Eastern Metropolitan
REGIONAL
FAMILY
VIOLENCE
PARTNERSHIP

Healing Interrupted: Systemic Barriers and Service Gaps Impacting Family Violence Recovery in Eastern Melbourne

Family Violence Therapeutic Working Group

November 2025

Acknowledgement of Country

The RFVP respectfully Acknowledge the Wurundjeri Woi Wurrung people and the Bunurong people who are the Traditional Owners of the Lands & Waterways on which we work.
We would like to express our deepest gratitude to all Elders Past, Present and future generations and extend that to all Aboriginal and Torres Strait Islander peoples, who have the Cultural and Spiritual connection to Land and Waterways.
We Recognise, Respect and Honour the Ancestors who lived on the land as free spirits for more than 65,000 Years. The RFVP strive for Equality, Safety & Commit to building a Brighter, Safer Future Together.

Colonisation and its ongoing impacts

We recognise that the violent dispossession of land and violation of rights perpetrated by successive governments and settlers has had profound and ongoing impacts for Aboriginal and Torres Strait Islander peoples. The oppression committed, including violence and abuse, forced removal of children from their families, stolen wages and economic exploitation, forced relocations and forced assimilation, has caused intergenerational and collective trauma, as well as broader inequity. Systemic racism, colonisation and discrimination continue to contribute to the disproportionately high rates of family violence experienced by Aboriginal and Torres Strait Islander women and children, which in many instances is perpetrated by non-Indigenous people who benefit from these systemic inequities and weaponise them as part of their pattern of violence. Addressing historical and ongoing injustices committed against Aboriginal and Torres Strait Islander peoples must be prioritised in our efforts to realise a world without family violence.

Recognition of Lived Experience

We recognise all who have experienced, or have been affected by, family violence and those who have lost their lives due to family violence. We are committed to working in partnership with Lived Experience Advocates and recognise the value of their knowledge in every aspect of our work.

Thank you to the following partner organisations who contributed to this report:

Anglicare
Australian Childhood Foundation
Boorndawan Willam Aboriginal Healing Service
Crossway Lifecare
Doncare
Each
Eastern Centre Against Sexual Assault
Family Access Network
FVREE
healthAbility
Statewide Children's Resource Program
The Orange Door
Uniting Vic Tas
VACCA

Thank you to the four lived experience advocates that shared their extensive insights of the service system and navigating support for their ongoing healing and recovery. Your experiences and quotes have shaped this report.

About the Regional Family Violence Partnership (RFVP)

The RFVP exists to foster a community where family violence is prevented and responded to holistically. Through leadership, advocacy, and professional and lived expertise, we integrate and optimise local systems, enhance workforce and community capacity, and advance equity and social justice.

The RFVP is the Family Violence Regional Integration Committee (FVRIC) of the Eastern Melbourne Area. The Eastern Melbourne Area covers the two Department of Families, Fairness and Housing (DFFH) areas of Inner Eastern Melbourne and Outer Eastern Melbourne, encompassing the seven Local Government Areas (LGAs) of Boorondara, Monash, Manningham, Whitehorse, Maroondah, Knox and Yarra Ranges.

The RFVP has representation from specialist family violence services as well as broader cross-sector organisations and alliances whose work intersects with family violence prevention, early intervention, response and recovery. RFVP members are leaders active in strengthening the family violence service system and ending family violence in the Eastern Melbourne Area.

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Executive Summary

This report from the Family Violence Therapeutic Working Group (FVTWG), a working group of the Regional Family Violence Partnership (RFVP), provides a critical, practice-informed analysis of the current state of therapeutic support for victim survivors of family violence in the Eastern Melbourne area. Building on the findings of the FVTWG's 2022 Issues Paper on Family Violence Therapeutic Service Capacity, the report examines how the service system has evolved and where further change is needed.

In April 2024, the FVTWG convened an initial workshop to test whether the issues they identified in 2022 remained current. Guided by the seven themes from the original Issues Paper, members from fourteen organisations, and two lived experience advocates, reviewed current service system experiences and synthesised their reflections into higher-level issues. This process revealed concerns extending beyond therapeutic programs to the need for a therapeutic response embedded across all stages of a client's journey. Over multiple workshops, the working group drew on practice knowledge, system mapping, and lived experience insights to identify key system barriers, emerging innovations, and transformative opportunities. As such, this report considers broader systemic issues that adversely impact on healing from family violence, not just those narrowly related to therapeutic intervention.

Misalignment Between Needs and Systems

A recurring challenge raised by contributors to this report is the persistent misalignment between the specific needs of clients and the limited, rigid service options available to them. Many organisations reported the difficulty of supporting victim survivors within service models that prioritise outputs and performance metrics over flexibility and individualised care. Lived Experience Advocates consistently expressed that they were rarely asked what they wanted or needed when accessing services and instead were referred to programs that did not align with their readiness, context, or recovery stage.

Healing and recovery approaches must be understood as existing along a continuum. Some interventions are appropriate in crisis, while others are better suited for later in the healing journey. However, the service system often applies a 'one-size-fits-all' model. This inflexibility leaves many victim survivors, particularly children and young people, and those with complex or evolving needs, falling through the cracks. Genuinely client-centred and trauma-informed responses require services to be agile and relational. This involves engaging in open, respectful and trauma-informed conversations with clients to understand what is most helpful for them at a given time, and ensuring that systems adapt to the individual, rather than the reverse.

Sector-wide Findings

This report identifies several critical themes:

Inflexible funding and reporting models prevent practitioners from working in trauma-informed, holistic, and culturally safe ways. Service targets often force early closure of therapeutic relationships even when continuity is essential for safety and healing.

Children and young people remain systemically invisible in both data collection and service design. Age-appropriate service responses for children and young people are lacking and their victimhood is frequently minimised or subsumed under that of a protective parent.

Wraparound, integrated support models combining therapeutic, practical, and advocacy support are currently rare and unfunded, despite their effectiveness. Initiatives like FVREE's Reimagining Pilot and Doncare's DAWN program show strong promise and deserve investment and formal evaluation.

Goal-based models reinforce unrealistic timeframes for recovery and can retraumatise clients by pressuring them into services before they are ready. Survivor-led Resources for Healing and Recovery developed in the Eastern Melbourne Area offer a viable alternative – replacing clinical goals with client-identified priorities and relationally guided session work.

Therapeutic responses for people using violence are underdeveloped. Men's Behaviour Change Programs (MBCPs), while important, do not meet the needs of many users of violence. There is a need to embed trauma-informed therapeutic responses for this group alongside accountability measures.

Workforce sustainability is at risk due to short-term funding, vicarious trauma, and high administrative burdens. Peer workers and lived experience advocates are still underutilised and underfunded, despite their potential to contribute to trauma-informed and client-led recovery.

Priority Areas for consideration

The report outlines a clear agenda for governments, funding bodies, and sector leaders in the Eastern Melbourne Area, including:

Adopt long-term therapeutic funding models that reflect the real timelines of healing. Services must be resourced to provide continuity of care over a minimum of 12 months, with flexibility to respond to periods of risk escalation and stabilisation.

Recognise therapeutic recovery as a core component of family violence response, not a final step. Integrating therapeutic support earlier in the service journey, including during crisis periods, can enhance safety, emotional regulation, and long-term recovery outcomes.

Promote language change within organisations, moving away from 'goalsetting' in client engagement and reporting, toward language that supports empowerment, safety, and dignity.

Support continued implementation of the Survivor-led Resources for Healing and Recovery through the development of a pilot project.

Develop and trial survivor-led outcomes reporting models, moving away from goal and target reporting and towards holistic and relational indicators of progress.

Advocate for therapeutic services to be formally recognised as core allocations within The Orange Door (TOD) Sector Report. This would more accurately reflect demand and elevate therapeutic recovery as essential, not supplementary.

Engage family violence therapeutic experts to design a long-term, evidence-based program aligned with best practice in trauma recovery.

RFVP member organisations to develop congruent policies and processes for sharing of MARAM risk assessments with therapeutic services and programs.

Advocate to the Australian Association of Social Workers and the Australian Psychological Society for the inclusion of more comprehensive, applied content on family violence, including work with children and young people across undergraduate and postgraduate programs.

Explore options for earlier therapeutic responses, including in first contact and risk escalation contexts.

Strengthen pathways for individuals considering leaving a violent relationship through access to therapeutic and case management support during pre-separation stages, not just after departure.

Improve integration between programs for victim survivors and those working with people who use violence, especially where there are opportunities to collaborate and ensure the safety and accountability of all parties involved in line with the MARAM Framework and Information Sharing Schemes.

Develop stronger partnerships with the Family Court to ensure referrals are made to specialist family violence therapeutic services, rather than to general family therapy or private practitioners who may lack the expertise to safely and effectively respond.

Opportunities for Research and University Partnership

The report identifies several priority areas for further research and university collaboration:

Scope and study unmet demand in the therapeutic response system, identifying where and why people are unable to access the support they need, and the outcomes of these service gaps.

Conduct a client experience project, to understand the recovery and healing journey of clients who have received siloed responses; versus a wraparound model of case management and therapeutic recovery.

Evaluate the impact of Survivor-led Resources for Healing and Recovery and outcomes reporting on practice and client experience.

Investigate the efficacy of multidisciplinary, creative, and non-traditional therapeutic interventions in trauma recovery.

Examine therapeutic needs and responses for people who use violence to support accountability and change.

To facilitate this, the report will be provided to Deakin, Swinburne, Latrobe and Monash Universities to support opportunities for postgraduate research and interdisciplinary exploration.

While specific recommendations for marginalised groups are not detailed, equity remains a priority. All initiatives will be guided by an intersectional approach, with the unique experiences and needs of diverse communities embedded throughout our work.

Introduction

The Eastern Metropolitan Regional Family Violence Partnership (RFVP) Family Violence Therapeutic Working Group (FVTWG) formed in 2020 and since this time has been exploring family violence therapeutic service system capacity in the Eastern Melbourne Area. In July 2022 the group produced the '**Family Violence Therapeutic Service Capacity – Issues Paper**'. The purpose of the paper was to understand the issues contributing to the high demand for services and limited capacity to respond to client needs and propose potential solutions.

The FVTWG has progressed several initiatives to tackle the identified issues. The **Therapeutic Programs Hub** on the RFVP website continues to be expanded to ensure clients are able to identify and access therapeutic support that addresses their needs. A 'backend' capacity spreadsheet was created to compliment the hub by streamlining the warm referral process between referring agencies and therapeutic services in the East. The effectiveness of this approach has not been evaluated but anecdotally, positive feedback has been received from The Inner and Outer Eastern Melbourne Area Orange Doors and the participating agencies state that the spreadsheet is being utilised and it has been beneficial to identify available programs, waitlist periods, and preferred referral processes.

The **Survivor-led Resources for Healing and Recovery** were designed and developed by lived experience advocates in 2023 based on recommendations from an advocate consultation that explored the concept of therapeutic readiness and application of 'goal setting' tools. The advocates told us that the concept of 'goals' and 'goal setting' can be problematic because this language can implicitly place a burden on victim survivors to achieve these goals. If goals are not achieved, further messages of shame or not being good enough can be triggered which in turn can replicate some of the abuse related messages victim survivors experienced. After this consultation, several organisations took the step to review their use of this language, however funding models which use this language have not changed. Use of the Survivor-led Resources for Healing and Recovery is commencing in several Eastern Melbourne area organisations and further implementation is currently being explored.

In April 2024 the FVTWG undertook a workshop to explore if the issues identified in 2022 were still current. Using the seven themes from the original issues paper, the working group members from fourteen organisations, and two lived experience advocates, discussed and documented what was currently occurring and experienced in and by the service system. The items were then themed into higher level issues and unpacked in further detail over further workshops and working group meetings over an 18-month period. The group uncovered issues beyond the therapeutic programs in the region and highlighted issues relating to a therapeutic response that is required across all phases of a client's journey. Thus, this report has extended beyond issues narrowly related to therapeutic intervention.

The intention of this paper is to transparently report on current issues and invite collaborative efforts to action the recommendations and suggested solutions. It has drawn on practice-based evidence and lived experience from the Eastern Melbourne area. The paper is not intended to be an academic paper or a review of all of the available research; as such, there is limited referencing throughout.

The quotes in this report are directly from lived experience advocates engaged by the RFVP. Their insights highlight why our continued focus on supporting long-term healing and recovery from family violence is so crucial.

Client Centred Response, Funding and Service Models

The need to provide a client-centred response for healing and recovery was identified as a key issue. However, the ability to provide this was found to be inherently linked to the way in which service models are designed and funded.

In order for responses to be truly client-centred, funding and service models must align with the needs of adults, young people and child victim survivors. Although there continues to be a level of inappropriate referrals to therapeutic services, as found in the 2022 'Family Violence Therapeutic Service Capacity – Issues Paper', this issue appears to stem from rigid and under-resourced systems that cannot respond flexibly. Fluid models of support that shift the focus to meeting individual needs, rather than the reporting needs and service delivery requirements of an organisation, are crucial.

Currently, inflexible funding and reporting requirements are not congruent with how we heard practitioners and victim survivors want and need to work to achieve meaningful outcomes. In effect, the rigid systems are constraining practitioners' ability to deliver client-centred support.

Funding often only allows for a short to medium term response, however evidence suggests that trauma informed intervention would require a longer term of support and/or engagement for meaningful and lasting benefit.

In 2023 the Eastern Regional Coordinators published 'Understanding Complex Support Needs of Clients in the Eastern Metropolitan Region'[1]. This resource illustrates the journey of three complex needs personas through the Eastern Melbourne area's health and community support services. The resource illustrates client journey timelines, and the way in which system characteristics can prolong this journey. For example, each of the three personas begins their therapeutic journey more than a year after first entering the system. This includes the victim-survivor 'Maddison' needing to navigate the service system herself. System barriers serve to delay therapeutic support and burden victim survivors instead of supporting them.

Overall, services are not funded to provide holistic support to a client and as such are not seeing and meeting the needs of a person as a whole.

> **"When services collaborate and involved me in the process that is when it gave me a sense of agency and control over my own life."**

Clients are also experiencing significant barriers when attempting to reengage with therapeutic services as their circumstances evolve. Victim survivors express the need for flexible, ongoing access to support that recognises their right to choose when and how they engage with services, rather than being confined to rigid, time-limited interventions. This is especially critical in Aboriginal specialist family violence services, where the ability to reconnect is often restricted by service agreements and funding cycles that do not align with the realities of healing and recovery. To ensure culturally safe, trauma-informed, and survivor-led support, funding models must be restructured to prioritise flexibility and long-term engagement. This includes drawing on the wisdom and models of Aboriginal Community Controlled Organisations, which already embed community-led, responsive approaches into their service delivery.

Too often, vital programs rely on short-term or philanthropic funding to be trialled and sustained. Family Access Network's 'Creative Arts Therapy Program' based in Box Hill has fortunately now secured long-term funding following a successful pilot that demonstrated strong engagement with young LGBTIQA+ people impacted by family violence, particularly those who had previously struggled to connect with services. This is an excellent outcome, though not always the case for other proven programs, many of which continue to face uncertainty despite clear evidence of their effectiveness.

[1] Eastern Regional Coordinators (2023), Understanding Complex Support Needs of Clients in the Eastern Metropolitan Region

Case Study: Rebuilding Life and Connection After Family Violence

Participant in the TRAK Forward Recovery Program

A program of Anglicare Victoria offering specialist therapeutic Family Violence recovery for non-offending adults, children and young people.

Four years ago, after multiple unsuccessful attempts to leave a violent and controlling relationship, a mother made the decision to leave with her two young children - then aged ten months and four years - and her elderly father. With no clear destination in mind, she fled in search of safety, driven by an overwhelming need to protect her children.

The aftermath of escaping family violence was not a clean break, but the beginning of a long and complex healing journey. She describes this journey as “isolating, triggering, convoluted, and complex,” but also filled with gratitude, moments of joy, self-acceptance, and growing kindness towards herself.

Initially referred to the **TRAK Forward recovery program**, she did not believe she needed the support, reflecting a common misconception that family violence is limited to physical acts. At the time, her self-esteem was non-existent. Her priority was the wellbeing of her children, and she vividly recalls sitting in a small office, overwhelmed and pleading for help.

What followed was the beginning of a therapeutic relationship that she now credits as life changing. Her TRAK Forward practitioner played a pivotal role in helping her make sense of the abuse she had experienced. Through consistent and trauma-informed support, she began to understand the patterns of coercive control that had shaped her relationship—yelling, spitting, punching walls, manipulation—and recognised them as abuse.

The early months post-separation were some of the most destabilising. Relocating to live with her mother, withdrawing from social life, and cutting contact with friends and social media were necessary steps for safety, but also left her isolated. The children's father continued to exert control from afar, often inserting himself into her social and familial relationships in an effort to retain power over her. Weekly counselling sessions during this period were critical to her survival and recovery.

At the end of this first phase of support, she described a renewed sense of self-worth and clarity. She could finally name her experiences as family violence and feel confident in advocating for herself and her children's right to safety and respect.

Three years later, she returned to the TRAK Forward program after self-referring in response to the commencement of family court proceedings initiated by her former partner. Despite living in another state, the proceedings reactivated deep trauma. She described this period as more traumatic than the years of abuse she experienced in her marriage, as her sense of safety and autonomy were once again under threat.

The re-engagement with TRAK Forward was profoundly validating. With ongoing support from the same practitioners, she applied the strategies she had learned during her initial period in the program to regulate her emotional state and stay grounded. This support was particularly vital, as her broader family - impacted by their own intergenerational trauma - was unable to provide the stability or empathy she needed during this time.

She credits the program with helping her remain mentally strong, emotionally regulated, and focused on parenting her two neurodivergent children with authenticity. The ability to approach her legal affidavit from a place of empowerment also helped reduce the financial strain of legal proceedings.
Reflecting on her journey, she speaks with pride about the person she has become and the joy her children now experience. She emphasises that while short-term, transactional supports - like emergency financial relief - can offer immediate reprieve, long-term transformational programs like TRAK Forward are essential for families to truly heal. These programs rebuild not just safety, but connection, trust, and a sense of self.

> **"I am proud of the person I am today and wish you could see how happy my children are."**
>
> -Lived Experience Advocate

Goal Setting

Short-term case management programs have extremely high key performance indicators and are goals focused. Organisational reporting typically measures success by the achievement of these goals, after which the service ends. While referral to counselling or therapeutic support is often included as a final goal, access to these services is limited. As a result, the longer-term goal of therapeutic recovery is frequently unattainable due to service shortages and high demand.

Goal achievement as a key funding marker proves a barrier to effective crisis and therapeutic response, with the expectation that the client has a time limit on their healing progress.

During the workshops for this report, it was observed that a significant number of The Orange Door (TOD) referrals to family violence case management include 'counselling' as a stated goal. However, it is not always clear whose goal this is—whether it originates from the client, the practitioner, or is inferred during the intake process—and what specific actions are intended to achieve it. For example, is the goal referring to psycho-education, group work, or other therapeutic interventions? These questions highlight a broader issue: at times, clients are unaware of the specific services they have been referred to or the nature of those services.

Lived Experience Advocates consistently expressed that they were rarely asked what they wanted or needed when accessing services and instead were referred to programs that did not align with their readiness, context or recovery stage.

> **"I was never once asked what I wanted."**

From The Inner East Melbourne Area Orange Door's perspective, goals listed at the point of referral are not intended as prescriptive tasks but rather as starting points for further exploration by the case management service in collaboration with the client. These goals, whether identified by Orange Door practitioners or the client should always be discussed transparently with the client as part of the allocation process and clarified or amended as appropriate.

> **"I was given numbers to call myself or websites to look up. The responsibility was all on me."**

While therapeutic services are often reflected in referral goals due to their relevance to recovery, they are not core Orange Door service allocations and operate their own intake and eligibility processes.

This gap is highlighted in The Orange Door sector report, which provides an overview of TOD referral, case and allocation volumes. The sector report highlights the source of incoming referrals to TOD and outgoing allocations to core partner agencies. The absence of therapeutic services within this data underscores the need for revised data fields to more accurately capture therapeutic needs and demand. It also raises important questions about why therapeutic services are not recognised as core components of family violence recovery within The Orange Door allocations reporting.

The Inner East Melbourne Area Orange Door also expressed that it cannot and does not refer clients to case management or therapeutic services without informed consent. Nonetheless, consultation feedback suggested that clients may remain confused about the services involved with their family, underscoring the importance of continued communication, clarity, and client-centred engagement throughout the support journey.

Recommendation

Advocate for family violence therapeutic services to be formally recognised as core allocations within The Orange Door (TOD) Sector Report. This would more accurately reflect demand and elevate therapeutic recovery as essential, not supplementary.

Supporting small adjustments in current ways of working may still necessitate reporting on goals for organisational purposes, however, the language of 'goals' need not be used with clients, as it can convey notions of success or failure that are inconsistent with a supportive, client-centred approach.

The Survivor-led Resources for Healing and Recovery can be used to support clients through case management and therapeutic recovery without having to use the language of goal setting.

Organisations who have commenced using the Survivor-led Resources report that they:

- Facilitate a shift in language, with a move away from clinical language to language which is person-centred, strength-based and future focused.
- Support session planning with the client.
- Provide safety and predictability about what can be expected.
- Provide individualised responses.
- Make space for clients.
- Promote safety at the core.
- Recognise the complexity of experience, with the naming of system tensions being helpful.
- Support the client's empowerment.

Organisations are now trying to fit the use of the resources into the funding deliverables required to be reported on. The questions from the Survivor-led Resources for Healing and Recovery have been embedded into the intake processes of several organisations. These questions are:

- **"When it comes to rebuilding, healing and recovery, the areas where I feel I need the most support are…"**
- **"When I think about receiving therapeutic support and care, I really hope for…"**
- **"When I think about receiving therapeutic support and care, I worry about…"**
- **"There are things I want someone supporting me to know and they are…"**
- **"What I wish for my future and our time together is…"**
- **"What I want support for during our sessions…"**
- **"Something I learned today is…"**
- **"Something I am most proud of since our last session is…"**
- **"Something I would like to work on before our next session is…"**

> **"It puts so much pressure on us. It was not healing; it was making it worse."**

It is important to note the shift in language within these questions, which encourages practitioners to move away from traditional goal-setting approaches and instead be led by the client's experiences and priorities.

> **"We are trying to meld into the goals of the organisations, rather than our goals."**

These questions can also serve as a tool for tracking progress over time. However, translating client-led responses into the structured reporting requirements of funding bodies requires nuance and may place additional burden on practitioners if the amount of translation required is excessive. To support true client-led practice, the language of goals must evolve to better reflect the realities of client journeys and practitioner work.

Recommendation
Support continued implementation of the Survivor-led Resources for Healing and Recovery through the development of a pilot project.

Recommendation
Evaluate the impact of the Survivor-led Resources for Healing and Recovery and outcomes reporting on practice and client experience.

Recommendation
Promote language change within organisations, moving away from 'goalsetting' in client engagement and reporting, toward language that supports empowerment, safety, and dignity.

Reporting Requirements

Current reporting frameworks do not adequately reflect the complexity or breadth of work undertaken by family violence services, particularly when operating within a multi-agency, whole-of-person and whole-of-family approach. Capturing how programs work together to support clients holistically would better reflect the scope of support provided by services and the resources required to do so. Moreover, while refining activity reporting is necessary, we must also move beyond restrictive, output-focused reporting practices to prioritise outcomes.

Significant components of family violence work, such as inter-agency collaboration, system navigation support, secondary consultations, and ongoing support following discharge, remain invisible within current reporting mechanisms. These activities, while not always client-facing, form the backbone of effective, integrated responses under the Multi-Agency Risk Assessment and Management (MARAM) Framework. The exclusion of this work from reporting frameworks contributes to a fragmented understanding of what service provision entails and limits opportunities to embed and scale promising practice.

There is also a strong case for shifting towards more narrative-based reporting that captures the richness and complexity of client outcomes. Although we need to improve activity-based reporting to better recognise and appropriately fund service provision, activity measures alone cannot demonstrate impact. Holistic and relational indicators of progress, including increased self-esteem or strengthened child and parental relationships, would better capture the meaningful client outcomes which can result from service intervention. Story-based approaches offer a more nuanced and contextualised understanding of impact, particularly when services are working collaboratively across disciplines to advance client goals. However, there is a lack of robust, evidence-based tools to support consistent outcome measurement, especially for programs operating in cross-sectoral or therapeutic recovery spaces. Investment in the development and testing of these tools is urgently needed to build the evidence base and strengthen system accountability.

Critically, current reporting structures also fail to capture work undertaken with children and young people, particularly in recognising them as victim survivors in their own right. Reporting continues to frame children and young people's experiences through the lens of the adult (usually parent) victim survivor, with casework recorded at the family unit level rather than disaggregated by individual child. This results in key areas of children and young people's experiences being overlooked. For instance, a practitioner with a caseload of twelve may in fact be supporting between 24 and 48 victim survivors when accounting for multiple children per family.

Without mechanisms to record and report on direct work with children and young people, there is a risk that this critical aspect of practice is undervalued and under-resourced.

Within FVREE's therapeutic program, reporting via the 'SHIP' database is currently limited to the case management domain of Health and Wellbeing. This narrow categorisation fails to capture the full scope of therapeutic work, including detailed planning, client feedback, and internal reporting that reflects both practitioner efforts and client outcomes. As a result, the depth and impact of therapeutic engagement is underrepresented, which can affect service visibility, evaluation, and future funding opportunities.

Recommendation

Refine current activity reporting to more accurately reflect the support provided by services, and develop and trial survivor-led outcomes reporting models, moving away from goal and target reporting and towards holistic and relational indicators of progress.

Therapeutic response starts with the clients' first interaction with the service system

Therapeutic response is often conceptualised as the final step in a victim survivor's service journey. This framing can result in support that is misaligned with both the needs of victim survivors and the non-linear nature of healing. In reality, every contact with services presents an opportunity to provide a therapeutic response. Whether formally acknowledged or not, this support begins with the client's very first interaction with the system. By recognising the therapeutic potential of all service interactions and offering flexible, responsive support, services can provide care that is more tailored, coordinated, and effective.

Creating an integrated continuum of therapeutic care

The workshops raised the idea of envisioning what it would look like to have the different components of the entire sector, such as case management and therapeutic recovery, integrated under a unified therapeutic care model. This would recognise that each interaction with services requires therapeutic elements and has the possibility to support therapeutic outcomes.

To achieve this services must be trauma-informed, with practitioners receiving comprehensive training to effectively address all aspects of a person's experience, including the somatic impact of trauma. Shifting language towards 'trauma transformative', rethinking how we frame therapeutic responses and unpacking what this looks like in practice would also be required. Distinguishing between therapeutic responses, therapy, and therapeutic care is crucial within this model, as each plays a different role in the healing journey.

Therapeutic responses refer to the intention and relational approach that orients how we engage with and support children, young people and adults to meaningfully and actively participate in decisions, planning and participation in the service responses that are available to them, with a focus on accompanying victim survivors to experience relational safety, care and agency in their journey of healing and recovery.

'Therapeutic' can define the policy, practice and relational approach adopted by an individual or an organisation that resources an environment of relational safety and accompaniment within which children, young people and adults are supported to experience connection, healing and positive wellbeing.

Therapy refers to the structured intervention or treatment of mental health symptoms, trauma, emotional and behavioural difficulties. Therapy is focused on relieving symptoms of distress, supporting recovery and improving mental wellbeing, growth and development. Therapy has clearly defined outcome focused goals and incorporates specific modalities to target symptom relief and improve mental well-being.

Therapeutic care is a holistic approach to caregiving with a focus on responding to relational and emotional needs of the person. Therapeutic care for children and young people also incorporates a focus on them in family and relational systems, in addition to focusing on support needs within the caregiving environment/system that is supporting that child or young person. Therapeutic care adopts a family and systems approach to improving the community and relational connections between family members and works with the broader support system to focus on how responses, decision making and interactions with a family can create stronger bonds and relationships.

Training to support integrated therapeutic responses

To embed a unified therapeutic care model across the continuum of crisis response, case management and therapy, further investment in workforce development will be needed. Training can support practitioners to integrate therapeutic responses in the context of their role. This includes building skills to engage in sensitive and effective conversations with clients, especially when conducting risk assessments or applying frameworks such as MARAM.

> **Trauma responsive practice is to talk about case closure from the very first session.**

Strengthening the ongoing skills and confidence of practitioners to provide therapeutic responses within systemic constraints is a critical component of workforce development. For example, when episodes of care end, careful application of therapeutic principles are needed to support meaningful, client-led transitions out of services. Conversations about the natural ending of support relationships—rather than clinical 'case closure'—require care, sensitivity, and a deep understanding of the trauma-informed principles underpinning family violence work. When these transitions are approached as part of a continuous, respectful therapeutic relationship, they provide a sense of safety and empowerment for victim survivors who may have developed trust in their practitioner over time. However, these skills are not static.

Practitioners often complete foundational trainings, such as MARAM, but are then left to interpret and implement complex frameworks in practice without structured opportunities for reflection or skill refinement. Each of the RFVP's annual MARAM Alignment and Systems Integration surveys conducted from 2022 - 2024, along with feedback from services, has consistently highlighted the demand for ongoing, accessible refresher training and reflective practice spaces, allowing practitioners to continually fine-tune their approaches and navigate challenging moments with confidence. Ongoing experiential learning opportunities have been identified as essential for building workforce capability.

Embedding the voices of Lived Experience Advocates in training and workforce development is also essential. Programs such as *Wisdom in Practice*[2] demonstrate the powerful impact of including lived expertise in professional learning, challenging assumptions and bias, deepening empathy, and partnering with clients.

Aligning Services with Client Needs

A recurring challenge identified in consultations is that despite practitioners genuinely wanting to help, victim survivors are often referred to programs that do not align with their specific needs. The key to aligning supports with the needs of victim survivors is engaging in open conversations with them to understand what would be helpful at the time, rather than trying to fit their needs into rigid service delivery options. Services must be flexible and responsive to the different needs and stages of an individual's journey, as a 'one-size-fits-all' approach is ineffective. Therapeutic approaches should be viewed along a continuum, with some interventions being appropriate in crisis situations, while others may be more effective later in the recovery process. Unfortunately, many clients fall through the cracks due to inflexible service models. It is important that victim survivors are able to make informed decisions about which programs they are referred to.

> **It is easy to fall through the cracks when no one is holding you and you are dissociating due to the trauma you are experiencing.**

Whilst some victim survivors find talk therapy to be beneficial, there are others who find an alternative healing modality to be what is most helpful to them, e.g. if they find it difficult to verbally articulate the impacts of family violence they are navigating. The only long-term therapeutic options available are generally accessed via a mental health care plan and private providers, which is often not affordable, including for those who are already facing financial hardship due to family violence.

Recommendation

Investigate the efficacy of multidisciplinary, creative, and non-traditional therapeutic interventions in trauma recovery.

[2] Keleher, H. (2023) Wisdom in Practice Pilot Program Evaluation Report. Unpublished.

Therapeutic response at any point in the journey

Funding and program operational models often locate therapeutic responses within a phased model of care across the service system, aligning these to increasing experiences of stability and a movement out of early crisis in a client's journey. These models may not, however, sufficiently consider the role that therapeutic responses can have in resourcing safety and stability. Many individuals interacting with these systems report frustration and, in some cases, further trauma due to a lack of recognition that their need for therapeutic intervention should be incorporated into early care and crisis responses.[3] Lived Experience Advocates, in a RFVP consultation exploring therapeutic readiness (2022), noted that while early crisis stages require more practical, safety, and legal support, there is also value in having therapeutic services available to help individuals process and respond to experiences of shame and fear at an early stage.

Researchers tend to agree that recovery is not linear, but instead is complex, multidimensional and unique to each individual[4]. These needs span across numerous sectors, requiring service systems to integrate and work dynamically. Therefore, in order to comprehensively meet the recovery needs of victim survivors, service systems must take a holistic approach to care[4].

Victim survivors often can identify what they need, but don't know what the service system can offer, and report that they have often been left to navigate the service system by themselves. It is essential to understand complex needs based on the client's lived experience, rather than simply following referral pathways. Services must understand and accompany individuals through their unique healing journeys, acknowledging services need to be resourced to do this. Therapeutic interventions should be tailored to the circumstances and needs of each client. This concept was highlighted by the RFVP Lived Experience Advocates consultation exploring therapeutic readiness.

Reconceptualising 'Intake' and Addressing Recovery Needs

The current concept of 'intake' often revolves around screening and eligibility, which could contribute to barriers in accessing timely support. To realise an integrated therapeutic care model across the system, we need to explore alternative models where the intake process serves to assess needs more holistically, focusing not just on eligibility but on the immediate and long-term needs of individuals and include possibilities for cross-agency collaboration.

A good example is the allocations process undertaken for adolescents using family violence in the home - a Child Wellbeing referral from The Orange Door to partner agencies. Care coordination occurs through weekly interagency meetings, where professionals collaborate to clarify client details, seek advice and additional information, and determine the most appropriate service response. These meetings are particularly valuable in guiding allocation decisions for clients with higher levels of complexity.

Recommendation

Explore options for earlier therapeutic responses, recognising that therapeutic recovery is a core component of family violence response, not a final step. Integrating therapeutic support earlier in the service journey, including during crisis periods, can enhance safety, emotional regulation, and long-term recovery outcomes.

[3] Domestic, Family and Sexual Violence Commission (2024) Yearly Report to Parliament, Domestic, Family and Sexual Violence Commission, Australian Government.

[4] Williams K, Harb M, Satyen L and Davies M (2024) s-CAPE trauma recovery program: the need for a holistic, trauma- and violence informed domestic violence framework. Front. Glob. Womens Health

Case Study: Empowering a Young Person Experiencing Family Violence through Collaborative Support

In 2024, a young person was identified as experiencing family violence by their mother during the mother's engagement with case management services. Both mother and young person were linked to counselling through a Children and Young Person's Therapeutic Practitioner. During these sessions, the Therapeutic Practitioner, alongside a Specialist Family Violence Advocate (SFVA), collaboratively identified safety concerns for the young person and developed tailored safety plans.

Following this, the young person was referred to the Brief Intervention Team for individual case management, based on their own goals. The Therapeutic Practitioner and SFVA worked closely together, conducting joint sessions to unpack the young person's needs, hopes, and challenges. Their coordinated, holistic approach addressed not only the therapeutic and emotional aspects of recovery but also practical supports, ensuring that the young person's wellbeing was supported comprehensively.

As a result of this collaboration, the young person was connected with the local Youth Homelessness team and was supported in obtaining their driver's license and assisted in setting up their own Centrelink account. Ongoing counselling focused on daily safety planning, emotional regulation, understanding family violence and its impacts, building self-advocacy skills, and navigating complex family dynamics while remaining at home.

This case highlights the benefits of providing a holistic response through collaboration between case management, therapeutic and homelessness supports. By integrating therapeutic care with practical support and safety planning, this approach promotes empowerment, resilience, and sustainable long-term wellbeing for young people affected by family violence.

Wraparound Support Models

Individuals experiencing violence face competing recovery needs, such as employment, mental health support, and housing, all of which can make the healing journey more challenging. There is a need for integrated supports that address these multiple issues without overwhelming individuals in distress. More long-term case management is necessary to assist clients in navigating these complex systems of care.

A wraparound approach, combining both therapeutic and case management responses, is vital. However, a wraparound approach also requires considerable resourcing. Prior to Family Violence Therapeutic Intervention ongoing funding occurring, demonstration projects occurred; in some cases, both case management and therapeutic intervention were able to be delivered by the same staff member and program. A common experience reported in this consultation was that when case management needs were high, including elevated family violence risk, risk of homelessness, and financial stress, the possibility of providing therapeutic intervention was greatly reduced. Practitioners frequently spent their time supporting clients with housing applications, accessing emergency relief, applying for intervention orders, developing safety plans and linking with legal services. When engaged in these intensive case management tasks, there was very little time available to focus on therapeutic work. Family Safety Victoria then advised that Family Violence Therapeutic Intervention programs were only to focus on therapeutic intervention, and not case management.

Funding limitations present a significant barrier to implementing the wraparound approach model widely. There are examples of programs in the Eastern Melbourne Area that have successfully integrated this approach, such as FVREE, Doncare, and Crossway Lifecare. Doncare's DAWN program, for example, has recently incorporated short-term case management into its therapeutic peer-led program, assisting with essential daily living tasks, like completing a tax return or paying fines. Tasks like these can feel impossible and overwhelming during times of crisis and can then be retraumatising to return to during recovery. Having support in these day-to-day tasks is crucial for many victim survivors to be able to start their recovery journey.

The lack of this type of wraparound support represents a significant service gap, compounded by a notable research gap. There is currently limited academic literature specifically addressing the importance of this support in effective healing and recovery, although it is a research area currently being explored by Deakin University. It is this wraparound support that is outside the scope of family violence case management, to the extent that a form of wrap around practical support similar to what can be provided by the National Disability Insurance Scheme (NDIS), e.g. including daily living supports, is required.

From a therapeutic practitioner perspective in the Eastern Melbourne area it is difficult to access practical supports for clients. This bi-directional and deeper integration of supports throughout the journey would provide more client centred support.

Engagement with Law Enforcement

In our analysis of the workshop themes, we found that police are rarely involved in discussions about therapeutic responses, despite being the first point of contact when someone in crisis is experiencing and/or using violence, including children and young people. Given their critical role in the early stages of intervention and the capacity of this initial response to lay a foundation for healing, it is important to ensure that law enforcement is included in regional discussions about therapeutic responses.

Recommendation

Conduct a client experience project to understand the recovery and healing journey of clients who have received siloed responses; verses a wraparound model of case management and therapeutic intervention.

Recommendation

Invite Victoria Police to engage with work of the RFVP Family Violence Therapeutic Working Group.

Case Study: FVREE Reimagining Pilot – Bringing Together Therapeutic Support and Case Management

FVREE's therapeutic team is participating in a pilot program that explores how therapeutic support and family violence case management can work together to provide holistic, recovery-focused support for women and children.
At the centre of the model is a strong partnership between the client—whether an adult, child or young person—a therapeutic practitioner, and a Specialist Family Violence (SFV) case manager who coordinates and leads the support. Depending on each client's needs, a 'care team' is formed, made up of both internal and external services, to support the client across all areas of their life, as guided by the case management framework.

A key feature of this model is the early involvement of therapeutic practitioners, who work alongside the case manager as part of the team. This means clients can start receiving counselling and wellbeing support earlier than in traditional models, because the case manager continues to monitor and manage any risk during this time. If the client's level of risk changes, they are already connected to a family violence specialist who can respond quickly and appropriately.
This approach reduces the need for repeated referrals and avoids interruptions to counselling due to changes in safety. It also helps ensure that therapeutic practitioners can stay focused on their specialist role, without being drawn into broader case management tasks.

The pilot is designed to provide wraparound, flexible support that considers all parts of a client's life. Lived experience advocates for the RFVP cited feeling that, with a goal-setting model, they became "compliant" to the needs of the service provider, as opposed to the reverse. By working in partnership with women and children, the wraparound model instead supports them to lead their own recovery, set goals that matter to them, and feel confident in continuing their journey well beyond the formal support period.

Impact of family violence on mental health

The intersection of family violence and mental health is deeply complex, shaped by the interwoven impacts of trauma, systemic fragmentation, and the siloed nature of service delivery. Family violence, whether physical, sexual, emotional, or psychological, can lead to significant and long-term mental health consequences that may persist well beyond the cessation of violence[5].

A key challenge is that mental health services, alcohol and other drug (AOD) services, and family violence services often work in parallel rather than in partnership, despite frequently serving the same victim survivor. Differing service models and funding streams, such as family violence therapeutic services funded by the Department of Families, Fairness and Housing, and mental health services funded by the Department of Health, contribute to these divisions. The system is commonly structured around siloed diagnoses and narrow definitions of 'primary' issues, which can result in victim survivors being bounced between services or having their referrals rejected for not meeting strict eligibility criteria. This is especially true for victim survivors experiencing family violence, mental illness, and substance use issues.

Victim survivors navigating these systems often do so during periods of extreme crisis, and must work to understand the formal and informal rules that govern each system. The burden of system navigation routinely falls on the victim survivor, who may be left to find and coordinate their own support privately due to a lack of integrated and responsive service provision. This reinforces systemic inequities and leads to further emotional, psychological, and financial strain, particularly for those who must draw on superannuation or other limited personal resources to access care.

Mental health practitioners play a crucial role in recognising and responding to family violence. However, without appropriate training, there is a risk that practitioners may miss indicators of violence, particularly emotional abuse and coercive control, or inadvertently collude with perpetrators by assuming they are supportive partners.

Victim survivors report feeling pressure to present as the 'ideal victim' in order to be believed or receive an appropriate response. The concept of 'not being abused enough' continues to undermine access to support, particularly for those whose experiences are non-physical but still profoundly harmful. Conversely, post-separation mental health needs can be viewed as too complex, or trauma as too severe, leading to victim survivors being excluded from services or deemed 'not ready'.

The trauma that underpins many mental health presentations is often rooted in family violence. Yet a clinical model, or framework, of mental health and recovery that does not explicitly acknowledge this can obscure the role of violence as a driver of distress. When family violence is treated as a secondary or unrelated concern, the perpetrator's actions may be minimised, or worse, ignored entirely. To improve outcomes, mental health services must be family violence-informed and trauma-aware. Cross-sector collaboration is essential, not optional, to ensure that victim survivors do not fall through the cracks of a fragmented system. This includes building shared understandings of family violence and trauma and complex needs, improving cross-referral pathways, and shifting the responsibility of system navigation from individuals to services and systems.

Where mental health services identify trauma symptoms precipitated or perpetuated by family violence, prompt referral to - and collaboration with - specialist family violence services can enable early, effective intervention and help prevent further harm.

Lastly, children and young people must be a central consideration in all responses. Family violence has significant, long-term impacts on children and young people's mental health and development. Early identification of family violence by child and youth mental health services, coupled with referral to and collaboration with specialist family violence services, is essential to support timely intervention and reduce the risk of ongoing harm. The system must move beyond single-issue models of care, designing for complexity by centring the lived experiences of women and children and recognising trauma as the common thread connecting people with community services.

Recommendation

Promote cross sector collaboration and an increased understanding of family violence in different sectors.

[5]Australia's National Research Organisation for Women's Safety. (2020). Violence against women and mental health (ANROWS Insights, 04/2020). Sydney: ANROWS.

Case Study: The Mental Health Toll of Surviving Family Violence

Cara* has spent more than a decade navigating the long-term mental health impacts of family and sexual violence which included daily sexual assault, coercive control, and prolonged psychological harm. As a result, she lives with complex PTSD, dissociative identity disorder, chronic dissociation, anorexia nervosa, and suicidality.

Her recovery journey has required access to intensive, multi-disciplinary support: psychologists, psychiatrists, community mental health teams, nutritionists, pelvic floor physiotherapists, and addiction services for alcohol and prescription drug use. Each of these mental health needs emerged in direct response to trauma but the system consistently failed to respond with the flexibility, coordination or compassion she needed.

Despite qualifying for the Disability Support Pension and eventually accessing the NDIS for complex PTSD and anorexia, Cara experienced repeated exclusion from public services due to "complexity" or lack of "readiness." Time-limited models, strict intake criteria, and disconnected referrals meant she was constantly retraumatised, pushed to retell her story, denied support, or told to call back when things were worse.

Throughout her recovery journey, Cara was forced to withdraw her entire superannuation over the span of a decade just to survive paying out of pocket for the trauma-informed care that was never offered through public pathways. This included surgeries and ongoing pelvic physiotherapy to address physical injuries from sexual violence, undertaken with little to no psychological support at the time.

"I was burning out just trying to stay alive and I was paying for the privilege. The system that harmed me then made me responsible for my own recovery."

Though Cara now has a private care team that walks alongside her, the mental toll of financial precarity, retraumatisation, and systemic neglect lingers. Her story is a stark example of how family violence doesn't end when the relationship ends and how mental health comorbidities can shape every aspect of recovery.

"If we don't talk about how trauma rewires your body and brain and build systems that reflect that, people like me will keep falling through the cracks."

*Name changed to protect identity

Capturing unmet demand

The issue of unmet demand, both in family violence response and therapeutic recovery, emerged as a significant theme in this deep dive in the Eastern Melbourne area, and it was also highlighted in the 2024 Yearly Report to Parliament by the Domestic, Family, and Sexual Violence Commission[6]. Both forums emphasised the need for a clearer understanding of unmet demand, including the services and support that are currently unavailable. Further data is required to fully grasp the extent of this issue. Key areas of unmet demand identified include:

- **Understanding the support needs that cannot be served** due to limitations in service models, such as demand outpacing supply; individuals whose presenting safety and healing needs are judged to be low risk, historic or lacking complexity; or individuals not deemed ready for therapeutic services. Additionally, referrals may be inappropriate for the services offered.
- **Identifying how many phone calls go unanswered.**
- **Measuring the number of referrals that are abandoned** by clients who are either unwilling or unable to wait due to long wait lists.
- **Understanding the extent of services not being provided** to clients who choose not to leave an abusive relationship.
- **Assessing how many people are unaware of where to seek assistance.**
- **Evaluating unmet demand resulting from service exclusion criteria**, particularly for children and young people.
- **Understanding how many people need further support** once they reach the service provision threshold and need to restart the process of accessing support.

> **"Understand and respond to unmet need rather than fit a person into available services."**

Additionally, our system currently defines the stages of support, with recovery often seen as something that begins only after a relationship ends. However, the 2023 RFVP Client Experience Report highlighted a need for counselling services to be available to individuals who are still in relationships, to help support their decision to leave should they choose to do so.

> **"Leaving is the scariest and most dangerous thing you will ever have to do. It is beyond my comprehension that family violence services can't help someone in this space."**

Clients have also expressed the need for someone to "walk alongside" them during their journey, helping with service navigation and stabilisation.

Understanding the full scope of unmet demand, how to accurately capture it, and developing mechanisms to report on it are crucial next steps in addressing these gaps in service provision.

> **"Their need is not going to be less because they have been rejected by a service. They will be left feeling that they are not worthy of a service."**

Recommendation
Scope and study unmet demand in the therapeutic response system, identifying where and why people are unable to access the support they need, and the outcomes of these service gaps.

Recommendation
Strengthen pathways for individuals to access appropriate supports when considering leaving a violent relationship.

[6]Domestic, Family and Sexual Violence Commission (2024) Yearly Report to Parliament, Domestic, Family and Sexual Violence Commission, Australian Government.

A significant gap exists in service responses to support a victim survivor when a perpetrator is released after a lengthy custodial sentence. This is another critical area of unmet demand within the service system and is particularly acute when perpetrators serve their full sentence and are not subject to parole conditions. In these circumstances, there is no justice system oversight, yet release is a period of heightened risk and fear for victim survivors, many of whom have long since exited family violence specialist services. Although there are pathways for re-engagement, without current family violence incidents having occurred, victim-survivors may be deemed at low risk with access to services further constrained by access eligibility, risk thresholds, waitlists and regional shortages.

Victim survivors are retraumatised when required to repeatedly justify their fear and re-disclose their experiences in order to access protections.

There also appears to be no clear pathway for prisons to share family violence risk relevant information to support services on a person's unconditional release, if not engaged with a victim survivor. Therefore vital information sharing may not occur, leaving the victim survivor without coordinated safety planning and vital information.

Case Study: Lack of Support and Information Sharing When Perpetrators Are Released From Custody

Cara's* story continues through this case study.

In March 2023, Cara was informed that the perpetrator responsible for the family violence against her, after many years serving a custodial sentence, was being considered for parole. This news caused significant psychological distress and reactivated trauma.

Cara attempted to apply for a new intervention order, as her previous one had expired during the perpetrator's incarceration. After approaching both the police and courts for assistance, she was informed that she would need to initiate the process herself, which meant disclosing in detail the history of rape, sexual assault, and other patterns of abuse she experienced. For her, this process was retraumatising, excruciating, and degrading. As a victim survivor of significant trauma, it was deeply painful to be placed in a position of having to 'prove' why her ongoing fear of her perpetrator was real and justified.

"I should not have to prove why I am afraid. I am terrified of the day he is released, and I absolutely believe he would take my life if given the chance."

The experience forced her to mask her terror in order to make others more comfortable, being told by services that 'he probably won't try to find you' while internally living with the daily fear that the perpetrator may one day act on threats to her life. Without advocacy or therapeutic support, the process became overwhelming, and no new intervention order is currently in place.

Cara's perpetrator has still not applied for parole, some 2 and a half years later, causing her to live in a constant state of vigilance, knowing that he could be released at any time without her having support or protections in place.

*Name changed to protect identity

Children and Young People

Safe Steps' recent documentary, Unanswered Calls, highlights that there is still a significant gap in meaningful support available to children and young people. A decade on from the Royal Commission into Family Violence, established in response to the tragic death of Luke Batty at 11 years of age, system reforms have predominantly centred on strengthening responses for adult victim survivors, despite the Commission's finding that support for children and young people was inadequate.

Early intervention for children and young people, ensuring they have access to support and healing from the outset, is not a new concept but is emerging as an area of increasing recognition. In the Eastern Melbourne area, the impact of family violence on children and young people is becoming more widely acknowledged, yet there is a growing demand for services that remains under-resourced or non-existent.

A significant gap this consultation identified is the lack of age-appropriate service responses for many children and young people. While the system offers a limited number of distinct therapeutic responses for both children and young people, access to these services often depends on children and young people receiving their own assessment. Currently, not all children and young people receive an individual assessment and case plan.

The capacity for young people to access services without parental consent or attendance has previously been identified as a challenge in the Eastern Melbourne area. Many young people in the mid to late adolescent years are not well served by child-focused approaches yet may also be unready or unable to engage with adult services. These access and developmental gaps are compounded by the way the system often ties support for children and young people to the readiness or participation of their parent.

In some cases, if an adult is not ready to engage in therapeutic supports themselves, concerns may arise regarding the potential benefit of therapeutic support for their children. This misses valuable opportunities to engage with children and young people when they are ready and most in need, while also potentially furthering trauma for the adult victim survivor by placing responsibility for their child's recovery on them.

Supporting a child or young person victim survivor is likely to relieve and benefit their parent, enhancing the recovery and wellbeing of both. Where an adult victim survivor is unable to take their children to appointments, involving schools or other community supports becomes essential to ensure the necessary care is provided. There is a clear need for greater recognition, flexibility and resources to adequately support the diverse experiences and recovery needs of children and young people.

Investing in these supports also strengthens secondary prevention efforts. When children and young people receive timely, wraparound, and therapeutic care, the system is not only responding to trauma but actively interrupting cycles of violence. Given that witnessing or experiencing violence in childhood is a significant risk factor for later becoming victims of intimate partner violence[7] or using violence as an adult[8], secondary prevention for children and young people is of great value.

The 2023 Australian Child Maltreatment Study exposed the concerning rates of violence against children[9]. It found that 44% of young people (aged 16-24) had experienced domestic and family violence as a child, 28% had experienced physical abuse, 26% had experienced sexual abuse and 35% had experienced emotional abuse. It also showed the far-reaching impacts of this violence, including significant increases in the likelihood of health service use[9] and health risk behaviours[10].

Where children and young people are using violence, important factors to recognise include, but are not limited to, their age, developmental stage, cognitive development, and if they have experienced family violence themselves. Violence can be the expression of unregulated trauma in a person who has not been sufficiently supported. This means, in order to interrupt cycles of family violence, funding should be focused on children and young people.

[7]World Health Organization. (2024). Fact Sheet: Violence against Women.
[8]Flood, M., Brown, C., Dembele, L., and Mills, K. (2022) Who uses domestic, family, and sexual violence, how, and why? The State of Knowledge Report on Violence Perpetration. Brisbane: Queensland University of Technology.
[9]Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D., & Malacova, E. (2023). The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report.
[10]Lawrence D, et al. (2023). The association between child maltreatment and health risk behaviours and conditions throughout life: The Australian Child Maltreatment Study. Med J Aust. 218 (6).

Children and young people need their own support services, when they are ready, that go long enough to focus not only on current and/or recent trauma but also focuses on developing skills and capacity to engage in positive relationships as they continue through their own lives. When an adult protective parent is involved with services and deemed not yet ready for therapeutic support, unless the child has received an assessment it is often assumed that the child is also not ready. Ideally recovery support works with the child/parent relationship. However, in some cases one member of the dyad may engage before the other and helpful work can still occur.

When case management is not available for individual children and young people, the nuances of their experiences can easily be missed. The inability of children and young people to access therapeutic support when Family Court matters are underway or there are orders prohibiting therapeutic support for children and young people without the consent of the parent using violence is a barrier to services' ability to support both the child and the protective parent.

Children and young people may often be at school or engaged in early learning when practitioners meet with the adult victim survivor, therefore the practitioner is unable to assess and to respond to children and young people as an individual client. This deep dive also uncovered that practitioners are often concerned about having vulnerable conversations with children and young people and causing more distress to them and their caregiver. Therefore, often a child or young person's experience is translated through the caregiver's interpretation, which brings its own challenges. Caregivers coming into services are very often experiencing distress, shame, guilt and a range of other emotions. There may be fear of child removal if a caregiver speaks about what their child may have experienced. This can make it difficult for them to think about what their child has experienced as it may exacerbate these feelings. Caregivers can believe they protected their children from the violence that has impacted the family functioning. Despite the caregiver's best actions and intentions, children and young people will very often have an experience of their protective caregiver's fear, focus on safety, and have a reduced ability to relax and be playful.

Family violence and coercive control are parenting choices, made by the person using these behaviours. It can be a very vulnerable conversation to acknowledge the protective behaviours of the safe caregiver and also let them know their children have experienced family violence, because of the person choosing violence.

In the Eastern Melbourne area it is still common for practitioners to use language such as "I'm working with a client and in relation to her children…" or "I'm working with a victim survivor and her children…" thus minimising the experience of the children and young people by making the primary focus the adult victim survivor.

The outcome of this is that children and young people often have no one to speak to regarding their experiences and their needs, and caregivers are unsupported in the healing of their children. Practitioners generally want to provide a service for children and young people but are often constrained by their perceived skill level and staff resourcing issues.

This is not the case for therapeutic services that are working with children and young people. Therapeutic services may be the only response that a child or young person receives where they can actually connect with a practitioner and talk independently as the primary client. When trust and rapport is built directly with them, it allows for their voice to be safely heard and responded to. Intervention focuses on recognising and building on the child or young person's strengths, and responding to the child's needs, e.g. emotional regulation. This approach also helps to ensure that their experiences are not lost in the parental narrative and prevents unresolved concerns that the child or young person is experiencing from becoming greater and more serious concerns.

Recommendation

Enhance practitioner capability and confidence to engage safely and effectively with children and young people through developmentally appropriate, trauma-informed conversations.

"We do not need to give children a voice: they have a voice. What we need is adults to listen to their voice."

Case Study: Creating Space for Safety and Disclosure – Supporting a Child Experiencing Ongoing Coercive Control

A child, David*, 10-years-old, was involved in a family violence therapeutic intervention group for primary school aged children. Both David and his mother Jenny* had allegedly experienced family violence from David's father. There was a current Family Violence Intervention Order (IVO) in place. David had twice-weekly scheduled phone calls with his father.

At the beginning of one group session, Jenny mentioned to the facilitator that David had been very distressed in the past week and wouldn't speak with her, making her very concerned for him. Towards the end of the session, the facilitator was speaking with David, and he mentioned he had let his father down. David disclosed that he and his father had 'a special project', just for the two of them.

David was to take a photo of everyone who visited their house, and their car, and send the images to his father, then immediately delete the message and photo. David's father reminded David frequently that because of Jenny (David's mother), he was not able to be with the family and stay connected to them. This project would allow him to feel part of the family and connected to them. David was unable to recognise this as his father continuing to perpetrate abuse and breach the active Family Violence Intervention Order (IVO).

David had missed taking a photo of one visitor and was concerned about letting his father down. After acknowledging his bravery and validating David's feelings it was decided he would be present while the facilitator told his mother (he chose not to tell her but to be with the facilitator). It was explained to David that his father's behaviour was not allowed, and why, and phone access was ceased for the remainder of David's engagement with the group.

Without the trust that David had developed in the facilitators, and the space created for him to speak of his worries, it is likely that this 'project' would have continued.

Jenny was supported by a group facilitator to speak with a specialist family violence practitioner, who then supported her to report the IVO breach. Jenny was referred for counselling support to continue her recovery journey.

David received one-on-one therapeutic support alongside his ongoing group participation, and he continued to engage enthusiastically in the group until he felt ready to exit the program.

This case highlights how coercive control can persist post-separation and how a person using violence may use children to maintain power and control. It also demonstrates the critical role of therapeutic children's programs in creating safe, trusting environments where children can disclose harm, understand their experiences, and begin to recover.

Programs such as this provide children and their caregivers with the tools and support they need not just to stay safe, but to heal and rebuild their lives.

*Names changed to protect identity

Long-term support

All forums and advocacy efforts strongly emphasise the necessity for services to offer long-term support, yet current funding models are not structured to accommodate this need. Therapeutic practitioners highlighted that extended therapeutic work, spanning 12 months or more, can lead to meaningful progress for clients. However, the current service model typically provides much shorter episodes of care, which often results in fragmented support, frequent referrals to various services, or the repeated opening and closing of service periods to circumvent the constraints of the funding model.

An episode of care in family violence therapeutic services usually means around 3-6 months, with high demand often driving this limit. This consultation identified that some services are seeking to offer more flexibility in the duration and intensity of support. However, current funding models are not structured to sustain the workforce required for longer-term or episodic care, where the level of support may need to fluctuate in response to changing circumstances, often linked to the perpetrator's behaviour. Recovery from family violence is non-linear and may require renewed engagement over time, and services must remain responsive to the evolving needs of each client. For many victim survivors, the effects of violence, and sometimes the violence itself, can continue long after separation, particularly where child custody arrangements mean ongoing contact with the perpetrator.

> **"It would be better for an organisation to tell you that they have limited time with you, rather than being told 'we need to close next month'. All of a sudden you feel really abandoned."**

Therapeutic programs and counselling are often regarded as the final step in the recovery journey for families affected by family violence. However, these supports are just as critical as any other intervention and should be prioritised accordingly. Unfortunately, many therapeutic programs are constrained by limited funding, resulting in small teams that are unable to meet the high demand for support.

This mismatch between need and access leads to long waitlists, causing many clients to either forgo support or seek help from general psychological services. These alternative services may lack the specific expertise required to navigate the complexities and dynamics of family violence, sometimes resulting in further harm, such as victim-blaming or minimisation of the perpetrator's behaviour.

The family violence sector is also clear that the lack of longer-term funding cycles is entrenching uncertainty and instability for a workforce already under pressure, resulting in uncertainty for the broader community around availability and continuity of support. Funding uncertainty leads to loss of workforce, and uncertainty for clients that are using those services. The regular defunding of programs in the sector makes accurate signposting difficult for practitioners and roughens the journey of the client through the sector. The frequent passing of clients between different services and practitioners ultimately inhibits their recovery, thus extending and complicating their journey and the cost of the response.

The 2024 Yearly Report to Parliament from the Domestic, Family and Sexual Violence Commission urges governments to explore new funding approaches that ensure more effective and consistent responses. At a national level, the Commission recommends that the Department of Social Services develop funding models that offer greater stability by extending the duration of funding periods[11]. This is relevant in Victoria and should be considered here.

Recommendation

Advocate for long-term therapeutic funding models that reflect the real timelines of healing. Services must be resourced to provide continuity of care over a minimum of 12 months, with flexibility to respond to periods of risk escalation and stabilisation.

Recommendation

Engage family violence therapeutic experts to design a long-term, evidence-based program aligned with best practice in trauma recovery.

[11]Domestic, Family and Sexual Violence Commission (2024) Yearly Report to Parliament, Domestic, Family and Sexual Violence Commission, Australian Government.

The Benefits of Long-Term Therapeutic Responses

Providing clients with access to long-term counselling support from the same practitioner is a critical component of trauma-informed care. As the therapeutic relationship strengthens over time, clients are more likely to feel safe, which enables them to engage with and process deeper layers of their trauma at a pace that aligns with their individual recovery journey.

Recovery from trauma is not linear, nor can it be confined to a predetermined timeframe. Each person's readiness to engage in different aspects of their healing unfolds gradually and uniquely. For some, this may begin with exploring the nature of their past relationships, processing the trauma and risks associated with leaving, and eventually confronting the long-term impacts of those experiences—often well after the relationship has ended.

Short-term models, such as 12-week programs, can inadvertently disrupt this process. When clients are required to restart their journey with a new practitioner, they must often re-tell their story, re-establish trust, reset therapeutic goals, and re-create a safe space—processes that can consume much of the limited time available. This not only risks re-traumatisation but may also delay or derail meaningful progress. Practitioners, too, can feel constrained—struggling to deliver trauma-informed support within the confines of rigid, time-limited service models.

A more effective, trauma-informed approach encourages clients to move in and out of counselling as needed, returning when they feel ready to explore new aspects of their trauma. This flexibility honours the natural rhythms of healing and supports a holistic, client-led model of care that values consistency, safety, and trust within the therapeutic relationship.

Limited Therapeutic Supports for People Using Violence

There is growing recognition in both research and practice that people who use family violence are a heterogenous cohort[12], and that for some within this group, their own experiences of violence and trauma influence their choice to use violence[13]. Despite this, there are limited referral pathways available for individuals who use violence to seek specialised therapeutic support for their trauma which concurrently addresses their violent behaviour.

Men's Behaviour Change Programs (MBCPs) currently serve as the primary support option for men who use violence. While MBCPs can incorporate a range of modalities and approaches, they are often unable to meaningfully address participants' experience of trauma within the scope of the program.

Furthermore, MBCPs are typically short-term and follow a set curriculum. Therefore, they are not able to be tailored to an individual's needs. Moreover, not all people who use family violence will be suitable for a group-based program and will require individual trauma-informed and family violence informed counselling to make change and take responsibility for their actions.

There is a critical need for non-collusive, trauma-informed counselling programs as part of a suite of interventions for people using violence. These programs should be integrated into a more personalised and comprehensive approach, recognising that, similar to victim survivors, individuals who use violence require a holistic and client-centred response to effectively address the myriad of factors which influence their choice to use violence. Additionally, like responses for victim survivors, ongoing and long-term support is essential.

Recommendation

Examine therapeutic needs and responses for people who use violence to support accountability and change for people who use family violence.

While we strongly emphasise that mental health issues should never be used as an excuse for violent behaviour, it is equally important to provide appropriate support for men's recovery. Therapeutic support is often perceived as a luxury for individuals who use violence; however, without such support, we fail to address their needs and effectively work towards preventing future violence. Ensuring practitioners receive adequate training regarding the drivers of gendered violence and resisting collusion can minimise risks associated with adopting a therapeutic approach.

Addressing other co-occurring issues such as substance use and gambling addictions is essential to a holistic, client-centred response. These often reflect deeper, intersecting needs and experiences of trauma for people using violence. Reducing stigma and offering the right support are vital to disrupting the cycle of harm.

It is crucial that we evolve our approaches to focus on the person using violence, ensuring that interventions are both comprehensive and effective. It is crucial that if persons using violence have a trauma history it is recognised as such. avoiding the common practice of misdiagnoses (e.g. ADHD) to provide quick and short-term remedies to their behaviour. Aboriginal Controlled Community Organisations have illustrated success in the men's behaviour change space by providing holistic support which addresses shame and guilt and encouraging reconnection with culture in a trauma informed way.

It was also acknowledged that most perpetrators will not seek or receive specialist family violence support[14,15]. This means that a collective range of non-specialist services must be upskilled to effectively respond to persons using violence, as often they will be the only services in contact with them. Systems cannot rely on MBCPs to be a panacea for family violence perpetration. While an important intervention, they must be integrated within a collaborative multi-agency ecosystem[15].

[12]The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia (ANROWS, 2022)

[13]Who uses domestic, family, and sexual violence, how, and why? The State of Knowledge Report on Violence Perpetration. Brisbane: Queensland University of Technology (Flood, M., Brown, C., Dembele, L., and Mills, K., 2022)

[14]I just felt like I was running around in a circle": Listening to the voices of victims and perpetrators to transform responses to intimate partner violence (ANROWS, 2022)

[15] The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence (ANROWS, 2025)

Case Study: The Impact of Emotional Abuse and Mismatched Interventions

Background
After enduring a prolonged period in an emotionally abusive relationship, Samantha* found the strength to leave her partner. However, the separation triggered a concerning escalation in his behaviour. He began sending her graphic images of self-harm, including photos of himself slitting his wrists. She received alarming calls from the Crisis Assessment and Treatment Team (CATT), and he made repeated attempts to be admitted to hospital.

When direct contact with Samantha became more difficult, his abusive and manipulative behaviours were redirected toward their eight-year-old daughter. This included emotional pressure, inappropriate disclosures, and attempts to involve the child in adult conflict—causing significant distress and harm.

Legal and Service Response
To protect herself and her daughter, Samantha obtained an Intervention Order (IVO). At the time, the only support pathway available for her ex-partner was a court-mandated Men's Behaviour Change Program (MBCP). However, this program was primarily designed for men who had used physical violence, and it did not adequately address the emotional and psychological tactics her former partner had used.

Participation in the program appeared to have the unintended effect of reinforcing his minimisation of harm. He later sent Samantha a message stating he "should have beaten [her]," suggesting that because his abuse wasn't physical, it wasn't considered serious.

Reflections and Implications
This case highlights a critical gap in the family violence response system: a lack of tailored interventions for perpetrators of non-physical forms of abuse. Emotional and psychological violence can be equally damaging and must be recognised and treated with equal seriousness. Placing individuals in programs that don't reflect their behaviours may not only fail to support change—it can reinforce harmful beliefs and entrench abusive patterns.

Years later, Samantha's former partner has still not received support or education appropriate to his behaviours. He continues to demonstrate an inability to engage with his child in a healthy, age-appropriate way, and struggles to manage conflict without anger or manipulation.

Ongoing Impacts on the Victim
For Samantha, the experience of emotional abuse and the inadequacy of systemic responses continue to have lasting impacts. She describes her current state as one of ongoing hyper-vigilance:

"As to the effects on me… I don't really know, I'm still putting out spot fires weekly. Even today I had to deal with the school—they realised the IVO expired. Really, I'm stuck in protection mode and will be in it for a long time…"

This enduring state of 'protection mode' reflects the chronic nature of post-separation abuse and the burden placed on victim survivors when systems fail to fully address the patterns and risks of non-physical violence. Without long-term, coordinated support and accountability structures, victim survivors are left to carry the weight of ongoing safety management, often in isolation.

*Name changed to protect identity

MARAM Framework Alignment

The *National Plan to End Violence Against Women and Children 2022–2032* highlights the importance of all governments harnessing broader workforces to help prevent and respond to domestic, family, and sexual violence. This priority is also reflected in Victoria's recently released *Third Rolling Action Plan to End Family and Sexual Violence 2025–2027*. A key objective of both plans is to ensure that all sectors involved in responding to violence work together more effectively. This principle underpins Victoria's MARAM Framework and collaborative multi-agency response, which continues to mature. To further strengthen this approach, Family Safety Victoria is currently developing a MARAM Model of Alignment.

A significant challenge identified in the Eastern Melbourne area is the limited sharing of MARAM risk assessments between agencies at the point of referral and significant struggles in access to risk assessments from some organisations. In many cases, only summary documents are provided, while full risk assessments, particularly those older than six months, are often considered outdated and not shared, impacting risk visibility and collaboration. As a result, clients often need to request their own MARAM assessments and share them independently with services, placing an additional burden on them.

Family violence is often a pattern of behaviour, rather than an isolated incident. Past behaviours of the person using violence can provide important indicators of future risk, and thus it is important that historical information of this nature is shared. Due to the highly dynamic nature of family violence risk, therapeutic services play a critical role in monitoring and responding to risk escalation. However, their ability to perform this function is limited when they are not privy to the full context and pattern of behaviour of the person using violence.

> **"If everyone spoke to each other, connected and talked, then my recovery outcomes would've been very different."**

There are also significant barriers to responding to the unique risk experienced by children, as MARAM risk assessments for a child are often simply a cut-and-paste of the adult risk assessment. Moreover, when child referrals are made, their risk assessments may be received, but the corresponding adult risk assessment is not, despite its potential to provide valuable context in assessing overall risk.

There are no good options for assessing risk and protective factors for young people that accurately capture their experiences and risk profile. For example, child risk assessment can be incorrect for someone aged 18 but the adult risk assessment tool is strongly aligned to intimate partner violence and may not accurately capture the impacts of family of origin violence. There is anticipation that the soon to be released Victorian Children & Young Person MARAM tools and Practice Guidance will address this.

Collaborative risk assessment and management also remains infrequent, despite the MARAM Framework being a cornerstone of our systemic response to family violence, and the framework emphasising the need for a coordinated approach across sectors to build a system that works together. Trust is a significant issue between organisations who are requested to share client information. This is perhaps related to being a system under pressure with frontline professionals who do not have enough time to connect with external services to develop trust to share information.

Recommendation

RFVP member organisations develop congruent policies and processes for sharing of MARAM risk assessments with therapeutic services and programs.

Recommendation

Support organisational alignment to the Children and Young Persons MARAM tools and practice guidance

Increased collaboration between victim survivor therapeutic programs and services working with people who use violence could strengthen outcomes for all involved. Despite this potential, perpetrator accountability remains a significant gap, and service responses continue to operate in silos. To address these challenges, there is a pressing need for more integrated and coordinated supports.

Effective responses to family violence are a shared responsibility that require coordination across all sectors. Death inquiries highlight that, despite multiple points of service contact, responses are often fragmented and lack cohesion. Identifying coercive control remains a persistent challenge, particularly in cases where physical violence is absent. Accurately assessing the level of risk and engaging in constructive conversations with those using violence are all essential components of a coordinated approach. Developing a shared understanding of family violence across services is crucial to ensuring interventions are timely, consistent, and effective.

Recommendation

Improve integration between programs for victim survivors and those working with people who use violence, especially where there are opportunities to collaborate and ensure the safety and accountability of all parties involved in line with the MARAM Framework and Information Sharing Schemes.

Utilisation of Family Violence Information Sharing Schemes (FVISS)

Case Example 1

A family was engaged in family violence therapeutic interventions across multiple agencies, with different supports in place tailored to the needs and ages of each family member. The family was living at an undisclosed address, which was intentionally withheld from the person using violence to support the family's safety.

During a session with a practitioner, one family member disclosed a serious concern: a photo had been shared with the person using violence that appeared to identify the school attended by their younger sibling. This raised fears that the person using violence might attempt to attend or approach the school.

Utilising the Family Violence Information Sharing Scheme (FVISS), this information was shared with the agency involved in working with the younger child for protection purposes. That agency then shared the risk relevant information with the child's primary school under FVISS, identifying the safety risk and potential for contact by the person using violence. The school was able to act immediately to implement safety measures, including increased monitoring of visitors and reinforcing safety protocols. This coordinated response helped to proactively mitigate risk and maintain the child's safety in their learning environment.

Case Example 2

A family violence therapeutic intervention program is supporting a family that includes primary school-aged children. The father, an alleged person using violence, is on remand, facing charges for alleged sexual assault against minors.

Given the high-risk nature of the circumstances, the service actively utilises the Family Violence Information Sharing Scheme to help protect and mitigate risk to the family. Through regular information sharing requests made to Corrections Victoria, the service has been able to confirm that the father is on remand, ensuring that safety planning and therapeutic work with the family remains informed and responsive to any change in circumstances.

Workforce capacity and capability

This consultation in the Eastern Melbourne area identified that the family violence sector faces challenges related to a portion of the workforce being relatively new and inexperienced. However, the introduction of the Mandatory Minimum Qualifications for the family violence workforce will better equip staff.

Currently a lack of experience, particularly in using frameworks like MARAM for risk assessment and management, continues to be an issue. Workforce capacity also remains a limitation, with a high demand for services and a growing number of new practitioners. This situation is exacerbated by the imposed short-term support periods, which can increase staff distress and contribute to burnout. The consultation also heard that there can be impacts of working out of alignment with personal values and evidence based best practice due to systemic constraints.

Practitioners' lived experience of family violence within the sector is often undervalued and siloed, limiting its potential impact. This knowledge, especially when shared by individuals with direct lived experience, can offer valuable insights and perspectives that are critical to the development of effective support services. However, it remains underutilised, and its integration into broader sector practices is still a significant challenge. The Department of Families Fairness and Housing Centre for Workforce Excellence is currently working on a 'Workers with Lived and Living Experience Project', for practitioners not currently working in a designated lived experience role.

There is a significant shortage of somatic training and supervision available within Australia, which leaves practitioners ill-equipped to address the somatic aspects of trauma. In addition, the sector is still losing highly experienced staff to burnout, particularly those who have their own lived experience or are facing vicarious trauma. The lack of support for practitioners in this way further strains the workforce and hinders the delivery of quality services.

A peer workforce was identified as a crucial resource, particularly for secondary prevention efforts. Secondary prevention initiatives are designed to prevent violence from recurring and reduce longer-term impacts and harm. The ability to be supported by someone with their own lived experience can be life-changing for clients. Moreover, utilising experience-based advocates to lead projects focused on re-stabilisation and other services can provide vital support for both clients and practitioners.

There is a need for increased funding and support for the lived experience peer workforce, similar to funding for peer workers provided by mental health funding bodies. Ensuring that peer workers are adequately trained, supported and appropriately remunerated will enhance their ability to contribute valuable knowledge and skills across all phases of the recovery journey.

The National Survey of Workers in the Domestic, Family, and Sexual Violence Sectors (2018) identified that the most common areas where workers felt additional training was needed included risk assessment, therapeutic approaches, legal training, general counselling, screening, and supervision training[16]. A new survey is being commissioned, with results expected in 2026. Additionally, there is a pressing need for more education on coercive control, particularly in how it is identified and addressed.

Recommendation

Advocate to the Australian Association of Social Workers; and the Australian Psychological Society for the inclusion of more comprehensive, applied content on family violence, including work with children and young people across undergraduate and postgraduate programs.

[16]Cortis, N., Blaxland, M., Breckenridge, J., valentine, k. Mahoney, N., Chung, D., Cordier, R., Chen, Y., and Green, D. (2018). National Survey of Workers in the Domestic, Family and Sexual Violence Sectors (SPRC Report 5/2018). Sydney: Social Policy Research Centre and Gendered Violence Research Network, UNSW Sydney. http://doi.org/10.26190/5b5ab1c0e110f

Self-care and Wellbeing

The importance of self-care and self-awareness within services and by practitioners cannot be overstated. If service providers are not modelling these principles, it becomes difficult for them to deliver support with the necessary awareness. Service providers must be equipped with tools for self-care and self-empowerment in order to foster a culture of wellbeing. This shift should start from within organisations, ensuring that providers are supported in developing their own self-awareness and resilience. Demand for service and delivery of high KPIs increases the required pace of the work making this difficult. Professionals can have limited time to reset between clients after exposure to distressing or high-risk work.

In rethinking therapeutic approaches, there is a need to focus on self-empowering aspects of an individual's experience rather than solely on therapeutic needs.

There is also a growing demand for alternative therapies and recovery support that can further facilitate empowerment. By addressing disempowerment, services can create pathways to end cycles of harm and encourage healing.

Practical tools and self-empowering activities are necessary to support individuals in regaining control over their own recovery. This includes providing clients with navigation tools for self-care and support that foster autonomy and empowerment throughout their journey. Service information at intake and throughout the client journey enables agency for people to make informed decisions about what supports they feel they need. This also invites collaborative practice between clients and practitioners to problem solve how the client might be able to access the supports they feel they need together.

Impact of Court Processes

Court proceedings are traumatising for victim survivors with or without children; in particular criminal court proceedings for family and sexual violence. Victims become a witness in their own case. They are restricted by the prosecution in what they can and cannot say for fear of risking a mistrial and victims are often isolated from family and supports during criminal trials. Not only is trauma extended by court proceedings, but recovery is prevented, as deep trauma therapy cannot be provided until these conclude. This can take extensive periods of time due to trials, mistrials and appeals, serving to keep victim survivors in a stagnant state of trauma.

> **"I find it easier to talk about the person who raped me, than to delve into my experience of the court process in therapy. That is how traumatising the criminal court process was for me."**

Another significant barrier to healing and recovery is the impact of Family Law Court proceedings, particularly in relation to parenting orders. The lack of support within legal systems, combined with the challenges of navigating co-parenting, often leads to re-traumatisation for those affected by family violence. This highlights the need for more comprehensive support for individuals engaging with the legal system to ensure their healing journey is not hindered.

Where Family Law Court orders require the consent of both parents to access therapeutic support, children may be denied services if the person using violence withholds consent and no accessible avenues exist to circumnavigate this. This is a barrier to children accessing timely and effective support, due to coercive control still occurring.

Recommendation

Develop stronger partnerships with the Family Court to ensure referrals are made to specialist family violence therapeutic services, rather than to general family therapy or private practitioners who may lack the expertise to safely and effectively respond.

Conclusion

This report underscores the urgent need to reimagine how therapeutic responses are understood, funded, and delivered within the family violence system. The current landscape is marked by fragmentation, inflexible service models, and a lack of sustained investment in recovery, particularly for children, young people, and those with complex or evolving needs. Despite these challenges, the report also highlights a growing body of practice wisdom, survivor insight, and emerging innovation that points the way forward.

Achieving truly trauma-informed, client-led therapeutic care requires a significant cultural and structural shift. It demands long-term investment, flexible funding mechanisms, and outcome measures that reflect the non-linear, relational nature of healing. It also requires a commitment to centring lived experience, embedding specialist therapeutic responses across the service continuum, and supporting the sustainability and capability of the therapeutic workforce.

Importantly, recovery does not occur in isolation within therapeutic programs alone. Every point of system contact, from crisis response and case management through to legal, health, and housing services, shapes the recovery journey. For many victim survivors, engaging with multiple parts of the system can be re-traumatising or exhausting. A truly therapeutic system therefore requires all sectors and practitioners to approach their work in ways that are restorative, validating, and supportive of healing, regardless of their primary function.

The findings and recommendations in this report offer a blueprint for systemic transformation. They call on governments, sector leaders, funders, and academic institutions to work in partnership with services, practitioners, and victim survivors to co-design a future where healing and recovery are not an afterthought, but a foundational component of every family violence response.

The Family Violence Therapeutic Working Group and the RFVP remain committed to driving this agenda forward, supporting implementation, championing innovation, and building the evidence base for what works. The opportunity now is to move from analysis to action and translate these insights into sustained, structural change that supports healing and long-term recovery for all victim survivors.

Recommendations

Within scope of the RFVP Family Violence Therapeutic Working Group

1. Explore options for earlier therapeutic responses, recognising that therapeutic recovery is a core component of family violence response, not a final step. Integrating therapeutic support earlier in the service journey, including during crisis periods, can enhance safety, emotional regulation, and long-term recovery outcomes.
2. Support continued implementation of the Survivor-led Resources for Healing and Recovery through the development of a pilot project.
3. Develop and trial survivor-led outcomes reporting models, moving away from goal and target reporting and towards holistic and relational indicators of progress.
4. Promote language change within organisations, moving away from 'goalsetting' in client engagement and reporting, toward language that supports empowerment, safety, and dignity.
5. Improve integration between programs for victim survivors and those working with people who use violence, especially where there are opportunities to collaborate and ensure the safety and accountability of all parties involved in line with the MARAM Framework and Information Sharing Schemes.
6. Develop stronger partnerships with family courts to ensure referrals are made to specialist family violence therapeutic services, rather than to general family therapy or private practitioners who may lack the expertise to safely and effectively respond.

For consideration by the broader RFVP

7. Strengthen pathways for individuals to access appropriate supports when considering leaving a violent relationship.
8. RFVP member organisations develop congruent policies and processes for sharing of MARAM risk assessments with therapeutic services and programs.
9. Support organisational alignment to the Children and Young Persons MARAM tools and practice guidance.
10. Invite Victoria Police to engage with work of the RFVP Family Violence Therapeutic Working Group.
11. Enhance practitioner capability and confidence to engage safely and effectively with children and young people through developmentally appropriate, trauma-informed conversations.
12. Promote cross sector collaboration and an increased understanding of family violence in different sectors.

Share this report with Deakin, Swinburne, Latrobe and Monash Universities to support opportunities for postgraduate research and interdisciplinary exploration.

13 Scope and study unmet demand in the therapeutic response system, identifying where and why people are unable to access the support they need, and the outcomes of these service gaps.

14 Conduct a client experience project, to understand the recovery and healing journey of clients who have received siloed responses; verses a wraparound model of case management and therapeutic intervention.

15 Evaluate the impact of Survivor-led Resources for Healing and Recovery and outcomes reporting on practice and client experience.

16 Investigate the efficacy of multidisciplinary, creative, and non-traditional therapeutic interventions in trauma recovery.

17 Examine therapeutic needs and responses for people who use violence to support accountability and change for people who use family violence.

18 Engage family violence therapeutic experts to design a long-term, evidence-based program aligned with best practice in trauma recovery.

Areas for advocacy

19 Advocate to the Australian Association of Social Workers; and the Australian Psychological Society for the inclusion of more comprehensive, applied content on family violence, including work with children & young people across undergraduate and postgraduate programs.

20 Advocate for long-term therapeutic funding models that reflect the real timelines of healing. Services must be resourced to provide continuity of care over a minimum of 12 months, with flexibility to respond to periods of risk escalation and stabilisation.

21 Advocate for family violence therapeutic services to be formally recognised as core allocations within The Orange Door (TOD) Sector Report. This would more accurately reflect demand and elevate therapeutic recovery as essential, not supplementary.

While specific recommendations for marginalised groups are not detailed, equity remains a priority for the RFVP. All initiatives will be guided by an intersectional approach, with the unique experiences and needs of diverse communities embedded throughout our work.

Aspirations for the sector

This report aimed to identify areas of transformation within the sector to enhance therapeutic care and responses. The following 'I wonder…' statements effectively summarise this vision.

I wonder…

- **about an integrated case management and therapeutic care model.**
- **about centring responses to children and young people alongside their families.**
- **what changes would happen if long-term support was more available.**
- **if we adapt the language to 'victim-survivor led'.**
- **what would happen if we reported on outcomes rather than targets, data and goals.**
- **if there were more people equipped to have conversations with people using violence who were trauma informed and accountability based, what outcomes we would see in relation to their children and the people they have perpetrated violence against.**
- **what would happen if we aligned responses to what children, young people, and adult victim survivors are telling us they need and what works.**
- **if we had a peer-led intake point, like the mental health sector, where you could speak with just a peer, and then move on to professional practitioner support.**
- **if we had funding and resources to support staff and to manage work burn out and vicarious trauma, and an increased understanding of wellbeing.**
- **what organisations could do differently with current resources to help support staff.**
- **what happens if there are channels to meaningfully deliver evidence to decision makers and funding bodies about what is working and create opportunities to scale and replicate this across different agencies.**

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VIOLENCE
PARTNERSHIP