
- children and young people
- people who identify as lesbian, gay, bisexual, trans/transgender, intersex, queer, asexual and other sexuality (LGBTIQA+), and
- people who use violence.

SFVS aims to ensure that in the long-term victim-survivors experience improved personal and family safety, wellbeing, mental health, and self-care. It aims to ensure children are safe, supported and have improved wellbeing. The aim of MBCPs funded under SFVS is that people who use violence stop using violent and abusive behaviours.

SFVS performance measures, as outlined in draft grant agreement material, include:

- number of service users assisted
- number of events / service instances delivered
- percentage of participants from priority target groups
- percentage of service users achieving individual goals related to independence, participation, and well-being
- percentage of service users achieving improved independence, participation, and well-being, and
- AWP activities completed according to scope, quality, timeframes, and budget.

Like FaRS, the Department does not impose limits on the number of sessions a service user can access under SFVS, however service providers can put in place policies and make decisions about the number of sessions provided to service users as part of ensuring efficient service delivery and meeting demand.

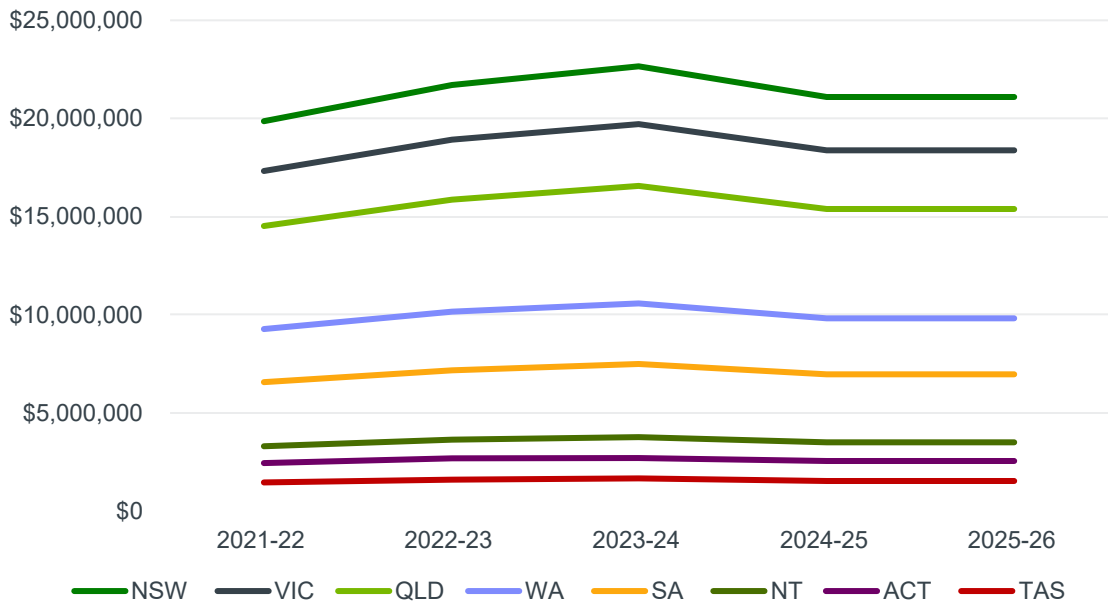
Like FaRS, services funded under the original SFVS can charge fees using an income-based sliding scale. Services are not allowed to refuse access or refer to other services based on incapacity to pay fees (Department of Social Services, 2021b). Services funded under the expansion of SFVS as part of the *Fourth Action Plan – National Plan to Reduce Violence Against Women* (4AP2) (Department of Social Services, 2019) cannot charge fees for service delivery.

1.3. Implementation of FaRS and SFVS funding

FaRS

In recent years, the Australian Government has made a significant investment in the FaRS and SFVS programs. From 2021-22 to 2025-26, Australian Government funding for the FaRS program totalled $400,345,040. Funding has remained stable for each state and territory since 2021-2022 (see **Figure 3** below).

Figure 3: FaRS expenditure from 2021-22 to 2025-26



Source: FaRS Program dashboard supplied by the Department

In 2022-23, over 85,000 individual service users received a FaRS-funded service. Service providers delivering these services included NGOs across all states and territories.

In 2023/24, service providers delivered 293,000 FaRS sessions. The service activities in FaRS covered a range of session types. Counselling sessions (one-on-one or couple/family counselling) made up the largest share each year. Other prevalent session types included intake/assessment sessions (initial consultations), information/advice/referral sessions, and advocacy/support sessions for service users navigating services. People seek help from FaRS-funded services for a diversity of issues, including for example grief and loss of loved ones; mental health issues; family and domestic violence; safety planning; communication difficulties; strengthening family relationships (including after separation) and emotional dysregulation. Service providers delivered a wide range of therapeutic responses, for example: cognitive behavioural therapy, internal family systems therapy, trauma informed counselling, and Gottman method relationship and family therapy.

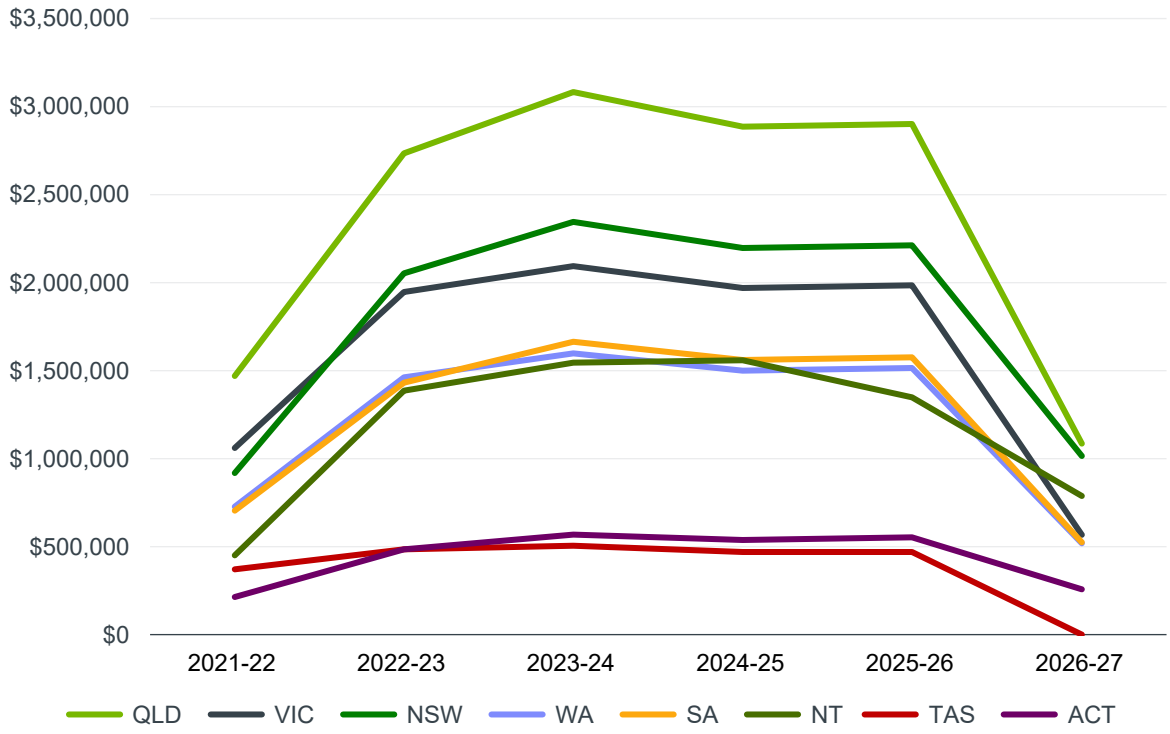
Education and skills training sessions and group programs were provided in smaller proportions. Most of these programs were parenting courses which covered topics such as understanding the emotional needs and responses of children, and strategies for co-parenting

during and after separation. Many of the courses were described as evidence-based and catered to the specific needs of children at different stages of their development. The Circle of Security Parenting course was referenced frequently as a FaRS funded service by a range of providers and users. Other notable courses delivered by service providers included Tuning in To Kids, Parenting After Separation, Keeping Kids in Mind, and the Nurtured Heart Approach. Some service providers reported that they provided specific parenting courses that focused on fathers. Other group programs delivered under FaRS include art therapy groups, and anger management courses and groups for adolescents and young adults which are delivered both in schools and at service provider locations.

SFVS

SFVS is funded as a sub-activity of FaRS with additional funding provided under 4AP2 (Department of Social Services, 2019). From 2021-2022 to 2026-27 SFVS received $45,854,483 of FaRS funding. From 2022-23 to 2026-27 SFVS received $14,852,076 under 4AP2. SFVS funding increased from 2021-22 to 2023-24. SFVS funding grants end on 30 June 2026 resulting in the steep decline shown below (see **Figure 4** below).

Figure 4: SFVS expenditure from 2021-22 to 2025-26[2]



Source: SFVS program dashboard supplied by the Department

Services funded under SFVS include (but are not limited to) MBCP and other supports for people who use violence; individual, group, couples, and families counselling for service users; child specific counselling and education initiatives (including some targeted at school-aged

[2] This figure includes SFVS-FaRS funding from 2021-2022 to 2026-27 and 4AP2 funding from 2022-2023 to 2026-27.

children). Thirty-eight organisations delivered SFVS services in 2023-24. Most SFVS service providers also offer FaRS. By 2022–23, SFVS providers were present in every state/territory, although services have been targeted towards areas of identified need. Eight organisations are specifically funded to deliver CSC services (all member organisations of Relationship Australia) and 10 are funded to deliver MBCPs.

In 2023/24, service providers delivered over 37,000 SFVS sessions. SFVS sessions were a mix of counselling (including trauma-informed therapy for women and children), advocacy/support sessions (help with safety planning, referrals to refuges, etc.), child-focused counselling or play therapy, and community education. Overall, counselling and advocacy/support were the dominant session types, while education and group activities formed a smaller portion. Intake/assessment was also important at the start of service.

MBCPs are a key component of SFVS offerings for people that use violence. MBCPs are typically run in a group format, with cohorts of 10–15 men meeting for a series of sessions. It is estimated that 6,930 MBCP sessions were run in 2023-24. These sessions include counselling, intake, information/advice/referral, education and skills. Some programs consisted of a module approach, in which each module focused on a specific theme. Some groups ran on a rolling basis. Service providers delivering MBCPs had parallel engagement with victim survivors to promote safety and accountability where appropriate.

CSC services provide children with access to counselling support under SFVS and are delivered solely by Relationships Australia (RA). In 2023-24, 1,861 service users received counselling through CSC. CSC programs were primarily one-on-one services with children, and sometimes their caregivers, and were aimed at those experiencing or at risk of experiencing family violence. They generally did not involve group sessions. The intention of CSC is to deliver age-appropriate counselling and psychoeducation for children, across a range of modalities.

Overlap between FaRS and SFVS

Service providers implement FaRS and SFVS in a variety of ways. The flexibility of the FaRS and SFVS programs' funding model allows for adaptive, placed-based delivery of a range of services. This gives service providers scope to design and deliver services which cater to the identified needs of their serviced communities, with providers encouraged through their funding agreements to use up to 10% of grant funding for the development of innovative concepts. Providers are also expected to monitor changes in their communities and adjust the services they deliver within the grant to meet the changing needs of families and children (see **Section 3.2** for more detail).

1.4. Alignment with relevant Government Frameworks

The FaRS and SFVS programs seek to align with a range of relevant Government frameworks. Both FaRS and SFVS play a significant role in supporting victim survivors of violence in line with the ***National Plan to End Violence Against Women and Children 2022-2032*** (Department of Social Services, 2022) which aims to eliminate gender-based violence and support services that deliver safe, accessible, and culturally responsive support. The plan promotes collaborative efforts across government and NGO sectors to ensure holistic service provision that addresses the unique needs of various populations, including Aboriginal and Torres Strait Islander people, CALD communities, and LGBTQIA+ individuals.

Both FaRS and SFVS seek to support children in line with the ***National Framework for Protecting Australia's Children 2021-2031*** (Department of Social Services, 2021c). This Framework aims to improve the safety and wellbeing of children and young people, especially those at risk of abuse and neglect, and of particular relevance, promotes child-centred and family-centred approaches aimed at prevention and early intervention. It emphasises the importance of Aboriginal and Torres Strait Islander self-determination and culturally appropriate supports, as well as addressing the unique needs of a range of children and young people, including those with a disability and those experiencing family violence.

FaRS and SFVS service providers are expected to set targets relating to reaching people with disability. ***Australia's Disability Strategy 2021-2031*** (Department of Social Services, 2021d) underscores the commitment to inclusive and accessible services for individuals with disability, ensuring that they receive equitable support within family violence and relationship services. The strategy aligns with human rights principles, advocating for greater accessibility and autonomy for individuals with disability within all social services.

As outlined in this report, people with mental ill-health are significant users of FaRS and SFVS funded services. The ***National Mental Health and Suicide Prevention Plan*** (Department of Health, Disability, and Ageing, 2021) reinforces the integration of mental health support within family violence and relationship services, recognising the intersection between mental health challenges (including suicidality), and experiences of violence and abuse. This plan calls for trauma-informed, person-centred approaches that strengthen self-management and resilience among service users.

Finally, SFVS funding has been specifically allocated to ACCOs in alignment with the ***National Agreement on Closing the Gap***. This Agreement is a formal agreement between Australia's federal, state, and territory governments and Aboriginal and Torres Strait Islander representatives to address long-standing inequalities experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians. The Agreement includes four Priority Reforms that focus on changing how governments work with Aboriginal and Torres Strait Islander people based around formal partnerships and decision making, building the community-controlled sector, transforming government organisations, and shared access to data and information at a regional level.

Scope

2. Scope

Allen + Clarke has been commissioned by the Department to conduct an independent evaluation of FaRS and SFVS programs. The scope of the evaluation encompasses assessing the efficiency, effectiveness, and appropriateness of these programs to inform ongoing service delivery, design, and future policy. The evaluation seeks to address seven key evaluation questions (KEQs, found at **Table 1** below) and to understand progress against the FaRS and SFVS Program Logics (see **Appendix B**).

This Evaluation Report addresses the seven primary KEQs. Sub-KEQs were developed to guide the design and approach to the evaluation. KEQ 5 relates to the level of need for FaRS and SFVS and how the need is distributed. While some preliminary analysis of KEQ 5 is included in this report, the evaluation question will be addressed in detail in a Modelling Report to be finalised by December 2025.

Table 1: Key Evaluation Questions

Effectiveness	
KEQ 1	**To what extent were the FaRS and SFVS programs successful at meeting short and medium-term outcomes in the Program Logic?**
1.1	As a result of FaRS, to what extent do families have increased knowledge, awareness and skills, or use effective strategies in identifying issues of personal and family safety; seeking help when needed, or knowing who they can confide in or turn to for support; improving or maintaining personal and family safety; modelling healthy, respectful relationships, including effective communication and conflict resolution; and improving their resilience, mental health and wellbeing when experiencing family breakdown or dysfunction.
1.2	As a result of FARS, to what extent do children have increased knowledge, skills, and access to support, or use effective strategies in improving their resilience, wellbeing and mental health when experiencing family breakdown or dysfunction.
1.3	As a result of SFVS, to what extent do victim survivors have improved knowledge and skills, or use effective strategies in identifying issues of personal and family safety, including violent or abusive relationships; seeking help when needed for issues of personal and family safety, or knowing who they can confide in or turn to for support; improving personal and family safety; and improving mental health and wellbeing.
1.4	As a result of SFVS, to what extent do children impacted by FDSV have improved knowledge, skills and access to support to feel safe, heard and supported; access supports where needed, or know who they can confide in or turn to for support when they don't feel safe (for example: professionals, families and friends); and improve their mental health and wellbeing.
1.5	As a result of SFVS, to what extent do people who use violence have increased knowledge and skills in techniques and strategies to reduce violent and abusive behaviours (short term); use effective strategies to reduce their violent and abusive behaviours (medium-term); and have increased knowledge and skills or use effective strategies in seeking help and accessing supports to reduce violent and abusive behaviours.
KEQ 2	**What factors affected the achievement of short and medium-term outcomes in the Program Logic for both FaRS and SFVS?**
2.1	What conditions produce the best outcomes? What were the main factors contributing to or associated with the achievement of outcomes?
2.2	What are the outcomes by service modality/type? Do outcomes differ by only Counselling, only Education or both Counselling and Education? To what extent is referral, case management or advocacy associated with achievement of outcomes?
2.3	Are there any other factors noted by service providers or service users that had an impact on outcomes (positive or negative, intended or unintended)?
2.4	What, if any, lessons can be drawn from the program to improve the effectiveness of future programs?

Appropriateness	
KEQ 3	**To what extent are FaRS and SFVS appropriate and aligned with the needs of service users and priority populations (including people experiencing trauma, family violence and sexual violence, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, people with disability and those identifying as LGBTIQA+) and with the service preferences of contemporary families?**
3.1	Who is it working for? Explore outcomes by FaRS and SFVS for people experiencing or at risk of FDSV, including adult and child victim survivors, their families and people who use violence; Aboriginal and Torres Strait Islander people, including adults and children/young people; CALD adults and children; adults and children identifying as LGBTQIA+' people with disability; and families with children at risk/experiencing child neglect or abuse.
3.2	The appropriateness of the design of both FaRS and SFVS for addressing the needs and service preferences of cohorts.
3.3	What is the appropriateness of the design of both FaRS and SFVS (including Child Specific Counselling and Men's Behaviour Change Programs) for addressing the needs and service preferences of contemporary families and children?
3.4	What is the way in which current programs meet community need and to what extent have FaRS and SFVS providers adapted their services to meet the needs of their communities?
3.5	What is the scope for components of the programs to be delivered virtually? What can be delivered virtually compared to face-to-face, and has the virtual component of service delivery been adequately explored by FaRS and SFVS providers?
KEQ 4	**To what extent do FaRS and SFVS complement or overlap with each other?**
4.1	To what extent are there significant programmatic differences between FaRS and SFVS? What are the similarities and differences?
KEQ 5	**What is the level of need for FaRS and SFVS and how is this need distributed?**
KEQ 6	**What are the barriers to implementing FaRS and SFVS?**
6.1	Factors hindering the delivery of FaRS and SFVS.
6.2	Factors enabling the delivery of FaRS and SFVS.
Efficiency	
KEQ 7	**Do FaRS and SFVS offer value for money?**
7.1	What are the program inputs (i.e. investment) and outcomes expressed in monetary terms? Can this be broken down by service type?
7.2	How does value for money for FaRS and SFVS compare to similar programs (based on existing reviews)?

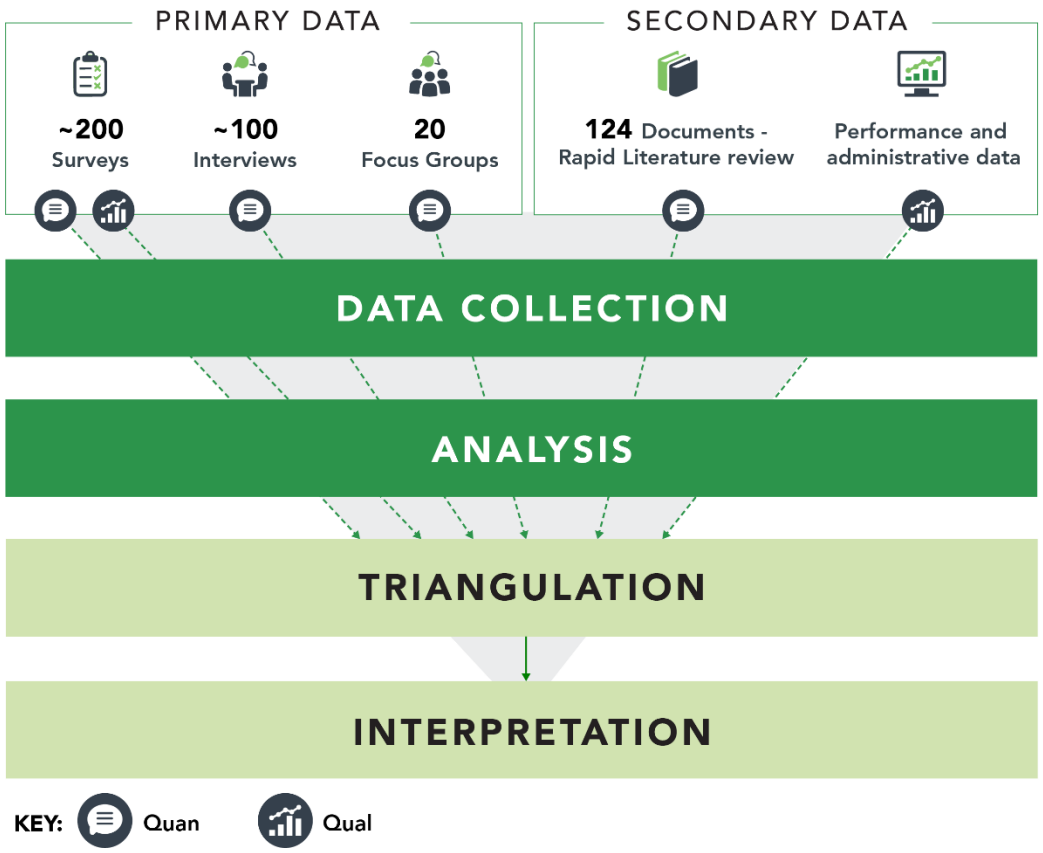
Methodology

3. Methodology

3.1. Overview of method

This evaluation adopted a mixed method, staged, sequential approach. The approach to data analysis and synthesis integrated quantitative data on service user outcomes and program expenditure for FaRS and SFVS, drawing from sources such as the Data Exchange (DEX) and Grants Payment System (GPS). Qualitative insights were gathered through a literature review, surveys, interviews, and focus groups with a range of stakeholders. Findings were then sense-checked through a series of sense-making workshops with the Department and other relevant stakeholders. **Figure 5** below summarises the approach taken by this evaluation to evidence-building.

Figure 5: Approach to evidence building



3.2. Ethical approach

The evaluation team was guided by a set of standards, ethical considerations, trauma-informed approaches, culturally safe and 'Do No Harm' principles. Data collection tools were carefully reviewed to ensure they were socially, emotionally and culturally safe. The overall approach followed best practice ethical processes and included several mitigations designed to minimise harm for all participants.

Due to the sensitive nature of this evaluation, including engagement with victim survivors, the evaluation team sought review and approval from three Human Research Ethics Committees (HRECs) before any service user recruitment or data collection took place. Approval was received as follows:

- final approval received from Bellberry Limited for the non-Aboriginal and Torres Strait Islander component of the evaluation on 18 March 2025
- final approval received from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) for the overall Aboriginal and Torres Strait Islander component of the evaluation on 20 March 2025, and
- final approval received from the Menzies School of Health and Research for the NT-specific Aboriginal and Torres Strait Islander component of the evaluation on 2 April 2025.

The evaluation team employed several measures to ensure ethical engagement with service providers and service users:

- A separation principle was applied to prevent potential re-identification of service users. Separate teams analysed the raw qualitative and quantitative datasets respectively. Neither team had access to the other's unit-level data. The data was aggregated and anonymised before being shared for mixed-method analysis.
- the reporting does not include any data which could be used to identify an individual service user. This is to protect their privacy and confidentiality.
- Participant Information and Consent Forms (PICFs) outlined limits to confidentiality so participants understood the actions that might be taken where a risk of serious harm to the participant or someone around them was identified.[3]
- A safety protocol was developed to protect participants' anonymity and manage risk of distress. PICFs included information on where participants could access appropriate confidential support.
- Service users were recruited through service providers to maximise safety, risk assessment and management, and minimise distress for service users.

3.3. Approach to Aboriginal and Torres Strait Islander engagement

The evaluation team's approach to Aboriginal and Torres Strait Islander engagement was designed to ensure that the values and cultural safety of Aboriginal and Torres Strait Islander people and communities were core to the analysis and identified opportunities. The work undertaken with Aboriginal and Torres Strait Islander participants follows the six core values in the **NHMRC guidelines for ethical conduct in research with Aboriginal and Torres Strait Islander people and communities**, as well as the best practice ethical principles for

[3] Service user participants under the age of 18 were provided with a Participant Information and Assent Form to sign prior to their interview. Consent was also sought from their parent/guardian with a specialised parents PICF provided prior to the interview.

engagement with Aboriginal and Torres Strait Islander peoples as per the **AIATSIS Code of Ethics** and **Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities: Guidelines for researchers and stakeholders 2018**. The evaluation team embedded the six values into engagement processes as follows:

- **Spirit and integrity:** The evaluation was conducted honestly, fairly, transparently and with respect for all participants and adhered to ethical frameworks and guidelines. All participants were fully informed of the purpose of the research and active and ongoing consent was sought.
- **Cultural continuity:** The evaluation was guided by principles of self-determination and the expertise of Aboriginal and Torres Strait Islander peoples. These included yarning circles and face-to-face yarning with Aboriginal and Torres Strait Islander victim survivors and ACCOs to ensure findings and identified opportunities for the evaluation reflected the knowledge and expertise held by Aboriginal and Torres Strait Islander peoples and their right to determine what is best for themselves, their families, and communities.
- **Equity:** The evaluation prioritised and valued the knowledge and contributions of Aboriginal and Torres Strait Islander peoples and ensured there were flexible, fair, and accessible opportunities for knowledge held by Aboriginal and Torres Strait Islander peoples to inform the evaluation. The project team ensured Aboriginal and Torres Strait Islander peoples were involved throughout the process and that outcomes of the evaluation were shared back with participants. This included holding a dedicated sensemaking session with ACCO service providers.
- **Reciprocity:** The evaluation ensured that all Aboriginal and Torres Strait Islander participants had the opportunity to define the key issues, such as cultural safety, and shape their participation in the evaluation in a way that benefited them and met their needs. The semi-structured interview approach ensured that Aboriginal and Torres Strait Islander people had the opportunity to share their experience of crisis response services and define key issues in their own words. A summary of key themes emerging from engagement with Aboriginal and Torres Strait Islander people and organisations was shared with people and communities who participated in the evaluation.
- **Respect:** Participation in the evaluation was voluntary, and the evaluation ensured that all participants provided fully informed consent and had their rights, values, beliefs, safety, and attitudes respected at all times. The evaluation team included a mix of genders to ensure face-to-face yarning with Aboriginal and Torres Strait Islander participants was conducted in a culturally respectful way.
- **Responsibility:** The evaluation team took responsibility for all outcomes and impacts of participation by Aboriginal and Torres Strait Islander peoples and adopted safety measures that ensured Aboriginal and Torres Strait Islander people and communities incurred no harm associated with participation. Prior to undertaking consultation with ACCO service provider staff and service users, the evaluation team, led by the Aboriginal and Torres Strait Islander Engagement Lead, met with the 5 in-scope ACCOs to discuss the evaluation and arrange site visit details. This included identifying necessary adjustments to ensure engagements were appropriate for their context and needs, including extended site visits, adjustments to survey delivery methods, and identification

of stakeholders to meet. These planning meetings allowed the evaluation team and ACCOs to foster a mutually beneficial working relationship.

The engagement phase with Aboriginal and Torres Strait Islander communities and peak bodies was led by the evaluation's Aboriginal and Torres Strait Islander Lead, and the Aboriginal and Torres Strait Islander Engagement Facilitator, alongside a non-Aboriginal team member.

The evaluation team acknowledges the importance of recognising the contribution of all stakeholders and ensuring the benefits of the evaluation outcomes are equitable, and valuable to Aboriginal participants and communities, including respecting data sovereignty principles. In line with this, a deidentified short report summarising the main ideas identified through consultations with Aboriginal and Torres Strait Islander people and organisations was shared with participating ACCOs and service users. A sensemaking session was also held to test the key findings that emerged from engagement with the 5 in-scope ACCOs.

3.4. Literature Review

The evaluation team undertook a Literature Review to frame and inform data collection, analysis, and findings. The review was guided by a series of research questions informed by an initial high-level review of relevant documents, the Program Logics, and consultation with the Department.

The evaluation team conducted a structured search of published grey and academic literature to build an understanding of best practice in family and relationship services and family violence services. A review was also conducted of existing program evaluations and national strategies including documents related to FaRS and SFVS provided by the Department. The team developed and applied inclusion and exclusion criteria to identify relevant and credible sources. Initially, 182 documents were identified and, in collaboration with the Department, 124 documents were agreed as being in scope.

3.5. Stakeholder engagement

The evaluation team engaged with people who have delivered and used FaRS and SFVS services. Insights from these engagements were used to validate and triangulate findings from the Literature Review and the analysis of secondary quantitative data, in order to provide rich insights into the KEQs.

Focus groups were held with service providers to build an understanding of their experiences delivering FaRS and SFVS programs, including:

- adaptions made to support program delivery
- enablers and barriers of service delivery
- collaboration and integration with other service providers, and
- whether programs are appropriately funded.

Surveys and interviews with service users were used to build an understanding of participants' experiences accessing FaRS and SFVS[4] programs including:

- the impact accessing services had on them and their family
- whether the service they accessed was suited or adapted to their needs
- how programs could be improved to better support outcomes for people accessing the service, and
- whether programs offer value for money.

3.5.1 Sampling approach

The evaluation team applied sampling criteria to build a sample of service providers and a purposive sample of service users from across Australia. Sampling criteria sought to include stakeholders from:

- a cross-section of states and territories
- Socio-Economic Index for Areas (SEIFA) rankings
- a selection of rural, regional and metropolitan sites
- a selection of specialist sites (including for example faith-based and culturally and linguistically diverse sites)
- a selection of sites that vary in service user volume as recorded in DEX data, and
- sites that provide a cross-section of services (including for example: advocacy/support, information/advice/referral, counselling, education and skills, training).

The sampling approach necessitated engagement with service users from several priority cohorts identified in the FaRS and SFVS guidance material (Department of Social Services, 2021a, 2021b). This was done to determine whether services were appropriately adapted to diverse needs, and what changes were advised to improve accessibility. Priority cohorts for this evaluation were:

- Aboriginal and Torres Strait Islander people,
- people with disability,
- people from CALD backgrounds, and
- people who identify as LGBTIQA+.

A detailed explanation of the sampling approach, including inclusion criteria for service users, can be found in **Appendix C**.

[4] This includes people who accessed MBCPs and CSC.

3.5.2 Recruitment approach

The evaluation team recruited both service provider staff and service users to the evaluation through service providers. All FaRS and SFVS service providers were invited to express interest in participating in a focus group and to support service user recruitment. This approach was chosen to maximise safety, risk assessment and management, and minimise participant distress. Further tailored approaches were used to support recruitment of people who use violence accessing MBCPs and young service users (under the age of 18) accessing CSCs, given the increased risks associated with engagement with these cohorts. This approach is commonly used in recruiting service users in the family violence sector.

The approach to recruitment emphasised participant autonomy and safety. The evaluation team provided tailored materials to service providers to support service user recruitment including adapted recruitment guides and recruitment email templates. Recruitment was guided by sampling criteria outlined in **Section 3.5.1** and further detailed **Appendix C**.

Focus groups with service providers were all held online, except for focus groups with most ACCO service providers which were held face-to-face. Service users were given the option of a virtual (phone or MS teams) or face-to-face interview (contingent on the evaluation team conducting a site visit at their service). All service users were remunerated for their participation with gift vouchers.

A detailed explanation of the recruitment approach, including specific approaches for CSC and MBCP service users, can be found in **Appendix D**.

3.5.3 Site visits

The evaluation team visited 9 sites to undertake service user interviews. Visits were made to service locations across a mix of urban, rural, and remote locations in the Australian Capital Territory (ACT), New South Wales (NSW), Northern Territory (NT), Queensland (QLD), South Australia (SA), and Victoria (VIC). The evaluation team visited 3 of the 4 ACCOs funded under SFVS. A focus group was held virtually with the FaRS funded ACCO and one ACCO was not visited because they had not yet commenced service delivery.

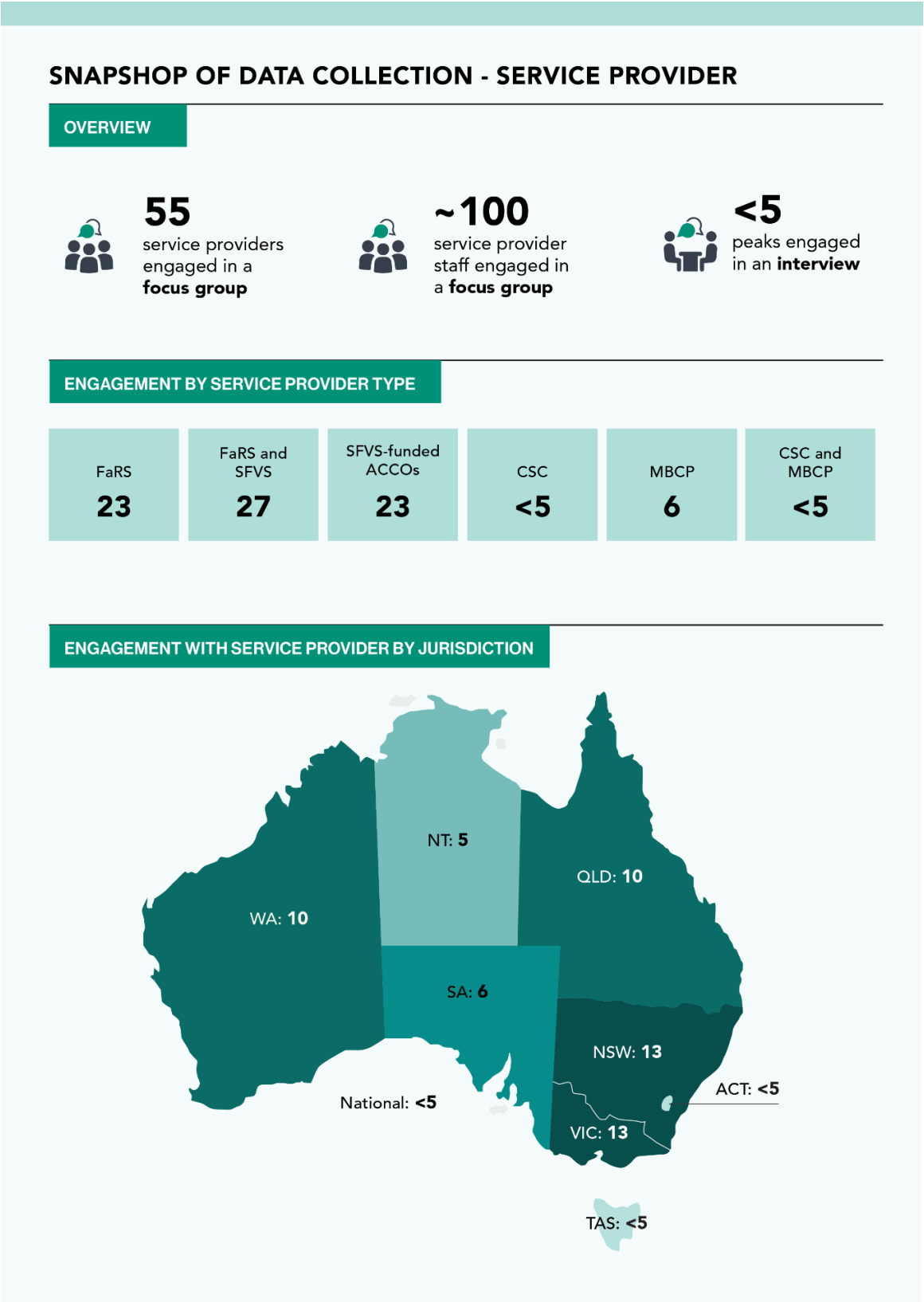
Site visits provided an opportunity to meet with service users in person, increasing the accessibility of the evaluation for those who did not want to undertake interviews virtually or over the phone. Site visits were also used successfully as a means of increasing service user recruitment in sites where the uptake was low.

3.5.4 Service provider focus groups

The evaluation team held 20 focus groups with 103 staff from across 55 service providers and peak bodies (not including participants who attended multiple workshops). This represents a strong response rate with 64.3% of service providers having at least one staff member participate in a focus group. Service providers represented each state and territory and reflected a mixture of SEIFA rankings, regions, locations, service sizes, and service user demographic bases.

Figure 6 below provides an overview of where service providers are located and what services they are funded to deliver.

Figure 6: Service provider demographics – focus group participants



Source: Service user focus group/interview and survey data

All focus groups were held online, except for 3 SFVS ACCO focus groups which were held in-person during site visits. Three additional informal interviews were held with ACCO service provider staff to gain greater insight into their experiences delivering SFVS in remote communities. Two additional yarning circles were held with men's and women's advisory groups at ACCOs to gain greater insight into community needs.

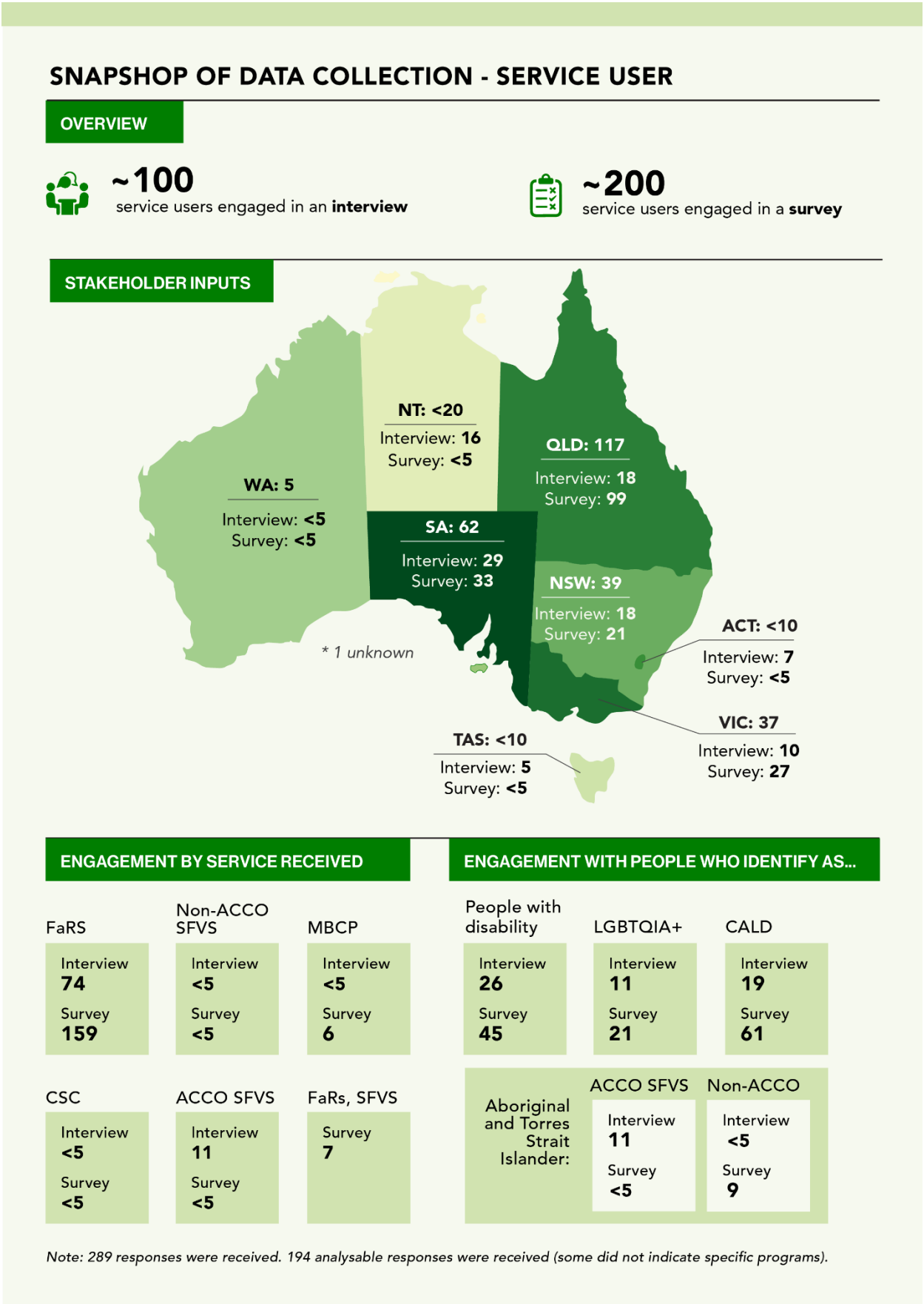
3.5.5 Service user interviews and surveys

Ninety-five interviews were held with FaRS and SFVS service users. Service users were drawn from a cross-section of service providers from each state and territory, which reflected a mixture of SEIFA rankings, regions, locations, and demographics. The majority of service users who participated in an interview engaged in individual counselling. A smaller proportion had participated in a parenting program or other group work activity, either on its own or in combination with counselling.

Interviews were largely conducted online using MS Teams or over the phone. Some interviews were conducted in person when members of the evaluation team were visiting a service location (and where the service user was comfortable meeting in person). All interviews with MBCP and CSC participants were held in person. In-person interviews were held in a private room on the premises of the service provider.

Service users also had the option to contribute to the evaluation through an online survey. Surveys were completed by 194 service users. Most survey respondents had accessed a FaRS service (n=159). In addition, more than half of these responses came from Queensland service providers (n=94) with service users from one provider making up the majority of responses from this cohort (n=72). This limits the generalisability of survey findings. **Appendix E** provides a detailed breakdown of the service user demographic participant sample **Figure 7** below provides an overview of service user interview and survey participant demographics by services received and priority cohort.

Figure 7: Service user interview participant demographics



Source: Service user interview and survey data

3.6. Qualitative data analysis

The evaluation team developed a coding framework, aligned with the evaluation objectives and KEQs, to structure the analysis of qualitative data. Using this framework, the evaluation team systematically coded interview and focus group notes and open-text survey responses to identify key themes and sub-themes emerging from engagement with service providers and users. Interview and focus group transcripts were used to identify quotes that exemplified analytical themes. This text-based analysis was conducted in NVivo Pro™ to identify patterns of commonality or significance. Findings were then synthesised in a structure that best addressed the KEQs. In parallel, descriptive analysis of quantitative survey responses was undertaken using Qualtrics' inbuilt tools and Excel.

3.7. Quantitative data analysis

As part of the evaluation's mixed-methods approach, the evaluation team analysed secondary quantitative data on service user outcomes and program expenditure from two key data sources:

- DEX data provided at the de-identified individual level by the Department
- an aggregated data extract that integrates data from GPS and DEX (referred to as the GPS - DEX data abstract) service-level performance and administrative data.

Throughout this report, all changes were statistically significant (p<.001). Various datasets pertaining to service user assessments, including all available Standard Client/Community Outcomes Reporting (SCORE) observations, formed the basis of the quantitative analysis. SCORE data measures the result of a service user's interaction with a funded service, making it the closest available proxy to outcome data. Data were analysed separately for FaRS and SFVS activities for the evaluation period, comprised of the six-month reporting periods between 1 July 2021 and 30 June 2024.

DEX data – service user level assessment outcome data overview

The unit of analysis is the individual service user as identified by the unique service user identifier. It is noted that more than one identifier may be assigned to the same individual if, for example, a person received services from multiple outlets or organisations. For these analyses however, each identifier is treated as representing one individual as there was no efficient, deterministic way to account for this artefact given these data.

There were 116,097 unique service user identifiers assigned to persons with at least one SCORE assessment recorded in the FaRS activity and 11,711 unique identifiers for those in the SFVS activity. The total number of unique identifiers was 126,600 indicating that 1,268 persons were potentially receiving services under both activities over the course of the evaluation period.

A total of 2,056,468 assessments were reported across all SCORE domains for FaRS. 208,481 assessments were reported across the relevant domains for SFVS. These correspond to 204,738 individual sessions (as identified by the unique session identifier) for

FaRS and 25,478 for SFVS. More than one assessment can be conducted in the same session (i.e. pre- and post-session). **Table 2** presents summary ratios for these activities.

Table 2: Service users and session with SCORE assessments, FaRS and SFVS, July 2021 to June 2024

Activity	Service users (n=)	Assessments (n=)	Sessions (n=)	Assessments per service user (mean)	Sessions per service user (mean)	Assessments per session (mean)
FaRS	116,097	2,056,468	204,738	17.7	1.8	10.0
SFVS (incl. 4AP2)	11,771	208,481	25,478	17.7	2.2	8.2

Source: DEX-SCORE data

The prevalence of assessments for individual SCORE domain for each service user and session varied. For example, SCORE assessments relating to family functioning were conducted for approximately 85.9% of FaRS service users compared to approximately 56.4% of service users for personal and family safety. Approximately one-third of sessions in both FaRS and SFVS included assessments of satisfaction with the services received, relating to approximately 45% of service users. FaRS service users had up to 88 assessments recorded for some domains within the assessment period, whilst SFVS service users had up to 40 assessments per domain.

Table 3 presents the summary statistics by individual SCORE domain for each activity.

Table 3: Summary statistics by relevant SCORE domain, FaRS and SFVS, July 2021 to June 2024

	FaRS					SFVS (incl. 4AP2)				
			Assessments per service user					Assessments per service user		
SCORE domain	% service users	% sessions	mean	median	range	% service users	% sessions	mean	median	range
Circumstances – Family Functioning	85.9	80.2	2.3	2	(1,75)	67.9	64.4	2.5	2	(1,34)
Circumstances – Mental health, wellbeing, and self-care	78.6	77.9	2.4	2	(1,86)	71.3	67.3	2.5	2	(1,31)
Circumstances – Personal and family safety	56.4	54.6	2.3	2	(1,75)	80.3	75.0	2.5	2	(1,31)
Goals – Changed behaviours	57.7	59.0	2.4	2	(1,75)	51.9	49.6	2.6	2	(1,34)

	FaRS					SFVS (incl. 4AP2)				
			Assessments per service user					Assessments per service user		
Goals – Empowerment, choice, and control to make own choices	53.7	53.4	2.3	2	(1,75)	57.4	53.5	2.4	2	(1,34)
Goals – Engagement with relevant support services	38.0	38.8	2.3	2	(1,75)	41.8	37.9	2.4	2	(1,31)
Goals – Changed impact of immediate crisis	31.3	33.2	2.3	2	(1,88)	38.6	35.0	2.4	2	(1,31)
Goals – Changed knowledge and access to information	64.4	59.7	2.4	2	(1,75)	58.4	52.5	2.3	2	(1,31)
Goals – Changed skills	70.7	69.2	2.3	2	(1,76)	51.7	46.7	2.4	2	(1,31)
Satisfaction – The service listened to me and understood my issues	46.6	34.0	1.7	1	(1,75)	45.1	33.5	1.9	1	(1,38)
Satisfaction – I am satisfied with the services I have received	45.7	33.3	1.7	1	(1,75)	43.8	31.7	1.9	1	(1,40)
Satisfaction – I am better able to deal with issues that I sought help with	45.2	33.3	1.7	1	(1,75)	42.6	31.7	1.9	1	(1,40)

Source: DEX-SCORE data

Demographic data and data relating to people with disability were provided by the Department in separate tables and applied to SCORE assessments using the service user unique identifier. These were used to partition the data by relevant cohorts.

Not all demographic data could be assigned for all service users due to the presence of non-unique profiles for some service users. For example, a service user may not have disclosed (or the outlet did not collect) demographic elements at the time of one session, and later disclosed in another session, leading to the creation of multiple records per service user. Multiple records also occurred where a service user may have moved residence between assessments and demographic records could not be attributed to specific sessions. Attempts were made to connect demographic records based on their creation date being proximal to the session date, however this could not be achieved deterministically.

Some service user identifiers were associated with demographic records containing multiple variations to core attributes such as gender and dates of birth. In such instances it is possible that the service user identifier referred to a group or family unit. Analyses by cohort proceeded using the subset of service users for whom relevant demographic information could be attributed uniquely. Sample sizes are presented accordingly for each analysis.

CALD service users were identified if they were not born in a mainly English-speaking country (Australia, England, Scotland, Wales, Northern Ireland, Republic of Ireland, New Zealand, Canada, United States of America and South Africa) or if their main language was not either English, Aboriginal English, Hawaiian English or Liberian English. **Table 4** presents a summary of demographic distribution by service users with at least one SCORE assessment.

Table 4: Demographic distribution, service users with at least one SCORE assessment, July 2021 to June 2024

Cohort	Category	n	%
Culturally and linguistically diverse	CALD	13,483	10.7
Gender	*Missing*	46,538	36.8
	Female	48,002	37.9
	Male	30,950	24.4
	Intersex	150	0.1
	Nonbinary	40	0.03
	Not stated	907	0.7
	Other	13	0.01
Aboriginal and Torres Strait Islander	*Missing*	46,538	36.8
	Aboriginal	4,643	3.7
	Torres Strait Islander	106	0.1
	Both	294	0.2
	Neither	70,122	55.4
	Not stated	4,897	3.9
Age <18 in any session	Under 18	12,061	9.5
Disabilities	Learning	1,564	1.2
	Physical	2,264	1.8
	Psychiatric	4,427	3.5
	Sensory	725	0.6
	Any	10,345	8.2

Source: DEX-SCORE data

Changes in SCORE over the evaluation period were analysed by domain and the following partitions outlined in **Table 5**. Note that for some cohorts (e.g. gender, Aboriginal and Torres Strait Islander, people with disability) some categories presented in demographics have been omitted or aggregated due to the presence of small counts presenting issues of identifiability in the data.

Table 5: Sample partitions for SCORE analysis

Partition type	Category	Levels
Service delivery	Activity	FaRS
		SFVS
	Delivery mode	Face-to-face
		Virtual
Cohort	Culturally and linguistically diverse	CALD
		Not CALD
	Disability	Any disability
		No known disability
	Aboriginal and Torres Strait Islander	Aboriginal and Torres Strait Islander
		Not Aboriginal and Torres Strait Islander
	Gender	Male
		Female
	Young people	Under 18
		18+

Appendix F provides a breakdown of DEX data.

3.7.1 Return on Investment

In order to respond to KEQ 7 as to whether the programs offer value for money, a high-level return on investment (ROI) analysis was undertaken. The ROI can be found in **Section 4.3**. An ROI is a type of economic evaluation, similar to cost-benefit analysis, which requires a comparison of inputs and outcomes (expressed in monetary terms). Inputs relate to Government investment into FaRS and SFVS. Outcomes relate to the benefits / impact of the programs that can be quantified.

The FaRS and SFVS Program Logics provide a useful platform to structure analysis for a ROI as they consider the cost (inputs) associated with service provision and outcomes including improved health (both physical and mental), improved family functioning, improved education outcomes, children placed in a safe environment, and improvements in other aspects of social determinants.

The ROI involved the following process:

- The evaluation team met with the Department to discuss assumptions, data availability, results, and interpretation.
- The evaluation team identified the cost of family and relationship breakdowns (i.e. harm) encompassing costs associated with family, domestic or sexual violence and child protection. This involved a review of the literature / policy documents.

- The evaluation team used the GPS - DEX data extract to identify the Government's annual investment in FaRS and SVFS including funding allocations across programs and activities.
- The evaluation team developed a value for money framework that utilised the '4E framework' (economy, effectiveness, efficiency and equity). The main source of data used for the 4E framework was the GPS - DEX data extract.
- The evaluation team used the unit record DEX data to identify improvements in SCORE for Circumstances domains of personal and family safety and family functioning.
- The evaluation team estimated the likely impact benefit of FaRS and SVFS in reducing the cost of harm using multiple sources of data including empirical evidence and previous modelling attempts.
- The evaluation team developed a range of scenarios to explore ROI including sensitivity analysis to test robustness of assumptions to results in estimating costs and benefits with variations tested in sensitivity analysis.
- The evaluation presented results in terms of a ratio expressing the potential benefits achieved for every one dollar invested.

3.8. Limitations and considerations

Challenges recruiting SFVS, MBCP and CSC service users

Whilst overall uptake of service users was satisfactory, there were challenges recruiting service users who accessed SFVS, MBCP and CSC services. Uptake also varied across jurisdictions. There are several contributing factors underpinning this low uptake:

- A review of literature on conducting research with victim survivors demonstrates that people who have experienced trauma are a challenging cohort to recruit. They can face barriers to engaging in research including fear of judgement, mistrust of researchers and research processes, privacy concerns, fear of legal implications for engaging in research, lack of motivation, time burden related to participation, and emotional strain (Ellard-Gray et al., 2015; Sabri et al., 2022). Research indicates that service providers may be reluctant to facilitate engagement with certain cohorts due to concerns for their safety and wellbeing if they were to engage in research (Kay, 2019). Several service providers emphasised that they placed priority on developing and maintaining therapeutic relationships with service users, noting that this was a delicate and time-consuming process and concern was expressed that recruitment to any form of external research or evaluation could impact this fragile relationship of trust.
- Several service providers indicated that low numbers of their service users consented to being contacted for evaluations during intake processes. This further limited the potential pool for them to draw from, even before applying safety screening processes.
- One service provider indicated they had a requirement for internal ethics approval to be completed before any of their service users could engage in research with internal or external parties. This could not be accommodated in project timelines.

- Male perpetrators face barriers to engagement, with the most significant obstacle being internal feelings of fear, shame, and guilt (Maddox et al., 2019). To support safe engagement, the evaluation implemented strict recruitment criteria and engagement processes for service users accessing MBCPs. This included a requirement that both people who use violence and victim survivors were receiving active case management. Recruitment criteria are outlined further in **Section 3.5.2** and **Appendix D**. Many men who completed the program who were deemed appropriate for engagement by the service provider were no longer receiving active case management, making them ineligible to participate. In addition, several providers were sometimes unable to confirm whether the victim survivor was receiving active case management.
- Family violence research indicates that many mothers are concerned about exposing their child to trauma, the potential for the involvement of external legal and child protection systems, and safety concerns if the person who uses violence finds out about their involvement in research (Mackey et al., 2024). The challenge relating to recruiting children in particular has been clearly articulated in the *National Plan to End Violence Against Women and Children 2022-2032* which highlights that 'prevalence data and information about children's experiences of family, domestic and sexual violence is difficult to obtain due to the sensitivity of the subject. Most large-scale population surveys focus on adult experiences or adults' perceptions of children's experiences. While these sources can provide some insights, they are likely to underestimate the true extent of children's exposure to family violence' (Department of Social Services, 2022). Since then, the Australian Child Maltreatment Study (2023) has found that child maltreatment is endemic across the population with a high prevalence of physical abuse (32.0%), sexual abuse (28.5%), emotional abuse (30.9%), and exposure to family violence (39.6%).

Several strategies were implemented to mitigate risks to recruitment arising from these challenges:

- Targeted engagement was conducted with 'champion' service providers (those involved in early focus groups) to promote the evaluation and provide ongoing support through phone calls, emails, and virtual or in-person meetings to these service providers. This engagement focused on providers servicing specific population cohorts or operating SFVS, MBCP and/or CSC programs. Targeted recruitment efforts, including planned site visits, contributed to increased response rates in key cohorts and jurisdictions by creating recruitment deadlines. These efforts helped boost numbers in underrepresented cohorts and jurisdictions.
- Surveys were sent to service users who submitted EOI forms but did not respond to requests for interviews to increase the likelihood of securing their input.
- The evaluation team was flexible, providing options for after-hours engagement and a range of modalities including face-to-face, virtual and phone engagements to meet service users' needs.
- Adjustments were made to the evaluation's sampling approach to gain further insight into service users' experiences. This included holding 20 additional FaRS and SFVS service user interviews and 4 additional focus groups with SFVS, MBCP, and CSC service providers, as well as with a non-ACCO NT service provider focus group.

Over half of FaRS service user survey responses came from Queensland, of which the majority came from one service. This limits the generalisability of FaRS service user survey responses. Overall, all survey data should be treated as indicative rather than representative.

Non-probability sampling of service user data and selection bias

This evaluation employed a non-probability sampling approach to service user recruitment, with participants screened and recruited through their service providers. While this approach was necessary to uphold trauma-informed, ethical engagement practices and ensure the safety and wellbeing of victim survivors, it introduced limitations. The primary limitation of non-probability sampling is the introduction of sampling bias, which may affect the extent to which findings reflect the broader service user population.

Specifically:

- Service provider participation was voluntary, and not all invited providers chose to participate. This may have skewed the sample of service users as participating providers may differ from those non-participating services.
- Selective recruitment within participating services also presents a risk of bias. Not all eligible service users were invited to participate, and providers may have consciously or unconsciously selected service users who were assessed as 'lower risk' or more stable, based on internal screening or eligibility processes. As a result, individuals with more acute or complex needs may be underrepresented.
- Selective sampling was further influenced by engagement patterns. Service users who had stronger relationships with services or had participated in more intensive or long-term programs (e.g. case management) were more likely to be recruited. In contrast, those who had disengaged, participated in group work only, or who received brief interventions were harder to reach, leading to a potential overrepresentation of service users with more intensive service experiences.
- Self-selection bias may also have occurred, with participants offered a modest incentive (a gift voucher) for completing interviews and surveys. This may have disproportionately attracted individuals who were more motivated or had more time and capacity to engage. One provider offered additional incentives to participants beyond what was offered by the evaluation team. However, as the participation rate from this provider was similar or lower than other providers, this is not expected to have meaningfully skewed results.

In anticipation of these limitations several strategies were embedded into the evaluation design to enhance the robustness and credibility of findings:

- Purposive sampling was used to increase diversity in the sample, targeting a mix of service provider types and sizes, geographic locations, and specific population cohorts.
- The mixed-methods research design enabled triangulation between primary qualitative data (e.g. interviews, surveys) and secondary outcome data (e.g. DEX-SCORE), which are less susceptible to sampling bias.
- All recruitment materials and methods were reviewed and approved by relevant HRECs, ensuring that processes were designed to be non-coercive and reduced bias.

- The evaluation team conducted ongoing monitoring of sample characteristics to ensure diversity in responses and identify any gaps in representation.

The data generated through interviews and surveys should not be interpreted as representative of the full population of service users. While limitations inherent to non-probability sampling cannot be fully eliminated, the measures above aimed to improve confidence in the qualitative insights generated and support a nuanced interpretation of findings within the context of this evaluation.

Attribution of FaRS and SFVS outcomes given overlap with other services

The evaluation did not examine the extent to which FaRS and SFVS overlapped with other non-FaRS and SFVS services accessed by participants. Without this data, it is not possible to determine the specific contribution of FaRS and SFVS to observed outcomes.

Limited validity of MBCP outcomes analysis

The evaluation's assessment of MBCP outcomes is limited by its reliance on self-reported data from a small number of MBCP participants (n=<10) and service provider observations gathered from DEX reporting and focus group participation. This approach is vulnerable to positive bias and social desirability effects, which may overstate the extent of genuine or sustained change. In addition, the evaluation did not gather data on perspectives of victim survivors and other affected family members on participants' motivation for behaviour change, or whether risk was reduced and safety increased. This limits the validity of any reported behaviour change outcomes arising from DEX, MBCP service users, and MBCP service provider data.

Literature review limitations

The literature review conducted to support this evaluation has some limitations including

- Evidence gaps around longitudinal studies and economic evaluations specific to per-victim costs of family violence created gaps in assessing cost-efficiency and cost-effectiveness comprehensively.
- Evidence gaps around culturally sensitive, trauma-informed care for those with complex, intersecting identities and evidence on effective service delivery options for people who use violence from different populations, created gaps in determining best practice approaches for these cohorts.
- Variations in survey instruments, geographic coverage, and sampling schemes across studies resulted in heterogeneous data, which created challenges for standardising metrics to support the comparison of outcomes.

Quantitative data limitations

Several caveats of using the individual DEX data are noted above including: an individual may have multiple service user identifiers; the prevalence of assessments for individual SCORE domain for each service user and session varied; all demographic data could not be assigned for all service users due to the presence of non-unique profiles for some service users; some service user identifiers were associated with demographic records containing multiple variations to core attributes such as gender and dates of birth; and issues with identifying CALD service users.

Importantly, changes in SCORE have been analysed based on earliest-latest SCORE repeated measures. This method utilises service users with at least 2 assessments for the given domain such that the change in SCORE can be measured within subjects. The non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last available outcome assessment in the evaluation period. Although this approach is methodologically sound, the earliest and latest individual assessments may not be indicative of a person's average change in outcomes. Either or both of the selected assessments could potentially be unrepresentative of the individual's outcome changes over the course of their engagement. Further, service users captured by the evaluation period may be at different stages of their engagement with the activities rather than the typical pre and post experimental design. Accordingly, a service user's earliest assessment in the evaluation period may not be from their first engagement with the activity and similarly for their latest assessment. This also meant that the time between the earliest and latest available assessments varied between service users, ranging from same-day assessments (24%) up to three years with a median of 50 days between earliest and latest assessments. Where a client had multiple reported assessments for the same domain on the same day (0.4%), the assessment with the lowest SCORE outcome was selected for both earliest and latest assessment. The GPS – DEX data extract provided by the Department included the financial years 2021-22 to 2023-24. This time frame was applied to the individual DEX data analysis and the value for money (ROI) analysis.

In providing the GPS - DEX data abstract, the Department noted several limitations consistent with individual DEX data such as problems with identifying individuals and service users, data pertaining to sessions, definitions of CALD service users, cell suppression when numbers are less than 5, certain activities associated with partial financial years, novation, potential issues with subcontracting services, identifying outlets and funding allocation across outlets (and regions), and various sensitivities associated with specific service providers. Further, there is also overlap in service provision across programs that make it difficult to isolate specific program funding. For example, some providers use SFVS funding to deliver MBCPs, the same funding also supports general SFVS services. Due to the flexible nature of SFVS funding, which allows providers to determine their service mix, it is not possible to quantify exactly how much is allocated to MBCPs. This allocation may vary year to year depending on provider priorities. Although the Department provided documentation to these limitations, they may impact on the accuracy and comparability of results with those generated from the individual DEX data. For example, the Department note that since GPS and DEX link at a level above the Activity ID, sessions and other DEX metrics cannot be attributed to each Activity ID and instead the same DEX numbers are attributed in full to each Activity ID. The individual DEX data does not contain a field for activity ID which further impacts on testing accuracy or consistency of data.

To support analysis for the evaluation, several validity tests have been undertaken by the evaluation team to understand the discrepancies between data sources. This included comparing the list of service providers using the legal entity legal name (GPS – DEX data extract) with leading organisation (individual DEX data) and noting several inconsistencies between data sources. There were multiple providers listed in the GPS – DEX data extract that were not listed in the individual DEX data, and vice versa. Client numbers (and sessions) calculated from the supplied individual DEX data (multiple various data sources) did not match those supplied in the GPS-DEX data extract. This could be an artefact of different service providers being captured or variations in extraction processes. A significant difference was also found in the identification of CALD service users: a magnitude of 10-fold difference between individual DEX data and the GPS – DEX data extract. This discrepancy is most likely due to variations in identifying CALD service users across data sources. In this report, we use the Data Exchange approach to counting people who identify as CALD only where they are both born outside Australia and speak a non-English language.

There are also significant limitations in undertaking the value for money and ROI analysis. There is a paucity of evidence to guide a ROI analysis. Accordingly, the value for money and ROI analysis relied on a range of data sources and assumptions. Costs were limited to DSS investment through activity-based expenditure and did not include additional costs incurred by providers or fees collected from clients as part of service delivery. A key issue of all ROIs is identifying impact and placing a monetary value on benefits articulated through the Program Logic models. These complexities form part of the limitations of data collection in this sector (Sardinha et al., 2022). Availability of linked data would circumvent most of these issues and reduce the need for assumptions.

The evaluation did not have access to quantitative data from service providers on the fees charged to service users for accessing FaRS programs under the sliding scale model. As a result, all analysis related to fees is based on a small, non-representative set of qualitative interview data and quantitative survey responses and should be interpreted with caution. DEX data did not capture the intensity (i.e. length) of sessions provided so the analysis is limited to the type of sessions provided. Further, we have not captured any geographical inconsistencies in the delivery of sessions. It is anticipated that the subsequent modelling exercise will consider this.

Context

3.9. Context of family life and relationships in Australia

Whilst understandings of contemporary Australian families have evolved since the inception of FaRS and SFVS funding, the need for the programs remains clear. This section provides an overview of the evolving landscape of families and their needs to provide a basis for understanding the context within which FaRS and SFVS operate.

The formation, structure and circumstances of Australian families have changed significantly over time. Family households made up 71% of Australian households in 2021 (Australian Institute of Family Studies, 2023a). There are several key trends in the composition and structure of these families. Firstly, the proportion of couple families without children has increased and the proportion with children has decreased. Between 1981 and 2021, the percentage of couple families with dependent children dropped from 47% of all families to 36%, while the percentage of couple only families rose from 29% to 39% (Australian Institute of Family Studies, 2023b). The Australian Institute of Families Studies (AIFS) suggests this reflects a rise in the number of older couples, consistent with expectations of an ageing population (Australian Institute of Family Studies, 2023a, 2023b).

Despite this trend, couple families with children (either dependent or non-dependent) remain the most common family arrangement in Australia as of 2021. There is diversity in how these families are composed including intact families, step-families, blended families,[5] grandparent families,[6] and multi-generational and extended household families[7] (Australian Institute of Family Studies, 2023b; Qu, 2020). The proportion of single-parent families has been relatively stable in recent years. Single parent families made up less than 9% of all families in 1981 and 1991 and increased to 11% in 2001, but have remained at a similar level since then (Australian Institute of Family Studies, 2023a, 2023b). While the proportion of male single parents has increased slightly in recent years, 82% of single parents are women (Australian Institute of Family Studies, 2023b; Naidoo et al., 2024). In families with dependent children (both couple- and single-parent families), the number of children per family has remained relatively stable over the past decade with 2 children as the most common family size overall (Australian Institute of Family Studies, 2023b).

[5] AIFS defines a blended family as a couple family with at least one natural or adopted child of both partners and at least one stepchild of either partner. A stepfamily is defined as a couple family with at least one stepchild of either partner in the couple and without any natural or adopted children of both partners.
[6] Families consisting of not only parents and children but also other members of the immediate family, including grandparents.
[7] Families in which a grand-parent-grandchild relationship is present and there is no parent-child relationship.

3.9.1 Families are more diverse

Families have become more diverse over time, with increasing proportions of Aboriginal and/or Torres Strait Islander and immigrant households, and same-sex couples (Australian Institute of Family Studies, 2023a, 2023b; Qu, 2020). There is significant variation in family structures across different cultural backgrounds (Naidoo et al., 2024).

A scoping review of research on family structure and wellbeing by Jensen & Sanner (2021) found that overwhelmingly, family structure appears to be defined by parents' marital status and that researchers often refer to two-married-biological-parent families, single-parent families, and stepfamilies when they use this term. However, many other family forms exist. Whilst legal ties or obligations and blood/genetics remain important elements in family composition and definition, individual experiences and understandings of family can be very different from that outlined in legislation or research (Budinski and Gahan, 2023; Jensen and Sanner, 2021). Jensen & Sanner (2021) caution that conceptualisations of family structure that centre the role of marriage in describing family reinforce Eurocentric definitions of kin, and observe that white European settlers and their descendants have historically held more narrow definitions of family based on marriage and biological ties than many historically oppressed groups. In a similar vein, both Budinski & Gahan (Budinski and Gahan, 2023), and Naidoo et al. (2024), emphasise that people's understanding of 'family' is shaped by culture and personal life experiences and circumstances, and understandings of what constitutes family vary across generations, sexuality, gender identity, cultural and linguistic background, and Aboriginal and/or Torres Strait Islander identity (Budinski and Gahan, 2023; Naidoo et al., 2024).

Reflecting this, in their analysis of the results of the fourth Families in Australia Survey, Budinski & Gahan (2023) found that CALD Australian participants were significantly more likely than other participants to view legal ties or obligations as important or very important when defining family compared to other participants (41% vs 30%), and significantly more likely to view common experiences and activities (29% vs 19%) and shared values, beliefs and traditions (38% vs 26%) as very important. CALD participants were also significantly more likely than other participants to view blood/genetics as important or very important (43% vs 34%). Budinski & Gahan (2023) posit that these results reflect the communalist family values within some migrant communities in Australia that privilege obligations to an extended kinship network and the family practices of generational interdependence, mutual exchange and obligation that are common within many traditional Asian communities.

According to Naidoo et al, (2024) there is a need to better understand Aboriginal and Torres Strait Islander families and kinship relationships. Their study contends that the datasets underpinning understanding of families can be biased in ways that may not be obvious. For example, the focus on a single household or on a limited number of blood relations may not recognise the care provided by kinship networks. This insight 'highlights the necessity of self-determination for peoples in the development of programs and services because of their deep knowledge of their own ways of 'doing family'' (Naidoo et al., 2024). Budinski & Gahan (2023) also found that Aboriginal and/or Torres Strait Islander participants were significantly more likely than non-Aboriginal and Torres Strait Islander participants to report that 'chosen family or close friends' were included in their family (62% vs 41%). In some Torres Strait Islander communities, a common collective approach to family composition and child rearing occurs under customary adoption. Under customary adoption, children are raised by non-biological

parents and community members from a young age. These adoptions take place for a range of cultural and contextual reasons, including infertility, wherein a couple or individual who are unable to conceive a child adopt and raise a child born to a family member or from their broader kinship network (Ban, 2022).

Extended kinship networks were often determined as much by obligation as individual choice (Budinski and Gahan, 2023). Budinski & Gahan (2023) describe Aboriginal and Torres Strait Islander collectivist kinship systems as dynamic and complex social structures that define how individuals relate to each other in terms of their roles, responsibilities and obligations, and suggest that Aboriginal and Torres Strait families often have a collectivist approach to child rearing where raising children is seen as the collective responsibility of all members of their community who are seen as 'family' (Budinski and Gahan, 2023).

At the same time, the authors caution against over-generalising Aboriginal and Torres Strait Islander people's views on family, and observe that understandings of family can differ by language, social or nation group, and by location, with diverse views between Aboriginal and Torres Strait Islander people living in urban and remote areas noted in particular (Budinski and Gahan, 2023).

Jensen & Sanner (2021) also highlight that literature often focuses on family-level explanations (for example: resources, parenting, stress) for why or how family structure shapes individual outcomes, with a lack of attention to how broader social systems have created family-level disparities. The authors explain by way of example that although there are clear racial and ethnic differences in trends of marriage and childbearing, family structure is generally studied and discussed in non-racialised contexts. As such, there is often little or no attention to how systemic racism has created racial differences in family structure or how a family's structure can lead to different impacts across racialised groups (Jensen and Sanner, 2021). This limitation was evident across much of the literature reviewed and should be borne in mind when considering the evidence relating to family composition and diversity.

3.9.2 Social and economic context of family life

Family life (including transitions in family structure, family processes and satisfaction) is influenced by, and influences, the social and economic context within which it is situated. Financial realities, work arrangements, approaches to domestic labour and caring, and health and disability all shape family life and relationships in complex ways.

Income and wealth

Naidoo et al. (2024) highlight strong links between family type, income, wealth, and financial stability, finding that couple parent families generally fare better economically than other family types. Their median weekly income is significantly higher, and their mean net wealth surpasses all others, making them less vulnerable to poverty and financial hardship. In contrast, foster and kin families, as well as single parent households, are at greatest risk of poverty and financial stress, including challenges like paying bills, skipping meals, or missing housing payments. Housing patterns also vary by family type: couple families are more likely to live in wealthier areas and own homes, while single parent and blended families are more likely to rent, including public housing. Despite financial disparities, satisfaction with homes

and neighbourhoods remains consistently high across family types, with only slight differences reported.

Work inside and outside the home

Significant changes in how Australians work continue to shape family life – and many of these changes are highly gendered. A key shift has been the increase in women's rate of workforce participation driven by changes in contraception, fertility, and partnering patterns; women's higher levels of education, leading to expanding opportunities in the labour market; the increased availability of part-time work and the introduction of gender work equality policies; and increased cost of living requiring dual incomes (Baxter, 2023). Participation rates have increased across all age groups other than those aged under 20, and the drop in participation around childbearing age has lessened considerably (Warren et al., 2020).

Despite this increase in women's participation in the workforce, there is clear evidence that in Australia gendered divisions of unpaid labour within households are deeply entrenched, with these tasks, including the 'mental load' of child care, falling more often to mothers (Baxter, 2024; Hewitt, 2021). While fathers now spend more time on child care than in previous decades, the impact of parenthood on fathers' time in unpaid care work has remained unchanged over a period of 20 years, remaining substantially below that of mothers' care time (Baxter, 2024). Drawing on parents' comments in their responses to the Families in Australia Surveys, Baxter (2024) attributes the gendered patterns in child care to gendered employment arrangements, meaning mothers are home and available more often, and may see it as 'fair' that the mother takes on more of the child care where the father has a 'breadwinner' role (Baxter, 2024). Gender role attitudes were also identified as playing a role, with some mothers commenting that their partner had expectations, or gender role attitudes, about who would do more of the child care, with this thought to be more of a mother's task (Baxter, 2024).

Although close to 15% of families include someone with a long-term health condition, impairment or disability who require care from another family member, there is substantial variation across family type. Research undertaken by Naidoo et al (2024) concludes that foster and other kin families, multigenerational families, single parent families and step and/or blended families are all more likely to be caring for someone with a long-term illness or disability. Unsurprisingly, people are more likely to report that they have caring responsibilities in their household among those family types where ill health and disability are more prevalent, particularly multigenerational families, step and/or blended families, and single parent families. This work is also highly gendered, with women carrying most unpaid care responsibilities (Standing Committee on Policy and Legal Affairs, 2024). Paid care sectors are similarly female-dominated and marked by low wages, insecure employment, limited bargaining power, and high rates of part-time or casual work (Prime Minister and Cabinet, 2024, 2023). Overall, women's paid and unpaid care work accounts for 53% of the gender pay gap in lifetime earnings and superannuation balances (Prime Minister and Cabinet, 2023).

3.9.3 Need for family violence, family, and relationship services

The need for family violence, family, and relationship services in the Australia is shaped by trends in the dynamics of family relationships. This section explores patterns in the pressures facing Australians' relationships. It then considers evidence relating to the impact of family relationships and transitions on individual wellbeing, as well as trends in family violence in Australia.

Pressures on family relationships in Australia

Pressure on family relationships in Australia is influenced by experiences of violence, control, and feelings of safety. Relationships Australia (2022) highlighted that feeling unsafe in close relationships—whether with a partner or family member—can be a marker of potential family violence, with 8.8% of Australians reporting they felt unsafe disagreeing with the most important person in their life. This was most common among people aged 75 and older (16.2%). Those who felt unsafe were also more likely to report emotional and social loneliness, and almost half (48%) managed their relationship issues alone. Additionally, 7% of Australians reported experiencing controlling behaviour in their most important relationship, with no strong patterns based on age, gender, or socio-economic background (Relationships Australia, 2022).

External pressures are also a significant challenge for Australian families. Relationships Australia (2022) found that 71.9% of Australians had experienced pressures in their most important relationship within the previous 6 months, with the average person facing 1 to 2 pressures. Common stressors included study or work commitments (25.8%), mental health issues (22.1%), and financial problems (20%). Nearly 20% of respondents cited the COVID-19 pandemic and unequal division of household tasks. Age played a key role: younger people (18–24 years) reported the highest levels of relationship pressure (86.5%), while nearly half (49.5%) of people aged 75 and over reported no pressures at all. Relationship length also influenced the types of pressures experienced. People in relationships under five years most often cited work/study (43.3%) and mental health (41.7%) as stressors, while those in relationships of 6–30 years pointed to the division of household tasks (29.5%). In contrast, 39.3% of people in relationships over 30 years reported no relationship pressures (Relationships Australia, 2022). Further, understandings of factors impacting families and relationships have changed with increased knowledge of their intersection with mental health (Andersen et al., 2021; Carr, 2025; Isobe et al., 2020; White et al., 2024), disability (Bertschi et al., 2021; Saleme et al., 2023; Walter et al., 2024) and other factors. Understandings of family violence have also shifted with increased awareness of actions constituting family violence including coercive control (including financial and emotional abuse) (Beckwith et al., 2023; Harris and Woodlock, 2019), and abuse and harassment via technology (Dragiewicz et al., 2022; eSafety Commissioner, 2023; Flynn et al., 2023).

Family dynamics, gender, and health status further affect relationship pressures. Parents faced similar issues to the general population, but the age of children shaped the types of challenges: those with children under 13 frequently cited the division of childcare as a major issue (66.1%), while those with teenagers were more likely to report household task division

as a stressor (31.1%) (Relationships Australia, 2022). Gender differences were minimal, though women were more likely than men to identify mental health as a pressure (26% vs. 18.1%). The group most affected overall were people with long-term mental health conditions—87% reported relationship pressures, often juggling 2 to 3 simultaneously, with over half (53.1%) facing 4 or more. In comparison, people with long-term physical health conditions or disabilities reported several pressures similar to or slightly higher than the general population (Relationships Australia, 2022).

Prevalence of family violence

The 2021-22 Australian Bureau of Statistics Personal Safety Survey (PSS) reports that an estimated 3.8 million Australian adults (20% of the population) have reported experiencing physical and/or sexual family and domestic violence since the age of 15. It is estimated that of all Australian adults: 11.3% (2.2 million) had experienced violence from a partner (current or previous cohabiting), 5.9% (1.1 million) had experienced violence from a boyfriend, girlfriend or date, and 7.0% (1.4 million) had experienced violence from another family member.

According to the 2021-22 PSS, in 2021-22, 1 in 6 women and 1 in 18 men had experienced physical and/or sexual violence, 1 in 4 women and 1 in 7 men had experienced emotional abuse, and 1 in 6 women and 1 in 13 men had experienced economic abuse by a current or previous cohabiting partner since the age of 15 (Australian Bureau of Statistics, 2023).

Quality of family relationships

When reporting on their household, and levels of conflict and how everyone gets along, most respondents to the 2021 Families in Australia Survey indicated their situation was positive, with only one in 10 saying there was ‘quite a bit’ or ‘a great deal’ of conflict in the household and about one in 5 saying there was some conflict. Most said there was a little (46%) or none (25%) (Baxter and Warren, 2021). Respondents living in households with parents or other adult relatives were most likely to report conflict (54% reporting either some, or quite a bit or a great deal of conflict) followed by respondents living with children and no partners (39% reporting either some, or quite a bit or a great deal of conflict) (Baxter and Warren, 2021).

Couples

In Relationships Australia’s 2022 National Survey, 60% of respondents identified their partner as the most important person in their life, and these individuals were more satisfied with their relationships than those who nominated a family member (31%) or friend (7.6%) (Relationships Australia, 2022). Similarly, the 2021 Families in Australia Survey found that 82% of people were satisfied or very satisfied with their relationship with a spouse or partner (Baxter and Warren, 2021). Relationship satisfaction was highest among older respondents, particularly those over 70 (63% very satisfied), and lower among people under 30 (40% very satisfied) (Baxter and Warren, 2021).

High satisfaction in couple relationships is strongly linked to open communication, meaningful conversations, mutual support, and shared enjoyable activities (Baxter and Warren, 2021; Relationships Australia, 2022). Conversely, frequent arguments and disagreements reduced relationship quality (Baxter and Warren, 2021; Relationships Australia, 2022). However, when

it comes to relationships post-separation, satisfaction often deteriorates. Of separated parents surveyed in the Families in Australia Survey, only 14% described their relationship with the other parent as friendly, while 32% reported a relationship marked by conflict and 9% reported fear (Baxter and Warren, 2021). These figures reflect a clear decline in relationship quality following family breakdowns.

Parents and children

Most parents report high levels of satisfaction in their relationships with their children. According to the 2021 Families in Australia Survey, 50% of parents with resident children were very satisfied with these relationships, and 36% were satisfied (Baxter and Warren, 2021). These findings align with Naidoo et al. (2024) who found average satisfaction scores near 8 out of 10 across all family types, with the highest in couple parent families (8.59) and multigenerational families (8.57), and slightly lower among single parent families (8.24), step/blended families (7.99), and foster/kin families (7.95). Satisfaction varied by the age of the children, being highest when children were aged 0–2 and declining during the teenage years (Baxter and Warren, 2021).

Single parent families reported the most strained relationships with the lowest satisfaction in partner and child-parent relationships. Single parents gave their current or former partner relationship a mean score of 7.3 out of 10, and their partner's relationship with the children just 5.6—significantly lower than in other family types (Naidoo et al., 2024). However, children's relationships with each other were generally positive across all family types, with mean satisfaction scores around 7.5 or higher (Naidoo et al., 2024). This was consistent with Baxter & Warren (2021) who found higher levels of harmony among younger children, with dissatisfaction increasing by 12% as children aged. These findings suggest that parenting programs and other similar content should be targeted at parents of teenagers and single parent households.

Intergenerational families

Adults living with their parent or another adult relative (other than a sibling) report an elevated level of household discord. These respondents to the 2021 Families in Australia Survey were more likely to rate the household relationships as 'fair', 'poor' or 'very poor' (42%) and more likely to experience conflict (52%) reporting 'some', 'quite a bit' or 'a great deal' (Baxter and Warren, 2021). Only 23% described the ability for members of the household to get along with one another as 'very good', compared to 66% of households comprising siblings or unrelated adults. Interestingly, 52% of respondents living with older children (i.e. aged over 18) described their ability to get along as 'very good' (Baxter and Warren, 2021). Fingerman et al (2020) suggest that due to competing needs for independence and connection, intergenerational relationships can be simultaneously close as well as irritating (Fingerman et al., 2020).

The impact of gender on the quality of family relationships

Gender continues to shape family dynamics, particularly around caregiving and household responsibilities. Women across all family types are more likely to report doing more than their fair share of both child rearing and domestic work, while men are more likely to believe that responsibilities are shared equally (Naidoo et al., 2024). This divide is particularly stark in

single parent families, where 75% of women say they shoulder the majority of parenting duties (Naidoo et al., 2024). These patterns also influence satisfaction, with men generally more content than women with how parenting tasks are divided, especially in multigenerational and foster/kin families where the gender satisfaction gap can be as large as 1.5 points out of 10 (Naidoo et al., 2024).

Similar trends appear in relation to household duties, where women again report doing more and feeling less satisfied. Women in single parent families consistently reported the lowest satisfaction levels with domestic task division (Naidoo et al., 2024). These imbalances have a clear emotional toll. Women are more likely than men to feel overwhelmed by parenting, describing it as exhausting, more work than pleasure, and harder than expected. This was especially true for women in multigenerational families, who reported higher levels of fatigue and stress (Naidoo et al., 2024). Notably, foster and kin families stood out as the only family type where men, not women, reported greater parenting difficulty on every measure (Naidoo et al., 2024).

Gender also plays a key role in emotional wellbeing and financial outcomes. Women often face greater financial hardship post-separation, especially when they are the primary caregiver and lack sufficient child support, placing children at increased risk of poverty (Hewitt, 2021). Despite these challenges, women are more frequently identified as central emotional figures in families. In Relationships Australia's (2022) survey, 21% of people named a woman (e.g. mother, sister, daughter) as their most meaningful relationship, compared to only 9% who named a man. The remaining 70% selected either a partner, friend, or neighbour – gender was not specified. Men were also less likely to be seen as emotional supports, more likely to experience emotional loneliness, and more likely to handle relationship issues alone. These findings suggest that while women often carry more responsibility, men may be more socially disconnected, highlighting the need to strengthen men's roles in family and emotional life.

Impact of family relationships and transitions on wellbeing

'Relationship satisfaction isn't just important for the health of relationships; it also predicts satisfaction with life' (Relationships Australia, 2022), and the literature reveals a close connection between family relationships, transitions, composition and processes and a person's subjective wellbeing. There is also evidence that family relationships impact children's development.

According to Relationships Australia (2022), the more satisfactory someone's important relationship, the better their subjective wellbeing. In addition, relationship pressures are associated with reduced relationship satisfaction, subjective wellbeing, and higher levels of loneliness (Relationships Australia, 2022). Relationships Australia (2022) found that describing a relationship as 'full' was the strongest predictor of subjective wellbeing. Conversely, feeling 'lonely' in a relationship was one of the greatest forecasters for feeling dissatisfied with life (Relationships Australia, 2022). Subjective wellbeing was lowest for those in middle age, before increasing as people age. Relationships Australia (2022) attributed these trends to the culminations of caring duties, deteriorating health and relationship breakdown in middle age before 'age helps people clarify and come to terms with the various changes in life and soothes worries related to what might be lacking.'

Relationship breakdown

Relationship breakdowns have had lasting impacts on a significant portion of the Australian population. According to Relationships Australia (2024), 31% of Australians report experiencing a break-up, separation, or divorce that still affects them today. This figure is higher for certain groups, including people with long-term mental health conditions (49%), disability (46%), long-term physical health conditions (41%), and LGBTQIA+ people (38%). The mental health impacts are well-documented, with increased risks of depression, anxiety, and suicidality. Divorced men are eight times more likely to die by suicide, and women also face elevated risks, particularly in the years surrounding separation (Relationships Australia, 2024).

Emotional and psychological challenges are common following relationship breakdowns. In Relationships Australia's 2024 survey, 44% of respondents reported emotional or mental health issues, including PTSD and loneliness, while 26% faced financial or practical challenges such as housing insecurity, legal issues, and co-parenting difficulties. Others reported intimacy and trust issues (18%), identity impacts like loss of confidence (13%), and experiences of abuse or trauma (8%). Only 3% reported positive personal growth outcomes. Those affected were also 1.5 times lonelier and more likely to experience pressures in later relationships. The findings suggest these impacts are shaped not only by the breakdown itself, but by broader social determinants such as socio-economic status, gender, and sexuality (Relationships Australia, 2024).

Despite these challenges, some people report positive transformations after a relationship ends. These include increased freedom and independence (22%), moving on to new relationships (19%), personal growth (15%), feelings of peace or relief (12%), and escaping abusive situations (7%) (Relationships Australia, 2024). Jensen and Sanner (2021) advocate for a more holistic view of wellbeing that includes resilience and positive outcomes, noting that current research too often emphasises dysfunction. They argue that capturing positive aspects like growth mindset and prosocial behaviour could more accurately reflect diverse family structures and experiences.

Child development and mental health

Recent literature has shifted focus from family structure to family processes, highlighting that the wellbeing of children and adolescents is better predicted by the quality of family relationships than by family composition alone (Tafà et al., 2022). Factors such as interparental conflict, reduced economic resources post-separation, and strained new relationships in reconstituted families are identified as key risks to adolescent development. Persistent conflict between parents—rather than the separation itself—is found to be the most damaging influence, particularly through a ‘spillover effect’ that reduces parents’ ability to respond to their children’s needs (Tafà et al., 2022). In some cases, conflict between parents may also continue beyond separation with ongoing tactics of coercive control, and sabotage of the protective parent’s (usually the mother) parenting relationship (Humphreys et al., 2019). Notably, maternal parenting stress was strongly linked to long-term aggressive behaviour in adolescents (Tafà et al., 2022). However, the development and mental health of children living with family violence is affected by sabotaging of the (usually) mother-child relationship by perpetrators of family violence (Kertesz et al., 2021).

Co-parenting has emerged as a significant protective factor in supporting children's mental health after separation. Effective co-parenting can mitigate the negative effects of separation, especially when paired with quality parenting and strong parent-child relationships (Tafà et al., 2022). These findings are particularly relevant in light of data from Relationships Australia (2024), which found that one in three people identified concerns about their children as the most lasting impact of relationship breakdown. Common challenges included co-parenting difficulties, estrangement, and the emotional impact of separation on children (Relationships Australia, 2024) as well as lack of respect for the other parent of the child which are features of most family violence situations.

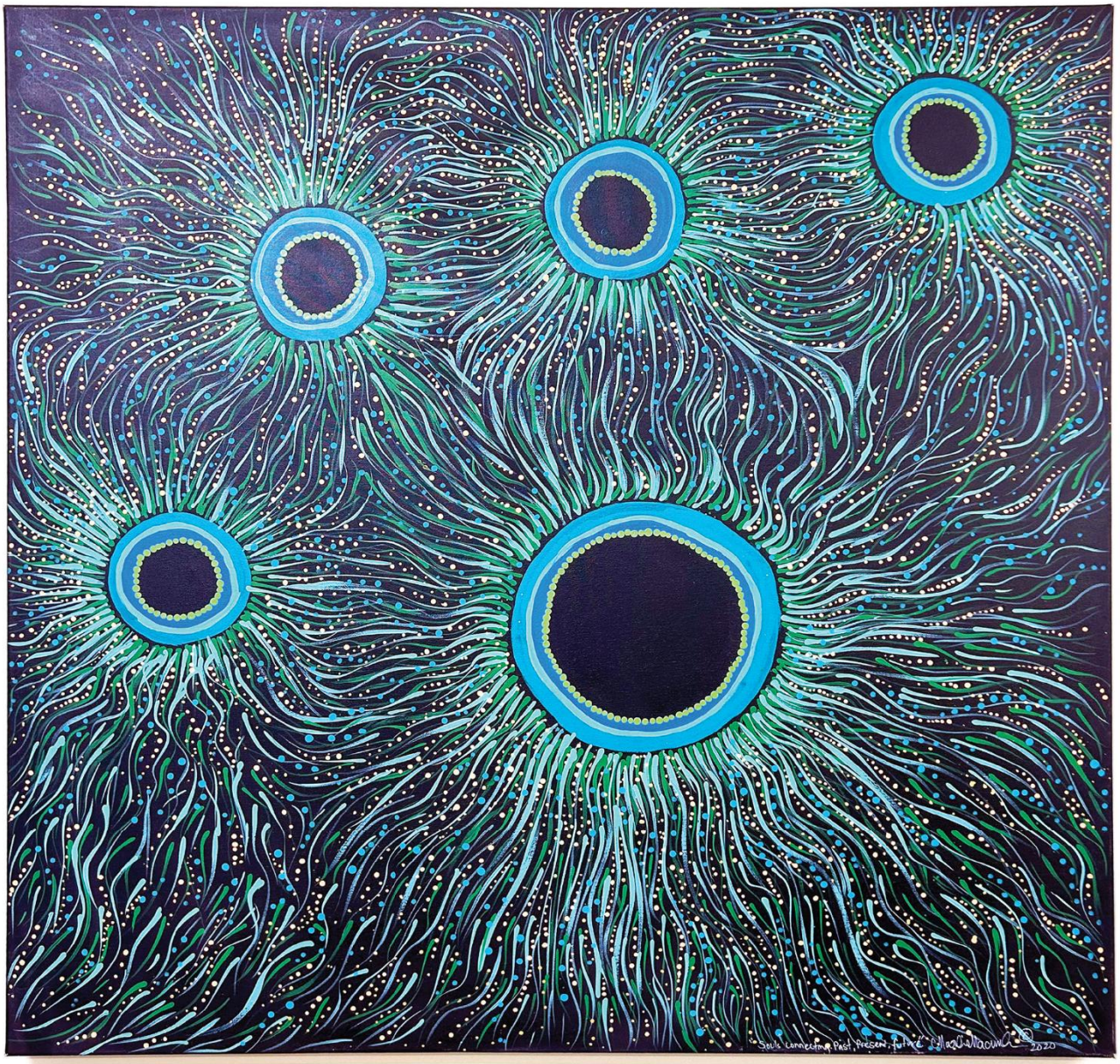
Additional stressors like work-family conflict also influence children's mental health. Vahedi et al. (2019) found that when parents struggle to balance work and family demands, children are more likely to experience a conflicted home environment. This environment, marked by parenting irritability and interparental tension, can lead to emotional and behavioural problems throughout childhood and adolescence. The impact was more persistent when the work-family conflict was experienced by mothers, reflecting the ongoing influence of gendered parenting roles in Australia. However, fathers' conflict was found to be more detrimental during children's adolescent years (Vahedi et al., 2019).

Accessing support

Many people are reluctant to seek professional help for relationship issues, with men being particularly unlikely to do so. Data from Relationships Australia (Relationships Australia, 2024, 2022) shows that while nearly half (46.2%) of Australians prefer to manage relationship issues on their own, others turn to informal supports such as friends (34%) and family (31%). Only a small portion (6.3%) reported they would seek help from a professional like a counsellor or psychologist if experiencing difficulties in their most important relationship (Relationships Australia, 2024)

Certain groups were more inclined to access professional support. Individuals with long-term mental health conditions, disabilities or chronic physical health issues were more likely than the general population to seek formal help, while carers were less likely (Relationships Australia, 2022). Notably, people were significantly more likely to seek counselling or therapy after a relationship had ended. Among those who reported lasting impacts from a relationship breakdown, 32% said they had accessed professional support (Relationships Australia, 2024).

Help-seeking behaviour also differed by gender. Men who had experienced relationship breakdowns were more likely to initially rely on avoidance, denial, or maladaptive coping strategies. Over time, they tended to lean on personal networks including children, family, or even their ex-partners rather than seeking formal help (Relationships Australia, 2024). In contrast, 74% of women reported accessing counselling or therapy, with those aged 45–64 being the most likely to do so. This indicates that both gender and life stage influence how individuals respond to relationship challenges and whether they engage with professional support services (Relationships Australia, 2024).



Efficiency

4. Efficiency

This section explores whether FaRS and SFVS offer value for money (KEQ 7) and the extent to which current funding allocations are sufficient.

4.1. Key findings

Finding	
1	**FaRS and SFVS provide value for money** Benefit Cost Ratios for FaRS and SFVS are high. FaRS and SFVS convert funding into a high volume of services and positive outcomes. This output relative to investment is efficient. The result is a cost per service well below comparable intensive interventions.

4.2. Value for money

This section uses the 4E Framework (Economy, Efficiency, Effectiveness, Equity) to assess the value for money of FaRS, SFVS, MBCP, and CSC. The ROI analysis focuses on FaRS and SFVS and does not include specific analysis of MBCP and CSC. A key advantage of the 4E Framework is that it aligns with the FaRS and SFVS Program Logics (found at **Appendix B**) that demonstrate a link from inputs and activities to outputs and outcomes.

'Economy' focuses on ensuring that the cost of providing services is reasonable given the quality required of that service. Economy relates to inputs for organisations to provide administrative and professional staff and Operational Guidelines that enable structure and management.

'Efficiency' relates to activities and outputs per dollar, sometimes referred to as efficiency ratios. This considers the type of activities funded and the outputs generated from funding. Outputs are measured in terms of number of service users, sessions, and referrals, with efficiency ratios expressed as cost per service user or cost per session.

'Effectiveness' focuses on providing evidence that the program is achieving results that are transformational and sustainable and that appropriate learning processes are in place to support this. Results are contextualised as both short, medium, and long-term outcomes with improvements measured in change in knowledge, skills, and circumstances in relation to family safety, relationships and resilience, and mental health and wellbeing outcomes. Improvements are measured via the SCORE approach in DEX, comparing pre- and post-service assessments across three domains: Circumstances, Goals, and Satisfaction.

Effectiveness is discussed in further detail in **Section 5**.

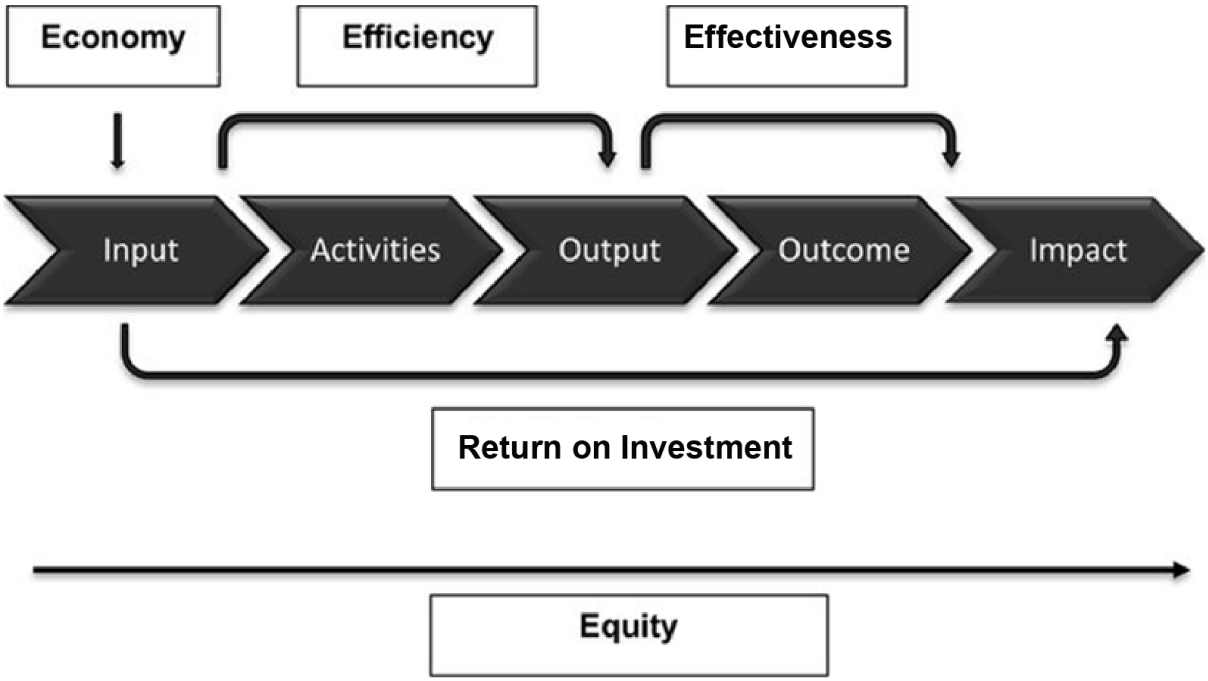
'Equity' focuses on providing evidence that specific measures have been put in place to support priority cohorts. For the purpose of this evaluation, equity is examined with reference to service user demographics and the geographical distribution of service outlets.

Equity is discussed in further detail in **Section 6**.

Data for the following value for money analysis are sourced from GPS – DEX extracts provided by the Department that enable a high-level analysis of the 4E's for the financial years 2021-22, 2022-23 and 2023-24. This analysis supplements the quantitative analysis reported in other KEQs.

Figure 8 below shows the alignment between the 4E framework and the FaRS and SFVS Program Logic models.

Figure 8: 4E framework aligned with Program Logic model



4.2.1 Economy (inputs)

A broad network of service providers delivers FaRS, SFVS, MBCP, and CSC across Australia with a wide geographic reach into metropolitan, regional, and remote communities. CSC services are delivered solely by Relationships Australia. Administrative and overhead costs are kept low through shared service models and co-location with other community services. For example, a 2018 survey found 80% of FaRS and SFVS service providers were co-located with other Department-funded services, facilitating integrated support for service users (Australian Institute of Family Studies, 2018). Flexible funding and service models facilitate economies of scale.

Table 6 below outlines funding totals for the period 2021-22 to 2023-24.

Table 6: FaRS and SFVS funding, 2021-22 to 2023-24

	FARS	SFVS (including 4AP2)	MBCP	CSC	MensLine
2021-22	$80,614,137	$9,409,094	$941,547	$1,774,768	$4,512,178
2022-23	$88,158,944	$12,396,856	$2,890,671	$4,161,309	$4,938,285
2023-24	$91,543,414	$13,634,178	$3,479,270	$4,951,622	$4,872,510
Total	**$260,316,495**	**$35,440,128**	**$7,311,488**	**$10,887,698**	**$14,322,974**

Source: DEX-GPS data

FaRS

FaRS is a large program with increasing funding each year, approximately $80.6 million in 2021-22, $88.2 million in 2022-23, and $91.5 million in 2023-24 (total allocated activity base expenditure) (see **Table 6**). This growth reflects continued investment in family support services. Around 82 service providers delivered FaRS in 2021-22, rising to 83 in 2022-23 and 84 in 2023-24. These included Relationships Australia, Anglicare, CatholicCare, and others across all states and territories, ensuring broad coverage.

SFVS

Funding for SFVS grew over the three-year period 2021-22 to 2023-24. In 2021-22, SFVS expenditure was about $9.4 million, increasing to $12.4 million in 2022-23 and further to $13.6 million in 2023-24 as additional services came online (see **Table 6**). The large increase after 2021-22 indicates a major scale-up of SFVS activities and coverage. SFVS was delivered by 37 service providers in 2021-22, increasing to 38 service providers in both 2022-23 and 2023-24. Many FaRS service providers also ran SFVS programs. The slight increase corresponds to new service providers funded under the 4AP2 initiative or expansion to additional regions. By 2022–23, SFVS service providers were present in every state and territory, although services are targeted to areas with identified need (e.g. regions with high family violence rates).

MBCP

Funding for 8 MBCP initiatives grew significantly over the three-year period from 2021 to 2024. In 2021-22, the combined MBCP funding was approximately $0.9 million. This expanded to $2.9 million in 2022-23 and $3.5 million in 2023-24 (see **Table 6**). The increase corresponds to more programs coming online. In 2021-22 only half of the eventual service providers had started. By 2022–23, all 8 programs were running, hence the tripling of funds from 2021-22. An additional 2 service providers were active at the end of the 2024 calendar year but are not included in this analysis as they are outside of the GPS – DEX data extract time frame. The continued increase into 2023-24 reflects program expansions and possibly higher unit costs for these intensive services. MBCP service providers are spread across multiple states. The funded providers cover major population centres and some regional areas, but there are known gaps in rural and remote regions.

CSC

Funding for CSC grew in tandem with the broader FaRS and SFVS expansions. In 2021-22, funding for CSC initiatives was $1.8 million. This increased to $4.2 million in 2022-23 and $4.95 million in 2023-24 (see **Table 6**). This pattern is similar to that of MBCPs where initial smaller programs were scaled up significantly after 2021. Four Relationships Australia branches provided CSC in 2021-22, expanding to 8 from 2022-23 onward. Every state and territory branch was funded to provide CSC.

MensLine

Funding for MensLine was $4.5 million in 2021-22 increasing to $4.9 million in both 2022-23 and 2023-24 (see **Table 6**). Services were provided by On the Line Australia Limited in 2021-22 to 2022-23. During 2023-24, Lifeline Australia added the MensLine counselling services to its range of digital services after an amalgamation with On the Line Australia. For the financial year 2023-24, services reached every state and territory with greater representation of service users from Victoria (28.4%), NSW (27.2%), Queensland (22.5%), and WA (9.2%). Other callers were from SA (6.7%), Tasmania (1.9%), ACT (1.6%), and NT (0.9%) with state identification not provided for 1.8% of service users.

4.2.2 Efficiency (activities and outputs per dollar)

FaRS

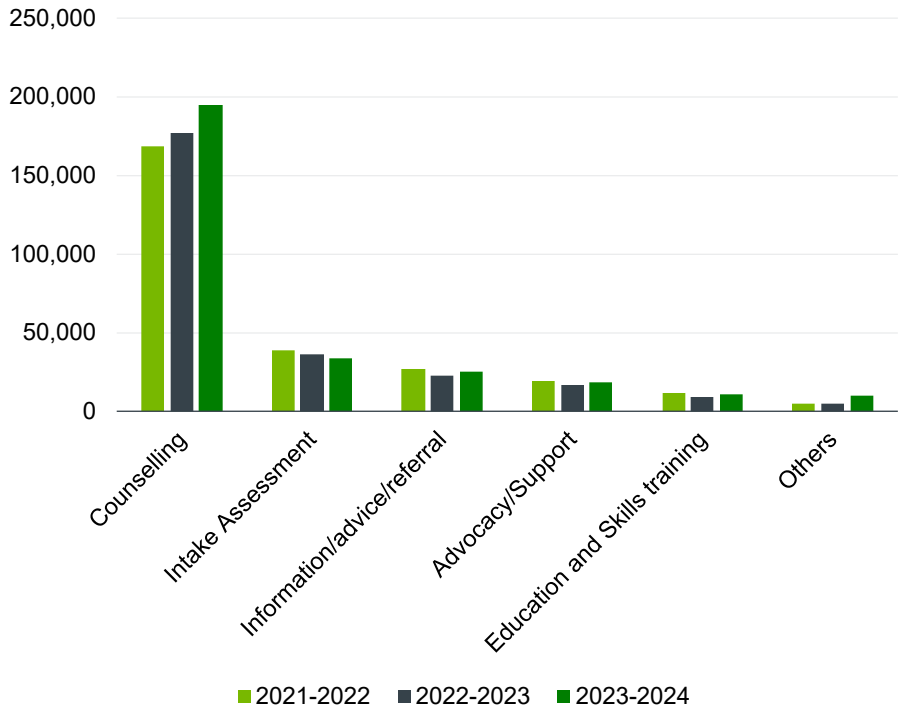
FaRS service providers delivered a high volume of services to service users: 84,333 individual service users in 2021-22, 85,000 in 2022-23, and 89,772 service users in 2023-24.[8] Service users ranged from intact families to separated parents, children, and other relatives. Services were also delivered to group service users (unidentified individuals in group sessions), with an estimated 6,723-10,098 group service users each year.[9]

FaRS service providers also delivered a very large number of sessions. A total of 269,716 sessions were delivered in 2021-22, 266,822 sessions in 2022-23, and 292,843 sessions in 2023-24.

Figure 9 provides a breakdown of sessions per financial year. Most sessions were counselling sessions (one-on-one or couple/family counselling), which also made up the largest share of sessions each year.

[8] Service user counts are based on service records and may count the same person twice if they attended different organisations.
[9] It is noted that group service user counts cannot be definitively determined because the same individuals may attend multiple group sessions without identification.

Figure 9: Number of FaRS sessions, 2021-22 to 2023-24



Source: DEX-SCORE data

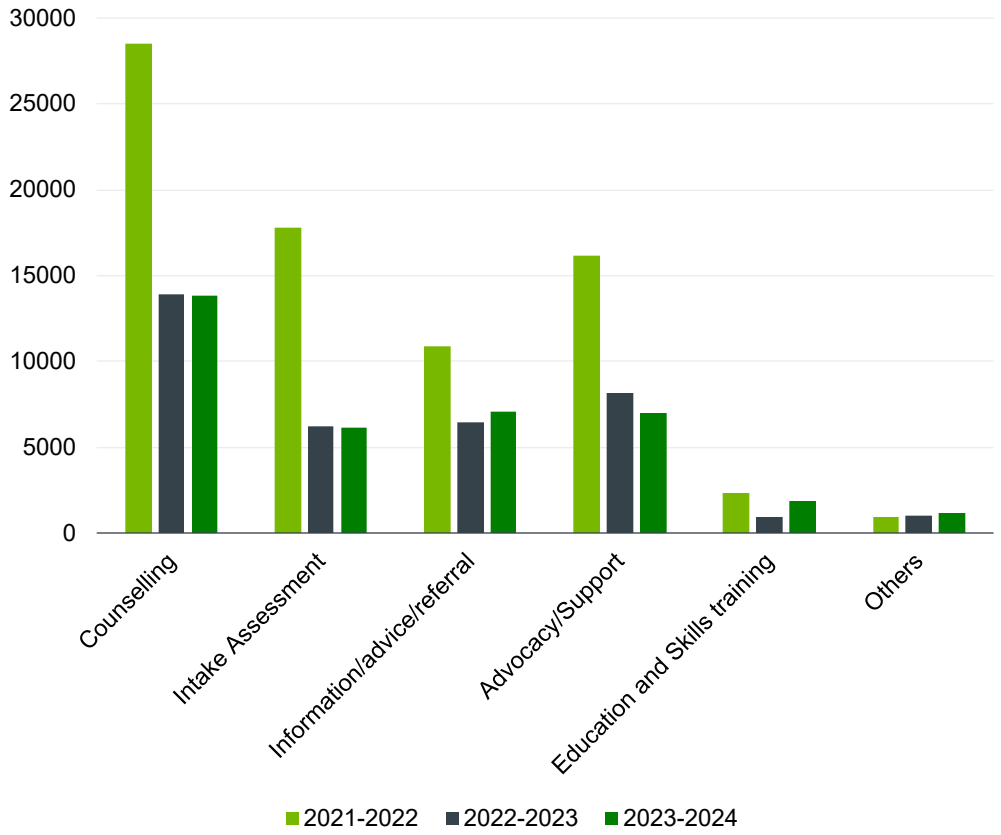
Cost per service user and session are outlined in **Figure 13** and **Figure 14** below, Expenditure for FaRS sessions is around $299-$330 on average, with 2022-23 being slightly less efficient (fewer sessions per dollar) than the other years. Efficiency rebounded in 2023-24 as sessions increased. Overall, the FaRS program maintained a consistent output per dollar, delivering about 3 sessions per $1,000 of funding each year.

SFVS

Service providers delivered SFVS services to 16,369 individuals in 2021-22, 8,808 in 2022-23, and 7,731 in 2023-24. The service user numbers have decreased over the three-year period, perhaps reflecting a deeper or more intensive service (and possibly broader service offerings). SFVS service providers also ran group-based activities such as community workshops or group counselling for children and youths. The estimated number of group service users was 1,847 in 2021-22, 905 in 2022-23 and 780 in 2023-24.

The number of SFVS sessions was highest in 2021-22 at 76,609, lower in 2022-23 at 36,675, with sessions increasing to 37,113 in 2023-24. This pattern reflects that early on, some SFVS services emphasised shorter interventions or group sessions (yielding more sessions), whereas later the program may have shifted to more intensive interventions per service user (resulting in fewer total sessions even with more funding). On average, each SFVS service user attended multiple sessions (around 4-5 sessions per service user annually). **Figure 10** provides a breakdown of sessions per financial year, noting counselling was the dominant session type.

Figure 10: Number of SFVS sessions, 2021-22 to 2023-24



Source: DEX-SCORE data

The cost per SFVS service user increased alongside funding from approximately $1,098 per service user in 2021-22 to $1,127 in 2022-23 and $1,280 in 2023-24. The cost per session increased from around $123 in 2021-22 to $338 in 2022-23 and $367 in 2023-24.

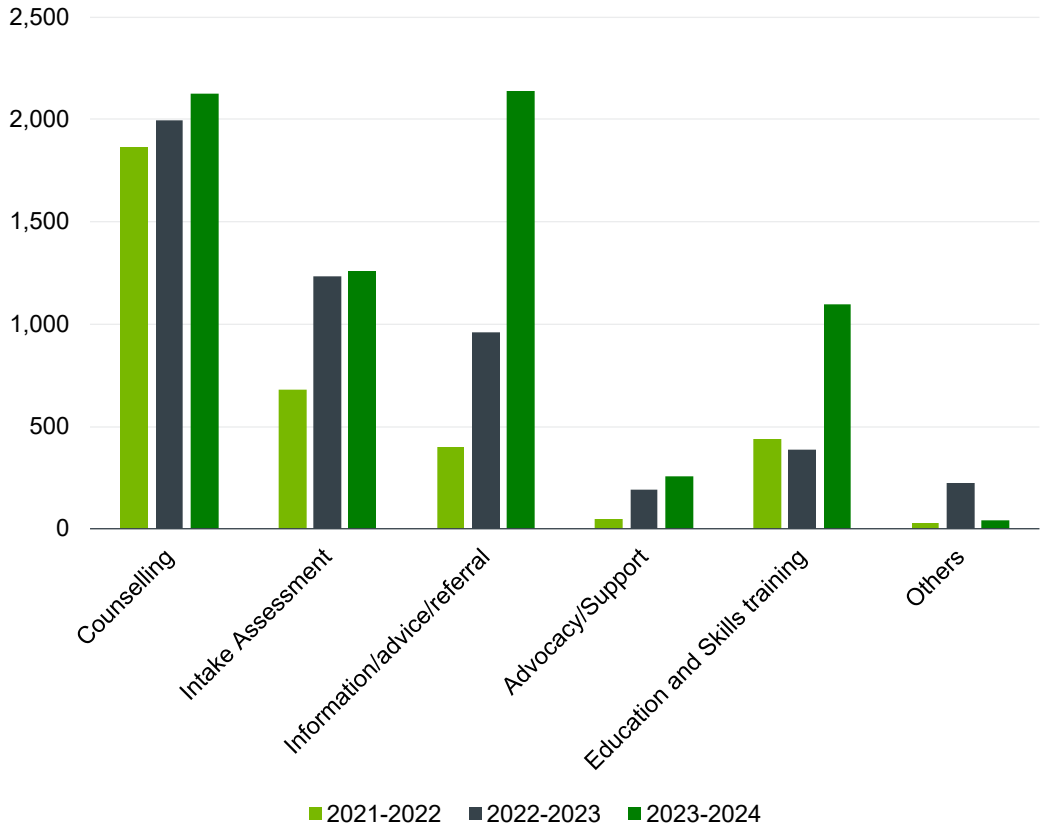
MBCP

The number of individual service users participating in MBCPs funded under SFVS rose each year, from 1,139 in 2021-22, to 1,490 in 2022-23, and 1,747 in 2023-24. This growth is to be expected given more programs started and existing programs reached capacity. The increasing service user numbers demonstrate expanding reach, although overall numbers are smaller than FaRS and SFVS.

MBCP programs are generally delivered as group programs with a number of men meeting for a set number of sessions. The total number of MBCP sessions is estimated at 3,470 in 2021-22, 4,997 sessions in 2022-23, and 6,930 sessions in 2023-24. These include all types of sessions (group meetings, individual check-ins, partner contacts, etc.). The increase in sessions aligns with the increase in programs and service users each year.

Figure 11 provides a breakdown of sessions per financial year.

Figure 11: Number of MBCP sessions, 2021-22 to 2023-24



Source: DEX-SCORE data

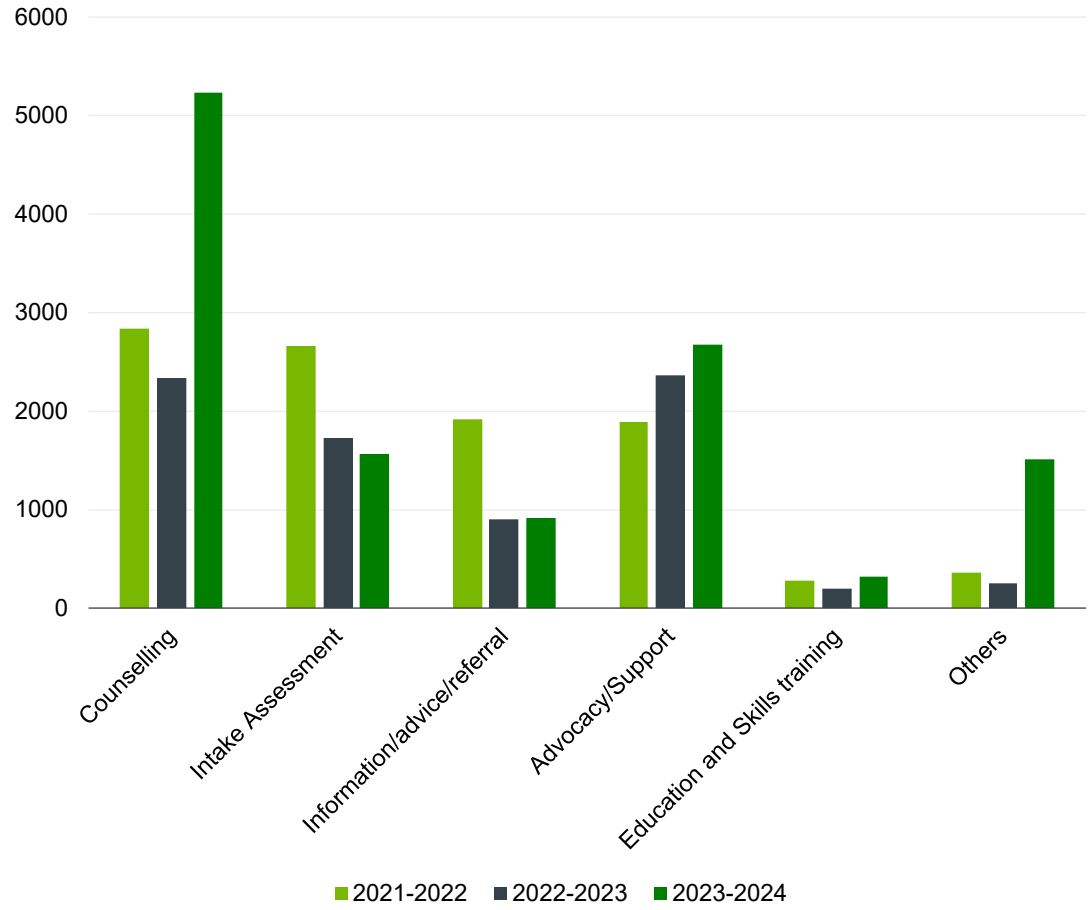
The cost per MBCP participant was relatively high due to the programs' intensive nature, costing around $827 per service user in 2021-22, increasing to $1,940 in 2022-23, and $1,992 in 2023-24. The cost per session was $271 in 2021-22, increasing to $578 in 2022-23, and $502 in 2023-24. The 2022-23 figure is slightly higher, suggesting perhaps shorter programs that year with fewer sessions per service user or startup cost issues for new service providers. By 2023-24 the cost per session came down slightly as efficiency improved. Overall, MBCPs cost more per participant than general counselling because of the required group facilitation, risk management, and length of service.

CSC

The number of service users who received services under CSC rose from 2,175 in 2021-22 to 2,526 in 2022-23 with a decrease to 1,861 in 2023-24. These child counselling programs were primarily one-on-one services with children and their caregivers. They generally did not involve 'group service users' in the way other programs might (except possibly therapeutic group activities for children). Considering the intense nature of child therapy, these figures represent a meaningful reach. The total number of Child Specific Counselling sessions delivered was substantial given the intensive work required: 8,509 sessions in 2021-22, 6,128 sessions in

2022-23, and 7,556 sessions in 2023-24.[10] Each child received on average 3-5 sessions (some would have many more, others perhaps a single assessment). **Figure 12** provides a breakdown of sessions per financial year. The fluctuation suggests some projects ramped down or shifted focus between years, but thousands of therapeutic sessions were provided annually to help children process trauma and strengthen resilience. These activities were recorded mostly as counselling and intake sessions.

Figure 12: Number of CSC sessions, 2021-22 to 2023-24



Source: DEX-SCORE data

The cost per service user for CSC rose from $816 per child in 2021-22, to $1,647 in 2022-23 and $2,661 in 2023-24. This trend indicates that as funding increased, the intensity per child also increased, with children potentially receiving more sessions or more specialist support. The cost per session also increased, from $209 per session in 2021-22, to $679 in 2022-23 and $655 in 2023-24.

MensLine

Two sources of information are available to examine the efficiency of MensLine Australia: the GPS – DEX data extract covering the period 2021-22 to 2023-24 and a data update provided

[10] The 2021–22 figure is higher than 2022–23, which might be due to one provider running many brief sessions initially (or 2022–23 data under-reporting).

directly by Lifeline up to June 2024. The latter data source is used in this analysis as it is more complete.

MensLine Australia experienced strong demand for its telephone and online chat counselling services in 2023-24, receiving 77,247 inbound calls of which 56,228 were answered (a 73% answer rate), up from 53,458 answered calls in 2022-23. The remaining 21,019 contacts went unanswered (either abandoned by the caller or not picked up). The median wait times for abandoned calls was 3.6 minutes in 2023-24, up from 2.36 minutes in 2022-23. Median talk times increased from 15 minutes in 2022-23 to 17.18 minutes in 2023-24, reflecting service users engaging in longer counselling conversations.

MensLine also provides callback counselling sessions. In 2023-24, a total of 3,067 outbound call attempts were made to service users, of which 2,820 were successfully connected (92% success). By comparison, outbound attempts were slightly higher in 2022-2023 (3,267) but have been declining since the COVID-19 pandemic. The average duration of outbound calls was 7.9 minutes in 2023-24 compared with 7.12 minutes in 2022-23, Of the outbound calls answered in 2023-24, 1,101 resulted in a completed counselling session. The remainder were shorter interactions not reaching a full counselling outcome. The demand for scheduled outbound counselling is seasonal, tending to decrease over the summer months, likely as service users' availability or needs fluctuate.

When contacting MensLine, service users are asked about the main problem or concern which led to them seeking help. Data for 2023-24 show that MensLine predominantly supports men with mental health and relationship challenges. Mental health was recorded as the primary issue in 42.7% of cases (21,611 contacts) and relationship problems in 24.3% of cases (12,279 contacts), whilst family violence was recorded in 5.6% of cases (2,852 contacts).

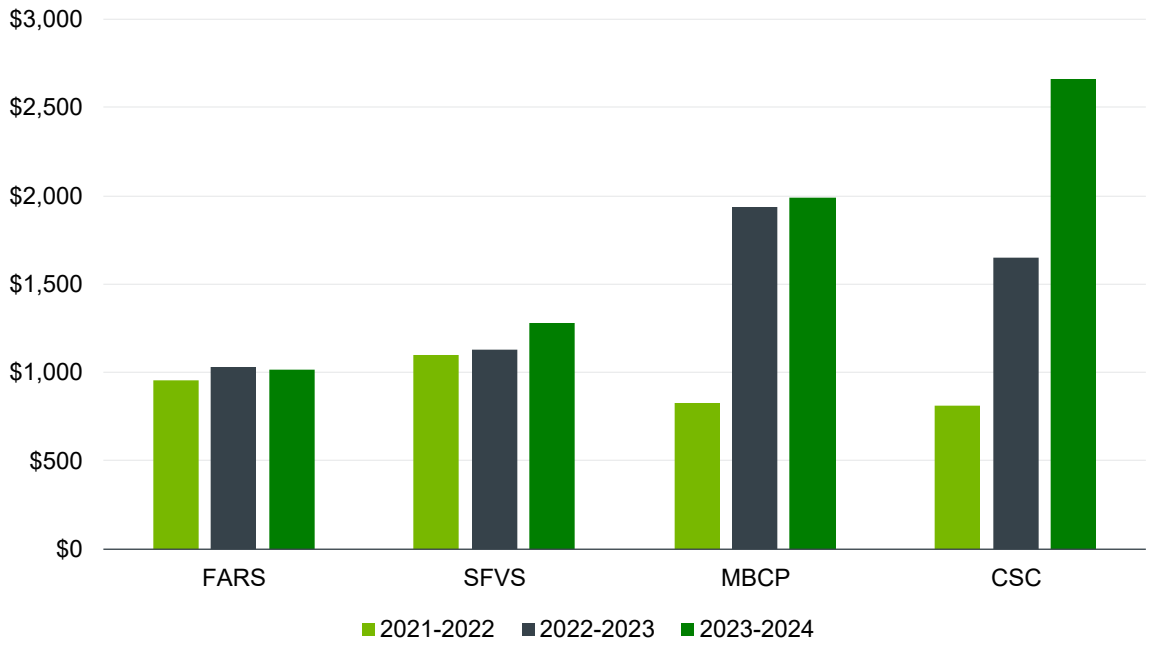
MensLine counsellors also provide referrals or service suggestions to callers for further support. In 2023-24, about 14.5% of interactions resulted in an outbound referral, amounting to 7,316 referrals given to service users. The other 85% of cases did not require an external referral with the issue handled within the counselling session. The most frequent referrals were to counselling services (1,975 referrals, 3.9% of all cases), followed by mental health services (837 referrals, 1.7% of all cases), and legal assistance and advice (789 referrals, 1.6% of all cases).

The average cost per answered call is estimated at $92.38 in 2022-23 and $86.66 in 2023-24. Client data was only available for 2023-24 (n=22,197) with cost per service user estimated at $219.51.

Comparison of cost per client and session for the four programs

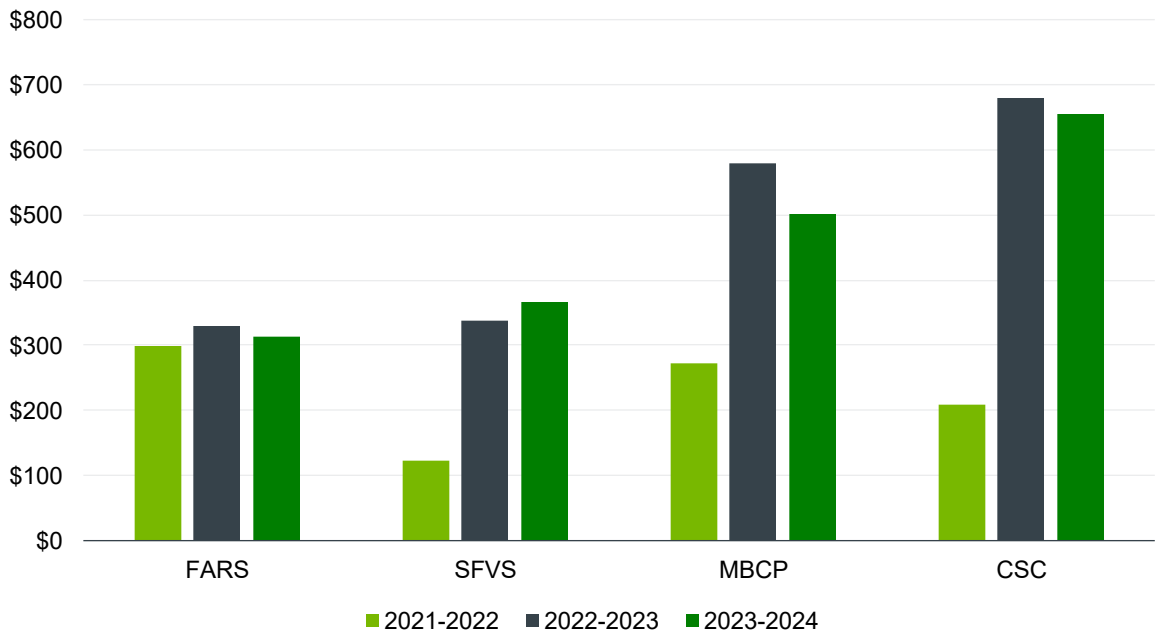
Figure 13 and **Figure 14** provide a comparison of cost per client and cost per session for each program across the period 2021-22 to 2023-24. The diagrams illustrate that both costs per client and cost per session have shown an increasing trend over time with MBCP and CSC incurring higher relative costs than FaRS and SFVS.

Figure 13: Cost per client



Source: DEX-SCORE data

Figure 14: Cost per session



4.2.3 International evidence relating to comparable interventions

Sheppard et al. (2024) undertook a systematic, scoping review of scholarly and grey literature published in English between 2010 and March 2023 relating to violence against women (VAW). In this systematic review, 19 studies were identified that reported on 24 interventions addressing VAW. The scope included only the most common forms of VAW including intimate partner violence, non-partner sexual violence, and dating violence amongst adolescents aged over 15. Interventions including those targeting women and men as victim survivors were eligible but only if most of the exposed population were women, with literature on violence against men or child abuse excluded. This review identified considerable divergence in the focus of violence prevention interventions across countries. Economic evaluations conducted in low and middle-income countries included empowerment, activism, and couples' training interventions, whereas in high-income countries, interventions focused more on training personnel, law enforcement, support services, and engagement with people who use violence.

Sheppard et al. (2024) suggest that while there is some evidence of cost effectiveness emerging for interventions implemented in specific contexts, overall, the evidence on costs and cost effectiveness of interventions for the prevention of VAW is limited. Suggestions for future work include embedding economic evaluation within future effectiveness trials and modelling the benefits and costs of interventions to better understand the societal impacts of programs. In the following analysis, we draw on this empirical research, together with program specific data, to generate several ROI estimates for FaRS and SFVS.

Four types of interventions were found to be cost effective across multiple settings or studies. These included community activism in Uganda and Ghana, gender transformative interventions with couples and individuals in Rwanda and Ethiopia, justice and law enforcement measures in the United States, and a training, support and referral program in General Practice in the United Kingdom. Conflicting evidence of cost effectiveness from two economic and social empowerment programs was found in South Africa. In relation to couples' interventions, the study found that 'engaging couples (and individuals) in gender transformative activities was cost effective in preventing cases of physical and/or sexual [intimate partner] violence when compared to a brief intervention in Ethiopia'. However, a gender transformative intervention in Rwanda which included community mobilisation, leadership training and community safe spaces was not found to be cost effective when compared to a couples' intervention (Sheppard et al., 2024).

In Zambia, compared to performing safety checks, counselling for couples experiencing alcohol misuse and violence was not cost effective. Some evidence was found for cost effectiveness of community activism interventions for the prevention of VAW in Ghana and Uganda (Sheppard et al., 2024).

Drawing on international examples, in the United Kingdom, family support and relationship education programs have shown returns in reduced welfare dependency and improved child outcomes, but scaling and consistent quality have been challenges (Churchill et al., 2020; Roy et al., 2022; Sheppard et al., 2024). Australia's FaRS network has maintained service quality and reach, which may explain its strong outcomes.

Studies in the United States on couple counselling and family therapy find improvements in relationship stability and child wellbeing, but often those programs charge fees and reach fewer low-income families, limiting equity. Australia's model of government-funded, broadly accessible family services is unique. The high service user volumes in Australia indicate a more extensive service coverage than in many countries, which might dilute intensity but still achieves measurable positive change.

The Washington State Institute for Public Policy (WSIPP) uses a comparable and comprehensive methodology to assess cost-benefit of research areas including juvenile justice, adult criminal justice, child welfare, children's mental health, adult mental health, and public health and prevention. Examples include:

- Child welfare: Intensive family preservation services are short-term, home-based crisis intervention services that emphasise out-of-home placement prevention. These programs are intended to prevent removal of a child from his or her biological home (or to promote his or her return to that home) by improving family functioning and have reported a benefit-cost ratio (BCR) of 5.14.
- Adult criminal justice: Treatment in the community for individuals convicted of sex offences. Programs use a broad range of therapeutic components, including individual and/or group counselling, cognitive behavioural therapy, aversion therapy, and other forms of psychotherapy. Treatment typically involves weekly outpatient sessions that last 1 to 2 hours and have reported a BCR of 0.12.

Personnel training, support, and referral intervention being delivered in General Practices to support victim survivors of VAW was evaluated at various stages as it was scaled up across the United Kingdom. It was found to be cost effective, at each stage of scale-up (Sheppard et al., 2024). Further, two interventions in the justice sector in the United States relating to civil legal aid services and long-term protection orders were found to have had a BCR and a positive ROI. In contrast, short-term protection orders in the United Kingdom were found to not be cost effective.

A study relating to a perpetrator intervention program for first-time people who use violence who have been categorised as 'low-risk' in the United Kingdom was also found to be cost effective stating that the 'economic benefits of reduced crime among intervention participants significantly outweighed the cost of implementation' (Sheppard et al., 2024). A study modelled the impact of a change in national policy in the United Kingdom to expand services and financial support to refugees and migrants experiencing family violence with a positive BCR reported over 10 years (with some uncertainties noted) (Sheppard et al., 2024). Another study was undertaken in the United Kingdom of support services by one provider which included refuge and housing, community outreach and independent advocacy support. The benefits were found to outweigh the cost of service delivery with an overall positive ROI. There was also some evidence to indicate the benefits of 'individual, family-, school-, and substance abuse-focused interventions for later prevention of crime and intimate partner violence modelled on an Australian population of adolescents and in later adulthood.' (Sheppard et al., 2024).

A study by Del Boca et al. (2024) highlights the outcomes of an evaluation undertaken in Italy of a parenting skills course of short duration. Parenting courses have become popular in Europe, with many countries incorporating these programs into their national strategies and

legislation. The program that was evaluated (the FACE program) intended to provide parents resources and knowledge to improve their parenting skills and impact the wellbeing of their children. The evaluation sought to understand the way in which FACE affected parents' awareness of the importance of spending time with their children, attending childcare centres, and of the use of digital devices (particularly post the COVID-19 pandemic). The evaluation found beneficial effects on 'the importance of living in an area that offers opportunities and of having good quality relationships with friends and family, on the level of self-confidence in sharing one's experiences with other parents; and in general, on the opinion that tablets and cell phones can be useful for learning, can give parents the opportunity to do something, and can calm children.' (Del Boca et al., 2024). This evaluation also found that those families that accessed the parenting course early consistently assigned more importance to being well-integrated into a community and having access to culture for their wellbeing.

A Benefit Cost Analysis of the 'Promoting First Relationships' (PFR) program (an attachment and strengths-based home visiting program for caregivers of children from birth to age 5 in Washington State) showed that the program had benefits. The analysis considered other studies seeking to tangibly quantify quality-of-life losses and highlighted that 'the divergence in estimates produced … suggests that different assumptions about victimisation costs are likely to play a key role in determining whether an investment is cost beneficial' (Kuklinski et al., 2020). The authors referenced a model and software tool developed by the WSIPP tool that provides information about which programs are effective in improving public outcomes and the expected returns on investment. The authors indicated that '…even modest assumptions about victim benefits led to substantially increased benefits from PFR.' (Kuklinski et al., 2020).

Cochrane et al. (2024) reported on a model-based cost-utility analysis which compared the usual care model provided under the Identification and Referral to Improve Safety (IRIS) intervention with IRIS+, an adapted program which provided coordinated whole-of-system family violence training and advocacy interventions. IRIS+ assisted primary care staff to identify, document, and refer men, women, and children experiencing family violence at 3 sites in England and 4 sites in Wales. Whilst this intervention included men, women, and children it did not include group MBCPs. The outcome measure used was quality-adjusted life years (QALYs). A societal lens, as opposed to a purely health perspective, was applied to the analysis. The analysis found that the IRIS+ intervention was saving £92 per patient over a ten-year time horizon and that it achieved gains of 0.003 in QALYs. The authors reported that this was the first study which assessed the 'potential cost-effectiveness of a primary care intervention providing support to all women, men, and their children experiencing domestic violence/abuse' (Cochrane et al., 2024). Whilst the outcomes of this cost-utility analysis were positive, there were significant uncertainties, including a small sample size, as indicated by the confidence intervals and simulation results (Cochrane et al., 2024).

4.3. Return on investment

A ROI benefit analysis compares a program's costs with the (quantifiable) economic and social benefits it generates. Although the costs of the FARS and SVFS programs are available (in terms of activity base expenditure), understanding the value of potential benefits is more difficult, particularly given the intermediate nature of outcomes identified in the Program Logics.

In undertaking a ROI that maps current expenditure with current (and projected) benefits, it is important to acknowledge the history of the FaRS program. This historical funding provides the platform for today's services and reinforces the importance of ongoing funding to maintain sustainable change.

Method 1: Applying Centre for International Economics (CIE) BCR results

A recent and relevant study relating to cost-efficiency and cost-effectiveness of the FaRS and SFVS programs was undertaken by the Centre for International Economics in September 2023 (the CIE Study). The CIE study was commissioned by Family and Relationship Services Australia (FRSA) to undertake a Cost-Benefit Analysis (CBA) of family and relationship services funded by the Australian Government. The scope of the CIE Study is broader than the scope of this evaluation because it included family law services as well as a broader range of families and children's activities. The CIE study found that 'family and relationship services provide a range of psychosocial, emotional, and physical benefits to Australians in need, and demonstrated a substantial return on investment' (Centre for International Economics, 2023). It found that almost all services were found to lead to 'improvements in family functioning and mental health, wellbeing, and self-care' and impacts on personal and family safety were 'significant' for specialist family violence services (Centre for International Economics, 2023). The CIE study found that 'when people receive counselling, parenting or relationship education, or adult mental health services, their level of distress is measurably lower than people who wanted services but did not receive them' (Centre for International Economics, 2023). Further, those receiving relationship education services saw greater reductions than recipients of other services on the Kessler psychological distress score. Receiving parental courses or parental support (relative to wanting but not receiving those services) was also found to reduce child difficulties scores in the internationally validated *Strengths and Difficulties* questionnaire.

The CIE study also drew on existing studies and research to highlight the impact of the FaRS and SFVS programs. It reported on a study by Schofield et al. (2015) that found that compared to individuals seeking relationship education, those seeking couples counselling tended to have more children, faced more severe relationship problems, experienced higher levels of depression and aggression, had lower levels of education, and encountered greater financial challenges (Centre for International Economics, 2023). Further, it reported that analysis by Drummond Street Services of the impact of FaRS as well as other programs found a reduction in mental health distress from the first to the final session, an improvement in child and young person wellbeing, an improvement in family relationships and an improvement in social connectedness (Centre for International Economics, 2023). It also reported that there is 'extensive evidence supporting couples counselling, like that used in FaRS, as being efficacious in reducing relationship distress' (Centre for International Economics, 2023). Despite these benefits, the CIE study did not identify any studies that estimated willingness to pay for receipt of family and relationship services.

SCORE data was used for the CIE Study and is used for this evaluation. Data is collected in DEX about the achievement of service user goals and satisfaction with services with service users asked to report the extent to which they have achieved their goals on a scale of 1 to 5, at the end of service provision. Changes in SCORE data associated with access to FaC services was found to be 'overwhelmingly positive', but SFVS have lower rates of goals being

achieved (Centre for International Economics, 2023). The approach taken in the CIE study to measuring the improvements in SCORE included estimating the benefits of improving age-appropriate development and family functioning; and estimating the benefits of improvements in personal and family safety, mental health, and wellbeing and other domains to estimate how these affect subjective wellbeing. The CIE study found that all services provide benefits that exceed costs (Centre for International Economics, 2023). The BCR of the FaC overall including all programs was found to be 8.67 with the net benefit $2.2 billion per year, with most of the net benefits deriving from improved subjective wellbeing of participants.

The Australian Government funded $585.5 million in family and relationship services in 2022/23, with the cost per service user reported at $1,185 (Centre for International Economics, 2023). The cost per service user used in the CBA undertaken by the CIE Study for FaRS was $774/service user-year; and for SFVS $1,084/service user-year.

The CIE study found that the benefits of all program components outweighed the costs. In 2022/23, the cost of FaRS was $68 million with a net benefit of $560 million and a benefit cost ratio of 9.20; and the cost of SFVS was $11 million with a net benefit of $161 million and a benefit cost ratio of 15.43.

To estimate the benefits of improving age-appropriate development and family functioning the authors relied on estimates of benefits from previous studies, which includes reducing societal costs of obesity, anxiety and depression, anti-social behaviour and improving productivity. To estimate the benefits of improvements in other SCORE domains, such as personal and family safety and mental health and wellbeing, the authors estimate how much these outcomes affect subjective wellbeing. The authors undertook extensive modelling using the Household, Income and Labour Dynamics in Australia (HILDA) data repository to estimate the value per change of one standard deviation, which is then combined with average change from earliest to latest SCORE. This study was the first (and only) attempt at using SCORE as the primary data source in an economic evaluation.

The BCR across all FaC was estimated at 8.67. FaRS was estimated at 9.20, and SFVS was estimated at 15.43. Although these estimates are very high, the authors suggest that BCRs remains positive under a range of plausible alternative assumptions. The authors found that the majority of net benefits come from increases in personal and family wellbeing (e.g. reduced fear and trauma, better relationships, greater happiness) rather than from pure financial savings. Better family functioning leads to improved mental health and school outcomes for children, which in turn improve those children's future employment prospects and reduce their likelihood of welfare dependence or contact with the justice system. In practical terms, the programs create substantial social value – healthier, happier, and more productive families – far exceeding the dollars spent.

Method 1 applies these BCR rates to FaRS and SVFS program costs for the year 2022-23. According to Department GPS data, activity base expenditure related to FaRS and SFVS in 2023-24 is estimated at $88.2 million and $12.4 million, respectively. Applying BCR results to FaRS and SFVS results in benefits estimated at $811 million and $191 million, respectively. Applying the average BCR result reported across all FaC (8.67), results in estimated benefits of $764 million for FaRS and $107 million for SFVS.

Method 2: Combining CIE value outcomes with contemporary SCORE data

Method 2 references the CIE study generated a dollar value of a 1 standard deviation change in various SCORE domains and multiplied these values with the average change from earliest to latest SCORE obtained from DEX. Contemporary unit level DEX data was analysed to examine mean change in SCORE from earliest to latest over the three-year financial year period 2021-22 to 2023-24. As per advice from the Department, outcome domains that are in scope for the current analysis and align with the CIE approach are Circumstances domains related to family functioning; personal and family safety; mental health, wellbeing and self-care. Although the CIE analysis included mental health, wellbeing and self-care, the dollar value for this domain was not reported in a consistent manner to family functioning and personal and family safety. Hence, it is excluded from this analysis.

Table 7 provides a summary of data required to generate ROI results for Method 2. The dollar value attached to each domain (from the CIE report) is multiplied by the mean change in SCORE for each domain (i.e. shift from earliest to latest SCORE using DEX data), adjusted by the proportion of service users reporting a positive change in their SCORE assessment (from DEX data) and then combining with the number of individual service users accessing FaRS and SFVS in 2022-23 from GPS – DEX extract.

Table 7: Combining CIE value outcomes with contemporary SCORE data, 2022-23

Domain	Value	Mean change in SCORE (earliest to latest)		Service users with positive change (%)		Number of service users	
		FaRS	SFVS	FaRS	SFVS	FaRS	SFVS
Personal and family safety	$9,881	0.56	0.91	42.6%	57.0%	85,298	8,808
Family functioning	$6,074	0.80	0.80	54.9%	54.9%	85,298	8,808

Source: CIE cost estimates, individual DEX data (mean change and service users with positive change), GPS – DEX data extract (number of service users)

The value of benefit generated by FaRS is estimated at $429.9 million ($201.3 million attributed to improvements in personal and family safety and $228.7 million attributed to improvements in family functioning). For SFVS, the value of benefit generated is estimated at $68.7 million ($45.3 million attributed to improvements in personal and family safety and $23.4 million attributed to improvements in family functioning). Comparing the value of benefits with the costs ($88.2 million for FaRS and $12.4 million for SVFS), results in a ROI of 4.88 for FaRS and 5.54 for SVFS.

Method 3: Transferring UK estimates to Australia

Dowrick et al (2022) quantified the social value of the Identification and Referral to Improve Safety (IRIS) program, a primary care response to domestic violence and abuse (Dowrick et al., 2022). The benefits of the program were measured in terms of prevention of future costs, i.e. by identifying and referring victims of domestic violence and abuse, the program prevents

further abuse and aggravation in the severity of abuse. In order to estimate the benefit of the IRIS Programme, the authors considered the average number of referrals each site received, multiplied by the unit cost of domestic violence and abuse and by the probability of reduction of abuse.

The unit cost of domestic violence and abuse was sourced from the UK Home Office assessment of the total costs of domestic violence and abuse in England and Wales (Oliver et al., 2019). The analysis relied on information gathered through the Crime Survey for England and Wales (CSEW). Information from the CSEW was used to calculate the likelihood of physical and emotional harm which are then used to estimate the costs of those harms (using the QALY method), the resulting health service costs and lost output.

The UK Home Office estimated the cost of domestic abuse at £66,192 million in 2016-17, equivalent to £34,015 per case. This converts to $67,661 Australian dollars in 2022-23, based on currency conversion in 2016-17 and Australian Bureau Statistics (ABS) consumer price indices. **Table 8** provides an overview of unit costs expressed in 2022-23 Australian dollars. Most costs relate to physical and emotional harm (71%) followed by lost output (21%) and health service use (4%).

Table 8: Transferring UK estimates to Australia

	2016-17 GBP	2016-17 AUD	2022-23 AUD	% contribution
Physical and emotional harm	£24,300	$41,426	$48,336.73	71%
Lost output	£7,245	$12,351	$14,411.51	21%
Health services	£1,200	$2,046	$2,387.00	4%
Victim services	£370	$631	$735.99	1%
Police costs	£645	$1,100	$1,283.01	2%
Criminal legal	£170	$290	$338.16	0%
Civil legal	£70	$119	$139.24	0%
Other	£15	$26	$29.84	0%
Total	**£34,015**	**$57,988**	**$67,661**	**100%**

Source: UK Home Office, currency converter, ABS CPI

Following Dowick's methodology, the benefit of FaRS and SFVS could be estimated by combining the unit cost of domestic violence and abuse with the probability of reduction of abuse and the total number of referrals received.

A number of assumptions are needed to undertake the ROI using this method. First, given that not all FaRS and SFVS service users present due to domestic violence and abuse, it is important to adjust accordingly. Results from the 2021-22 PSS show that about 27% of Australian women aged 18 and over have experienced violence or abuse by an intimate partner or family member since the age of 15. This proportion is identical to the qualitative findings from this evaluation that found 27% of FaRS service users interviewed were victim survivors of family violence. It is plausible that a higher proportion of SFVS service users were survivors of domestic violence and abuse but 27% is applied to both FaRS and SFVS cohorts. Second, the Circumstances domain related to personal and family safety is used as a proxy

for the reduction of abuse. As noted above, for the three-financial year period from 2021-22 to 2023-24, 43% and 57% of FaRS and SVFS assessed service users, respectively, rated a positive improvement. Third, according to the Department GPS-DEX data extract, the number of referrals for FaRS in 2022-23 was 22,986 and 6,465 for SVFS. It is acknowledged that FaRS provides a range of services beyond referrals and service users may have benefited from additional sessions or services provided. In 2022-23, referrals accounted for 9% and 18% of all FaRS and SVFS sessions provided, respectively. Using referrals only is therefore a very conservative estimate. **Table 9** provides an overview of results for Method 3 ROI. The value of benefit generated by FaRS is estimated at $178.9 million and $67.3 million for SFVS. Comparing value of benefits with the costs ($88.2 million for FaRS and $12.4 million for SVFS), results in a ROI of 2.03 for FaRS and 5.43 for SVFS.

Table 9: Overview of results of ROI analysis, 2022-23

	FARS	SVFS
Cost per assault	$67,661	$67,661
Number of referrals (2022-23)	22,986	6,465
% service users subject to abuse	27%	27%
Percent positive outcome (personal and family safety)	43%	57%
Dollar value of benefit	$178,886,770	$67,320,697
Total cost	**$88,158,944**	**$12,396,856**
BCR	**2.03**	**5.43**

Source: UK Home Office (cost per assault), GPS – DEX data extract (number of referrals, service users) Individual DEX data (service users with positive change), Qualitative findings (subject to abuse)

Although Method 3 ROIs are lower than that estimated for Method 2, Method 3 only considers improvements in personal and family safety. It is interesting to note, that using two different methodologies, the benefit attached to improvements in personal and family safety are reasonably consistent across methods. FaRS generated an estimated $201 million in benefits under Method 2 and $179 million in benefits under Method 3 (using 2022-23 data). SFVS generated an estimated $45 million in benefits under Method 2 and $67 million in benefits under Method 3 (using 2022-23 data).

Method 4: Applying a burden of disease framework

Family violence inflicts a significant burden of disease on the Australian population, especially on women. This burden can be quantified in Disability-Adjusted Life Years (DALYs), a measure that combines years of life lost (YLL) due to premature death and years lived with disability or illness (YLD). DALYs provide a holistic view of how much healthy life is lost in a population due to a particular cause or risk factor. The 2024 burden of disease study by the AIHW quantifies the attribution of child abuse and neglect, intimate partner violence (IPV) and

bullying victimisation on total burden (Australian Institute of Health and Welfare, 2024a). These risk factors of disease and injury burden vary by gender and age. Child abuse and neglect assess the impact of various forms of abuse and neglect (physical, sexual, emotional, neglect, and exposure to family violence) on mental health, physical health, and overall well-being, extending across the lifespan. IPV refers to behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. Bullying victimisation is defined as exposure to negative actions repeatedly and over time from one or more people and involves a power imbalance between the person who uses violence and the victim.

Table 10 provides an overview of 2024 burden of disease (BOD) estimates for child abuse and neglect, IPV and bullying victimisation. Child abuse and neglect result in 123,429 DALYS, or 2.5% of the total BOD. IPV account for 40,477 DALYS (0.7% of total BOD) and bullying victimisation accounts for 7,985 DALYS (0.1% of total BOD). IPV is more prevalent among women, reflected in higher disease burden. According to the AIHW (2024a), about one in every 60 DALYs in women is attributable to health issues arising from IPV including depressive and anxiety disorders, suicide and self-inflicted injuries, homicide and violence, alcohol use disorders, and early pregnancy loss. For women aged between 18-44 years, IPV has been identified as the main preventable risk factor contributing to illness and death. IPV contributes more to disease burden than well-known health risks like smoking, obesity, or hypertension in that cohort.

Table 10: Overview of BOD estimates

Risk factor	Sex	YLL	YLD	DALY	% DALY
Child abuse & neglect	Females	10,631	59,771	70,403	2.5%
Intimate partner violence	Females	7,460	33,017	40,477	1.5%
Bullying victimisation	Females	0	4,648	4,648	0.2%
Child abuse & neglect	Males	23,269	29,757	53,026	1.8%
Bullying victimisation	Males	0	3,337	3,337	0.1%
Child abuse & neglect	Persons	33,900	89,529	123,429	2.1%
Intimate partner violence	Persons	7,460	33,017	40,477	0.7%
Bullying victimisation	Persons	0	7,985	7,985	0.1%

Source: (Australian Institute of Health and Welfare, 2024a)

One DALY represents the loss of the equivalent of one year of full health. A comparable measure is a QALY that represents the value of an equivalent of one year of full health. The Pharmaceutical Benefits Advisory Committee considers medicines with an incremental cost-effectiveness ratio below $45,000 to $60,000 per QALY gained to be more likely to be

recommended for funding. Previous Australian studies have adopted a $50,000 per QALY threshold and the WHO suggest a cost-effectiveness threshold of GDP/capita per QALY. The Australian Office of Impact Analysis estimates the value of a human life year (i.e. the estimate of the value society places on reducing the risk of dying) is $235,000 in 2023 dollars. Applying a conservative estimate of $50,000 per DALY to the disease burden places the cost of child abuse and neglect at $6.17 billion, IPV at $2 billion and bullying victimisation at $399 million.

While it is challenging to precisely quantify the DALYs potentially averted by FaRS and SFVS, we can draw on available data and logical inference to assess potential impact. FaRS and SFVS are key components of Australia's public health approach to family violence. They align with what research identifies as effective strategies: early intervention, victim support, and perpetrator accountability. By addressing problems before they escalate to violence, FaRS likely prevents a portion of would-be family violence cases. By addressing problems after violence has occurred (and preventing recurrence), SFVS reduces the severity and repetition of harm. Both approaches complement law enforcement and legal responses by focusing on underlying relationships and behaviours. The effectiveness of FaRS and SFVS is articulated through the Program Logic models (see **Appendix B**) and contextualised through improvements in SCORE domains (see **Section 5** and **Appendix F**).

By strengthening relationships and improving family functioning, FaRS and SVFS can address risk factors for child abuse and neglect, IPV and bullying victimisation. For example, improvements in personal and family safety and mental health directly translate to lower ongoing burden. If a service user moves from severe PTSD to mild symptoms thanks to counselling, the personal DALY burden from mental illness is reduced. If a child in a violent home is helped by an SFVS program and avoids developing a conduct disorder or repeating the cycle of violence, that again reduces future health and social burdens. If a participant in a MBCP takes responsibility for their behaviour and learns non-violent ways of relating, even if not all participants reform, those who do can spare their family further harm, directly reducing DALYs associated with repeated assaults or chronic fear.

The primary goal of FARS and SVFS is to ensure the safety and well-being of children, with a focus on keeping families together where possible and providing support to those struggling. In 2022-23, around 1 in 32 (180,000) Australian children under the age of 18 years came into contact with the child protection system. The NSW government has estimated the future cost of providing services to this population (to the age of 40 years) at $191 billion or $61,000 per person (the average cost increases to $203,336 per Aboriginal person).

Conducting a ROI using BOD data requires assumptions about the impact of FaRS and SVFS on the relevant risk factors. It is more than plausible to suggest that these programs have an impact.

Four scenarios are used to test the implications of a lower disease burden on ROI calculations:

1. A 2% reduction in the attributable burden from child abuse and neglect, IPV and bullying victimisation, would avert 3,438 DALYS, equivalent to a monetary benefit of $172 million. Compared with a combined cost of FaRS and SVFS (in 2022-23), this would generate a ROI of 1.71. A 3% reduction would result in a ROI of 2.56, and a 5% reduction a ROI of 4.27.

2. A 2% reduction in the attributable burden from child abuse and neglect alone, would avert 2,469 DALYS, equivalent to a monetary benefit of $124 million. Compared with a combined cost of FaRS and SVFS (in 2022-23), this would generate a ROI of 1.23. A 5% reduction would result in a ROI of 3.07, a 10% reduction would result in a ROI of 6.14.

3. A 5% reduction in the attributable burden from IPV alone, would avert 2,024 DALYS, equivalent to a monetary benefit of $101 million. Compared with a combined cost of FaRS and SVFS (in 2022-23), this would generate a ROI of 1.01. A 7% reduction would result in a ROI of 1.41, a 10% reduction would result in a ROI of 2.01.

4. Suicide and self-inflicted injuries are attributable to BOD estimates for child abuse and neglect and IPV. The ABS provides information on the number of deaths by suicide (2,419 male deaths and 795 female deaths in 2023) and the average age of death (45.8 years in males and 41 years in females). Combined with average life expectancy suggest a potential YLL of 37.4 years in males and 41.0 years in females. Converting to a DALY measure, one death by suicide results in loss of 37.4 years (or DALYS) in males and 41.0 years (or DALYS) in females, much higher for children taking their own lives. The monetary value of this DALY (using $50,000 per DALY) is estimated at $1.9 million and $2 million for each male and female death, respectively. If FaRS and SFVS could avert 52 deaths by suicide (equivalent to 1.6% of total lives lost due to suicide), averting 2,038 DALYS at a benefit of $102 million, this would generate a ROI of 1.01. A 5% reduction could avert 160 deaths by suicide, averting 6,272 DALYs and generating a ROI of 3.12.

4.3.1 Value for money comparable to similar programs

In considering value for money comparable to similar programs, it is critical to understand the current cost of family and relationship breakdowns (i.e. harm) encompassing costs associated with family, domestic or sexual violence and child protection. The Department commissioned KPMG to quantify the cost of violence against women and their children in Australia. **Table 11** shows an estimated total cost of $21.7 billion which, when adjusted for inflation, equates to approximately $32.8 billion in current dollars. The report considered a range of categories:

- Pain, suffering and premature mortality of victims: The pain and suffering experienced by the victim, which can lead to long-term effects on psychological and physical health, and premature mortality for victims.
- Consumption: Replacing damaged property, defaulting on bad debts, and the costs of moving.
- Production: Being absent from work, and employer administrative costs
- Administrative: Police, incarceration, court system costs, counselling, and violence prevention programs.
- Transfer payments: Loss of income tax of victims/survivors, people who use violence and employers; additional social welfare payments; victim compensation payments and other government services.

- Health system: Public and private health system costs associated with treating the effects of violence against women.
- Second generation: The costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime.

Table 11: Current cost of family and relationship breakdowns

Categories	Cost
Pain, suffering and premature mortality of victims	$10.4 billion
Consumption	$4.4 billion
Production	$1.9 billion
Administrative	$1.7 billion
Transfer payments	$1.6 billion
Health system	$1.4 billion
Second generation	$0.33 billion
Total	**$21.7 billion**

Source: KPMG 2016

The burden of disease framework (Method 4 of ROI) can also be used to generate costs of family violence using the risk factors of child abuse and neglect, IPV and bullying victimisation. **Table 12** provides a summary of BOD using two methods to value a DALY - $50,000 per DALY and $235,000 per DALY. The second approach considers the Australian Office of Impact Analysis estimates of the value of a human life year. Using $50,000 per DALY provides an estimate of $8.6 billion; using the Value of Statistical Life Year (VSLY) ($235,000 per DALY) provides an estimate of $40.4 billion.

Table 12: Burden of disease - DALY

Risk factor	Sex	DALY	Using $50k / DALY	Using VSLY
Child abuse & neglect	Females	70,403	$3.5 billion	$16.5 billion
Intimate partner violence	Females	40,477	$2,0 billion	$9.5 billion
Bullying victimisation	Females	4,648	$0.23 billion	$1.1 billion
Child abuse & neglect	Males	53,026	$2.7 billion	$12.5 billion
Bullying victimisation	Males	3,337	$0.17 billion	$0.78 billion

Risk factor	Sex	DALY	Using $50k / DALY	Using VSLY
Child abuse & neglect	Persons	12,3429	$6.2 billion	$29.0 billion
Intimate partner violence	Persons	40,477	$2.0 billion	$9.5 billion
Bullying victimisation	Persons	7,985	$0.40 billion	$1.9 billion
Total		**171,891**	**$8.6 billion**	**$40.4 billion**

Source: (Australian Institute of Health and Welfare, 2024a)

Compared to generalist or reactive services, FaRS and SFVS demonstrate lower per-capita delivery costs. Reviews undertaken by ANROWS and AIFS rank both FaRS and SFVS in the top quartile for outcomes versus investment (Australian Institute of Family Studies, 2024a; Bell and Coates, 2022; Coates et al., 2022; Rose and Coates, 2021). Both FaRS and SFVS also demonstrate high long-term social and fiscal savings.

Previous studies of family services in Australia showed strong returns. The recent CIE (2023) report found a ROI of 9.2 and 15.4 for FaRS and SFVS, respectively, indicates that each are performing above past benchmarks (this may be due to improved outcome measurement via SCORE, as well as possibly greater effectiveness of services over time).

Programs with similar aims (strengthening families, preventing harm) such as intensive home visiting for at-risk infants, or parenting programs like Triple P, typically show positive but modest ROI, often in the range of 2:1 to 5:1 when rigorously evaluated. The CIE FaRS ROI of 9.2 suggests that the integrated, flexible support provided by FaRS may be more cost-effective than siloed interventions.

4.3.2 Sufficiency of funding

Government investment in FaRS has its origins in marriage guidance and family counselling grants dating from 1959. While investment remained minimal through the 1970s and 1980s, funding was dramatically expanded in the 1990s. The 1996 budget doubled support for family/relationship services and by 1996-97, the FRSP budget was roughly $28 million in total, of which about $17.9 million funded the broad Family and Relationship Counselling programs. After 2000, FaRS funding continued rising. In 2003-04, government funding was about $56 million, after this FaRS funding has been relatively stable in the $65–90 million range. The SFVS component was introduced later and is smaller growing from $4.7m in 2017-18 to almost $14 million in 2023-24.

Table 13 and **Table 14** show the Government's annual investment in FaRS and SFVS and specific SFVS program from 2021-22 to 2023-24.

Table 13: Government annual investment for FaRS and SFVS

	FARS	SFVS	Total
2021-22	$80,614,137	$9,409,094	$90,023,231
2022-23	$88,158,944	$12,396,856	$100,555,801
2023-24	$91,543,414	$13,634,178	$105,177,591
Total	**$260,316,495**	**$35,440,128**	**$295,756,623**

Source: FaRS and SFVS Program Dashboards supplied by the Department

Table 14: Government annual investment for SFVS programs

	MBCP	CSC	MensLine	ACCO
2021-22	$941,547	$1,774,768	$4,512,178	$793,931
2022-23	$2,890,671	$4,161,309	$4,938,285	$1,036,336
2023-24	$3,479,270	$4,951,622	$4,872,510	$1,060,414
Total	**$7,311,488**	**$10,887,698**	**$14,322,974**	**$2,890,681**

Source: SFVS Program Dashboard supplied by the Department

While the majority of FaRS funding is sourced from Australian Government grants, FaRS providers are permitted to charge fees to service users, typically on a sliding scale based on household income. However, service users cannot be denied services due to an inability to pay. SFVS services must be offered free of charge to participants by service providers who receive funding under 4AP2. By way of example, one provider's fee schedule indicates that for counselling services, fees are calculated at $1 per $1,000 of household income, capped at $110 per session. For concession card holders, a flat fee of $30 per session applies. These fees have been designed to contribute to service costs while ensuring accessibility for all service users. They are supplementary and aim to enhance service sustainability without compromising access.

While specific national revenue figures from service user fees are not available, such fees would constitute a minor portion of overall funding (estimates suggest less than 3% of program funding). Qualitative data provides further detail. 74% of survey respondents indicated that they had to pay a fee to access a FaRS or SFVS service, with 24%, 36% and 35% of service users indicating that they had to pay between $1-$30, $31-$60, $61-$90, respectively (**Figure 48**). 83% agreed or strongly agreed that the fee to access the service was reasonable (see **Figure 47**).

Whilst funding levels for FaRS and SFVS have increased, there are indications that funding has not kept pace with demand or the increasing complexity of service user needs. The high societal costs of family breakdown and violence (manifested through burden of disease estimates) serve as a counterfactual. As noted in the ROI analysis, even capturing a small fraction of those avoided costs can justify program expenditures. The CIE study showed that most benefits came from improved wellbeing rather than direct cost savings, yet even the direct savings (like court and health costs avoided) were large relative to program cost. Few

other social programs have such a mix of substantial non-monetary benefits plus significant monetary savings. For instance, employment services might save government welfare payments, but they do not necessarily create large wellbeing improvements. Mental health programs improve wellbeing but may not save money immediately. However, FaRS and SFVS are impressive in their improvement of lives and reduction of future expenses.

Despite this, both FaRS and SFVS are experiencing significant funding shortfalls that hinder their ability to meet increasing demand and service complexity. These shortfalls manifest as waitlists, staff turnover, and limits to sessions per service user. While recent funding initiatives have provided some relief, they have not fully addressed the systemic underfunding issues. Sustainable, long-term investment is necessary to ensure these essential services can effectively support families and individuals in need. Modelling will provide further context to unmet need.

Effectiveness

5. Effectiveness

Aligned with the overarching program aims (see **Section 1**), the FaRS and SFVS programs each have specific goals to achieve within the short, medium, and long term (see Program Logics at **Appendix B** and **Table 15** below). This section outlines the extent to which the FaRS and SFVS programs have been successful at meeting their short- and medium-term outcomes (KEQ 1); and what factors have affected the achievement of these outcomes (KEQ 2).

Table 15: FaRS and SFVS short- and medium-term outcomes

	FaRS	SFVS
SHORT-TERM OUTCOMES	Families have increased knowledge, awareness and skills in: • identifying issues of personal and family safety, including violent or abusive relationships, • knowing who they can confide in or turn to for support and • learning strategies to improve or maintain personal and family safety	Victim survivors have improved knowledge and skills in: • identifying issues of personal and family safety, including violent or abusive relationships; • knowing who they can confide in or turn to for support; • learning strategies to improve personal and family safety and • learning strategies to improve mental health and wellbeing.
	Families have increased knowledge, skills and access to support in: • modelling healthy respectful relationships, including effective communication and conflict resolution and parenting skills (including shared parenting)	Children impacted by FDSV have improved knowledge and skills in: • knowing who they can confide in or turn to for support when they don't feel safe (e.g. professionals, families and friends) and • improving their mental health and wellbeing
	Families and children have improved knowledge, skills and access to support to improve their resilience, mental health and wellbeing when experiencing family breakdown or dysfunction	People who use violence have increased knowledge and skills in: • techniques and strategies to reduce violent and abusive behaviours; and • seeking help to reduce violent and abusive behaviours.
MEDIUM-TERM OUTCOMES	Families use effective strategies to: • identify issues of personal and family safety, including violent or abusive relationships; • seek help when needed for issues of personal and family safety and • improve or maintain personal and family safety.	Victim survivors use effective strategies to: • identify issues of personal and family safety, including violent or abusive relationships; • seek help when needed for issues of personal and family safety; • improve personal and family safety; and • improve mental health and wellbeing.
	Families use effective strategies to: • model healthy, respectful relationships, including effective communication and conflict resolution; and • improve their parenting skills (including shared parenting)	Children impacted by FDSV: feel safe, heard and supported; access supports when needed and are supported to improve their mental health and wellbeing.
	Families and children use effective strategies to improve their resilience, wellbeing and mental health when experiencing family breakdown or dysfunction	People who use violence use effective strategies to: • reduce their violent and abusive behaviours and • seek help and access supports to reduce violent and abusive behaviours.

5.1. Key findings

Findings	
2	**FaRS and SFVS are effective in improving outcomes in personal and family safety, mental health and wellbeing and relationships for many Australians.** Overall, people who use FaRS and SFVS services experience improvements across the short- and medium-term outcomes in the Program Logics. These outcomes include improved knowledge and skills relating to personal and family safety, respectful relationships and conflict resolution, and resilience, wellbeing and mental health.
3	**The flexibility of the program guidelines is a key factor contributing to the effectiveness of FaRS and SFVS** The FaRS and SFVS Operational Guidelines grant service providers latitude to tailor service provision to the needs of their communities and individual service users. Service providers are using this flexibility to shape their service offerings and modes of delivery (including the use of virtual platforms) in ways that enhance outcomes. While this flexibility is a key strength of the programs, there is evidence that the program guidelines are sometimes applied inconsistently. Further research is needed to understand how this impacts equitable access to services.
4	**Changes in Australian society, service systems and workforce are placing FaRS and SFVS under pressure** There is increasing complexity in service user presentations and needs. Service users are presenting with higher rates of family violence, mental ill health, neurodiversity and intersecting disadvantages. At the same time, service providers report challenges referring service users into a service system which is under strain. While a key enabler of the success of the FaRS and SFVS programs is the expertise and dedication of service providers, some feel inadequately trained or equipped to meet the increasingly complex needs of many service users. These trends are increasing the demand for services, requiring more intensive and integrated service responses, and impacting providers' capacity to respond to these demands.
5	**FaRS and SFVS are filling key gaps in the public health and social services system** FaRS is intended to be primarily a prevention and early intervention program. Increasing client complexity mean FaRS and SFVS services are often providing services across the intervention spectrum, including crisis response. Many service providers are delivering these services without adequate training and resources.

There is evidence that a minority of FaRS service users are seeking support through the FaRS program because clinical mental health services are unavailable or inaccessible.

5.2. Achievement of short and medium-term outcomes

There is evidence that overall, people who use FaRS and SFVS services experience improvements across the short- and medium-term outcomes in the Program Logics. DEX-SCORE data demonstrates improvement in the mean increase in earliest to latest SCORE changes for Circumstance and Goal domains (see **Table 16** below).[11] This aligns with feedback from service users, who reported in interviews and surveys that accessing a FaRS or SFVS service had a positive impact on their relationships, families, and/or their personal wellbeing (see **Section 5.2.1** and **Section 5.2.2**). All comparisons were statistically significant (p<.001).

Table 16: Earliest to latest mean SCORE change for overall Circumstance and Goal domains, FaRS and SFVS, July 2021 – June 2024

Activity	Outcome type	Total service users (n=)	SCORE change (mean)
FaRS	Circumstances	73,827	+0.77
	Goals	73,483	+1.13
SFVS (incl. 4AP2)	Circumstances	7,462	+0.92
	Goals	7,131	+1.06

Source: DEX-SCORE data

Positive change was observed in 62.7% of FaRS service users and 66.5% of SFVS service users for relevant Circumstances and 72.8% of FaRS service users and 69.7% of SFVS service users for Goals (see **Table 17**).

Table 17: Percentage of service users with positive SCORE change for overall Circumstance and Goal domains, FaRS and SFVS, July 2021 – June 2024

Activity	Outcome type	Service users with positive mean change (%, n=)
FaRS	Circumstances	62.7% (n=46,253)
	Goals	72.8% (n=53,480)
SFVS (incl. 4AP2)	Circumstances	66.5% (n=4,962)
	Goals	69.7% (n=4,972)

Source: DEX-SCORE data

[11] All increases were statistically significant (p <.001) in Wilcoxon test utilising the Bonferroni adjustment to account for the number of comparisons.

All priority cohorts for whom DEX data is available showed improvement in mean earliest to latest SCORE changes for Circumstance and Goal domains with more than half of all service users across each of the cohorts experiencing a positive change in their mean SCORE (see **Table 18** and **Table 19** below).[12]

Table 18: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Circumstance outcomes by cohort, FaRS and SFVS, July 2021 – June 2024

Cohort		FaRS			SFVS (incl. 4AP2)		
		Total service users (n=)	SCORE change (mean)	% with positive change	Service users (n=)	SCORE change (mean)	% with positive change
CALD	Non-CALD	42,938	1.21	74.6	3,912	1.1	71.1
	CALD	2,845	1.19	71.6	330	1.01	67
Aboriginal and Torres Strait Islander	Non-Aboriginal and Torres Strait Islander (or unknown)	70,887	1.13	72.8	6,652	1.06	70
	Aboriginal and Torres Strait Islander	2,596	1.17	73.1	479	1.04	66.4
People with disability	Without disability (or unknown)	68,047	1.14	72.9	6,161	1.05	69.8
	With disability	5,436	1.06	70.8	970	1.13	69.4
Gender	Female	27,289	1.22	74.9	2,877	1.16	73.7
	Male	17,792	1.2	73.6	1,306	0.96	64.6
Age	Adults	66,930	1.12	72.7	6,168	1.1	71
	Under 18 years	6,442	1.26	74.1	946	0.83	61.5
All service users			**1.13**	**72.8**	**7,131**	**1.06**	**69.7**

Source: DEX-SCORE data

Similarly, all cohorts showed improvement in mean earliest to latest SCORE changes for Goal domains with more than half of all service users experiencing a positive change (see **Table 19**).

[12] Recent changes to DEX reporting now record non-binary or self-identified gender identify. This change was introduced in February/March 2024. DEX does not capture data on service user sexuality. For these reasons, the evaluation does not provide analysis on DEX data related LGBTQIA+ status

Table 19: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by cohort, FaRS and SFVS, July 2021 – June 2024

Cohort		FaRS			SFVS (incl. 4AP2)		
		Total service users (n=)	SCORE change (mean)	% with positive change	Service users (n=)	SCORE change (mean)	% with positive change
CALD	Non-CALD	4,2938	1.21	74.6	3,912	1.1	71.1
	CALD	2,845	1.19	71.6	330	1.01	67
Aboriginal and Torres Strait Islander	Non-Aboriginal and Torres Strait Islander (or unknown)	70,887	1.13	72.8	6,652	1.06	70
	Aboriginal and Torres Strait Islander	2,596	1.17	73.1	479	1.04	66.4
People with disability	Without disability (or unknown)	6,8047	1.14	72.9	6,161	1.05	69.8
	With disability	5,436	1.06	70.8	970	1.13	69.4
Gender	Female	27,289	1.22	74.9	2,877	1.16	73.7
	Male	17,792	1.2	73.6	1,306	0.96	64.6
Age	Adults	66,930	1.12	72.7	6,168	1.1	71
	Under 18 years	6,442	1.26	74.1	946	0.83	61.5
All service users		**73,483**	**1.13**	**72.8**	**7,131**	**1.06**	**69.7**

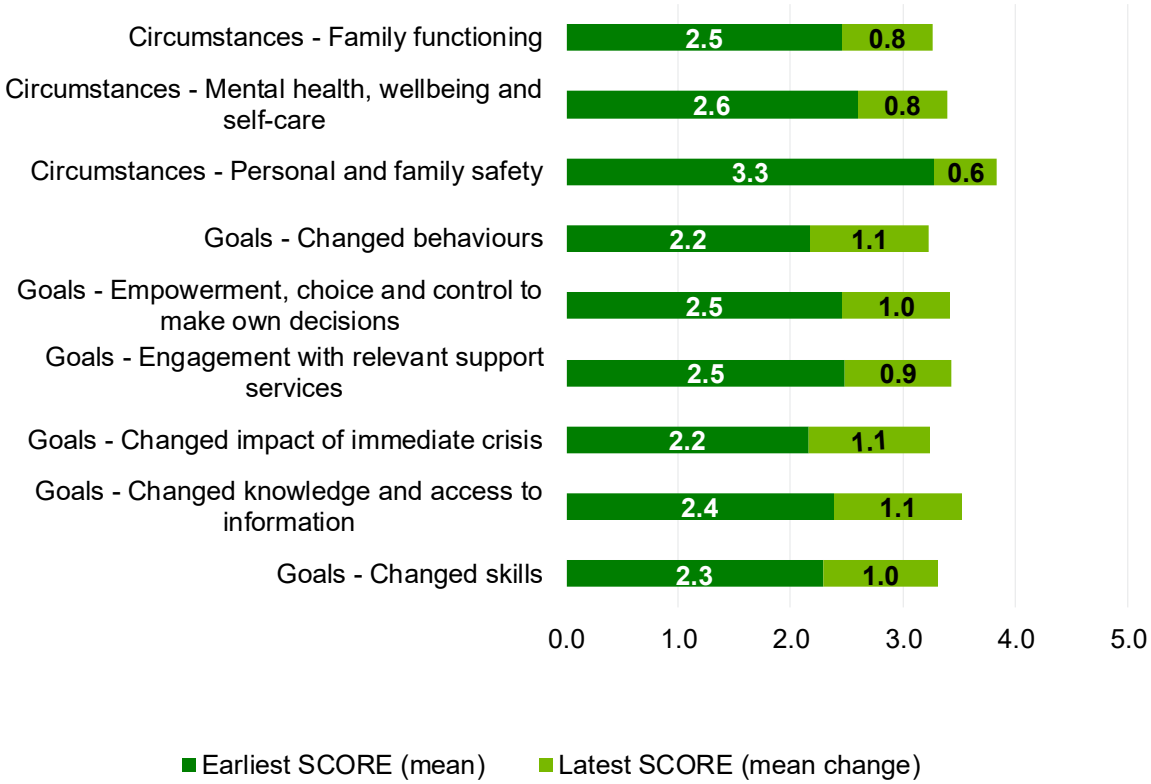
Source: DEX-SCORE data

Section 5.2.2 and **Section 6.4** provide a more detailed breakdown of outcome for cohort.

5.2.1 Achievement of outcomes for FaRS

Overall, FaRS service users are benefiting from their participation in the program and are highly satisfied with the services they receive. On a 5-point outcome SCORE scale, average Circumstance SCOREs including family functioning; mental health, wellbeing and self-care; and personal and family safety increased by approximately +0.75 points from earliest to latest, on average, for service users who provided SCORE data. FaRS also performed well in helping service users progress toward their self-identified goals. Goal attainment SCOREs increased by around +0.95 points on average (see **Figure 15**).

Figure 15: Earliest to latest mean SCORE change for specific Circumstance and Goal outcomes by cohort, FaRS, July 2021 to June 2024



Source: DEX-SCORE data

In percentage terms, 54.9% of FaRS service users experienced improved family functioning, 55.5% experienced improved mental health, and wellbeing; and 42.6% experienced improved personal and family safety. The percentage increase for personal and family safety is likely due to FaRS' focus on family and relationship issues with more serious issues of family violence being referred to SFVS. Approximately 60–65% of FaRS service users had positive goal outcomes (see **Table 20**).

Table 20: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, FaRS, July 2021 – June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	54.9% (n=36,522)
	Mental health, wellbeing and self-care	55.5% (n=33,940)
	Personal and family safety	42.6% (n=17,913)
Goals	Changed behaviours	64.5% (n=27,682)
	Changed impact of immediate crisis	66.4% (n=15,105)

Outcome Type	Domain description	Service users with positive mean change (%, n=)
	Changed knowledge and access to information	66.2% (n=33,137)
	Changed skills	63.9% (n=33,985)
	Empowerment, choice and control to make own decisions	61.0% (n=24,818)
	Engagement with relevant support services	60.4% (n=17,110)

Source: DEX-SCORE data

Service user satisfaction with FaRS services was high across both quantitative and qualitative data. DEX data indicates that around 94% reported an overall positive outcome on satisfaction surveys each year. Evaluation survey data – while less positive – nonetheless indicates high levels of satisfaction with 77.8% (n=151) of respondents indicating they were satisfied (28.4%, n=55), or very satisfied (49.5%, n=96) with the service they received.

Personal and family safety

A key component of the FaRS program is to provide early intervention and prevention services for families at risk of breakdown, children at risk of abuse or neglect and families at risk of experiencing disadvantage or vulnerability. A core component of prevention and early intervention is ensuring that individuals and families can identify risks to their safety and wellbeing. Broadly, FaRS supported some service users to identify and address issues of family safety, including violent or abusive relationships. DEX-SCORE data for the personal and family safety domain shows FaRS service users experienced a 0.6 increase in the earliest to latest mean SCORE with 42.6% experiencing a positive change (see **Table 21**).

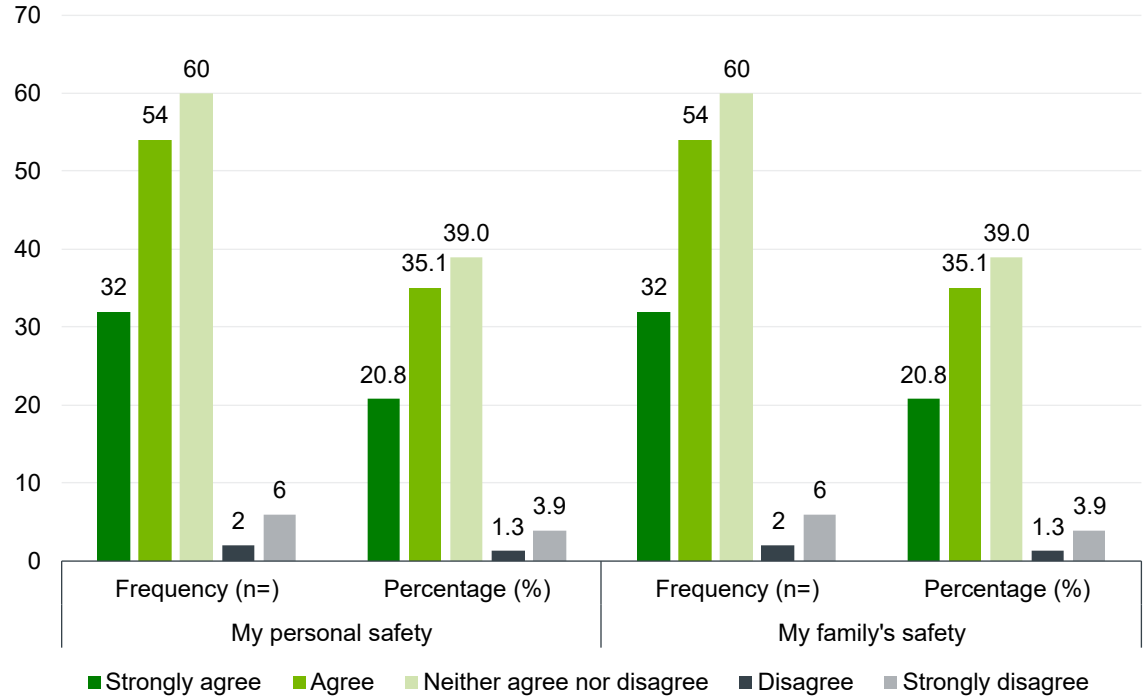
Table 21: Earliest and latest mean SCORE change and percentage of service users with positive SCORE change for personal and family safety, FaRS, July 2021 – June 2024

Outcome type	Domain	SCORE change (mean, n=)	Service users with positive change (%, n)
Circumstance	Personal and family safety	0.6 (n=42,074)	42.6% (n=17,913)

Source: DEX-SCORE data

Over half of service users surveyed reported improvements in personal safety (55.8%, n=86) and in family safety (56.4%, n=87) (see **Figure 16** below).

Figure 16: As a result of using the service I have experienced positive changes in my personal safety / my family's personal safety, FaRS service users (n=154)



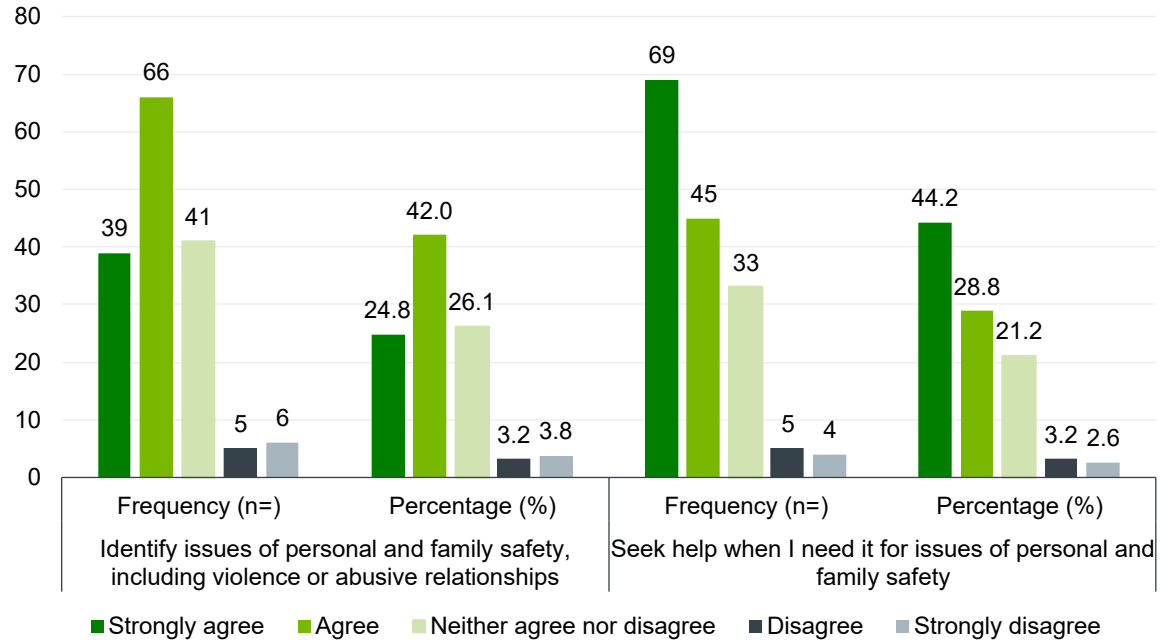
Source: Service user survey

For some service users who identified as victim survivors, accessing FaRS services (particularly counselling services) helped them to recognise that they were in abusive relationships. Victim survivors were a key cohort accessing FaRS services, with 27% (n=20) of FaRS service users interviewed, and 18% (n=29) of FaRS survey respondents identifying as victim survivors. Seven victim survivors directly noted that their service provider educated them about family violence, identifying abuse within their relationships, and information on navigating their relationships to support the safety of themselves, and their families.

> *When I went there, I had been married for [over 20] years. I was told that I was probably in a family violence marriage all my married life, but I didn't know that. Just them explaining to me all the parts of the family violence – the emotional, psychological, I wasn't aware of all of that stuff. They've helped me with my daughter – they've seen my child on occasion. That's some of the things that have helped me – with grounding strategies, help sleeping, all those sorts of things, and just talking and listening* ***– FaRS service user***

Over 65% of survey respondents agreed or strongly agreed that they had strategies to identify issues of personal and family safety (67.3%, n=105) or seek help for issues of personal and family safety (73.1%, n=114) (see **Figure 17** below). Several service users reflected that attending a service which believed and affirmed their experiences supported them to feel safe. As a result, some service users reported increased confidence in applying their skills and knowledge within their relationships.

Figure 17: As a result of using the service, I now have strategies to identify issues of personal and family safety, FaRS service users (n=158) / seek help when I need it for issues of personal and family safety, FaRS service users (n=157)



Source: Service user survey

Where the service did not increase feelings of personal and family safety, service users reported their service provider did not tailor their service to the presenting issue. Consequently, they did not feel understood, or that the service they received was relevant to their needs. For further information on factors affecting outcomes for service users see **Section 5.3**.

Some FaRS service users reported that their service provider had given them referrals to other specialist services, including mental health services, supporting their knowledge and ability to seek support outside of the FaRS service provider. However, some FaRS service users said they were either not referred to other services or the services that they were referred to were unhelpful or had long wait times which made getting access difficult.

> *The counsellor has said to my mum … I think she might benefit from seeing a psychologist by herself, but I don't think she has [referred her]. I find the services […] a little more passive* ***– FaRS service user***

Modelling healthy and respectful relationships

FaRS generally increased service users' knowledge, skills and access to support to enable them to model healthy relationships. Communication difficulties, and conflict as a result of these difficulties, were common presenting issues for FaRS service users. Couples and families found FaRS services helpful in developing more effective communication skills. This included active listening skills, remaining calm, and practicing empathy. Collaborating as a family, or as partners, enabled service users to better understand one another.

> *What I loved about [service provider] is that they gave me, my son and daughter each an individual counsellor. Every week we came back, and they gave us new ideas and tips about how to communicate together. It was never about blame, it was about progressively working together and working on having a good relationship* ***– FaRS service user***

Other techniques that supported the modeling of healthy relationships included breathing and grounding skills, which enabled service users to be more present, and less reactive when in conflict with their partners.

> *Yeah, I definitely learned from couples counselling. I definitely learned from my side, at least to communicate better. I definitely had tendencies to just, you know, blame and say 'you never and you always' type of […] arguments, which were never helpful. So […] they provided some techniques I definitely learned and do use [them] for myself […] bringing myself back to moment, I can spiral pretty quick[ly], so I do appreciate techniques that help me […] ground myself* ***– FaRS service user***

These techniques and skills supported service users to better manage conflict and supported the modeling of healthy relationships by enabling service users to communicate and solve their issues collaboratively. Service users reported that the skills they had learnt through FaRS had resulted in improvements in their relationships or had enabled partners to decide to separate. This was seen as a success by service users, as they were now able to communicate with future partners more effectively, and understand their own communication styles.

> *[It] helped me get through two emotionally hard relationships and come out the other side with a clearer perspective of my own needs and actions –* ***FaRS service user***

Service users who found that engagement with FaRS did not improve their communication or conflict resolution skills noted that their counsellor or facilitator was unable to provide concrete techniques that they could use in their day-to-day lives (see **Section 5.3** for more detail).

Resilience, mental health and wellbeing

For many service users, the FaRS service has been instrumental to their mental health and wellbeing. The DEX-SCORE change for mental health, wellbeing, and self-care was the highest mean earliest-latest SCORE change (alongside family functioning) across the Circumstances domains at 0.8. 55.5% of service users recorded a positive change (see **Table 22**).

Table 22: Earliest and latest mean SCORE change and percentage of service users with positive SCORE change for mental health, wellbeing, and self-care, FaRS, July 2021 to June 2024

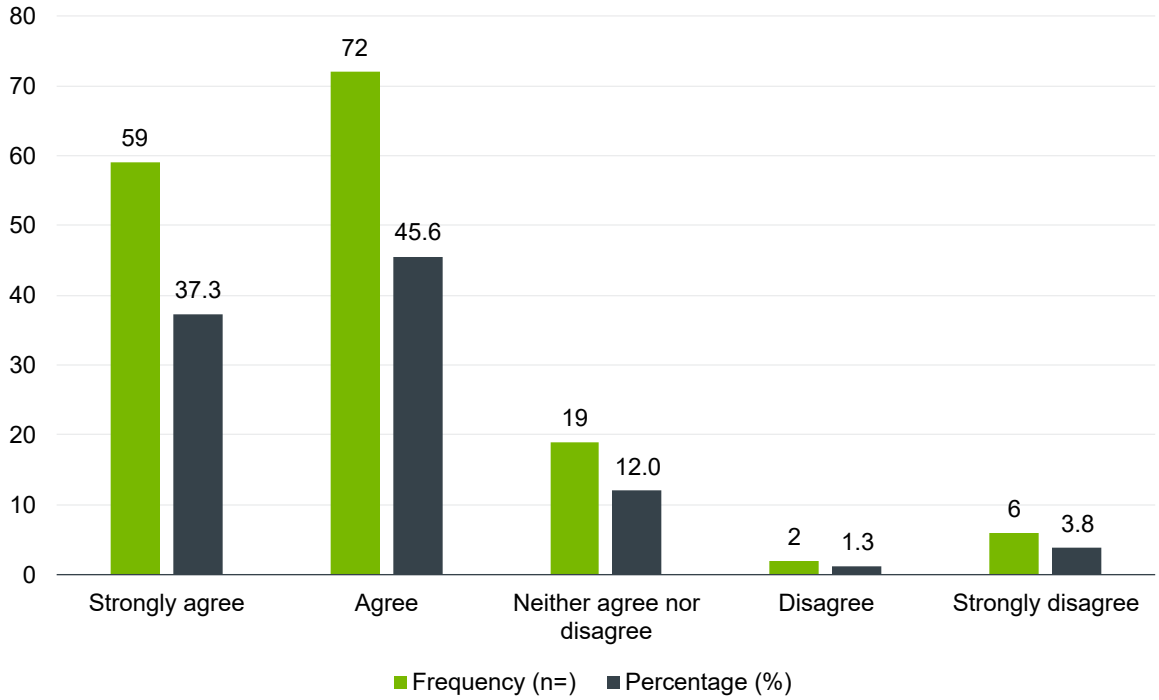
Outcome type	Domain	SCORE change (mean, n=)	Service users with positive change (%, n)
Circumstance	Mental health, wellbeing, and self-care	0.8 (n=61,150)	55.5% (n=33,940)

Source: DEX-SCORE data

Service users described presenting to their FaRS provider for a wide range of mental health and wellbeing issues, including trauma, grief, anxiety, depression, relationship or familial difficulties, and an inability to cope with issues or challenges in their day to day lives.

As a result of accessing a FaRS service, the majority of service user survey respondents agreed (45.6%, n=72) or strongly agreed (37.3%, n=59) that they had strategies to improve their mental health and wellbeing (see **Figure 18** below).

Figure 18: As a result of using the service, I now have strategies to improve mental health and wellbeing, FaRS service users (n=158)



Source: Service user survey

Some service users reported that their provider supported them to better understand themselves by discussing different perspectives, and by reflecting on their past experiences and their emotional responses to them. Accessing FaRS services enabled service users to develop emotional regulation skills as they face challenges in their everyday lives. Several service users reported that the issues impacting them were complex. Emotional regulation skills supported feelings of independence and inner strength for service users.

> *I think in a way, because even though you're using a service to help you, which is a support […] It helps you to become more independent because once you can master or control your emotions and learn to self soothe or be there for yourself, you don't always need someone there for you* ***– FaRS service user***

Similarly, many service users who felt positively about the FaRS service they received reflected that their provider had helped them to develop a range of resilience skills, including mindfulness, stronger boundaries, and how to process feelings of grief.

> *As the counselling progressed, she taught me techniques because my mind sometimes gets stuck on things, and I can't get rid of it, and I suffer from anxiety, and she taught me mindfulness. I have been using that technique and it has been very helpful [for] me* ***– FaRS service user***

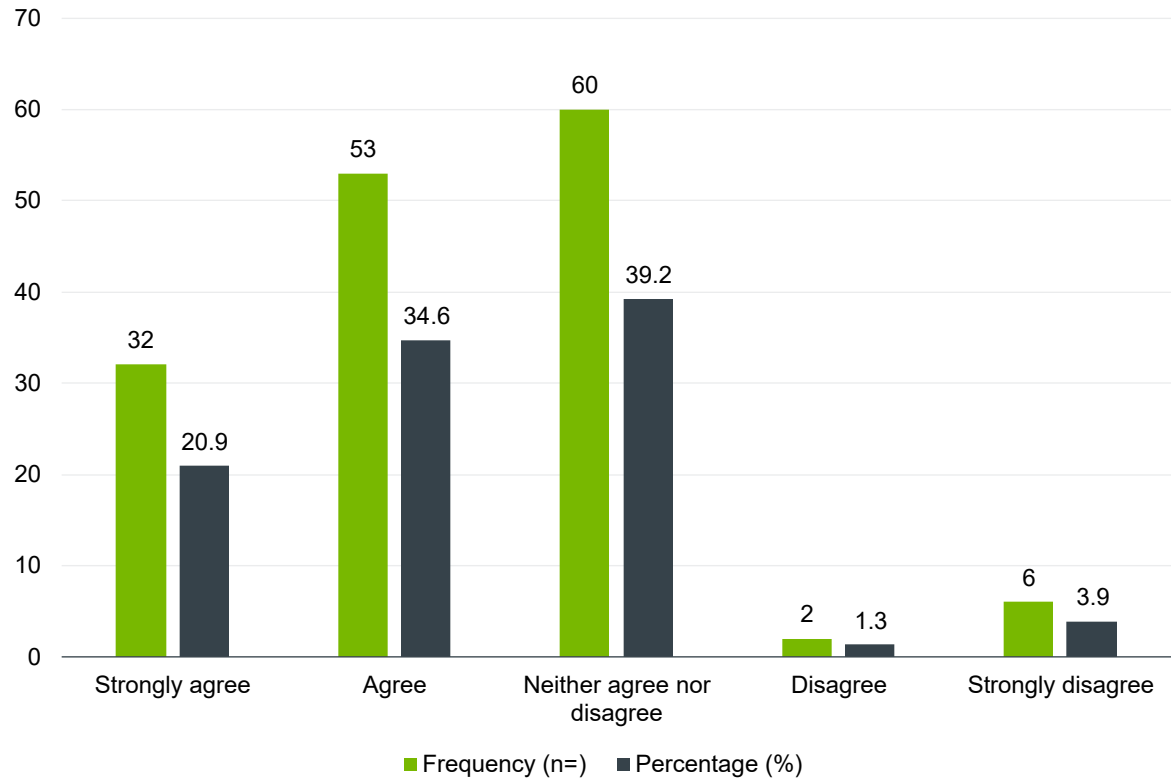
> *I've got a lot of issues with being a people pleaser and being a yes man, [I've learnt] how to put my needs out without breaking down* ***– FaRS service user***

However, a minority of service users reflected that their provider had not supported them with concrete techniques to use in their everyday life. This was a gap for some service users, who wanted to develop skills to support their mental health and wellbeing.

> *There could be some other techniques that could be part of it. Mindful approach – I've done some breathing with different counsellors not just talking but also visualisations. More things like that, they work for me. But I haven't gotten to that with this counsellor* ***– FaRS service user***

FaRS service users consistently expressed that having an independent and knowledgeable professional to discuss their experiences with helped them feel safe, heard and understood. Many described their service provider as a safe and trusted person with whom they could discuss issues and experiences which they felt unable to share with others. Attending a FaRS service improved their sense of connectedness and reduced their feelings of social isolation. The experiences of FaRS survey respondents were similarly positive, with 34.6% (n=53) agreeing, and 20.9% (n=32) strongly agreeing, that as a result of accessing a FaRS service, they had experienced positive changes in their wellbeing (see **Figure 19**).

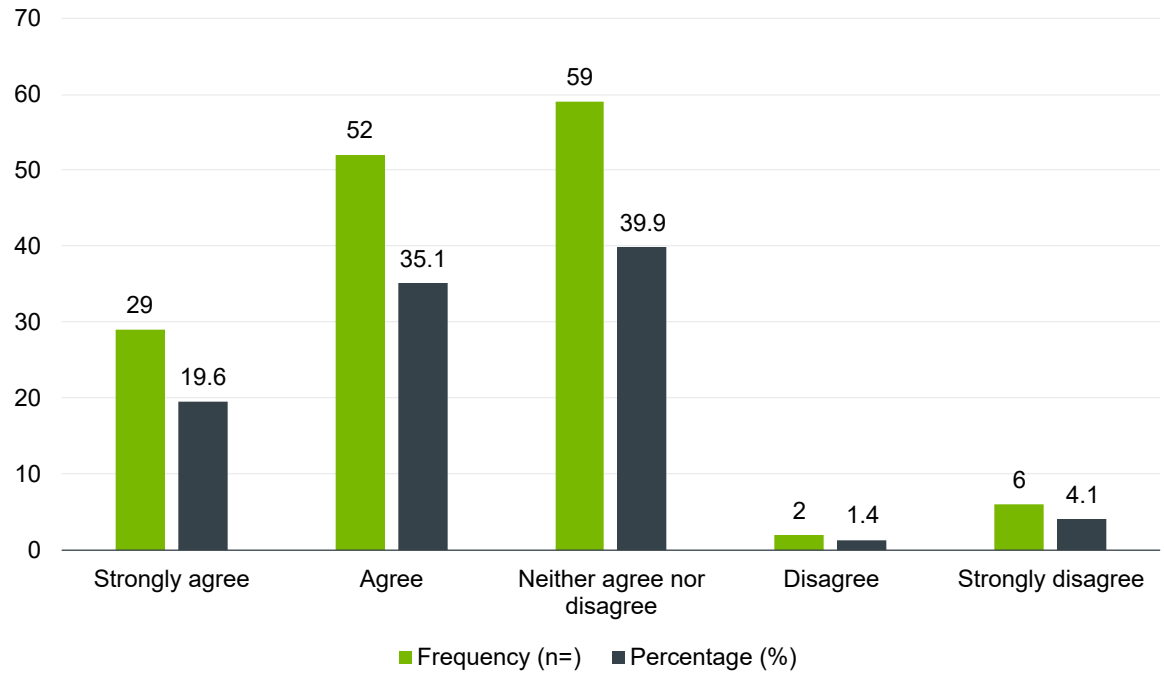
Figure 19: As a result of using the service, I have experienced positive changes in my wellbeing, FaRS service users (n=153)



Source: Service user survey

Some service users noted that accessing a FaRS service had enabled them to feel more positive about their future, with 35.1% (n=52) agreeing, and 19.6% (n=29) strongly agreeing that as a result of using a FaRS service, they feel more positive about the future (see **Figure 20** below).

Figure 20: As a result of using the service, I feel more positive about the future, FaRS service users (n=148)



Source: Service user survey

Reflecting the effectiveness of counselling services, a previous report published by Relationships Australia (2023a) found that 91.0% of counselling service users agreed that they felt the service listened to them and understood their issues. This report also found that at least double the number of service users reported positive family functioning, and positive mental health and wellbeing following counselling by Relationships Australia. Drummond Street Services, a provider of FaRS and SFVS, undertook an evaluation to understand the impact of their services on their service users, utilising a range of peer reviewed measures and indicators, including the DASS-21 (Depression Anxiety Stress Scale) (Centre for Family Research and Evaluation, 2019). They found that following the final delivery of services, adult service users decreased their mental health distress by an average of 33.4%.

Parenting skills

For many service users, the FaRS service proved useful for improving their parenting skills. Qualitative data indicated that overall, service users with children increased their knowledge and skills in parenting through the program. Some service users who accessed parenting classes reported that they better understood their children, their emotional needs and drivers of their behaviour. Many FaRS service users who participated in a parenting program reported that they developed insight into their own emotional responses to their children. Consistent with literature of best practice in parenting programs, these service users described an improvement in their self-efficacy and resilience, allowing them to better model calm and positive interactions (Darvishnia et al., 2023). A large proportion of service users also reported learning a range of techniques to support their child's development. Techniques included effective communication skills with children, approaches to resolving conflict, and supported play.

> *My problem was that I was over involving myself when playing with [child]. To get the most out of her play, I needed to step back a bit and observe her playing and interact with her verbally instead of taking the responsibility to entertain her and to allow her to entertain herself […] I had no knowledge of that beforehand. After going to Circle of Security, it took the pressure away from parenting – instead of thinking I needed to constantly entertain her – it's a two-way street. I was there to protect her and help her feel secure. She's there to learn and explore and play not just with me but with herself* ***– FaRS service user***

Additionally, some service users with children who accessed counselling services (including individual, relationship, and family counselling) reported that their counsellor helped them to understand the perspectives of their children and provided recommendations for how to approach parenting.

> *[Counsellor] has given me some really good ideas for parenting with troubled children. I've noticed a big change in the children, [it has] given me some strategies… [It] helps me feel like I'm on track, [that I] can improve* ***– FaRS service user***

Some adult services users experiencing separation found accessing FaRS funded services beneficial in parenting their children. Both parenting classes and counselling helped service users to better co-parent during and after separation. Separating service users learnt techniques to improve their communication and co-parenting.

> *We have two children and I think you know, for us it was like, how do we then navigate […] talking to the kids and […] be civil to each other at a […] quite emotionally charged time […] we were trying to work out what we could do that might involve the kids and so we contacted [the service] did a remediation plan and […] it was good cause it gave us a space to talk without it being so emotionally charged* ***– FaRS service user***

Some service users noted that the knowledge and skills they had developed through accessing a FaRS funded service changed their relationships with their children. The program has improved built their confidence in parenting and had a positive impact on overall family dynamics.

> *Has been a great support framework and I have seen significant improvement in how I tackle situations… Other thing I would call out is that we are constantly changing and what you thought was the problem, is not the problem […] [it has been] helpful for problems as things have shifted in direction [it's] been good for family dynamics* ***– FaRS service user***

Where service users reported that accessing a FaRS funded service did not improve their skills or knowledge in parenting, they noted that the content did not feel relevant to them, or

that their service provider was ineffective in teaching parenting skills and techniques. For some service users, this related to the style of course.

> *There's a lot of reading through the slides, I remember when I was in there, my scenario wasn't relevant, …and when I feel it's irrelevant, [it's] natural to switch off. Because I go in with an open mind, still happy to come, but to be picky, that's something that could be improved* ***– FaRS service user***

Figure 21: FaRS Program Logic outcomes linked to evaluation findings

The table below provides an overview of achievements against Program Logic outcomes for FaRS.

PROGRAM LOGIC OUTCOME	EVIDENCE			
	DEX SCORE domains*^	Evaluation data – service user surveys**	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
SHORT-TERM OUTCOMES				
Families have increased knowledge and skills in: • identifying personal and family safety issues • seeking support for personal and family safety issues • strategies to improve or maintain personal or family safety • modelling healthy, respectful relationships • parenting skills.	Families experience a: **1.1** increase in mean SCORE for Goal: Changed knowledge and access to information. **1.0** increase in mean SCORE for Goal: Changed skills. **0.9** increase in mean SCORE for Goal: Engagement with relevant support services.	**77.8 %** (n=151) of survey respondents were satisfied with the service they received. **62.9%** (n=122) of survey respondents agreed or strongly agreed that they now have strategies to identify issues of personal and family safety as a result of using the service.	Service users reported warmth, communication skills, empathy and active listening from counsellors and facilitators Service users reported providers were knowledgeable in their area of work and topics including parenting, family relationships, interpersonal relationships and trauma. Service users consistently reported that accessing FaRS services had an instrumental impact on their relationships, families and personal wellbeing. Service users described increased knowledge and skills in their relationships including developing more effective communication skills, active listening skills, being less reactive and remaining calm. Service users described how collaborating together as a family, or as partners, helped them to better understand one another.	Service providers described collaborating with other services and engaging in warm referrals to support service users to know who they can turn to for support. Service providers described the popularity of parenting and other education and support programs, including the impact of increasing accessibility through virtual service offerings.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

PROGRAM LOGIC OUTCOME	EVIDENCE			
	DEX SCORE domains*^	Evaluation data – service user surveys**	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
When experiencing family breakdown or dysfunction families and children have knowledge and skills to improve: • mental health • wellbeing • resilience.	**0.8** increase in mental health, wellbeing and self-care.	**77.3%** (n=150) of service user survey respondents agreed or strongly agreed that they had strategies to improve their mental health and wellbeing because of accessing a FaRS service.	Service users reported that the service had been instrumental to their mental health and wellbeing, understanding themselves, and dealing with experiences including trauma, grief, anxiety, depression and relationship difficulties. Accessing FaRS services helped service users develop emotional regulation skills, supporting feelings of independence and inner strength. Accessing FaRS services helped service users navigate relationship breakdowns, including improved communication with their ex-partner and relationship modelling for their children.	Service providers described providing support to service users over extended periods of time, including support to service users who left and returned to programs as they needed support.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

PROGRAM LOGIC OUTCOME	EVIDENCE			
	DEX SCORE domains*^	Evaluation data – service user surveys**	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
MEDIUM-TERM OUTCOMES				
Families use effective strategies to: • identify personal and family safety issues • seek support for personal and family safety issues • improve or maintain personal and family safety • model healthy respectful relationships • improve parenting skills.	Families and children experience a: **0.8** increase in mean SCORE for Circumstance: Family Functioning. **0.6** increase in mean SCORE for Circumstance: Personal and family safety. **1.1** increase in mean SCORE for Goal: Changed behaviours.	Over **65%** of survey respondents agreed or strongly agreed they had strategies to: • identify issues of personal and family safety (**67.3%**, n=105) • seek help for issues of personal and family safety (**73.1%** n=114).	Counselling services supported FaRS service users to recognise that they were in abusive relationships. FaRS service users noted their service provider educated them about family violence and supported their own and their family's safety. Service users reported increased knowledge and skills in parenting including understanding their children, their emotional needs, and their own emotional responses to their children. Service users reported learning techniques including effective communication skills, approaches to resolving conflict, and supported play. Service users reported improved individual relationships between them and their children, increased confidence in parenting, and positive impacts in overall family dynamics.	Service providers emphasised the importance of providing wraparound support to service users with complex needs to ensure they were safe, stable, and able to make the most of FaRS to achieve lasting change.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

PROGRAM LOGIC OUTCOME	EVIDENCE			
	DEX SCORE domains*^	Evaluation data – service user surveys**	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
When experiencing family breakdown of dysfunction families and children use effective strategies to improve their: • mental health • wellbeing • resilience	Families and children experience a: **0.8** increase in mean SCORE for Circumstance: Mental health, wellbeing, and self-care. **1.1** increase in the mean SCORE for Goal: Changed impact of immediate crisis.	**64.4%** (n=125) of survey respondents said they have completely or mostly been able to maintain strategies learned during sessions with the service.	Service users commented positively on accessing counselling for support during acute mental health crises and learning and applying strategies to benefit their mental health and their relationships. Service users reported their provider supported them to better understand themselves and use effective strategies including emotional regulation skills to assist them in their everyday lives.	Service providers described how the flexibility of the FaRS model allows them to adjust both program and individual service provision to meet identified needs and achieve better, lasting outcomes.

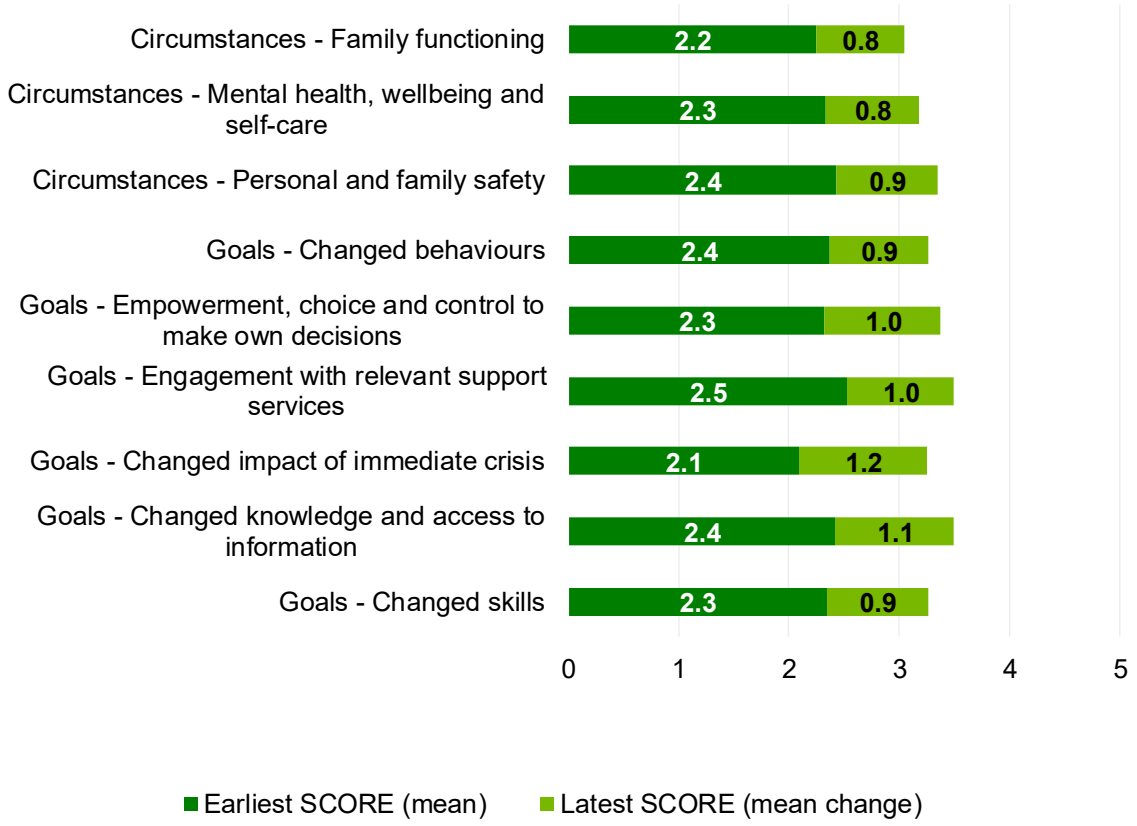
**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

5.2.2 Achievement of outcomes for SFVS

The following section details findings related to the achievement of short- and medium-term outcomes for SFVS.

Overall, SFVS had a positive impact on victim survivors, and is showing positive progress towards achieving short- and medium-term outcomes. DEX data indicates that almost two-thirds of SFVS service users improved their circumstances related to family functioning; mental health and wellbeing and self-care; and personal and family safety. Average Circumstance SCOREs (e.g. feeling of safety, stability) increased by approximately +0.80-+0.84 points on the 5-point scale from earliest to latest SCORE, higher than FaRS. The average Goal SCORE change was +0.81-+0.99 (see **Figure 22**). All comparisons were statistically significant (p<.001).

Figure 22: Earliest to latest SCORE mean changes within subjects for specific Circumstances and Goals domains, SFVS, July 2021 to June 2024



Source: DEX-SCORE data

Table 23: Percentage of service users with a positive SCORE change for Goal outcomes by cohort, SFVS, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	54.9% (n=2,911)
	Mental health, wellbeing and self-care	56.0% (n=3,092)
	Personal and family safety	57.0% (n=3,585)
Goals	Changed behaviours	57.2% (n=2,209)
	Changed impact of immediate crisis	67.3% (n=1,932)
	Changed knowledge and access to information	63.8% (n=2,772)
	Changed skills	58.8% (n=2,318)
	Empowerment, choice and control to make own decisions	62.2% (n=2,648)
	Engagement with relevant support services	58.3% (n=1,833)

Source: DEX-SCORE data

Satisfaction in SFVS was very high with around 89–94% of service users reporting positive satisfaction with the service. This means almost 9 in 10 service users felt the service was helpful and met their expectations. These satisfaction rates increased in later years. This quantitative finding is also reflected in the qualitative data, which indicates high satisfaction rates with SFVS services.

Personal and family safety

DEX-SCORE data for the Circumstances domain personal and family safety shows SFVS services experienced a 0.9 increase in the earliest to latest mean SCORE with 57.0% experiencing a positive change (see **Table 24**).

Table 24: Earliest and latest mean SCORE change and percentage of service users with positive SCORE change for personal and family safety, SFVS, July 2021 to June 2024

Outcome type	Domain	SCORE change (mean, n=)	Service users with positive change (%, n)
Circumstance	Personal and family safety	0.9 (n=6,292)	57.0% (3,585)

Source: DEX-SCORE data

Many service users reflected that accessing a SFVS service had been crucial in helping them identify their relationships as abusive and understanding issues of both their own safety and the safety of their families. This was particularly notable for service users who were experiencing non-physical forms of abuse, such as coercive control and financial abuse. These service users often reflected that prior to using the service, they did not know that they

were experiencing abuse, nor the diversity of forms that family violence can take. Service users noted that this knowledge would help them in future relationships.

> *A number of things [counsellor] has been able to provide in terms of education have been very significant […] it was very supportive and validating, [she was] able to provide a lot of knowledge, technical knowledge, not just resources, something as simple as sending a document on boundaries, and what a bill of rights might look like […] [I] hadn't understood how the relationship had evolved into a dangerous [one]* ***– SFVS service user***

> *The education that [counsellor] gave me was brilliant. You could tell that she understood that I didn't know what I was in, she was able to educate me in a really sensitive way. It was a lot to take on. I'm an educated, smart, confident woman. And still this was a lot for me to take on […] The way she was able to educate me was incredible. If you could clone her – she was amazing* ***– SFVS service user***

> *My counsellor was able to give me a deeper understanding as to what to most value in a relationship. She also taught me techniques to better deal with difficult situations in all relationships. As I was a survivor of domestic violence, I'm currently working on myself before putting myself out there for another relationship. However, when the time comes for a new relationship, I do think I will be better equipped to deal with conflict and difficulties if they arise –* ***FaRS and SFVS service user***

Improved knowledge of family violence enabled service users to more readily identify family and personal safety concerns. Providers collaborated with service users to create safety plans and establish safety supports, assisting service users and their families to remain safe while navigating their relationships. Discussing ways to safely access the services themselves also supported feelings of safety for service users.

> *Because my situation was financial control and coercive control and knowing that they had ways to help me […] to work with me to make sure I was safe with what I was doing and can help […] myself without him knowing, was one of the biggest things for me* ***– SFVS service user***

The survey sample size for SFVS respondents (n=<5) is low and so is not generalisable. It is noteworthy however, that all respondents agreed that accessing the program had improved their personal and family safety and they had learned strategies for identifying issues of personal safety, and how to seek help and improve their safety accordingly. All respondents also indicated they had learned strategies to model healthy relationships and improve their parenting skills.

The small number of SFVS service users that did not see improvements in their perceptions of safety noted that their provider did not tailor their services to their specific needs or situation. These service users felt as if their service provider did not accurately listen to their situation, and as if their service providers were undertaking a 'check box' exercise.

Mental health, wellbeing and self-care

For many service users, the SFVS service has been instrumental to their mental health and wellbeing. The DEX-SCORE change for mental health, wellbeing, and self-care was the highest mean earliest-latest SCORE change was 0.8 with 56.0% of service users recording a positive change (see **Table 25**).

Table 25: Earliest and latest mean SCORE change and percentage of service users with positive SCORE change for mental health, wellbeing, and self-care, SFVS, July 2021 – June 2024

Outcome type	Domain	SCORE change (mean, n=)	Service users with positive change (%, n=)
Circumstance	Mental health, wellbeing, and self-care	0.8 (n=5,523)	56.0% (n=3,092)

Source: DEX-SCORE data

SFVS service users were consistently highly positive about the impact that accessing SFVS had on their mental health and wellbeing, and in understanding where to access support. The detrimental impact of family violence on mental health and wellbeing on victim survivors is well documented in the literature. Service users often reflected that they had accessed their service in a time of great need, when they struggled with fear, safety, isolation, depression, and self-esteem issues. The vast majority of SFVS service users noted that their service provider was transformative to their mental health and wellbeing. Accessing services that were affirming and did not discount or deny their experiences made service users feel validated and less isolated.

> *Dealing with [counsellor] has been life changing, when I'm saying that this is happening, [it's a] breath of fresh air to have someone who says I'm not exaggerating and I'm not making things up* ***– SFVS service user***

For some service users, accessing a SFVS service enabled them to cope as they navigated a range of complex issues associated with family violence, including the family law and justice systems.

> *Kept me alive and at work. Last time I was going through court, [I] lost my job because I couldn't handle to do my things, I had to go part time. [Now] I'm doing full-time work and full-time parenting and self-representing, [there's] no way I could have had that without the service* ***– SFVS service user***

Many service users reflected that they felt more resilient and empowered as a result of participating in counselling, and that this also improved their wellbeing and mental health.

> *It has changed every area of my life. It's changed me as a mother; it's changed me as a friend. It's changed me as a family member. It's changed how I feel about my finances and money and that I can be independent […] The empowerment she gave me has helped me to feel strong enough to go through this process on my own terms* ***– SFVS service user***

Developing skills in self-care and compassion were also key to positive changes in mental health and wellbeing for service users.

> *She was also giving me personal development tips on how to take care of myself personally to get through the process to acknowledge that you're a victim of domestic violence. You needed to put these systems in place to do that safely –* ***SFVS service user***

In general, service users felt that they could confide in their service providers and access them for support, even if they had stopped attending the service. However, a small number of SFVS service users were not referred to other appropriate services. This was a deeply felt gap for these service users. Similarly, and aligned with outcomes for FaRS, some service users had difficulty accessing the SFVS service as they did not know such services existed. Several service users recommended better advertising of the services so that more people could access these supports.

Children

The evaluation found a positive impact on children who accessed child-specific counselling services. Circumstance domains for children include wellbeing, safety, or family functioning from the child's perspective. Approximately 66% of children showed an overall positive change in circumstances by the end of service. By 2023-24, about 63% had improved circumstances. This suggests that most service users who are children experienced better emotional or family circumstances (for example: they felt safer or more stable) after counselling. The average improvement was in the order of +0.8 points on the 5-point scale, similar to other programs (see **Table 26**).

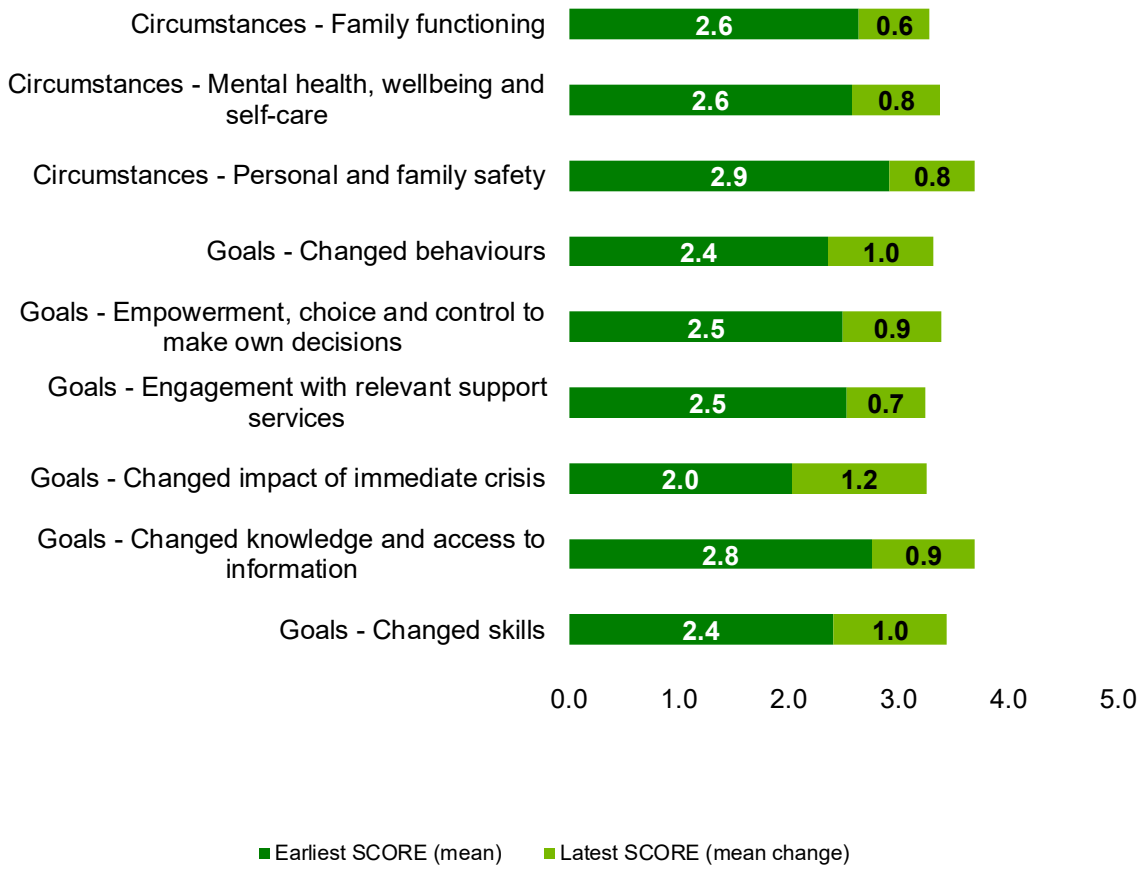
Table 26: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by cohort, SFVS, under 18, July 2021 – June 2024

Outcome Type	Service users (n=)	SCORE change (mean)	Service users with positive mean change (%, n=)
Circumstances	859	0.77	65.9% (n=566)
Goals	946	0.83	61.5% (n=582)

Source: DEX-SCORE data

Children (with help of their counsellors/parents) set therapeutic goals like coping with anger, improving school behaviour, or overcoming trauma symptoms. The data shows around 62% reaching positive goal outcomes between their earliest and latest available SCORE assessments. This upward shift might reflect better goal setting and attainment as programs matured. In practical terms, almost three quarters of children achieved notable progress (for example, a child might regain a sense of safety or improve their emotional regulation, meeting their counselling goals). Satisfaction data for children's services can often be misleading (as parents often respond on behalf of young children). The satisfaction outcomes reported are extremely high, an average of 97% across the 3 financial years, implying that families felt the support for their children was very beneficial. The cohort of service users who were under the age of 18 years at the time of their earliest and latest SCORE assessments showed improvement in all domains, on average. Knowledge, Skills, Behaviours and Confidence domains showed the largest improvement. Improvements in Family and Mental Health domains were also high. All changes were statistically significant (p<.001). Earliest to latest SCORE changes in service users who are children, and adult service users followed similar trajectories (as outlined in **Figure 23**). Detailed tables are presented in **Appendix F**. Whilst the qualitative insights into the outcomes of accessing a CSC service on children are limited, due to the small sample size of children involved within the evaluation, the available insights reflect the quantitative findings.

Figure 23: Earliest to latest SCORE changes within subjects, SFVS service users under 18 years old, July 2021 – June 2024



Source: DEX-SCORE data

Table 27: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, SFVS service users under 18 years old, July 2021 – June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	59.6% (n=3,202)
	Mental health, wellbeing and self-care	63.8% (n=3,383)
	Personal and family safety	44.4% (n=1,500)
Goals	Changed behaviours	67.9% (n=2,812)
	Changed impact of immediate crisis	65.5% (n=1,333)
	Changed knowledge and access to information	66.8% (n=2,915)
	Changed skills	69.6% (n=3,343)
	Empowerment, choice and control to make own decisions	68.6% (n=2,520)
	Engagement with relevant support services	60.0% (n=1,528)

Several service providers reflected that there is an unmet need for mental health supports for children, both as victim survivors of family violence in their own right, and as young people navigating everyday challenges. This is particularly important, given the impact of family violence on personal safety, and mental health and wellbeing.

Service providers consistently noted the importance of ensuring children had a safe, trusted adult with whom to discuss their feelings, and this was reflected by service users as well. Establishing rapport with an independent and trusted adult supported children to feel safe.

> *I think really for children to be able to experience having a trusted adult in their life if their counsellor ends up being one of the only trusted adults that they can talk to and be safe with […] I think the impact is on […] [the] role modelling of how adults can be safe and should be safe and caring and putting the needs of the child first […] for a child to be heard and have their voice recognised –* ***SFVS service provider***

> *It has helped me not get as angry and feel more calm and safe. She has helped me feel, and saying that it's ok to feel how I feel and that I'm not the only person who has that, and people are here for me –* ***CSC service user***

Some service users reflected that they had developed key emotional regulation techniques, such as accepting their feelings, empathy, methods for coping with discomfort, and communication skills.

> *I've learnt that everyone has their own thoughts and opinions. I've also learnt that it's ok to feel these emotions that I feel, and everyone feels them, [and] you can always be yourself and it doesn't really matter cos everyone's different. You can make new friends by just saying hi* – ***CSC service user***

People who use violence

Findings on the outcomes of MBCPs are limited due to the evaluation's reliance on self-reported data from a small number of MCBP service users (n= ≤5) and observation data from service providers through DEX reporting and focus groups. The evaluation did not collect data on MBCP participants' partner or ex-partner's perceptions around their changed behaviour. In addition, there is a growing body of evidence indicating that sustained MBCP outcomes are contingent on whole-of-system approaches which centre victim survivor recovery, perpetrator accountability, and risk management (Australia's National Research Organisation for Women's Safety, 2025; Hamilton et al., 2025; Helps et al., 2025) (see **Section 6.4.2**). Whilst the quantitative data indicates most participating men showed improved circumstances by program end, it is not possible to determine the extent to which this resulted in actual behaviour change for participants. Between 51% and 65% of MBCP service users had an overall positive change in circumstances. The average Circumstance SCORE change was in the order of +0.70-+1.05. Notably, the positive outcome rate was slightly higher in 2021-22 (65%) and dropped to 51% in 2023-24, possibly as programs expanded to higher risk service users who may have had more difficulty achieving change.

MBCP participants set personal goals (for example: to stop violent behaviours or improve communication) with GPS-DEX data showing that between 56% and 69% of service users attained a positive goal outcome, depending on the year. In 2021-22, the data shows about 69% achieved their goals, whereas in 2023-24 around 56% achieved goal success. These are encouraging figures, suggesting that about 3 out of 5 service users who were engaged within a program were able to make progress toward non-violence goals by program end. Overall, 1 in 10 service users rated a negative outcome with respect to goals.

Satisfaction SCOREs for MBCP users were very high, with 82% to 98% of participants reporting positive satisfaction. For example, in 2022-23 about 98% of service users provided favourable feedback. Satisfaction increased over the period, possibly as program delivery became more refined and responsive to participants' needs. High satisfaction could suggest that those who stayed in the program felt it was beneficial to them on a personal level.

The qualitative data found a moderately positive impact on people who accessed MBCP, with a need for more services in this space. However, qualitative insights into the outcomes of accessing a MBCP on service users are limited, due to the small sample size (n=<10) of service users involved within the evaluation.

A common theme for service users was that the MBCP provided them a safe place to discuss their emotions and experiences. These collaborative discussions with other participants and facilitators were key to enabling a deeper understanding of their behaviours. In these discussions, service users reflected on their behaviours, and their life experiences to take accountability for their behaviour.

> *I participate in the [MBCP] […] taking responsibility course and […] It's about being able to open up about toxic masculinity and the way violence and anger is portrayed in relationships […] being able to actually have a safe place to talk about things, learn things, see other people's opinions and not feel judged, or you could be emotional and like actually feel […] it helps everyone out in their own way and there's not many things that I've ever experienced that are similar to that in the sense that it's usually like counsellors or there's not usually other people that you can relate to there and then hear other stories –* ***MBCP service user***

There were positive indications of increased knowledge and skills in reducing violent behaviour amongst men who accessed MBCP. Some service users commonly report improved communication and conflict resolution techniques, such as the correct use of space, and building empathy and understanding the perspectives of others.

The survey sample size for MCBP service user respondents (under 10) is low and so is not generalisable. Respondents were mixed in their feedback. Most agreed the program had increased their knowledge of how to reduce violent and abusive behaviours, access support, and apply strategies accordingly, although one disagreed. No detail was given in open-text responses to explain this.

Relationships Australia, a large provider of the FaRS and SFVS programs, have noted positive impacts on their service users. Relationships Australia noted that demand for MBCPs had increased, with delivery to 694 participants in 2022-2023 (Relationships Australia, 2023a). They suggest that this increase is due to the increased focus on people who use violence taking responsibility for their behaviour. Relationships Australia has also altered their MBCPs to have continual, rolling intake for groups, rather than 'closed' groups. This allows people experiencing violence to have earlier access to the Family Safety Contact support service, supporting their safety and reducing risk of harm.

An evaluation of the 'Choose Change' Early Intervention Family and Domestic Violence Program, developed by Communicare with funding from the Department, indicated promising effectiveness in reducing family violence-related behaviours among participants, with positive impacts on self-awareness, accountability, and interpersonal skills. The Choose Change evaluation indicated that Change Star assessments, an evaluation tool to measure service user change in knowledge, attitudes and behaviours, showed that participants generally improved in areas such as taking responsibility, communication, and emotional regulation, with reported increases in empathy and recognition of the impact of their actions on others. Police data also pointed to a decrease in family violence-related police contacts among participants, with a majority demonstrating reduced engagement in violent behaviours after entering the program. Additionally, stakeholders and participants reported high satisfaction, suggesting that the program's evidence-based content and individualised delivery contributed to meaningful behaviour change and positive outcomes for participants and their families (Eric Dillon Consulting, 2022).

Figure 24: SFVS Program Logic outcomes linked to evaluation findings

The table below provides an overview of achievements against Program Logic outcomes for SFVS.

PROGRAM LOGIC OUTCOME	EVIDENCE		
	Dex SCORE domains*^	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
SHORT-TERM OUTCOMES			
Victim survivors have improved knowledge and skills in: • identifying personal and family safety issues • seeking support for personal and family safety issues • strategies to improve personal and family safety • strategies to improve mental health and wellbeing.	Victim survivors experienced a: **1.1** increase in mean SCORE for Goal: Changed knowledge and access to information. **0.9** increase in mean SCORE for Goal: Changed skills. **1.0** increase in mean SCORE for Goal: Engagement with relevant support services. **1.0** increase in mean SCORE for Goal: Empowerment, choice, and control to make own decisions.	Victim survivors described being heard and supported to name and understand their experience as family violence. Service users described receiving tools and techniques supporting feelings of safety. Many service users reflected that accessing a SFVS service had been crucial in identifying their relationships as abusive, and understanding issues of both their own safety, and the safety of their families.	Service providers described collaborating with other services and engaging in warm referrals to support service users to know who they can turn to for support.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*

^^DEX-SCORE data is for the period July 2021 to June 2024

***Evaluation data is for the period June 2024 to September 2025*

PROGRAM LOGIC OUTCOME	EVIDENCE		
	Dex SCORE domains*^	**Evaluation data – service user interviews****	**Evaluation data – service provider focus groups****
Children impacted by family violence have improved knowledge and skills in: • seeking support when they don't feel safe • strategies to improve mental health and wellbeing.	Children experienced a: **0.9** increase in mean SCORE for the Goal: Changed knowledge and access to information. **1.0** increase in the mean SCORE for the Goal: Changed skills.	Children reported appreciating having someone to talk to, who took them seriously, respected their privacy and did not judge them.	Service providers emphasised best practices of applying whole-of-family approaches and centering children and young people to give them a voice. Service providers emphasised the importance of having staff that had sufficient knowledge and experience providing counselling to children.
Perpetrators have increased knowledge and skills in: • seeking help to reduce violent and abusive behaviours • strategies to reduce violent and abusive behaviours.	Whilst the quantitative data indicates most participating men showed improved circumstances by program end, it is not possible to determine the extent to which this resulted in actual behaviour change for participants. Between 51% and 65% of MBCP service users had an overall positive change in circumstances. The average Circumstance SCORE change was in the order of **+0.70 - +1.05**.	Adults using family violence showed insight and motivation to change their behaviours. Intrinsic motivations of restoring family relationships were described by MBCP service users.	Service providers described working to establish relationships and trust with people who use violence to ensure their ongoing and effective participation in MBCPs.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

PROGRAM LOGIC OUTCOME	EVIDENCE		
	Dex SCORE domains*^	Evaluation data – service user interviews**	Evaluation data – service provider focus groups**
	MEDIUM-TERM OUTCOMES		
Victim survivors use effective strategies to: • identify personal and family safety issues • seek support for personal and family safety issues • improve personal and family safety • improve mental health and wellbeing.	Victim survivors experienced a: **0.8** increase in mean SCORE for Circumstance: Family Functioning. **0.8** increase in mean SCORE for Circumstance: Mental health, wellbeing, and self-care. **0.9** increase in mean SCORE for Circumstance: Personal and family safety. **0.9** increase in mean SCORE for Goal: Changed behaviours. **1.2** increase in mean SCORE for Goal: Changed impact of immediate crisis.	Service users described accessing services as lifesaving during acute mental health crises. Service users consistently reported that accessing FaRS and/or SFVS services had an instrumental impact on their relationships, families and personal wellbeing.	Services providers emphasised the importance of providing wraparound support to victim survivors to ensure they were safe, stable, and able to make the most of SFVS to achieve lasting change. Service providers described how the flexibility of the SFVS model allows them to adjust overall program and individual service provision to meet identified needs and achieve better, lasting outcomes.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

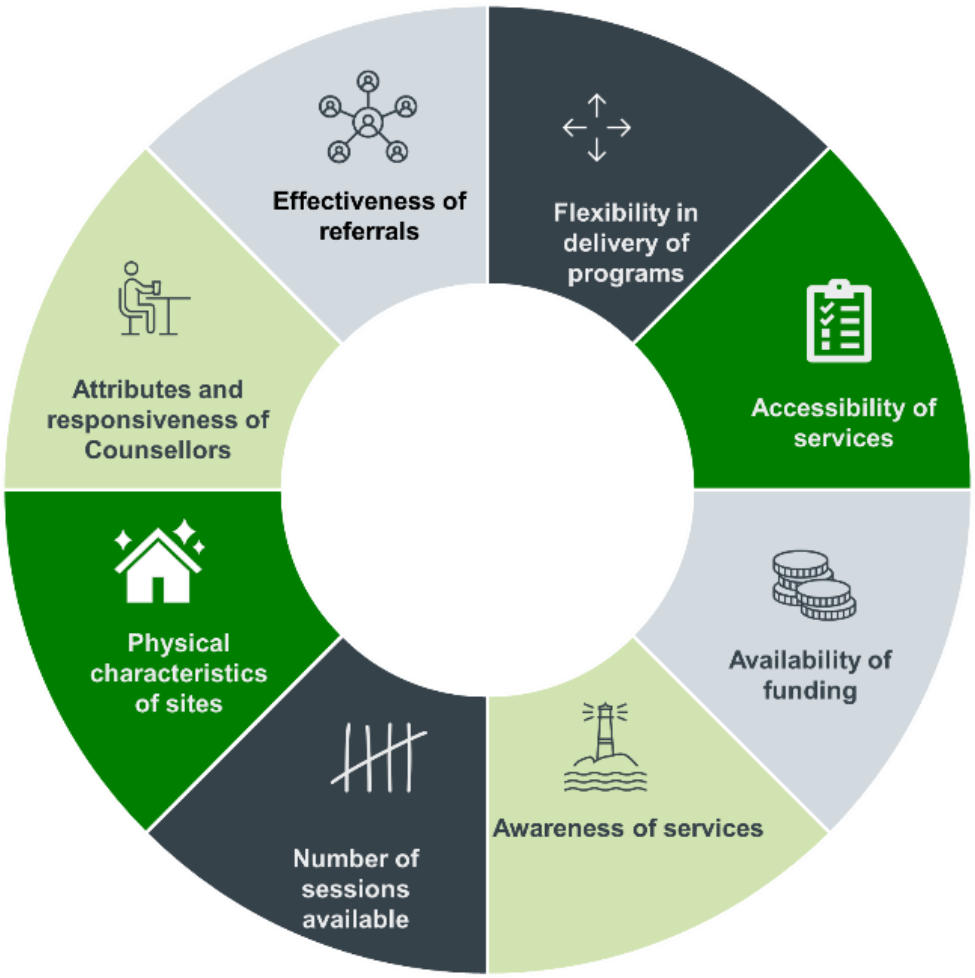
PROGRAM LOGIC OUTCOME	EVIDENCE		
	Dex SCORE domains*^	**Evaluation data – service user interviews****	**Evaluation data – service provider focus groups****
Children impacted by family violence: • feel safe, heard, and supported • access supports when needed • are supported to improve their mental health and wellbeing.	Children experienced a: **0.8** increase in mean SCORE for the Circumstance: Mental health, wellbeing, and self-care. **0.8** increase in mean SCORE for the Circumstance: Personal and family safety. **1.0** increase in mean SCORE for the Goal: Changed behaviours. **1.2** increase in mean SCORE for the Goal: Changed impact of the immediate crisis. **0.7** increase in the mean SCORE for Goal: Engagement with relevant support services.	Children reported appreciating having someone to talk to, who took them seriously, respected their privacy and did not judge them.	Service providers emphasised best practices of applying whole-of-family approaches and centering children and young people to give them a voice.
Perpetrators use effective strategies to: • reduce their violent and abusive behaviours • access supports to reduce violent and abusive behaviours.	The average Circumstance SCORE change was in the order of **+0.70 - +1.05**.	Intrinsic motivations of restoring family relationships described by MBCP service users translated into personal strategies of showing accountability and approaching relationships differently	Service providers emphasised the importance of specific practice strategies to address violent and abusive behaviours, including healing approaches, sensitive engagement in relation to anger management and emotional regulation, and adjusting delivery to suit service users with low literacy levels or cognitive disabilities.

**Changes in SCORE have been analysed utilising clients with at least two assessments for the given domain such that the change in SCORE can be measured within subjects and the non-parametric Wilcoxon statistical test is applied to the ranked differences between the first and last outcome*
^^DEX-SCORE data is for the period July 2021 to June 2024
***Evaluation data is for the period June 2024 to September 2025*

5.3. Factors affecting achievement of outcomes

This section describes the factors that influenced the achievement of short and medium-term outcomes for the FaRS and SFVS programs (KEQ 2). These are outlined at **Figure 25** below.

Figure 25: Factors impacting achievement of outcomes



5.3.1 Factors enabling the achievement of outcomes

There is considerable overlap between the factors which support the achievement of outcomes for both FaRS and SFVS. For this reason, this section addresses FaRS and SFVS together.

Attributes of counsellors and facilitators

Service users who said they benefited from the service often identified their counsellor or facilitator's therapeutic skill, knowledge and expertise as important aspects of their positive experience. Service users highlighted their service provider's warmth, communication skills, empathy and active listening, and often described them as a safe person with whom to share their challenges.

Service users often reflected that they felt their service provider did not judge or criticise them. The independence of service providers supported open conversations, in contrast to relying on support from friends or family who service users felt may be more subjective. These attributes encouraged service users to feel seen, understood, and supported. The importance of strong therapeutic relationships is highlighted in the literature especially when engaging with victim survivors. Consistent, stable staffing and tailored, survivor-led services allow therapeutic bonds to form, and are key to effective recovery. Group settings that foster peer support, as well as individual interventions, help survivors build trust and readiness for engagement in both starting and concluding their therapeutic journey (S. Brown et al., 2022).

> *A lot of things I can't say to my kids or my husband, I can't share it with someone else. [Counsellor] has helped me a lot, she listens […] she doesn't say 'you're wrong' she tells me I'm doing well […] she can tell me I've done it right or wrong and move on* – ***FaRS service user***

> *It's been really good for me to talk to [counsellor], to have somebody that's not family. It's not friends, and it's not judgmental. It's just listening, and she's really helping a lot* – ***FaRS service user***

Service users often shared that their service provider was knowledgeable in their area of expertise, such as parenting skills, family relationships, mental health modalities, interpersonal relationships, psychoeducation and trauma. This made service users feel confident and supported their learning and growth. Service users reported learning techniques and skills which were applicable to their needs. Service users benefited from 'homework' tasks between sessions, which encouraged them to apply the skills learnt in sessions to their everyday life.

Service provider knowledge and expertise was particularly important for SFVS service users. The specialist expertise of SFVS counsellors in family violence, trauma informed approaches, family systems, the impacts of family violence on children, and healing and recovery were essential. This expertise enabled service providers to build rapport and trust with victim

survivors, ensuring victim survivors felt heard, understood, and safe. This aligns with engaging in a trauma informed approach, consistently reflected in the literature as imperative for working with victim survivors. Kulkarni (2019) notes that staff who normalise survivors' coping mechanisms and behaviours support a trauma-informed approach to healing.

Service providers tailored their service flexibility to the needs of individual victim survivors. This individualised approach is a core component of a trauma-informed approach (Kulkarni 2019). SFVS service users also valued practical tools and techniques, including safety planning and advice relating to the family court system.

> *The location, the ease of getting the appointments, the understanding – you have people who think they understand but they are not qualified with dealing with it all, it's not just DV there are other factors in that – counsellors are trained in multiple aspects, not just that […] my case has been quite complex […] it has gone through being a nightmare to being able to juggle it a bit better –* ***FaRS service user***

> *It's given me a lot of strength. She's given me homework […] She's given me processes on coping with bereavement (self-love rainbow), information on self-sacrificing, lots on self-care and exploring personal individual values which you lose when you go through DV, so a lot has been on that. She also did some worksheets on nurturing children that have been through DV, and on power and control – that's just some of them* ***– SFVS service user***

> *I'm never going to feel safe, [she has] given me tools to deal with those feelings of unsafety, [she] has helped with my relationships, with my kids because I can connect with them, be present with them, being able to park things, [knowing that it] doesn't need to be done while the kids are awake, really great practical skills* ***– SFVS service user***

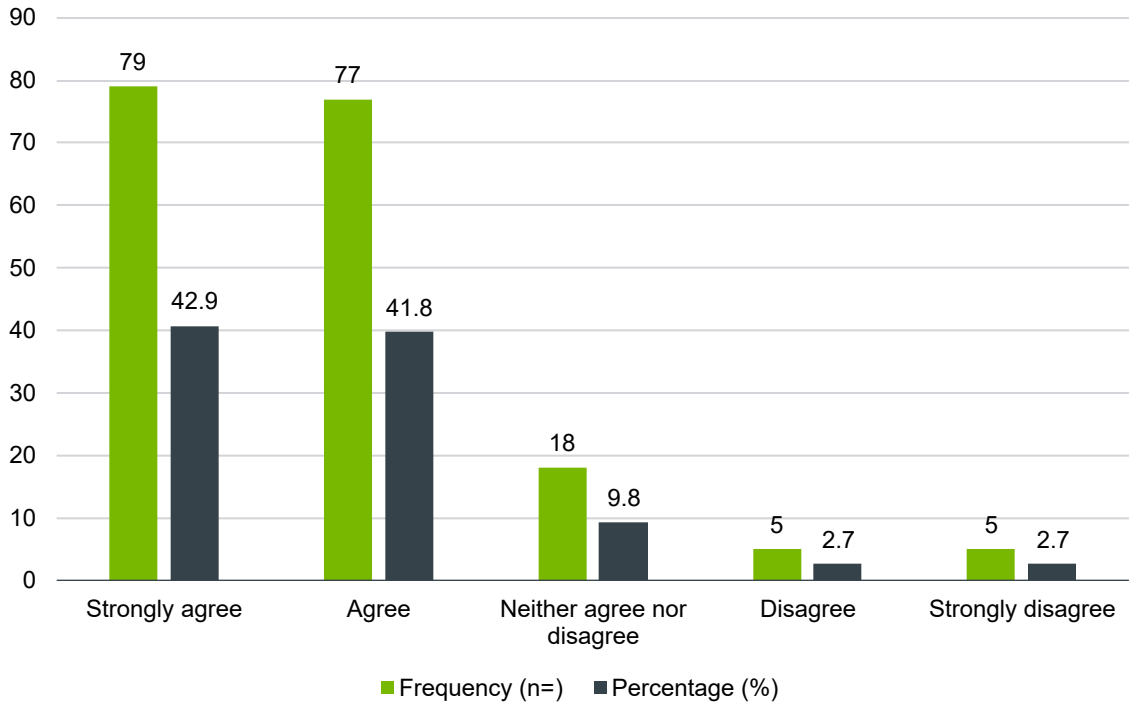
Factors associated with service provider sites

Accessible and welcoming service provider sites contributed to positive service user experiences. Service users regularly noted that the physical space they attended was welcoming, well decorated, and cosy. Similarly, many service users reported that service provider reception staff were friendly and helpful. These factors contributed to feelings of comfort and safety for service users. The literature supports this finding, noting that services in welcoming, physically accessible environments staffed by stable, friendly personnel are more effective in building trust and supporting sustained engagement (Brown et al., 2022).

> *Very high standard of professional excellence, well lit, clean, open, music playing, new furniture, bathrooms are impeccable, windows in all the counselling rooms; nothing would improve the service –* ***FaRS service user***

Approximately 84.7% of survey respondents (n=156) agreed or strongly agreed the location of the service was easy to access (see **Figure 26**).

Figure 26: The location of the service was easy to access, FaRS and SFVS service users (n=184)



Source: Service user survey data

Service provider sites were often in central locations, which many service users found accessible. Some service users noted that they were able to access their provider using public transport, whereas others indicated challenges in accessing provider sites.

Service users and providers spoke positively about the co-location of FaRS and SFVS services with other providers in a 'hub' location. Co-location enables service users to address a range of needs in a single location and was especially valued by service users with children. Service providers considered 'hub' locations to be especially useful for service coordination and supporting warm referrals.

A survey of FaRS and SFVS undertaken in 2018 found that co-location of the FaRS/SFVS funded service and other community-based services is the norm. It found that approximately 80% of FaRS and SFVS services are co-located with other services funded by the Department. This is beneficial for service users, providing easy access to services (Australian Institute of Family Studies, 2018). Similarly, it enables direct collaboration with other services, supporting a linked up approach to delivery (Australian Institute of Family Studies, 2018). Co-located services found in the 2018 survey include family services, specialist alcohol or other drugs, gambling services, specialist family violence services, and sexual assault services. Similar co-located services were described by service providers in focus groups.

> *We are very fortunate to deliver in a hub set up with state and federally funded services in one location. That really helps us to provide multidisciplinary wrap around support. We feel FaRS work best if connected with other services under a hub style model – **FaRS service provider***

The benefits of co-location are recognised in the literature. Evidence from Australia and the United Kingdom has demonstrated that service co-location is an effective model for addressing the complex needs of victim survivors. Cortis and Smyth (2024) explored an Australian initiative providing co-located specialist family violence financial counselling in women's legal services. The co-location of services was identified as an effective model for addressing the complex needs of victim survivors, particularly those experiencing economic abuse. The initiative integrated specialist financial counsellors within women's legal services, creating a holistic approach that combined legal and financial expertise to provide comprehensive support for women affected by family violence (Cortis & Smyth, 2024). A United Kingdom-based study by Cleaver et al. (2019) identified that the co-location of services—where agencies are physically situated together— enhanced communication and coordination. This approach streamlined support for victim survivors, leading to more efficient and comprehensive service delivery, reducing fragmentation, and encouraging professionals to share knowledge.

Service flexibility

Service flexibility was another key factor enabling FaRS and SFVS outcomes. Service providers and users alike noted that flexible service delivery made it possible for providers to better meet the needs of service users.

One area of flexibility reported by stakeholders was that service users were able to access the service when needed, allowing them to cease attending and resume sessions as required. This supported service user autonomy and growth and enabled service users to feel confident leaving the service when they were ready, with the knowledge that they could reattend when needed.

> *Honestly, [it's] been really, really good… I was doing weekly appointments, fortnightly and then monthly, then I was discharged from the service, but then when things went downhill for me [I could] get back into the same counsellor…because I've been on my journey with my mental health… I'm doing relatively well… I've made significantly more progress, and [it] wouldn't have happened without that counsellor, the fact that I was discharged, [and to] have a mental health professional say that I was doing so well, knowing that the support was still there [to come back to] – **FaRS service user***

> *Our program is open-ended, and people come and might be here for a while or little time. Overall, they are having their needs met. I am not sure how to frame that – life ebbs and flows. People stay with us as long as they need to and then people move on – **FaRS service provider***

Some providers supported service users by adapting their approaches to better meet their needs. This included adapting services and resources to meet service users' level of literacy, existing psychoeducation, and individual preferences.

> *I am not very good at reading and writing […] when we go, we talk…about things, she puts it in terms I can understand […] which is what people need […] you need to get people with the right language and the right skills to do, and in this place […] you've got it – **FaRS service user***

In some cases, service providers helped service users to access basic material needs such as housing support, food, and essential services.

> *It has been convenient. They work around you. They see what days' work for you and what times. They normally ring from a no ID number. I'm very cautious of phone calls. I've asked if they can send a text message before they ring. They work with you to make you feel safe and make you feel comfortable – **FaRS service user***

> *They helped me with housing after my mum died – I was going to get kicked out of her house and they helped me with getting support letters to get housing – now I am category 1 for housing. [Counsellor] helped me achieve that – **FaRS service user***

For further information on service adaptations for service users see **Section 6.4**.

Referrals to other services

Service providers routinely referred service users to other services when needed. Several service users reported that their provider had either recommended, or provided warm referrals, to other services to support their specific needs. These services included housing support, mental health practitioners such as psychologists, and family violence and mental health crisis services. In some instances, service users were referred to other programs offered by the service provider such as individual counselling, art therapy groups, or parenting classes.

> *As we progressed and I was talking to her about things that were upsetting me, it was very overwhelming for me as all these things were happening at once. She helped me find other facilities or people that would help me in those situations which was really, really good and she helped ease my anxiety – **FaRS service user***

While feedback on referrals was generally positive, some FaRS service users said they were either not referred to other services or the services that they were referred to were unhelpful or had long wait times which made getting access difficult.

> *The counsellor has said to my mum … I think she might benefit from seeing a psychologist by herself, but I don't think she has [referred her]. I find the services […] a little more passive* ***– FaRS service user***

5.3.2 Factors impairing the achievement of outcomes

This section describes the factors which impaired the achievement of outcomes of FaRS and SFVS. This section primarily relates to both FaRS and SFVS programs, as relevant factors overlap considerably. However, some factors which impaired outcomes for service users are specific to SFVS. These are discussed at the end of this section.

Lack of responsiveness to presenting issue amongst some providers

Some service users reported that their FaRS or SFVS provider did not adequately address their presenting needs. Some service users felt that their counsellor did not fully listen to or understand the issues for which they were seeking support or did not take an individualised approach to their needs. These service users felt they did not benefit from attending.

> *There's such a variation in experiences of [domestic violence]. She stuck to the format and just read off of a piece of paper, it wasn't tailored to me, wasn't individualised […] I walked out of there thinking I've just spent $30 to let you know that I don't feel safe. I was another number […] she was warm, but it came back to, you're not tailoring it, I'm just a number basically* ***– FaRS service user***

In some cases, service users who accessed courses found that the subject matter was not relevant to their needs. These service users found it difficult to engage in classes which did not meet their content expectations. Clearer descriptions of course content may prevent service users from enrolling in courses which are not relevant to their needs.

Lack of provider therapeutic knowledge and expertise amongst some providers

For some service users, a lack of expertise in their service provider was a perceived barrier to engagement with the service, and their growth. Some service users felt that their service provider did not have the knowledge or skills to address their presenting issues. Service providers who were perceived as lacking the appropriate expertise were unable to teach service users practical skills or techniques to support them in their everyday lives.

> *No real strategy behind her counselling, I don't know if they do any prep before or after what strategies I can bring, it's always what we bring to the table. Sometimes I need to think of things beforehand – **FaRS service user***

Several service users reported that their provider had a gap in expertise or therapeutic skills which impacted the service user's experience. Understanding neurodiversity in particular was emphasised as a gap, although one service user praised their counsellor and service for their approach to autism, reflecting that capacities and capabilities between services vary.

> *The first thing I said in that session was to be honest I don't feel like this is going to help. It was mainly referring to her approach. I said to her I hope it does, but I don't know. We talked she's very professional and very calm and she aims at looking at the good things, at the bright side but because she doesn't understand the ASD [autism spectrum disorder] approach there are certain things that when you do it the normal way it doesn't work for people with ASD. It leaves them with a feeling that this doesn't help because it's not applicable to how their brain works […] We came out of there a bit dazed. A bit meh **– FaRS service user***

Some victim survivors accessing FaRS services felt that their service provider lacked the specialised training or knowledge to help them. These service users felt that their providers did not have insight into the complexity of family violence and its impact on their wellbeing, or their families.

> *Would be great to have parenting programs connected to [domestic violence]; talking to a family counselling at [service provider], felt it was missing […] feel there's a gap between all the services – **FaRS service user***

Finding FaRS and SFVS funded services

Several service users noted they were previously unaware that FaRS services existed and that they had difficulty knowing where to look for help. It was frequently noted that FaRS services were not well advertised and that community awareness of the services was low. A number of service users recommended the service they accessed to their networks and wished that their services were better advertised to enable more people to access help. Sometimes, these service users had already referred their friends and family experiencing similar challenges to their provider.

> *Growing more awareness of the program, maybe advertising it a little bit […] [I] feel like people have to get to crisis point or near crisis point to find this, whether it be from a childcare point of view, antenatal care, [it was] a lot of me searching for this information […] feel like it's not widely accessible – **FaRS service user***

Wait times amongst some providers

Many service users interviewed described long wait times as a barrier to accessing services. For courses or groups, awaiting the next available intake was reported by some service users as being a lengthy process, with some courses having a waitlist of over 6 months. Some service users reported that they waited several months for their first counselling appointment/session, while others expressed concern about the long interval between appointments due to provider's workforce and capacity. Limited counsellor capacity sometimes resulted in service users accessing a counsellor who did not meet their preferences, including for example their gender and specific expertise of counsellors. Some service users, who had considerable waiting times for initial appointments, were not referred to other appropriate services during this waiting period, leaving individuals without support, potentially exacerbating their issues.

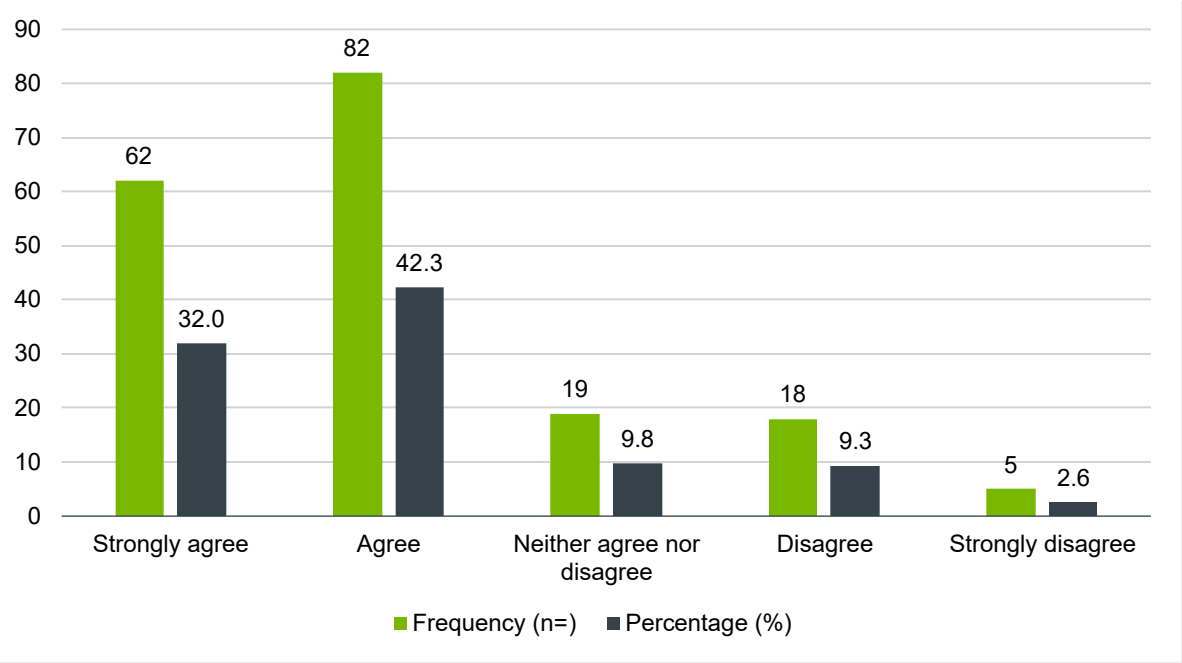
> *When someone finds the courage to reach out to [service provider] for support in an abusive relationship, especially while still living with their abuser, they need help immediately, not in months. The current waiting lists are far too long for situations that are ongoing and often escalating. Abuse doesn't pause just because someone is on a waiting list. This isn't just about discomfort, it's about emotional safety, mental health, and sometimes even physical survival. Time is critical. Support should be offered within two to three weeks at most. For someone living in fear or confusion, each day without help can feel like an eternity –* ***FaRS service user***

> *Well, I asked for help about six months ago. Yeah, and it took about 3 months to […] get to talk to somebody […] biggest problem was that there weren't people there I could talk to during the wait –* ***FaRS service user***

> *I feel like I've always had to wait a long time for appointments, I guess it's always felt like a long time when you're in that position where it's like I need help now –* ***FaRS service user***

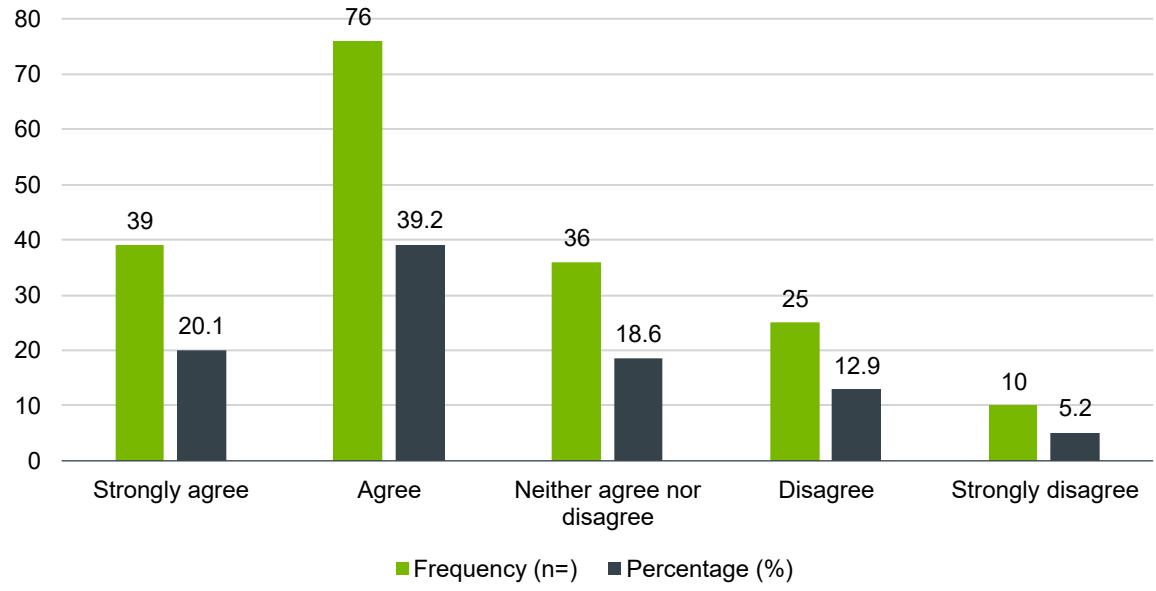
These concerns were not, however, reflected in survey data. In contrast to reports during interviews, 74.2% (n=144) of service user survey respondents agreed or strongly agreed they were able to get appointments on days and times convenient to their families (see **Figure 27** below) and 59.3% (n=115) indicated they did not have to wait too long to get an appointment (see **Figure 28**). Of this total, most respondents who received SFVS exclusively or both FaRS and SFVS agreed or strongly agreed they were able to get appointments on days and times which suited them.

Figure 27: I was able to get appointments on days and times which were convenient to me and my family, FaRS and SFVS service user (n=186)



Source: Service user survey data

Figure 28: I didn't have to wait too long to get an appointment, FaRS and SFVS service users (n=186)



Source: Service user survey data

Requirement for parental consent from both parents for SFVS

Children often need consent from both parents to access counselling and other services. Some service users wanted their children to access support for the trauma they had experienced as victim survivors in their own right, but their child's other parent refused to provide consent. Often, this refusal occurred in situations involving separating parents. Service providers characterised this as another form of control and abuse used by people who use violence.

> *The issue of joint consent required in court orders meaning you have to seek consent from both parents including perpetrators, which is a continuation of family violence through system abuse. It is time consuming and challenging, particularly for when you want to seek timely help for a child who is stressed or traumatised. If we cannot get joint consent without conditions, then we have to decline service. Probably it's a little bit different in other programs where joint consent is not required - able to attend non-FV specific mental health services for example* ***– SFVS service provider***

> *[I'm'] really hoping for external support, that has been challenging because I didn't have consent –* ***SFVS service user***

Access to childcare services or support for SFVS service users with children

Service users occasionally had difficulty accessing their SFVS provider with their children as some providers do not have child friendly meeting rooms or onsite childcare. For some service users, finding and paying for childcare so that they could attend a session was a barrier to engagement.

Number of SFVS sessions offered by some providers

Some service providers limit the number of sessions (often to 6-10 sessions) available to each service user under their SFVS program. These policies have been introduced to manage service user demand, including waitlist length. These limitations are not required by the Department. For victim survivors, and some service provider staff delivering counselling services, limits on service delivery were a perceived barrier to positive outcomes. Service provider staff noted that it often took several sessions to build rapport, trust, and establish feelings of safety within the sessions, particularly for victim survivors, who usually presented with complex trauma. Many service provider staff reflected that the number of sessions was not enough to comprehensively support service users to navigate the complexities of being a victim survivor of abuse. Understanding risk, and safety planning, required time and ongoing communication between providers and service users. Two service users noted that they had intentionally lengthened the space between their appointments in order to extend the period of time with their service provider.

> *The brief intervention model is incredibly limiting, particularly when we are helping women with complex post-traumatic stress, providing safety and [developing] a relationship with these women, [undertaking] risk*

> *assessment, getting to know their story, helping them maintain their personal sense of safety, all the things take a lot more time – **SFVS service provider***

> *Building trust might take three sessions - to build rapport and [a] relationship and provide them with a sense of safety. [SFVS is a] brief intervention model, the reality of the work is that it takes time, and it takes more than 6 sessions, even more than ten sessions, often the women are really shocked that it is limited. We need to have these discussions at the start, it's not trauma-informed – **SFVS service provider***

> *I would not like my counselling to finish until I am comfortable, ready to stand on my own two feet. I do not feel comfortable to let them go yet – **SFVS service user***

Appropriateness

6. Appropriateness

This section addresses the appropriateness of the current FaRS and SFVS model for contemporary service users, including priority cohorts, and the appropriateness of tele-practice. It examines barriers to effective implementation and opportunities for its expansion (KEQ 3); the complementarity and overlap between FaRS and SFVS (KEQ 4); the current level and distribution of need for FaRS and SFVS (KEQ 5); and perceived enablers and barriers to effective implementation of the current FaRS and SFVS model (KEQ 6). Whilst the current level and distribution of need is considered at a high level in this report, it will be the subject of further research during a subsequent phase of this project.

6.1. Key findings

	Findings
6	**FaRS and SFVS are largely meeting the needs of most priority cohorts, although there remains scope for improvement** There is evidence that FaRS and SFVS are successfully reaching Aboriginal and Torres Strait Islander people and communities and people who identify as culturally and linguistically diverse (CALD) and are achieving positive outcomes for these cohorts. Rates of participation in FaRS and SFVS by people with disability are lower than is expected based on population and family violence data. However, outcomes for people with disability are consistent with outcomes for the general population. Evidence on reach and outcomes for the LGBTQIA+ community is limited as Data Exchange (DEX) data does not fully capture LGBTQIA+ status.
7	**Aboriginal Community Controlled Organisations (ACCOs) are designing and implementing culturally appropriate, community-controlled services, but are reliant on other funding sources to meet client and community needs** Some ACCOs have successfully leveraged their existing relationships and trust with their communities to lay firm foundations for ACCO-led SFVS programs. SFVS program guidelines have enabled ACCOs to co-design flexible, trauma-informed and integrated approaches, which embed community ownership. Current SFVS funding arrangements are insufficient to support full implementation of these approaches which currently rely on other support to operate.
8	**Child-Specific Counselling (CSC) services are achieving positive outcomes for children** Services delivered to children are supporting positive outcomes for children and play an important role in ensuring children and young people feel seen, heard, and recognised. Data suggests that there is significant unmet need for support for children who have experienced or been exposed to family violence.

	The key challenge to scaling CSC is securing counsellors with specialist skills and experience to work with children.
9	**There is demand for more programs directed at changing the behaviour of men who use violence, and scope to clarify the roles such programs play in SFVS** Whilst it was not possible for this evaluation to assess the extent to which the Men's Behaviour Change Programs (MBCPs) have led to behaviour change for participants, interviews with a small number of MBCP participants demonstrated these individuals had very positive experiences with the programs. A range of stakeholders described a lack of services directed towards men who use or are at risk of using violence and identified this as a barrier to offering an integrated response to family violence and family violence risk.
10	**The current mix of face-to-face and virtual service delivery is effective and appropriate, but there is scope to increase virtual service delivery in the right circumstances** Nearly 20% of FaRS and SFVS services were delivered virtually from January to June 2024. Virtual service delivery has increased accessibility – particularly for people living in rural and remote areas, some people with disability, and people with caring responsibilities – and offers service providers greater flexibility and efficiency. While virtual FaRS and SFVS services achieve outcomes for service users broadly comparable to face-to-face services, many service users and providers prefer face-to-face delivery of counselling services. Considerations such as safety, building trust and rapport and privacy inform assessments of whether virtual delivery is appropriate. There is particular scope for expansion of virtual delivery of education programs (such as parenting programs) and hybrid delivery of counselling services.

6.2. Alignment with the needs of service users

The FaRS and SFVS model in its current format aligns with the preferences and needs of contemporary Australian families. These services offer programs that reflect diverse families and the needs of their service users, both in their content and delivery.

FaRS service user interview participants described accessing services as either individuals or a family unit for a range of reasons including:

- parents accessing services with adult children to resolve family conflict, trauma, abusive relationships or estrangement, including people in multi-generational households,
- parents accessing services with their children to improve family functioning,
- separating parents accessing services with their children to navigate post-separation,
- couples accessing services to address relationship breakdown or navigate separation,

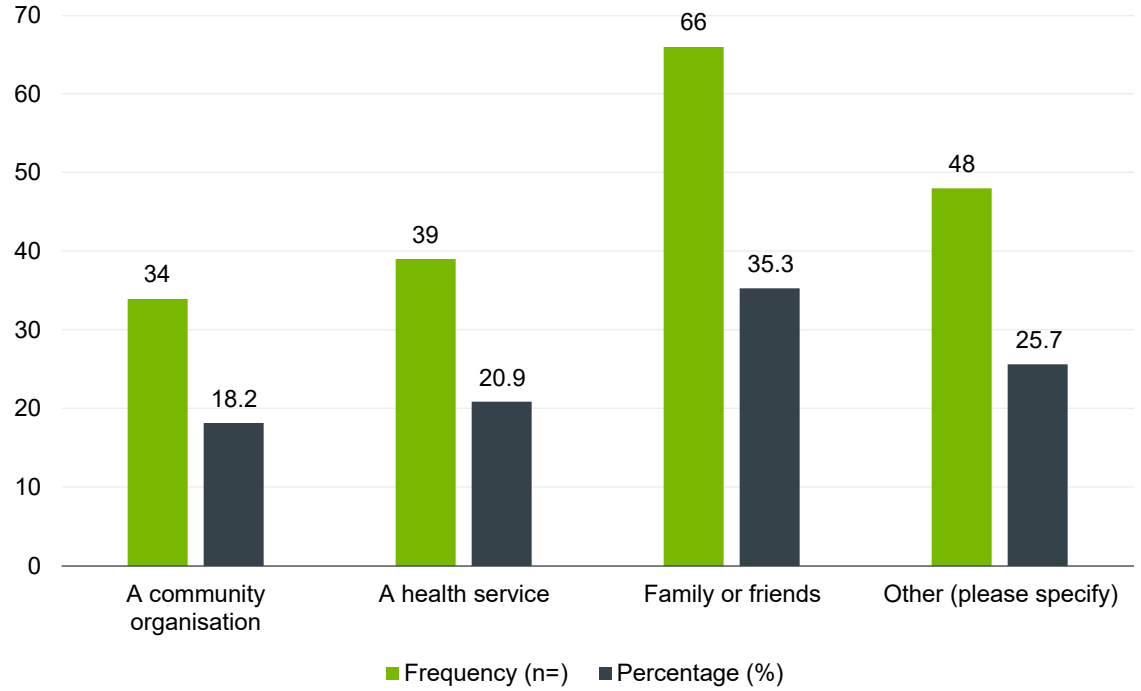
- individual women accessing services to seek support as victim survivors, including seeking support to address historical trauma from abuse experienced in earlier adulthood or childhood,
- individuals accessing services to address grief, loss, or bereavement after death of parents or partners,
- individual accessing services to cope with significant life transitions and their impact on their individual and family functioning (including for example retirement),
- individuals accessing services to address acute and non-acute mental health issues,
- individuals accessing services to seek counselling support in roles as carers for parents or partners, and
- individuals accessing parenting programs to improve parenting skills.

> *So […] we're dealing with a lot of issues around depression and anxiety. There's historical family violence, so that could be because we're dealing with a lot of older people as well […] you know, [from 30 to 60] years ago so [it] becomes like a trauma that is only being talked about now […] The other one is family conflict as opposed to family violence in terms of family falling out with each other and not being on speaking terms and creating all that tension and […] stress within the family unit and extended family and all that kind of thing* ***– FaRS service provider***

> *It is not always self-evident when people first present what program is most appropriate for them. They might have some FaRS programs but then get triaged into another program if we find something more appropriate for them. They get moved across as it suits needs that arise* ***– FaRS service provider***

The majority of service user survey respondents heard about the service they attended through family or friends (n=66, 35.3%) or other sources (n=48, 25.7%). Other sources included internet searches, their children's school, court or police referrals or exposure through working in health or similar sectors (see **Figure 29** below).

Figure 29: How did you first hear about the service, FaRS and SFVS service users (n=187)



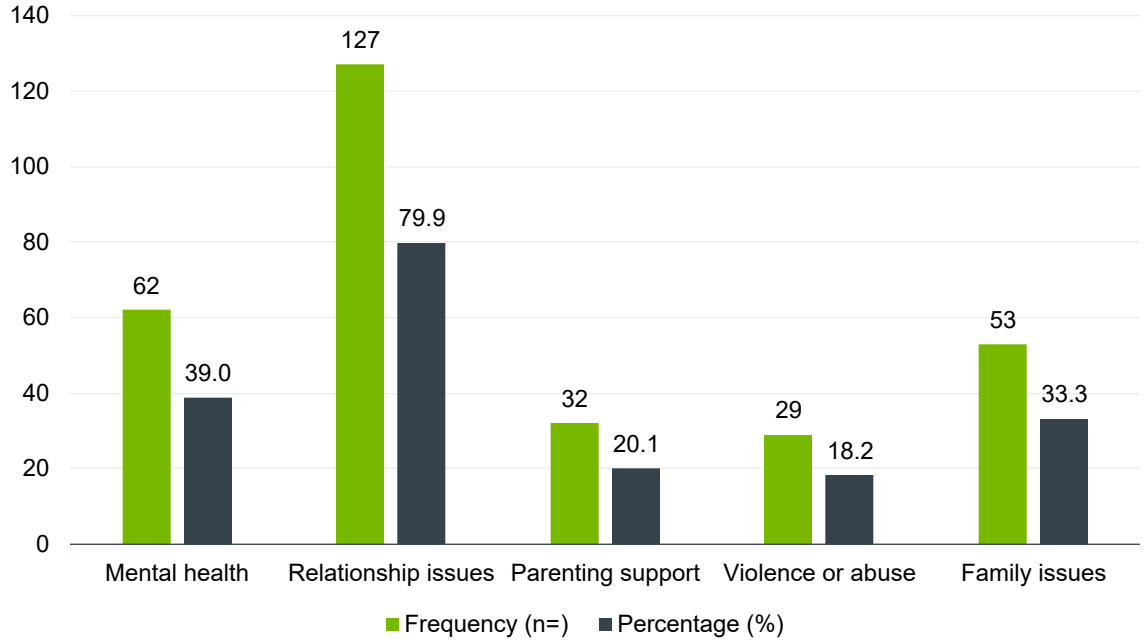
Source: Service user survey data

All SFVS service users cited family violence as the motivating factor for seeking support. A significant minority of FaRS services users similarly cited this as a need including 18.2% (n=29) of survey respondents (see **Figure 30** below) (see **Section 6.6**).

In line with the primary focus of FaRS on supporting families during significant life changes (including for example: formation, extension and separation) (Department of Social Services, 2021a), relationship issues (79.9%, n=127) was the most commonly selected motivation for FaRS service user survey respondents for seeking support. Mental health was the second most common (39.0%, n=62). Survey respondents were less likely to indicate 'family issues' (n=53, 33.3%) or 'parenting support' (n=32, 20.1%) as a motivation for seeking support (see **Figure 30**). FaRS service providers continue to serve an important function in addressing relationship issues with people actively seeking individual and couples counselling and other related supports. Across 2022-23 and 2023-24, almost 66% of services delivered to service users were counselling sessions, including one-on-one or couple/family counselling. Other service types such as initial consultations, information/advice/referral sessions, advocacy/support sessions for service users navigating services, and education and skills-training sessions were also provided to FaRS service users.

SFVS service user survey respondents primarily indicated violence or abuse as a motivation for seeking support, in line with the purpose of SFVS programs.

Figure 30: What motivated you to seek support from these services, FaRS service users[13]



Source: Service user survey

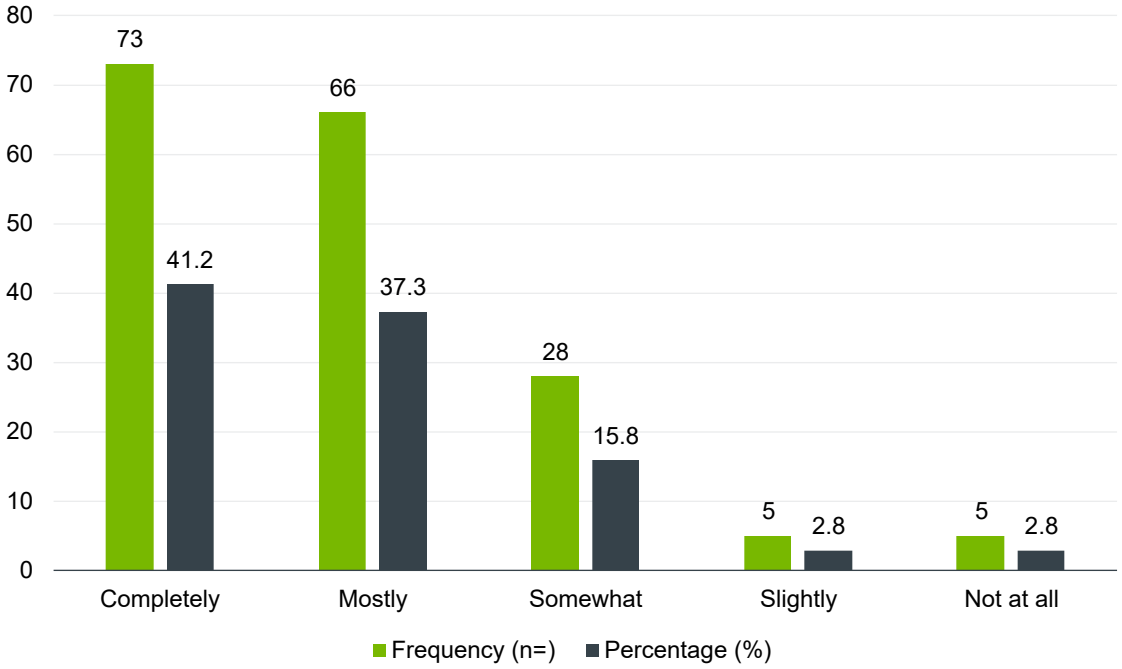
84% (n=162) of service users broadly agreed that FaRS and SFVS meets the needs of contemporary Australian families.

> *More contemporary Australian families are isolated from their families or friends. Women hold a lot more at home. This service is good to support those women* ***– FaRS service user***

Approximately 78.5% (n=139) of survey respondents reported the service completely or mostly addressed their individual needs (including relationship status, family dynamics, cultural background, disability, and other identify factors) (see **Figure 31** below). Of this total, most respondents who received SFVS exclusively or both FaRS and SFVS said services either completely or mostly met their individual needs.

[13] A total response count is not provided for this figure as respondents could select multiple options.

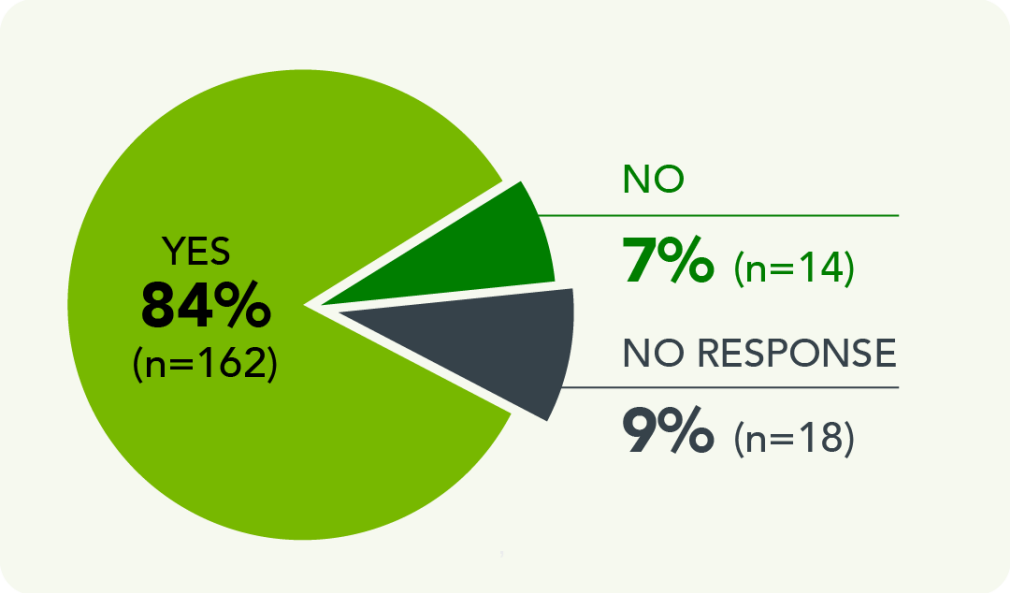
Figure 31: Did the service meet your individual needs (e.g. relationship status, family dynamics, cultural background, disability), FaRS and SFVS service users (n=177)



Source: Service user survey

Approximately 83.5% (n=162) of survey respondents agreed that FaRS and/or SFVS services meet the needs of contemporary Australian families (see **Figure 32**). Of this total, most respondents who received SFVS exclusively or both FaRS and SFVS agreed.

Figure 32: Do you feel that the service meets the needs of contemporary Australian families, FaRS and SFVS service users (n=194)



Source: Service user survey

Service providers attributed positive service user experiences, in part, to the flexibility of the FaRS and SFVS model (see **Section 6.7** for more detail). This flexibility allows providers to implement a range of initiatives, underpinned by varied therapeutic methods. These initiatives are place-based and responsive to the individual and community needs of the populations they serve.

Some FaRS service users complimented their service's responsiveness to their needs. They attributed this to several factors, including counsellors being matched to family members based on skills and background; providing ad hoc, informal counselling over the phone outside of formal appointments; and their understandings of different family compositions.

> *My family is blended, and I think the counsellor was understanding of those challenges* ***– FaRS service user***

For FaRS and SFVS service users who did not have their needs met, reasons included service staff lacking the requisite expertise or experience, for example around neurodiversity (see **Section 6.4.6** and **Section 5.3.2** for more detail). During interviews and focus groups, service users and service providers reported that services were mixed in their ability to adjust to some individual needs. In addition to neurodivergence, other identified gaps included culturally appropriate approaches for CALD individuals and Aboriginal and Torres Strait Islander communities (see **Section 6.4** for more detail), and support for complex issues including post-partum depression and alcohol and drug misuse.

> *We need to be able to have staff that have the skills to be able to work with people with complex disabilities, including mental health illnesses […] we don't have much funding in FaRS for upskilling of staff […] In terms of diversity, you know, we're really needing […] neurodiversity affirming approaches in our practice* ***– FaRS service user***

Mental health arose as a significant factor driving help seeking behaviour among FaRS service users. This reflects the intersection of mental health with family and relationship issues (Andersen et al., 2021; Carr, 2025; Isobe et al., 2020; White et al., 2024). Responses to the service user survey showed that mental health was most often selected as a co-motivator alongside relationship issues (33.3%, n=53). Only 3% (n=5) identified mental health as the sole motivating factor for seeking support through FaRS.

Similarly, approximately half of FaRS service users interviewed identified mental health as a reason for seeking support. During interviews, several FaRS service users said that they accessed counselling during an acute mental health crisis because they were unable to find accessible support elsewhere. In these cases, a lack of access to affordable mental health services led users to seek support from FaRS, which was free or comparatively low cost.

> *I can't talk highly enough about it. I still have a marriage because of it. [Counsellor] has a broad understanding of mental health issues. I'm here because of my husband's mental health stuff. The counsellor is good at talking to him about what he needs to do without him being blamed for it, or me being blamed for it* ***– FaRS service user***

> *Just before Christmas I tried to commit suicide – they saved my life 100%. I would not be here if not for them* ***– FaRS service user***

> *If I hadn't gone there and had not reached out, I probably wouldn't exist right now. I felt more valued, like, they gave me back my confidence which was good. [Financial counsellor] helped me sort out a budget and I kept it going and I am sitting quite comfortable and he helped me do that. [Counsellor] is going to help me get out into the community. I still haven't done that, but working on it with [her]* ***– FaRS service user***

> *They give me tips and techniques to do things with grounding and things like that […] for PTSD but I don't think I have PTSD. Grounding has helped me. [I] go outside, and grab hold of a plant, I feel the textures of the plant and leaf, smell the leaf using that to mentally put yourself into a level playing field* ***– FaRS service user***

6.3. Use of virtual service delivery

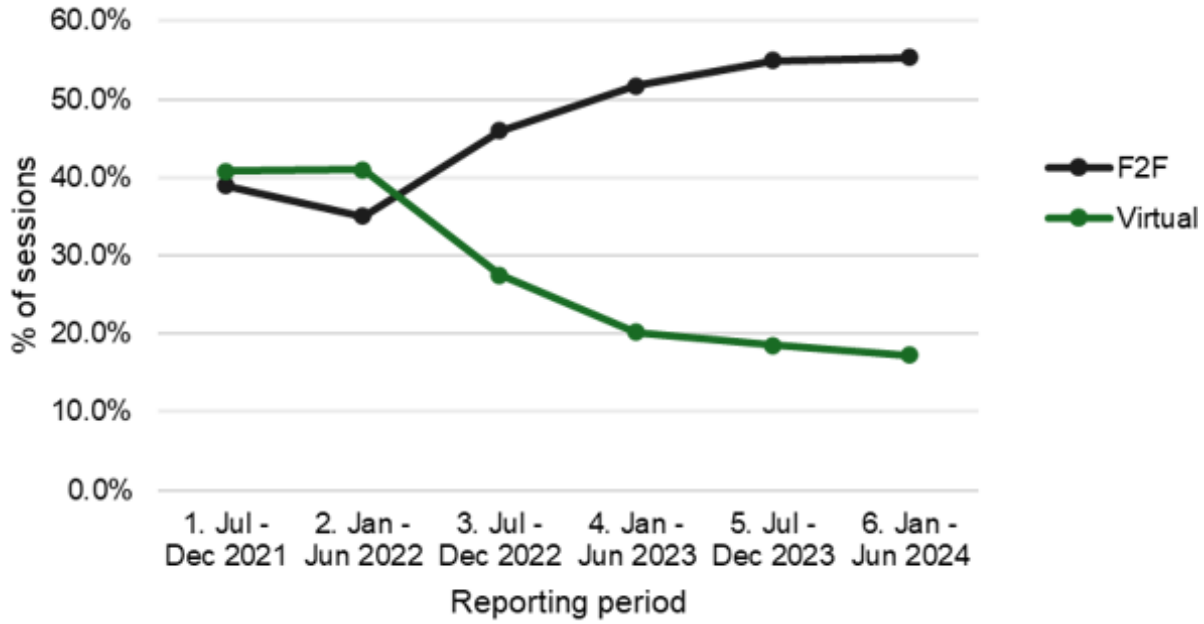
Tele-practice or virtual service delivery – where telecommunications technology is used to provide remote support to service users - emerged during the COVID-19 pandemic as a critical service delivery model in the family and relationship services sector in Australia and globally. Virtual service delivery has been widely adopted by FaRS and SFVS service providers. However, the details of their approaches vary. Some FaRS and SFVS services provide hybrid options (including allowing people to move between in-person and virtual), a minority offer in-person counselling only, and a small number of FaRS providers provide largely virtual or over the phone counselling or online parenting programs. Service providers also vary in their virtual service offerings, with the most common including individual counselling, parenting and other education programs, and MBCPs.

Service provider approaches to virtual service provision is shaped by their capacity and capability, local digital infrastructure, service user digital literacy, and the appropriateness of virtual or in-person delivery for particular service users or programs (including consideration of risks to safety and the therapeutic relationship).

Research highlights that the shift to tele-practice during the COVID-19 pandemic has allowed service providers to significantly expand how many people are able to access services (Cortis et al., 2021). This is reflected in FaRS and SFVS DEX data, which show that virtual service provision peaked at over 40% of sessions in January – June 2022. Since the easing of

pandemic restrictions, the proportion of FaRS and SFVS sessions delivered virtually has declined steadily to below 20% in the most recent reporting period (see **Figure 33** below).[14] This mirrors feedback from service providers, who described a drop in demand for virtual services.

Figure 33: Mode of delivery (sessions) by reporting period



Source: DEX-SCORE data

Influence of service delivery modality on outcomes

Notwithstanding service users' perception of the usefulness of virtual services, there is evidence that both FaRS and SFVS services delivered virtually achieve positive outcomes for service users. Analysis of SCORE data indicates improvements across all SCORE domains where services are delivered. However, the data is more equivocal on whether face-to-face or virtual service delivery is more effective in leading to outcomes for service users. The SCORE change for FaRS service users is equal to or slightly better for face-to-face engagement than virtual engagement. This trend is largely reversed however for SFVS services users. **Table 28** illustrates these trends.

[14] 20.3% of sessions had no information regarding service delivery mode available. Sessions were categorised as face-to-face if the service setting was listed as a justice, education or healthcare facility, outlet, client residence, community venue, or partner organisation. Sessions were categorised as virtual if the delivery mode was listed as digital, telephone or video.

Table 28: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by delivery mode, FaRS and SFVS

Activity	Delivery mode	Outcome Type	Service user (n=)	SCORE change (mean)	Service users with positive mean change (%, n=)
FaRS	Face to face	Circumstances	33,627	0.85	64.4% (n=21,646)
		Goals	33,656	1.28	75.1% (n=25,266)
	Virtual	Circumstances	16,118	0.71	57.5% (n=9,267)
		Goals	16,358	1.09	68.7% (n=11,231)
SFVS (incl. 4AP2)	Face to face	Circumstances	3,420	0.85	63.9% (n=2,184)
		Goals	3,258	0.96	66.1% (n=2,153)
	Virtual	Circumstances	906	0.89	61.3% (n=555)
		Goals	837	1.01	62.1% (n=520)

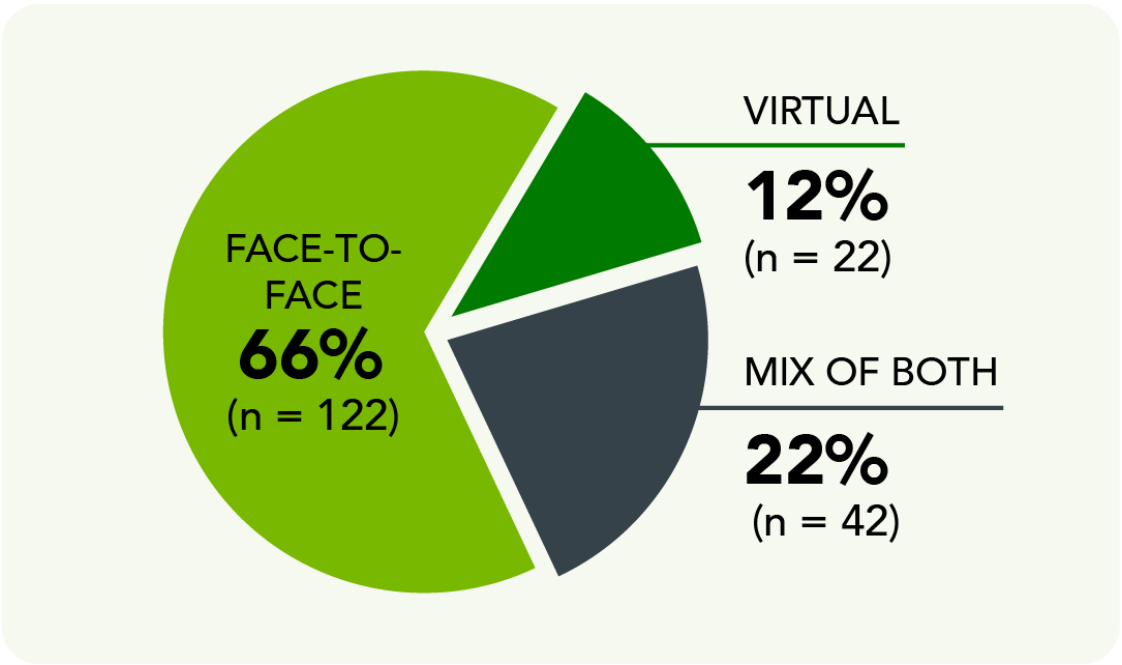
Score: DEX-SCORE data

Service user survey data on virtual and in-person delivery models

Service user survey data reinforces a shift towards in-person delivery models. It indicates that, overall, respondents are favouring face-to-face delivery and are broadly satisfied with the mode of delivery they are receiving. 66% of FaRS and SFVS service user survey respondents accessed services face-to-face with the remainder accessing virtual or hybrid services (see .

Figure 34). The range of delivery types was similar across FaRS, SFVS, and dual FaRS SFVS survey respondents, suggesting service providers are offering a range of service delivery options.

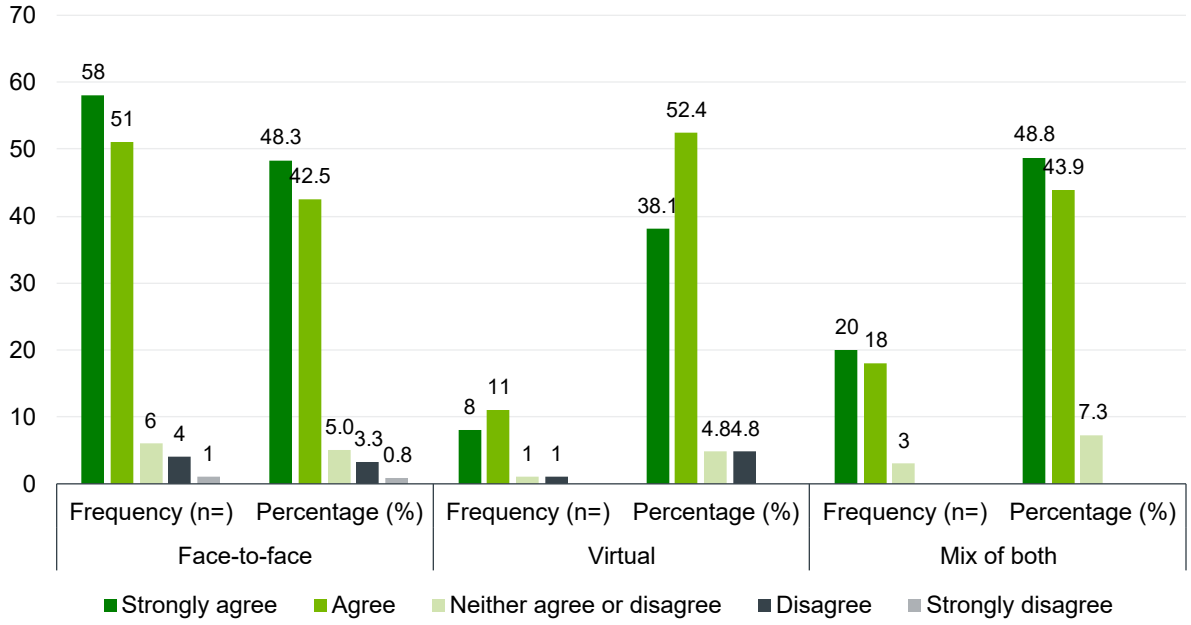
Figure 34: How were the sessions delivered (i.e. mode of delivery), FaRS and SFVS service users (n=186)



Source: Service user survey data

Overall, 87.6% (n=170) of all survey respondents agreed or strongly agreed that they were able to access services through a mode of delivery which suited them (see **Figure 35**).This indicates that current modalities are meeting service user access needs. Most respondents who received SFVS exclusively or both FaRS and SFVS services agreed or strongly agreed they were able to access a mode of delivery which suited them.

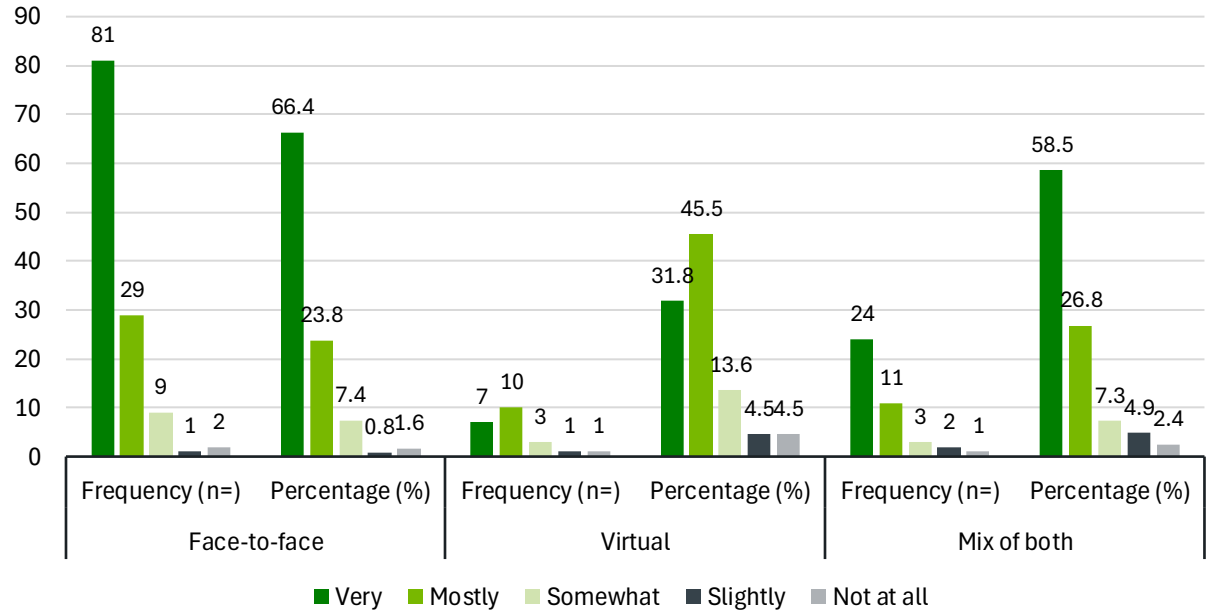
Figure 35: I was able to access services through a mode of delivery (face-to-face, virtual, or a mix) which suited me, FaRS and SFVS service users (n=187)



Source: Service user survey

While a consistently high proportion of service users reported that the mode of service delivery they accessed suited their needs, survey data on the perceived effectiveness of services varied by mode of delivery. Approximately 90.2% (n=110) of service users who received face-to-face delivery only and 85.4% (n=35) who received both face-to-face and virtual found it to be very or mostly useful. In contrast, 77.3% (n=17) who received virtual only found it to be very or mostly useful (see **Figure 36** below). Most SFVS survey respondents found their mode of delivery to be very or mostly effective.

Figure 36: How effective was this mode of delivery, FaRS and SFVS service users



Source: Service user survey data

Advantages and limitations of virtual service delivery

The evaluation has found that the primary advantage of virtual service delivery of FaRS and SFVS services is the expansion of access to the programs. Both the literature and service providers highlighted the potential for virtual service delivery to enhance access, particularly for people with complex needs who may struggle to travel long distances or attend in-person sessions. This includes residents of regional and remote areas and some people with disability (Ghidei et al., 2023; Joshi et al., 2021; Su et al., 2022), as well as single parents without access to childcare supports.

> *For us […] virtual delivery has really added value to overcome some of the other complexities that our clients face […] So we had for example a scenario a couple of years ago where we ran a group online. There was one man who had lost his licence, so he couldn't physically come to the site and there was another man who had an [apprehended violence order] AVO against him [which meant] he couldn't come within a 5-kilometre radius of the centre of town, but our office is in the centre of town, right? It's those sorts of added complexities that we were able to address through tele-practice – **FaRS service provider***

Virtual service delivery may also offer people greater flexibility. Tele-practice can be tailored to service user preferences, offering multiple modalities (e.g. video, phone, text) and scheduling options, such as shorter, more frequent appointments, to accommodate service user needs (Joshi et al., 2021). For many, the ability to control the pace and format of their therapy was empowering and made them more likely to continue with accessing services (Ghidei et al., 2023). Virtual service delivery can also be more private, allowing people to engage in sessions without fear of stigma or exposure to people who use violence (Joshi et

al., 2021). This can be particularly important for people experiencing family violence, or those living in small communities.

Several FaRS and SFVS service providers described the potential advantages of virtual service provision for service delivery capacity and the workforce. These providers observed that by allowing for greater flexibility in when and how services are delivered and accessed, additional programs (such as parenting programs) can be scheduled, reducing waitlist times. Tele-practice also provides attractive work from home arrangements for staff, improving the ability of service providers to recruit and retain staff and address workforce vacancies.

> *[…] with the onset of COVID […] We pretty immediately were able to transition into [online service delivery] […] and that's actually become quite the norm for us, so zoom delivery for counselling and group work. So, a lot of our groups that were always face-to-face, we can only get people to do online now and …it's worked quite well. There are some […] differences and challenges […] I'm thinking about our mandated groups. People who are maybe more forthright in face-to-face are probably I found more inclined just to be very laid back and disengaged online, so there are little changes that happen* ***– FaRS service provider***

Service providers and service users were particularly positive about the effectiveness of virtual delivery of group education programs such as parenting programs. Literature, service providers and service users were generally aligned in the view that virtual delivery increases convenience and flexibility, allowing parents to attend sessions while managing childcare and reducing travel time, and creating a relaxed atmosphere for participants (Kohlhoff et al., 2020). Some parents also commented on the value of virtual communities created through these programs, which can provide both peer and expert support (Su et al., 2022).

> *So what we've found is 90% of our parent education programs are now being run online and we've seen a huge uptake and we've also seen people sticking to them longer […] I think it's also when we know the socioeconomic pressures that many people are […] experiencing at the moment the ability to […] do the session from their work and take time off rather than the commute time or having to find childcare for the times that they could then just be doing it online for that short period of time has been really helpful for our clients* ***– FaRS service provider***

> *[Video calls] have been an efficient way [to engage in the parenting program] that have kind of made me then go, oh yes, I can do that day because I'm in the office […] I can go into a meeting room, so that's made it a lot more doable* ***– FaRS service user***

Tele-practice and digital interventions may not, however, be suitable for all types of services, and outcomes can vary depending on the nature of the intervention and the target population (Cortis et al., 2021; Joshi et al., 2021). MBCP providers gave mixed feedback on the suitability of virtual service delivery for MBCP programs. While some offered online groups which had increased accessibility, others noted the difficulties of building rapport and maintaining relationships and engagement with people who use violence when delivering services over the phone. Recent research suggests that MBCPs can be adapted to online formats including seeking victim survivor consent for online service delivery, reducing groups sizes, simplifying content and extending sessions to reduce time pressures; and adapting techniques and engagement methods to enhance participant engagement, including more self-completion activities and 'breakout room'-based activities for smaller group discussions (Opoku and Heard, 2024).

> *In terms of [MBCPs] I have thought about this a lot. Some of the challenges we had in working with men who use violence in COVID, for example we had to be really mindful about our practise in a virtual space, and we pared back some of the probably big-ticket items … we didn't want to do trauma work in a virtual setting. […] We had one situation luckily [with a] very experienced practitioner where the victim survivor was listening at the door to the session and she bursts through and said he's lying. So, there was, you know, we just had to keep kind of reinvesting in 'what does the physical space look like? What are the risks?' I don't know how much research is out around virtual work for men who use violence. I think there's some movement around it and then there's the other part, the flip side that goes something is better than nothing* **– *MBCP service provider***

Evidence on the suitability of virtual delivery of counselling services is mixed. A majority of FaRS and SFVS service providers expressed a preference for face-to-face counselling, which they felt made it easier to build rapport and a therapeutic connection. This preference was echoed by most of the service users engaged during the evaluation, despite some research indicating that rapport can still be built virtually in some instances (Kohlhoff et al., 2020).

> *Sometimes I have phone appointments, but I normally go into the office. I prefer face-to-face […] When you talk to people on the phone – I have a big thing about seeing peoples' demeanour, your eyes […] I feel more comfortable and comforted with people [in-person]. On the phone, they can't see you physically and you don't see them physically either. It's more personal when you're talking face-to-face* **– *FaRS service user***

> *Giving [counselling] to […] clients […] online, I found that actually it was the one good thing that came out of COVID. It actually made people realise how available [services are] […] That broadens things because some of my clientele might be, you know living [far away] […] So if I've got people coming down for a contact, I will try and encourage them to come in to the office […] just to help them with their accountability and to build their capacity for meeting, you know, those day-to-day needs for their children. But you know where it's not possible we do online, and it works really successfully. I actually find sometimes that doing it in this way can be quite helpful for clients because the engagement can actually be higher* ***– FaRS service provider***

Where service providers and users expressed comfort with virtual services, this was often in the context of a hybrid model, with emphasis placed on services adapting to the needs of service users when and where possible. This often involved establishing rapport through initial face-to-face sessions, before transitioning to virtual sessions, with the provision of face-to-face services when need was particularly acute. The flexibility of hybrid options was also identified as a positive by some FaRS and SFVS service users, including those with acute mental health issues, experiences of family violence, or other difficult life circumstances. Hybrid options allowed them to move between different modalities depending on what was happening in their life that particular week (Joshi et al., 2021).

> *We have so many clients who have social anxiety who may have some safety concerns about coming in, you know, or they can't get the time away from work or from their family […] Having said that, we did do some research and did note that most of our clients have said that they are happy with like a hybrid model, but they would prefer at least to have that initial session face-to-face which was really interesting. It's like getting that sense of the person getting to know the practitioner face-to-face, and then they're often happy to go online* ***– FaRS service provider***

Flexible communication between counsellors and service users was valued. Some FaRS service users reported being able to contact their counsellor for support outside of scheduled sessions via phone or email. Counsellors also proactively reached out to service users during particularly difficult periods.

> *Given the nature of our issues, I wouldn't do virtual full time because it's too hard with my mental health but sometimes on the morning of an appointment, I'll email [my counsellor] and say I'm having an awful morning – can you call me instead* ***– FaRS service user***

There was clear consensus among FaRS and SFVS service providers that virtual delivery is more appropriate for some services than others. Key considerations include the complexities of creating a safe, therapeutic environment remotely, including ensuring privacy (Joshi et al., 2021) and maintaining oversight and control over participants' engagement (e.g. ensuring

there were no distractions). SFVS service providers highlighted the increased complexities associated with maintaining a safe, therapeutic environment where family violence is a factor, particularly if the service user still lived with the person who uses violence. For these reasons, a large majority of SFVS service users expressed a preference for face-to-face engagements. Similar concerns were raised by a smaller number of service providers regarding virtual delivery of couples and/or family counselling.

> *We offer if people want to do it on Zoom or Teams or face-to-face and we will actually travel a little way to meet at one of our other offices as well […] It's less confronting for some people to not be in the room face-to-face and be able to do it on online. But I think one of the challenges that we've come across is also the safety aspect when you're working with couples… who else is in the room? The confidentiality side. So that's tricky. We have to ask lots of questions. And I think one of the examples was a couple that decided to lay on the bed together and wanted counselling and we went no, …let's work out a different way to do this because we hadn't been able to gauge whether there [were] any safety concerns first. … but I think the upside is you can actually get the service to more places* ***– FaRS service provider***

Overall, FaRS and SFVS service providers emphasised the importance of taking a case-by-case approach when considering virtual service delivery. The approach should factor in the needs, dynamics and preferences of the service user and their situation, balanced with access considerations – while always prioritising safety.

> *For some it works [virtual delivery] even better… and for some it doesn't work very well […] I'm thinking like a couple or families. They need a fair amount of […] your presence to help manage the dynamics [which] is very hard online. In person, that becomes far [easier], but there are others where it works amazingly and actually has been great. [Virtual delivery] has expanded our opportunity with people who we may not have been able to reach otherwise* ***– FaRS service provider***

> *We definitely offer [SFVS via tele-practice]. I think as other people have highlighted childcare - being able to access in, you know, really small windows of time, those kinds of things. Sometimes we've had women access from work, so [they'll] just go find a quiet room that they can have an hour and do their session, you know, where they can't take the extra hours to travel…. So, it's definitely face-to-face is always preferred. It's the safest option in terms of being able to make sure that there's confidentiality and all of those things. And we have to, you know, kind of go through all of that in quite a lot in quite a lot of depth if we're going to offer it in another way. But we definitely do offer [tele-practice] as an option* ***–SFVS service provider***

> *I think one of the challenges that we've come across [virtually] is the safety aspect when you're working with couples [or] children. Who else is in the room? […] but I think the upside is you can actually get the service to more places and in [region] […], there are so many pockets of communities that are disadvantaged [and] don't drive or can't get transport. That's another downside is that sometimes [they] don't have [access to] the technology* **– *FaRS service provider***

There is also evidence that some of the challenges associated with virtual service delivery can be more pronounced for some service user cohorts, including some Aboriginal and Torres Strait Islander people, children, and some CALD communities. The reasons for this include cultural preferences for face-to-face engagement, and the complexities of ensuring secure and private communication in some remote Aboriginal and Torres Strait Islander communities where phones are often shared between multiple people.

> *[…] we didn't have a lockdown for COVID, so that whole online delivery of services was not normalised for people [here]. We have a lot of people who have problems with technology […] There's a lot of digital refugees up here and they don't have the capacity to manage all of that online stuff or… people hand phones around and every week they've got a different phone […] That whole comfort with the delivery of services online is not here yet and I know government is pushing for that more and more, but it's […] third world country up here* **– *FaRS service provider***

While a range of literature suggests that tele-practice can be beneficial and suitable for children and young people (Copson et al., 2022b; Joshi et al., 2021; Kohlhoff et al., 2020), one CSC provider said virtual engagement was generally inappropriate for the delivery of CSC services due to the difficulty of ensuring the child is in a safe, private environment and remain engaged over the screen. The literature suggests that the age of the young person engaged in the service is a key consideration. One study found that adolescents and Generation Z victim survivors were more engaged in interventions that were delivered virtually or via social media (Dasgupta and Melvin, 2024; Joshi et al., 2021). This was attributed to their familiarity and comfortability with technology (Copson et al., 2022; Joshi et al., 2021) and the perceived increased privacy and security (Dasgupta and Melvin, 2024).

Barriers and enablers of effective virtual service delivery

Service providers identified several barriers and enablers to appropriate and effective virtual delivery of FaRS and SFVS services. The first is the importance of upskilling workers to ensure they have the capabilities to effectively work with service users through virtual channels. Offering video conferencing training, technical support, and peer learning opportunities were identified as important enablers.

> *[Offering] online [options] […] has been […] a big change and that definitely makes us put our services in a position that we can reach more clients in in that way. But again, it's a skill to do the work online so you know to actually train up and skill up your therapist to be able to do that effectively. But that's been really a positive change* ***– FaRS service provider***

The second is acknowledging and responding to the digital divide, which can include either digital illiteracy or inadequate access to appropriate technology and internet (particularly in regional areas). Communities and individuals more likely to experience digital illiteracy and limited access to technology, include rural and remote communities, older people, some Aboriginal and Torres Strait Islander communities, some CALD communities, and people from lower socioeconomic backgrounds. Taking this into account when determining the proper role of virtual service delivery in the FaRS and SFVS programs is essential to ensuring existing disadvantages and barriers to access are not further entrenched.

> *We've been trying to come around [geographic distance as a barrier to access for FaRS and SFVS programs] by offering telehealth sessions, but not everybody in regional locations, and especially [*Aboriginal and Torres Strait Islander] *people, have access to technology or [phone/internet] networks, right, so it can be patchy in regionals areas to be able to provide those services […] We can't have [telehealth] offered for regional people that don't have access to technology or don't have the means for it* ***– Dual FaRS SFVS service provider***

> *I'm too old to be doing all this virtual [and] tech stuff. That's not what I grew up with* ***– FaRS service user***

> *We had to invest an awful lot not only into the training of our staff […] but then training for the clients too to build up their confidence, to give them the resources to be able to engage in in an online space, including loan devices, including setting up a computer in their village [in] another service provider and saying you can go there and participate there so you have to be very creative to make it work* ***– FaRS service provider***

Overall, available evidence suggests that there is scope to increase virtual service delivery for FaRS and SFVS within the framework of the current hybrid approach which prioritises safe and equitable access based on service user preference and service capacity and capability.

Tele-practice has the potential to play an enhanced role in expanding access to FaRS and SFVS services, effectively extending the reach of high-quality services to underserved communities. With proper support (including training for staff and service users and adaption of existing programs to fit virtual delivery) and infrastructure (including loan devices, remote access stations) virtual approaches can serve as an alternative to face-to-face, in some circumstances. Specifically, there is scope to expand virtual delivery of education programs and increase hybrid approaches to individual counselling.

Ultimately decisions about service modality must be service user-focused, considering access needs and constraints, safety and wellbeing, therapeutic consideration, digital literacy and equity, culture, and service user preferences. Approximately 50.8% (n=62) of survey respondents who accessed their service face-to-face indicated they would still access the service if it was provided virtually. This demonstrates that while half of service users are open to accessing services virtually, it is important to maintain face-to-face options to ensure those seeking in-person support are able to access the services they need.

> *To be able to utilise those options, whether it be face-to-face or virtual… when you're in a rural or remote community, you've got to use what can work for the client* ***– SFVS service provider***

6.4. Alignment with the needs of priority populations

This section considers to what extent FaRS and SFVS are appropriate and aligned with the needs of service users and priority populations, including people who have experienced trauma, family violence and sexual violence, Aboriginal and Torres Strait Islander peoples, CALD people, people with disability, and those identifying as LGBTIQA+, as well as the service preferences of contemporary families more broadly, as articulated in KEQ 3.

The literature on service delivery for priority populations highlights a need to apply an intersectional lens to address barriers and tailor support to diverse individual, community and family needs (Corrie and Moore, 2021; Jones et al., 2023; Waller et al., 2023). Service providers and users provided further insight into the unique service needs and barriers for priority communities. Generally, service providers and service users reflected positively on the alignment of FaRS and SFVS with priority population needs. Positive feedback centred on several key themes: the usefulness of practical tools and strategies shared through engagement, staff making adjustments to improve clarity generally or in response to disability and mental health needs, and the care and attention staff used to apply empathetic and service user-centred approaches. Several service users shared positive examples of specific effort and tailoring to address individual and family needs.

Service providers and service users also described challenges and less positive experiences relating to FaRS and SFVS services. Several service providers spoke about constraints relating to the limits set by services on the number of sessions available per service user. Service providers introduced these limits in response to the need to manage waitlists, balanced against addressing service user need, workforce capability and other barriers (see **Section 6.7** for more detail). Some service providers indicated that this affected their ability to

tailor approaches for priority populations or offer sustained support. A few service users spoke about barriers and negative experiences including those relating to disability access, pronoun use, and limited ability to fully engage with services due to difficulties with child-care arrangements.

6.4.1 People experiencing trauma, family violence and sexual violence

Several previous evaluations on programs targeted at improving and maintaining the personal safety and wellbeing of victim survivors have highlighted the benefits of tailored, trauma-informed interventions that equip survivors with skills to self-manage, utilise support networks, and ultimately reclaim autonomy in their lives (Albanesi et al., 2021; Trabold et al., 2018). These evaluations relate to interventions that are tailored to different recovery stages to allow victim survivors to identify their risks and make informed decisions about their safety, and subsequent access to a combination of legal aid, psychological support, and safe housing. Albanesi et al. (2021) describe a model which provides consistent psychological support through both individual and group trauma-informed counselling, as empowering victim survivors to manage trauma symptoms and work towards long-term recovery. This intervention showed that regular engagement in these therapeutic environments facilitated resilience-building, decreased anxiety, and improved coping mechanisms. This is further supported by Trabold et al. (2018), whose findings underscore that trauma-informed care significantly reduces symptoms of depression and anxiety in victim survivors, contributing to a more holistic sense of wellbeing as individuals navigate the complexities of disrupted family relationships.

Literature also indicates that a focus on a strong therapeutic relationship is key in helping families engage with safety measures; and that clinicians' behaviours, such as normalising parents' struggles and adopting a non-judgmental approach, has enabled mothers to openly recognise their challenges and needs (Fogarty et al. 2022). This approach highlights that clinician rapport and trust are foundational best practices, especially in enabling participants to access and utilise safety networks effectively (Fogarty et al., 2022).

Overall, FaRS and SFVS services are responding well to the needs of people experiencing family violence despite some capacity and demand challenges (see **Section 6.6** for more detail). Victim survivors were a key cohort accessing FaRS services, with 27% (n=20) of FaRS service users interviewed, and 18% (n=29) of FaRS survey respondents identifying as victim survivors. Seven victim survivors directly noted that their service provider educated them about family violence, identifying abuse within their relationships, and information on navigating their relationships to support the safety their safety, and the safety of their families. Many service users reported positive experiences with accessing services for matters relating to experiences of family violence, often emphasising the service user-centred and empathetic response they received from services.

DEX data from 2021/22-2024/25 indicate that the number of female and male service users in FaRS were approximately equal, but the number of sessions attended by females was 28% higher than that of males. For SFVS there were 2.6 times as many females as males and approximately 4 times the number of sessions attended by females than those attended by males.

Analyses of the earliest and latest SCORE by gender showed that number of female service users in FaRS with at least two SCORE assessments in any given domain was 50% higher than that of males and 2.8 times higher in SFVS. Sample sizes are presented in **Appendix F**. Mean SCORE improved for both cohorts across all domains. Behaviour, Confidence, Impact, Knowledge, and Skills improved most. All comparisons were statistically significant (p<.001).

Table 29: Earliest to latest mean SCORE change for overall Circumstance and Goal domains for gender, FaRS and SFVS

Activity	Gender	Outcome Type	Service users (n=)	SCORE change (mean)	Service users with positive mean change (%, n=)
FaRS	Female	Circumstances	27035	0.8	63.4% (n=17132)
		Goals	27289	1.22	74.9% (n=20437)
	Male	Circumstances	17681	0.79	62.7% (n=11092)
		Goals	17792	1.2	73.6% (n=13090)
SFVS (incl. 4AP2)	Female	Circumstances	2998	0.98	68.7% (n=2061)
		Goals	2877	1.16	73.7% (n=2119)
	Male	Circumstances	1252	0.83	61.0% (n=764)
		Goals	1306	0.96	64.6% (n=844)

Source: DEX-SCORE data

Figure 37: Earliest to latest SCORE changes within subjects, FaRS service users by gender, July 2021 to June 2024

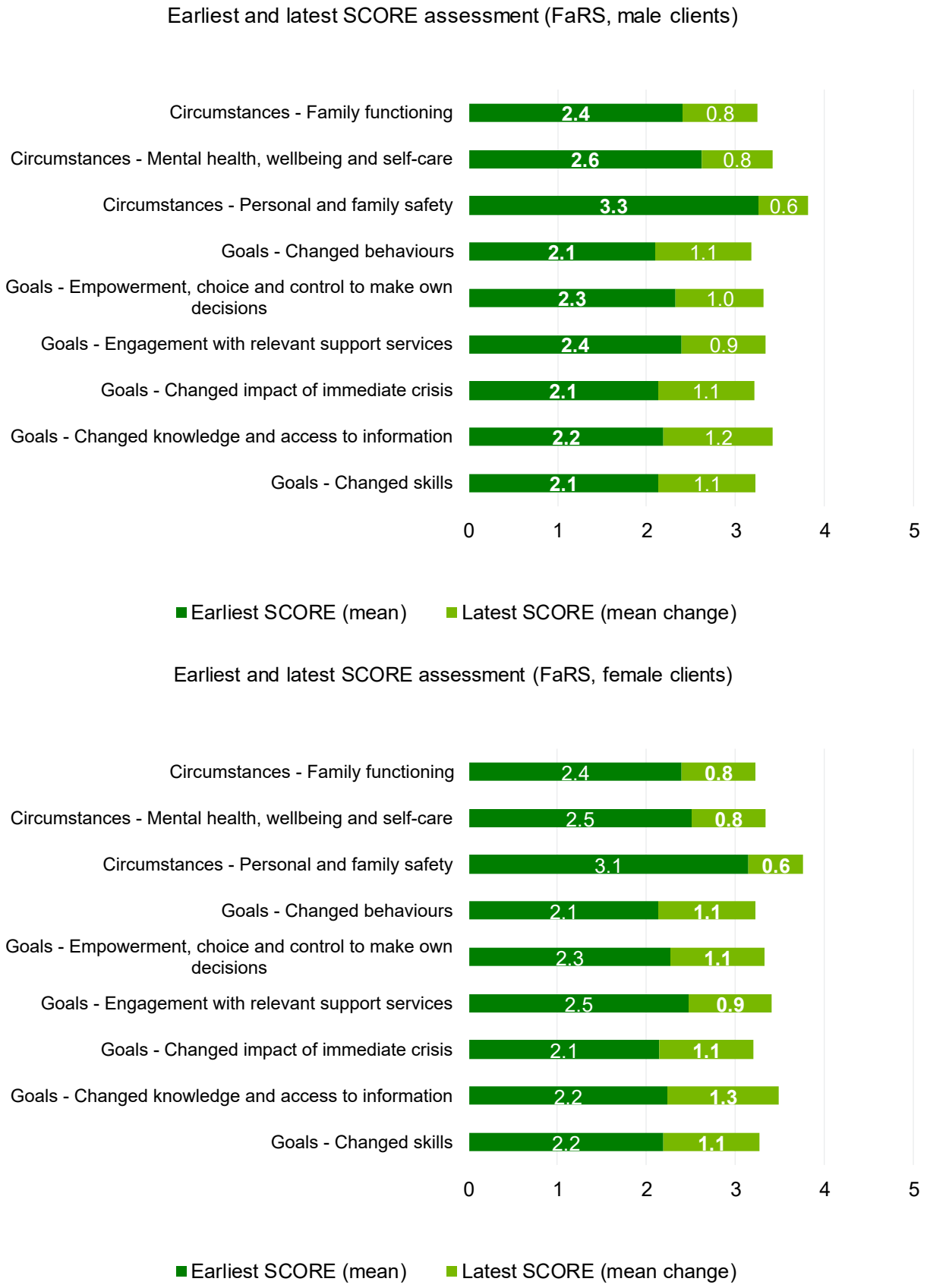


Table 30: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, FaRS service users by gender – female, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	55.4% (n=13,483)
	Mental health, wellbeing and self-care	56.6% (n=12,774)
	Personal and family safety	45.5% (n=6,833)
Goals	Changed behaviours	65.5% (n=10,285)
	Changed impact of immediate crisis	65.3% (n=5,335)
	Changed knowledge and access to information	69.4% (n=127,50)
	Changed skills	66.1% (n=12,704)
	Empowerment, choice and control to make own decisions	64.9% (n=9,683)

Source: DEX-SCORE data

Table 31: Percentage of services users with positive SCORE change for specific Circumstance and Goal domains, FaRS service users by gender – male, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	56.3% (n=9,035)
	Mental health, wellbeing and self-care	54.8% (n=7,902)
	Personal and family safety	42.1% (n=4,181)
Goals	Changed behaviours	64.7% (n=6,973)
	Changed impact of immediate crisis	66.4% (n=3,228)
	Changed knowledge and access to information	68.6% (n=8,272)
	Changed skills	65.8% (n=8,363)
	Empowerment, choice and control to make own decisions	63.0% (n=5,797)
	Engagement with relevant support services	60.0% (n=3,960)

Source: DEX-SCORE data

Figure 38: Earliest to latest SCORE changes within subjects, SFVS service users by gender, July 2021 to June 2024

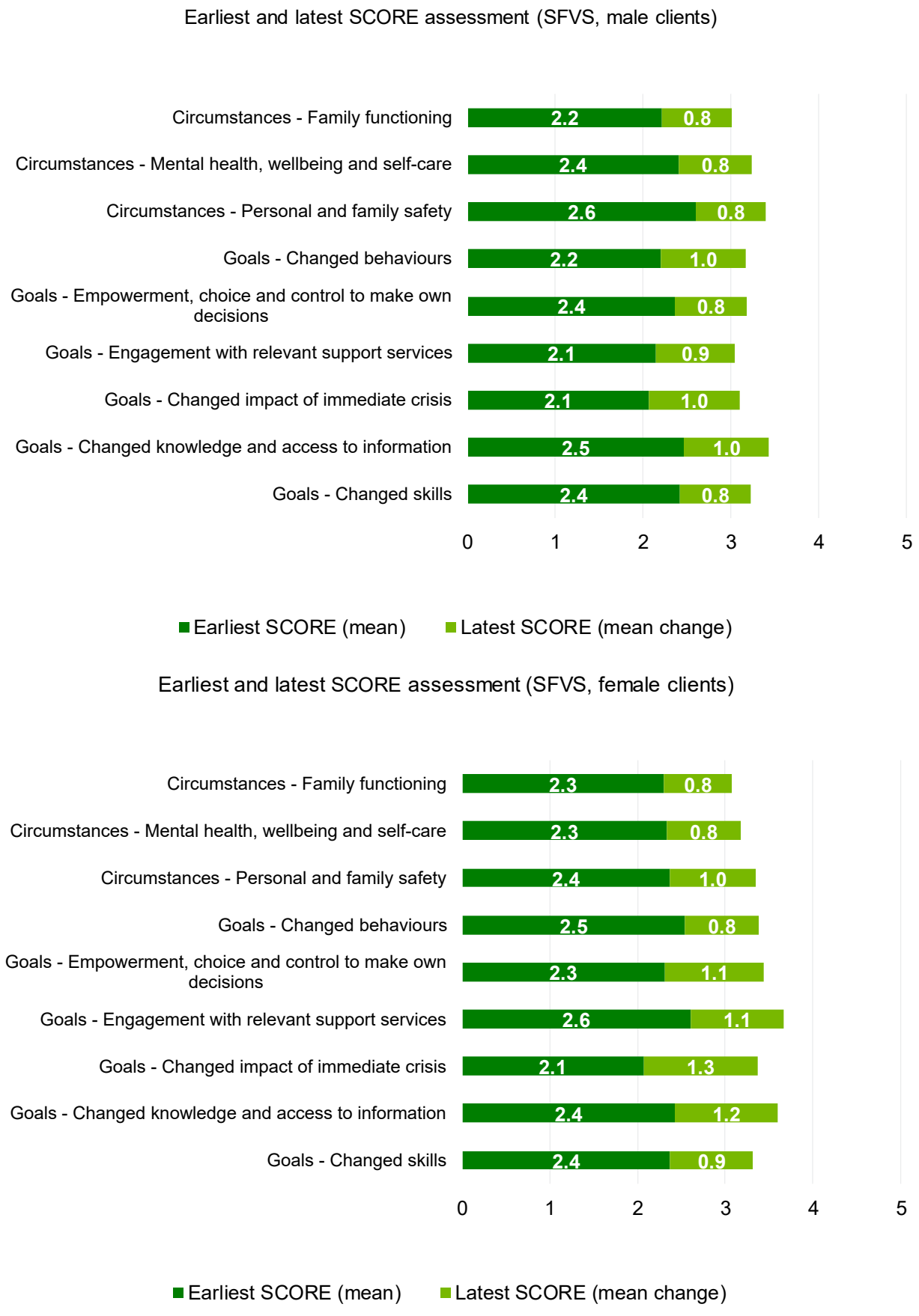


Table 32: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, FaRS service users by gender – female, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	54.5% (n=1,053)
	Mental health, wellbeing and self-care	55.8% (n=1,138)
	Personal and family safety	59.3% (n=1,582)
Goals	Changed behaviours	56.5% (n=726)
	Changed impact of immediate crisis	72.4% (n=935)
	Changed knowledge and access to information	66.6% (n=1,208)
	Changed skills	60.3% (n=941)
	Empowerment, choice and control to make own decisions	64.3% (n=1,209)
	Engagement with relevant support services	61.0% (n=794)

Source: DEX-SCORE data

Table 33: Percentage of services users with positive SCORE change for specific Circumstance and Goal domains, FaRS service users by gender – male, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	51.6% (n=497)
	Mental health, wellbeing and self-care	53.5% (n=521)
	Personal and family safety	50.0% (n=500)
Goals	Changed behaviours	57.5% (n=545)
	Changed impact of immediate crisis	63.2% (n=234)
	Changed knowledge and access to information	60.9% (n=464)
	Changed skills	55.2% (n=388)
	Empowerment, choice and control to make own decisions	53.5% (n=302)
	Engagement with relevant support services	54.1% (n=209)

Source: DEX-SCORE data

FaRS and SFVS service providers described how both FaRS and SFVS services are addressing experiences of trauma linked to diverse dynamics and experiences across family and relationship types. Flexible referral pathways across FaRS and SFVS services support the ability to address complex and overlapping experiences for individuals and families relating to family violence (see **Section 6.5** for more detail).

> *We are dealing with a lot of issues around depression, anxiety and historical family violence because we are dealing with a lot of older people from 40, 50, 60 years ago. It's a trauma that's only spoken about now* – ***SFVS service provider***

While the Department does not place limits on the number of sessions an individual can receive under FaRS or SFVS, many service providers set their own limits in order to manage demand. Some FaRS service providers expressed concern that limits set by services on the number of counselling sessions and other supports in order to meet demand can result in insufficient time to address service user needs through a holistic, sustained approach. Several service providers receiving SFVS funding made similar observations, noting that providing 6 to 10 sessions is not trauma-informed or adequate for conducting case management and risk assessment or to establish a relationship with service users.

> *The brief intervention model [of SFVS] is incredibly limiting, particularly when we're working with women who have complex post-traumatic stress disorder. We find this work is relational. It's about providing safety and [building] relationships with these women when they come into this space […] all the things [that] really take a lot more than six to ten sessions* – ***SFVS service provider***

> *The complexity when you have domestic violence and mental health…[the] practitioner will try to manage the risk rather than continuing the work of the client […] they manage the risk in the moment rather than addressing what the client has come to us for* – ***FaRS service provider***

FaRS and SFVS service users also offered insight into how services are being accessed and experienced by people experiencing family violence. Several service users described positive and in some instances life-changing experiences of their engagement with service workers, including feeling heard and supported.

> *I had one psychologist tell me I needed to harden up […] this has been my journey with [psychologists], and this is why actually dealing with [service worker] has been life-changing […] It's a breath of fresh air to have someone who says I'm not exaggerating and I'm not making things up* – ***FaRS service user***

Positive comments from SFVS service users offered insight into the particular strategies, skills, and strengths of the SFVS service response that providers are applying as specialists in family violence service delivery. These comments related to strategies that avoided re-traumatisation, including consistency in the engagement and not having to repeat their story, and comments about how SFVS service providers helped them to understand and name their experiences.

> *That one-hour appointment – I'll remember it to the day I die. It completely took the top of my head off [and] filled it with all this new information […] She educated me on coercive control. That changed everything and I'm so, so grateful because had I not had that support in my life, I would still be stuck in that cycle* ***– SFVS service user***

> *It made me realise it's not my fault […] [It] helped me get focus and step it out. I was seeing one person consistently […] [it] helped me feel calm […] [I] didn't have to rehash it all out* ***– Dual FaRS SFVS service user***

> *Before I reached out to them […] [I] didn't know how to verbalise. [The service] helped me how to accept and understand that it was domestic violence* ***– Dual FaRS SFVS service user***

Men and boys

It is well-established that family violence is highly gendered, with the majority of victim survivors being women. However, a growing body of research indicates that men also experience various forms of family violence, including physical, psychological, financial, and sexual abuse, from both female and male partners. Despite this, male victim survivors of family violence remain a largely 'hidden' group, facing unique barriers to recognition, help-seeking, and access to appropriate support services (Hine et al., 2022). Themes from the literature regarding experiences and service access barriers for male victim survivors include descriptions of societal expectations about masculinity, strength, and stoicism that can deter help-seeking or cause male victim survivors to fear they will be ridiculed or not believed. The lack of visible, male-oriented services can exacerbate feelings of isolation and discouragement from seeking help, as men are unsure where to go or doubt they will receive appropriate support (Huntley et al., 2019).

The literature identifies several factors supporting provision of gender-specific and inclusive services for men. Support from family members and friends can play a crucial role in encouraging men to seek help and validate their experiences as abuse. Receiving support anonymously was identified as an important enabler for effective service delivery. Confidential helplines provide an accessible and low-stakes environment where men can seek support without compromising their sense of masculinity. Service providers engaged through the literature emphasised the importance of validation and anonymity in helping men feel seen and heard (Hine et al., 2022).

While the literature described various enablers and barriers for male victim survivors, due to the low uptake of surveys and interviews for SFVS, MBCP, and CSC service users, there were few direct examples of experiences described by service providers and service users to draw upon (see **Section 3.8**). These insights from the literature nonetheless provide considerations for the design and delivery of FaRS and SFVS for male victim survivors.

The literature highlights several factors that promote engagement of fathers in parenting support programs. Single-gender group work was identified as a key enabler for enhancing

fathers' involvement. Fathers expressed a preference for programs that recognised their unique experiences and needs as parents and spaces where they could discuss the challenges and rewards of fatherhood with other men. Single-gender groups created a 'safe space' for fathers, allowing them to speak openly without concerns about judgment from partners. Additionally, normalising the experience of fatherhood and associated challenges through sharing experiences with other fathers undergoing similar transitions helped to reduce feelings of isolation and uncertainty around fatherhood. Building male social support networks can motivate attendance and sustained engagement, as fathers value the chance to connect with other fathers (Pfitzner et al., 2020).

Literature also shows that engaging both mothers and fathers in parenting interventions leads to enhanced outcomes for both parents and children. Co-parenting programs, which address parenting consistency, relationship quality, and support between partners can improve engagement and lower parenting stress. Involving both parents ensures comprehensive family support and enhances the impact of the interventions (Lechowicz et al., 2019).

Haines et al. (2022) also highlight the value of trauma-informed and strengths-based interventions in father-inclusive programs. In their study, practitioners created a safe space for fathers to reflect on their own trauma and understand its influence on their behaviours. This non-confrontational, relational approach allowed practitioners to build trust with participants, enabling a process of self-exploration and accountability. Storytelling and emotional awareness connect past trauma with current actions, enabling fathers to address harmful patterns constructively. These findings support a multidisciplinary, family-centred model to address the socio-cultural and trauma-based factors that shape fathers' experiences and behaviours.

6.4.2 People who use violence

People who use violence are a priority cohort for SFVS service delivery. SFVS includes MBCPs that support people using violence to address and change their behaviour. Ten organisations are funded to deliver MBCPs through SFVS funding across Australia. Approximately 1,747 service users accessed MBCPs in 2023-24 and between 51% and 65% of MBCP service users had an overall positive change in circumstances. The average Circumstance SCORE change was in the order of +0.70-+1.05.

The literature identifies a range of themes and best practices relating to service delivery for people using violence, including: non-judgmental and authentic facilitation; understanding and addressing trauma by working through their own histories of violence, helping individuals to take responsibility; cognitive behavioural therapy (CBT) techniques' using small settings with consistent members to allow for trust-building and a sense of accountability within the group (Morrison et al., 2021) and recognising both external motivations (e.g., child custody disputes or legal pressures) and personal motivations such as maintaining or restoring family relationships (Nicholas et al., 2020). The literature also identifies a range of techniques and theories guiding approaches to men's behaviour change. Many of these practices were reflected by service users in this evaluation.

Self-reflection and accountability

Programs that foster self-reflection and accountability have shown significant effectiveness in family violence interventions. Nicholas et al. (2020), in their practical evaluation guide for MBCPs, emphasise 'belief and behaviour reflection' as foundational in helping people who use violence examine and dismantle the beliefs that rationalise or normalise their violent actions. By encouraging critical self-awareness, participants gain insight into how their behaviours impact others, which is essential for sustainable behavioural change. Nicholas et al. (2020) also emphasise that accountability, through accepting responsibility, is crucial, as it reduces denial and minimisation among people who use violence. This, in turn, supports deeper engagement with self-management and increases the likelihood of proactive help-seeking.

The Duluth Model, as discussed by Baptista and Tagliamento (2021), complements these principles by focusing on dismantling power dynamics through structured cognitive-behavioural methods. The model encourages participants to acknowledge the tactics of control and abuse, such as intimidation or emotional abuse, that they may use to exert dominance in relationships. Group sessions focus on exploring themes of respect and equality, promoting awareness of the harm caused by violence. Baptista and Tagliamento (2021) note that while the Duluth Model effectively raises self-awareness and fosters accountability, the success of this approach varies depending on the cultural and personal background of participants.

The literature highlights that integrating CBT with motivational interviewing has shown promise in addressing initial resistance to change, supporting self-reflection, and encouraging self-motivation. Baptista and Tagliamento (2021) observe that motivational techniques are particularly valuable in increasing participant engagement by aligning the intervention with each person's unique motivations and goals. For example, by addressing attitudes towards gender norms, motivational interviewing supports the reduction of violent behaviour, especially when culturally adapted. As Baptista and Tagliamento (2021) emphasise that 'for greater effectiveness, programs must consider individual, community, and institutional factors', highlighting the need for holistic and adaptable approaches that resonate with participants' diverse backgrounds.

Hine et al. (2022) examined the Caring Dads program, a father-specific intervention designed to address domestic and family violence by helping fathers recognise and alter abusive behaviours. In the Australian context, this program supports fathers in acknowledging the consequences of their actions and adopting child-centered, non-violent parenting approaches. Motivational interviewing is a key component in the program, using participants' desire to improve relationships with their children as a catalyst for change. Participants report greater self-awareness and a deeper understanding of how violence impacts family wellbeing, with outcomes including enhanced safety for mothers and improved parenting dynamics (Hine et al., 2022). This positive effect is echoed in other evaluations of Caring Dads, which show similar improvements in parenting practices and family relationships.

MBCP service users identified benefits of group-based work including increased accountability and gaining insight into other men's experiences, including men from different age groups and backgrounds. They also spoke about building understanding of themselves and what drives

their behaviours, including an understanding of the impact of family violence from their childhood where this was relevant, as well as learning techniques for managing conflict.

MBCP service user motivations for participation included wanting to change their behaviour, improve their relationships with their partner and families, and heal past trauma to break abusive behavioural cycles.

> *I travel three hours to get here [by public transport]. I don't drive because fuel is too expensive […] [At night] I stay at a friend's house in the city rather than going back up because I wouldn't get up till late […] If there were more places where it was offered it would be awesome because I think that this could help a lot of people* ***– MBCP service user***

> *I'm not here to say I want my partner to forgive me and let's get back to how things were […] That's unrealistic. What I'm here to say in front of my partner and my children is the way I behaved is no longer and I want to go forward behaving in a much more […] pragmatic way. I'm not saying I won't get angry, I'm not saying I won't make mistakes, but I'm a lot more aware of it. I'm a lot more careful about going forward* ***– MBCP service user***

> *[I like] being able to talk about different things and being able to open up […] so then in the future when similar situations happen, you can think about them in a different way. You've got other perspectives and […] different ways to try and deal with things. It gives […] good tools for life and the relationships in the future* ***– MBCP service user***

Skill-Building and Communication Techniques

Skill-building programs that focus on respectful and constructive communication are essential in reducing violent behaviour and supporting lasting behavioural improvements. Nicholas et al. (2020) advocate for integrating practical tools that promote non-violent, positive communication, equipping individuals with strategies to handle interpersonal conflicts without resorting to aggression. Skill-building aligns with evidence showing that respectful communication helps de-escalate potentially violent situations, thus reducing the risk of recurrence.

The Risk-Need-Responsivity (RNR) model further supports these findings by tailoring interventions based on individual risk levels and specific needs.[15] Radatz et al. (2021) and Day et al. (2019) affirm that the RNR framework, which combines cognitive-behavioural methods with customised approaches, enhances program engagement and reduces reoffending. The framework addresses criminogenic needs, such as substance abuse or pro-

[15] The RNR framework was developed by Canadian psychologists Donald A. Andrews and James Bonta in the 1990s to guide effective rehabilitation practices and reduce recidivism in the criminal justice system.

violence attitudes, and adapts to the learning styles and cultural backgrounds of participants, providing a model for effective, accountable interventions that focus on safe behavioural change (Radatz et al., 2021; Day et al., 2019).

A need for whole-of-system approaches

There is a growing body of evidence showing that achieving quality outcomes in MBCPs is challenging without a whole-of-system approach (Australia's National Research Organisation for Women's Safety, 2025; Hamilton et al., 2025; Helps et al., 2025). This approach involves collaboration across a range of family violence services to support both victim survivors and perpetrators. It enables better behaviour change outcomes, greater visibility, and more effective risk management through a shared understanding of the fluctuating levels of risk and safety experienced by service users and their families. Given the need for system-wide involvement, outcomes from MBCPs cannot be attributed solely to individual practitioners or programs.

Some CSC service providers echoed these findings, highlighting the benefits of approaches that involve men, women, and children in separate but connected whole-of-family approaches. This wraparound model provides support to the whole family and addresses family violence perpetration as part of a broader, inclusive approach.

> *We try to deliver holistic program […] working with dad in the men's behaviour change, working with mum in our women's program, and then working with the child and we find we don't do it all at once. We would start the work with dad and then if it's safe to do so with mum and with the child and we find when we're working with the whole-of-family holistically that intervention tends to have more of an impact. –* ***CSC service provider***

> *We're working with men in the [MBCP] and they're still using violence [so] it would be unsafe to do family work or couples work […] But one thing that you know we really feel would assist is not just behaviour change or case management but therapeutic interventions for men because for so many of the men we work with, their biggest motivator is reunification with children […] They're not there for really any other reasons. […] We also acknowledge that a 20-week program isn't [going to] change a cycle of violent behaviour. So, some of the men in our case management program, we refer outside to counsellors or psychologists to work at work on early trauma and other issues. But that's also limited in terms of our funding and what we can do and I guess the recognition is if that was something we could offer, so the whole family could sit within our agency and we could run men's behaviour change, we could also do some therapeutic work with Dad, we can work with the child, we can work with the mum […] work with the whole family. But I really think a missing link is that therapeutic work with Dad –* ***CSC service provider***

Barriers to engagement

MBCP service providers offered a range of insights into barriers to MBCP engagement. Challenges reported included: reluctance from some family violence services to engage with MBCP providers due to a perception of collusion, men dropping out once meeting court-mandated number of sessions, and a need for service providers to tailor sessions with men one-on-one for longer than funding anticipates (e.g. due to disability or low literacy levels impacting engagement capacity). MBCP service providers also described high demand and backlog, particularly in association with increased community expectation regarding accountability and visibility of adults using family violence.

> *There's been an increased expectation for [MBCP] providers to assess, monitor and track for risk […] all of that work is held in our case management and individual session so we're working with men for longer […] and we've got increased accountability from our funders and from […] the community […] We want to be able to meet that expectation and do it really well which means we're holding men visible in the program for longer which means there's a backlog* ***– MBCP service provider***

MBCP service providers emphasised the need for more funding to address these challenges and meet demand, while also ensuring best practice delivery, including incorporating understandings of mental health and trauma as part of healing-focused approaches. Specifically, this funding is needed to support the complexity and ongoing requirements of MBCP work, including enhanced case management and focused individual engagement centred on motivation and accountability. Some MBCP service providers also described increased demand from requirements to align with state-level risk management frameworks leading to increased case management and handling.

Culturally adaptive approaches

The importance of culturally specific, individualised interventions is underscored across several studies. Butters et al. (2020) advocate for interventions that move away from one-size-fits-all approaches, such as the Duluth Model, in favour of methods that consider participants' demographic profiles, co-occurring issues (for example substance abuse or mental health conditions), and their readiness for change. Literature also highlights the benefits of using typologies, such as distinguishing between 'family-only' and 'generally violent' offenders, to inform targeted interventions. Motivational interviewing has also proven effective in reducing resistance, particularly when tailored to each individual's readiness to change (Butters et al., 2021). This personalisation enhances program engagement and reduces recidivism, promoting safety for survivors of family violence. Short et al. (2019) further reinforce the need for culturally responsive approaches, particularly when working with individuals from Māori and Pasifika communities in Aotearoa New Zealand. In these cases, restorative practices and community-based healing are essential for supporting accountability without stigma. Collaborating with iwi (tribal) services and community organisations, these programs help participants address and modify harmful behaviours in culturally relevant ways, supporting a more holistic and enduring change (Short et al., 2019). By fostering non-shaming, constructive self-reflection, these programs enable participants to reframe their behaviours within the broader context of their cultural identities.

MBCP service users also commented on the benefits they got from individualising the approach to behaviour change, noting that it gave them an increased understanding of how their experiences in childhood and family history impacted on their behaviour as adults.

> *[I was] talking about some stuff from my childhood and some things that happened with my mum when I was younger and it actually kind of opened my eyes up […] There's a lot of […] trauma that I experienced back then that I can still feel that, but don't even realise it […] [I] wasn't expecting to go through something like that in a course like this […] [It] also made me think about the way that my mum was treated by her ex-partner and the behaviours that I portray and have portrayed, and the fact that some of that's probably learned behaviours and the fact that like it was like a normal when I was a kid* ***– MBCP service user***

6.4.3 Addressing the needs of Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander people are a priority cohort for FaRS and SFVS service delivery. The FaRS and SFVS programs are well-positioned to contribute to the achievement of priority reforms and outcomes for Aboriginal and Torres Strait Islander people, including the ***National Agreement on Closing the Gap*** and the ***Aboriginal and Torres Strait Islander Action Plan 2023–2025*** under the ***National Plan to End Violence against Women and Children 2022–2032***. In particular, the objectives of FaRS and SFVS align with:

- Closing the Gap Outcome 13: Aboriginal and Torres Strait Islander families and households are safe (Target: By 2031, the rate of all forms of family violence and abuse against Aboriginal and Torres Strait Islander women and children is reduced at least by 50%, as progress towards zero)
- Closing the Gap Outcome 4: Children thrive in their early years
- Closing the Gap Outcome 14: People enjoy high levels of social and emotional wellbeing.

Under the SFVS Operational Guidelines (Department of Social Services, 2021a), Aboriginal and Torres Strait Islander people must be given access to services funded under the program. While the FaRS Operational Guidelines (Department of Social Services, 2021b) do not identify Aboriginal and Torres Strait Islander people as a priority cohort, both guidelines place a responsibility on service providers to ensure that Aboriginal and Torres Strait Islander people have equal and equitable access to services, and to work in ways that are fair, open and transparent in engaging with Aboriginal stakeholders and organisations.

Between 2021-22 to 2023-24, an average of 5.4% of FaRS service users and 12.5% of SFVS service users identified as Aboriginal and/or Torres Strait Islander. This suggests that – overall – both programs are reaching Aboriginal and/or Torres Strait Islander people and communities as intended.

Outcomes for Aboriginal and/or Torres Strait Islander service users

There is some evidence that both FaRS and SFVS are leading to positive outcomes for Aboriginal and/or Torres Strait Islander service users. The mean change in SCORE outcomes for Aboriginal and/or Torres Strait Islander FaRS service users is positive across all SCORE domains (see **Table 34**).

Table 34: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by Aboriginal and Torres Strait Isander status, FaRS and SFVS

Activity	Aboriginal and Torres Strait Islander	Outcome Type	Service users (n=)	SCORE change (mean)	Service users with positive mean change (%, n=)
FaRS	No or unknown	Circumstances	71,349	0.77	62.6% (n=44,696)
		Goals	70,887	1.13	72.8% (n=51,583)
	Yes	Circumstances	2478	0.86	62.8% (n=1,557)
		Goals	2,596	1.17	73.1% (n=1,897)
SFVS (incl. 4AP)	No or unknown	Circumstances	6,979	0.93	67.0% (n=4,676)
		Goals	6,652	1.06	70.0% (n=4,654)
	Yes	Circumstances	483	0.83	59.2% (n=286)
		Goals	479	1.04	66.4% (n=318)

Source: DEX-SOURCE data

Figure 39: Earliest to latest SCORE changes within subjects, Aboriginal and Torres Strait Islander FaRS service users, July 2021 to June 2024

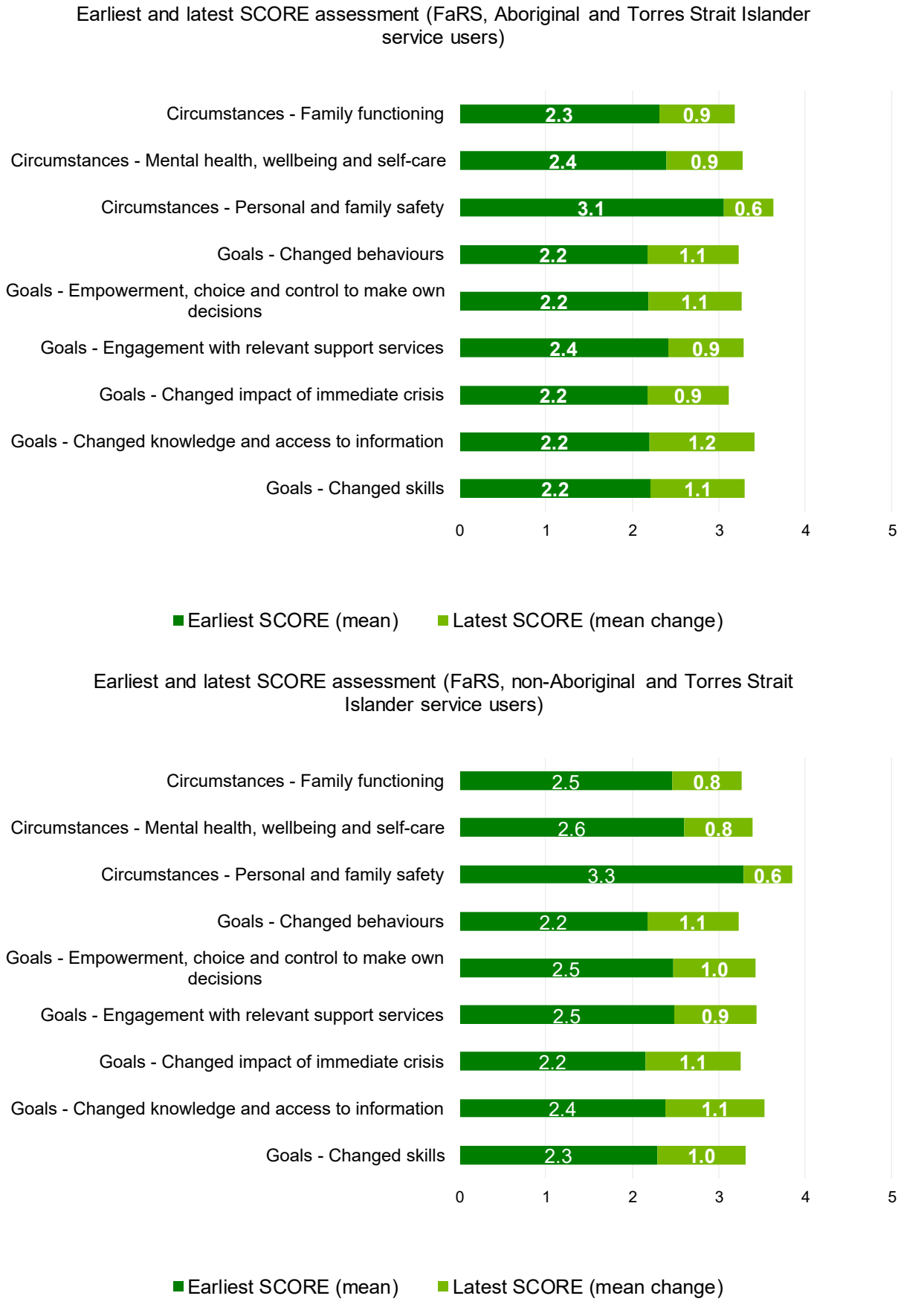


Table 35: Percentage of services user with positive SCORE change for specific Circumstance and Goal domains, Aboriginal and Torres Strait Islander service user FaRS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	54.7% (n=1,189)
	Mental health, wellbeing and self-care	55.3% (n=1,176)
	Personal and family safety	42.5% (n=653)
Goals	Changed behaviours	60.9% (n=980)
	Changed impact of immediate crisis	58.4% (n=454)
	Changed knowledge and access to information	66.4% (n=1,178)
	Changed skills	62.5% (n=1,264)
	Empowerment, choice and control to make own decisions	62.7% (n=915)
	Engagement with relevant support services	56.6% (n=647)

Source: DEX-SCORE data

Table 36: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, non-Aboriginal and Torres Strait Islander service user FaRS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	54.9% (n=35,333)
	Mental health, wellbeing and self-care	55.5% (n=32,764)
	Personal and family safety	42.6% (n=17,260)
Goals	Changed behaviours	64.6% (n=26,702)
	Changed impact of immediate crisis	66.7% (n=14,651)
	Changed knowledge and access to information	66.2% (n=31,959)
	Changed skills	63.9% (n=32,721)
	Empowerment, choice and control to make own decisions	60.9% (n=23,903)
	Engagement with relevant support services	60.6% (n=16,463)
	Changed behaviours	64.6% (n=26,702)

Source: DEX-SCORE data

SCORE data indicate that SFVS is also achieving positive outcomes for Aboriginal and Torres Strait Islander service users (see **Figure 40** below). However, the degree of improvement in outcomes for Aboriginal and Torres Strait Islander people accessing SFVS services is generally slightly lower than non-Aboriginal service users. This is particularly marked in relation to the Goals of empowerment, choice and control (confidence domain), and changed behaviours, as well as the family functioning Circumstances domain. Conversely, the improvement in outcomes for changed knowledge and access to information is slightly higher for Aboriginal and/or Torres Strait Islander services users.

Figure 40: Earliest to latest SCORE changes within subjects, Aboriginal and Torres Strait Islander SFVS service users, July 2021 to June 2024

Table 37: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, Aboriginal and Torres Strait Islander SFVS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	46.8% (n=141)
	Mental health, wellbeing and self-care	49.8% (n=159)
	Personal and family safety	53.6% (n=229)
Goals	Changed behaviours	54.3% (n=134)
	Changed impact of immediate crisis	66.2% (n=151)
	Changed knowledge and access to information	64.2% (n=190)
	Changed skills	56.8% (n=147)
	Empowerment, choice and control to make own decisions	57.1% (n=157)
	Engagement with relevant support services	55.6% (n=145)

Source: DEX-SCORE data

Table 38: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, non-Aboriginal and Torres Strait Islander SFVS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	55.3% (n=2,770)
	Mental health, wellbeing and self-care	56.4% (n=2,933)
	Personal and family safety	57.2% (n=3,356)
Goals	Changed behaviours	57.4% (n=2,075)
	Changed impact of immediate crisis	67.4% (n=1,781)
	Changed knowledge and access to information	63.7% (n=2,582)
	Changed skills	59.0% (n=2,171)
	Empowerment, choice and control to make own decisions	62.6% (n=2,491)
	Engagement with relevant support services	58.6% (n=1,688)

Source: DEX-SCORE data

Service provision by ACCOs

The Department has provided grants to 4 ACCOs in the NT to deliver services designed with and for their communities. An additional ACCO in Western Australia receives FaRS funding. Each ACCO receives funding to support 2 FTE or less. DEX data indicate that during the evaluation period 15.4% of SFVS service users who identify as Aboriginal or Torres Strait Islander received a service from an ACCO, corresponding to 15.2% of sessions.

ACCOs use the funding to provide a range of services in their communities including:

- a drop-in centre for men
- mums and kids' group
- community sessions
- social and emotional wellbeing services
- safety planning
- counselling
- housing support
- advocacy and education.

These services are often delivered alongside other programs funded from a range of sources as part of a holistic, wraparound service delivery model with a focus on improving social and emotional wellbeing and creating a safe, welcoming space for people to access.

Many aspects of ACCOs' SFVS programs align with best practice in the design and delivery of family violence services in Aboriginal and Torres Strait Islander communities. This includes high level of community ownership and governance, and programs which embed trauma-informed, whole-of-community and integrated approaches. However, in order to achieve this, ACCOs are drawing heavily on other programs and funding sources, which questions the sustainability of the current SFVS funding settings for ACCOs.

Current funding arrangements are also constraining ACCOs' capacity to implement other aspects of good practice, including building workforce diversity and resilience, supporting development of local Aboriginal workforces, and expanding their services to meet community needs.

Outcomes, enablers and barriers

There is insufficient quantitative evidence to determine whether outcomes for Aboriginal and Torres Strait Islander service users are better when services are delivered by an ACCO or a mainstream service. DEX data limitations – including the small number of ACCO service users and accompanying SCORE assessments – mean that this evaluation is unable to determine whether the type of service provider (ACCO or mainstream) correlates with differences in SCORE changes.

However, qualitative data and the literature suggest that ACCOs are often well positioned to deliver comprehensive supports within their communities (Morgan, 2022). ACCOs are

generally well equipped to navigate the complex needs of Aboriginal and Torres Strait Islander people, as they can integrate local cultural knowledge, foster community trust, and provide support with an understanding of the broader socio-political context. The literature suggests that community-led initiatives can address not only immediate safety concerns but also long-term healing and empowerment, which are crucial for overcoming intergenerational trauma (Langton and Smith, 2020).

While the number of ACCO service users engaged through this evaluation was small, those who did engage were very positive about the services they had received. Service users described feeling respected, learning new skills, and having their needs met. Some also described the value of being connected to other supports and building relationships with both service providers and other women.

> *When I came here there's lots of doors and I've been opening – training, food, many doors. They were all easy to open […] The service is [also] helping [my child's father]. The road back there is a bumpy road – the road ahead is a straight road* ***– ACCO SFVS service user***

A key barrier to Aboriginal and/or Torres Strait Islander people accessing services relating to family violence is mistrust. Feelings of shame and fear of punitive responses, fear of breaches in confidentiality and re-traumatisation from insensitive responses, prior experiences of racism and stereotyping by service providers, and fear of child removal, can all act as barriers to seeking support (Australian Human Rights Commission, 2020; Fiolet et al., 2021; Langton and Smith, 2020).

There is some evidence that ACCOs funded through SFVS are effectively addressing this barrier. Service users identified the relationships of trust developed with ACCOs and their service providers as a key factor in their satisfaction with – and effectiveness of – the program. Both service users and service providers described the value of creating safe spaces and relationships, as an entry-point to accessing other services and supports. Service providers also described the way in which an individual's relationship with the service can evolve over time. Some service users described re-engaging with the same service provider for different reasons over time, as their circumstances and needs changed, which points to enduring relationships of trust.

A key barrier to access for several ACCO service users was transport. Many relied on service providers for pick up and drop off to attend services for counselling or programs. Some service users and providers also identified a need for transport during crisis or to leave unsafe situations, particularly in very remote areas. Service providers described the challenge of providing culturally appropriate services across vast distances and indicated that significant resourcing was needed for transport. The critical nature of transport in crisis situations was highlighted by a service user, who described dangerous gaps in support when trying to escape family violence.

> *Once I caught the bus, I asked the police to escort me, but they were busy. It's at midnight and it arrives in [the large town] at 3am. No transport to take me to the crisis centre. I spent the night with family in [large town] and then went to the safe house in the morning. I thought a taxi would be waiting there when I arrived. My family's place was a long way away. There was no taxi. No police. I was there with my baby at 3am. I didn't feel safe. I was scared* ***– ACCO SFVS service user***

Other barriers to access described by ACCO service users and providers included:

- language barriers, including resources and programs in language (noting also the range of languages spoken)
- lack of awareness in the community about what services are available
- lack of access to social housing and other essential supports in the community (which lay outside the scope of SFVS funding)
- stigma or safety risks.

Community control and cultural safety

All ACCOs engaged as part of this evaluation emphasised that the ability to achieve positive outcomes in Aboriginal communities relies on co-design, community ownership and control. This is consistent with findings from the literature that community involvement and self-determination are key principles of service design and delivery that help to ensure cultural safety by allowing Aboriginal and Torres Strait Islander communities to guide program design, implementation, and evaluation. Programs with community ownership not only better align with the values of Aboriginal and Torres Strait Islander peoples but also empower individuals and communities in their healing journey, enhancing trust and engagement (Carlson et al., 2021; Langton and Smith, 2020; Morgan, 2022).

Funding of ACCOs under SFVS represents a positive step, consistent with Priority Reform 2 of the ***National Agreement on Closing the Gap*** and Reform Area One of the ***Aboriginal and Torres Strait Islander Action Plan 2023–2025***, which calls for the transfer of power, control, decision-making and resources to Aboriginal and Torres Strait Islander communities and their organisations in the family violence sector. Each of the ACCOs engaged has robust and comprehensive community-led governance processes in place and undertakes co-design and consultation to develop and adapt their programs.

ACCO service providers considered the flexibility of SFVS funding requirements and eligibility to be a key strength of the program as it allows for community co-design to ensure services are tailored to the community, and for rapid adaptation to changing community needs. There was a view however that funding cycles and reporting processes should better recognise and reflect the time and effort involved in meaningful co-design and community-led governance.

> *Actually, what's needed is funding [for] community, Aboriginal-led organisations to be able to deliver programs that have been identified as a need for their community rather than a government coming and saying, 'this is the program that we're going to facilitate because we've heard about it from NT that this is what's needed […] Imagine what these programs would be if it [weren't] guided by the immense amount of knowledge that […] is brought by Aboriginal community-led perspective?* ***– ACCO SFVS service provider***

Community control contributes to cultural safety and connection to community, which are also key principles of good practice in the prevention and response to violence against women (Brown, 2019; Fiolet et al., 2020). Other factors identified in consultations and in the literature as supporting cultural safety include the employment and development of Aboriginal and/or Torres Strait Islander workers, training and retention of non-Aboriginal workers (to build skills, relationships and reduce 'churn') and resourcing to support adaptation and creation of culturally appropriate resources (including in language) (Fiolet et al., 2020).

> *Big barrier to accessing services is white people. People are shy and don't want to share. That's where [ACCO advisory group] comes in. Our team can speak the language, and we work alongside the white people. We work closely alongside them. They follow our advice –* ***ACCO SFVS advisory group member***

Service design

A key focus for the ACCO service providers receiving SFVS funding is the delivery of services which embed a multi-layered, holistic, family-based, whole-of-community, whole-of-life course approach. These approaches reflect three dimensions which are consistent with best practice identified in the literature:

1. **'Whole-of-community approach'**

Aboriginal and Torres Strait Islander peoples recognise family violence as affecting not only individuals but also families, communities, and cultural well-being, and value resources that serve not only survivors but also people who use violence and other family members affected by violence (Fiolet et al., 2021). Better practice approaches reflect the interconnected family structures and ensure inclusivity of all family members (Brown, 2019; Fiolet et al., 2021).

ACCOs as well as service users engaged during this evaluation identified a critical need for services and programs which work with men to prevent violence and hold men who use violence to account. ACCOs highlighted a gap in the availability and accessibility of MBCPs and men's parenting programs. Support for men should be based in holistic, whole-of-person approaches and focus on a range of areas including fathering, mental health, alcohol and other drugs, community integration after leaving prison, and healthy relationships. Programs should be transparent and involve community input, be non-shaming and non-judgemental, and centre victim-survivor voices (Brown, 2019).

> *Everyone is screaming out for [MBCPs]. We don't have that service –* ***ACCO SFVS service provider***

2. Trauma-informed, strengths-based programs

High rates of violence in some Aboriginal and Torres Strait Islander communities are linked with historical and social factors, including intergenerational trauma from colonisation, systemic discrimination, and socioeconomic challenges (Australian Human Rights Commission, 2020; Langton and Smith, 2020). Many Aboriginal and Torres Strait Islander families experience intergenerational trauma, which can manifest as psychological distress, substance misuse, and violence. The ongoing impact of colonisation and associated trauma presents a barrier to some traditional models of care. Interventions that recognise this historical context are better suited to meet the mental and emotional health needs of Aboriginal and Torres Strait Islander parents and children (Strobel et al., 2022).

Consistent with best practice (Brown, 2019; Fiolet et al., 2021) and with Reform Area 2 of the ***Aboriginal and Torres Strait Islander Action Plan 2023–2025***, ACCOs delivering SFVS services have adopted explicitly strengths-based, trauma-informed frameworks which focus on community strengths and resilience, empower users, validate their experiences, and encourage pride in cultural identity. Programs also seek to restore and support identity, cultural connection, and intergenerational healing, which the literature identifies as essential for emotional and spiritual healing (Carlson et al., 2021; Morgan, 2022).

> *It's a good program; it's a safe space. We go outdoors on little adventures; it's a lot of fun. They provide transport, food, after services, or if we need to access other services for DV, counselling [they refer us]. I love the program; my son loves it. He loves seeing the other kids. I've been coming nearly every day –* ***ACCO SFVS service user***

The naming and framing of the SFVS program around 'family violence' was considered by some ACCO service providers to be inconsistent with a strengths-based approach. Moreover, concerns about confidentiality can be a significant barrier for Aboriginal and Torres Strait Islander individuals seeking support for family violence, as many fear judgment or retaliation within close-knit communities (Australian Human Rights Commission, 2020; Fiolet et al., 2021; Langton and Smith, 2020).

> *We call it social and emotional wellbeing. SFVS stigmatises it. The name is not strengths based – when the women saw the name – straight away they said what are we here for? What are we doing?* ***– ACCO SFVS service provider***

3. Integrated service delivery

ACCO service providers described the complexity arising from the ongoing impact of colonisation and associated trauma. This includes risks stemming from limited access to safe housing, economic instability, and the complex trauma associated with forced removal of

children and disconnection from community and culture (Australian Human Rights Commission, 2020; Langton and Smith, 2020).

ACCO service providers emphasised the critical importance of providing integrated services and working in partnership with other providers. This is seen as essential to meeting the complex needs of individuals, families and communities and to building relationships and trust. Service providers therefore act as brokers, or step in to provide wide-ranging supports themselves, such as assisting with obtaining identification documents, and housing and transport support. This is consistent with literature which identifies multiagency coordination – through joint case management, service referrals, and interagency capacity building – as a core component of good practice to prevent violence against women in the NT (Brown, 2019).

> *We believe that integrated services are a more cohesive service system that collaborates and partners and brings strengths and different things together is a better service system than what we currently have, which encourages agencies and services to operate on their own or with discrete projects and programs, and it just doesn't work for the community. I think we have a shared belief about that. So, we're always looking for opportunities to come together and value, share, collaborate. We're probably bringing all of us bringing tens of thousands of dollars worth more to this work than what it would have had if it was just a standalone project* ***– ACCO SFVS service provider***

ACCOs and service users also identified a need for services to be better equipped to reach service users through more outreach, place-based services and transport options. Service providers also highlighted the complexity of responding to family violence in circumstances where women wish to remain on Country and in their community, and the limited options available to them. There is evidence that in-community support improves engagement and outcomes (especially when delivered by Aboriginal and Torres Strait Islander healthcare workers or culturally trained staff) and that successful interventions are those that use adaptable models that include home visits, community-based outreach, and flexible scheduling to accommodate family needs (Australian Human Rights Commission, 2020; Strobel et al., 2022).

Workforce

ACCOs identified workforce as a key challenge and opportunity. ACCOs emphasised the importance of employing local Aboriginal workers to deliver SFVS programs as their cultural knowledge and skills are critical to ensuring community control and the success of service delivery. The literature indicates that staffing by Aboriginal and Torres Strait Islander workers can enhance culturally competent care which is grounded in Aboriginal and Torres Strait Islander perspectives, and fosters greater trust and support (Fiolet et al., 2021) (Langton and Smith, 2020). Recruiting and retaining Aboriginal and Torres Strait Islander staff can create a more inclusive environment and reduce the barriers Aboriginal and Torres Strait Islander women face when seeking support (Langton and Smith, 2020).

However, providers described a shortage of skilled local workers and noted that developing the local workforce requires investment over an extended period. Current SFVS funding is not sufficient or long-term enough to support this workforce development.

> *We have as a system failed in building a strong Aboriginal workforce so then when there's an opportunity to access funding like this, you're now attached to timelines and [a] timeframe that has to be delivered, it runs pretty hamstrung to invest in the development. We're doing the work as fast as we can but there's not enough time and money and effectiveness in building the workforce to… bring people with us – **ACCO SFVS service provider***

ACCOs also noted the importance of building diverse teams to ensure service delivery and interactions are culturally appropriate, particularly considering the sensitivities inherent in family violence work. This includes a mix of Aboriginal and non-Aboriginal, male and female workers. Each ACCO currently receives sufficient funding to employ 2 FTE or less. For some ACCOs, the inability to recruit a sufficiently large and diverse team has compromised their ability to deliver their SFVS programs as planned.

> *[This program] specified at the start that it's meant to have an independent dads and kids' group. And that's not really possible for me, as a white female worker to be going and having a dads and kids' group. In partnership with [a partner] we tried to get that up and going, but even then, I can't do the things that I do with the mums – **ACCO SFVS service provider***

Attracting and retaining skilled workers to remote areas is a persistent challenge, made even more difficult by housing shortages in many communities. Non-Aboriginal staff often require extensive training on cultural safety and understanding the unique context of Aboriginal and Torres Strait Islander family violence (Langton and Smith, 2020). High staff turnover can impact service delivery, cultural competence and continuity of care for service users.

Current SFVS funding settings do not adequately support ACCOs to build diverse teams, to embed workforce resilience, or to develop a local workforce. Lack of longer-term funding certainty further complicates workforce sustainability and development.

Funding

There is scope to better align SFVS funding settings for ACCOs with principles underpinning good practice in the design and delivery of family violence services to Aboriginal and Torres Strait Islander communities.

SFVS funding to each ACCO (2 FTE or less) represents a small proportion of each organisation's overall funding. The success of their SFVS programs relies on integrated service design which means relying on funding 'in kind' from other programs, staff, and partners. While this amplifies the impact of the SFVS investment, it places pressure on already-stretched resources and is not necessarily sustainable.

> *Without the other services supporting it, there's no way that it's enough. The only way we can make it work is to top it up –* ***ACCO SFVS service provider***

SFVS-funded ACCOs identified several ways in which current funding settings do not meet need. The first is that demand outstrips service capacity. ACCOs described significant unmet need in their communities for services, which they are currently unable to resource. One program has actively avoided promotion because it is unable to meet existing demand from referrals.

> *[SFVS] funds just one position and all of these other programs integrate and work across teams and so I think in terms of bang for your buck - we get a lot… If you didn't have all these multiple components, you wouldn't be able to execute the requirements for this one position because it's not possible to complete all those tasks culturally safe[ly] and have outcomes because […] that's just not humanly possible […] We're doing a lot with the limited funding that we have, but we're not meeting the needs - nowhere near* ***– ACCO SFVS service provider***

The second is that ACCO service providers are often unable to build on what they have found works because of a lack of FTE. One ACCO described being unable to expand outreach and instituting regular follow-ups for individuals who have engaged with their program, despite knowing that these approaches are effective in supporting sustained engagement. Some ACCOs also described being limited in their ability to deliver preventative, general therapeutic, and community development activities because of the need to direct their limited SFVS resources towards crisis response.

> *[Would] the program survive without other wraparound services? No. It wouldn't survive […] I can walk into a household of 15 people, and I'm expected to support one mum. I need more to achieve the outcomes needed for this –* ***ACCO SFVS service provider***

As noted in the preceding section, current SFVS funding to ACCOs is insufficient to support workforce resilience, the onboarding and development of local Aboriginal and/or Torres Strait Islander workers, and/or gender balance within program staff. There is also evidence that greater certainty and longer funding cycles of SFVS funding to ACCOs would support more effective service delivery. The Australian Human Rights Commission found that in the NT a 'revolving door' of services characterised by insufficient multi-agency integration and coordination has compromised the delivery of culturally safe, holistic and sustained supports, and undermined community trust (Australian Human Rights Commission, 2020). Programs require long-term, ongoing funding to support knowledge and staff retention, multi-agency collaboration, and relationship and trust building with communities (Brown, 2019; Carlson et al., 2021). ACCOs offered clear feedback that the current SFVS funding settings (including both quantum and duration) are not currently optimised to support sustainable best-practice service design and delivery with Aboriginal and Torres Strait Islander communities.

Data and reporting

Some ACCOs raised concerns about the Department reporting requirements and the appropriateness of DEX. These concerns centred on:

1. **Effectiveness and appropriateness of DEX data:** Several ACCOs questioned the extent to which DEX and SCORE tell a full and accurate picture about the services they provide and the difference they make. Providers considered that a lot of their effort is not captured in DEX. This includes case management and brokerage, community consultation, co-design and governance, time spent strengthening partnerships and multi-agency responses, and the time invested in building relationships and trust.[16] Some ACCOs also expressed concern that the assumptions about progress and outcomes are inappropriate and inadequate in Aboriginal and Torres Strait Islander contexts, and do not properly account for the significant complexity and inter-generational disadvantage experienced by many communities. The SCORE model may not be sufficiently nuanced or tailored to capture meaningful changes achieved through ACCO programs.

> *I think it's important for accountability for programs that are being funded to be able to articulate what they're doing, but allowing for the way that it's being reported [by] putting emphasis on the strength that is needed to put in time to build a relationship […] But then how is that […] able to be shared to government? Do they value that?* ***– ACCO SFVS service provider***

2. **Impact of data collection on trust:** Several ACCOs described the process of asking wide-ranging, personal questions for the purpose of DEX data collection as damaging to the development of therapeutic relationships. Mistrust is a key barrier to Aboriginal and Torres Strait Islander people accessing services relating to family violence. Service providers expressed concern that the requirement to obtain personal information and conduct SCORE assessments early in a person's engagement with the service acted as a barrier to engagement and undermined trust.

> *We have to report on that DEX data – that's another level of whitefella world. That takes up a lot of time […] It's really inappropriate. [We are] delivering a program to people who have already got enough on their plate. Trying to build that trust – asking those questions it jeopardises it. Someone comes to you and wants help – asking where they get paid from and their disability – interrupts trust –* ***ACCO SFVS service provider***

3. **Data sovereignty:** One provider raised concerns about the extent to which the Department's DEX requirements for FaRS and SFVS grantees honour principles of Indigenous Data Sovereignty. Concerns were raised that some data is collected which is not directly related to the service being provided, and that Aboriginal and Torres Strait Islander service providers and service users have little insight into, or control of, how information is used. Data sovereignty is a key tenet of self-determination and is recognised

[16] Non-ACCO service providers similarly noted that additional effort they are required to undertake to meet service user demand is not captured in DEX (see **Section 6.6** and **Section 6.7**).

as a priority area (Australian Government, n.d.; Department of Social Services, 2023; Maiam nayri Wingara and Yardura Walani, 2025; National Indigenous Australians Agency, 2024).

> *The other issue is data sovereignty. I don't know any other program that I manage that asked for as much. It's very invasive […] And I really think across the board across - certainly the NT in Australia - there's real issues with people not understanding […] data sovereignty and how things are stored and transparent. And the problem is like, what are they doing with the information?* ***– ACCO SFVS service provider***

4. **Administrative burden:** The ***Aboriginal and Torres Strait Islander Action Plan 2023–2025*** highlights the extent to which Aboriginal and Torres Strait Islander services are overburdened for data and reporting. ACCOs also described the weight of the SFVS reporting burden as disproportionate to the funding received, and excessive compared to other funders. Current reporting requirements (in particular SCORE) assume that an individual will receive sustained, individual support in the form of, for example, individual counselling. Because ACCOs focus on whole-of-community responses, and because Aboriginal and Torres Strait Islander service users may disengage and re-engage in a variety of integrated programs over time, the assumption of linear progress underlying SCORE may not be suitable. This is exacerbated where providers are delivering group programs which require SCORE assessments of each participant.

6.4.4 Culturally and linguistically diverse communities

People from CALD communities are a priority cohort for FaRS and SFVS service delivery. Family, relationship, and family violence services for CALD communities face unique challenges and require culturally competent approaches. The literature identified key barriers, needs, and effective service delivery models specific to CALD. These include:

- language and interpreter access barriers based on limited availability, cost and confidentiality concerns (Pokharel et al., 2023)
- barriers to disclosing violence or seeking help due to family violence often being considered a stigmatised or taboo topic that should not be discussed outside the home, fears of community judgment, social isolation, and deportation (Pokharel et al., 2023; Truong et al., 2020)
- specific norms across cultures, which place high value on family unity, loyalty or devotion (Satyen et al., 2019).

Systemic inequities and trauma are also a significant barrier for many CALD service users. These can include:

- for CALD women, experiences of systemic discrimination, social isolation and the cumulative stress of settlement in a new country, including a history of trauma from war or torture, creating vulnerability and service access barriers (Pokharel et al., 2023).
- reluctance from CALD migrant women to access services and seek help based on fears about immigration status, deportation and residency, particularly where this is tied to their partner (Satyen et al., 2019)
- children from CALD backgrounds taking on a caretaker role for their parents by assisting with service access and decision-making, sometimes affecting power dynamics, creating conflict and increasing mental health issues for these children, particularly in cultures where deference to adults is important (Joshi and Gartoulla, 2024).

The literature revealed examples of best practices and preferred service models for CALD communities, including:

- Ensuring cultural competency of service providers: The importance of ongoing cultural competency training for service providers, with the ‘ASKED’ model (Awareness, Skill, Knowledge, Encounters, Desire) being recommended as a framework for self-reflection to improve responsiveness to CALD women’s needs (Pokharel et al., 2023).
- Sustained community engagement: Engaging faith leaders in training, family violence prevention and awareness-raising efforts to help build trust in services within CALD communities (Pokharel et al., 2023) and providing safe, nonjudgmental and culturally safe spaces with community leaders to encourage help-seeking (Truong et al., 2020).
- Mindfulness-based approaches: Using mindfulness models to build safety and self-management for victim survivors to regulate stress and process trauma, prevent re-traumatisation, and empower help-seeking behaviour (Vroegindewey and Sabri, 2022)

- Culturally appropriate programs: Using culturally responsive community-based programs, such as helplines and culturally specific services, to provide education on early identification of risks associated with family violence and support options (including safety planning) (Dudgeon et al., 2021)
- Privacy-focused interpreter usage: Effective training in interpreter use, including options for remove and pseudonym-based services, to address confidentiality risks (Pokharel et al., 2023)In addition, the WHO's Mental Health Gap Action Program, which has developed intervention strategies tailored to address common family-related mental health challenges, such as parental anxiety, depression and stress is a useful tool for addressing family-related mental health across cultural contexts (World Health Organization, 2022).

Service provision to culturally and linguistically diverse communities

36.7% of service users accessing FaRS and 22.8% of service users accessing SFVS identify as CALD. While the mean earliest-latest Knowledge SCORE change is better for CALD than for non-CALD FaRS service users, other domains are on-par or slightly below non-CALD service users. For SFVS, the domains of family and mental health are slightly improved on mean earliest-latest SCORE change for CALD than non-CALD service users.

Analyses of earliest and latest SCORE assessments by domain using DEX data show that CALD service users for both FaRS and SFVS programs improved on all domains (see **Figure 41** and **Figure 42** below). Goals domains improved the most, consistent with other cohorts. All changes were statistically significant (p<.001). Detailed data are provided in **Appendix F**. This suggests that FaRS and SFVS are meeting the needs of CALD service users.

Table 39: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by CALD status, FaRS and SFVS

Activity	CALD	Outcome Type	Service user (n=)	SCORE change (mean)	Service user with positive mean change (%, n=)
FaRS	No	Circumstances	42600	0.8	63.4% (n=27008)
		Goals	42938	1.21	74.6% (n=32031)
	Yes	Circumstances	2815	0.75	58.7% (n=1652)
		Goals	2845	1.19	71.6% (n=2036)
SFVS (incl. 4AP2)	No	Circumstances	4092	0.94	66.4% (n=2719)
		Goals	3912	1.1	71.1% (n=2782)
	Yes	Circumstances	223	0.97	66.8% (n=149)
		Goals	330	1.01	67.0% (n=221)

Figure 41: Earliest to latest SCORE changes within subjects, FaRS service users by CALD status, July 2021 to June 2024

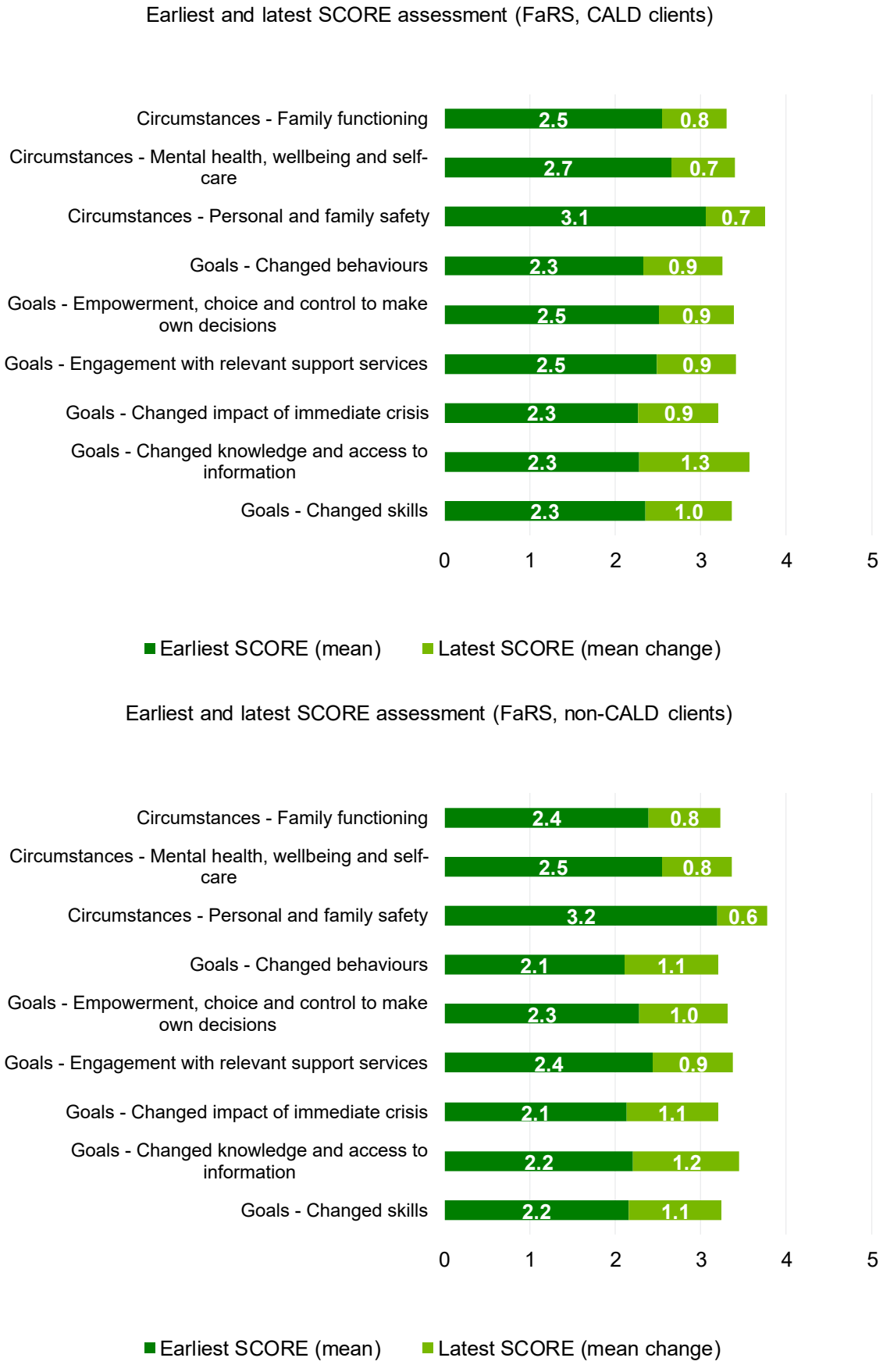


Table 40: Percentage of services users with positive SCORE change for specific Circumstance and Goal domains, CALD FaRS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	51.3% (n=1,309)
	Mental health, wellbeing and self-care	51.8% (n=1,091)
	Personal and family safety	46.9% (n=665)
Goals	Changed behaviours	59.3% (n=871)
	Changed impact of immediate crisis	60.4% (n=395)
	Changed knowledge and access to information	69.8% (n=1,442)
	Changed skills	62.8% (n=1,073)
	Empowerment, choice and control to make own decisions	60.0% (n=786)
	Engagement with relevant support services	58.6% (n=569)

Source: DEX-SCORE data

Table 41: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, non-CALD FaRS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	56.0% (n=21,522)
	Mental health, wellbeing and self-care	56.1% (n=19,900)
	Personal and family safety	44.0% (n=10,501)
Goals	Changed behaviours	65.5% (n=16,636)
	Changed impact of immediate crisis	65.9% (n=8,332)
	Changed knowledge and access to information	69.1% (n=19,932)
	Changed skills	66.2% (n=20,273)
	Empowerment, choice and control to make own decisions	64.4% (n=14,923)
	Engagement with relevant support services	59.7% (n=9,573)

Source: DEX-SCORE data

Figure 42: Earliest to latest SCORE changes within subjects, SFVS service users by CALD status, July 2021 to June 2024

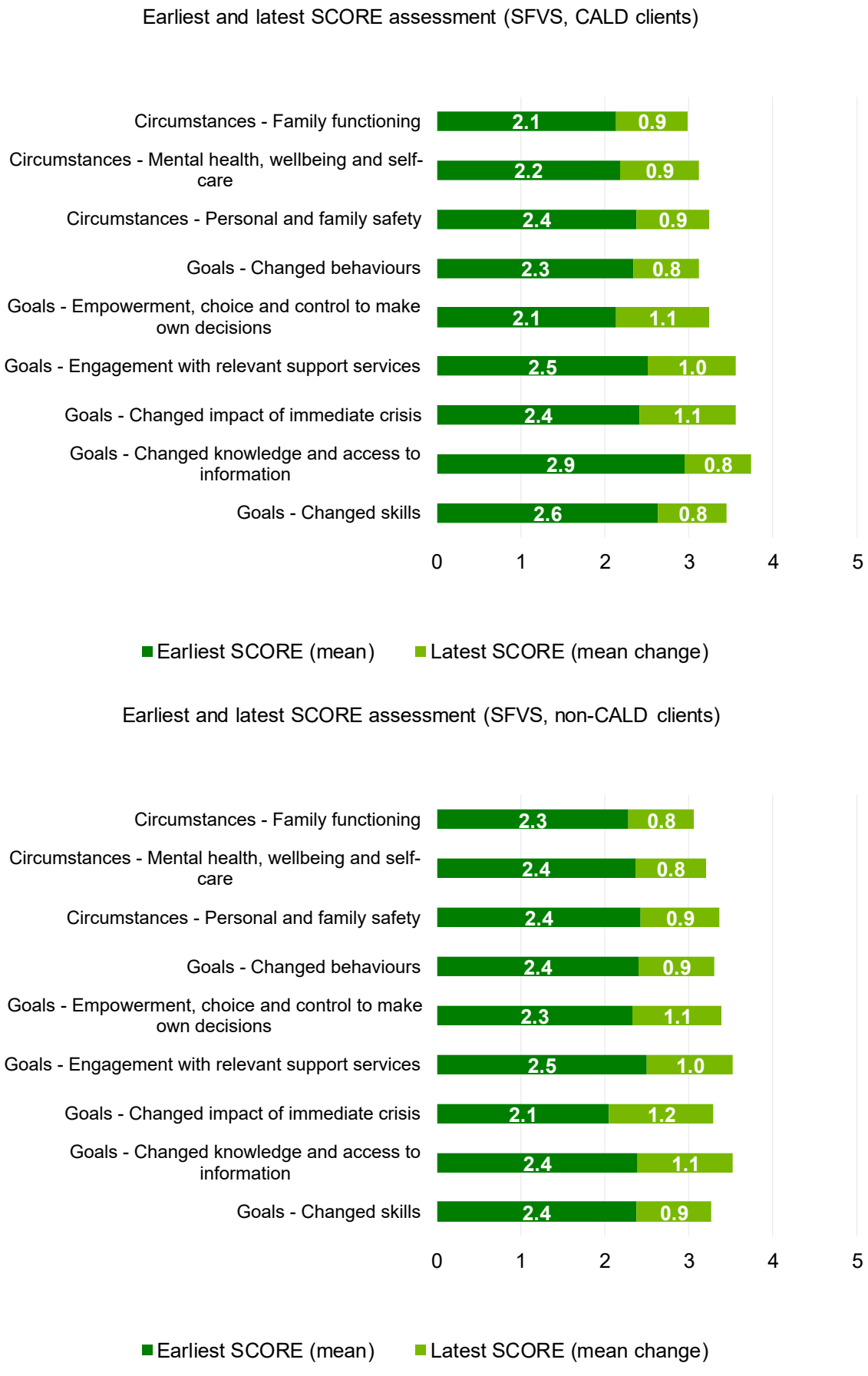


Table 42: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, CALD SFVS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	52.3% (n=79)
	Mental health, wellbeing and self-care	58.7% (n=105)
	Personal and family safety	57.6% (n=99)
Goals	Changed behaviours	53.7% (n=65)
	Changed impact of immediate crisis	67.7% (n=44)
	Changed knowledge and access to information	56.2% (n=126)
	Changed skills	53.5% (n=68)
	Empowerment, choice and control to make own decisions	62.0% (n=80)
	Engagement with relevant support services	60.6% (n=40)

Source: DEX-SCORE data

Table 43: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, non-CALD SFVS service users, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	53.6% (n=1,492)
	Mental health, wellbeing and self-care	55.0% (n=1,579)
	Personal and family safety	56.8% (n=2,019)
Goals	Changed behaviours	57.1% (n=1,221)
	Changed impact of immediate crisis	70.4% (n=1,141)
	Changed knowledge and access to information	65.7% (n=1,563)
	Changed skills	58.8% (n=1,279)
	Empowerment, choice and control to make own decisions	61.7% (n=1,451)
	Engagement with relevant support services	59.4% (n=979)

Source: DEX-SCORE data

Despite the positive outcomes shown in SCORE data, FaRS and SFVS service providers reported that they felt mixed in their ability to meet the needs of CALD communities. Some noted success at developing programs and service delivery approaches aligning with cultural understandings and language of different communities, including SFVS providers establishing CALD-specific MBCPs. Others reported difficulty in this space. Barriers identified included lack of access to, and funding for, interpreters and bilingual staff. This barrier to interpreters was exacerbated by the reluctance of some CALD service users to work with people from their

own cultural group for privacy reasons. The value of partnering with specialist CALD organisations to bolster capability and address skills gaps was also emphasised.

> *We have done a lot of work in this space and we're really proud of it…one of the really good examples is a collaboration [we had] with the local multicultural service…I think that collaboration with other organisations that are experts in those cohorts and client are really, really important because we're not going to pretend that we know how to do a good job in those spaces* ***– FaRS service provider***

Linked to findings from the literature regarding culturally adapted educational campaigns, which may use terms like 'family safety' instead of 'domestic violence' (Truong et al., 2020), some FaRS and SFVS service providers described the importance of accounting for different cultural understandings of the social context of violence, trauma, and family relationships and how these are described. This requires tailoring and specific treatment of topics including parenting, accountability, and family violence which can present challenges for services, requiring support from and collaboration with CALD communities and organisations.

> *A huge body of work has to be done with clients, particularly male perpetrators, before you can talk about taking responsibility. Working with men from CALD communities around violence there are huge barriers. We need more time and dedicated resources* ***– SFVS service provider***

> *It's a challenging relationship working with specific CALD groups around violence, there's so many cultural considerations to take into account for each […] that it becomes a difficult space to work in* ***– SFVS service provider***

FaRS service users from CALD communities generally reported positive experiences whether they attend a mainstream or CALD specific service. These positive experiences were related either to general rapport with their service worker or specific connection and rapport based on their service worker sharing their cultural background.

> *I am Greek, raised in Greece, and now living here. I like how [my counsellor] sees things. She's Australian but has a Greek background. That gives me a different perspective and mindset. I like the mindset that Aussies have. I need someone to understand my background too, and [my counsellor] has that combination of both* ***– FaRS service user***

6.4.5 Individuals identifying as LGBTQIA+

People who identify as LGBTQIA+ are a priority cohort for SFVS service delivery. Although recent changes to DEX reporting now record non-binary or self-identified gender identify, this change was introduced in February/March 2024. Given this recent change, and because DEX does not capture data on service user sexuality, this evaluation does not provide analysis on DEX data related LGBTQIA+ status.

A review of the literature and feedback from LGBTQIA+ service users gathered during this evaluation provides insight into barriers and best practice responses for LGBTQIA+ communities and how FaRS and SFVS services are being experienced by people from LGBTQIA+ communities.

LGBTQIA+ individuals navigating family violence face complex challenges that differ from those encountered by cisgender, heterosexual victim survivors. The literature highlights specific experiences and dynamics for LGBTQIA+ victim survivors, including:

- Experiencing distinct forms of abuse linked to gender and sexual identities, such as threats of 'outing' or withholding gender-affirming resources. Minority stress – stemming from social stigma and discrimination — compounds this vulnerability, affecting self-esteem and mental health (Gray et al., 2020; Lusby et al., 2022; Turner and Hammersjö, 2024).
- A strong sense of community loyalty, leading to hesitation to disclose abuse to avoid stigmatising their community (Lusby et al., 2022; Turner and Hammersjö, 2024).
- Finding it difficult to approach mainstream services perceived as heteronormative or biased, further complicating their help-seeking journey (Lusby et al., 2022; Turner and Hammersjö, 2024).
- Experiencing internalised doubts about their right to seek help, often stemming from societal stigma and narratives framing family violence as a predominantly heterosexual issue. This perception, combined with isolation from traditional support networks, can make it harder for LGBTQIA+ survivors to recognise their experiences as abuse (Gray et al., 2020; Turner and Hammersjö, 2024).

The literature suggests several best practice approaches for inclusive service delivery for LGBTQIA+ people experiencing family violence, including:

- Inclusive and affirming program design: Tailoring programs that address LGBTQIA+ specific dynamics and represent LGBTQIA+ relationships (Gray et al., 2020; Lusby et al., 2022; Turner and Hammersjö, 2024).
- Community-led initiatives and LGBTQIA+ Practitioners: Grassroots, community-led services are preferred and more likely to be trusted by many LGBTQIA+ survivors (Gray et al., 2020; Lusby et al., 2022).
- Cultural safety and trauma-informed care: Trauma-informed and culturally safe services are critical, with providers who respect LGBTQIA+ identities, using correct pronouns, and understanding the impact of minority stress. Creating safe spaces where survivors feel

validated helps reduce re-traumatisation risks and build trust (Gray et al., 2020; Lusby et al., 2022; Turner and Hammersjö, 2024).

- Whole-of-organisation support for inclusivity: A culture of inclusivity should be embedded at all levels of an organisation, with leadership endorsing and modelling LGBTQIA+ inclusive practices. Visible LGBTQIA+ representation, comprehensive staff training, and an affirming organisational culture strengthen the support environment for both service users and staff (Lusby et al., 2022)
- Building and honouring community trust: Establishing and maintaining trust within LGBTQIA+ communities is fundamental for effective service engagement. Providers who actively connect with LGBTQIA+ communities and employ LGBTQIA+ practitioners create more accessible, reliable support options for survivors who may distrust mainstream services (Gray et al., 2020; Lusby et al., 2022).

Service provision to LGBTIQA+ people

Some FaRS and SFVS providers identified difficulty engaging with LGBTIQA+ individuals and couples. This was attributed to a range of barriers, primarily centred on stigmatisation with a preference for private services or people's preference to not disclose their identity either at all, or until trust had been established with their provider, with some referring to fear of discrimination from faith-based organisations specifically. Some SFVS providers noted that the numbers of LGBTIQA+ people attending for family violence support was low relative to the prevalence of family violence in LGBTIQA+ relationships.

Several LGBTQIA+ service users spoke about the importance of engaging with staff members from the LGBTQIA+ community. For them, support from an LGTBTQIA+ staff member helped build feelings of trust, connection and rapport, though service users also praised the service they received even where they weren't supported by someone from their community or where some parts of the service were less positive. This reflected findings in the literature about the value placed on community-led initiatives and peer support from LGBTQIA+ practitioners (Gray et al., 2020; Lusby et al., 2022).

> *I think it would be good to have more diversity among the counsellors. I don't believe [service worker] was a member of the LGBTQIA+ community, but she was sensitive to needs and it wasn't an issue. From memory, I think the wait for a queer counsellor was even longer* ***– FaRS service user***

LGBTQIA+ service users generally reported positive experiences, with some describing specific effort and tailoring to make the service more welcoming.

> *The service was very supportive [as a LGBTQIA+ person]. They were always very open to even adapting content to be more LGBTIQIA+ specific at times. I can't think of anything they could have done to change it* ***– FaRS service user***

Some negative examples were also reported, with one participant describing poor experiences regarding the use of pronouns on forms, some of which only included binary options for gender. This reinforces the importance of whole-of-organisational inclusivity and trauma-informed care for LGBTQIA+ communities, including through visible LGBTQIA+ representation, staff knowledge and correct pronoun use (Gray et al., 2020; Lusby et al., 2022; Turner and Hammersjö, 2024).

> *I was still being misgendered and labelled as a woman, that's the only negative experience I had. I noticed on the form the gender options were male or female, there wasn't an option for preferred name or pronouns* – ***FaRS service user***

6.4.6 People with disability

Experiences of family violence for people with disability differ to those experienced by people without disability due to the intersection of gender inequality and ableism. This includes physical abuse, such as withholding food, water, or care; sexual violence, such as demanding sexual activity in return for caregiving or using a physical impairment to force sexual activity; emotional abuse, such as denial of disability or neglect, abandonment, and deprivation; economic abuse, such as theft of disability support payments or abuse of Power of Attorney; and coercive control, such as making people with disability believe abuse behaviours occur in all relationships (Centre for Non-Violence and Modified Service Delivery, 2024; People with Disability Australia and Domestic Violence NSW, 2021)

People with disability also face a range of barriers to accessing services including social or physical isolation; lack of accessible, disability-friendly services or crisis accommodation; lack of understanding of their experience as family violence; and discriminatory understandings of disability and a perception of them as a 'burden' which shifts blame for the perpetrator to the person being abused (People with Disability Australia and Domestic Violence NSW, 2021).

People with disability face multiple barriers in accessing family violence services, such as social isolation, inaccessible facilities, and discriminatory attitudes that often blame victims rather than perpetrators (People with Disability Australia and Domestic Violence NSW, 2021). These issues are worsened by a lack of collaboration between family violence and disability services, leaving critical gaps in care. Individuals with intersecting identities, such as Aboriginal and Torres Strait Islander status and socioeconomic disadvantage, experience additional challenges including cultural and systemic barriers and lack of financial independence (Jones et al., 2023; People with Disability Australia and Domestic Violence NSW, 2021). Holistic, intersectional support is essential and can be improved through formal partnerships between services, shared training, inclusive service delivery, and joint advocacy to address systemic barriers (Robinson et al., 2021).

Robinson et al. (2021) use Levesque, Harris, and Russell's (2013) access and accessibility framework to analyse how family violence services can better support individuals with disabilities. The five dimensions—approachability, acceptability, availability, affordability, and appropriateness—highlight a holistic view of access, beyond physical adjustments, to include social, emotional, and informational considerations. Barriers faced and best practice approaches as synthesised by Robinson et al. (2021) include:

- ensuring that initial points of contact, such as crisis hotlines or police interactions, are handled by trained personnel who understand the needs of people with disabilities is crucial for initial engagement
- training staff on disability rights and respectful, inclusive communication, emphasising active listening, empathy, and cultural sensitivity
- prioritising structural and operational flexibility to accommodate the diverse needs of individuals with disabilities.
- allowing face-to-face interactions as much as possible, which participants preferred over phone interactions will help to facilitate clearer communication.

Service provision for people with disability

There is evidence that while people with disability are accessing FaRS and SFVS services, they are doing so at a rate lower than disability prevalence in the Australian or victim survivor population. DEX data indicates that from 2021/22 to 2023/24, 9.7% of FaRS services users and 11.4% of SFVS service users identified as having a disability. This is a significant proportion of service users, but less than the estimated 18% of people in Australia with disability (Australian Institute of Health and Welfare, 2024b). In addition, women with disability are almost twice as likely as women without a disability to experience physical or sexual violence or emotional abuse. Those who have an intellectual or psychological disability are at an even higher risk compared to those with a physical disability (Australian Bureau of Statistics, 2021). Fewer than one in three incidences of these threats to physical safety are reported to police (Australian Bureau of Statistics, 2021), meaning the true extent of family violence within this population is unknown. While disability is not a priority factor for FaRS, SFVS Operational Guidelines require service providers to prioritise (among other priority groups) women with disability.

The most prevalent disability reported by service users was psychiatric disability at 6.0% of all FaRS service users and 6.6% of all SFVS service users, followed by learning disability at 1.8% of all FaRS service users and 2.8% of all SFVS service users.

Analyses of change in SCORE between earliest and latest assessments indicated improvement in all domains, on average, for service users with a known disability (see **Figure 43** and **Figure 44** below). Improvement in outcomes for people with disability are consistent with - and in the case of SFVS, slightly greater than – service users without disability. Satisfaction with services was rated consistently high but also showed improvement. Skills, Knowledge, Confidence and Impact showed the most improvement. All changes were statistically significant (p<.001). Sample sizes varied by domain from n=547 to n=4604 for FaRS and n=79 to n=879 for SFVS. Detailed data are presented in **Appendix F**.

Table 44: Earliest to latest mean SCORE change and percentage of service users with a positive SCORE change for Goal outcomes by disability status, FaRS and SFVS, July 2021 – June 2024

Activity	Disability status	Outcome Type	Service users (n=)	SCORE change (mean)	Service users with positive mean change (%, n=)
FaRS	No or unknown	Circumstances	68,482	0.78	62.7% (n=42939)
		Goals	68,047	1.14	72.9% (n=49631)
	Yes	Circumstances	5,345	0.76	62.0% (n=3314)
		Goals	5,436	1.06	70.8% (n=3849)
SFVS (incl. 4AP)	No or unknown	Circumstances	6,498	0.91	66.3% (n=4305)
		Goals	6,161	1.05	69.8% (n=4299)
	Yes	Circumstances	964	1	68.2% (n=657)
		Goals	970	1.13	69.4% (n=673)

Figure 43: Earliest to latest SCORE changes within subjects, FaRS service users by disability status, July 2021 to June 2024

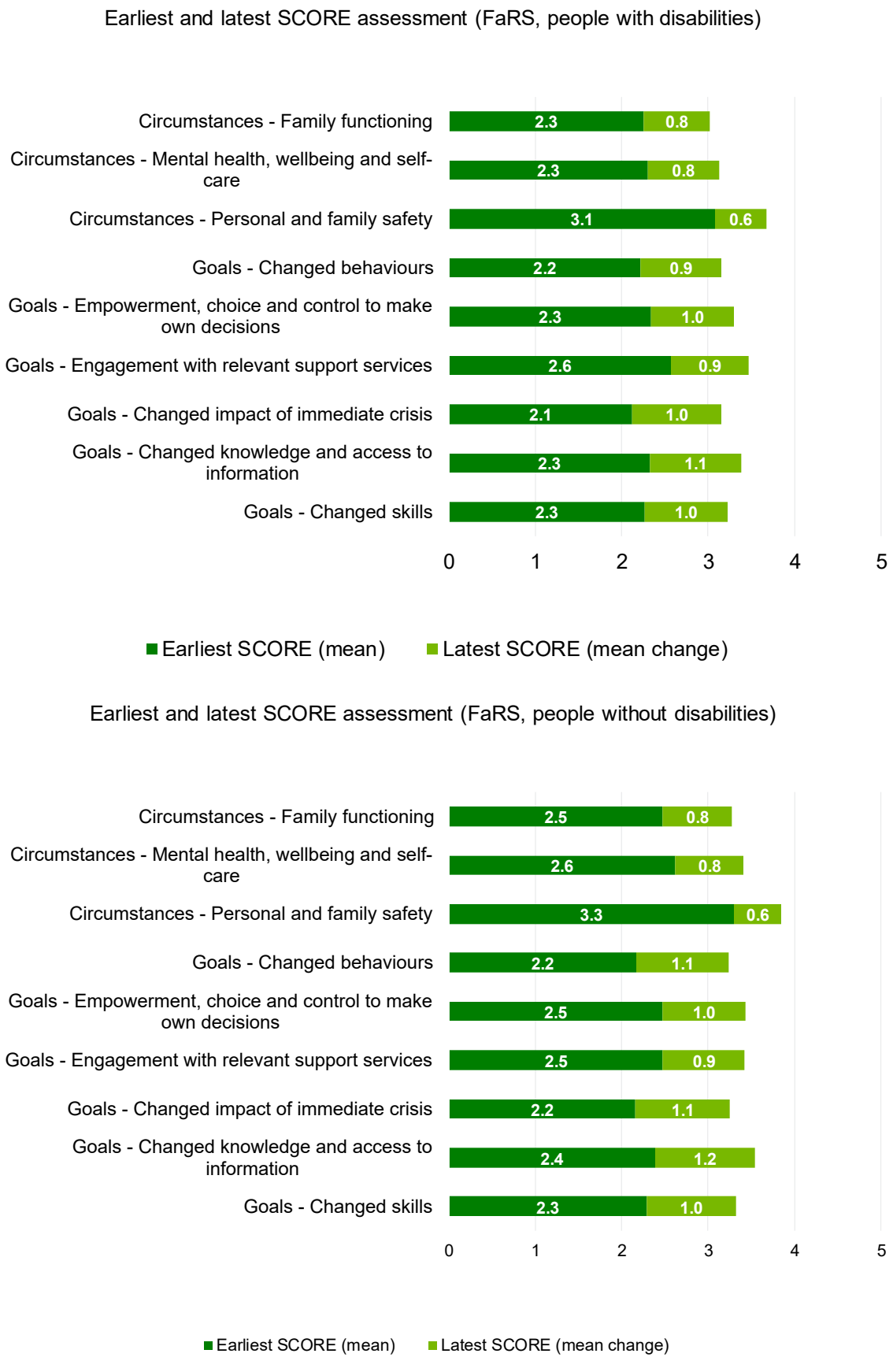


Table 45: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, FaRS service users with disabilities, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	53.8% (n=2,479)
	Mental health, wellbeing and self-care	56.0% (n=2,473)
	Personal and family safety	44.2% (n=1,357)
Goals	Changed behaviours	59.3% (n=2,087)
	Changed impact of immediate crisis	63.2% (n=1,178)
	Changed knowledge and access to information	64.7% (n=2,189)
	Changed skills	61.2% (n=2,315)
	Empowerment, choice and control to make own decisions	61.1% (n=1,784)
	Engagement with relevant support services	58.1% (n=1,263)

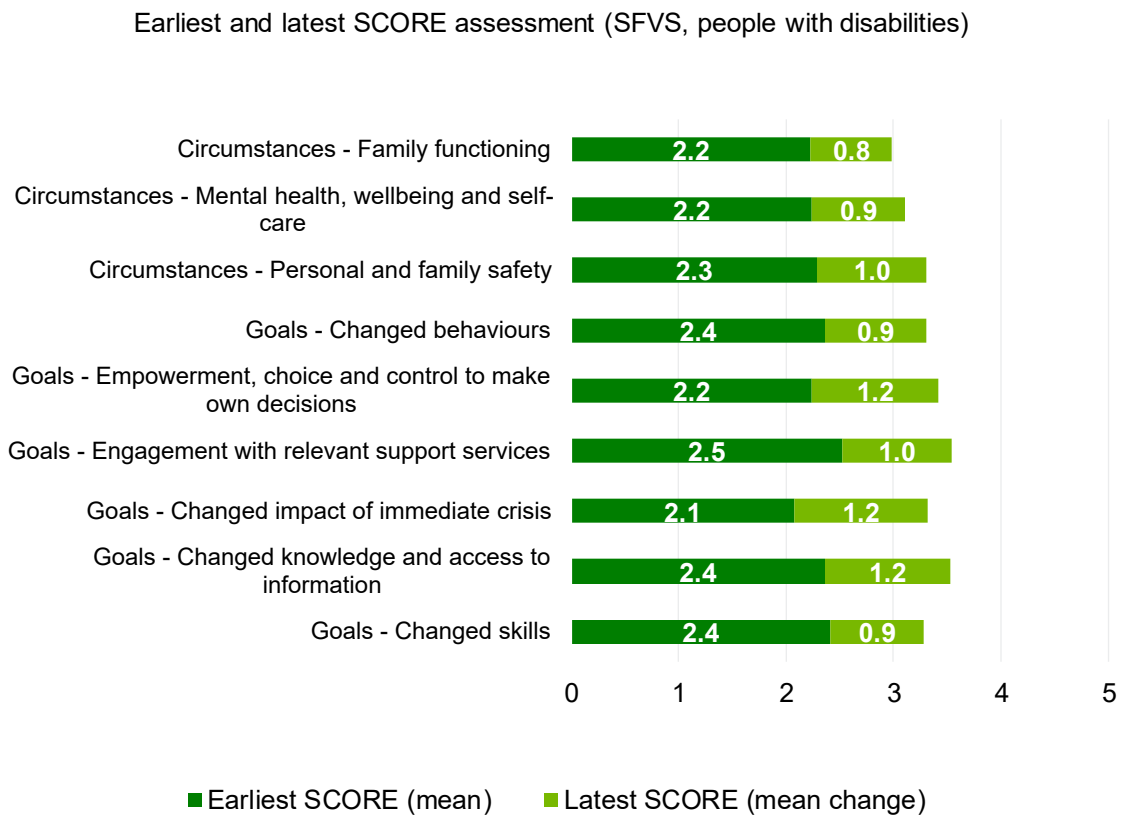
Source: DEX-SCORE data

Table 46: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, FaRS, people without disabilities, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	55.0% (n=3,4043)
	Mental health, wellbeing and self-care	55.5% (n=3,1467)
	Personal and family safety	42.4% (n=16,556)
Goals	Changed behaviours	65.0% (n=25,595)
	Changed impact of immediate crisis	66.7% (n=13,927)
	Changed knowledge and access to information	66.3% (n=30,948)
	Changed skills	64.1% (n=31,670)
	Empowerment, choice and control to make own decisions	61.0% (n=23,034)
	Engagement with relevant support services	60.6% (n=15,847)

Source: DEX-SCORE data

Figure 44: Earliest to latest SCORE changes within subjects, SFVS service users by disability status, July 2021 to June 2024



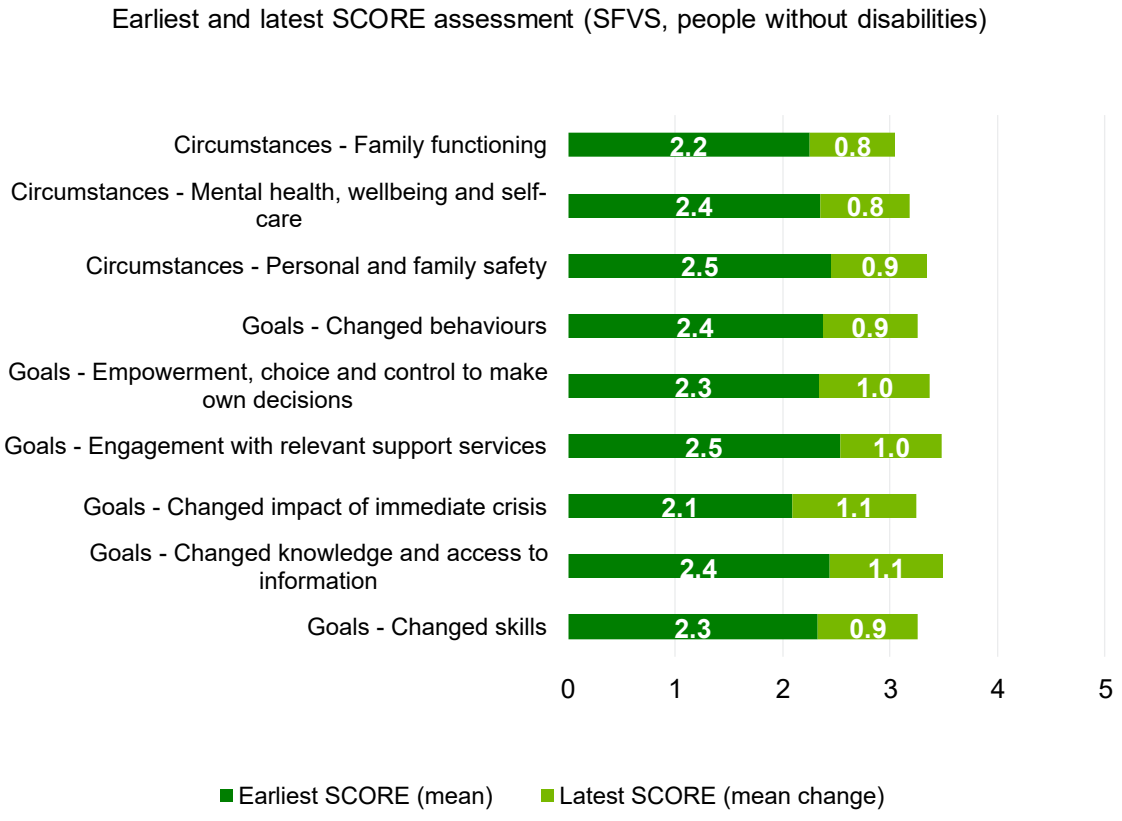


Table 47: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, SFVS, people with disabilities, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	51.6% (n=326)
	Mental health, wellbeing and self-care	56.0% (n=373)
	Personal and family safety	59.4% (n=522)
Goals	Changed behaviours	57.3% (n=318)
	Changed impact of immediate crisis	71.8% (n=346)
	Changed knowledge and access to information	65.4% (n=398)
	Changed skills	56.1% (n=290)
	Empowerment, choice and control to make own decisions	61.6% (n=346)
	Engagement with relevant support services	56.1% (n=238)

Source: DEX-SCORE data

Table 48: Percentage of service users with positive SCORE change for specific Circumstance and Goal domains, SFVS, people without disabilities, July 2021 to June 2024

Outcome Type	Domain description	Service users with positive mean change (%, n=)
Circumstances	Family functioning	55.3% (n=2,585)
	Mental health, wellbeing and self-care	56.0% (n=2,719)
	Personal and family safety	56.6% (n=3,063)
Goals	Changed behaviours	57.1% (n=1,891)
	Changed impact of immediate crisis	66.4% (n=1,586)
	Changed knowledge and access to information	63.5% (n=2,374)
	Changed skills	59.3% (n=2,028)
	Empowerment, choice and control to make own decisions	62.3% (n=2,302)
	Engagement with relevant support services	58.6% (n=1,595)

Source: DEX-SCORE data

There is evidence that service users with disability received more intensive services than those without disability. While people with disability constituted 9.7% of FaRS service users, they received 17.2% of sessions. The pattern is similar – if less pronounced – for SFVS, in which people with disability comprise 11.4% of service users and 15.5% of sessions.

Several services, including an MBCP service, described adapting programs to suit people with disability including offering virtual access options and providing one on one rather than group

sessions. This reinforced findings from the literature about accessibility and structural and operational flexibility to address the needs of service users with disability (Robinson et al., 2021).

> *[We] work with clients with assorted disabilities – work to adapt programs accordingly, practitioners adapt on an individual basis. We also give options on how they can do intake, including encouraging them to do it in-person if we think they will face barriers to completion* ***– FaRS service provider***

Service users made positive comments about the approach of service workers in making adjustments and using service user-centered approaches which showed understanding about disability, including hidden disabilities.

> *They're very well versed in hidden disabilities including mental health and autism* ***– FaRS service user***

> *I guess my disability is mental health. I guess I'm not really good at processing or kind of coming up with something on the spot. If it seemed like I wasn't understanding they would kind of explain it more clearly and slowly, which helped* ***– FaRS service user***

FaRS and SFVS providers identified that internal limits on counselling sessions and other programs can make it difficult to address parenting and other relationship behaviours that may be affected by disability, including neurodiversity. Some services reported staff lacked skills to appropriately address needs of people with disability with a subsequent need for funding to support training (see **Section 6.7** for more detail).

> *We need to be able to have staff that have the skills to be able to work with people with complex disabilities, including mental health illnesses as well…but then of course we don't have much funding…for upskilling. In terms of diversity, we're really needing…neurodiversity affirming approaches to put into practice* ***– FaRS service provider***

> *People are coming in with mental health, neurodiversity etc impacting on relationships and capacity to parent. Short, small caps mean these are not addressed, change is not sustainable, and you feel trapped in a loop of not being able to make sustainable change* ***– FaRS service provider***

Some FaRS service users with disability also reported physical access barriers, with comments relating to narrow access and doors, bright lighting, and other factors contributing to sensory overload. Linked to more general findings about the strengths and limitations of virtual service delivery (see **Section 6.9.2**) and comments on this theme from service providers, service users with disability made specific comments about the benefits of mixed virtual delivery and in-person delivery.

> *Given the nature of our issues, I wouldn't do virtual full-time because it's too hard with my mental health. But sometimes on the morning of an appointment, I'll email [service worker] and say I'm having an awful morning, can you call me instead* ***– FaRS service user***

> *I have autism and ADHD, scheduling and attending can be difficult, having to be in-person is a lot more emotional and mental energy than necessary* ***– FaRS service user***

There are limited evaluation data and research on how people's service needs vary based on the specific type of disability they have. Some general principles have been identified including adapting information resources and communication styles to be accessible, including using Plain English and engaging accessible information specialists to create and modify material, and asking people with a disability who are receiving a service on how best it can be adapted to suit their and their families individual needs (Centre for Non-Violence and Modified Service Delivery, 2024).

6.4.7 Children and young people

From 2021-2 to 2023-24, almost 20,000 children and young people under 18 received a FaRS or SFVS service. This represented 7.4% of FaRS service users, and 14.7% of SFVS service users. SCORE data indicates positive outcomes for this cohort of service users. The analyses of earliest and latest SCORE assessments showed improvement in all domains for both programs. on average. Impact, Knowledge, Skills, Behaviours and Confidence domains showed the largest improvement for FaRS service users under 18 years of age, and Impact, Behaviours, Knowledge and Skills domains showed the largest improvement for SFVS service users in this cohort. Satisfaction with services was consistently high for this cohort. All changes were statistically significant ($p<.001$). Detailed tables are presented in **Appendix F**.

CSC is part of the SFVS service offering, providing dedicated support for children who experience or witness family violence as victim survivors in their own right. Four Relationships Australia organisations provided CSC in 2021-22, expanding to seven from 2022-23 onward. (see **Section 5.2.2** for more detail on the impact that SFVS funding is having on children). This section focuses on the extent to which SFVS funding is appropriate and aligned with the needs of children. In 2023-24 close to 1,500 children received dedicated counselling. Approximately 55-63% of children showed an overall positive change in circumstances by the end of service. By 2023-24, about 63% had improved circumstances.

Themes from the literature and in comments from service providers and service users engaged offered further insight into the importance of recognising children and young people as victim survivors in their own right, as well as right bearers under the United Nations Convention on the Rights of the Child (United Nations, 1989), and the engagement approaches and strategies supporting this.

The prevalence of child maltreatment in Australia, including children and young people experiencing neglect, emotional, and physical abuse, is high, with 62.2% of the Australian population aged 16 – 65 having experienced some form of child maltreatment (Haslam et al.,

2023). AIHW data indicates that in 2022–23, approximately 30,900 children commenced intensive family support services and of these, 32% were aged under 5 years (Australian Institute of Health and Welfare, 2024b). Children and young people affected by family violence face unique challenges that require tailored, youth-specific support.

A strong recurring theme from the literature was the need to ensure children and young people feel seen, heard, safe, and recognised as victim survivors in their own right. Their perspectives on safety and coping can differ significantly from adults, requiring intersectional, children and youth-centred approaches that see children young people as active participants in their own support and recovery (Corrie and Moore, 2021). Harkin et al (2020) observe that the typical family support model primarily addresses parental needs to benefit children and young people, sidelining input from children and young people. This parental focus limits active participation and visibility from children and young people, particularly when parents restrict or 'gatekeep' what children can express to practitioners (Harkin et al., 2020; Stafford et al., 2021). Young people experiencing violence, whether from a parent or intimate partner, are often overlooked as victim survivors. Instead, services typically categorise family violence as adult-centric, neglecting children and young people's experiences. This is reflected in children who are bereaved by family violence, who often face isolation and face barriers accessing age appropriate services (Alisic et al., 2023).

A meta-synthesis by Noble-Carr et al. (2020) highlights the unique needs and preferences of children and young people impacted by family violence, underscoring their desire for both physical and emotional safety. They value having trusted individuals to talk to—whether adults or peers with similar experiences—and emphasise the importance of being taken seriously and having their voices heard (Noble-Carr et al., 2020). Children and young people associate being listened to with feeling valued, which enhances their self-esteem and provides a foundation for healthy development (Stafford et al., 2021). Conversely, they may feel marginalised, frustrated or lonely when adults dismiss their perspectives, particularly when services are adult-centric rather than age-appropriate (Alisic et al., 2023; Harkin et al., 2020).

These studies underscore the need for child-inclusive practices as an everyday aspect of family support, positioning children as competent social actors capable of contributing meaningfully to decisions that affect their lives (Alisic et al., 2023; Harkin et al., 2020; Noble-Carr et al., 2020; Stafford et al., 2021).

Literature supports a shift from traditional 'protection over participation' models to approaches that uphold children's rights to self-expression and agency, as enshrined in Article 12 of the UN Convention on the Rights of the Child. This shift involves challenging beliefs about children's capacities, addressing logistical constraints, and fostering a culture that sees children as active participants in their own care. Embedding child-inclusive practices within family support services requires systemic changes that recognise children's agency, making their voices a routine and valued aspect of service delivery. By integrating these perspectives, family support services can develop more responsive, empowering environments that better serve children and families (Harkin et al., 2020; Stafford et al., 2021).

Research shows that supporting children to improve their safety and wellbeing requires a multifaceted approach that combines education, structured support, and community

involvement. Prevention efforts must also involve families and service systems that create safer environments and reinforce protective behaviours.

Strengths-based and trauma-informed interventions in school, family, and other community settings, play a vital role in supporting children exposed to violence. By offering structured, supportive environments that promote resilience and self-concept, these programs help children develop coping strategies and overcome barriers to service engagement. Sustained support to children, including follow-up or booster sessions, promotes safety, and maintains and reinforces mental health benefits achieved in trauma-informed care settings, highlighting the need for continuity and support across environments to strengthen mental health outcomes for young victim survivors. This aligns with the World Health Organisations (WHO) (2022) INSPIRE framework, which advocates for a multi-layered approach where caregivers, communities, and services work together to create networks that foster safety and support self-management, allowing parents and children to recognise abuse and seek timely support.

International examples of best practice

A comparison of family support service reform in Australia and internationally provides insight into similarities and potential enhancements to service delivery models in Australia.

England, Ireland and Spain have placed a strong emphasis on multi-agency collaboration and evidence-based practices. Reforms undertaken in those jurisdictions offer valuable lessons for enhancing service delivery in Australia. Reforms in these countries were influenced by international frameworks like the UN Convention on the Rights of the Child and European Union policies that emphasise children's rights and positive parenting. These countries have restructured their systems to emphasise child welfare, early intervention, and multi-agency collaboration, often under significant economic pressure (Churchill et al., 2020).

In England, multi-tiered systems like Sure Start and Children's Centres deliver integrated, co-located services combining universal and targeted support. Ireland has taken a holistic approach through Tusla, integrating child welfare and early intervention under a single framework, with collaborative tools like the Meitheal model supporting tailored, cross-sector responses to family needs. Spain has focused on evidence-based family preservation strategies, digital parenting resources, and promoting positive parenting. Programs such as Ireland's Tusla and Spain's positive parenting initiatives emphasise the importance of professional development, data collection, and coordination across sectors (health, education, and social services) to improve outcomes for families (Churchill et al., 2020).

Learnings can also be drawn from Victoria's evidence-based Family Preservation and Reunification Response as well as individual examples such as the Jannawi Family Centre.

Service provision to children and young people

Several SFVS and CSC service providers described a need for more direct engagement with children and young people, reinforcing themes from the literature relating to children's and young people's voice and agency. CSC service providers described the capacity of CSC services to improve children's ability to self-regulate, create a safe space and support network, and provide them with a voice – often for the first time in their lives. Many CSC service providers also noted that the effectiveness of counselling was contingent largely on the ability of counsellors to establish rapport with the child, highlighting the need to ensure staff are sufficiently skilled and experienced in working with young people.

> *Giving children that voice and holding that alongside a protective lens without silencing them – that's a real issue we juggle* ***– CSC service provider***

> *When we are seeing children, we have a whole-of-family approach, trying to work systematically even though we see the child as a client in their own right because when there's family violence there are different social and emotional impacts on the child* ***– CSC service provider***

CSC service providers identified several barriers to effective engagement with children and young people including:

- gaining consent from both parents for the child's participation in counselling (although this was possible in some circumstances).[17]
- lack of capacity in services to provide a whole-of-family-approach in some locations
- lack of suitably qualified workers with experience of working with children
- parental mistrust of services
- providing appropriate services in-language to CALD communities.

Linked to findings from the literature about the value children place on having trusted individuals to talk to and feel heard (Noble-Carr et al., 2020), child service users reported positive experiences, speaking about enjoying having someone to talk to, who took them seriously, respected their privacy and did not judge them. All noted they liked play-based approaches to counselling. The physical space in particular was important to children, with some noting they appreciated having toys and other 'kids' stuff' in the counselling waiting room, whilst others commented they wanted more books and other materials in the service.

> *It has helped me not get as angry and feel more calm and safe. She has helped me [and says] that it's ok to feel how I feel and that I'm not the only person who has [felt] that and people are here for me* ***– CSC service user***

> *I miss her [the support worker]. I miss talking […] She took it seriously if I told her what happened to me at school* ***– CSC service user***

> *[In response to a question about what she would change] More big kid books, especially books about movies in the waiting room. The books in the wait[ing] room are little kid books or word search clues. I want colouring sheets, pencils and textas* ***– CSC service user***

[17] This includes using formal applications to family law courts by parents who use violence which seek to order that children do not receive counselling or other forms of medical care. Such applications, if successful, may be part of a broader pattern of systems abuse and coercive control within a relationship.

Parents engaged in counselling also identified a range of benefits including improvements in their child's behaviour and wellbeing.

> *[I] really appreciate [counsellor's] no-nonsense approach to [my child]. She is building trust in a professional way […] [My child] is able to see it as a professional relationship, but one which she can confide in like a friend* – ***FaRS service user***

Child to parent violence

Child-to-parent violence (CPV), which includes behaviours such as adolescent violence in the home (AVITH), refers to acts where a young person uses physical, verbal, psychological, or financial means to exert power and control over a parent. Presentations of CPV are predominantly directed at mothers and can stem from a range of factors including prior exposure to violence. This exposure to violence is similarly reflected in the literature in relation to sibling-to-sibling violence, wherein the normalisation of violence may reinforce sibling to sibling aggression and violence (Boxall et al., 2024; Tompsett et al., 2016). CPV presents complex and multi-faceted challenges for families, requiring flexible, whole-family, and trauma-informed approaches that recognise the intertwined experiences of all family members impacted by CPV and AVITH (Campbell et al., 2023; Toole-Anstey et al., 2024).

The literature identifies several unique barriers to effective service delivery faced by mothers impacted by CPV, including: feelings of shame and fear of judgment, particularly for single mothers who may feel heightened scrutiny over their parenting; hesitation to disclose CPV due to concerns about negative consequences for their child, such as involvement with child protection or criminal justice systems; isolation, limited service availability and confidentiality concerns for mothers in rural areas in particular (Toole-Anstey et al., 2024) and experience of some mothers experiencing intimate partner violence (IPV) seeing its patterns repeated in their children as CPV which creates complexity, burden and increased reluctance to seek help (Campbell et al., 2023).

Best practices in working with mothers impacted by CPV involve: providing holistic support that accounts for dual experiences of CPV and IPV; enhancing service awareness and accessibility, particularly in rural areas (Toole-Anstey et al., 2024); using whole-of-family approaches to address needs and experiences of family violence across the family unit comprehensively; providing trauma-informed care to address the needs of children and adolescents as well as cumulative family trauma (Campbell et al., 2023; Toole-Anstey et al., 2024) and leveraging pre-existing relationships of trust, including with familiar networks or individuals like a GP, to support help-seeking and disclosure by mothers impacted by CPV (Toole-Anstey et al., 2024).

While the literature emphasises the complexity and growing need to address child to parent violence, there were few direct examples of CPV described by service providers and service users. However, one service provider focus group identified this as a major gap.

> *One of the gaps within the service is we don't offer the service to teenage boys. A lot of police reports are child to parent violence. We don't have the capacity to run a program targeted for teenage boys* **– *CSC service provider***

FaRS and SFVS service providers also commented on the importance of engaging in holistic work across families generally and in relation to experiences of trauma and family violence, suggesting familiarity with whole-of-family approaches as a best practice principle guiding their work (Campbell et al., 2023; Toole-Anstey et al., 2024).

One ACCO also described CPV as a major focus for them, describing their work and focus on violence prevention and early intervention programs aimed at teenage boys.

6.5. Complementarity of FaRS and SFVS

This section addresses KEQ 4: 'to what extent do FaRS and SFVS complement or overlap with each other?' It discusses the program differences and similarities between FaRS and SFVS, as well as examining the significant crossover in day-to-day service provision for victim survivors.

FaRS and SFVS are distinct programs with significant overlap

FaRS and SFVS are two distinct but interrelated programs, with SFVS existing as a sub-activity of FaRS (see **Section 1** for more detail). Under Operational Guidelines, FaRS is focused primarily on supporting families during significant life changes such as formation, extension, or separation through early intervention and preventative practices (Department of Social Services, 2021a), while SFVS aims to strengthen family and community functioning by support those who are experiencing, witnessing, or at risk of family violence (Department of Social Services, 2021b). Each is aimed at servicing distinct (albeit similar) cohorts. Each offers similar activities based largely around counselling, education, and other supports. Reach and capacity vary between the two due to the comparatively small size of SFVS funding. Under Operational Guidelines, FaRS and SFVS are able to refer service users to each other as required, either internally or externally (Department of Social Services, 2021b). There are 81 FaRS service providers, 38 of which also provide SFVS.

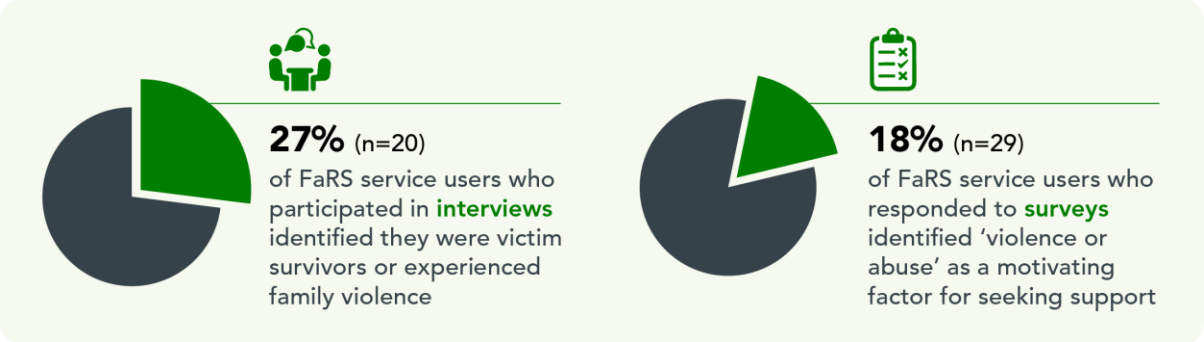
There is evidence to suggest that the referral pathways into FaRS and SFVS programs differ. Referrals to SFVS are more likely to come from other specialised family violence services, and specialist drug and alcohol services. This contrasts with FaRS, where self-referral has consistently been the most common referral mechanism into the program. This aligns with the core differences in the service offering, with SFVS centered on the needs of those experiencing family violence.

While FaRS and SFVS each have program differences, dual FaRS SFVS service providers agreed that there was significant overlap in how services were applied with some service users transferred internally across programs to meet demand and need.

Use of FaRS funding to support victim survivors

Despite FaRS not being specifically targeted at family violence, a significant minority of FaRS service users engaged through interviews and surveys either: explicitly identified as a victim survivor; said experiences of family violence (current or historical) led them to seek support; or realised during counselling that they were experiencing family violence (see **Figure 45**).

Figure 45: FaRS service users self-identified experiences of family violence



Source: Service user interview and survey data

Service providers indicated that the use of FaRS funding to support victim survivors often occurred to offset SFVS waitlist times or to support low-risk victim survivors, particularly after crisis periods had passed. For services that received FaRS funding exclusively, the high numbers of victim survivors accessing FaRS services was mainly due to there being a lack of appropriate or accessible specialised family violence services in their area. Some providers expressed concern that FaRS practitioners in some instances lacked specific family violence training and experience. However, most victim survivors who accessed FaRS were satisfied with their experience. The benefits of professional development for service providers by experiencing both services was also raised.

> *I think another strength is the ability to upskill practise from […] FaRS and SFVS combining together. The water cooler conversations become super helpful for them just having exposure to […] both programs [which] I think informs and supports better practise for our workers* ***– Dual FaRS SFVS service provider***

Dual delivery

DEX data indicates that the number of people receiving services from both FaRS and SFVS is significantly less than those receiving services from one program only. In supplied DEX data:

- 90.7% of unique service user identifiers were in FaRS only
- 7.1% in SFVS only
- 1.1% in the SFVS-4AP2 activity only
- 1% were represented in both FaRS/SFVS

- 0.3% were in both FaRS/SFVS-4AP2.

While anecdotally there is some crossover between the programs, quantitative datasets indicate that most service users are serviced exclusively within one funding stream.

Nonetheless, FaRS and SFVS service providers described their staff working collaboratively to meet service user needs. This was further enabled in some services where staff worked dual roles across both.

> *We work very closely with the SFVS program because we have a lot of families and couples that present for relationship counselling where they may be more appropriate for [SFVS]* ***– Dual FaRS SFVS service provider***

Service providers highlighted that having access to both FaRS and SFVS funding enabled:

- use of FaRS to provide continued support to victim survivors who initially engaged with SFVS
- the provision of immediate support when SFVS waitlists were too long but immediate support was needed
- FaRS and SFVS in tandem to address diverse needs across families with family members engaged through different program streams, enabling a holistic, wraparound approach
- informal and formal training and information sharing between programs to support best practice delivery
- the funnelling of service users who required specialist support relating to family violence to SFVS, often based on disclosures emerging during FaRS intake, assessment, or counselling sessions with internal, warm referrals and continued support enabled by co-location (Churchill et al., 2020).

> *We do cross-pollinate between FaRS and SFVS depending on availability as we are overwhelmed with demand* ***– Dual FaRS SFVS service provider***

> *Having the SFVS counselling space co-located with our family support program and our FaRS counsellors […] means that I have some really wonderful options around step down [if] the […] family violence has been addressed and it may be more suitable for a client to be sitting with […] the generalist counsellor to just manage general mental health and well-being […] That's the idea of a 'no wrong door' policy […] It makes for a much smoother transition when I can go across the room, knock on the door, and have a chat with that family support worker about what this family might need* ***– Dual FaRS SFVS service provider***

> *The main crossover is that it's an easy referral pathway – it means we can coordinate well and share information where appropriate* ***– Dual FaRS SFVS service provider***

> *Referrals come in fast and furious…sometimes we close the waitlist from an ethical point of view…we contact them even after 8-12 weeks and they are still very keen to get support. There just [aren't] enough services […] We used to run groups out of the SFVS funding, but we've moved what we can to FaRS* ***– Dual FaRS SFVS service provider***

This complexity, high levels of demand, and necessary mixed use of FaRS and SFVS for diverse service offerings created additional administrative burden that some providers identified as requiring dedicated staffing and investment (see **Section 6.7** for more detail).

6.6. Level of need and distribution of need

This section addresses KEQ 5: 'What is the level of need for FaRS and SFVS and how is this need distributed?' It discusses coverage and distribution of FaRS and SFVS, geographical and service gaps, and service provider perspectives on need.

Coverage and distribution

Figure 2 shows the distribution of FaRS and SFVS service provider outlets across Australia.

FaRS

FaRS had nationwide reach, with every state and territory having FaRS service coverage. No significant population centres lacked access, although remote and sparsely populated regions received fewer direct services relative to population needs. Services were provided from 472 outlets in 2021-22 and 517 in 2022-23. Every state and territory had FaRS service coverage. Major metropolitan and regional areas were well-served, though some very remote localities had limited on-the-ground services. Funding was sometimes shared across multiple SA2 regions to cover thinly populated areas, so some remote communities may have been served via outreach rather than a local office.

The service user mix was diverse across demographic characteristics. Gender was relatively balanced, with about 46.0% female and 47.2% male service users over the three-year period (0.16% identified as intersex with the remainder 'not stated'). Approximately 9.7% of service users reported a disability, 5.4% identified as Aboriginal or Torres Strait Islander and 36.7% were from CALD backgrounds.

SFVS

SFVS services were delivered in targeted locations. The program funded on average 156 outlets nationwide (summing all provider outlets attributed to SFVS). Many providers operated 1 or 2 outlets for SFVS (often co-located with FaRS). Some regions (especially parts of Victoria, NSW, Queensland, WA) had multiple SFVS sites, whereas large remote areas were

serviced mainly by outreach from a central hub. Not every community has a local SFVS; however, by 2022–23 the program covered most high-need regions. For instance, SFVS funding was allocated to dozens of SA2 areas, though some rural areas still lacked a dedicated SFVS presence. Generally, metropolitan and regional centres with higher populations and need were served, while very remote areas remained harder to cover.

SFVS service user demographics reflected the target population dealing with family violence. Across the three-year period, 71.6% of were female and 27.4% male, as many services support women and children (and men who use violence are often counted separately under MBCP). A notable 13.5% of SFVS service users identified as Aboriginal or Torres Strait Islander, indicating outreach to Aboriginal and Torres Strait Islander communities experiencing family violence. 11.4% of service users reported a disability while 22.8% of service users were CALD. These figures highlight that SFVS reached several priority groups, including a high proportion of Aboriginal and Torres Strait Islander families in need of violence-related support.

MBCP

The eight MBCP providers captured in the GPS – DEX extract operated through an average of 17 outlets over the three-year period. Some providers have up to 5 outlets where others have only one. These outlets are mostly in urban centres and larger regional towns. Many rural areas still lack local MBCPs, meaning men from those areas either travelled or participated remotely (if available). The geographic gaps in MBCPs are a known issue, data confirms that by 2023-24, some states/regions had multiple MBCP sites (e.g. NSW, Queensland, SA each had at least one), but coverage was not universal.

The GPS – DEX data extract suggests that the majority (56%) of MBCP participants are male. While this appears low for a men's program, it may reflect data recording practices where female participants, such as partners or support people rather than primary service users, are included in the dataset. A significant proportion of MBCP service users come from diverse backgrounds. Across these programs, close to 16% reported a disability, 13% identified as Aboriginal or Torres Strait Islander and 3.5% of service users identified as CALD. The proportion of Aboriginal and Torres Strait Islander participants is noteworthy, as it indicates efforts to include Aboriginal and Torres Strait Islander men.

CSC

The 7 CSC providers captured in the GPS – DEX extract operated through an average of 22 outlets over the three-year period. CSC is only provided through Relationships Australia. Some providers have up to 7 outlets where others have only one. Generally, each provider operated in their jurisdiction, covering both metropolitan and some regional areas. Regions without a Relationships Australia presence (or without this specific funding) might not have had equivalent services. Overall, the spread of outlets indicated that most states had at least one funded child counselling hub.

Although the GPS – DEX extract did not report age breakdowns, it is likely that participating children span a range of ages. Almost three-quarters (72%) of all service users were female with a relatively small proportion from priority groups; 10% reported a disability, 7.5% were

Aboriginal or Torres Strait Islander and 3.3% of service users were CALD.[18] There is significant variation across service providers with some services seeing only Aboriginal or Torres Strait Islander service users.

MensLine

The MensLine service continues to predominantly support male service users, reflecting its target demographic (men seeking help). In 2023-24, 95% of service users identified as male, 4% as female and <1% as another gender or not stated. In 2023-24, the largest age group of callers was 35-44 years (26%), followed by 25-34 years (23%) and 45–54 years (17%) and younger men 18-24 years (14%). A minority (4%) of MensLine service users identify as Aboriginal and/or Torres Strait Islander. Many callers did not report a disability, or the information was not captured. In 2023-24, 51% of service users' disability status was 'unknown or not stated', and 35% reported having no disability. Among those who did report a disability, the most common type was psychiatric disability (9%). There was no information reported regarding CALD status.

Geographical and service gaps

While the above programs (FaRS, SFVS, MBCP, CSC, MensLine) collectively cover a broad range of family services, the analysis highlights some geographical and service gaps. Certain remote and rural areas of Australia did not receive local services proportional to their population needs in this period. For example, very remote communities (in parts of NT, northern WA, western Queensland) often had no onsite FaRS or SFVS services, and families in those areas would need to access help in regional towns or via outreach. Similarly, MBCPs were largely absent outside major centres, leaving a service gap for rural men. The data showed that funding was attributed to many SA2 regions, yet some areas, especially those sparsely populated, were covered by shared funding or not at all. Areas with high Aboriginal or Torres Strait Islander populations and socio-economic disadvantages sometimes lacked a proportional level of services, though Aboriginal and Torres Strait Islander-focused efforts were present in programs like CSC and some SFVS. In summary, by 2023-24 there was near-full coverage in metropolitan and large regional Australia, but remote and some outer-regional communities remained under-serviced relative to need. This will be further explored in the modelling phase of the broader evaluation.

Service provider perspectives on need

Most FaRS and SFVS service providers noted that the need for their services was growing in both volume and complexity. There are more people seeking services and presentations are increasingly complex with need for more ongoing, intensive, and tailored supports, including case management. FaRS and SFVS service providers have reported high levels of demand, reflecting previous research which found that 50% of surveyed FaRS and SFVS practitioners were overwhelmed by their personal caseload at least some of the time, while 42% of surveyed

[18] Note that demographic data for this cohort is drawn from a GPS DEX extract, whereas demographic data for other cohorts is drawn from unit record DEX data.

FaRS and SFVS services were overwhelmed by demand at least some of the time (Australian Institute of Family Studies, 2018).

Several FaRS service providers described service users as presenting with increasingly complex and intersecting needs including mental health, alcohol and other drugs, housing precarity, financial insecurity and other financial crises, court referrals and legal support, and migration and integration support. In some cases, this has increased workload and service user service length with additional support required to facilitate access to and navigation of other services. This was further complicated in some rural and regional areas where the ability to refer to appropriate, specialist services, either during wait periods or following the conclusion of the funded support period, was limited due to there being minimal service options with long wait times for the few services that are available.

> *[…] for every client […] if you were to spend an hour […] you would probably need […] another hour for case management, and that doesn't include the extensive case notes and assessments that [counsellors] have to do. When's there's a complex client and a complex presentation there's a lot more documents that need to be completed […] The other thing is all the referrals out then [required] follow-up, making sure they're safe* ***– Dual FaRS SFVS service provider***

Several FaRS and SFVS service providers reported a lack of funding or staff capacity and skills to deal with this increased complexity, meaning they either refer service users to other services or draw on other federal or state funding to supplement funding gaps. For some service providers this need to provide more intensive support sits in tension with the need to ensure people do not become reliant on services, that those on waitlists also get help, and that target numbers are met under AWPs. Several service providers described engaging increasingly in case management and other forms of more intensive support which were not able to be recorded in DEX reporting, meaning this additional work is not formally recognise by the Department..[19]

Service providers gave mixed feedback about their capacity to meet demand. While some said they were able to meet demand, most indicated that they were unable to do so in a timely manner. Larger organisations who received FaRS and SFVS funding tended to report having greater flexibility and capacity to meet complex needs due to internal service offerings (including through co-located models of delivery, and a greater capacity to make referrals and form relationships with external services). Smaller services, who received FaRS funding only and those with regional and rural footprints were more likely to report difficulty.

[19] ACCO service providers similarly noted that additional effort they are required to undertake to meet service user demand is not captured in DEX (see **Section 6.4.3**).

> *Yes, we're able to meet the need but the demand is high and […] we had […] a period of time […] [where] we [couldn't] take any anyone because our wait list is already too far […] Like I said, we don't advertise and every time we've gone 'look, we've had a gap, maybe we should mention it', you know, suddenly we'll get an influx of like 20-30 referrals and it's like OK, it's closed again* ***– FaRS service provider***

Most FaRS and SFVS service providers reported that they had seen an increase in victim survivor presentations. This growth in demand for family violence services was attributed, in part, to greater awareness in the community about what family violence is and how to seek support accordingly.

> *I can definitely see an increase in demand in the community for family violence support over the last few years. I don't know if that's because of increased awareness. You know, people are getting more education about what family violence is, and then we're seeing that reflected in our services.* ***– SFVS service provider***

Waitlists, reported anecdotally during focus groups and interviews, varied, ranging from 2 weeks to 12 months in the case of one MBCP service provider. Some SFVS services reported having to close waitlists due to the extent of demand. Similar to adaptions made by Relationships Australia (2023b), one MBCP service provider reported moving from a closed to rolling intake for group sessions to alleviate wait times.

SFVS service providers, including those who supplied MBCPs and CSC, emphasised the difficulty they experienced meeting demand for specialised services. This was attributed to a range of factors including current SFVS funding not matching the extent of demand and difficulties experienced hiring diverse and qualified specialist workers to deliver these programs, particularly in rural, regional, and remote areas.

CSC service providers noted increased complexity of case work as well, including intensive compliance, service user satisfaction, risk management requirements (including mandatory reporting processes), and reporting and data entry requirements. This was said to be complicated further by some staff lacking training in systems and tools required for these processes and the need for increased managerial supervision and training of staff as a result. Providing wraparound, whole-of-family support to children and their families was said to often involve increasingly complex issues, necessitating further internal and external referrals. Two CSC service providers noted the need for complementary MBCP-CSC service delivery to support whole-of-family approaches to meet demand across both areas effectively.

> *[The unmet need] is absolutely enormous across Australia […] We know from the amount of police reports how many children are witnessing or experiencing and being victims in their own right with family and domestic violence. […] [Not] all those people are coming in for counselling and then you have […] what people don't see or don't report. So, it's a massive problem I think for the Australian community, […] The unmet need is enormous* ***– CSC service provider***

Due to the heightened complexity of the presentations within the MBCP cohort, MBCP service providers reported increased need to provide risk assessments of service users, further adding to case load and creating backlog. They noted the high needs of this cohort, with several intersecting issues which impeded men's readiness to effectively engage with MBCPs, such as untreated mental health issues, disabilities, and homelessness. Several called for a shift to a 'healing focus' for MBCPs with increased emphasis on addressing trauma to support long-term change, noting that this was not supported with the current small founding amount and prescriptive MBCP model.

> *You might have the best content in the world but […] you haven't got that readiness […] it just goes over their head* ***– MBCP service provider***

Overall, staff across all service types were said to have an increasing care coordination and case management role, supporting service users to access services before, during, and after accessing counselling or other programs. This was said to have subsequent implications for case load, the length of time of service provision, and waitlists because of the increased number of people being actively held beyond their allotted service period. In addition, FaRS and SFVS service providers are increasingly providing additional supports to their service users including case management, material aid, transport assistance to access the service in-person, and the loan of devices for remote access. These additional supports are often covered by a mixture of funding sources. In addition, they are not currently captured in DEX reporting.

> *[…] our program is open-ended, and people come, and they may be there for quite a while, or they may only be there for a little time. Yet overall, they actually are having their needs met. So sustained [change from accessing programs] I'm not sure how I would want to describe that or interpret that because life ebbs and flows, so we generally find that people stay with us as long as they need to, and then they move on… It's an interesting question because we can't fix up everything in someone's life, but we can work on this issue at this time* ***– FaRS service provider***

> *I feel that our counsellors are very skilled and they're very committed and I feel that their adaptation [to complex presentations] would be a […] a lot easier on them and prevent burnout […] [if] there was allowance made for case management because […] we see 4 or 5 clients. Now if they have 5 […] complex clients […], there is not much leeway there to do the case work, or the consult or the secondary consults or consent so I feel that less is more. Less clients but […] being able to give more time for the client […]* ***– FaRS service provider***

6.7. Enablers and barriers to implementation

This section considers the barriers and enablers to delivery of FaRS and SFVS, as articulated in KEQ 6.

Enablers and barriers to the implementation of FaRS and SFVS reflect both the strengths and challenges underpinning its design and delivery. On one hand, its flexible delivery model allows service providers autonomy in how they deliver programs. This enables, for example, the matching of service users with suitable practitioners based on capability, experience, and background. This flexibility supports a responsive and integrated service model, particularly for providers with both FaRS and SFVS funding. On the other hand, barriers include limited funding, increasing complexity and program aims of early intervention and short-form intervention. These challenges underscore the need for greater guidance around implementation, increased funding, culturally safe practice, workforce development, and strengthened interagency collaboration to improve outcomes across the family violence, family, and relationship service sectors in Australia.

Table 49 below summarises enablers and barriers to implementation

Table 49: Enablers and barriers to implementation of FaRS and SFVS

Enablers	Barriers
Flexibility of the FaRS and SFVS model: Service providers deliver adaptive, service user-centred programs and care that are responsive to individual and community need.	**Funding shortfalls limiting flexibility and innovation:** Service providers' ability to adapt to meet service users' needs were contingent on the amount of FaRS SFVS funding they received, funding received from other sources, and their ability to collaborate with and refer to other services. Lack of access to crisis brokerage and childcare support further limits their ability to meet service user needs. **The tension between the flexible, early intervention model and the complexity of need:** Service users are presenting with complex needs which require more extensive, long-term support.
Partnerships, co-locations, and holistic models of care: 'No wrong door' policies allow service providers to give wraparound, continuous care. Where support cannot be provided in-house, referrals – enabled through strong relationships and partnerships with other service providers – are beneficial.	**Partnerships, co-locations, and holistic models of care:** Limited service options in rural and remote areas, long waitlists, and unclear referral pathways. Collaboration is undermined by competitive tendering processes, insufficient time given to relationship building due to a focus on meeting demand, and differences in approaches to service delivery.
Workforce size, capacity, and capabilities: Staff are highly trained and competent. Due to the diversity and strength of their workforces some service providers can match service users to counsellors based on needs.	**Workforce size, capacity, and capabilities:** Shortage of specialist staff and training opportunities to meet increasing service user complexity. Barriers to hiring and retaining staff, particularly in rural and remote areas, which undermines continuous care.

Enablers	Barriers
Culturally appropriate service provision: Some service providers were successful in developing programs with and for Aboriginal and Torres Strait Islander and CALD communities. This was attributed to sustained engagement which allowed for trust building and for programs to be catered to need.	**Culturally appropriate service provision:** Barriers include lack of resourcing and time for relationship-based work and developing adaptations and lack of trust in some communities.
Implementing the sliding scale fee model: The majority of FaRS service users who were charged fees did not report them as an accessibility barrier.	**Implementing the sliding scale fee model:** Some FaRS service providers were unable to use fees to raise funds due to the low incomes of their service user base.
Data and information systems: FaRS and SFVS reporting enables outcome-based measures.	**Data and information systems:** Current reporting mechanisms do not reflect all relevant inputs into service delivery. In some instances, reporting is duplicative and time-consuming, creating an additional workload.

Flexibility of the FaRS and SFVS model

The flexibility and breadth of the FaRS and SFVS model was identified by most service providers as a key strength, enabling them to deliver adaptive, service user-centred programs and care tailored to individual and community need to support a diverse range of service users at both the individual and family-level. As a result, FaRS and SFVS providers are delivering counselling and other programs that are responsive to the needs of contemporary Australians (see **Section 6**). This flexibility circumvents a common barrier in the implementation of family violence, family, and relationship programs, namely inflexible activity focused delivery models (Brown et al., 2022; Kulkarni, 2019), while simultaneously enabling holistic, service user-centred approaches (Brown et al., 2022; Honisett et al., 2022; Kulkarni, 2019),

> *Just from a rural and remote perspective, I think FaRS works best when it's given that element of flexibility and [gives] the provider opportunity to work within a framework that enables us to deliver a place-based response […] I just pray and hope that we'll never lose the flexibility to create place-based responses under these funding streams such as FaRS* ***– FaRS service provider***

Partnerships, co-locations, and holistic models of care

Literature highlights that implementing a 'no wrong door' approach through a centralised service model helps to ensures families can access a range of supports without fear of being turned away. Service users are provided with choice, control, and flexibility within their support journey, allowing for continuity of care (Brown et al., 2022; Honisett et al., 2022). Further, collaborative, cross-sector partnerships enhance service delivery by addressing the multifaceted needs of victim survivors through streamlined, warm or active referrals and interagency coordination. Partnerships with sectors such as housing, mental health, and legal

support are essential, especially in complex family violence cases (Brown et al., 2022; Kulkarni, 2019).

Several FaRS and dual FaRS SFVS service providers attributed their success in part to their co-located service delivery model underpinned by a 'no wrong door' policy. This was said to allow for warm, 'in-house' referrals, reducing strain on service users by enabling continuous, holistic care. Dual FaRS and SFVS service providers were supportive of the interrelationships between the two funding streams as they allow for service users to be escalated or deescalated as necessary (see **Section 6.5** for more detail). A previous survey of FaRS and SFVS services found that approximately 80% are co-located with other services funded by the Department (Australian Institute of Family Studies, 2018), indicating that this model is likely commonplace. It is noted, however, that not all services have the funding, physical space, or staff capacity to provide this type of service with at least 3 FaRS service providers identifying these as limitations to providing wraparound care.

Undertaking collaboration for integrated service delivery, including building and maintaining effective relationships with a range of government and non-government services is required under Operational Guidelines (Department of Social Services, 2021a, 2021b). Aligning with best practice around community engagement and cross-sector partnerships (Brown et al., 2022; Honisett et al., 2022; Kulkarni, 2019), this work must abide by principles around being community-led and centred (Department of Social Services, 2021a, 2021b).

Several FaRS and SFVS service providers described establishing relationships with other services to support effective referral pathways for priority populations for mental health and other needs.

> *[…] the reality of it is we don't have capacity if clients are coming through with more holistic needs […] you know not just family and domestic violence […] but there is drug and alcohol involved and all the rest […] We have to outsource. It's not easy but we've found […] some pretty good partnerships in the community [with external services]* ***– SFVS service provider***

Several FaRS and SFVS providers reported that referrals were received from and made to a range of organisations including The Orange Door, Headspace and local mental health services, local health services and housing and homelessness services.

> *I think some of the biggest barriers we find [are] because in [major regional city] there's not many places that offer free counselling support, so […] we're the first point of contact and a lot of the barriers that we see for people linking in […] around mental health [is cost]. You know, we always consult very heavily with [local mental health service] when we hit that level of support that needs a […] clinical lens. Obviously, the biggest barrier is cost and so, we often find that we're supporting clients in a bit of an interim between services that they can't quite afford yet, [that] they're not ready to access yet* ***– FaRS service provider***

Additionally, FaRS and SFVS services said they were increasingly engaging with systems such as child protection, courts, and police, often receiving referrals or working with individuals involved in legal proceedings. This involvement can affect service user attendance and expectations, with some disengaging after completing mandated sessions, and others expecting more legal advice or support than services are typically equipped to provide.

> *[…] we're also seeing, you know, referrals come through the court too […] [The] courts will say go to [service provider] if you want your police family violence order varied. So, there's a bit of an expectation there that the service will be [a part of] that process […]* ***– SFVS service provider***

Some FaRS services reported adapting to the needs of CALD, Aboriginal and Torres Strait Islander peoples, and other users by providing external referrals to more appropriate services and then supporting reinitiation of FaRS counselling or other programs if the person was interested.

> *I think it's impossible now not to have an element of case management to be able to support the clients and work [with] your [service and community] partnerships, [for example] having people come […] from the [Aboriginal and Torres Strait Islander] community to come sit in sessions with [Aboriginal and Torres Strait Islander] clients [who] access our service. There's […] things that we've adapted to be able to provide the support that we can but […] it doesn't […] actually sit within the FaRS program, it's an external thing that we've had to adapt to meet the need* ***– FaRS service provider***

FaRS and SFVS providers noted several barriers to effective referrals and collaboration. For some, including those in rural and remote areas, limited service options meant it was not possible to make referrals at all. For others, unclear referral pathways and inadequate service mapping, partnered with a fractured mental health system, made it difficult to offer warm referrals or coordinate care effectively. As several FaRS and SFVS service providers noted, alternative services often have long waitlists, further complicating referral processes. One FaRS and one SFVS provider noted that collaboration and referral processes were undermined in metropolitan areas by competitive tendering processes which meant services were more likely to 'gatekeep' referrals. Further, one FaRS service provider noted that establishing strong, working relationships is time-consuming and is deprioritised to address high service user demand.

> *[…] if we think about collaboration and building a connection with other service providers it's really time consuming and it takes a lot of hard work to build trust, especially if we think about our ACCOs, you know, to really build a meaningful partnership there. With the increase in client work that we have to do that sort of gets pushed […] to the bottom of the list* ***– FaRS service provider***

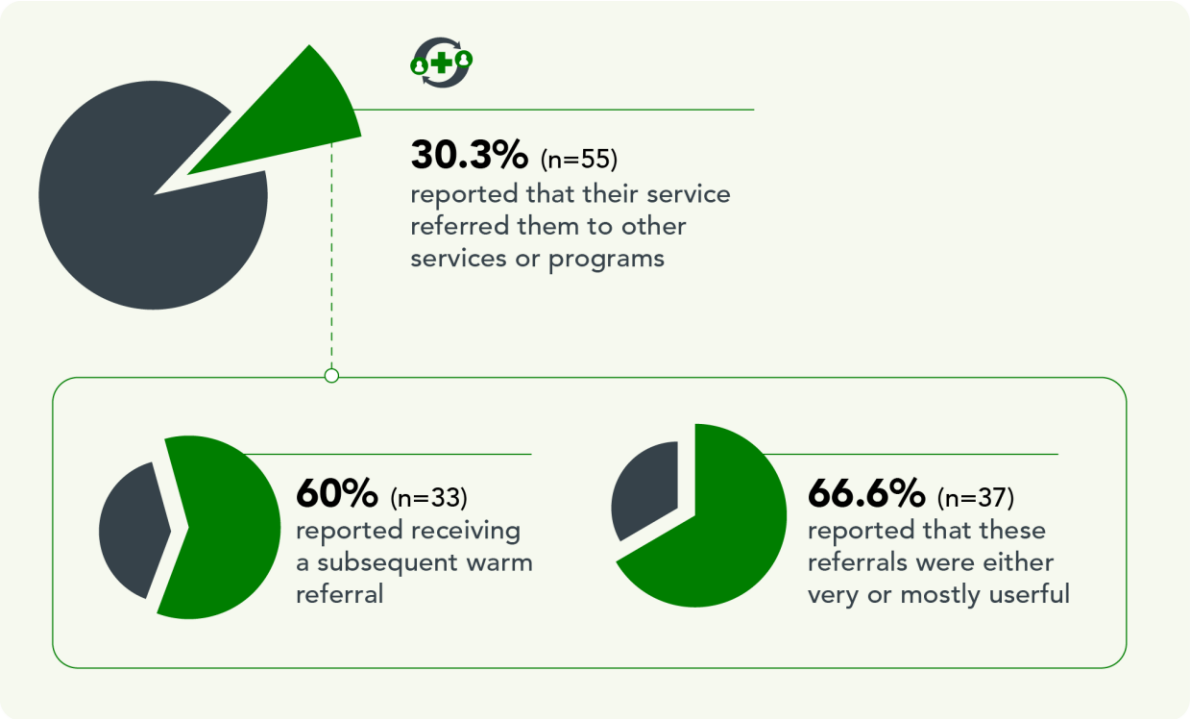
> *I wish there was more time for stakeholder engagement […] and spending time […] engaging with other services because […] we find a couple of services that are fabulous and we can link […] our clients in with […] [but] we will get a little message from one of our colleagues at that organisation 'please can you stop sending people to us because we don't have [capacity]' and that's vice versa –* ***FaRS service provider***

Differences in organisational values, priorities, and protocols across services can lead to conflicting approaches that can further disrupt cohesive service delivery. Professional silos and hierarchical barriers can prevent effective multiagency collaboration, complicating the ability of services to adapt shared practices and responsibilities. This can also include an absence of shared understanding of family violence between different agencies which can lead to inconsistent approaches and significantly hinder cohesive service delivery. Some MBCP service providers described challenges they experienced engaging with other family violence services in shared case management of victim survivors and other collaborative activities. They expressed concern that their work was incorrectly seen to be 'collusive'. This misalignment – or r misunderstanding – of service priorities commonly disrupts cohesive service delivery in the family violence sector. Overcoming these challenges requires clear role definitions, strong leadership, and open communication to build trust and ensure effective partnerships (Cleaver et al., 2019; Honisett et al., 2022; Wendt et al., 2021).

> *So, we do have a bit of pushback from women's services [on] collaborating. So, when we're feeling like there's a risk there we can't get on to the woman and we're trying to collaborate with services that we know she's engaged with […] Even allowing us to be on the safety action meeting like we keep getting told no and it's like we're all here [to keep] women and children safe […] I've done several referrals to it, we know where the men are, but still no. Like if [the man] doesn't show up to an appointment and things like that there is that stress of risk and safety* ***– MBCP service provider***

Only a third of service users (n=55, 30.3%) reported receiving referrals to external service providers. Of this cohort over half (n=33, 60%) reported receiving a warm referral (where their provider organised the referral on their behalf) and two-thirds (n=37, 66.6%) report that the referral was either very or mostly useful (see **Figure 46** below). SFVS and FaRS service user respondents gave similar responses with approximately half receiving referrals of which most found them to be mostly or very useful. This suggest that where referrals are being provided, they are effective and align with best practice around referrals being supported and service-led (Brown et al., 2022; Kulkarni, 2019).

Figure 46: Service user survey data on referrals – highlights, FaRS and SFVS service users



Source: Service user survey data

Overall, the ability of FaRS and dual FaRS SFVS service providers to refer service users, collaborate, or outsource support depended heavily on their capacity and capability to establish strong, working relationships with other services, and the availability of other services in the area. When available, cross-service collaboration and referrals allow FaRS and SFVS service providers to establish referral pathways for priority populations and those with more complex needs they are unable to address (Honisett et al., 2022; Kulkarni, 2019). This helps to ensure the right support for the individual, and to address waitlists. Several FaRS and SFVS service providers attributed their success in meeting service user needs to their strong relationships with local services. For those without the capacity, capability, or option to provide, their ability to assist service users is limited with some opting to hold them for longer to ensure they at least get some form of support.

Workforce size, capacity, and capabilities

Services that are staffed by consistent, friendly personnel are more effective in building trust and supporting sustained engagement (Brown et al., 2022). Research indicates that there is a shortage of specialised staff, particularly in rural and underserved areas delivering services for victim survivors of family violence, making it difficult to consistently provide high-quality support. Some social workers report discomfort in initiating discussions about family violence with service users, fearing that sensitive conversations might disrupt relationships or provoke negative reactions (Pelkowitz et al., 2023). In addition, literature highlights that limited training in trauma-informed, culturally sensitive approaches further restricts workers' ability to support service users from diverse backgrounds effectively (Honisett et al., 2022; Kulkarni, 2019)

Many FaRS and SFVS providers noted a need to provide additional funding to upskill practitioners to meet the increase in complex service user needs, and to provide up-to-date

practice and knowledge. Some noted that while their staff were highly skilled and competent, their ability to address highly complex, intersecting needs was limited.

> *I think the breadth of complexity that counsellors will see under FaRS is quite significant. […] There's no one day that seems to be an easy counselling day […] You'll move from someone who's experiencing family violence […] and then your next person's got mental health [concerns], then you're dealing with a couple who might be [having] communication issues. [There] are so many services and areas of the sector that are slammed and [they] can't take clients in or have long wait lists so people are really asking us to hold them in the space and support them […] The experience level that counsellors need to have is really quite profound […] and it can be quite challenging as an organisation to make sure that all of your staff are across such a broad range of issues* ***– FaRS service provider***

> *There's no degree that someone can go and do that sends them to us and they're ready to do work. […] Practitioners present and then organisations will spend a lot of time and energy empowering and equipping people so that we can support our communities effectively* ***– SFVS service provider***

> *In terms of relationship counselling our practitioners need to have a very broad understanding of a lot of quite specialist areas and then link them in with those specialist services […] So I think the burden in terms of making sure our workforce is equipped, not burnt out and […] feel empowered in their space is also [important]* ***– FaRS service provider***

Identified areas for additional training highlighted by service providers included:

- supporting children as family violence victim survivors
- supporting children and adults with neurodivergence
- engaging in trauma-informed, non-collusive support for people who use violence
- utilising healing-based approaches to MBCPs
- addressing the use of technology to abuse and harass and other newly recognised forms of family violence
- improving virtual service delivery capabilities and understanding
- improved understanding of family violence for FaRS counsellors.

> *I feel that there's too much of an expectation on our counsellors to be across too many complexities and I don't think that they're either skilled or trained or confident and neither should they be, because that's not really what they signed up for. So that's always been a bit of an issue for our staff, and it burns them out and they leave* ***– FaRS service provider***

> *We need to be able to have staff that have the skills to be able to work with people with complex disabilities, including mental health illnesses […] we don't have much funding in FaRS for upskilling of staff […] In terms of diversity, you know, we're really needing […] neurodiversity affirming approaches being put in […] practise* ***– FaRS service provider***

> *[…] sometimes where there is domestic family violence in their presentation for FaRS, you know, how do we best support them? We do have specialists that work with us but even with the MBCP, that wait list is […] huge […] Then looking at those specialist population groups […] we have […] yarning circles and various other presentations that can support, but there's definitely unmet needs in terms of […] workforce specialist training […] –* ***Dual FaRS SFVS service provider***

Several FaRS and SFVS service providers noted barriers to hiring and retaining suitability qualified staff including those with appropriate diversity, qualifications, skills, and experience to support priority cohorts. This is particularly heightened in rural and remote areas, with some providers holding vacant counsellor positions for over a year. This was attributed in part to a lack of qualified staff living nearby and difficulty securing housing to attract candidates from elsewhere. The importance of stable and consistent staffing was recognised by both FaRS and SFVS service providers and service users, with several service users identifying that they either appreciated not having to 'retell their story' when a counsellor left or changed, and conversely others highlighting frustration with lack of handovers. Some service providers expressed that high turnover of staff and challenges hiring staff undermined their ability to provide continuity of care, noting that they were competing with the private sector which could offer higher pay, more secure employment, and more professional development opportunities.

> *[…] there's not as much in terms of the ability to recruit those who are bilingual in our areas, they tend to go to more specialised services, so a lot of the gaps [are] with our CALD communities or those who have low [English] literacy levels* ***– FaRS service provider***

CSC and MBCP service providers emphasised the difficulty recruiting and retaining suitably qualified and experienced staff, as did FaRS and SFVS providers in regional and rural locations.

> *We are getting young people applying for positions, which is not a bad thing, but they come with little or no experience so we are now in a position where we're employing people with an expectation [that] they can do really complex work. We do as much as we can […] sending people off for training but I really think the training element is essential to consider for any future funding of this service* ***– CSC service provider***

The ability of services to match service users to counsellors, thereby providing service user-centred care is contingent on their capacity to hire and retain suitability qualified, skilled, experienced, and knowledgeable staff from diverse backgrounds. One FaRS service user attributed the success of their counselling to the service matching her and her family with counsellors who understood their background and needs, while another 2 service users attributed the lack of success to the inability of their services to do the same.

Culturally appropriate service provision

Community engagement is critical for establishing trust, particularly among disadvantaged and culturally diverse groups. Services that emphasise culturally safe practices build stronger relationships, enabling them to deliver services that are respectful, relevant, and responsive to the specific needs of each community (Brown et al., 2022; Honisett et al., 2022). However, literature indicates that many services struggle to provide culturally safe and inclusive support, particularly for Aboriginal and Torres Strait Islander families and other culturally diverse communities. In the case of Aboriginal and Torres Strait Islander people, effective care must recognise the importance of kinship, intergenerational trauma, and community networks. In practice, cultural safety is often undermined by rigid procedures and time pressures that limit flexibility and extended care delivery. Services that fail to apply intersectional, trauma-informed approaches risk overlooking the complex identities and experiences of survivors, leading to reduced trust, engagement, and effectiveness (Kulkarni, 2019; Pelkowitz et al., 2023; Wendt et al., 2021).

Experiences providing culturally safe services varied, with several FaRS and SFVS service providers noting challenges providing services to Aboriginal and Torres Strait Islander communities. This was attributed to a range of a factors including lack of resourcing, the ongoing effects of colonisation and intergenerational trauma, and the remoteness of many communities.

Some FaRS and SFVS service providers discussed their success in establishing a range of programs for Aboriginal and Torres Strait Islander men and women, which they attributed to collaboration with Aboriginal and Torres Strait Islander communities and services through long-term, relationship building and inputs from their Aboriginal and Torres Strait Islander staff members. Some also cited the development of innovative and successful programs targeted at priority populations with several FaRS and SFVS service providers noting successful collaboration with local CALD groups to deliver individual and group counselling work and MBCPs. Establishing trust with local communities through sustained community engagement is vital to developing culturally safe practices and programs (Brown et al., 2022; Honisett et al., 2022).

The tension between the flexible, early intervention model and the complexity of need

Effective service delivery for victim survivors' centres on a survivor-centred, empowerment-based model. Under this model, services are tailored to respect and prioritise victim survivors' unique needs, goals, and cultural contexts. Services that empower victim survivors to navigate their options and make decisions foster autonomy, enabling positive outcomes and resilience (Brown et al., 2022; Kulkarni, 2019). Further, creating trusting therapeutic relationships is crucial. Consistent, stable staffing and tailored and victim survivor-led services allow therapeutic bonds to form, which are key to effective recovery. Group settings that foster peer support, as well as individual interventions, help victim survivors build trust and readiness for engagement in both starting and concluding their therapeutic journey (Brown et al., 2022; Honisett et al., 2022).

Service providers reported that the number of service users presenting to FaRS and SFVS programs with complex and intersecting needs – including family violence, mental health, disability and neurodiversity, and housing and financial insecurity – has increased (see **Section 6.6** and **Section 6.7** for more detail). As a result, several FaRS and SFVS service providers noted that their counselling programs are increasingly reactive, as they find themselves under pressure to provide crisis response and case management. This included in some instances holding FaRS service users for longer than their allotted service period, to more effectively address needs and meet outcome-based performance measures around participant independence, participation, and wellbeing. This currently sits in tension with the stated goals of FaRS to focus on early intervention and prevention.

Given the breadth of services and cohorts listed under FaRS Operational Guidelines, the current flexibility and open-endedness of the service model is a 'double-edged sword' where services are expected to address a wide range of needs as part of 'early intervention' approach. As service user presentations are becoming more complex, it is becoming increasingly challenging for service providers to address these needs and overall service demand in a timely manner. Several FaRs and SFVS service providers reported that their staff were increasingly providing more in-depth, long-term support including case management, and that this was not recognised in funding or captured in DEX data reports or AWPs.

> *That's the trickiness of how broad it is, which is wonderful, and it's important to have but if you're asking us to service all these different needs, which one do you want us to focus on? Because we can't stretch it so thin that many people fall through a gap versus if we focus on one group […] who else is going to service the other group?* ***– FaRS service provider***

> *I think the adaption that's happened over the years has been this was set up as an early intervention program […] and now you've got the high and complex needs clients or individuals […] coming in. That wasn't necessarily the original intent of the service, but it's adapted and so there is a huge need for counselling and for groups around [a] variety of areas, parenting, life skills, relationships* ***– FaRS service provider***

> *[…] there's an internal struggle going on because people need help and they're coming to you at that point […] so it's really important that people get it in the way that they need it at the location that they need it […] [FaRS] was intended as an early intervention service and its now […] moving in a different direction to match society's needs post-COVID* ***– FaRS service provider***

Many FaRS and dual FaRS SFVS service providers identified that FaRS funding was being used as a 'catch all' with counsellors needing to meet the varied needs of their service users who often cannot access services elsewhere. This included an increased provision of mental health focused supports with FaRS' no or low-cost fee model serving as major drawcard for service users in a mental health system characterised by fragmentation and unaffordability.

> *We see people for almost any reason. A bone of contention within that [is] sometimes we try to be a jack of all trades and master of none* ***– FaRS service provider***

> *The other thing is housing and accommodation options for our young people and families. It's continuing to be on the rise which makes it hard […] for us when we're trying to support our people when there is actually the practical stuff not being addressed. Obviously here we also have the mental health services with long wait periods […] It's hard to hold [service users]. Sometimes I think we're doing a disservice to our people by seeing […] very unwell people in the FaRS space where really, they need to be getting that tertiary level support* ***– FaRS service provider***

Some FaRS service providers also noted that their services were increasingly being accessed at the family court separation stage, providing guidance and case management to individuals and families, while trying to retain a therapeutic lens.

> *FaRS is identified as being an early intervention program as well, attempting to make change before we get to the stages of crisis and Family Court and Children's Court but if we're still in this position that we're stretched so thin that we have to be reactive, we can't actually start to build some of those more responsive and proactive stages […] That's what I'm finding a lot of our programs are struggling with: how do we become that early intervention? Because at the moment it's, 'We'll capture you, we'll take you in, we'll do it all', but [that] might be within the bounds of the work that we want to be doing, or should be doing?* ***– FaRS service provider***

MBCP service providers stated that there were increased workloads around individual case management with a need to work with men one-on-one in some instances for longer than funding anticipates due to disability or low literacy levels impacting engagement capacity. In addition, there is an increased expectation that services assess and manage risk under state-

based family risk assessment frameworks; additional work which is not covered by SFVS funding.

> *There's been an increased expectation for [MBCP] providers to assess, monitor, and track for risk […] All of that work is held in our case management and individual session so we're working with men for longer […] and we've got increased accountability from our funders and from […] the community […] We want to be able to meet that expectation and do it really well which means that we're holding men visible in the program for longer which means there's a backlog* ***– FaRS service provider***

Some SFVS service providers also highlighted that the complexity of caseloads was misaligned with funding allocations, which in turn had the capacity to undermine delivery of trauma-informed services. They emphasised that delivering counselling for service users with complex needs in particular was time consuming and that it was not reasonable to expect relationship to be established, and issues to be addressed within such a short space of time.

> *The brief intervention model [of SFVS] is incredibly limiting, particularly when we're working with women who have complex post-traumatic stress disorder […] We find this work is relational […] it's about providing safety and relationships with these women when they come into this space and often it's when's we're looking at assessments […] getting their story, looking at ways to support them to manage […] and maintain their personal sense of safety, all the things [that] really take a lot more than six to ten sessions.*[20] ***– SFVS service provider***

> *In terms of the family violence work, it's quite complex […] it takes time, but the [FaRS and SFVS] model is […] set up based on the brief intervention […] It's six to ten session […] and in some cases [the] person […] may be entering general [FaRS] counselling and then disclose they're experiencing family violence so all of a sudden under [state-based family violence risk assessment framework] […] you have to respond to family violence and do the risk assessments […] In this program […] you get what you get and then [counsellors] have to […] take responsibility either of case management, counselling, a bit of a family work as well in such a brief intervention space. […] With such a small FTE for us to actually even incorporate [victim survivors lived experience] and […], apply the learnings […] to enhance the service [is difficult]* ***– FaRS service provider***

Some FaRS and SFVS service provider staff called for the program model to shift to accommodate long-term, case management approaches to more effectively and sustainably support high-needs service users, in line with identified best practice (Wendt et al., 2021a).

[20] Whilst caps have not been placed on service delivery by the Department, international organisational caps have been applied in some circumstances to manage funding allocations.

Current funding arrangements, as well as DEX and AWP reporting requirements, do not adequately capture or support this shift in practice – particularly given that FaRS and SFVS do not provide brokerage funding for crisis-level support (Pelkowitz et al., 2023). SFVS in particular was noted as having an inappropriate model for the sustained, intensive support needed by some service users (Wendt et al., 2021a) with many service providers limiting the number of sessions available to an individual service user to 6 to 10 sessions.

Overall, the brief intervention model of FaRS and SFVS – arising from the need to meet demand within prescribed funding amounts - sits in tension with shifting service user demands and expectations and identified best practice around holistic, care delivery which requires more intensive, long-term supports in some instances.

Funding shortfalls limiting flexibility and innovation

The literature highlights that without outcome-based funding, services struggle to implement comprehensive, customised support, and often lack resources for community partnerships, specialised staff training, and program evaluation (Honisett et al., 2022; Kulkarni, 2019). Insufficient funding reduces the flexibility and efficacy of service delivery (Honisett et al., 2022; Kulkarni, 2019). This was reflected in qualitative data which shows that the capacity of service providers to capitalise on the flexibility of the FaRS and SFVS model varied depending on the extent of FaRS and SFVS funding, funding from other sources, and ability to refer to and collaborate with local services to support service delivery.

Service providers varied in their reliance on FaRS and/or SFVS funding. Some identified it as core funding, while for others it formed only a small portion of their service offering. Many service providers highlighted that funding was inadequate to cover the extent of need for support in their area.

> *[…] the need to do more with less is a real challenge when you are trying to do therapeutic work […] We are getting more of what I call hamburgers with the lot* ***– FaRS service provider***

> *[…] the key message for us is that the funding needs to be relevant to the times. The funding needs to meet the challenges of the day and maybe it needs to be […] specific X amount for direct client work […] and X amount for case management because I don't think […] government should ignore [this]. They know the complexities; they know the issues that […] our [service] users are having […] You can't be offering the same amount of funding as […] you were ten years ago […] it just doesn't cut it* ***– FaRS service provider***

Some FaRS and SFVS service providers identified several other challenges with the current funding model including lack of access to crisis brokerage and other forms of immediate support. This included funding to cover transport to access services, housing, and other material support - a common barrier to effectiveness identified within the literature (Pelkowitz et al., 2023). Several FaRS and SFVS service providers also indicated that lack of childcare

or creche facilities onsite limited their ability to work with parents, and single parents in particular, as it was not therapeutically safe to have a child in the room during counselling sessions. In some circumstances, this was overcome by offering virtual service delivery (see **Section 6.3** for more detail).

> *We find that quite a big barrier also [is] location and transport. A lot of our clients are [from a] low socioeconomic cohort so if we're not an area where public transport is easily accessible or they can't walk to us, you know from the local bus stop or from the local school. if [there's] children […] then we do find a lot drop out* ***– FaRS service provider***

> *One of the barriers that we find […] is specifically around referrals that we get for homeless people, unfortunately […] When you're looking at Maslow's hierarchy of needs, […] they're worrying about when [there is a] roof […] coming over their head and where their next meal is coming from […] A lot of the time […] they're depressed, they're anxious, so they get referred into the counselling team, but they're just not in a place where they can actually […] do counselling justice* ***– SFVS service provider***

Implementing the sliding scale fee model

While fees are not charged for SFVS, fees may be charged for the delivery of FaRS services. FaRS service providers varied in how they applied the sliding scale fee model. While they recognised that Department had adjusted funding with the expectation that services made up the difference through fees, some found this difficult due to the low incomes of their service population which meant they are unable to charge fees sufficient to cover the gap. One FaRS service provider noted that this issue was heightened in rural and remote areas where the cost of service delivery was higher due to large geographic distances and the complexities of their service users' needs. In addition, services reported waiving or applying small nominal fees for some service users to increase accessibility, citing concerns about increased cost of living (see **Section 4.3.2** for more on the efficiency of the sliding scale fee model).

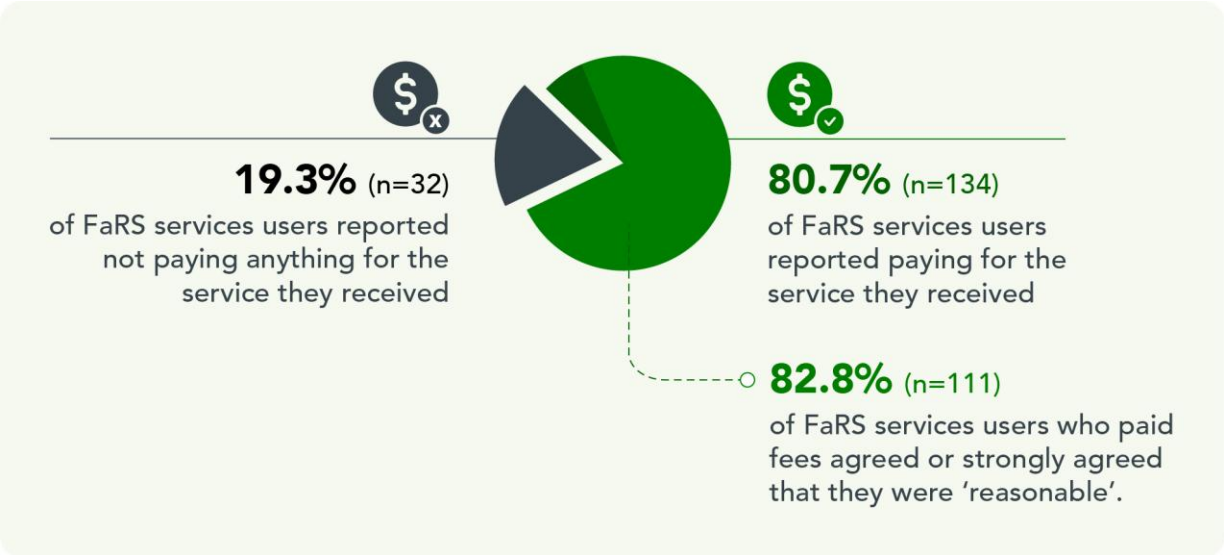
> *[…] my understanding is […] [there is an] […] expectation we charge fees to make up [the] difference. We have not been able to make up the difference due to high needs, and the low financial status of participants –* ***FaRS service provider***

> *We are not charging fees. We tried for a trial period but found it was creating another hurdle for our clients because we operate in low SES areas* ***– FaRS service provider***

While FaRS service providers expressed concern about the impact of fees on service user accessibility, survey data indicates that the majority of FaRS service users are paying fees and that they consider the fees to be 'reasonable' (see **Figure 47** below). Fee-paying FaRS service user survey respondents mostly reported accessing counselling (n=122), alongside

education programs, information and advice, and referrals to other programs. A minority (n=12) did not access counselling, instead accessing education programs, information and advice, case management, and/or referrals.

Figure 47: FaRS service user feedback on fees



Source: Service user survey data

The majority of FaRS service users who accessed counselling reported paying either $31-60 (n=48, 35.8%) or $61-90 (n=47, 35.1%) to access counselling services (see **Figure 48** below). As shown above, the majority (n=111) found these fees to be 'reasonable' with only 5.2% (n=6) disagreeing or strongly disagreeing.

Figure 48: How much did you have to pay per session, FaRS service users (n=140)

Source: Service user survey data

This suggests that when fees are charged, they are not creating a barrier to accessibility, allowing services to more successfully reach target cohorts, while maintaining a degree of financial sustainability.

> *[Counselling services for victim-survivors] are very important to creating healthy relationships for people like myself that can't afford private treatments* ***– FaRS service user***

Data and information systems

Literature indicates that inconsistent service user data systems create challenges in service coordination and continuity of care. Standardised, shared data systems are essential for improving service efficiency, supporting continuity, and reducing the administrative load on families seeking support (Honisett et al., 2022; Wendt et al., 2021). Several FaRS and dual FaRS SFVS service providers identified a need for more outcome-based reporting, adding that the current system creates duplicative reporting across DEX and internal case reporting (Honisett et al., 2022; Kulkarni, 2019). Currently, FaRS and SFVS have a mixture of activity and outcome-focused measures based around number of service users assisted and service provided and the percentage of service users with improved independence, participation, and well-being, as well as AWP activities completed according to scope, quality, timeframes, and budget.

Several FaRS and SFVS service providers noted that current DEX reporting fails to capture the nuance of service demand, the service user journey and the extent of work required for effective and impactful service delivery. This included accounting for the additional work being undertaken by staff to meet the complex needs of service users, including case management. Interpretation and application of SCORE reporting processes was said to vary across services. Some expressed concern that the variations in how people report with SCORE may lead to potential inaccuracies in the recording of participant progress, depending on how a particular program worked and how a participant engaged with it over time. This included participation in a program being staggered due to wait times and other life circumstances and difference in scoring depending on what type of counselling is being delivered, and people scoring themselves lower after successfully completing a program and having increased self-awareness.

In addition, several FaRS and SFVS service providers said that nuances around service user retention rates – for example those who leave MBCPs after completing the court mandated number of sessions – cannot be captured due to the lack of space for qualitative reflections. Some FaRS providers also felt that DEX was inappropriate for brief interventions or group work, in which the intervention cannot reasonably be expected to achieve outcomes on its own but may contribute as part of a broader service response. Several FaRS and SFVS service providers also said DEX does not adequately reflect the effort and resources which are invested in foundational work to build trust and rapport which as substantiated in available research (Brown et al., 2022; Honisett et al., 2022; Kulkarni, 2019) is necessary to support complex service users.

> *[…] you could be scoring from two [sessions] and they're kind of stayed at the two [sessions] because there's other things that have come up for them, so the goals they've identified […] continue [to be] scored the same. I think that's really admin heavy […], and [it] doesn't […] reflect the actual work, the qualitative work […] that has gone into supporting those families or the individual […] I think there's limitations in terms of how we report that [to] really showcase the work that has happened* ***– FaRS service provider***

Several FaRS and SFVS providers noted that data entry and reporting is time consuming for both counsellors and managers with administrative work and supervision required to complete each effectively and some duplication of effort from internal systems. This reflects feedback provided by SFVS-funded ACCO service providers (see **Section 6.4.3** for more detail).

> *[…] all the data stuff that's coming in now […] [is] demanding […] so sometimes you're taking away the time with the client* ***– SFVS service provider***

> *So, if I look at particularly just my patch that I'm holding here for all of our translating interpretive services, we're actually using [another funding source] […] [that] enables us to engage interpreters but […] we can't actually report that against [FaRS] when we come to the AWP because it's not mapped to it* ***– FaRS service provider***

Some FaRS service providers noted that AWPs and KPIs were not being refreshed often enough to reflect current demand and service delivery. Other FaRS providers suggested objectives and expectations for funding could be clearer without being prescriptive to support place-based approaches. While the flexibility of FaRS and SFVS gives great freedom in application it means the Department's expectations are not always clear.

> *I was thinking that it would actually be really good to have some sort of standard Program Logic for FaRS services across the board and it might be hard with the diversity of services but then if we can have that and then do the program mapping with the different FaRS service offerings and then clear referral pathways, you know, that could support referrals* ***– FaRS service provider***

Appendices

Appendix A: Glossary

Term	Definition
4AP2	4AP2 refers to providers who received SFVS funding as part of the Fourth Action Plan of the *National Plan to Reduce Violence against Women and their Children 2010-2022* (Department of Social Services, 2019).
ACCO	Aboriginal and Torres Strait Islander Community Controlled Organisations
ACT	Australian Capital Territory
Advocacy/Support	Providing support to a family member making an appearance in the Family Court or Children's Courts (Gilmour, n.d.)
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIFS	Australian Institute of Family Studies
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and other drugs
AVITH	Adolescent violence in the home
AWP	Activity Work Plan Document which details activities that a grant recipient will implement under the Grant Agreement. The AWP is negotiated with, and approved by, the Department (Department of Social Services, 2021a)
BCR	Benefit-cost ratio
CALD	Culturally and Linguistically Diverse.
CBA	Cost-benefit analysis
CIE Study	Centre for International Economics Study (Centre for International Economics, 2023)
Community capacity building	Developing a community's skills in strengthening family relationships
Commonwealth Child Safe Framework	A whole-of-government policy that sets minimum standards for creating and embedding a child safe culture and practice in Commonwealth entities and Commonwealth funded third parties
Counselling	Counselling for couples, families, children, or vulnerable people experiencing relationships issues

Term	Definition
CSEW	Crime Survey for England and Wales
CPV	Child-to-parent violence
CPS	Child protection services
CSC	Child Specific Counselling
DALY	Disability-adjusted life year
DEX	Data Exchange
DEX-SCORE	SCORE is designed to measure the result of a service users' interaction with a funded service. This data helps build an understanding of the impact the service is making on a service user's life. SCORE capture occurs at a point in time in a service users service journey where a practitioner notes changes, or at logical review points (e.g. beginning, middle, and end of service provision). Organisations report to DEX against several SCORE domains to measure client outcomes using their own tools and methods. SCORE may be reported through a practitioner assessment, a client self-assessment, support person assessment, or a joint assessment.
Education and skills training	Relationship education courses or skills and education training for families, children, and couples.
EOI	Expression of Interest
FaC	Families and Children Activity The FaC activity is delivered by the Australian Department of Social Services under the Families and Communities Program and aims to support families, strengthen relationships, improve the wellbeing of children and young people and increase participation of people in community life to enhance family and community functioning (Department of Social Services, 2021a).
FaRS	Family and Relationships Services is a sub-activity of the Families and Children Activity of the Families and Communities Program. FaRS provide early intervention and prevention services and focus on at-risk families including those at risk of breakdown, with children at risk of abuse or neglect, and/or experiencing disadvantage or vulnerability. FaRS is funded by the Department to deliver broad-based counselling and education to families of different forms and sizes. FaRS services focus primarily on early intervention and prevention and are targeted to critical family transition points including formation, extension, and separation. The Department funds grant

Term	Definition
	recipients to deliver FaRS in specified service areas (Department of Social Services, 2021a).
FNAAFV	First Nations Advocates Against Family Violence
FRSA	Family and Relationship Services Australia
FRSP	Family Relationship Services Program FRSP is currently administered by the Attorney Generals Department. It aims to improve the wellbeing of Australian families, particularly those with children who are separating, or are at risk of separation. It provides community-based services to help separate or separating families to avoid court processes and supports heathier transitions through range of offerings including but not limited to family law counselling, family dispute resolution, and parenting orders programs.
HILDA	Household, Income and Labour Dynamics in Australia
HREC	Human Research Ethics Committee
Information/Advice/Referral	Information session, brokerage to obtain other services or referral to another service (e.g. legal, mental health etc.) (Gilmour, n.d.)
Intake and assessment	Assessing a client in an initial session (Gilmour, n.d.)
IPV	Intimate partner violence
IRIS	Identification and Referral to Improve Safety
KPI	Key performance indicator
LGBTIQA+	Lesbian, gay, bisexual, trans/transgender, intersex, queer, and other sexuality (including asexual), gender, and bodily diverse people
MBCP	Men's Behaviour Change Program
NGO	Non-government organisation
Partnership approach for FaRS and SFVS	All organisations are required to participate in the partnership approach. For FaRS, participation means organisations must record service users' outcomes, known as Standard Client/Community Outcomes Reporting (SCORE) reporting. Organisations are not required to collect extended demographics data from their service users but may choose to do so for their own purposes. Organisations must meet the following minimum requirements: • Report an initial and at least one subsequent Circumstances SCORE for at least 50% of identified service users.

Term	Definition
	• Report an initial and at least one subsequent Goals SCORE for at least 50% of identified service users. • Report Satisfaction SCOREs for at least 10% of identified service users. A SCORE assessment is recorded at least twice for each service user – once towards the beginning of service delivery and once again towards the end. Where practical, organisations can record multiple SCORE assessments for a service user at regular intervals to track how the service user's outcomes change over time. Please refer to the Data Exchange Protocols (section 7) for more information
PFR	Promoting First Relationships
Priority FaRS clients	Families, couples, children and individuals, but priority should be given to: • couples forming long-term relationships • families experiencing relationship issues or at risk of breakdown • families with children at risk of abuse or neglect • families experiencing disadvantage or vulnerability • individuals, couples, children and families who are experiencing or at risk of family or family violence (Department of Social Services, 2021a)
Priority SFVS clients	Families, couples, children and individuals, but priority should be given to: • people who identify as Aboriginal and Torres Strait Islander • people from cultural and linguistically diverse backgrounds • women with disability • children and young people • LGBTIQ communities • people who use violence (Department of Social Services, 2021b)
QALY	Quality Adjusted Life Year
RNR	Risk need responsivity
ROI	Return on investment
SCORE Reporting	Standard Client/Community Outcomes Reporting
SEIFA	Socio-Economic Indexes for Areas
SFVS	The Specialised Family Violence Services (SFVS) program is a component of the Family and Relationship

Term	Definition
	Services sub-activity under the Families and Children Activity of the Families and Communities Program. SFVS uses a whole-of-family approach to strengthen family and community functioning and improve personal and family safety by providing support to individuals, couples, children and families who are experiencing, witnessing or at risk of family or domestic violence. This also includes help to individuals who use violent or abusive behaviour (Department of Social Services, 2021a). The Department funds grant recipients to deliver SFVS in areas of need based on factors such as a demonstrated need for family violence services, community demographics and location, and the capability of grant recipients to target services towards groups of people who are particularly vulnerable to experiencing family and domestic violence.
SNAICC	National Voice for Our Children (formerly known as Secretariat of National Aboriginal and Islander Child Care)
The Department	Department of Social Services
Unidentified service users for FaRS and SFVS	No more than 10% of an organisation's service users in a reporting period should be recorded as unidentified service users. The Department expects organisations to deliver services to service users who are known to their staff. While organisations might deliver education, skills or information sessions to groups of people, they should collect service user details for each individual participant and record them as individual service users in the Data Exchange, where possible. The Data Exchange Protocols provide further guidance on recording unidentified service users.
VAW	Violence against women
WHO	World Health Organisation
WSIPP	Washington State Institute of Public Policy
YLD	Years lived with disability or illness
YLL	Years of life lost

Family and Relationship Services (FaRS)

Inputs	Outputs	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Funding **Organisations** - **Staff** (program managers, counsellors, specialists) **Administration** - The FaRS-SFVS Operational Guidelines provide structure and management of SFVS funds by providers	Number of clients supported Number of activities/sessions attended Number of referrals made	Families have increased knowledge, awareness and skills in: • identifying issues of personal and family safety, including violent or abusive relationships • knowing who they can confide in or turn to for support • learning strategies to improve or maintain personal and family safety Families have increased knowledge, skills and access to support in: • modelling healthy respectful relationships, including effective communication and conflict resolution. • parenting skills (including shared parenting) Families and children have improved knowledge skills, and access to support to improve their resilience, mental health and wellbeing when experiencing family breakdown or dysfunction	Families use effective strategies to: • identify issues of personal and family safety, including violent or abusive relationships • seek help when needed for issues of personal and family safety • improve or maintain personal and family safety Families use effective strategies to: • model healthy respectful relationships, including effective communication and conflict resolution. • improve their parenting skills (including shared parenting) Families and children use effective strategies to improve their resilience, wellbeing and mental health when experiencing family breakdown or dysfunction	Families and children experience improved **family safety and security** Families and children experience improved **family functioning**, including modelling healthy respectful relationships and using positive parenting practices Families and children experience improved **wellbeing and resilience** during family transitions

Specialised Family Violence Services (SFVS)

Inputs	Outputs	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Funding - $54 million has been committed to the Activity over 5 years until 30 June 2027. **Organisations** - 18 organisations funded under FaRS and 12 providers funded under the National Plan. **Staff** (program managers, counsellors, specialists) **Administration** - The FaRS-SFVS Operational Guidelines provide structure and management of SFVS funds by providers	Number of clients attending who are experiencing or at risk of experiencing FDSV Number of clients who are perpetrators of violent and abusive behaviours Number of activities/sessions attended Number of referrals made	**Victim survivors** have improved knowledge and skills in: • identifying issues of personal and family safety, including violent or abusive relationships • knowing who they can confide in or turn to for support • learning strategies to improve personal and family safety • learning strategies to improve mental health and wellbeing **Children** impacted by FDSV have improved knowledge and skills in: • knowing who they can confide in or turn to for support when they don't feel safe (e.g. professionals, families and friends). • improving their mental health and wellbeing **Men's Behaviour Change only:** Perpetrators have increased knowledge and skills in: • techniques and strategies to reduce violent and abusive behaviours • seeking help to reduce violent and abusive behaviours	**Victim survivors** use effective strategies to: • identify issues of personal and family safety, including violent or abusive relationships • seek help when needed for issues of personal and family safety • improve personal and family safety • improve mental health and wellbeing **Children** impacted by FDSV: • feel safe, heard and supported • access supports when needed • are supported to improve their mental health and wellbeing **Men's Behaviour Change only:** Perpetrators use effective strategies to: • reduce their violent and abusive behaviours • seek help and access supports to reduce violent and abusive behaviours	**Victim survivors** experience improved: • **personal and family safety** • **wellbeing,** mental health and self-care **Children are safe, supported** and have improved **wellbeing** **Men's Behaviour Change only:** Perpetrators of violence stop using violent and abusive behaviours

Appendix C: Sampling approach

The evaluation team worked with the Department to develop the following sampling framework to guide engagement with service providers and service users.

Service providers

The evaluation team sought to engage up to 80 staff from service offering FaRS and/or SFVS funded services, along with 2 Aboriginal and Torres Strait Islander peak bodies who specialised in family violence prevention and children's wellbeing. These engagements occurred through a mixture of online and in-person focus groups. All service provider organisations who offer FaRS and/or SFVS funded services were invited to engage in focus groups and to support the recruitment of service users for interviews and surveys. **Table 50** below sets out the sampling framework for service providers, as well as Aboriginal and Torres Strait Islander peak bodies.

Table 50: Sampling framework for service providers and peak bodies

Provider type	Total provider population	Number of focus groups	Number of participants	Engagement method
SFVS service providers	n=38	n=3	n≥16	90-minute online focus group
FaRS service providers	n=82	n=6	n≥48	
Men's Behaviour Change Providers	n=10	n=2	n=10	
Child Specific Counselling service providers	n=8	n=1	n=8	
ACCO service providers	n=5	n=5	≥16	60-minute focus group
Northern Territory non-ACCO service providers	n=3	n=1	n≥2	60-minute focus group
First Nations Advocates Against Family Violence	n=1	n=1	n≥3	60-minute focus group
National Voice for Children (SNAICC)	n=1	n=1	n≥3	60-minute focus group

The evaluation sought to elicit data from a diverse cross-section of services providers and service users. All FaRS and SFVS service providers were invited to express interest in

participating in a focus group. Expressions of interest were then assessed against the criteria outlined in **Table 51** below to ensure a diversity of service provider organisations. Where any gaps arise, the evaluation team reached out specifically to recruit service provider organisations with relevant profiles to fill the gap.

Table 51: Service provider sampling criteria

Dimension	Total provider population
Services provided	FaRS, SFVS or both
Activity type	Number of services provided across each key activity, including: • intake and assessment • information and referral • advocacy and support • education and skills training • counselling
Size	Number of individual FaRS and/or SFVS service users (ensuring a cross-section of small, medium and large providers)
Location	State or territory of operation
Remoteness	Remoteness Area (RA)
Level of socioeconomic advantage	Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD)
Service provision to people with disability	Number and percentage of services provided to service users with disability
Service provision to CALD people	Number and percentage of services provided to CALD service users
Specialisation	Provides one or more of the following: • Child Specific Counselling Services • Men's Behaviour Change Program • Faith-based services

Service users

The evaluation sought to conduct 110 individual interviews with adult service users, with specific targets for service users identifying as belonging to each priority cohort. As part of this process the evaluation team sought to engage a minimum number of service users across both FaRS and SFVS. The sampling approach to adult service users is purposive.

Several population groups are identified in KEQ 3 as priority cohorts for the evaluation. These are derived from the cohorts which are priorities for the FaRS and SFVS programs (see the Program Logics in **Appendix B**). To ensure service user perspectives were included in

consideration of KEQ 3, service users from the following priority cohorts were sought out specifically:

- Aboriginal and Torres Strait Islander people
- people living with a disability
- people identifying as lesbian, gay, bisexual, transgender, queer/questioning, intersex, and/or asexual (LGBTQIA+)
- people identifying as culturally and linguistically diverse (CALD) (persons who identify as having a cultural background outside of the predominant Anglo-Australian culture/heritage, for example in cultural/ethnic identity, language, country of birth, heritage/ancestry, national origin, race, and/or colour).[21]

The evaluation also sought to conduct 15 interviews with service users aged 7 to 17 accessing CSC. Due to the small sample size, a convenience sampling approach was used in which young people who meet the inclusion criteria were recruited irrespective of whether they belong to any priority cohort.

An overall sample size of 125 service user interviews strikes a balance between feasibility and the ability to gather meaningful insights. **Table 52** below outlines the sampling framework for service users for interviews.

Table 52: Sampling framework for service user interviews

Service user group	Target cohort	Sample	Program split	Engagement method
Adults (age 18+)	Individuals living with disability	N=10	FaRS: n≥5	60-minute individual interview
			SFVS: n≥5	
	Individuals identifying as CALD	N=10	FaRS: n≥5	
			SFVS: n≥5	
	Individuals identifying as LGBTQIA+	N=10	FaRS: n≥5	
			SFVS: n≥5	
	Individuals engaging in Men's Behaviour Change Programs	N=10	SFVS only	
	Service users not identifying as belonging to a priority cohort	N=50	FaRS: n≥25	
			SFVS: n≥25	

[21] Definition developed by the Prime Minister and Cabinet CALD network (https://www.pmc.gov.au/resources/pmc-inclusion-and-diversity-strategy-2023-26/understanding-inclusion-and-diversity)

Service user group	Target cohort	Sample	Program split	Engagement method
	Aboriginal and Torres Strait Islander service users accessing services from SFVS-funded ACCO service providers	n=20	FaRS: n=1 SFVS: n=5	
Young people (aged between 7 and 17 years)	Child Specific Counselling service user	N=15	Note Child Specific Counselling is currently only provided by eight Relationships Australia member organisations.	30-minute individual interview

The evaluation team also developed and disseminated an online survey for service users and sought 150 survey responses. As part of this cohort, the evaluation sought to recruit a minimum of:

- 25 young service users aged between 12 and 17 years old, inclusive.
- 25 participants in Men's Behaviour Change programs
- 25 Aboriginal and/or Torres Strait Islander service users.

An approach which combines elements of purposive and convenience sampling was used to achieve the desired sample size. The initial approach involved FaRS and SFVS service providers inviting all eligible service users to respond to the survey (where it is safe to do so). The evaluation team conducted a stocktake of responses at the midpoint of the consultation period to assess any gaps in responses from target cohorts and sought to recruit further participants through more targeted recruitment (i.e. by directly approaching certain service providers to support recruitment to the survey) to achieve the desired sample size.

Table 53 below sets out the inclusion criteria for adult and child participants for both interviews and surveys. Any person satisfying the inclusion criteria below was eligible to participate. These criteria were applied by service providers to identify potential participants for the evaluation.

Table 53: Service user interview and survey inclusion criteria

Adult service users	Young service users	Men's Behaviour Change Program Service Users
Inclusion criteria		
Aged 18 or over	Aged between 7 and 17 years (inclusive)	Aged 18 or over
Located in Australia	Located in Australia	Located in Australia

Adult service users	Young service users	Men's Behaviour Change Program Service Users
Received at least one FaRS and/or SFVS service within the past 12 months	Has engaged with a professional in a Child Specific Counselling SFVS service within the last 12 months	Received at least one service from a FaRS funded MBCP within the past 12 months
Is able to provide informed consent	Has a parent or guardian who is suitable to provide consent and who consents to their participation OR has the capacity to provide consent independently of their parent/guardian (if the young person is aged 16-18)	Is able to provide informed consent
Has been assessed by their service provider as being in circumstances that will enable them to safely participate in the evaluation. There are a number of questions service providers may consider to assess this for adults: • Is there a risk that participating in the evaluation will expose the service user to harm or exacerbate any existing risk? • Is there any other risk, wellbeing or structural issue that may cause that service user to be exposed to harm as a result of participating in the evaluation?	Has been assessed by their service provider as being in circumstances that will enable them to safely participate in the evaluation. There are a number of questions service providers may consider to assess this: • Is there a risk that participating in the evaluation will expose the young service user to harm or exacerbate any existing risk? • Is there any other risk, wellbeing or structural issue that may cause that young service user to be exposed to harm as a result of participating in the evaluation?	Both the MBCP service user and the victim survivor are actively engaged in case management (as indicated by the MBCP service provider). The MBCP service user has been assessed by their service provider as being in circumstances that mean that their participation will not exacerbate any risks.
Exclusion criteria		
Has expressly not consented to be contacted for survey/research/evaluation purposes	Relevant person (young person or parent/guardian) has expressly not consented to be contacted for survey/research/evaluation purposes	Has expressly not consented to be contacted for survey/research/evaluation purposes

The evaluation originally sought to conduct 800 surveys and 105 interviews. This was revised to 150 survey responses and 125 interviews in April 2025 to offset difficulties experienced with recruiting SFVS service users.

The overall sampling approach was not designed to provide a statistically powered sample of FaRS and SFVS service users. Instead, it was designed to capture and provide qualitative data from across a cross-section of service users. Inputs from interviews with service users have been triangulated with inputs from the service user survey and service-level performance and administrative data.

Appendix D: Recruitment approach

Both service provider staff and service users were recruited to participate in the evaluation through service providers. Recruitment occurred through a preliminary e-mail sent by the department to all service providers funded under FaRS and/or SFVS introducing the evaluation. The evaluation team then followed up with a subsequent email relating to the evaluation and how service providers can help. All FaRS and SFVS service providers were invited to nominate staff members for focus groups and identify eligible service users to participate in interview or survey.

Service provider focus groups

Following the Department's introductory email, the evaluation team sent all FaRS and SFVS providers an email inviting the organisation to express interest in participating in a focus group and to nominate one staff member to take part. Service providers were asked to express interest by sending an email to the evaluation team nominating a staff member to participate. Because service provider staff participated as part of their usual work hours additional remuneration was not necessary and was not supplied.

The evaluation team assessed the number and distribution of expressions of interest, and apply the criteria set out in **Table 51** above to ensure a diversity of service provider organisations. Based on this assessment, the evaluation team selected service provider organisations for inclusion in the focus groups and extended an invitation to participate to their nominated staff member.

Adult service users

Many FaRS and SFVS service users were experiencing or at risk of experiencing family violence and/or trauma or distress. To ensure recruitment to participate in the evaluation was ethical, safe, and trauma-informed, the evaluation team recruited service users through service providers. This approach leveraged the established trust between service users and services, ensuring that recruitment was carried out by trusted individuals or groups familiar to the participants. This helped to create a safe environment for participants while also increasing the likelihood of higher engagement and participation.

All SFVS and FaRS service providers were asked to identify service users who met the inclusion criteria outlined in **Table 53** above and who they assessed as being in circumstances that will enable them to safely participate in the evaluation. Services had varied approaches to undertaking risk assessments depending on their area of operation. States and territories, as well as individual organisations, had differing protocols and tools in place for risk identification and management (including risks of family violence and risks to child safety). Service providers were expected to assess any risk to their service users consistent with their organisational policies and procedures, and relevant jurisdiction-specific protocols. In applying these frameworks, service providers were asked to draw on their knowledge of the service user, their context and history. Service providers were asked to exercise their professional judgment and discretion to select potentially eligible service users for screening.

The evaluation team engaged service providers early, especially those working in high demand or under-resourced settings, to establish relationships, and foster trust. The evaluation team supported them to tailor the recruitment process to suit service users. To

support this process, the evaluation team prepared a video presentation to guide service providers on ethical recruitment of service users and updated recruitment material in response to service provider requests to reduce its complexity.

All adult interview and survey participants were offered a $50 or $25 grocery voucher respectively as a form of remuneration.

Recruiting service users through service providers raised risks of coercion in the recruitment process. Several measures were taken to mitigate this:

- Participation vouchers were provided at the beginning of each engagement via email, text, or physically and participants were reminded that they can withdraw at any time, and this will not impact their ability to use the voucher.
- The PICFs made it clear that responses provided by service users are confidential (unless it is necessary to share the information for their safety or the safety of others) and accordingly service providers will not be aware of responses provided.
- All PICFs emphasised that participation is optional, that services providers will not be informed whether someone participated in an interview (unless it is necessary to share the information for their safety or the safety of others), and that withdrawal will not impact the service user's ability to access services.
- Each interview guide included a note reminding interviewers to re-establish consent with participants before each interview.

Adult service user interview recruitment

The evaluation team asked service providers to directly reach out in-person or by phone (unless the service user has expressed a preference for another form of communication) to the service users they have assessed as potential participants to gauge their interest and willingness to participate in an interview. Where the service user expressed interest in participating in the evaluation, either they or the service provider (on their behalf) completed a short Expression of Interest (EOI) form. The service providers were asked to only share the information requested in the form with the service user's consent. As part of the assessment and recruitment process, service providers were asked to assess the safest way to contact individual service users. The form includes questions relating to:

- the service user's contact details and preferred method of contact
- whether the person lives with a disability
- whether the person identifies as belonging to a culturally or linguistically diverse community
- whether the person identifies as LGBTQIA+.

The EOI form was hosted in Qualtrics, a secure online survey platform that allows for confidential and/or anonymous survey completion using encrypted and secured servers based in Australia. The EOI form was shareable in multiple formats including a hyperlink and QR code. EOI forms submitted to the evaluation team were accessible only to approved members of the evaluation team and once downloaded from Qualtrics were housed in locked folders. As EOI forms were received, the evaluation team used a purposive sample of service users

based on the sampling framework set out above. The evaluation team contacted the selected service user to arrange an interview and to establish:

- whether the person requires an interpreter to provide informed consent and to participate fully in an interview
- whether they have a preference as to the gender of their interviewer
- whether the person has other accessibility needs
- whether the person would like to have a family member or support person at the interview, and the name of the person (to enable the service provider to screen for safety).

Adult survey user recruitment

To recruit adult service users to respond to the survey, the evaluation team emailed all FaRS and SFVS service providers requesting them to invite their service users by email or text to complete the survey. The survey was shareable in multiple formats including a hyperlink and QR code. For MBCP service users, surveys were only sent by the service provider to MBCP service users who were currently receiving active case management and for whom the victim survivor was also currently receiving active case management to ensure safety. This distinct approach for MBCP service users is outlined below.

MBCP service user recruitment

The evaluation used additional eligibility criteria for MBCP service users as outlined above in **Table 53**. This included a requirement that all interviews with MBCP service users were held face-to-face. All these criteria and requirements were implemented to ensure the safety of people who use violence, victim survivors, and the evaluation team.

The evaluation team worked with service providers to identify MBCP service users who were appropriate for engagement. The following process will be undertaken to support recruitment:

- **Step 1:** Two virtual focus groups were with MBCP service providers. All 10 MBCP service providers were invited to participate with one representative attending from each service provider. The primary aim of the focus group was to collect data for the purposes of the Evaluation. A secondary aim of the focus group was to support recruitment of service users to subsequent interviews. Accordingly, time was allocated in these focus groups to discuss the recruitment approach with participating service providers and to identify necessary changes to the approach to recruitment to ensure that it aligns with the methods used by service providers.
- **Step 2:** A screening process was undertaken by service users. In addition to the screening criteria, a prerequisite for recruitment of MBCP service users was that they must be currently receiving active case management and the victim survivor must also be receiving active case management from a service provider.
- **Step 3:** The EOI process was conducted. Once eligible service users who were interested in participating in the evaluation were identified, the evaluation team contacted the service provider to ensure that the participant is currently receiving MBCP services and active case management and to confirm that it is safe and appropriate for the service user to participate. A risk assessment and management protocol was established with service

providers for each service user to ensure that the necessary supports and risk mitigation strategies were in place. The evaluation team then contacted participants and schedule a face-to-face interview.

- **Step 4:** The day before the scheduled interview with MBCP service users, the evaluation team contacted the service provider to ensure that the risk level is still as it was at recruitment, and that it was still safe and appropriate for the service user to participate. If circumstances change and it was no longer safe or appropriate for the service user to participate based on the service provider's assessment of the situation, the interview was to be postponed to a later date (if feasible) or cancelled, if required.[22]
- **Step 5:** In conducting interviews with MBCP service users, the evaluation team sought to safeguard against non-collusive practice through an approach that prioritised accountability and minimised potential bias. To uphold this standard, the presence of individuals in the interview room was carefully considered. If during recruitment, the evaluation team determined that it might be inappropriate for the designated service provider to attend the interview due to a conflict of interest or perceived bias, another staff member from the organisation who was not directly involved in the participant's case was to be invited by the evaluation team to attend the interview. This third party was to serve as a neutral observer, fostering an environment conducive to open dialogue while safeguarding against collusion. This did not occur for any MBCP interview. This interview structure aimed to reinforce ethical practice and maintain the integrity of the process and safety of all individuals involved.
- **Step 6:** Post-interview, the evaluation team called the service user's service provider to check in with them and provide a debrief about the engagement. The evaluation team encouraged the service provider to follow up with the service user. The debrief, and relevant follow up, was guided by the service provider.

Young service users

The evaluation sought to engage with young people who had participated in CSC services under the SFVS program. Service providers delivering CSC services under SFVS were asked to identify young service users who meet the inclusion criteria outlined above in **Table 53** and who they assessed as being in circumstances that enabled them to safely participate in the evaluation. As the service provider has knowledge of both the child and their parent or guardian, the evaluation team relied on providers to ensure that the child was suitable to safely participate, and that the parent or guardian was suitable to provide consent.

Young service user interviews

Service providers were asked to identify young people aged 7-17, who fit the eligibility criteria for participating in an interview. All interviews were held in-person. For the purposes of this evaluation, consent from the parent/guardian consent from all service users who are under 18 years old was sought, unless they are aged 16 and over and are deemed by the service provider to have the capacity to give independent consent (a mature minor). Service providers

[22] Note: This was not necessary for any MBCP service user interview that was conducted for this evaluation.

were expected to have their own systems in place to ensure they obtained written consent from a parent or guardian to work individually with the child or young person.

The evaluation team asked service providers to directly reach out to the young service user they have assessed as potential participants, and to their parent/guardian where necessary to gauge their interest and willingness to participate in an interview.

Where the young person (and where relevant their parent/guardian) expressed interest in participating in the evaluation, the service provider completed the EOI form. The service provider only shared the information requested in the form with the young person's assent and where required their parent/guardian's consent.

The evaluation team then contacted the young person or their parent/guardian (as appropriate) to confirm they have understood the research and that they still consented to participate. Where consent was provided, the evaluation team arranged an interview. The evaluation team also liaised their parent/guardian to establish:

- whether the young person required an interpreter to provide informed consent and to participate fully in an interview
- whether they had a preference as to the gender of their interviewer
- whether the young person had other accessibility needs
- whether the young person wanted to have a family member or support person at the interview, and the name of the person (to enable the service provider to screen for safety).

The evaluation's Children's Engagement Lead led all direct engagement with children and young people, and young service users were provided with the names of their interviewers prior to their interview. The approach to engagement was adapted based on the age and development stage of the young person and included observational and play-based engagement, as well as semi-structured interviews.

Young service user surveys

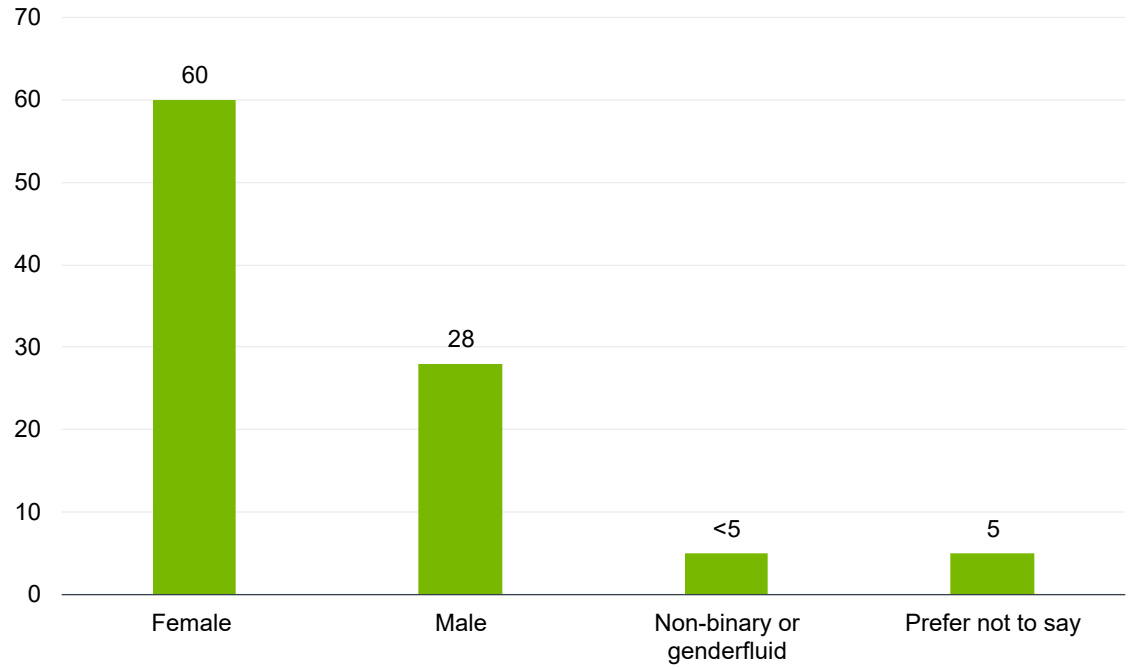
To recruit young people to respond to the survey, the evaluation team provided service providers with the link to the survey and information about the evaluation, encouraging them to invite service users to complete the survey where they consider it safe to do so, and in line with the inclusion and exclusion criteria. In assessing the safety of the child or young person's environment, the service providers were asked to consider the risk of family members or others accessing their personal information (e.g. watching them complete the survey).

Where a service provider assesses a young service user to be eligible and in circumstances which enabled them to complete the survey safely, they were asked to send the survey link:

- directly to the young service user, where the young person is aged 16 or older and is assessed by the service provider as being a mature minor
- to the parent/guardian of the young person where the young service user is under 16 or is not a mature minor. The parent/guardian was asked to provide consent before the young person completes the survey.

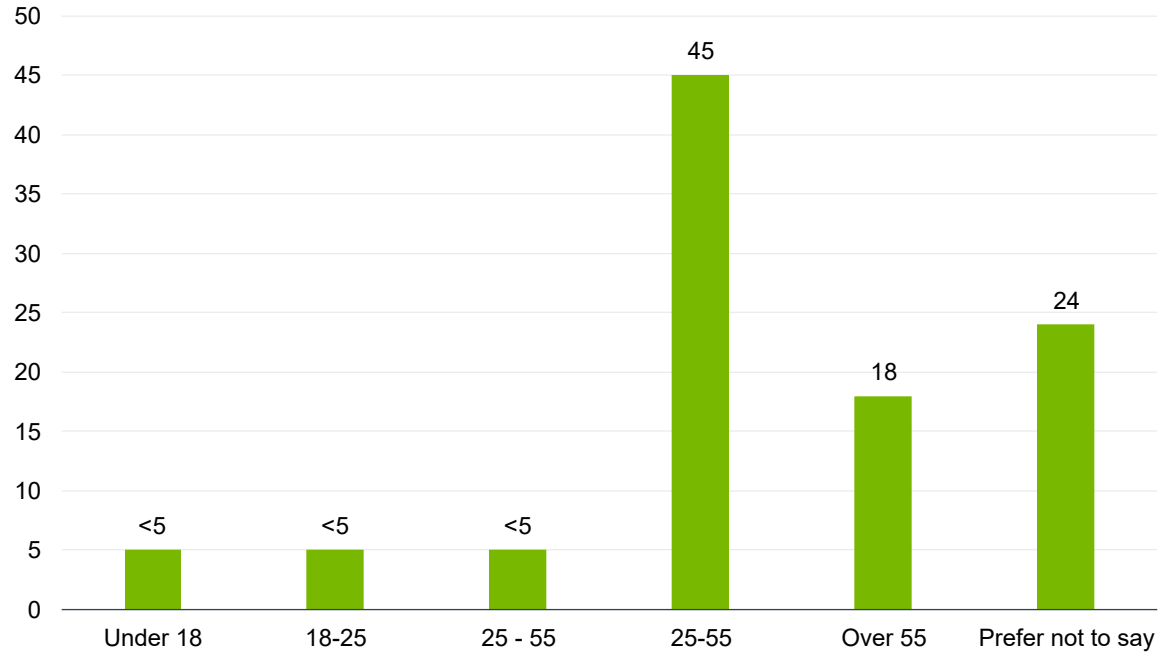
Appendix E: Service user demographic data – participant sample

Figure 49: Service user interview demographics – gender[23]



Source: Service user interview data

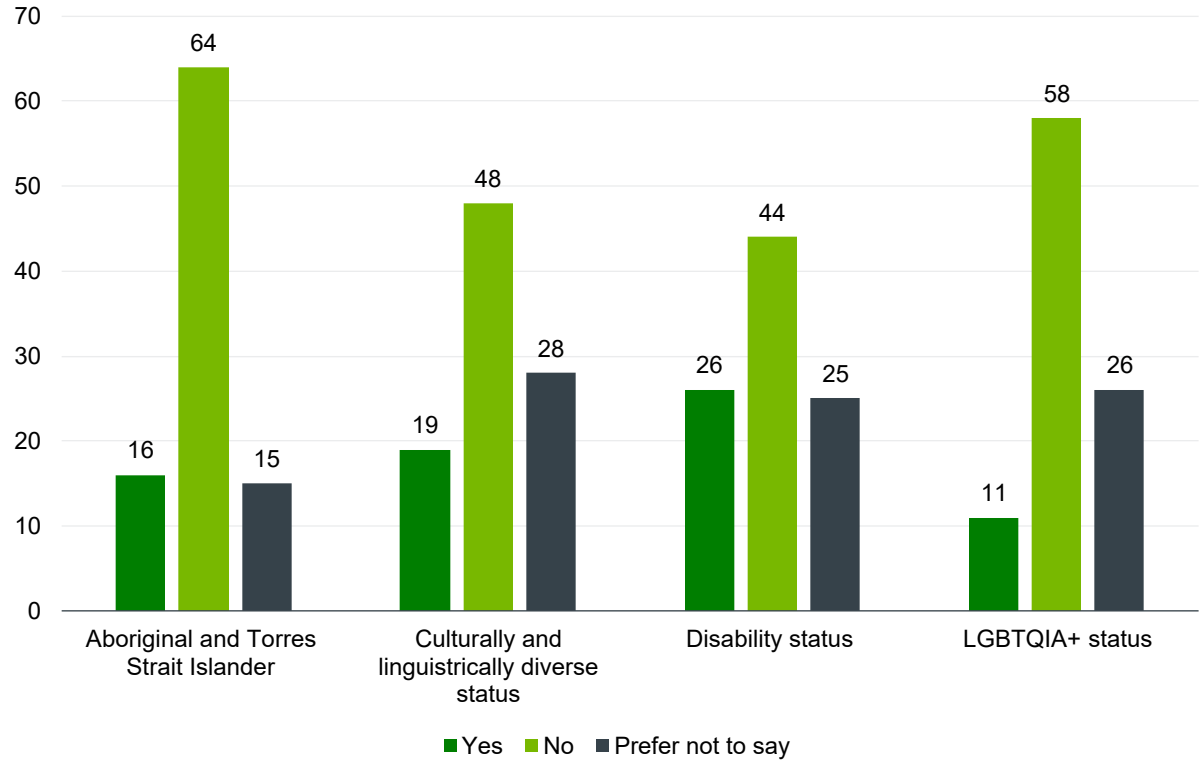
Figure 50: Service user interview demographics – age[24]



Source: Service user interview data

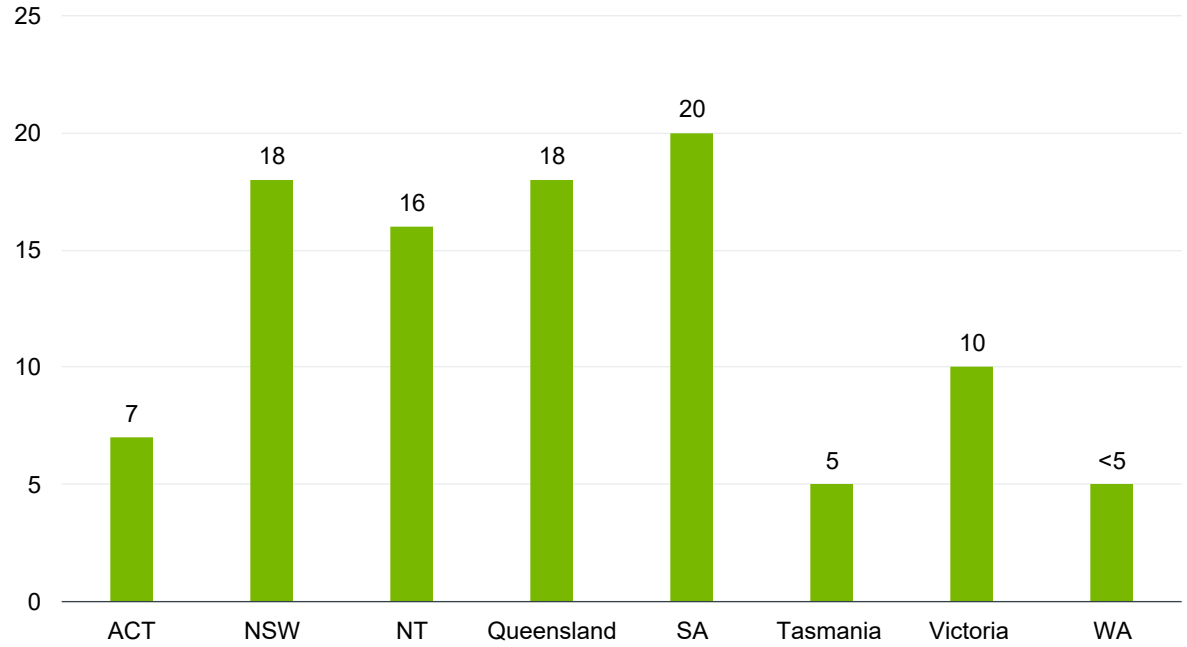
[23] Percentage count has been excluded from this bar chart as two categories received less than 5 respondents, necessitating measures to protect anonymity.
[24] Percentage count has been excluded from this bar chart as three categories received less than 5 respondents, necessitating measures to protect anonymity.

Figure 51: Service user interview demographics – priority cohorts



Source: Service user interview data

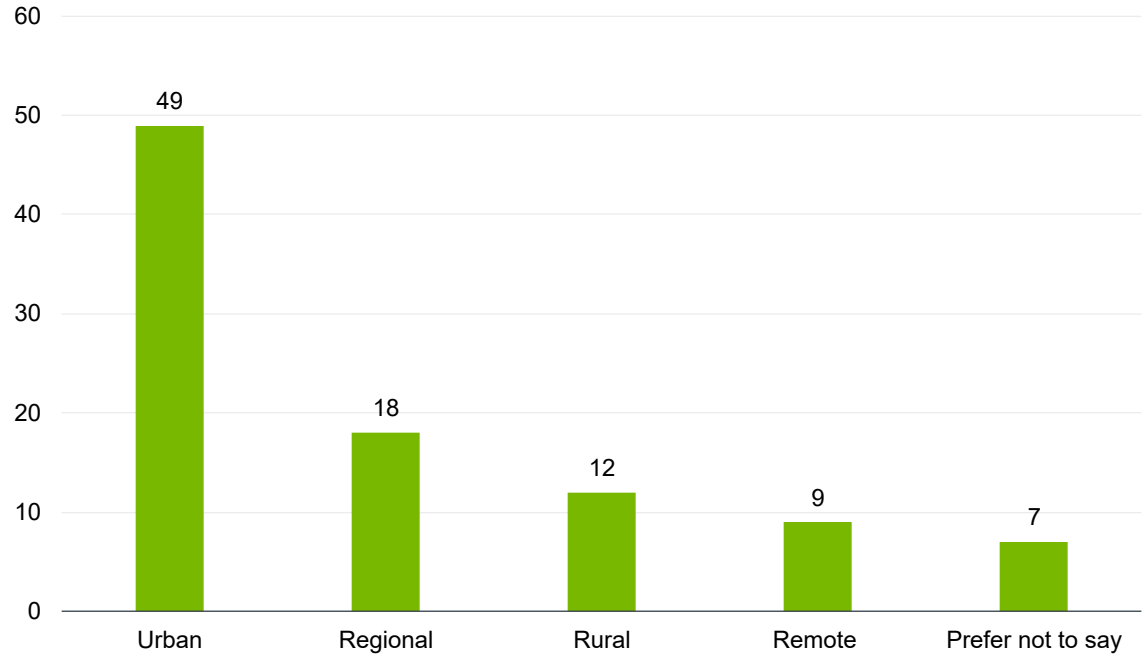
Figure 52: Service user interview demographics – state and territory[25]



Source: Service user interview data

[25] Percentage count has been excluded from this bar chart as one category received less than 5 respondents, necessitating measures to protect anonymity.

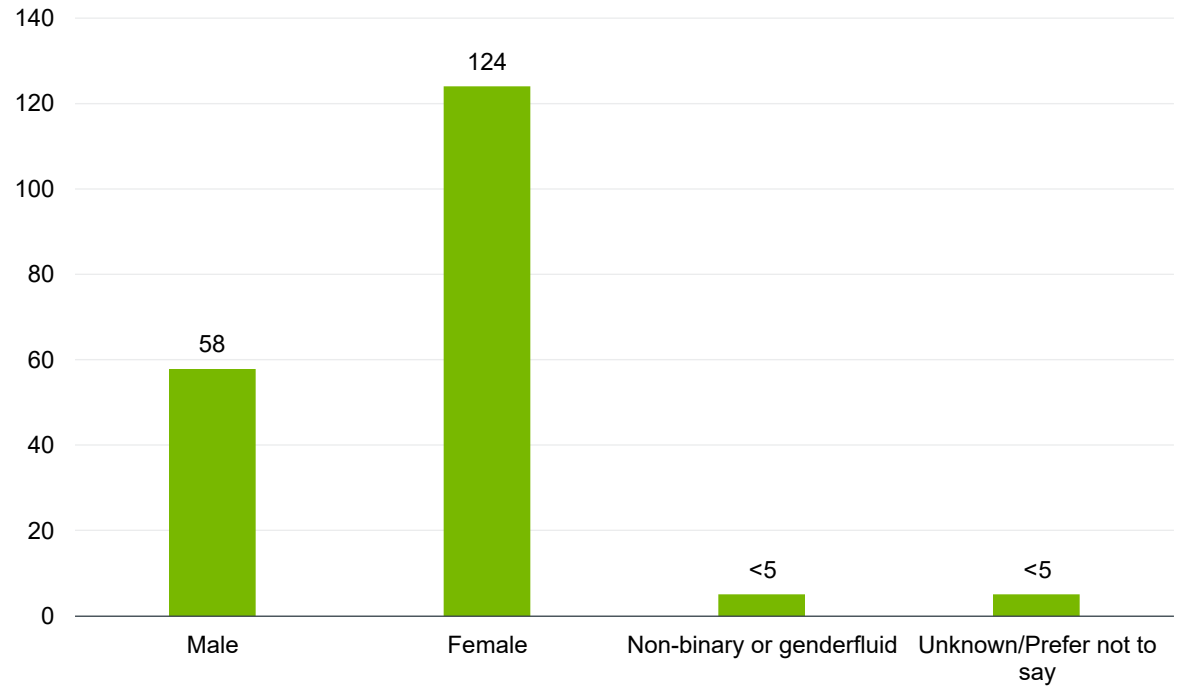
Figure 53: Service user interview demographics – geographic location



Source: Service user interview data

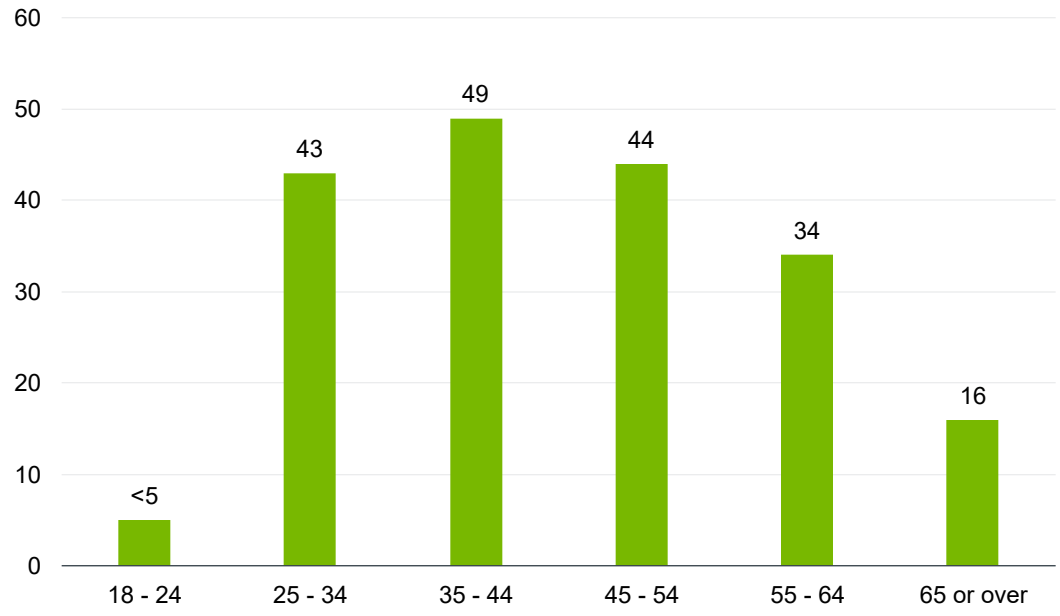
Service user survey – demographics

Figure 54: Service user survey demographics - gender[26]



Source: Service user survey data

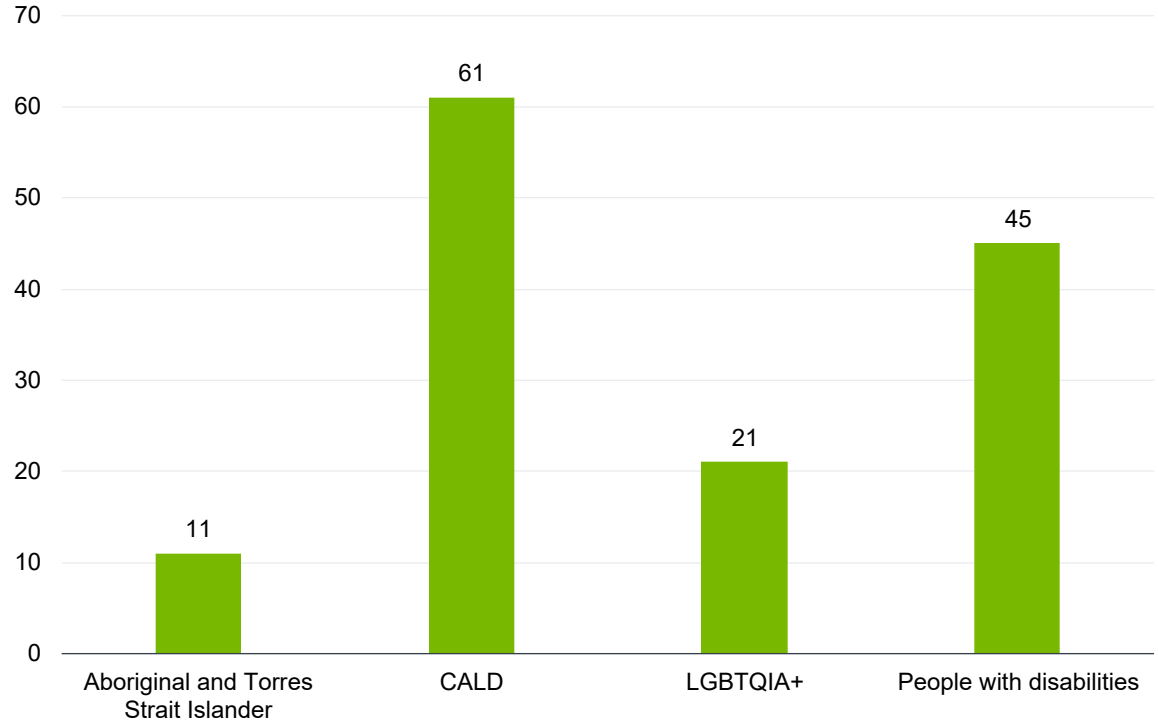
Figure 55: Service user survey demographics - age[27]



Source: Service user survey data

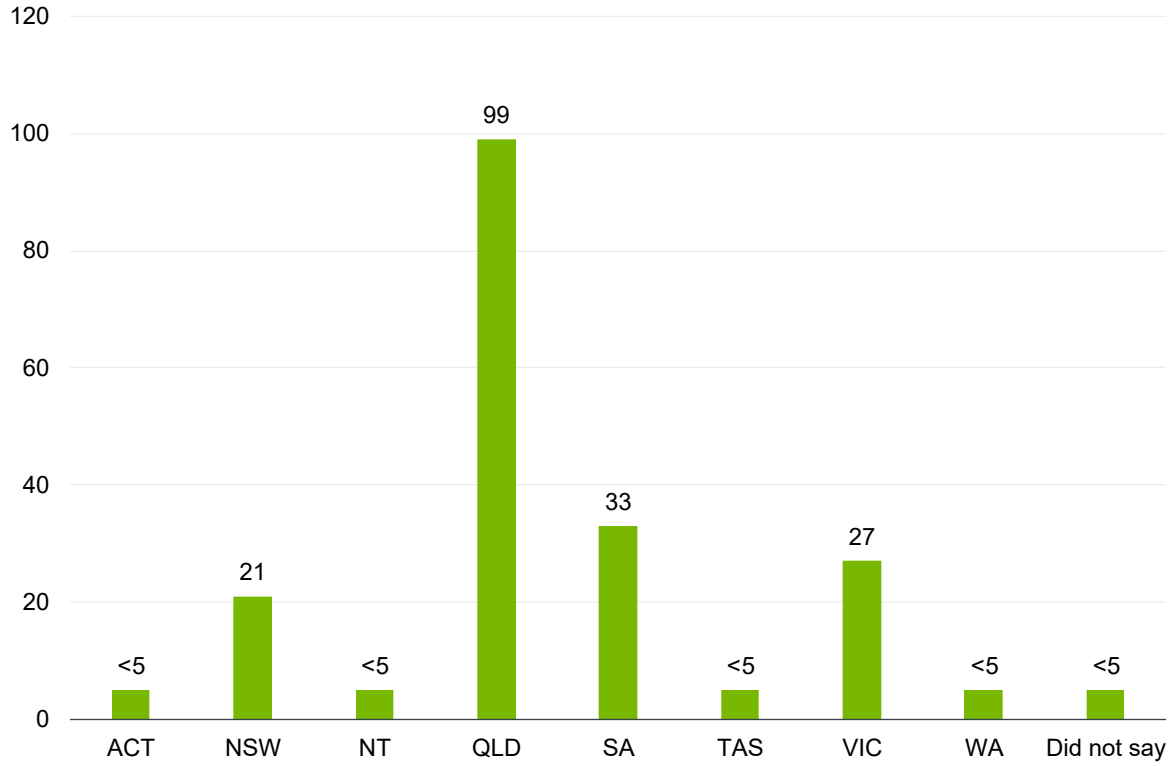
[26] Percentage count has been excluded from this bar chart as 2 categories received less than 5 respondents, necessitating measures to protect anonymity.
[27] Percentage count has been excluded from this bar chart as one category received less than 5 respondents, necessitating measures to protect anonymity.

Figure 56: Service user survey demographics – Priority cohorts



Source: Service user survey data

Figure 57: Service user survey demographics – state and territory[28]



Source: Service user survey data

[28] Percentage count has been excluded from this bar chart as several categories received less than 5 respondents, necessitating measures to protect anonymity.

Appendix F: DEX data

Changes between earliest and latest available assessments per client per outcome were analysed using the nonparametric Wilcoxon statistical test for relevant outcomes and for clients with at least two SCORE assessments per domain. A Bonferroni adjustment to the threshold for statistical significance was applied based on the total number of pairwise tests conducted for all cohorts and all domains including those not presented (1,132 tests). Test results are provided in summary tables below.

DEX data – FaRS and SFVS

Table 54: Mean earliest-to-latest SCORE change (within subjects) by Activity, July 2021 to June 2024

Activity	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Circumstances	Family functioning	0.8	225513256.5	66,488	<.001	54.9% (n=36,522)
		Mental health, wellbeing and self-care	0.8	189422241	61,150	<.001	55.5% (n=33,940)
		Personal and family safety	0.56	126318319.5	42,074	<.001	42.6% (n=17,913)
	Goals	Changed behaviours	1.06	55321950	42,922	<.001	64.5% (n=27,682)
		Changed impact of immediate crisis	1.09	17802843.5	22,742	<.001	66.4% (n=15,105)
		Changed knowledge and access to information	1.15	82701853	50,037	<.001	66.2% (n=33,137)
		Changed skills	1.03	97075543.5	53,207	<.001	63.9% (n=33,985)

		Empowerment, choice and control to make own decisions	0.96	68534107.5	40,682	<.001	61.0% (n=24,818)
		Engagement with relevant support services	0.94	38408386.5	28,319	<.001	60.4% (n=17,110)
SFVS (incl. 4AP2)	Circumstances	Family functioning	0.8	1404284.5	5,307	<.001	54.9% (n=2,911)
		Mental health, wellbeing and self-care	0.84	1464457	5,523	<.001	56.0% (n=3,092)
		Personal and family safety	0.91	1761403.5	6,292	<.001	57.0% (n=3,585)
	Goals	Changed behaviours	0.89	675204.5	3,864	<.001	57.2% (n=2,209)
		Changed impact of immediate crisis	1.17	234809.5	2,871	<.001	67.3% (n=1,932)
		Changed knowledge and access to information	1.07	605980	4,347	<.001	63.8% (n=2,772)
		Changed skills	0.92	616577	3,939	<.001	58.8% (n=2,318)
		Empowerment, choice and control to make own decisions	1.05	655602	4,257	<.001	62.2% (n=2,648)
		Engagement with relevant support services	0.96	433624.5	3,144	<.001	58.3% (n=1,833)

Source: DEX-SCORE data

Delivery mode

Table 55: Mean earliest-to-latest SCORE change (within-subjects) by delivery mode, FaRS service users, July 2021 to June 2024

Activity	Delivery mode	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	F2F	Circumstances	Family functioning	0.85	37162243	29,329	<.001	56.2% (n=16,472)
			Mental health, wellbeing and self-care	0.89	29523347	26,987	<.001	59.1% (n=15,945)
			Personal and family safety	0.65	14280141	15,770	<.001	45.6% (n=7,196)
		Goals	Changed behaviours	1.13	10728370	20,664	<.001	66.2% (n=13,687)
			Changed impact of immediate crisis	1.21	2860503	11,457	<.001	69.4% (n=7,948)
			Changed knowledge and access to information	1.36	9944109	22,025	<.001	71.2% (n=15,681)
			Changed skills	1.14	12905605.5	22,193	<.001	66.7% (n=14,803)
			Empowerment, choice and control to make own decisions	1.11	7996427	16,737	<.001	64.5% (n=10,791)
			Engagement with relevant support services	1.07	3455734.5	10,677	<.001	64.5% (n=6,886)
	Not reported	Circumstances	Family functioning	0.68	14649364.5	14,180	<.001	52.5% (n=7,451)

			Mental health, wellbeing and self-care	0.63	10648090.5	12,060	<.001	50.5% (n=6,096)
			Personal and family safety	0.44	9938616.5	10,207	<.001	39.3% (n=4,015)
		Goals	Changed behaviours	0.91	1271291	5,603	<.001	59.6% (n=3,337)
			Changed impact of immediate crisis	0.77	878643.5	3,450	<.001	58.0% (n=2,002)
			Changed knowledge and access to information	0.83	8561548	11,710	<.001	59.0% (n=6,910)
			Changed skills	0.91	7872701	12,700	<.001	60.3% (n=7,656)
			Empowerment, choice and control to make own decisions	0.86	6121886	9,965	<.001	60.0% (n=5,979)
			Engagement with relevant support services	0.71	5840973.5	8,724	<.001	53.5% (n=4,671)
	Virtual	Circumstances	Family functioning	0.78	8519614.5	14,207	<.001	52.2% (n=7,411)
			Mental health, wellbeing and self-care	0.73	8173719	13,581	<.001	51.1% (n=6,936)
			Personal and family safety	0.51	6262358.5	10,149	<.001	37.9% (n=3,851)
		Goals	Changed behaviours	0.99	2441469.5	9,709	<.001	62.9% (n=6,108)

			Changed impact of immediate crisis	0.97	586046	4,072	<.001	63.9% (n=2,604)
			Changed knowledge and access to information	1.08	2819564	1,0244	<.001	63.2% (n=64,74)
			Changed skills	0.92	3804629	11225	<.001	60.2% (n=6,760)
			Empowerment, choice and control to make own decisions	0.75	2988772	8541	<.001	53.0% (n=4,531)
			Engagement with relevant support services	1.04	891143	5053	<.001	62.7% (n=3,167)

Source: DEX-SCORE data

Table 56: Mean earliest-to-latest SCORE change (within-subjects) by delivery mode, SFVS service users, July 2021 to June 2024

Activity	Delivery mode	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (incl. 4AP2)	F2F	Circumstances	Family functioning	0.83	313271.5	2,745	<.001	54.1% (n=1,486)
			Mental health, wellbeing and self-care	0.89	307110	2,806	<.001	57.3% (n=1,607)
			Personal and family safety	0.79	359503.5	2,689	<.001	52.1% (n=1,401)
		Goals	Changed behaviours	0.99	129703	2,091	<.001	59.9% (n=1,253)
			Changed impact of immediate crisis	0.97	52454.5	1,274	<.001	57.9% (n=738)
			Changed knowledge and access to information	0.99	134041	2,110	<.001	59.6% (n=1,257)
			Changed skills	0.94	154520.5	2,020	<.001	59.2% (n=1,196)
			Empowerment, choice and control to make own decisions	0.92	139794.5	1,900	<.001	58.2% (n=1,106)
			Engagement with relevant support services	0.78	124363.5	1,441	<.001	52.0% (n=749)
	Not reported	Circumstances	Family functioning	0.68	105430.5	1,161	<.001	53.7% (n=623)
			Mental health, wellbeing and self-care	0.71	88294	1,179	<.001	52.4% (n=618)
			Personal and family safety	1.14	153219	2,184	<.001	65.1% (n=1,421)
		Goals	Changed behaviours	0.69	43708.5	753	<.001	51.4% (n=387)
			Changed impact of immediate crisis	1.5	13436	949	<.001	83.2% (n=790)
			Changed knowledge and access to information	1.31	42693	1,271	<.001	73.5% (n=934)

			Changed skills	0.99	33495	1,028	<.001	62.1% (n=638)
			Empowerment, choice and control to make own decisions	1.31	55815	1,351	<.001	69.4% (n=938)
			Engagement with relevant support services	1.25	28609.5	1,053	<.001	67.7% (n=713)
	Virtual	Circumstances	Family functioning	0.88	12142.5	633	<.001	55.8% (n=353)
			Mental health, wellbeing and self-care	0.92	17482	688	<.001	55.7% (n=383)
		Goals	Personal and family safety	0.78	23187.5	679	<.001	51.5% (n=350)
			Changed behaviours	0.89	9114.5	456	<.001	53.7% (n=245)
			Changed impact of immediate crisis	1.07	2670	265	<.001	60.8% (n=161)
			Changed knowledge and access to information	0.94	7487	407	<.001	59.2% (n=241)
			Changed skills	0.85	5372	380	<.001	53.7% (n=204)
			Empowerment, choice and control to make own decisions	0.88	7281	443	<.001	57.3% (n=254)
			Engagement with relevant support services	0.91	2413.5	251	<.001	56.2% (n=141)

DEX data – CALD

Table 57: Mean earliest-to-latest SCORE change (within-subjects) by CALD status, FaRS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Non-CALD	Circumstances	Family functioning	0.83	71210393.5	38,446	<.001	56.0% (n=21,522)
			Mental health, wellbeing and self-care	0.82	59372541.5	35,461	<.001	56.1% (n=19,900)
			Personal and family safety	0.59	38632546	23,881	<.001	44.0% (n=10,501)
		Goals	Changed behaviours	1.09	16571221	25,414	<.001	65.5% (n=16,636)
			Changed impact of immediate crisis	1.07	5743089.5	12,635	<.001	65.9% (n=8,332)
			Changed knowledge and access to information	1.24	24698444	28,864	<.001	69.1% (n=19,932)
			Changed skills	1.09	27874536.5	30,632	<.001	66.2% (n=20,273)
			Empowerment, choice and control to make own decisions	1.03	19833613.5	23,179	<.001	64.4% (n=14,923)
			Engagement with relevant support services	0.93	12427044	16,027	<.001	59.7% (n=9,573)
	CALD	Circumstances	Family functioning	0.76	278174	2,553	<.001	51.3% (n=1,309)
			Mental health, wellbeing and self-care	0.74	206791.5	2,108	<.001	51.8% (n=1,091)

			Personal and family safety	0.7	126464.5	1,419	<.001	46.9% (n=665)
		Goals	Changed behaviours	0.93	74385	1,468	<.001	59.3% (n=871)
			Changed impact of immediate crisis	0.94	16659.5	654	<.001	60.4% (n=395)
			Changed knowledge and access to information	1.29	105644.5	2,066	<.001	69.8% (n=1,442)
			Changed skills	1.01	105198.5	1,709	<.001	62.8% (n=1,073)
			Empowerment, choice and control to make own decisions	0.88	67197.5	1,310	<.001	60.0% (n=786)
			Engagement with relevant support services	0.92	43551.5	971	<.001	58.6% (n=569)

Source: DEX-SCORE data

Table 58: Mean earliest-to-latest SCORE change (within-subjects) by CALD status, SFVS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (incl. 4AP2)	Non-CALD	Circumstances	Family functioning	0.78	380785	2,784	<.001	53.6% (n=1,492)
			Mental health, wellbeing and self-care	0.84	353681	2,873	<.001	55.0% (n=1,579)
			Personal and family safety	0.93	501206.5	3,556	<.001	56.8% (n=2,019)
		Goals	Changed behaviours	0.9	200479.5	2,140	<.001	57.1% (n=1,221)
			Changed impact of immediate crisis	1.24	52488	1,621	<.001	70.4% (n=1,141)
			Changed knowledge and access to information	1.13	146116.5	2,380	<.001	65.7% (n=1,563)
			Changed skills	0.9	191876.5	2,174	<.001	58.8% (n=1,279)
			Empowerment, choice and control to make own decisions	1.06	177377	2,350	<.001	61.7% (n=1,451)
			Engagement with relevant support services	1.02	89282	1,648	<.001	59.4% (n=979)
	CALD	Circumstances	Family functioning	0.85	930	151	<.001	52.3% (n=79)
			Mental health, wellbeing and self-care	0.94	1040	179	<.001	58.7% (n=105)
			Personal and family safety	0.86	1109	172	<.001	57.6% (n=99)

		Goals	Changed behaviours	0.77	584	121	<.001	53.7% (n=65)
			Changed impact of immediate crisis	1.14	130.5	65	<.001	67.7% (n=44)
			Changed knowledge and access to information	0.8	1667	224	<.001	56.2% (n=126)
			Changed skills	0.81	725	127	<.001	53.5% (n=68)
			Empowerment, choice and control to make own decisions	1.1	593.5	129	<.001	62.0% (n=80)
			Engagement with relevant support services	1.05	165	66	<.001	60.6% (n=40)

Source: DEX-SCORE data

DEX data – disability

Table 59: Mean earliest-to-latest SCORE change (within-subjects) by disability status, FaRS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Persons without (or unknown) disabilities	Circumstances	Family functioning	0.81	193773169	61,884	<.001	55.0% (n=34,043)
			Mental health, wellbeing and self-care	0.79	163012115.5	56,730	<.001	55.5% (n=31,467)
			Personal and family safety	0.56	108398774	39,005	<.001	42.4% (n=16,556)
		Goals	Changed behaviours	1.07	45355294	39,405	<.001	65.0% (n=25,595)
			Changed impact of immediate crisis	1.09	14823301.5	20,879	<.001	66.7% (n=13,927)
			Changed knowledge and access to information	1.15	70663493	46,652	<.001	66.3% (n=30,948)
			Changed skills	1.03	82486878.5	49,425	<.001	64.1% (n=31,670)
			Empowerment, choice and control to make own decisions	0.96	58574025	37,763	<.001	61.0% (n=23,034)
			Engagement with relevant support services	0.94	32423845	26,147	<.001	60.6% (n=15,847)
	Persons with disabilities	Circumstances	Family functioning	0.77	1200154.5	4,604	<.001	53.8% (n=2,479)
			Mental health, wellbeing and self-care	0.82	991075.5	4,420	<.001	56.0% (n=2,473)

			Personal and family safety	0.59	685204.5	3,069	<.001	44.2% (n=1,357)
		Goals	Changed behaviours	0.93	490227	3,517	<.001	59.3% (n=2,087)
			Changed impact of immediate crisis	1.03	135794.5	1,863	<.001	63.2% (n=1,178)
			Changed knowledge and access to information	1.06	469150	3,385	<.001	64.7% (n=2,189)
			Changed skills	0.96	589611	3,782	<.001	61.2% (n=2,315)
			Empowerment, choice and control to make own decisions	0.96	389397	2,919	<.001	61.1% (n=1,784)
			Engagement with relevant support services	0.9	252994	2,172	<.001	58.1% (n=1,263)

Source: DEX-SCORE data

Table 60: Mean earliest-to-latest SCORE change (within-subjects) by disability status, SFVS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (incl. 4AP2)	Persons without (or unknown) disabilities	Circumstances	Family functioning	0.8	1092166	4,675	<.001	55.3% (n=2,585)
			Mental health, wellbeing and self-care	0.83	1162895.5	4,857	<.001	56.0% (n=2,719)
			Personal and family safety	0.89	1358440.5	5,413	<.001	56.6% (n=3,063)
		Goals	Changed behaviours	0.88	511762.5	3,309	<.001	57.1% (n=1,891)
			Changed impact of immediate crisis	1.15	181143.5	2,389	<.001	66.4% (n=1,586)
			Changed knowledge and access to information	1.06	462261.5	3,738	<.001	63.5% (n=2,374)
			Changed skills	0.93	480686	3,422	<.001	59.3% (n=2,028)
			Empowerment, choice and control to make own decisions	1.03	512750.5	3,695	<.001	62.3% (n=2,302)
			Engagement with relevant support services	0.95	332973	2,720	<.001	58.6% (n=1,595)
	Persons with disabilities	Circumstances	Family functioning	0.75	19610	632	<.001	51.6% (n=326)
			Mental health, wellbeing and self-care	0.86	17097.5	666	<.001	56.0% (n=373)

			Personal and family safety	1.02	25802	879	<.001	59.4% (n=522)
		Goals	Changed behaviours	0.94	11191.5	555	<.001	57.3% (n=318)
			Changed impact of immediate crisis	1.24	2868	482	<.001	71.8% (n=346)
			Changed knowledge and access to information	1.16	9669.5	609	<.001	65.4% (n=398)
			Changed skills	0.87	8102	517	<.001	56.1% (n=290)
			Empowerment, choice and control to make own decisions	1.18	8725	562	<.001	61.6% (n=346)
			Engagement with relevant support services	1.02	6628	424	<.001	56.1% (n=238)

Source: DEX-SCORE data

DEX data - Aboriginal and Torres Strait Islander

Table 61: Mean earliest-to-latest SCORE change (within-subjects) by Aboriginal and Torres Strait Islander status, FaRS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Non-First Nations (or unknown)	Circumstances	Family functioning	0.8	211968696	64,313	<.001	54.9% (n=35,333)
			Mental health, wellbeing and self-care	0.79	177667854.5	59,022	<.001	55.5% (n=32,764)
			Personal and family safety	0.56	118366768	40,537	<.001	42.6% (n=17,260)
		Goals	Changed behaviours	1.06	51630214	41,313	<.001	64.6% (n=26,702)
			Changed impact of immediate crisis	1.09	16515248	21,964	<.001	66.7% (n=14,651)
			Changed knowledge and access to information	1.14	77338065	48,264	<.001	66.2% (n=31,959)
			Changed skills	1.02	90448086	51,185	<.001	63.9% (n=32,721)
			Empowerment, choice and control to make own decisions	0.96	64170559	39,222	<.001	60.9% (n=23,903)
			Engagement with relevant support services	0.94	35470137	27,175	<.001	60.6% (n=16,463)
	First Nations	Circumstances	Family functioning	0.87	208863	2,175	<.001	54.7% (n=1,189)

			Mental health, wellbeing and self-care	0.88	186566	2,128	<.001	55.3% (n=1,176)
			Personal and family safety	0.58	125344.5	1,537	<.001	42.5% (n=653)
		Goals	Changed behaviours	1.06	61843	1,609	<.001	60.9% (n=980)
			Changed impact of immediate crisis	0.94	24270.5	778	<.001	58.4% (n=454)
			Changed knowledge and access to information	1.21	89337	1,773	<.001	66.4% (n=1,178)
			Changed skills	1.08	115840	2,022	<.001	62.5% (n=1,264)
			Empowerment, choice and control to make own decisions	1.07	71388	1,460	<.001	62.7% (n=915)
			Engagement with relevant support services	0.88	58044.5	1,144	<.001	56.6% (n=647)

Source: DEX-SCORE data

Table 62: Mean earliest-to-latest SCORE change (within-subjects) by Aboriginal and Torres Strait Islander status, SFVS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (including 4AP2)	Non-First Nations (or unknown)	Circumstances	Family functioning	0.81	1217416	5006	<.001	55.3% (n=2770)
			Mental health, wellbeing and self-care	0.85	1288794	5204	<.001	56.4% (n=2933)
			Personal and family safety	0.92	1513754	5865	<.001	57.2% (n=3356)
		Goals	Changed behaviours	0.9	581974	3617	<.001	57.4% (n=2075)
			Changed impact of immediate crisis	1.17	197106	2643	<.001	67.4% (n=1781)
			Changed knowledge and access to information	1.07	533072	4051	<.001	63.7% (n=2582)
			Changed skills	0.93	530439.5	3680	<.001	59.0% (n=2171)
			Empowerment, choice and control to make own decisions	1.06	569636	3982	<.001	62.6% (n=2491)
			Engagement with relevant support services	0.96	366741.5	2883	<.001	58.6% (n=1688)
	First Nations	Circumstances	Family functioning	0.55	6575.5	301	<.001	46.8% (n=141)
			Mental health, wellbeing and self-care	0.65	5615.5	319	<.001	49.8% (n=159)

			Personal and family safety	0.84	9375	427	<.001	53.6% (n=229)
		Goals	Changed behaviours	0.75	3456	247	<.001	54.3% (n=134)
			Changed impact of immediate crisis	1.13	1652	228	<.001	66.2% (n=151)
			Changed knowledge and access to information	1.17	2334.5	296	<.001	64.2% (n=190)
			Changed skills	0.8	3243	259	<.001	56.8% (n=147)
			Empowerment, choice and control to make own decisions	0.89	3021	275	<.001	57.1% (n=157)
			Engagement with relevant support services	0.94	2779	261	<.001	55.6% (n=145)

Source: DEX-SCORE data

DEX data – gender

Table 63: Mean earliest-to-latest SCORE change (within-subjects) by gender, FaRS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Females	Circumstances	Family functioning	0.82	28650418.5	24,337	<.001	55.4% (n=13,483)
			Mental health, wellbeing and self-care	0.83	23236832.5	22,566	<.001	56.6% (n=12,774)
			Personal and family safety	0.62	15206209	15,022	<.001	45.5% (n=6,833)
		Goals	Changed behaviours	1.09	6460648.5	15,713	<.001	65.5% (n=10,285)
			Changed impact of immediate crisis	1.05	2537232.5	8,168	<.001	65.3% (n=5,335)
			Changed knowledge and access to information	1.25	10125029	18,380	<.001	69.4% (n=12,750)
			Changed skills	1.08	11540639	19,207	<.001	66.1% (n=12,704)
			Empowerment, choice and control to make own decisions	1.05	7739518	14,917	<.001	64.9% (n=9,683)
			Engagement with relevant	0.93	4964442	10,107	<.001	59.5% (n=6,016)

			support services					
	Males	Circumstances	Family functioning	0.84	12031239	16,046	<.001	56.3% (n=9,035)
			Mental health, wellbeing and self-care	0.8	10270918	14,420	<.001	54.8% (n=7,902)
			Personal and family safety	0.56	6660335	9,926	<.001	42.1% (n=4,181)
		Goals	Changed behaviours	1.08	2977708	10,784	<.001	64.7% (n=6,973)
			Changed impact of immediate crisis	1.08	766253	4,863	<.001	66.4% (n=3,228)
			Changed knowledge and access to information	1.23	4119813	12,067	<.001	68.6% (n=8,272)
			Changed skills	1.09	4508582	12,701	<.001	65.8% (n=8,363)
			Empowerment, choice and control to make own decisions	0.99	3407095	9,197	<.001	63.0% (n=5,797)
			Engagement with relevant support services	0.94	2078222	6,600	<.001	60.0% (n=3,960)

Table 64: Mean earliest-to-latest SCORE change (within-subjects) by gender, SFVS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (including 4AP2)	Non-First Nations (or unknown) Females	Circumstances	Family functioning	0.78	188497	1,933	<.001	54.5% (n=1,053)
			Mental health, wellbeing and self-care	0.84	175200	2,040	<.001	55.8% (n=1,138)
			Personal and family safety	0.97	263998.5	2,669	<.001	59.3% (n=1,582)
		Goals	Changed behaviours	0.84	79989	1,285	<.001	56.5% (n=726)
			Changed impact of immediate crisis	1.3	29784.5	1,292	<.001	72.4% (n=935)
			Changed knowledge and access to information	1.17	81270.5	1,813	<.001	66.6% (n=1,208)
			Changed skills	0.94	78249	1,560	<.001	60.3% (n=941)
			Empowerment, choice and control to make own decisions	1.13	96379.5	1,881	<.001	64.3% (n=1,209)
			Engagement with relevant support services	1.06	53592	1,302	<.001	61.0% (n=794)
	First Nations Males	Circumstances	Family functioning	0.79	42048.5	964	<.001	51.6% (n=497)
			Mental health, wellbeing and self-care	0.84	41919.5	973	<.001	53.5% (n=521)

			Personal and family safety	0.8	45588	1,001	<.001	50.0% (n=500)
		Goals	Changed behaviours	0.97	34023	948	<.001	57.5% (n=545)
			Changed impact of immediate crisis	1.03	3918.5	370	<.001	63.2% (n=234)
			Changed knowledge and access to information	0.97	18200	762	<.001	60.9% (n=464)
			Changed skills	0.81	29885	703	<.001	55.2% (n=388)
			Empowerment, choice and control to make own decisions	0.81	16751	564	<.001	53.5% (n=302)
			Engagement with relevant support services	0.9	5949.5	386	<.001	54.1% (n=209)

Source: DEX-SCORE data

DEX data – age

Table 65: Mean earliest-to-latest SCORE change (within-subjects) by age group, FaRS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
FaRS	Adults	Circumstances	Family functioning	0.78	193521509	60,992	<.001	54.5% (n=33,247)
			Mental health, wellbeing and self-care	0.76	161649720.5	55,723	<.001	54.7% (n=30,487)
			Personal and family safety	0.55	108367080.5	38,622	<.001	42.4% (n=16,387)
		Goals	Changed behaviours	1.03	45947461.5	38,689	<.001	64.1% (n=24,815)
			Changed impact of immediate crisis	1.08	14871042.5	20,651	<.001	66.5% (n=13,737)
			Changed knowledge and access to information	1.13	69932899	45,589	<.001	66.2% (n=30,169)
			Changed skills	1	81980871	4,8291	<.001	63.3% (n=30,575)
			Empowerment, choice and control to make own decisions	0.92	58723722	36,924	<.001	60.2% (n=22,245)
			Engagement with relevant support services	0.94	31939798	25,714	<.001	60.5% (n=15,555)
	Under 18 years	Circumstances	Family functioning	1.06	1160552.5	5,376	<.001	59.6% (n=3,202)
			Mental health, wellbeing and self-care	1.13	1020058.5	5,306	<.001	63.8% (n=3,383)
			Personal and family safety	0.63	639154	3,376	<.001	44.4% (n=1,500)

		Goals	Changed behaviours	1.32	396926	4,144	<.001	67.9% (n=2,812)
			Changed impact of immediate crisis	1.11	120838.5	2,035	<.001	65.5% (n=1,333)
			Changed knowledge and access to information	1.3	492657	4,365	<.001	66.8% (n=2,915)
			Changed skills	1.34	585424	4,806	<.001	69.6% (n=3,343)
			Empowerment, choice and control to make own decisions	1.38	344957	3671	<.001	68.6% (n=2,520)
			Engagement with relevant support services	0.98	280275.5	2,548	<.001	60.0% (n=1,528)

Source: DEX-SCORE data

Table 66: Mean earliest-to-latest SCORE change (within-subjects) by age group, SFVS service users, July 2021 to June 2024

Activity	Cohort	Outcome type	Domain	SCORE change (mean)	Wilcoxon	n	p	Service users with positive change (%, n)
SFVS (incl. 4AP)	Adults	Circumstances	Family functioning	0.82	973064.5	4,578	<.001	55.8% (n=2,554)
			Mental health, wellbeing and self-care	0.84	1062158.5	4,801	<.001	55.8% (n=2,680)
			Personal and family safety	0.93	1351010	5,596	<.001	57.4% (n=3,211)
		Goals	Changed behaviours	0.88	512363.5	3,412	<.001	56.8% (n=1,937)
			Changed impact of immediate crisis	1.16	191139	2,611	<.001	67.5% (n=1,763)
			Changed knowledge and access to information	1.09	444343.5	3,808	<.001	64.7% (n=2,463)
			Changed skills	0.91	443750	3,436	<.001	58.5% (n=2,010)
			Empowerment, choice and control to make own decisions	1.07	485761.5	3,823	<.001	62.6% (n=2,392)
			Engagement with relevant support services	1	257457	2,689	<.001	59.5% (n=1,599)
	Under 18 years	Circumstances	Family functioning	0.63	35689	704	<.001	48.2% (n=339)
			Mental health, wellbeing and self-care	0.81	30193	696	<.001	56.2% (n=391)
			Personal and family safety	0.77	25547	674	<.001	53.6% (n=361)
		Goals	Changed behaviours	0.97	9862	442	<.001	60.4% (n=267)
			Changed impact of immediate crisis	1.22	2074.5	255	<.001	65.1% (n=166)

			Changed knowledge and access to information	0.94	11879.5	526	<.001	57.6% (n=303)
			Changed skills	1.04	12482	494	<.001	61.5% (n=304)
			Empowerment, choice and control to make own decisions	0.9	10882	420	<.001	59.0% (n=248)
			Engagement with relevant support services	0.75	17094.5	435	<.001	51.0% (n=222)

Source: DEX-SCORE data

Appendix G:Bibliography

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