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National survey of FaRS-funded service providers

Overview of services and service provider perspectives

RESEARCH REPORT 2018

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Summary

This report contains the results of a mixed methods research study exploring the characteristics and activities of Department of Social Services' (DSS) funded Family and Relationship Services (FaRS) and Specialised Family Violence Services (SFVS).

The project was undertaken so that the DSS can better understand the nature and type of FaRS and SFVS activities, their referral pathways, risk-management practices, service linkages and approaches to meeting client needs. The research also aimed to share participants' strategies and approaches for identifying and responding to local community needs.

The results from this research will help to inform future service delivery and design, as well as support the capacity building of services and workers supporting those experiencing, or at risk of, domestic and family violence.

Key messages

- Regardless of their location, most FaRS and SFVS delivered a similar range of (primarily therapeutic) centre-based programs and referral services. Many also offered outreach activities, particularly in regional and remote areas.
- Self-referrals were the largest source of referral for all FaRS and SFVS. SFVS were more likely than FaRS to have referrals to or from police, other domestic and family violence services and specialist drug and alcohol services. Services in regional and remote areas were more likely than metropolitan services to have referral pathways into, or out of, child protection services.
- FaRS and SFVS services worked collaboratively across a range of sectors but referrals and collaborative relationships were most common with similar family services. Co-location was the norm for FaRS and SFVS and was believed to enhance service provision and collaboration.
- Staff within FaRS and SFVS had a high degree of confidence in the quality of their service, their professional skills and their services' procedures and protocols for managing risk. However, FaRS and SFVS staff expressed a need for building their capacity to work with clients who use violence.
- Staff within FaRS and SFVS reported that their services spent the largest proportion of time on intake and referrals. This reflected the importance and time-consuming nature of such work. Less staff time was available for early intervention activities or post-service follow-up.
- FaRS and SFVS staff in all geographical areas indicated that their service did not always have the resources or staffing levels needed to undertake follow-up work with clients or to identify and respond to changing community needs.
- The concept of 'early intervention' had several meanings in staff usage. Although many FaRS and SFVS staff indicated a desire for working with families before a crisis or violence had occurred, they usually had limited opportunity to do so. Consequently 'early intervention' in practice usually entailed dealing with clients who disclosed issues, such as domestic and family violence, at the initial referral and intake stage.

1 Introduction

1.1 Background to the study

The Department of Social Services (DSS) commissioned the Australian Institute of Family Studies (AIFS) to undertake research for the purpose of investigating the activities of DSS Family and Relationship Services (FaRS) funded service providers, with a focus on Specialised Family Violence Services (SFVS). FaRS are a key point of contact and intervention for families experiencing difficulties, including domestic and family violence (DFV). Because FaRS are a universal service that aims to strengthen family relationships, prevent breakdown and ensure family and child wellbeing, they can provide an early intervention 'triage' regarding family violence for all families accessing services. Within the broader FaRS network of services, a small number of agencies also provide SFVS. However, DSS is currently seeking a greater understanding of how FaRS (including the SFVS) are dealing with DFV and/or how they interact with other agencies or services.

Three overarching questions guided the research:

1. What services are being provided by FaRS and SFVS funded service providers?
2. What are some of the challenges and gaps experienced in delivering these services?
3. What does integration and/or linkage of FaRS services with funded and non-funded family services look like at this point in time?

This research consists of:

1. an online survey developed as part of a consultative process with DSS and FaRS and SFVS service providers
2. targeted qualitative interviews with FaRS and SFVS service providers.

The survey and interviews focused on the types of services provided; whether these services connected to other relevant services; how respondents identified and managed risk; and the successes and challenges that services experienced when attempting to meet the needs of women, children and families. In particular, the research aimed to share respondents' strategies, approaches, perceptions and experiences for meeting, managing and responding to local community needs.

1.2 Structure of the report

The report begins with a brief description of the research methodology. The research findings are then presented in four sections which address the three overarching research questions. The first section describes the characteristics of the FaRS and SFVS survey respondents and the types of FaRS and SFVS services they provide. The second part explores the relationships between services, the referral pathways of FaRS and SFVS service users across metropolitan, regional, and rural and remote areas of Australia, and co-location arrangements within DSS and non-DSS funded services. The third section describes how services attempt to address community needs. The final part of the report describes issues related to staffing capacity training and retention.

Appendix A presents tables showing the descriptive analyses of the online survey data. Only results relevant to the key overarching research questions are discussed in the body of the report. Appendix B shows the interview schedule used by researchers during the qualitative interviews.

The results of this quantitative and qualitative research are presented in the form of summaries and tables derived from the survey results. These are drawn together with quotes and summaries taken from the information provided during the qualitative interviews, which expand on the survey findings. Throughout

the report, FaRS and SFVS service providers who participated in the online survey are referred to as 'survey respondents' and those who participated in the qualitative interviews are referred to as 'interviewees'.

Although SFVS are a subset of FaRS, in this report the term 'FaRS' refers to services without an SFVS. SFVS, in contrast, can include both SFVS that also have a mainstream FaRS component and the small number of SFVS that indicated (in their survey responses) that they were a standalone service.

2 Research methodology

The project methodology of this research study comprised two components. The first was a national, web-based survey targeted at FaRS and SFVS service providers, inclusive of managers and practitioners. The survey was supplemented by a small number of targeted, semi-structured telephone interviews with FaRS and SFVS managers and practitioners.

2.1 Online survey

The online survey collected information about participating FaRS' and SFVS' broad area of operations and geographic location. It focused on how the services operated, the types of clients seen by services, referral processes and processes for dealing with domestic and family violence (DFV).

To develop the survey, AIFS undertook scoping activities of similar cross-sectional and longitudinal studies, reviewed relevant DSS literature, consulted with DSS and key stakeholders (regarding survey domains/focus areas, testing of recruitment strategy), and made use of the information provided during a consultation and 'workshopping' process between the AIFS research team, DSS and a group of FaRS and SFVS service providers (comprising managers and practitioners). Before commencement of the main fieldwork, the survey was pilot tested with relevant DSS and AIFS staff, as well as with an advisory group of Victorian FaRS and SFVS program managers.

An email invitation alert and information sheet drafted by AIFS, and circulated by the DSS through their service delivery networks, alerted FaRS and SFVS service providers of the study and encouraged them to participate. AIFS subsequently circulated a link to the survey to relevant individuals and organisations whose names and contact details were provided by DSS and/or by other individuals within the relevant organisation. Due to staffing changes at FaRS across the period of the research project, finding relevant addresses proved to be a time-intensive process.

Individuals, particularly program managers receiving study information, were encouraged to pass the link on to other relevant people within their organisation. Individuals receiving the link then chose whether or not to (anonymously) complete the 15-minute survey. The online survey was hosted on AIFS' secure servers.

The fieldwork period spanned four weeks of active recruitment with an extension of two weeks to mitigate the effects of the data collection period falling across December–January (making the fieldwork period six weeks in total). Reminder emails were sent at weekly intervals to the networks and to key personnel, reminding them to participate and/or to forward the invitation email on to potential respondents.

2.2 Qualitative interviews

The second component of the project methodology consisted of telephone interviews with key stakeholders (primarily program managers) from FaRS and/or SFVS providers. Concurrent to the online survey, qualitative interviews were conducted with service providers (in their professional capacity) in order to explore aspects of their service that were difficult to capture in an online survey. The interviews were semi-structured and explored general themes relating to:

- the factors influencing FaRS and SFVS program outcomes
- SFVS strengths and points of difference from other FaRS services
- the ways in which FaRS and SFVS services work with and/or refer to other services
- ways of building service and worker capacity for dealing effectively with DFV.

2.3 Study sample and data analyses

The online survey was completed by 212 participants. Of these, 146 survey respondents indicated that they worked primarily in FaRS, 60 said they worked in both FaRS and SFVS, and six reported that they worked solely in SFVS. There were respondents from FaRS and SFVS in all Australian states and territories.[1] As such, the survey sample represented services from across Australia and provided data useful for a descriptive snapshot of the activities undertaken by FaRS and SFVS activities, their client and referral patterns and the issues that staff and managers commonly confront in their work.

However, there were some limitations to the survey and some care should be taken when interpreting results. The small sample size and the opportunistic recruitment method (whereby respondents anonymously opted into the survey after receiving an email invitation circulated within their organisation) meant that it was not possible to control the sample's structure. The anonymous responses and the absence of a sampling frame of the entire eligible population of FaRS staff mean that it was not possible to determine how representative of all FaRS and SFVS, or their staff, the survey respondents were. The data analysis was primarily descriptive in nature. For the most part, calculation of statistical significance, or analysis of differences within and between subgroups, was not appropriate or could not be meaningfully calculated.

Nine interviewees from nine different FaRS and/or SFVS participated in the qualitative interviews. The interviewees were drawn from the list of contacts provided to AIFS by DSS. The interviews provided contextual understanding of the descriptive data gathered from the online survey. They gave insight into the individual strategies, approaches, perceptions and experiences adopted by interviewees (and their respective services) in order to meet, manage and respond to local community needs.

1 In the July–December period, when survey fieldwork began, there were 82 organisations delivering FaRS services at 481 sites. The data on the number of organisations or sites represented by respondents were too incomplete or unreliable to accurately calculate but indicated that staff from at least 50 organisations completed the survey.

3 What do we know about participants in this research?

This section describes:

- the characteristics of the FaRS and SFVS survey respondents
- the types of FaRS and SFVS services they provide
- where their services are offered across metropolitan, regional, and rural and remote areas of Australia.

3.1 Gender, roles and service type

The online survey was completed by 212 participants, representing a range of FaRS and SFVS services across Australia. More than three quarters of survey respondents (*n* = 169) were female. The sample comprised practitioners (*n* = 114) and managers (*n* = 61), as well as survey respondents working in both of these roles (*n* = 37). A larger proportion of survey respondents worked full-time (*n* = 131) than part-time (*n* = 81).

As noted above, due to the survey's sample size and composition, care should be taken when interpreting the results as the findings cannot be generalised to the entire FaRS and SFVS population. The sample is representative of the survey respondents who participated in the online survey. Table 3.1. shows a breakdown of the characteristics of survey respondents.

Table 3.1: Characteristics of survey respondents

	Female		Male		Total	
	n	%	*n*	%	*n*	%
Total	**169**	**80**	**40**	**19**	**212**	**100**
Respondent role						
Practitioner	89	53	22	55	114	54
Manager	47	28	14	35	61	29
Both	33	20	4	10	37	17
Working hours						
Full-time	100	59	29	73	131	62
Part-time	69	41	11	28	81	38
Service type						
FaRS	119	70	25	63	146	69
SVFS	4	2	2	5	6	3
Both	46	27	13	33	60	28

Note: Totals includes non-responses. Percentages may not add up to 100% due to rounding.

3.2 Where are FaRS and SFVS services located?

We cover the lower part of New South Wales, our Canberra Services go north to Goulburn, along the south coast, south from Batemans Bay, Cooma, Queanbeyan, and those southern areas … In the Riverina we're funded by New South Wales government departments to deliver a Headspace service, a family referral service, which is linked with Child Protection, and a rural Outreach program funded by Presentation Sisters, which is a religious organisation in Wagga. (Service provider)

In the survey we asked managers and practitioners about their service's primary location. The majority of respondent services were located across metropolitan and inner regional areas of Australia (*n* = 112). Just over 10% of services were located in outer regional and remote areas (*n* = 24).

The responding FaRS and SFVS services had a broadly similar distribution across metropolitan, regional and remote parts of Australia. However, a larger proportion of FaRS services (*n* = 19) compared to SFVS services (*n* = 3) were located in outer regional and remote areas of Australia. This is an expected outcome given the overall larger number of mainstream FaRS. Table 3.2. shows the spread of FaRS and SFVS service locations across Australia based on the information provided by survey respondents.

Table 3.2: Main service locations by service type

	FaRS		SFVS		Total	
	n	%	*n*	%	*n*	%
Total	**146**	**69**	**66**	**31**	**212**	**100**
Geographic remoteness						
Major cities of Australia	74	51	38	58	112	53
Inner regional Australia	31	21	15	23	46	22
Outer regional Australia	22	15	10	15	32	15
Remote/very remote Australia	19	13	3	5	22	11
Services at multiple locations						
Respondents' employer provides services at another location	67	46	35	53	102	48

Note: Total includes non-responses. Percentages may not add up to 100% due to rounding. Total of FaRS

Close to half of the survey respondents reported that they (or their service) also provided services at a secondary location. The geographic distribution of secondary locations across Australia was similar to the primary locations (see Table 3.3). That is, most secondary locations were either in the same geographic remoteness area or one level further out. No services operated in separate states (with the potential exception of one remote community where their postcode area crossed the border).

Table 3.3: Secondary service locations by service type

	FaRS		SFVS		Total	
	n	%	*n*	%	*n*	%
Total number of services	**146**	**69**	**66**	**31**	**212**	**100**
Major cities of Australia	30	45	16	48	46	46
Inner regional Australia	14	21	6	18	20	20
Outer regional Australia	13	20	8	24	21	21
Remote/very remote Australia	9	14	3	9	12	12

3.3 FaRS and SFVS activities

We offer counselling and community education to people from age three up across each stage of a lifespan. We deal with mental health issues and we work individually and in family groups. We have expertise in domestic violence and trauma-informed counselling. (Service provider)

Overall, survey respondents indicated that FaRS and SFVS offered a similarly wide range of services. The survey responses suggested that regardless of whether services were located in metro, inner regional or outer regional and remote areas, FaRS and SFVS core business was to provide centre-based programs, information, advice and referral to individuals, families, couples and children. Outreach services, in-home support, online services and community events/services were offered by all services to a lesser degree, although regional and remote services were more likely than metropolitan services to offer outreach and in-home services. This is likely a reflection of the sometimes wide geographical area served by non-metro services. Table 3.4 shows a breakdown of the service modes across Australia.

Table 3.4: Types of services offered, by geographic remoteness

	Metro (*n* = 103)		Inner regional (*n* = 43)		Outer regional/remote (*n* = 51)	
	n	%	*n*	%	*n*	%
Service types offered						
Centre-based individual programs	80	78	41	95	37	73
Information/advice/referral	78	76	35	81	45	88
Centre-based group programs	77	75	36	84	33	65
Centre-based couple programs	70	68	36	84	33	65
Centre-based parent programs	61	59	36	84	34	67
Centre-based child/youth-focused programs	52	50	28	65	31	61
Telephone services	56	54	22	51	23	45
Centre-based family programs	51	50	23	53	26	51
Outreach services	38	37	27	63	25	49
Case management	43	42	11	26	28	55
Community events/services	28	27	14	33	26	51
Online services	16	16	4	9	9	18
In-home support	8	8	5	12	11	22

Counselling was the primary activity for practitioners in both FaRS and SFVS, although SFVS practitioners reported spending less time on family therapy, education and skills training, mediation, and working with children and young people than did FaRS (see Appendix A, Table A5 on page 25). This finding reflects the specialised nature and targeted approach of SFVS work relative to the broader FaRS services.

Survey respondents from both FaRS and SFVS reported that their service as a whole spent the largest proportion of time on intake and referral processes, reflecting both the importance and time-consuming nature of such work (see Appendix A, Tables A5 on page 25 and A6 on page 26). Supervision and professional development and trialling innovative approaches to service provision were the next most time-consuming activities for both FaRS and SFVS. Both groups of survey respondents reported a similarly low amount of time on early intervention. In section 6 we discuss issues relating to staff resources and capacity to undertake early intervention work. It is also worth noting that interviews with participants indicated that there were varying definitions of 'early intervention' and that the term could be applied at different points in the service spectrum. Although interviewees indicated that they would ideally like to work with families before violence had occurred, they often had limited opportunity to do so because referrals into the service typically occurred after a violent event or crisis. Therefore, for FaRS and SFVS interviewees, 'early intervention' instead often meant early referral of clients into appropriate services (such as SFVS) when clients disclosed domestic and family violence (or other issues) at the referral and intake stage. As such, 'early intervention' overlapped with referral and intake, the activity on which services spent the most time.

As part of their service provision, both FaRS and SFVS providers reported using a range of information and communication technology (ICT) tools and devices to support service provision (see Table 3.5). These include telephones, text messaging, websites, skyping, video conferencing, online services, social networking sites and smart phone apps. A small proportion of survey respondents from metro (8%), inner regional (14%) and outer regional/remote areas (20%) reported not using any ICT tools and devices at their service. Qualitative interviews with participants indicated that some clients, especially in regional and remote areas, preferred face-to-face contact and the personal relationships that this enabled.

Table 3.5: Service delivery: ICT tools and devices, by location

	Metro (*n* = 103)		Inner regional (*n* = 43)		Outer regional/remote (*n* = 51)	
	n	%	*n*	%	*n*	%
Our service uses the following for counselling, education, consultation, support groups and outreach ...						
Telephone services	72	70	26	60	35	69
Text messaging	71	69	27	63	31	61
Websites	60	58	23	53	21	41
Skype, video conferencing	41	40	12	28	23	45
Online services	17	17	8	19	17	33
Social networking sites	21	20	5	12	15	29
Smart phone apps	18	17	11	26	7	14
We don't use any of these at our service	8	8	6	14	10	20

During the qualitative interviews, participants also indicated that services commonly have to work across a range of treatment and service provision modes according to client needs. For example, one interviewee reported that a SFVS worker may work with one parent while another worker will work with the second parent and, if appropriate, a third worker may work with the child/children as well. Different modes of contact, or service, could be required by each of these clients. Another interviewee described shared service arrangements, whereby the service could have a FaRS worker who would co-facilitate a youth and wilderness program (an outdoor program) administered by another service because the program addressed issues around young people's experiences of parental separation. Workers indicated that this mode of working across families, couples, young people and children was complex and that careful consideration needed to be given to professional development to ensure workers had the appropriate skills and general life experience to perform these roles adequately.

4 Service and sector relationships

FaRS and SFVS services do not work in isolation; rather, they form part of wider local and regional networks of services that could be both a source or recipient of client referrals and/or provide additional services to FaRS and SFVS clients.

This section explores:

- the relationships between services (including between mainstream FaRS and SFVS)
- referral pathways of FaRS and SFVS services users across metropolitan, regional, and rural and remote areas of Australia
- the co-location arrangements within DSS and non-DSS funded services.

4.1 Referral intake

FaRS and SFVS services aim to support families and strengthen family relationships. To achieve this, FaRS and SFVS commonly receive referrals from a range of sources. Self-referrals were the biggest source of both FaRS and SFVS clients. The family, friends and neighbours of clients, other professionals based within FaRS and/or SFVS and the legal sector (e.g. legal assistance, family law courts) were also reported as important sources of referrals. However, referrals were also received from a range of other sectors. This reflected the wide range of services that FaRS and/or SFVS clients had often already encountered before their referral and the range of issues that may have brought them into contact with services (see Table 4.1 on page 10). Due to their focus on family and domestic violence (FDV), and the multiple and complex needs of many FDV clients, SFVS were more likely to receive referrals from police, housing services and specialist drug, alcohol and FDV services than were mainstream FaRS. Nonetheless, self-referrals were still the largest source of referral into SFVS.

The survey data indicated few differences in sources of referrals between metropolitan, regional, and rural and remote areas. However, it was notable that respondents in metropolitan areas reported that their service had fewer referrals from child protection agencies than did those from regional or remote areas (see Appendix A, Table A9 on page 27). The reasons for this difference are unclear but suggest that regional or remote areas may have a different client population and/or slightly different client needs.

As noted in section 3.3, survey respondents to the online survey indicated that intake and assessment processes are a central component of the work of FaRS and SFVS and constitute a large proportion of their working time (also see Appendix A, Table A6 on page 26). Information provided from the qualitative interviews indicated that the referral intake was a key factor in setting the direction of support for families and family members. During intake it was determined if the client engaged with FaRS in the first instance or if they were to be immediately referred to SFVS (and/or other services). One interviewee described the intake process conducted by workers called 'Family Advisers'. A family adviser was said to spend up to 20 minutes talking to a new client on the phone. The advisers were required to work from scripts that included a risk assessment protocol to identify violence and safety issues. If any level of violence, abuse, inter-relation harassment, or threat was expressed by the client at this time, the individual was immediately referred into the SFVS where they could receive support from a worker who specialised in family violence.

Table 4.1: Most commonly reported sources of referrals to FaRS and SFVS

	Total (%)	SFVS (%)	FaRS (%)
Self-referral	45	37	47
Family/friend/neighbour	28	23	29
Other professional at your service	25	24	26
Legal (e.g. legal assistance, family law courts)	24	23	24
Child protection agencies	20	24	19
External family services	18	20	18
Health (e.g. community health centre, mental health)	18	16	18
Specialist (e.g. alcohol or other drugs, gambling, FDV, sexual assault)	16	25	13
Police	15	22	12
Clergy	10	7	11
Education	12	8	13
Housing (e.g. short-term crisis refuge accommodation)	10	17	8
Financial	8	8	7

However, providers also indicated that many clients do not disclose over the telephone the level of violence happening in their family and this could have implications for their service and referral pathway. For example, many 'early intervention' FaRS clients already had violence in their relationship that could not be detected at intake. In these cases, the client could transfer over to SFVS at a later date. However, participants in the qualitive interviews indicated that allocation to either FaRS or SFVS often happened at the first point of contact. Clients who were initially allocated to FaRS but later disclosed incidents of DFV would often remain in the FaRS service, and receive the services they needed there (including referrals to other specialist DFV services), rather than being reallocated to a SFVS. In this way, clients could have continuity of service. There was insufficient data to indicate how widespread these intake and referral practices were.

Providers also indicated that referral intake could be a time-consuming process and that managing waiting lists was an ongoing challenge for FaRS and SFVS services. Providers indicated that clients had to be triaged to ensure that no-one is at risk; however, this in turn placed additional demands on staff skills and capacity as risk assessment became a skill that all staff needed to have in order to keep up with service user demands. This could also require services to periodically reassess and develop their referral and intake procedures in order to manage demand.

> *Probably three or four years ago, we started this transition to a central intake model, because we were realising that pretty much every program was doing their own intake and a client could come in 42 different pathways … so it was working out what's best for the client. From that, we've built an interim client database to capture the data that we need, and to understand what we actually need to build, so we have one client database. (Service provider)*

4.2 Referral pathways and engagement

> *I think people always do the very best they can to work towards a common goal. (Service provider)*

In providing support to families, FaRS and SFVS services referred their clients to a range of other services. Referrals to other services from metro, inner regional, and outer regional and remote FaRS and SFVS were generally similar. However, just as services in outer regional and remote areas were more likely to gain referrals from child protection services, they were also more likely than metropolitan-based services to refer *into* child protection services, as well as into health, housing, education, police and specialist services (e.g. alcohol and other drugs, gambling, specialist FDV and sexual assault). These referral pathways may reflect differences in client populations and/or the types of issues that clients present with at FaRS and SFVS services in the outer regional and remote areas. In contrast, survey respondents in outer regional and remote areas reported fewer referrals to children and parenting support services compared to survey respondents in metro and inner regional areas (see Table 4.2).

For the most part, FaRS and SFVS services most commonly engaged with, and referred to, other community family services as well as child protection agencies. Liaison and referral with other service sector types did occur but this work did not appear to comprise the core business of FaRS and SFVS services. These other sectors included financial assistance, legal services (e.g. legal assistance, family law courts), health (e.g. community health centres, mental health services), housing (e.g. short-term crisis refuge accommodation), education, police and specialist services (e.g. alcohol or other drugs, gambling, specialist FDV, sexual assault). There was little difference in the types of other services available in the local catchment areas of metro, regional, and outer regional and remote areas (see Appendix A, Table A11 on page 28).

The following example drawn from the qualitative interviews illustrates the range of entry points into FaRS and SFVS services as well as the complexity of some referral pathways as clients engage and work with a range of service providers.

> *We do have elderly people come through – if they're looking for a specific service … so for elder abuse, where there's family violence, gambling, because we have the Gamblers' Help program and financial counselling; they may have come through their program – and our housing programs, we probably get a number of people come through our doors because of that. (Service provider)*

Table 4.2: Most frequent destination services for FaRS and SFVS referrals, by geographic remoteness

	Metro (%)	Inner regional (%)	Outer regional/ remote (%)
Family and Relationship Services (FaRS)	36	42	39
Specialised Family Violence Services (SFVS)	29	24	15
Family Law Services	23	24	20
Communities for Children Facilitating Partner	10	6	10
Children and Parenting Support	26	30	20
Intensive Family Support Services	14	17	16
Other DSS funded services	18	15	20
Family services	15	14	16
Child protection agencies	13	13	20
Financial	15	13	22
Legal (e.g. legal assistance, family law courts)	29	22	25
Health (e.g. community health centre, mental health)	21	14	28
Housing (e.g. short-term crisis refuge accommodation)	13	14	22
Education	15	10	21
Police	16	12	21
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	20	21	22
Other	12	7	8

4.3 Relationships with DSS and non-DSS funded services

> *We work with the Family Relationship Centre and also the [service] who work across mediation, it's one of the things that we do really well, simply because we're co-located. (Service provider)*

Ninety-one per cent of FaRS and SFVS services reported that they were co-located with at least one other service (both DSS funded and non-DSS services). This indicates that co-location is the 'normal' arrangement. Not surprisingly, this co-location was most common with other similar services including family and relationship services, Family Law Services and services offering support to parents and children. Table 4.3 shows a breakdown of the type of other DSS funded services with which FaRS and SFVS were co-located. For the most part there was little significant variation between regional areas with regards to the types of services with which FaRS were co-located. However, respondents from outer regional/remote areas were somewhat more likely to be co-located with Intensive Family Support services than were those from metro or inner regional areas.

Respondents from metro areas were slightly less likely to be co-located with housing services than were non-metro areas (see Appendix A, Table A13 on page 29).

Table 4.3: DSS funded services most commonly co-located with respondents' service (by service type)

	FaRS (*n* = 146)		SFVS (*n* = 66)		Total (*n* = 212)	
	n	%	*n*	%	*n*	%
Co-located with ANY DSS service	122	84	53	80	175	83
Type of DSS co-located service						
Family Law Services	62	42	34	52	96	45
Other FaRS	61	42	30	45	91	43
Children and Parenting Support	40	27	25	38	65	31
Financial Counselling, Wellbeing and Capability	25	17	18	27	43	20
Other SFVS	18	12	15	23	33	16
Emergency Relief	18	12	14	21	32	15
Intensive Family Support Services	22	15	8	12	30	14
Communities for Children Facilitating Partner	9	6	9	14	18	8
Community Mental Health	8	5	8	12	16	8
Personal Helpers and Mentors Service (PHaMS)	10	7	3	5	13	6

The qualitative interviews indicated that co-location or proximity could influence referral pathways or collaborative service delivery. For example, one interviewee reported that her service was located near a range of Family Law Services and this enabled them to form beneficial relationships, and work with, those services. In this instance, the FaRS service she worked for often took referrals from the Family Relationship Centre or the Children's Contact Service. In these cases, where parents were often going through separation and divorce, and/or where family violence had been identified, the FaRS team would provide counsellors to work with individuals within that family.

Information from the qualitative interviews also indicated that 'co-location' did not always entail entire services being located at the same site. For example, one interviewee described arrangements where individual workers were situated at particular organisations. As part of an outreach program in a metro area, workers were located in Aboriginal and Torres Strait Islander organisations in the jails, in the youth detention centre and in child and family centres funded by the state government. These workers provided community services such as child health, maternal health, dentists, physios, play groups and child care. They could be based at these locations from anywhere between one day a fortnight to one or two days a week.

More than half of survey respondents reported that the service they worked for was co-located with a non-DSS funded service, indicating this is also a common arrangement, particularly with other family services and those that have a similar specialist focus (see Table 4.4). There was relatively little difference between the types of services that FaRS and SFVS services were co-located with, with family services the largest grouping for both service types. SFVS were slightly more often co-located with other FDV and housing services – which may reflect their specialist focus and the finding that SFVS more often referred into or out of such services than did mainstream FaRS – however, the difference between services was small.

Although FaRS and SFVS most often referred to or from, worked and/or were co-located with similar types of family services, the wide range of service types with which they reported connections was indicative of the complex needs of their clients and the wide range of relationships required to meet client needs. Participants in the qualitative interviews described multi-service and multi-disciplinary work as a key part of their service. Such collaborative working most often arose as interviewees attempted to respond to the needs of clients as they emerged.

> *We obviously work with the client as with where they're currently at and what their needs are and if there's a service that we think can benefit the client and support them … we'll obviously refer people into those services and then our staff will work together in that kind of case management model to support the client and it might be that I would say, 'Well, actually, right at this moment in time we think you need to go and have some family counselling or mediation and then come back and deal with other things, because that's where you're at the moment. (Service provider)*

Table 4.4: Non-DSS funded services most commonly co-located with respondents' service (by service type)

	FaRS (*n* = 146)		SFVS (*n* = 66)		Total (*n* = 212)	
	n	%	*n*	%	*n*	%
Co-located with ANY non-DSS service	102	70	48	73	151	71
Type of co-located service						
Family services	48	33	26	39	74	35
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	29	20	20	30	49	23
Housing (e.g. short-term crisis refuge accommodation)	23	16	16	24	39	18
Youth services	24	16	10	15	34	16
Out-of-home care	16	11	6	9	22	10
Financial	15	10	10	15	25	12
Education	15	10	2	3	17	8
Disability	13	9	4	6	17	8
Health (e.g. community health centre, mental health)	12	8	8	12	20	9
Child protection agencies	12	8	5	8	17	8
Employment	9	6	1	2	10	5
Legal (e.g. legal assistance, family law, courts)	2	1	3	5	5	2
Police	2	1	1	2	3	1

5 Community needs

I think about when we first started, we had very set, you know, you do this, you do this and you do this. And now we try to be a little bit more adaptive to what's going on at the time, responsive to local community needs … being flexible and responsive to the needs as they're emerging. (Service provider)

In the qualitative interviews, participants indicated that for FaRS and SFVS to be effective, they needed to be embedded within their local communities so that they could identify, and respond to, community needs as they emerged or changed\. Hence, to some extent, although most FaRS and SFVS provided a generally similar range of services regardless of their location (see section 3.3 on page 7), they also sometimes needed to modify and change the way they provided services in order to ensure they continued to meet community needs. This section describes the ways in which services identified and addressed such community needs.

5.1 Responding to community needs

We're doing some research at the moment about what best practice looks like in a contact centre. There's lots of things around sensory gardens and those sorts of things that we can utilise. (Service provider)

At the client level, FaRS and SFVS survey respondents indicated that the main issues they dealt with in their work were family relationships, family violence, mental health, parenting, exposure of children to family violence, and emotional abuse and/or anger issues (see Table 5.1).

Table 5.1: FaRS and SFVS service user issues, frequency of encounters

How often do you deal with the following issues?	Score out of 5 (average of responses)			Often/always encounter issue (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Family relationships	4.6	4.7	4.4	97	97	97
Family violence	4.0	3.8	4.4	82	100	76
Alcohol and other drugs	3.4	3.4	3.4	44	43	45
Mental health	3.9	3.9	3.8	77	69	79
Gambling	2.5	2.5	2.5	7	7	7
Homelessness	2.5	2.4	2.8	12	14	12
Parenting	4.3	4.3	4.1	87	83	89
Elder abuse	2.0	1.9	2.1	3	3	3
Legal issues	3.2	3.2	3.3	46	52	44
Adolescent violence	2.7	2.6	3.0	15	21	13
Disability	2.6	2.6	2.5	51	52	51
Cultural issues	3.1	3.2	3.0	32	24	34
Exposure of children to family violence	3.7	3.6	4.1	68	86	63
Child abuse and/or child safety and/or child neglect	3.3	3.3	3.5	45	59	41
Emotional abuse and/or anger issues	4.1	4.0	4.3	88	100	84

Note: Totals based on scale 1–5 with 1 = Never deal with these issues and 5 = Always deal with these issues.

Elder abuse and gambling were much less frequently encountered or addressed in the respondents' services. These results are largely to be expected given that FaRS' and SFVS' key purpose is to provide services to support families and strengthen family relationships. However, reflecting the wide range of issues that FaRS and SFVS clients could present with, or that could be associated with family conflict, staff also reported that their work could entail dealing with issues relating alcohol and other drugs, gambling, homelessness, elder abuse, legal issues, adolescent violence, disability, cultural issues and child abuse or neglect.

Participants in the qualitative interviews indicated that services undertook a range of activities to monitor community needs and the issues that clients most commonly presented with. This, in turn, could inform service practice. For example, one interviewee reported that the service she worked for used community educators, a community house and a comment mechanism on their website to collect community feedback and identify community needs. The findings from these activities were aggregated by the service's research and evaluation team and combined with relevant literature, ABS statistics and local socio-demographic data to build a picture of community needs and inform appropriate service responses. At times, the emergence or identification of new forms of demand presented a challenge, as services attempted to both serve their existing body of clients (or current core service areas) and adapt to changing needs.

In the qualitative interviews, participants from both FaRS and SFVS also identified a range of ways in which they had responded to changing levels of demand or specific community needs. For example, one service, after identifying the high levels of service collaboration required to undertake their work, had created specific staff roles for facilitating service integration and for further service innovation. Another service allocated 'portfolios' to team members, which were then taken to local community stakeholders for consultation.

Services could also give consideration to the role of the physical environment as a means of facilitating engagement with clients. One interviewee reported that the service had created a purpose-built, rooftop garden for young people at one of their service locations. This garden was built after the service identified young people's desire to have a location that was not a standard office but in which they could receive services or participate in group activities.

5.2 Responsiveness to specific community groups

The fact that we've got a refugee health clinic, you know, that really helps. (Service provider)

There are identified groups of people that come into our organisation that if we were to just do the same with them it wouldn't be the best practice. (Service provider)

FaRS and SFVS survey respondents reported that they generally had moderately high levels of ability and skill in providing assistance to specific community groups such as culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander peoples (ATSI), and lesbian, gay, bisexual, transgender and intersex (LGBTI) clients. Slightly lower levels of confidence were reported with respect to addressing the needs of clients with disability. Although the difference was small (and not statistically significant), this may indicate a need for further capacity building (see also Table 5.7 on page 18).

Table 5.4: Respondent assessments of services' ability and skills in assisting specific community groups

	Score out of 5 (average of responses)			Responses agree/ strongly agree (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Our service has the ability and skills to assist CALD clients	3.9	3.8	3.9	75	74	75
Our service has the ability and skills to assist ATSI clients	3.9	3.8	4.0	77	72	79
Our service has the ability and skills to assist clients with disability	3.8	3.8	3.8	69	68	74
Our service has the ability and skills to assist LGBTI clients	3.9	3.9	3.9	78	78	77

Note: Totals based on scale 1–5 with 1 = Strongly disagree and 5 = Strongly agree.

The qualitative interviews provided further insight into the challenges of meeting the needs of specific community groups. One interviewee reported that her service had noticed an increase in demand from the CALD community within the last 18 months to two years. This awareness of a growing need arose from the manager's

connections within the local CALD community. After one of the community elders had flagged a need, the service undertook research into how the program could be delivered and eventually this resulted in the service obtaining a grant to run an eight-week pilot parenting program for the Sudanese community that focused on differing cultural traditions, beliefs about parenting and attitudes towards education. Due to the amount of work required to start up and run the pilot program, the service ran at a loss. Hence, although providers and funders felt that the pilot was successful in meeting the needs of this specific local community group, no further funding was granted for its continuation.

Providers in the qualitative interviews also identified the elderly as a community group who could require specific responses to a complex set of needs. When describing how many clients require a range of complex issues to be dealt with simultaneously, rather than in isolation, one provider used elder relationship support services as an example. She reported that there had been an increase in the number of older people ringing the service seeking support of various kinds but that when exploring the conflict issues, the service often discovered instances of abuse or violence. However, in many instances, the older person was not able to name the behaviour as abuse or violence, or they had not considered the conflict issue that they presented with at the service to be abuse or violence. Hence, providers needed to be aware that they may be required to explore beyond the issues that these clients sought assistance with.

5.3 Service capability to meet and manage community needs

> *When I first started in the early days of being CEO, we had an average fee of $60 a session. Now most people pay $20. And most, more than 30% pay nothing, so the median in other words is $20, so our fee income has massively dropped. That's one way we know that we're working with a different population. (Service provider)*

> *We're trying to be innovative and responsive to who the audience is that we're getting approached by. (Service provider)*

FaRS and SFVS services work with a range of community groups, many of them with complex needs; as a result, providers can face a range of challenges in identifying and meeting local community needs. On the whole, managers and practitioners in FaRS and SFVS were confident about the ability (in terms of skills and knowledge) of their service to carry out their core work in meeting community needs and rated their own professional competence high on most items. There was little difference between regions in this regard, with survey respondents in outer regional and remote regions generally expressing the similar levels of confidence about skills and knowledge as those in metropolitan areas.

In terms of the overall service, FaRS and SFVS survey respondents expressed the highest levels of confidence in their service's skills and knowledge with respect to core service delivery activities such as counselling of families, individuals and children as well as intake and assessment (see Table 5.5). Both SFVS' and FaRS' ability to undertake work outside their core service delivery functions were rated less highly. In particular, survey respondents appeared to express some reservations about their service's ability to undertake prevention, early intervention, and client follow-up, or to trial innovative approaches to service provision. These different ratings do not necessarily relate directly to the services' objective competence in these areas but rather can reflect provider perceptions of what they currently do well versus those areas where they feel that they could do better (or would like to do more) but have limited opportunities, limited resources (see section 6 on page 19) or require further capacity building and training.

Both FaRS and SFVS survey respondents also rated their own professional competency relatively highly. More specifically, they rated highly their skills and knowledge in providing services related to family relationships, parenting, complex needs, and in making appropriate referrals (see Table 5.6).

Despite survey respondents in both SFVS and FaRS generally rating their skill levels as high, they were less likely to highly rate their skills and knowledge in providing services to clients who use violence. This indicates a potential need for capacity building in these areas. It is notable that when asked to identify their capacity-building needs, FaRS providers most commonly identified a need for training and capacity building in working with perpetrators of violence. In contrast, a much smaller proportion of SFVS providers indicated a need for capacity building in this area (see Table 5.7). Again, it should be noted that these self-ratings do not necessarily reflect objective levels of skill or knowledge but rather practitioner perceptions of what they do best and where they could develop further capacity.

Table 5.5: Respondent confidence in their services' skills and knowledge

	Score out of 5 (average of responses)			Responses agree/ strongly agree (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Prevention	3.6	3.4	3.7	59	57	60
Intake and assessment	4.2	4.3	4.2	89	95	86
Early intervention	3.6	3.4	3.7	62	57	65
Service delivery (with individuals, couples, families)	4.5	4.5	4.5	96	98	95
Crisis intervention	3.8	4.0	3.7	69	75	66
Client follow-up and assessment of outcomes	3.5	3.4	3.5	54	49	57
Supervision and professional development	4.0	4.0	3.9	80	75	82
Trialling innovative approaches to service provision	3.4	3.2	3.4	51	49	51

Note: Totals based on scale 1–5 with 1 = Strongly disagree (no confidence) and 5 = Strongly agree (high confidence).

Although FaRS and SFVS providers gave similar ratings of their professional skills across a range of domains, there were some notable differences in their responses indicating what capacity building would most help them meet service demands. In particular, staff at FaRS indicated a higher preference for building capacity in working with perpetrators, behaviour change programs and identifying and responding to violence. In contrast, the responses from staff working at SFVS indicated stronger preferences for building capacity in competency, risk assessment and working with older people and people with disability. These differences appear to reflect both the more specialised nature of SFVS, the specific needs of their client groups, and the particular skills and competencies required to undertake this work. Staff at both service types indicated a strong desire for additional capacity building in measuring client outcomes.

Table 5.6: Practitioner self-assessments of current skills and knowledge

	Score out of 5 (average of responses)		Responses of excellent/good (%)	
	SFVs	FaRS	SFVs	FaRS
Work with individuals, couples and families to improve their relationships	4.4	4.3	97	98
Work with parents to improve their parenting and focus on the needs of their children	4.5	4.2	86	97
Work with individuals, couples and families with complex needs	4.3	4.3	89	88
Work with victims of violence	4.1	4.5	89	77
Work with clients who use violence	3.6	4.0	65	57
Work with families where children have experienced child abuse and/or neglect	3.9	4.2	79	74
Refer clients in cases involving family violence to appropriate services	4.3	4.6	89	87
Refer clients who may be suicidal or at immediate risk of self-harm to appropriate services, if necessary	4.3	4.5	93	92
Refer clients in cases where child abuse and/or neglect is apparent	4.3	4.5	91	93

Note: Totals based on scale 1–5 with 1 = very poor (level of skills and/or knowledge) and 5 = Excellent (level of skills and/or knowledge).

Managing risk and safety for service users and themselves is a further significant element of the work of respondents in meeting service user needs. FaRS and SFVS survey respondents again expressed generally high levels of confidence in their service's procedures and protocols for identifying and managing risk and safety issues for service users (see Appendix A, Table A16 on page 30). However, survey respondents also reported that their services faced high levels of demand and this could lead to practitioners feeling overwhelmed by their caseloads and/or the demands on their service. More specifically, 50% of FaRS and SFVS practitioners reported that they were overwhelmed by their personal caseload at least some of the time, while 42% of FaRS and

SFVS managers reported that their service was overwhelmed by client demand at least some of the time (see Appendix A, Table A17 on page 31; also see section 6.1 on page 19 on issues relating to staff capacity).

Despite this, survey respondents reported that around three quarters (74%) of clients were seen in a time frame appropriate to meeting their needs (see Appendix A, Table A17 on page 31). Survey respondents indicated that in the minority of cases where they could not see clients at an appropriate time, this potentially could exacerbate or entrench issues or risks. However, in most of these instances, services were able to refer clients to another service. This finding is consistent with the findings discussed in section 3.3 (on page 7), which indicated that the provision of information, advice and referral is one of the core business activities of FaRS and SFVS.

Table 5.7: Expressed need for capacity building to improve service provision, most common responses

	SFVS (%)	FaRS (%)	Total (%)
Working with perpetrators	28	50	44
Measuring client outcomes	38	34	35
Behaviour change programs	17	39	33
Risk assessment	15	4	24
Child-centred approaches	23	23	23
Cultural competency	36	16	22
Working with people with a disability	32	16	21
Working with children/young people	25	19	20
Identifying and responding to violence	15	22	20
Working with the elderly	19	9	12

6 Staff capacity and retention

To meet the complex needs of local communities, a combination of professional and personal qualities is needed, particularly for the provision of sustainable services. This section will describe the capacity of services (largely in terms of staffing and/or resources) to meet community and client needs and to train and retain staff.

6.1 Staff capacity

We've got a real shortage of skilled staff out there at the moment … we've had all this injection of funding but we actually don't have the staff to put in those roles. (Service provider)

Although the previous sections indicated that FaRS and SFVS survey respondents expressed relatively high levels of confidence in their quality of their service and their own professional skills, survey respondents in all geographical areas identified issues with staffing levels and capacity that negatively affected their ability to perform all core activities. In particular, survey respondents across both FaRS and SFVS indicated that their service did not always have the resources or staffing levels needed to undertake follow-up work with clients or to identify and respond to changing community needs (see Table 6.1). This echoes the earlier reported finding (see section 3.3 on page 7) that survey respondents spend a relatively small amount of time on such activities, in comparison to service delivery and intake. Survey respondents from SFVS, in particular, indicated that they struggled with sufficient staff capacity to meet general service user needs.

Table 6.1: Service capacity of FaRS and SFVS over last 12 months

	Score out of 5 (average of responses)		Responses agree/ strongly agree (%)	
	SFVS	FaRS	SFVS	FaRS
Our service has enough staff to meet service user demands	2.4	2.9	16	36
Our service has enough staff to adequately intake and assess clients, including their safety	3.2	3.3	48	60
Our service has enough staff to identify and respond to changing needs in our community	2.6	2.9	13	35
Our service has the capacity to follow up clients	2.8	3.1	29	47
Our service has the capacity to provide prevention and early intervention services	3.0	3.2	41	56

Note: Totals based on scale 1–5 with 1 = Strongly disagree and 5 = Strongly agree

Service capacity was reported as an issue by survey respondents across all geographic areas. Although survey respondents in outer regional and remote areas were slightly more positive about their service's staffing capacity (while still indicating capacity issues), the small number of survey respondents from these areas means that this finding should be interpreted with caution.

Table 6.2: Service capacity by location

	Score out of 5 (average of responses)			Responses agree/ strongly agree (%)		
	Metro	Inner region	Outer region/ remote	Metro	Inner region	Outer region/ remote
Our service has enough staff to meet service user demands	2.71	2.45	2.94	30	19	40
Our service has enough staff to adequately intake and assess clients, including their safety	3.37	3.07	3.36	58	50	60
Our service has enough staff to identify and respond to changing needs in our community	2.8	2.64	2.98	27	19	40
Our service has the capacity to follow up clients (e.g. around referral outcomes)	2.85	3	3.22	34	45	48
Our service has the capacity to provide prevention and early intervention services	3.01	3.2	3.36	41	43	54

Note: Totals based on scale 1–5 with 1= Strongly disagree and 5 = Strongly agree.

The qualitative interviews similarly indicated that service capacity was an issue for FaRS and SFVS services. Interviewees indicated that although services worked hard to meet community needs, they could struggle to manage service demand. This often involved juggling current client demands with emerging community needs.

> *I think the thing to say is … it used to be full of people who would want help with their relationship, under that general umbrella heading. Now as time has gone on, because we're working with a more disadvantaged population, the group has got loads of mental health, suicide, financial troubles, high conflict, abuse, depression … it's a lot more complex than, you know, 10 years ago. (Service provider)*

> *We've had so many families wanting help with young people and suicide, and we've had so many families wanting help with older people … ageing issues and family violence stuff is an ageing issue in families … so we haven't looked for them. Usually we're looking for how we can be more relevant to ones we know we're not reaching, but they're the two – the other two are ones that are just jumping out at us without us needing to look, and it is really – you know, how we resource that when we know it's a need, but without taking away from the demand that's already there. (Service provider)*

Another interviewee noted the ripple effect that the provision of training could generate. For example, in addition to dealing with the costs of ensuring staff received appropriate training, when services with already stretched resources had staff away to attend training, the service's capacity to meet client needs was further challenged.

As noted earlier in the discussion on waiting times, when services could not see clients within a reasonable time they were often able to refer them to other services. However, demands on service time and resources could also mean that services' capacity to offer new services – or even to undertake intake or referral activities – to emerging client groups was limited. One participant in the qualitative interviews stated that at times, the demands on her service meant that every two or three weeks they had to stop accepting new clients for a couple of days. In such instances, the service would sometimes have to request clients call back the following Monday or leave a telephone number for the service to follow up.

Participants in the interviews also indicated that a service's capacity and capability did not only rest on the professional qualifications or technical skills of its staff, or on overall staffing levels, but on the staff's personal characteristics and the kinds of staff the service could employ. For example, one participant in the interviews noted that male community members are more likely to engage with a male counsellor. This participant described how her male counsellor generally worked with male clients and ran specific parenting programs for men, for which uptake from male clients was consistently high. She rated this worker highly for his professional skill but also for his life experience as a parent and grandfather. However, because the service only had one other male counsellor to help deliver the program, they were only able to run it twice a year.

6.2 Staff development and retention

Staff recruitment and retention issues were described as further affecting the service capacity issues identified above. In particular, participants in the qualitative interviews indicated that the recruitment and retention of staff was challenging for services. In particular, recruitment and retention of young people and people from CALD and Indigenous communities was described as an ongoing issue for FaRS and SFVS services, as was obtaining and keeping staff in outer regional or remote areas.

> *If you've not grown up in that kind of environment [outer regional area], it's very difficult to get people there … we've done it many times. We've recruited people from cities and they've gone out just with an idyllic dream of what it's like living out there … and they don't last. On paper they're great because they've got the qualifications and skills but they don't have the life experience. (Service provider)*

Participants in the qualitative interviews described recruitment processes where they would have to choose between applications from well-qualified individuals with little on-the-ground experience or individuals with intricate knowledge, expertise and experience with local community groups but few or no formal qualifications. As a result, services described having to adopt a range of strategies to fill positions and to ensure their staffing profile was appropriate to user demand. One service, for example, described forming relationships with universities in order to have temporary student placements. This provided the students with valuable work experience but also allowed the service to identify potential candidates for future work, when vacancies arose, and to observe the student's suitability for that specific service. Services also indicated that employing staff with few formal qualifications, but with good connections to the local community, was often important for meeting community needs, and ensuring cultural appropriateness, particularly (but not exclusively) in remote areas.

> *We increasingly employ Aboriginal and Torres Strait Islander and core community workers who might not have the qualifications but who are trained in some kind of Diploma level, Graduate Diploma, Vocational Diploma level to provide therapeutic services … we've got good numbers in those programs, we've got good numbers of staff that we've employed from those communities. (Service provider)*

7 Discussion

Somehow, we just get more trauma cases in all our programs too. I'm not exactly sure how that works but maybe that just means we're getting better at understanding trauma as an issue for a lot of the people … so in other words then, we're seeing people for longer too. So, you know, the actual idea of early intervention … as the name is really not exactly correct. I mean it is in one sense but you know, we have got a different population than we did before. (Service provider)

The role of FaRS and SFVS services is to support families, strengthen family relationships, prevent family breakdown and ensure family and child wellbeing. In this context, the purpose of the study was to develop a better understanding of the services offered by FaRS and SFVS services and, in particular, how they deal with domestic and family violence. Greater insight into the challenges and gaps experienced in delivering these services was also sought, along with an understanding of how FaRS and SFVS services work with each other and with non-funded DSS family services.

The sample size achieved in this study allowed for an indicative description of the kinds of activities undertaken by FaRS and SFVS, and of the issues commonly addressed during service delivery and when meeting client needs. However, the study population was not necessarily representative of the entire FaRS and SFVS population and so the results of the survey (and qualitative interviews) need to be interpreted with care.

On the whole, the FaRS and SFVS delivered a similar range of centre-based programs (predominantly counselling services) and information, advice and referral services. Service delivery outside service centres, such as outreach and home-based services, were less common but were offered by many services, especially those in regional or remote areas where clients could potentially live some distance from the service centre. Because the SFVS are embedded within the broader FaRS it is unsurprising that the broad activity types undertaken in each site – counselling, group work, etc. – were similar in their outline. However, the specialised nature of SFVS, and their clients' particular suite of needs, meant that they did have different referral pathways into and out of the service and somewhat different needs for staff capacity building. There were also some observed differences in referral paths between metropolitan and regional and remote areas, with the latter more likely to be involved with child protection services. Because of the relatively small number of non-metropolitan services participating in the study, it is unclear if this difference reflected a real difference in client needs or presenting issues or if it was simply an artefact of the small sample.

For all services types, referral and intake processes (including risk assessment) were a central part of their job and played a significant role in the referral pathway of clients and in determining the kinds of services they received. Moreover, although early intervention was identified in several measures as something that services had limited time or staff capacity to perform, it appears that 'early intervention' could cross over with intake and referral processes. Because clients rarely presented at FaRS and SFVS services before violence occurred, or in the early stages of relationship difficulties, providers had limited opportunities to intervene very early. However, when clients disclosed issues during intake, providers were able to identify client needs and refer them appropriately. This was in itself a form of early intervention. However, this also meant that services were reliant to some degree on clients disclosing issues early; when they did not do so, this could have implications for their subsequent referral pathways and the types and timing of the services they received.

Respondents to the survey generally depicted FaRS and SFVS, in all geographical areas, as being highly competent in their core activities, in most domains of professional skill and in their service's procedures and protocols to manage community needs. Almost all participants also indicated that their service was embedded in the local community, both in terms of their connections to other services and in their attempts to be responsive to local community needs. Indeed, despite survey respondents indicating that they had limited time to undertake

service innovation, and relatively low confidence in their ability to do so, provider descriptions (in the qualitative interviews) of their attempts to meet changing local community needs, and the survey respondents' awareness of the need to 'do things differently', suggested sometimes high levels of innovation.

Co-location with other services also proved to be the norm in all geographical areas and clients' sometimes complex needs meant that collaborative approaches were also common. Such collaborative approaches were important not only for meeting client needs but also allowed services to manage their workloads by referring clients to other services when they lacked capacity.

However, although survey respondents generally described their service and themselves as doing a good job and meeting community needs, they also identified several challenges and areas for capacity building. In particular, survey respondents identified a lack of staff capacity to undertake a range of service activities, particularly early intervention and client follow-up. Further, both FaRS and SFVS survey respondents indicated that their services were finding it increasingly challenging to address what they perceived as the growing complexity of family needs in addition to identifying and meeting the emerging needs of specific community groups. In this context, although early intervention, client follow-up and innovative approaches to service provision were regarded as an important aspiration, they were made increasingly difficult by issues with service capacity, staff retention and increased client needs.

Appendix A: Descriptive results of the online survey – All tables

Table A1: Characteristics of survey respondents

	Female		Male		Total	
	n	%	*n*	%	*n*	%
Total	**169**	**80**	**40**	**19**	**212**	**100**
Respondent role						
Practitioner	89	53	22	55	114	54
Manager	47	28	14	35	61	29
Both	33	20	4	10	37	17
Working hours						
Full-time	100	59	29	73	131	62
Part-time	69	41	11	28	81	38
Service type						
FaRS	119	70	25	63	146	69
SVFS	4	2	2	5	6	3
Both	46	27	13	33	60	28

Table A2: Main service locations by service type

	FaRS		SFVS		Total	
	n	%	*n*	%	*n*	%
Total	**146**	**69**	**66**	**31**	**212**	**100**
Geographic remoteness						
Major cities of Australia	74	51	38	58	112	53
Inner regional Australia	31	21	15	23	46	22
Outer regional Australia	22	15	10	15	32	15
Remote/very remote Australia	19	13	3	5	24	11
Services at multiple locations						
Respondents' employer provides services at another location	67	46	35	53	102	48

Table A3: Secondary service locations by service type

	FaRS		SFVS		Total	
	n	%	*n*	%	*n*	%
Total	**146**	**69**	**66**	**31**	**212**	**100**
Major cities of Australia	30	45	16	48	46	46
Inner regional Australia	14	21	6	18	20	20
Outer regional Australia	13	20	8	24	21	21
Remote/very remote Australia	9	14	3	9	12	12

Table A4: Types of services offered, by geographic remoteness

	Metro (*n* = 103)		Inner regional (*n* = 43)		Outer regional/ remote (*n* = 51)	
	n	%	*n*	%	*n*	%
Service types offered						
Centre-based individual programs	80	78	41	95	37	73
Information/advice/referral	78	76	35	81	45	88
Centre-based group programs	77	75	36	84	33	65
Centre-based couple programs	70	68	36	84	33	65
Centre-based parent programs	61	59	36	84	34	67
Centre-based child/youth-focused programs	52	50	28	65	31	61
Telephone services	56	54	22	51	23	45
Centre-based family programs	51	50	23	53	26	51
Outreach services	38	37	27	63	25	49
Case management	43	42	11	26	28	55
Community events/services	28	27	14	33	26	51
Online services	16	16	4	9	9	18
In-home support	8	8	5	12	11	22

Table A5: Proportion of practitioner time spent on activities

	Total (%)	SFVS (%)	FaRS (%)
Counselling	58	56	59
Education/skills training	38	27	41
Advocacy/support	31	26	32
Working with children	29	20	32
Working with young people	28	22	30
Case management	27	24	28
Family therapy	26	18	28
Mediation	15	7	17
Other	18	9	21

Note: Respondents were practitioner or practitioner-manager respondents only

Table A6: Proportion of service time spent on activities by service type and by role

	Total (%)	Managers (%)	Practitioners (%)	SFVS (%)	FaRS (%)
Intake and assessment	72	72	72	66	74
Supervision and professional development	37	34	38	28	41
Trialling innovative approaches to service provision	32	31	34	22	36
Service delivery (with individuals, couples, families)	32	33	32	26	34
Prevention	31	29	32	24	34
Crisis intervention	26	28	26	21	29
Early intervention	22	20	24	20	23
Client follow-up and assessment of outcomes	20	22	19	16	22

Note: Proportions add up to more than 100% – practitioners commonly apportioned more than 100% on this measure so it is best used as an indicator of activities on which they spent the most time rather than an estimate of actual proportions.

Table A7: Service delivery – ICT tools and devices, by location

	Metro (*n* = 103)		Inner regional (*n* = 43)		Outer regional/remote (*n* = 51)	
	n	%	*n*	%	*n*	%
Our service uses the following for counselling, education, consultation, support groups and outreach ...						
Telephone services	72	70	26	60	35	69
Text messaging	71	69	27	63	31	61
Websites	60	58	23	53	21	41
Skype, video conferencing	41	40	12	28	23	45
Online services	17	17	8	19	17	33
Social networking sites	21	20	5	12	15	29
Smart phone apps	18	17	11	26	7	14
We don't use any of these at our service	8	8	6	14	10	20

Table A8: Most commonly reported sources of referrals to FaRS and SFVS

	Total (%)	SFVS (%)	FaRS (%)
Self-referral	45	37	47
Family/friend/neighbour	28	23	29
Other professional at your service	25	24	26
Clergy	10	7	11
External family services	18	20	18
Child protection agencies	20	24	19
Financial	8	8	7
Legal (e.g. legal assistance, family law courts)	24	23	24
Health (e.g. community health centre, mental health)	18	16	18
Housing (e.g. short-term crisis refuge accommodation)	10	17	8
Education	12	8	13
Police	15	22	12
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	16	25	13

Table A9: Most commonly reported sources of referrals, by location

	Total (%)	Metro (%)	Inner regional (%)	Outer region/ remote (%)
Self-referral	45	46	42	45
Family/friend/neighbour	28	27	24	31
Other professional at your service	25	25	27	25
Clergy	10	15	7	4
External family services	18	20	16	17
Child protection agencies	20	14	25	29
Financial	8	7	7	9
Legal	24	22	30	23
Health	18	15	18	22
Housing	10	8	15	11
Education	12	11	15	11
Police	15	16	9	17
Specialist	16	14	18	16

Table A10: Most frequent destination services for FaRS and SFVS referrals, by geographic remoteness

	Metro (%)	Inner regional (%)	Outer regional/ remote (%)
Family and Relationship Services (FaRS)	36	42	39
Specialised Family Violence Services (SFVS)	29	24	15
Family Law Services	23	24	20
Communities for Children Facilitating Partner	10	6	10
Children and Parenting Support	26	30	20
Intensive Family Support Services	14	17	16
Other DSS funded services	18	15	20
Family Services	15	14	16
Child protection agencies	13	13	20
Financial	15	13	22
Legal (e.g. legal assistance, family law courts)	29	22	25
Health (e.g. community health centre, mental health)	21	14	28
Housing (e.g. short-term crisis refuge accommodation)	13	14	22
Education	15	10	21
Police	16	12	21
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	20	21	22
Other	12	7	8

Table A11: Other services in FaRS/SFVS catchment area, by geographic remoteness

	Total (*n* = 212)	Metro (*n* = 112)	Inner regional (*n* = 42)	Outer regional/ remote (*n* = 55)
Service types				
Family services	93	93	96	93
Child protection agencies	86	83	89	89
Community services	84	79	91	87
Health (e.g. community health centre, mental health)	84	80	87	91
Children's counselling services	83	84	89	76
Disability	83	78	91	85
Police	82	76	83	93
Education	79	72	85	89
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	79	73	85	87
Legal (e.g. legal assistance, family law courts)	78	73	80	85
Financial	77	71	83	85
Housing (e.g. short-term crisis refuge accommodation)	77	68	87	89
Employment	76	68	83	89
Youth programs/services	74	66	76	89
Men's programs/services	68	65	76	69
Elder services	60	55	65	67

Table A12: DSS funded services most commonly co-located with respondents' service (by service type)

	FaRS (*n* = 146)		SFVS (*n* = 66)		Total (*n* = 212)	
	n	%	*n*	%	*n*	%
Number of FaRS co-located with DSS services	122	84	53	80	175	83
Type of DSS co-located service						
Family Law Services	62	42	34	52	96	45
Other Family and Relationship Services (FaRS)	61	42	30	45	91	43
Children and Parenting Support	40	27	25	38	65	31
Financial Counselling, Wellbeing and Capability	25	17	18	27	43	20
Other Specialised Family Violence Services (SFVS)	18	12	15	23	33	16
Emergency Relief	18	12	14	21	32	15
Intensive Family Support Services	22	15	8	12	30	14
Communities for Children Facilitating Partner	9	6	9	14	18	8
Community Mental Health	8	5	8	12	16	8
Personal Helpers and Mentors Service (PHaMS)	10	7	3	5	13	6

Table A13: Non-DSS funded services most commonly co-located with respondents' service (by service type)

	FaRS (*n* = 146)		SFVS (*n* = 66)		Total (*n* = 212)	
	n	%	*n*	%	*n*	%
Number of FaRS co-located with non-DSS services	102	70	48	73%	151	71%
Type of co-located service						
Family services	48	33	26	39	74	35
Specialist: alcohol or other drugs, gambling, specialist Family Domestic Violence, sexual assault	29	20	20	30	49	23
Housing (e.g. short-term crisis refuge accommodation)	23	16	16	24	39	18
Youth services	24	16	10	15	34	16
Out-of-home care	16	11	6	9	22	10
Financial	15	10	10	15	25	12
Education	15	10	2	3	17	8
Disability	13	9	4	6	17	8
Health (e.g. community health centre, mental health)	12	8	8	12	20	9
Child protection agencies	12	8	5	8	17	8
Employment	9	6	1	2	10	5
Legal (e.g. legal assistance, family law, courts)	2	1	3	5	5	2
Police	2	1	1	2	3	1

Table A14: DSS funded services most commonly co-located with respondents' service (by geographic remoteness)

	Metro		Inner regional		Outer regional/ remote	
	n	%	*n*	%	*n*	%
Co-located with ANY DSS service	95	85	40	87	40	74
Type of co-located service						
Family Law Services	53	47	23	50	20	38
Other Family and Relationship Services (FaRS)	56	50	21	46	14	27
Children and Parenting Support	34	30	13	28	18	35
Financial Counselling, Wellbeing and Capability	22	20	7	15	14	27
Other Specialised Family Violence Services (SFVS)	22	20	4	9	7	13
Emergency Relief	20	18	2	4	10	19
Intensive Family Support Services	12	11	4	9	14	27
Communities for Children Facilitating Partner	3	3	5	11	10	19
Community Mental Health	9	8	3	7	4	8
Personal Helpers and Mentors Service (PHaMS)	3	3	4	9	6	12

Table A15: Non-DSS funded services most commonly co-located with respondents' service (by geographic remoteness)

	Metro (*n* = 80)		Inner regional (*n* = 35)		Outer regional/ remote (*n* = 35)	
	n	%	*n*	%	*n*	%
Co-located with ANY non-DSS service	80	71	35	76	35	65
Type of co-located service						
Family services	39	35	23	55	12	21
Specialist (alcohol or other drugs, gambling, specialist FDV)	33	29	9	21	7	13
Housing (e.g. short-term crisis refuge accommodation)	15	13	13	31	11	20
Youth services	16	14	10	24	8	14
Out-of-home care	12	11	5	12	5	9
Financial	14	13	4	10	7	13
Education	14	13	2	5	1	2
Disability	9	8	1	2	7	13
Health (e.g. community health centre, mental health)	13	12	2	5	5	9
Child protection agencies	11	10	2	5	4	7
Employment	8	7	1	2	1	2
Legal	4	4	0	0	1	2
Police	2	2	0	1	1	2

Note: Data on remoteness not available for all respondents.

Table A16: Procedures and protocols for managing risk and safety

	Average score out of 5		Agree or strongly agree (%)	
	SFVs	FaRS	SFVs	FaRS
The service I work for has procedures and protocols that support me to:				
Identify safety concerns for my client	4.7	4.5	100	96
Identify safety concerns for other family members	4.6	4.4	98	92
Identify safety concerns for myself or other workers	4.6	4.4	92	96
Work with clients to reduce or minimise the violence	4.6	4.3	100	90
Work to reduce or minimise the violence for other family members	4.5	4.3	98	89
Manage safety concerns for myself or other workers	4.5	4.4	96	92
Refer my client and/or other family members to other relevant services	4.5	4.4	94	94
Manage critical incidents	4.4	4.3	94	90
Receive the support I need after a critical incident	4.4	4.2	88	86

Table A17: Service demands by service type (FaRS or SFVS)

	Total (%) (*n* = 126)	FaRS (%) (*n* = 96)	SFVS (%) (*n* = 30)
Frequency with which practitioners felt overwhelmed by their caseload			
Never	8	10	0
Rarely	23	24	20
Sometimes	50	50	50
Often	17	14	27
Always	2	2	3
Frequency with which managers felt service overwhelmed by demand	**(*n* = 86)**	**(*n* = 57)**	**(*n* = 29)**
Never	6	7	3
Rarely	15	14	17
Sometimes	42	39	48
Often	30	35	21
Always	7	5	10
Effects of service demand on client needs			
Percentage of services' clients seen within a time frame appropriate to their needs/presenting issue	74	75	71
Percentage of services' clients who reported experiencing increased risk or more entrenched problems because of waiting times?	16	16	16
Percentage of services' clients who had to be referred to another service?	12	12	12

Table A18: FaRS and SFVS service user issues – frequency of encounters

How often do you deal with the following issues?	Score out of 5 (average of responses on scale 1–5)			Often/always deal with these issues (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Family relationships	4.6	4.7	4.4	97	97	97
Family violence	4.0	3.8	4.4	82	100	76
Alcohol and other drugs	3.4	3.4	3.4	44	43	45
Mental health	3.9	3.9	3.8	77	69	79
Gambling	2.5	2.5	2.5	7	7	7
Homelessness	2.5	2.4	2.8	12	14	12
Parenting	4.3	4.3	4.1	87	83	89
Elder abuse	2.0	1.9	2.1	3	3	3
Legal issues	3.2	3.2	3.3	46	52	44
Adolescent violence	2.7	2.6	3.0	15	21	13
Disability	2.6	2.6	2.5	51	52	51
Cultural issues	3.1	3.2	3.0	32	24	34
Exposure of children to family violence	3.7	3.6	4.1	68	86	63
Child abuse and/or child safety and/or child neglect	3.3	3.3	3.5	45	59	41
Emotional abuse and/or anger issues	4.1	4.0	4.3	88	100	84

Note: Totals based on scale 1–5 with 1= Never deal with these issues and 5 = Always deal with these issues.

Table A19: Respondents' assessments of service ability and skills in assisting specific community groups

	Score out of 5 (average of responses)			Responses agree/ strongly agree (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Our service has the ability and skills to assist CALD clients	3.9	3.8	3.9	75	74	75
Our service has the ability and skills to assist ATSI clients	3.9	3.8	4.0	77	72	79
Our service has the ability and skills to assist clients with disability	3.8	3.8	3.8	69	68	74
Our service has the ability and skills to assist LGBTI clients	3.9	3.9	3.9	78	78	77

Note: Totals based on scale 1–5 with 1 = Strongly disagree and 5 = Strongly agree.

Table A20: Respondent confidence in their services' skills and knowledge

	Score out of 5 (average of responses)			Responses agree/ strongly agree (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Prevention	3.6	3.4	3.7	59	57	60
Intake and assessment	4.2	4.3	4.2	89	95	86
Early intervention	3.6	3.4	3.7	62	57	65
Service delivery (with individuals, couples, families)	4.5	4.5	4.5	96	98	95
Crisis intervention	3.8	4.0	3.7	69	75	66
Client follow-up and assessment of outcomes	3.5	3.4	3.5	54	49	57
Supervision and professional development	4.0	4.0	3.9	80	75	82
Trialling innovative approaches to service provision	3.4	3.2	3.4	51	49	51

Note: Totals based on scale 1–5 with 1 = Strongly disagree and 5 = Strongly agree.

Table A21: Practitioner self-assessments of current skills and knowledge

	Score out of 5 (average of responses)		Responses good/ excellent (%)	
	SFVs	FaRS	SFVs	FaRS
Work with individuals, couples and families to improve their relationships	4.4	4.3	97	98
Work with parents to improve their parenting and focus on the needs of their children	4.5	4.2	86	97
Work with individuals, couples and families with complex needs	4.3	4.3	89	88
Work with victims of violence	4.1	4.5	89	77
Work with clients who use violence	3.6	4.0	65	57
Work with families where children have experienced child abuse and/or neglect	3.9	4.2	79	74
Refer clients in cases involving family violence to appropriate services	4.3	4.6	89	87
Refer clients who may be suicidal or at immediate risk of self-harm to appropriate services, if necessary	4.3	4.5	93	92
Refer clients in cases where child abuse and/or neglect is apparent	4.3	4.5	91	93

Note: Totals based on scale 1–5 with 1 = Very poor (level of skills and/or knowledge) and 5 = Excellent (level of skills and/or knowledge).

Table A22: Expressed need for capacity building to improve service provision – most common responses

	SFVS (%)	FaRS (%)	Total (%)
Working with perpetrators	28	50	**44**
Measuring client outcomes	38	34	**35**
Behaviour change programs	17	39	**33**
Risk assessment	15	4	**24**
Child-centred approaches	23	23	**23**
Cultural competency	36	16	**22**
Working with people with a disability	32	16	**21**
Working with children/young people	25	19	**20**
Identifying and responding to violence	15	22	**20**
Working with the elderly	19	9	**12**

Table A23: Respondents' rating of their service's capacity to engage with and refer to other services

	Score out of 5 (average of responses)			Responses excellent/good (%)		
	Total	SFVs	FaRS	Total	SFVs	FaRS
Family services	4.3	4.2	4.3	88	90	87
Child protection agencies	4.3	4.3	4.3	87	83	89
Financial	3.9	3.9	3.9	70	66	71
Legal (e.g. legal assistance, family law courts)	4.1	4.2	4.1	78	83	77
Health (e.g. community health centre, mental health)	4.0	3.9	4.1	76	72	77
Housing (e.g. short-term crisis refuge accommodation)	3.7	3.9	3.7	62	69	59
Education	3.7	3.6	3.7	61	52	64
Police	4.1	4.0	4.1	78	76	78
Specialist: alcohol or other drugs, gambling, specialist FDV, sexual assault	4.1	4.2	4.0	79	79	79

Note: Totals based on scale 1–5 with 1 = Very poor (level of skills and/or knowledge) and 5 = Excellent (level of skills and/or knowledge).

Table A24: Respondents' assessment of service capacity by service type (over last 12 months)

	Location	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Total (*n*)
		n(%)	*n*(%)	*n*(%)	*n*(%)	*n*(%)	
Our service has enough staff to meet service user demands	FaRS	15(11)	47(35)	23(17)	40(30)	9(7)	134
	SFVS	8(14)	31(53)	10(17)	7(12)	2(3)	58
	Total	23(12)	78(41)	33(17)	47(24)	11(6)	193
Our service has enough staff to adequately intake and assess clients, including their safety	FaRS	9(7)	29(22)	16(12)	67(50)	13(10)	134
	SFVS	1(2)	17(29)	12(21)	25(43)	3(5)	58
	Total	10(5)	46(23)	28(15)	92(48)	16(8)	193
Our service has enough staff to identify and respond to changing needs in our community	FaRS	12(9)	43(32)	32(24)	39(29)	8(6)	134
	SFVS	1(2)	31(53)	18(31)	7(12)	1(2)	58
	Total	13(7)	74(39)	50(26)	46(24)	9(5)	193
Our service has the capacity to follow up clients (e.g. around referral outcomes)	FaRS	9(7)	39(29)	26(19)	48(36)	12(9)	134
	SFVS	5(9)	28(48)	8(14)	15(26)	2(3)	58
	Total	14(7)	67(35)	34(18)	63(33)	14(7)	193
Our service has the capacity to provide prevention and early intervention services	FaRS	9(7)	29(22)	34(26)	44(33)	18(13)	134
	SFVS	5(9)	19(33)	10(17)	23(40)	1(2)	58
	Total	14(7)	48(25)	44(23)	67(35)	19(10)	193

Table A25: Respondents' assessment of service capacity by location (over last 12 months)

	Location	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Total (*n*)
		n(%)	*n*(%)	*n*(%)	*n*(%)	*n*(%)	
Our service has enough staff to meet service user demands	Metro	10(10)	43(43)	17(17)	26(26)	4(4)	100
	Inner regional	7(17)	19(45)	8(19)	6(14)	2(5)	42
	Outer region/remote	6(12)	16(32)	8(16)	15(30)	5(10)	50
Our service has enough staff to adequately intake and assess clients, including their safety	Metro	3(3)	23(23)	16(16)	50(50)	8(8)	100
	Inner regional	4(10)	13(31)	4(10)	18(43)	3(7)	42
	Outer region/remote	3(6)	10(20)	8(16)	24(48)	5(10)	50
Our service has enough staff to identify and respond to changing needs in our community	Metro	6(6)	40(40)	27(27)	22(22)	5(5)	100
	Inner regional	3(7)	18(43)	13(31)	7(17)	1(2)	42
	Outer region/remote	4(8)	16(32)	10(20)	17(34)	3(6)	50
Our service has the capacity to follow up clients (e.g. around referral outcomes)	Metro	6(6)	42(42)	18(18)	29(29)	5(5)	100
	Inner regional	4(10)	15(36)	4(10)	15(36)	4(10)	42
	Outer region/remote	4(8)	10(20)	12(24)	19(38)	5(10)	50
Our service has the capacity to provide prevention and early intervention services	Metro	8(8)	33(33)	18(18)	32(32)	9(9)	100
	Inner regional	2(5)	7(17)	15(36)	15(36)	3(7)	42
	Outer region/remote	4(8)	8(16)	11(22)	20(40)	7(14)	50

Appendix B: Interview schedule

The Family and Relationship Services survey

Qualitative component: Topic guide

Interviewer guidance note

The following is a guide to the questions to be asked as part of the consultations/discussions for the FaRS survey. The discussion will not be a strict question and answer exchange nor do questions have to be repeated verbatim. Rather, the questions listed here are a guide to overall topics and/or are open-ended to allow participants to freely express their opinions/experiences in their own words. Prompts can be used for clarification or for eliciting further information.

It is not necessary to ask every question if a topic has already been covered earlier or it is not relevant to a specific participant. Issues raised by participants that are not part of the interview schedule should be followed up if deemed to be of relevance to the research questions.

Introduction

The Australian Institute of Family Studies have been asked by the DSS to undertake some surveys and consultations about FaRS and SFVS services so that they can better understand how these services are working on the ground. Many of you will have already completed the online survey part of this project. This discussion is for exploring topics that weren't covered in the survey or that might benefit from being explored in more depth.

Your participation in this discussion is voluntary and you don't have to answer all the questions we ask. If you need a break at any time just let me know.

[For group discussion] Can I also ask that everyone honours the privacy of others in the group by not identifying who said what after the focus group has ended.

Question and prompts. Note: the order of questions and prompts may vary depending on the participant narrative/ trajectory of the discussion	Intent of question/interviewer guidance
1. To start, can you tell me a little bit about what your service(s) does well? **Prompts**: How is this different from other services? How are SFVS different from other FaRS?	*This question and follow-up probes aim to develop understanding of service strengths and distinguish between SFVS and other FaRS.* *This line of questioning can also lead to discussion of barriers and challenges. If not, this can be discussed in subsequent questions.*
2. How do you make sure you are responsive to your local community? **Prompts**: How do you identify community needs? How can you make sure you're meeting them? Are there community groups that need special attention or focus? CALD, ATSI, LGBTI, WWD, homeless? How are their needs different? How do you work differently with these groups?	*Understanding community responsiveness* *The extent to which FaRS/SFVS are dealing with particular groups with high needs* *Strategies for working with groups with high needs*
3. Can you tell me how you work with other services? **Prompts**: Internal or external? *If no*: Why not? *If yes*: What kinds of services? Are these mostly internal or external services? Do they work with Family Law Services? How do you work with them? (e.g. referrals, service coordination, collaboration?) What is the nature of your relationship with other services? Co-location? Is it a formal arrangement (e.g. MOU)? Co-location? Personal networks? Regular or ad hoc? (if different relations for different services – why?) *Both*: How easy is it to work with/refer to other services? Do you do it enough? Are there barriers to working with other services? What are they? Is there an appropriate service network around you? Are there any gaps?	*Extent and type of service collaboration* *Barriers to collaboration* *Service gaps*
4. What do you think would help your service better meet community/client needs (besides more money)? 5. How well do you think you work with other services? What might help you to work better? **Prompts**: What do you think is stopping that from happening? How do you evaluate how well the service is working?	*Barriers and service gaps*