

Submission to the
Second Action Plan Consultation
**National Plan to
End Violence**

Against Women and Children 2022-2032

Submitted by **Stand Again**, June 2026
Support for male victims of family violence



Stand Again
Support for male victims
of family violence
www.standagain.com.au

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22

Service providers for
~2m animals
impacted by
DFV

350

Dedicated service
providersⁱⁱ for 2.7m
female victims'
of DFV

5

Dedicated service
providersⁱⁱⁱ for 1.5m
male victims
of DFV

There are more service providers to
support pets impacted by DFV than
to support male victims of family
and domestic violence

i: WESNET (Women's Support Network) is Australia's national peak body for specialist domestic and family violence services and claims approximately 350 members (no public listing available)

ii: 'Dedicated Service Providers' are those that primarily service a segment of victims of DFV (such as a gender, LGBTQI, elder or youth), in addition to the count of providers above, there are 58 unspecified DFV services in Australia some of which may also be within the WESNET member base

iii: Of the 5 male dedicated service providers, 2 are male perpetrator first, and victim support second services, 1 (Stand Again) has been in operation for only 12 months, and 1 operates only in one Territory



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of family violence

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Executive Summary

Stand Again welcomes the opportunity to contribute to the Second Action Plan consultation. This submission is offered in the spirit of strengthening Australia's response to family violence for all victim-survivors.

Australia's sustained investment in ending domestic, family and sexual violence has produced meaningful progress. The Department of Social Services has demonstrated the mechanism and the capability to drive change in this space, and that investment is essential and must continue. The Second Action Plan commits to "a focus on victim-survivors from all communities and backgrounds." This submission responds to that commitment.

What the analysis found

Stand Again conducted a gap analysis of 336 DFV service providers across 19 service lines and all Australian states and territories. The analysis identified communities and service lines where provision falls significantly below any reasonable benchmark.

- **An estimated 1.74 million victim-survivors are potentially underserved.** Applying a benchmark of 1 dedicated provider per 10,000 victim-survivors, the analysis estimates that approximately 1.41 million male and 330,000 female victim-survivors do not have access to adequate dedicated service provision.
- **Male victim-survivors have fewer dedicated service providers than animals impacted by DFV.** Of the 336 providers identified, 237 serve female victims, 22 serve pets and animals, and 5 serve male victims. The service density for male victims is 1 provider per 291,500 people. For female victims it is 1 per 11,400. For pets it is 1 per 89,600.
- **Dedicated male victim-survivor services have uneven distribution and varied foci.** 2 providers lead with male perpetrator services as their primary offering, victim services as secondary (categorised as victim service for the purpose of the analysis). 3 providers operate only on a State & Territory level with densities of 1 provider per 24.2k, 1 provider per 144.2K and 1 provider per 270.2K. Leaving an estimated 1.01 million men across NSW, VIC, QLD, SA, TAS, and NT served only by the 2 national online providers.
- **Critical service lines have zero dedicated provision for male victim-survivors.** 71 crisis accommodation services exist for women. 20 exist for pets. 1 exists dedicated for men. 70 DFV legal support services exist for women. Zero exist for men. 4 DFV-specific suicide prevention services exist for women. Zero exist for men, despite men accounting for ~75% of suicide deaths in Australia. DFV-specific suicide prevention is underserved for both populations.



- **Approximately 930K female perpetrators have no behaviour change pathway.** 54 behaviour change programs exist for male perpetrators. 5 exist for female perpetrators. ABS data shows 94.6% of male victims, and 1.7% of female victims experienced partner violence from a female partner, representing an estimated 1.4 million female perpetrators nationally. The sole dedicated female perpetrator service operates in one state. The remaining 930K female perpetrators have no providers or programs to support behaviour change.

The cost of leaving these gaps open

The absence of dedicated services carries measurable costs across the health, justice, housing, and employment systems. Victim-survivors who cannot access specialist DFV services present to GPs, use mental health care plans, and engage with Employee Assistance Programs without specialist capability.

This produces longer treatment pathways and poorer outcomes. Where DFV remains unaddressed, costs escalate: family court proceedings reach \$80,000 to \$120,000 per party in high-conflict matters, psychological injury workers' compensation claims average \$288,542 in NSW, and suicide is estimated at \$1.7 million per death.

- **The estimated annual downstream cost of these service gaps is approximately \$7 billion** across the health, justice, housing, and employment systems. This is limited to the underserved male and female victim-survivors identified in this submission only. It excludes the estimated downstream cost of 1.4 million female perpetrators. The true cost of the service gaps identified in this submission could be higher.
- The cost of violence against women and their children has been estimated at \$22 billion per year. No equivalent study has been conducted for male victim-survivors. The true total cost of all DFV (including men, youth, elder, and LGBTQI) to the Australian economy has never been calculated.
- **The human cost is carried by families.** Without dedicated services, victim-survivors remain in abusive relationships because there is nowhere to go. Children remain in households where one parent is being abused and the other is the abuser, with no intervention pathway for either.
- The Consultation Paper identifies the risk that isolated individuals who cannot find legitimate support are drawn into harmful online communities. Dedicated DFV services provide credible, health-focused pathways at the point of highest vulnerability.



Filling these gaps requires tailored understanding

The screening and assessment tools in current use were developed for and validated on female populations. In 2018, the U.S. Preventive Services Task Force identified the absence of valid, reliable screening tools for intimate partner violence in men as a gap.

- **Male victim-survivors present through mechanisms shaped by cultural norms:** they minimise, describe practical problems rather than identify abuse, and contain emotion rather than express it.
 - Without tools designed for these presentations, there is a risk that male victim-survivors are not identified, or are misidentified as perpetrators.
- **61% of male victim-survivors reach out for help and find services with language not tailored to their experience or no dedicated services at all**
 - ABS data shows that 61% of men who experienced partner violence sought advice or support, a rate comparable to women at 63%.
 - The barrier is not that men refuse to seek help. The barrier is that when they do, dedicated services barely exist.
 - Gender-neutral or female-oriented services do not engage male victim-survivors at scale as the language does not align with male victim presentation.
 - Research confirms that male victims require dedicated, explicitly branded services to be effectively supported.

What addressing these gaps achieves

Extending the DFV service landscape delivers measurable outcomes. 1.74 million underserved victim-survivors gain access to specialist support.

- **Inefficiencies in the health system** are reduced as presentations are directed into specialist pathways.
- **Suicide risk is reduced** through dedicated DFV-specific prevention for both men and women.
- **The radicalisation pipeline is disrupted.**
- **Children in families affected by violence benefit** from a supported parent with an exit pathway.

In addition, 1.4 million female perpetrators gain access to accountability and behaviour change programs.



These outcomes advance four existing government commitments:

- the 2021 Parliamentary Inquiry (Recommendation 54, unactioned),
- the National Men’s Health Strategy 2020–2030,
- the National Suicide Prevention Strategy 2025–2035, and
- workplace psychosocial safety legislation.

To achieve these outcomes, the Second Action Plan should:

- **Build the infrastructure to serve underserved communities (Recommendations 1–3).** Commission a national gap analysis and scoping study beyond the preliminary analysis conducted here. To assess current supply v demand, service line coverage, define benchmarks, and recommend a funding pathway. Fund the growth of dedicated services, targeting an estimated 141 additional male victim-survivor providers, 33 additional female victim-survivor providers, 37 crisis accommodation services for men, 38 legal support services for men, at least 17 female perpetrator behaviour change programs, and at least 10 DFV-specific suicide prevention services for men and women. Establish a national male victim-survivor partnership network.
- **Reach men before crisis (Recommendations 4–7).** Commission research into effective messaging for male help-seeking. Develop a national outreach strategy using language and channels designed to reach men where they are. Support workplace-based prevention and early intervention programs. Include male victimisation in front-line worker education across health, police, legal, and community services.
- **Strengthen the evidence base (Recommendations 8–12).** Commission research into DFV-related suicide risk for male and female victim-survivors. Commission research into male victim-survivor presentations to inform clinical practice and tool development. Invest in validated screening tools for male populations. Commission research into female perpetrator behaviours to support targeted behaviour change programs.

The detailed evidence base, service chain analysis, and full recommendations are provided in the body of this submission.



1

Dedicated crisis accommodationⁱ for **1.5m male victims** of DFV

20

Providers of crisis shelters for **~2m animals** impacted by DFV

A pet impacted by family violence has a statistically greater probability of finding crisis accommodation than a human male victim-survivor

i: Services exclusively male victims of DFV. This is in addition to 71 crisis accommodation providers that exclusively service female victims of DFV, and 7 of unspecified or neutral gender focus.



Response to Priority Area 1: Victim-Survivors

"Strengthening a whole of society and life-course approach to prevention, early intervention, response, recovery and healing with a focus on victim-survivors from all communities and backgrounds."

This response addresses the consultation questions:¹

- What service or system responses would make the biggest difference to victim-survivors' safety, wellbeing, healing and recovery?
- What helps people access support earlier, and what barriers prevent people from seeking help or engaging with systems and services?

Key points

- An estimated 141 additional dedicated male victim-survivor service and an estimated 33 additional female victim-survivor service providers are needed.
- 37 dedicated crisis accommodation services are needed for male victim-survivors. Currently 1 exists.
- Dedicated DFV legal support and financial support services are needed for male victim-survivors. Currently zero exist.
- At least 10 DFV-specific suicide prevention services are needed for men and women.
- At least 17 additional female perpetrator behaviour change programs are needed. Currently 5 exist across two states.
- The estimated annual downstream cost of leaving these gaps open for victim-survivors is approximately \$7 billion across the health, justice, housing, and employment systems.
- The estimated annual downstream cost of the underserved 1.4 million female perpetrators has not been calculated. The total costs of these gaps could therefore be higher than \$7 billion.

¹ ANROWS. (2026). Evidence to Action: Consultation Paper, Priority Area 1, pp. 22-30, 44-45



The scale of the underserved population

1.5 million men in Australia have experienced violence, emotional abuse, or economic abuse by a cohabiting partner.² One in seven Australian men has been affected.

ABS data shows that 94.6% of male victims of partner violence experienced it from a female partner.³ This sits alongside the 2.7 million women who have experienced the same forms of harm.

The Second Action Plan's commitment to a "whole of society" approach and "victim-survivors from all communities and backgrounds" encompasses this population.

The commitment to "response, recovery and healing" applies to these 1.5 million men, who are currently served by fewer than five dedicated services.

The 2021 Parliamentary Inquiry into Family, Domestic and Sexual Violence recommended that the government commission research into male victimisation and review the adequacy of services for men as victim-survivors (Recommendation 54). These recommendations have not been acted on. This submission's gap analysis responds directly to that unacted commitment.

Gap analysis of Australia's DFV service provider landscape

Stand Again conducted an analysis on over 700 service listings from the 1800RESPECT (the Australian Government's national service directory), conducted supplementary desktop research, and reviewed individual organisation websites.

336 DFV service providers⁴ were identified and mapped against 19 service lines across the victim-survivor lifecycle and across all Australian states and territories.

To ensure methodological consistency across segments, the analysis relies strictly on publicly accessible, active service directories available to a victim-survivor at the point of help-seeking, excludes unlisted or closed membership networks.

² Australian Bureau of Statistics. (2023). Partner Violence, 2021-22. ABS.

³ ABS Personal Safety Survey 2021-22, Partner Violence. 94.6% of male victims experienced partner violence from a female partner.

⁴ Excluding duplicates, individual offices, police stations, courts, and holistic (non DFV focused) providers. 336 providers represent a baseline desktop audit of the 1800RESPECT directory supplemented by independent research; unlisted grassroots services may exist.



Focus of this analysis

This submission has focused the gap analysis on providers that are dedicated towards:

- female victim-survivor providers,
- male victim-survivor providers,
- female perpetrators
- male perpetrators
- and providers that support pets impacted by DFV.

For the purpose of this gap analysis, service providers that were dedicated to elder, youth, and LGBTQI only services were excluded (though overlaps exist).

Further analysis of providers dedicated to these other populations using the same methodology would likely identify additional gaps in the DFV service provider landscape. Recommendation 1 (detailed later) identifies the analysis should be extended to encompass all communities, explore individual capacity of providers comparative to demand, and clarify areas for integration - to ensure a full DFV service landscape is mapped.

Service lines were mapped to understand what the service providers delivered

The 19 service lines have been grouped into 5 categories aligned with the lifecycle of DFV, including:

- 'Prevention' (4 service lines e.g. public education)
- 'Early Intervention' (4 service lines e.g. Crisis Helplines)
- 'Response' (6 service lines e.g. Crisis Accommodation)
- 'Recovery & Healing' (3 service lines e.g. Peer support networks); and
- 'Accountability' (2 service lines e.g. Men's behaviour change program')

The definition of each service line, plus the gap analysis methodology, limitations, and summary data are provided in Appendix A. Mapping each service provider was based on the providers publicly available information.

Limited victim-survivor provider benchmarks exist

For victim services a benchmark of "1 provider per 10,000 people" benchmark was used. This was drawn from the Council of Europe Istanbul Convention, which recommends a minimum of 1 shelter space per 10,000 inhabitants for crisis accommodation.



It is the only internationally recognised benchmark for DFV service provision. This benchmark uses total population as the denominator, this submission applies it to the victim-survivor population, which is a more conservative application.

Recommendation 1, detailed later, suggests Australian Government have an opportunity to set their own benchmarks across Service Lines to conduct target DFV landscape modelling.

The 1:10K benchmark used for gap analysis in this submission can be considered a preliminary benchmark when applied to the broader service lines, as it was designed for physical crisis accommodation rather than the full range of service lines (including outreach, helplines, counselling, and legal support). It is applied in this submission as the best available starting point in the absence of Australian-specific benchmarks at time of analysis.

Definitive benchmarks for the Australian context will need to be developed and is captured in Recommendation 1 detailed later. Australian benchmarks should be developed at a Service Line and Delivery Mode level (online, physical metro location, physical rural location). And account for factors such as:

- How directly the service line impacts victim-survivor safety and recovery outcomes
- Demand and capacity for those Service Lines
- Target propensity of target population segment to seek help (i.e. following investment in outreach and awareness),
- Unique needs or barriers of the Service Line (e.g. physical constraints, cultural barriers to overcome etc.)

It is recommended that Australian benchmarks be set at a Service Line and Delivery Mode level, applied equitably across all population segments.

This ensures the same standard of provision is targeted for female, male, gender diverse, young and old victim-survivors, and avoids embedding different expectations of service adequacy.

Structure of following sections

The following gaps are presented at four levels:

1. by victim segment (the population served),
2. by victim segment by state (geographic distribution),
3. by victim segment by service line (the functions provided), and
4. by perpetrator accountability providers and programs.

At each level, the analysis identifies where provision falls below the used benchmark (provision exists, but services a high population level), including absolute zeros (no provision exists).



Gap Analysis Layer 1: Service Providers by Victim Segments

Table 1: Population Served Per Service Provider Per Victim Segment

	General DFV	Female Victim	Male Victim	Pets/Animals
Estimated Population	4,159K	2,702K	1,458K	1,972K
No. Providers	58	237	5	22
Provider to Population Ratio	1 : 71.7K	1 : 11.4K	1 : 291.6K	1 : 89.6K
Target Ratio Benchmark	TBC	1 : 10.0K	1 : 10.0K	TBC
Target No. Providers	TBC	270	146	TBC
Current Provider Gap	TBC	33	141	TBC

Note: The Istanbul Convention benchmark applies to crisis accommodation spaces. It is used here as the sole internationally recognised structural proxy for service density in the absence of Australian-specific benchmarks.

Summary of insights:

Female victim-survivor dedicated providers is close to benchmark

- 237 service providers serve only female victims⁵. Noting that WESNET represents approximately 350 member organisations to support female victim-survivors (no public listing).⁶
 - With an estimated 2.7M female victim-survivors, **this represents 1 service provider per 11.4K female victims.**
- Using the Istanbul Convention benchmark, this would suggest female victim services still remain just below benchmark – though it is closer to benchmark than other segments.

⁵ 32 of which also provide male behaviour programs

⁶ The analysis relies on publicly accessible service directories available to a victim-survivor at the point of help-seeking. The difference between this value and the 350 WESNET listing suggests additional services may operate outside the national referral platform.



- To achieve benchmark, a target value of 270 providers is needed (assuming identified quantity of 237, not the WESNET value of 350 members) which means **an additional 33 providers are needed.**

Male victim service provider numbers are significantly below benchmark

- 5 dedicated service providers are dedicated to male victims.⁷ With an estimated 1.5M male victim-survivors, this represents **1 service provider per 291.6K male victims**
 - Only 2 dedicated male victim-survivor services were listed on the Government's 1800RESPECT national referral platform at time of analysis.⁸
 - **2 of the identified service providers primarily service male perpetrators**, and male victims as a secondary target. They were tagged to male victim category for this exercise.
 - 3 of the providers operate at a State or Territory level only
- Using the same benchmark for women service providers of 1 : 10K, then the target number of providers is 146 dedicated service providers. **This means an additional 141 providers are needed.**

General victim services can be serviced by dedicated service providers

- 58 general DFV provider or gender unspecified⁹ service providers were identified¹⁰.
- Some providers listed as gender neutral were later confirmed to service female victim survivors only (see example provider below).
- No benchmarking was conducted on this segment as:
 - no proxy or benchmark target was identifiable in the research
 - addressing gaps in dedicated gendered services will meet this target segment's needs

Pets impacted by DFV are well covered, focused on crisis accommodation

- 22 service providers service pets and animals impacted by DFV. With an estimated 2M pets¹¹ impacted by DFV, this represents **1 service provider per 89.6K animals.**

⁷ 1800RESPECT national service directory, extracted and analysed June 2026. Supplemented by desktop research.

⁸ Stand Again applied for inclusion in the directory at time of analysis and was approved within 24 hours

⁹ No gender serviced identified on their website, or state will accept any gender

¹⁰ These 58 could potentially be included within the 350 members of WESNET or genuinely service the combined male, female, and other victim-survivors. Mensline is included in this count as their focus is mental health, relationship, perpetrator programs, and family violence

¹¹ An estimated 1.97 million pets are in households affected by family violence, based on ABS household pet ownership rates applied to the DFV-affected population.



- No identifiable benchmark could be identified for this segment, as such no gap analysis conducted.

Some DFV services explicitly exclude male victims of family violence.

Figure 1: Example general DFV service which services all demographics except men

Redacted
family violence service

Who we work with

Our community Family violence sector Our supporters

Our community

We work with women, children, and gender diverse people from all age groups with experience of family violence in the Victorian community. This includes:

- people with disabilities
- people from culturally and linguistically diverse backgrounds
- Aboriginal and Torres Strait Islanders
- the LGBTQI+ community
- children and young people

Quick exit

The above service provider example states on their listing “We work with all people in the community affected by family violence”. However, make no mention of heterosexual men in their ‘who we work with’ page.

Other services reviewed during the service provider and line analysis list women, children, gender diverse people, people with disabilities, culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, and the LGBTQI+ community as people served - while making no mention of men impacted by family violence.



These services are not gender-neutral, and are not inclusive. As such were listed as 'female victim survivor focused' in the analysis.

They are services that have chosen to exclude heterosexual men as a service design decision.

Two male victim survivor providers lead with services for male perpetrators

Figure 2: Example male victim service which leads with perpetrator services

The [Redacted] is a state-wide 24-hour service. This service provides telephone information and referral to ongoing face to face services for men who are concerned about their violent and abusive behaviours.

This service will also assess the child's experience if there are children in the family and provide information about accessing legal advice, accommodation and other support services for people who have been served with a violence restraining order.

The [Redacted] also provides information and support for men who have experienced family and domestic violence.

If you are assisting someone who does not speak English, first call the Translating and Interpreting Service (TIS) on 13 14 50. They can connect you with the service of your choice and interpret for you.

The above service provider example is one of only 5 identified as serving male victim-survivors.

The description leads with support for 'men who are concerned about their violent and abusive behaviours' before referencing male victims in its 3rd paragraph. A man visiting this page while seeking help as a victim first encounters language that assumes he is the perpetrator.

This framing reflects the broader challenge identified in this submission: even within the small number of services that accommodate male victims, the default positioning for some of these is perpetrator-first.

The gaps are likely to be:

- Support 1800RESPECT to ensure all applicable WESNET members, and dedicated male victim service providers are listed on their services
- Fund the addition of:
 - 33 dedicated female victim-survivor service providers, and
 - 141 dedicated male victim-survivor service providers



Men account for approximately 75%
of suicide deaths in Australia.ⁱⁱ

Yet for the 1.5 million male victim-
survivors of DFV, no tailored suicide
support exists

4

Dedicated DFV
suicide prevention
servicesⁱ for ~**2.7m**
female victims
of DFV

0

Dedicated DFV
suicide prevention
services for **1.5m**
male victims
of DFV

i: Stand Again gap analysis of 336 DFV service providers, June 2026, 4 DFV-specific suicide prevention services were identified within female victim-survivor organisations. Zero were identified for male victim-survivors.

ii: ABS Causes of Death, Australia, 2023. Men accounted for approximately 75% of all suicide deaths in Australia.

Note: National Suicide Prevention Office. (2025). National Suicide Prevention Strategy 2025–2035. Identifies family violence as a risk factor for suicidal distress.



Gap Analysis Layer 2: Service Providers by Segment by State or Territory

Table 2: Population Served Per Service Provider Per Segment

Segment		General DFV	Female Victim	Male Victim	Pets/Animals
Coverage					
National	Est. Pop	4,159K	2,702K	1,458K	1,972K
	No. Providers	2	7	2	2
NSW	Est. Pop	1,409K	915K	494K	915K
	No. Providers	17	95	0	6
	Gap	TBC	Over by 3	49	TBC
VIC	Est. Pop	1,028K	668K	360K	668K
	No. Providers	16	30	0	5
	Gap	TBC	37	36	TBC
QLD	Est. Pop	771K	501K	270K	501K
	No. Providers	8	36	1	4
	Gap	TBC	14	26	TBC
WA	Est. Pop	411K	267K	144K	267K
	No. Providers	6	30	1	1
	Gap	TBC	Over by 3	13	TBC
SA	Est. Pop	324K	211K	114K	211K
	No. Providers	3	14	0	1
	Gap	TBC	7	11	TBC
ACT	Est. Pop	69K	45K	24K	45K
	No. Providers	4	5	1	1
	Gap	TBC	0	1	TBC
TAS	Est. Pop	102K	66K	36K	66K
	No. Providers	1	9	0	2
	Gap	TBC	Over by 2	3	TBC
NT	Est. Pop	44K	28K	15K	28K
	No. Providers	1	11	0	0
	Gap	TBC	Over by 8	1	TBC

Note: The Istanbul Convention benchmark applies to crisis accommodation spaces. It is used here as the sole internationally recognised structural proxy for service density in the absence of Australian-specific benchmarks.



Summary of insights:

Female victim-survivor service providers are well represented in all areas except Victoria

- 4 of the States & Territories were 'over represented'. *Note: This is based on preliminary analysis based on estimated population and a preliminary benchmark. Recommendation 1 may identify a different victim population in these geographies and define these levels appropriate.*
- VIC and QLD may be underrepresented with gaps of 37 and 14 service providers respectively. Some of this is addressed via the 7 National services.

Male victim-survivor service providers are significantly underrepresented across 5 States

- NSW, VIC, SA, TAS, and NT have no State or Territory level service provider representation.
- Largest gaps include: NSW with a gap of an estimated 49 providers, VIC with a gap of 36 providers, QLD with a gap of 26 providers, WA with a gap of 13 providers and SA with a gap of 11 providers.
- ACT has an existing service provider, with a gap of 1.
- NT, TAS have no providers and low gap to address. These may benefit from their own dedicated providers.

General DFV services are potentially misbalanced in distribution across the Nation

- General DFV service target segments can be met through dedicated providers. Observation on the distribution shows:
 - ACT has a provider to population ratio of 1:17K which may be close to ideal
 - NT, VIC, WA, NSW have a provider to population ratio of 1:40 to 1:90K. How these providers integrate as a network across dedicated service providers in those States/Territories and Nationally may determine if gaps exist here
 - QLD, SA, TAS, and National have provider to population ratios of over 1:90K gaps here may need to be addressed.
- The role for General DFV services may therefore be either 'stop gap' measures to meet unmet demand from dedicated providers, integration partners, or generalist providers. Further exploration is required during Recommendation 1.



Pets have provider representation in all States and Territories except for NT.

- No benchmark is available for pet DFV services, however observation on the distribution shows that all States and Territories are represented except for NT. This may be serviced via the National coverage providers, however a physical presence (i.e. crisis accommodation) should be explored for NT.

It should be noted that the discrepancy between sum of additional gaps by State and Territory, and service provider gaps identified in Gap Analysis Layer 1 are attributed to:

- Some geographies were over the benchmark
- National providers (not included at a State level gap analysis)
- Rounding

Network integration across DFV providers is a critical gap

Recommendation 3 also identifies Network and Integration across the DFV provider landscape as a key activity to be completed (i.e. collaboration, inter-provider referrals, service line delivery support etc.).

Therefore, some of the final gaps across the geographies, and between segment focused providers may be addressed via provider integration and collaboration.

This topic is explored in greater detail later in this submission.

The gaps are likely to be:

- Fund either the addition of new providers and / or the geographic extension of existing providers to address gaps of:
 - ~30 service providers in VIC and ~10 in QLD dedicated to female victims of DFV
 - ~40 service providers in NSW, ~35 in VIC, ~20 in QLD, ~10 each in WA and SA, and ~2 each in NT and TAS dedicated to male victims of DFV
 - 1 service provider in NT for pets impacted by DFV



Gap Analysis Layer 3: Service Line Coverage by Segment

Table 3: Count of Service Line Coverage Per Victim Segment

Service Line \ Segment	Segment			
	General DFV	Female Victim	Male Victim	Pets/Animals
Estimated Population	4,159K	2,702K	1,458K	1,972K
No. Service Providers	58	237	5	22
PREVENTION				
Public Education & Awareness	14	67	2	2
Workplace Programs	1	10	1	
Specialist Workforce Development	5	21	1	
Research	1	10	1	
EARLY INTERVENTION				
Self Assessment Tools	2	6	1	
Practitioner Screening Tools	5	14		
Crisis Helplines	7	18	1	
Case Management & Referrals	12	58		
RESPONSE				
Crisis Accommodation & Home Safety	7	71	1	20
Specialist Counselling	29	153	5	1
Generalist Counselling	13	14	1	
Legal Support	15	70		
Financial Support	16	28		
Suicide Prevention (DFV-specific)	1	4		
RECOVERY AND HEALING				
Ongoing Support	4	45	1	
Peer Support Networks	4	43	1	
Advocacy & Policy Representation	8	49	1	2



Summary of insights

There are more crisis accommodation services for pets impacted by DFV than for men.

- 71 providers of crisis accommodation for female victims (1 per 38,000 women).
- 20 providers of crisis accommodation for pets and animals (1 per 98,000 animals).
- 1 dedicated provider for crisis accommodation for male victims, operating in the ACT only (serving 24,000 men in the ACT).
 - The remaining 1.43 million male victim-survivors across all other states and territories have no dedicated DFV crisis accommodation.
- 7 General DFV crisis accommodation providers may support the unmet demand from female and male victim-survivors, however this will not meet the total gap in provision.

Male victim-survivors have zero dedicated DFV legal, financial, or case management support services in Australia.

- 70 legal support services exist that are dedicated for female victim-survivors.
 - 15 exist within general DFV services.
 - Zero are dedicated to male victim-survivors.
- 28 financial support services exist that are dedicated for female victim-survivors
 - 16 exist within general DFV services.
 - Zero are dedicated to male victim-survivors.
- 58 Case management and referral services exist that are dedicated for female victim survivors
 - 12 exist within general DFV services.
 - Zero are dedicated to male victim-survivors.

There is no dedicated DFV-specific suicide prevention service for men, despite men accounting for 75% of suicide deaths.

- 4 DFV-specific suicide prevention services were identified for female victim-survivors.
 - 1 was identified within a general DFV provider.
 - Zero exist for male victim-survivors.



- Given that men account for approximately 75% of suicide deaths in Australia,⁶ and that the National Suicide Prevention Strategy identifies family violence as a risk factor for suicidal distress,¹² the absence of DFV-specific suicide prevention for male victim-survivors is a critical gap.
- Dedicated research into DFV-related suicide risk for both men and women would strengthen the national response.

A State by State breakdown of Service Line coverage has been included in Appendix A for additional reference.

The gaps are likely to be:

- Fund existing or new service providers to extend service lines to cover:
 - Crisis accommodation for
 - male victims of DFV (in all geographies yet prioritising NSW, VIC, QLD.).
 - female victims in VIC and QLD
 - pets in NT
 - Dedicated DFV suicide prevention (not generalist) support for male and female victim-survivors
 - Legal support for male victim-survivors (in all geographies yet prioritising NSW, VIC, QLD.).
 - Financial support for male victim-survivors (in all geographies yet prioritising NSW, VIC, QLD.).

¹² Suicide Prevention Australia. (2024). The Cost of Suicide in Australia. ABS Causes of Death, 2023.



Gap Analysis Layer 4: Perpetrator Behaviour Providers & Programs

Table 4: Count of Behaviour Change Per Segment

Segment Service Line	General DFV	Female Victim	Male Victim	Pets/Animals	Female Perpetrator Only	Male Perpetrator Only				
Estimated Population	4,159K	2,702K	1,458K	1,972K	1,425K	2,773K				
No. Service Providers	58	237	5	22	1	13				
PREVENTION										
Workplace Programs	<i>Redacted to focus on Behaviour Change Only</i>					1				
Specialist Workforce Development						1				
RESPONSE										
Specialist Counselling						3				
RECOVERY AND HEALING										
Ongoing Support						1				
Advocacy & Policy Representation						1				
ACCOUNTABILITY										
Men's Behaviour Change Programs					8	32	3			11
Women's Behaviour Change Programs					3	1			1	

Summary of insights

Only 5 behaviour change programs exist for female perpetrators, despite an estimated 1.4 million female perpetrators¹³.

- The 54 male perpetrator programs are distributed across NSW, VIC, QLD, WA, and SA, though with gaps in TAS, NT, and ACT.

¹³ ABS data shows 94.6% of male victims and 1.7% of female victims experienced partner violence from a female partner. This represents an estimated 1.4 million instances of female-perpetrated partner violence requiring accountability pathways. This figure is a demand estimate based on victim-reported prevalence and does not adjust for cases where multiple victims may report the same perpetrator.



- 60% of the programs (32) are operated by female victim-survivor service providers.
- The 15 dedicated male perpetrator providers are concentrated in four states.
- 5 female perpetrator behaviour change programs were identified, operating across VIC and WA only. These serve an estimated 490,000 female perpetrators in those two states (1 per 96,000).
 - The remaining 930,000 estimated female perpetrators across NSW, QLD, SA, ACT, TAS, and NT have no dedicated behaviour change provider.
 - Without programs that address female perpetration, the system has no pathway to interrupt the cycle of violence affecting the 1.4 million men and women who experienced partner violence from a female partner. This is a gap in the accountability framework, not only the victim support framework.
- Some crisis helplines (e.g. DVConnect) primarily provide services for male perpetrators yet were counted as a Male Victim service provider. As such were not captured in the above. This is a limitation of the analysis conducted at the time (how the provider was categorised by segment) and should be addressed in Recommendation 1 to ensure a fuller picture is obtained on the DFV landscape.

The gaps are likely to be

- Fund existing or new service providers to extend perpetrator programs for:
 - 930,000 estimated female perpetrators across NSW, QLD, SA, ACT, TAS, and NT
 - Additional service providers for female perpetrators across VIC and WA
 - Explore if these programs should be delivered by male victim-survivor service providers, aligned to how 60% of existing male perpetrator programs are predominantly delivered by female victim-survivor dedicated service providers
- Explore if both male and female dedicated service providers should consider expanding into service lines with low/no coverage such as: Public education & awareness; Self-assessment tools; Practitioner screening tools; Suicide prevention; Ongoing support; and Peer support networks. To provide perpetrator tailored services beyond a program



Why men need dedicated, gender-specific services

Men seek help at comparable rates to women

ABS data shows that 61% of men who experienced physical and/or sexual violence by a previous partner sought advice or support, a rate comparable to women at 63%.¹⁴

The barrier is not that men refuse to seek help. The barrier is what happens when they do.

When men seek help, the system is not designed for them.

Of the estimated 889,000 male victim-survivors¹⁵ who have sought some form of help, virtually all are most likely to enter generalist pathways because only 5 dedicated male victim services exist nationally.

When a male victim-survivor seeks support from a service that is not designed for his experience, several outcomes are common, he may:

- be assessed through a framework designed to identify female victims and male perpetrators, resulting in questions about his own behaviour rather than the abuse he has experienced.
- be told that support is only available for women.
- find that the practitioner has no specialist understanding of coercive control or family violence as experienced by men.

Some DFV services describe themselves as serving “families” or use non-gendered language.

While these services play an important role, they are typically built around the female victim-and-children model (see example included in Gap Analysis Layer 1). The intake processes, practitioner training, group programs, and accommodation are not yet designed for male presentations.

A man walking into a family-focused DFV service finds nothing designed for his experience, even when the door technically says it is open to him. This is explored further in the Response to Priority Area 5 detailed later in this submission.

¹⁴ ABS Personal Safety Survey 2021-22, via AIHW (2024), Family, Domestic and Sexual Violence Summary. 61% of men and 63% of women who experienced physical and/or sexual violence by a previous partner sought advice or support. Data for men experiencing current partner violence is not available.

¹⁵ 61% of 1,457,800 male victim-survivors = 889,258. Based on ABS Personal Safety Survey 2021-22 (via AIHW 2024).



Men do not relate to the language DFV services use.

Research describes a “lexicon gap” in male victims:¹⁶ men do not use or relate to words like “victim,” “survivor,” or “abuse.”

Instead, they describe their experiences using practical terms like “stress at home,” “custody issues,” or “financial pressure.”¹⁷

Because men do not see themselves in standard DFV service advertising and language, they do not engage with it.

This is not a failure of individual men.

It is a design mismatch of outreach efforts and service offering language that were built for a different population.

Research confirms dedicated services are the solution.

A review of help-seeking by male victims found that the “invisibility of services” is a major barrier, and that men actively require dedicated approaches that formally recognise their specific context.¹⁸

Studies examining internal and external barriers to help-seeking among male victims of female-perpetrated intimate partner violence identify six key themes:

- **Four internal barriers**
 - blind to the abuse,
 - maintaining relationships,
 - male role expectations, and
 - excuses for the partner
- **Two external barriers**
 - fear of seeking help and
 - nowhere to go.¹⁹

The barriers of “blind to the abuse”, “fear of seeking help” and “nowhere to go” are not metaphorical. They are a result of limited understanding of the language used by male victim-survivors, and insufficient outreach that educates men, validates their experiences, and guides them to healthy support services.

¹⁶ Walker, A., Lyall, K., Silva, D., Craigie, G., Mayshak, R., Costa, B., Hyder, S., & Bentley, A. (2020). Male Victims of Female-Perpetrated Intimate Partner Violence, Help-Seeking, and Reporting Behaviors: A Qualitative Study. *Psychology of Men & Masculinities*, 21, 213–223. Australian sample of 258 men.

¹⁷ Taylor, J.C., Bates, E.A., & Colosi, A. (2021). Barriers to Men’s Help Seeking for Intimate Partner Violence. *Journal of Interpersonal Violence*, 36(19–20).

¹⁸ Huntley, A., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis. *BMJ Open*, 9(6).

¹⁹ Lysova, A., Hanson, K., Dixon, L., Douglas, E.M., Hines, D.A., & Celi, E.M. (2022). Internal and External Barriers to Help Seeking: Voices of Men Who Experienced Abuse in the Intimate Relationships. *International Journal of Offender Therapy and Comparative Criminology*, 66(5).



Further research confirms that dedicated, visible, male-specific signalling - a clear “this is for you” - acts as a primary facilitator that breaks down the shame and isolation preventing men from reporting abuse.²⁰

The barrier to support is not that men refuse to seek help. The barrier is that when they do, the system has almost nothing dedicated to offer them.

The case for dedicated services follows established sector logic.

The women's DFV sector was built on the principle that gendered violence requires gendered responses.

The same principle applies to male victim-survivors, whose presentations, barriers, and service needs are shaped by a different set of gendered norms.

The evidence base for comparative service outcomes across the DFV sector remains limited for all populations. Building dedicated male victim-survivor services is the prerequisite for generating that evidence base.

A coordinated network is needed to integrate the DFV service landscape

The current DFV service landscape for male victim-survivors is limited and fragmented.

Five dedicated providers operate independently, with no formal coordination mechanism, no shared referral pathways, and no collective voice in policy discussions.

By contrast, female victim-survivor services benefit from a mature coordination infrastructure through WESNET.

WESNET provides its ~350 members with

- **national advocacy** and policy representation,
- **shared technology platforms** including the 1800RESPECT referral pathway,
- resource and **knowledge sharing** across providers,
- coordinated **data collection** and reporting,
- **workforce development** support, and a
- **unified voice in government consultations** such as this one.

²⁰ Lim, B.H. et al. (2024). Barriers to and Facilitators of Help-Seeking Among Men Who are Victims of Domestic Violence: A Mixed-Studies Systematic Review.



This coordination infrastructure is a significant contributor to the effectiveness of Australia's female victim-survivor services. It took decades to build.

A comparable coordination function is needed for male victim-survivor services.

A dedicated partnership network for male victim-survivor support services, established early, replicating the WESNET model, can potentially amplify the outcomes of the emerging male victim-survivor service landscape. It can provide

- a coordination point for **cross-referral** between dedicated male victim providers,
- **shared service standards** and quality frameworks,
- collective **workforce development** and training,
- coordinated **data collection** to build the national evidence base,
- a single **point of engagement for Government** on policy and funding, and
- a platform for **sharing best practices** across providers at different stages of maturity

Integration between gendered provider networks may unlock greater benefit

The male victim survivor partnership network should not operate in isolation from the existing female victim-survivor coordination infrastructure.

Research on Coordinated Community Responses (CCR) in the DFV sector consistently demonstrates that specialist agencies coordinating through cross-system collaboration produce better outcomes than fragmented or siloed approaches.²¹

This submission applies the same principle to coordination between specialist gendered networks. Dedicated specialist networks for each population (female victims, male victims, gender diverse, elder, youth) coordinating with each other will deliver stronger outcomes than a single network attempting to serve all populations.

Specialist focus is what makes networks effective. A single network covering all genders, identities, and age groups risks diluting that focus and defaulting to the needs of its largest constituency.

Practical integration could include:

- **cross-referral pathways** so that a female victim service encountering a male victim can refer him directly to a dedicated provider and vice versa,

²¹ Johnson, L. & Stylianou, A.M. (2022). Coordinated Community Responses to Domestic Violence: A Systematic Review of the Literature. *Journal of Family Violence*.



- **shared training on recognising presentations** across genders so that all practitioners can identify and appropriately refer victim-survivors regardless of gender,
- **collaborative research and data sharing** to build a comprehensive national evidence base on DFV across all populations, and
- **joint advocacy to Government** on system-wide gaps and priorities.

Existing national providers such as Stand Again may be positioned to fulfil the male victim-survivor services.

The collaboration with WESNET and the broader female victim-survivor sector should be a foundational design principle of any new network (male, gender diverse, youth, elder), ensuring that Australia's DFV response operates as one networked system.

Integration may support bridging the cultural divide between genders

The cultural benefit of this integration extends beyond service delivery. Australia's response to DFV has at times been characterised by gendered division, where advocacy for one population is perceived as opposition to another.²²

An integrated collaborative network that brings male and female victim-survivor services together sends clear messages:

- **The DFV sector solves this together**, a true National Plan to End Violence.
- **Supporting male victims does not diminish the support available to female victims** and vice versa.
- Addressing female perpetration **does not undermine the focus on male perpetration**.

The service landscape works best when it fosters cooperation between providers across all segments, grounded in a shared commitment to ending violence for everyone.

The cost of the gap

The gaps identified in this analysis carry measurable costs across Australia's health, justice, housing, and employment systems.

These costs are incurred because victim-survivors who cannot access dedicated specialist DFV services instead present to generalist systems that are not equipped to

²² Strengthening harm reduction strategies for boys and men in Australia: thinking differently about dominant discourses on gender-based violence. Harm Reduction Journal, Springer Nature (2026).



identify or address the underlying DFV dynamic. The result is longer treatment pathways, repeat presentations, and poorer outcomes at higher cost.

This section estimates the downstream cost of the service gaps identified in this submission, across both male and female victim-survivor populations only (i.e. excluding male and female perpetrators identified in the gap analysis).

The financial cost to the system

When a victim-survivor of family violence cannot access a dedicated DFV service, they do not disappear from the system. They present to GPs, use Better Access mental health care plans, access psychologists through Employee Assistance Programs, engage with family law proceedings, and in some cases present to homelessness and crisis services.

In each of these settings, the practitioner is unlikely to have specialist DFV capability. The intervention addresses symptoms without identifying or resolving the underlying dynamic.

Mental Health Care Plan

A victim-survivor cycling through a Better Access mental health care plan receives 10 sessions per year at a Medicare rebate of approximately \$93 per session, with out-of-pocket costs of \$80 to \$150 per session²³ depending on the provider.

Across a generalist treatment cycle of two to three years without specialist DFV intervention, the combined system and patient cost is approximately \$6,300 per person²⁴.

A dedicated specialist DFV service addresses the DFV dynamic directly, reducing both cost and duration by resolving the cause rather than managing the symptoms.

Family Court

Where DFV remains unaddressed, costs escalate across other systems. Family Court proceedings for a straightforward parenting matter cost approximately \$15,000 per party.

A high-conflict matter involving allegations of coercive control, supervised contact, and psychological assessments costs \$80,000 to \$120,000 or more per party.²⁵

Victim-survivors who are destabilised by unaddressed family violence are more likely to face escalating proceedings.

²³ Medicare Benefits Schedule 2025. Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative. Australian Government Department of Health and Aged Care.

²⁴ Stand Again estimate based on Medicare Benefits Schedule 2025 rates. Assumes 10 psychology sessions and 4 GP consultations per year across a 3-year generalist treatment cycle.

²⁵ Ignify Legal (2026), based on 2025 Australian family law market rates.





\$7B

**Annual downstream
cost** from
underserved
DFV victim-
survivorsⁱ

An estimated 1.74 million male and female victim-survivors are underserved by Australia's current DFV service landscape.

Creating strain on parts of the system not designed to support it.

i: Across the health, justice, housing, and employment systems, the estimated cost is approximately \$7 billion per year. This estimate is attributable to the identified service gaps for victim-survivors. It excludes the cost of under addressed female perpetrators (1.4million). This suggests the true total economic cost of DFV in Australia is significantly higher than the commonly cited KPMG (2016) report of \$22 billion (which is limited to the cost of violence against women and their children in Australia).



Homelessness

Specialist homelessness services represent a further downstream cost. Total government expenditure on specialist homelessness services was \$1.5 billion in 2023-24, supporting approximately 289,000 clients at an average cost of \$5,200 per client.

DFV clients represent 40% of all specialist homelessness service presentations, approximately 115,000 people per year.

One in three requests for short-term or emergency accommodation were unmet.²⁶

For male victim-survivors, who have access to only 1 dedicated DFV crisis accommodation service in ACT, the pathway from family violence to homelessness services is direct. For the female victim-survivors in the 33-provider gap, access may be similarly constrained in areas where dedicated services do not yet operate.

Workers Compensation

The average cost of a psychological injury workers' compensation claim in NSW has increased from \$146,000 in 2019-20 to \$288,542 in 2024-25. Psychological claims represent 12% of all claims but 38% of total cost, with a median time off work of 30.7 weeks.²⁷

Family violence is a recognised psychosocial hazard under WHS legislation across all jurisdictions.²⁸

Suicide

The cost of suicide is estimated at approximately \$1.7 million per death.²⁹ Men account for approximately 75% of suicide deaths in Australia³⁰. The National Suicide Prevention Strategy identifies family violence as a risk factor for suicidal distress³¹. DFV-specific suicide prevention services are minimal for women and absent for men.

The National Men's Health Strategy 2020-2030 explicitly lists males experiencing violence as a priority health population. The service gaps identified in this submission represent an unaddressed commitment under that strategy.

The table below estimates the annual downstream cost of the service gaps identified in this submission.

²⁶ AIHW. (2025). Specialist Homelessness Services Annual Report 2024-25. Productivity Commission. (2024). Report on Government Services 2023-24.

²⁷ NSW Treasurer's Workers Compensation Ministerial Statement, March 2025. Safe Work Australia. Insurance Council of Australia submission to NSW Parliamentary Inquiry 2025.

²⁸ Safe Work Australia. (2024). Managing Psychosocial Hazards at Work: Code of Practice.

²⁹ Suicide Prevention Australia. (2024). The Cost of Suicide in Australia.

³⁰ ABS Causes of Death, Australia, 2023.

³¹ National Suicide Prevention Office. (2025). National Suicide Prevention Strategy 2025-2035. Australian Government.



Table 5: Estimated Cost of Identified DFV Gap To Aust. Economy

Cost Pathway	Per Person Cost	Source	Estimated Victim Survivors in Gap	Est. Annual Cost
Generalist Mental Health Cycling (no DFV capability)	\$2,096/year	Medicare Benefits Schedule 2025; ABS PSS 2021-22 via AIHW	548,579	\$1,149.82M
Family Court Escalation	\$50,000/party	Ignify Legal 2026	60,000	\$3,000.00M
Specialist Homelessness Services	\$5,200/episode	AIHW SHS 2024-25	46,000	\$239.20M
Workers Compensation (Psychological Injury)	\$288,542/claim	NSW Treasurer March 2025	8,000	\$2,308.34M
Suicide	\$1.7M/death	Suicide Prevention Australia 2024	300	\$510.00M
Estimated total avoidable cost				\$7,207.36M

Across the health, justice, housing, and employment systems, the estimated cost is approximately \$7 billion per year.

- This estimate uses the ABS help-seeking rate (61% for men, 63% for women) to determine the population of victim-survivors who have sought help and entered generalist systems due to the absence of dedicated services.³²
- Estimates for family court, workers' compensation, and suicide-related costs are indicative and based on the proportion of these system costs attributable to DFV.
- These estimates should be refined through the demand analysis proposed in Recommendation 1.

Total cost to the economy of the gaps in domestic violence service provision could be higher than \$7 Billion per year

The cost of violence against women and their children has been estimated at \$22 billion per year.³³ That study was scoped exclusively to female victims and their

³² ABS Personal Safety Survey 2021-22, via AIHW (2024), Family, Domestic and Sexual Violence Summary. 61% of men and 63% of women who experienced physical and/or sexual violence by a previous partner sought advice or support. Data for men experiencing current partner violence is not available.

³³ KPMG. (2016). The Cost of Violence against Women and their Children in Australia. Prepared for the Department of Social Services. Study scope covers violence against women and children only. No equivalent study has been commissioned for male victim-survivors.



children. No equivalent study has been conducted for male, gender diverse, youth and elder victim-survivors, or the cost of female and male perpetrators.

The total cost of all domestic and family violence to the Australian economy, including male victim-survivors and female and male perpetrators, has never been calculated.

Therefore, this submission's estimate of approximately \$7 billion in annual downstream costs attributable to only the identified victim-survivor service gaps suggests the true total economic cost of DFV in Australia is significantly higher than the commonly cited \$22 billion figure.

The human cost to victims and their families

The financial costs reflect a deeper human reality.

Without dedicated services, male victim-survivors remain in abusive relationships because there is nowhere to go.

- **Their mental health declines** while they stay.
- **Children remain in households where one parent is being abused** and the other is the abuser, with no intervention pathway for either.
- **The system has not given these families an exit.**

This is also true for the 330K female victim-survivors in the gap between current provision and the benchmark, however National providers could fill this gap.

It is true at a far greater scale for the 1.4 million male victim-survivors with almost no dedicated provision in the existing DFV service provider landscape.

Dedicated services for victim-survivors also support the objectives of the Safe and Supported National Framework for Protecting Australia's Children 2021–2031.³⁴

When a parent experiencing coercive control is stabilised through specialist support, the children in their care benefit directly. They gain a supported parent with a pathway out of the abusive dynamic.

Investing in victim-survivor services is a child safety investment.

³⁴ Department of Social Services. (2021). Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031. Australian Government.



What the Second Action Plan should do

Recommendation

1

Addresses Q1 and Q6

Commission a national service line gap analysis

A scoping study to assess:

- Current capacity of existing DFV providers
- Current service line coverage (e.g. request service providers to self-select coverage against the service lines provided within this submission as a form of validation)
- Target demand needs for each segment of female victims, male victims, female perpetrators, male perpetrators over the next 5 years, by SLA (youth, LGBTQI, elder may also be considered)

Identify a target DFV landscape service model

- Identify target service line density by delivery mode: Online, physical rural v metro
- Define DFV landscape service line gap between target and current capacity
- Work with existing providers to define what from the gap they can meet with and without Government support
- Define an approach to address any remaining service provider and service line gaps

Recommendation

2

Addresses Q1 and Q2

Fund the growth of service providers, and service line coverage

Utilising the gap analysis from Recommendation 1 to fund an estimated (TBC):

- Additional 141 dedicated male-victim service providers across all States and Territories with a primary focus on NSW, VIC, QLD in the first instance
- Additional 33 dedicated female victim service providers in VIC and QLD

Support existing and additional providers to meet service line gaps, estimated at:

- Crisis accommodation for male victim-survivors (in all States and Territories)



	<ul style="list-style-type: none"> • Dedicated DFV suicide prevention support for both male and female victims • Legal support and financial support services for male victim-survivors in all States and Territories <p>Introduce or expand service provision of existing DFV providers for female perpetrator behaviour change programs</p> <ul style="list-style-type: none"> • To meet the, at min, 930K estimated population of female perpetrators with no State based providers (NSW, QLD, SA, ACT, TAS, and NT) • Explore if male and female perpetrator providers should extend beyond programs into other service lines
<p>Recommendation</p> <p>3</p> <p><i>Addresses Q1</i></p>	<p>Establish a national integrated victim-survivor partnership network</p> <p>Phase 1: Pilot years 1-2</p> <ul style="list-style-type: none"> • Pilot a male victim-survivor partnership network (replicating the WESNET coordination model) • Existing national providers such as Stand Again may be positioned to fill this role <p>Phase 2: Scale years 2-4</p> <ul style="list-style-type: none"> • Work with the male victim partnership network to identify DFV landscape gaps and encourage service provider and service line growth to meet targets defined in Recommendations 1 and 2 <p>Phase 3: Network Integration year 5</p> <ul style="list-style-type: none"> • Optimising for network integration and collaboration across all DFV service providers, supported by WESNET, the male victim survivor equivalent, and other peer bodies (e.g. LGBTIQ DFV Interagency NSW, youth, elder partnership networks etc.)



2

Independent providers actively seek to validate a **male victims experience**

With almost no government supported outreach to validate a male victims experience, and almost no dedicated male victim services – institutionally isolated men are at risk of being radicalised by extreme content



Response to Priority Area 2: Prevention and Early Intervention

"Embedding initiatives where people live, work, learn and connect to address the gendered drivers of this violence."

This response addresses the consultation questions:³⁵

- How can governments, communities, schools, workplaces, online platforms and others better support people to recognise and respond to harmful attitudes and behaviours?
- What emerging issues should the Second Action Plan address in relation to primary prevention and early intervention?

Key points

- The absence of legitimate services creates a help-seeking vacuum.
- Research confirms that isolated individuals who cannot find tailored support are vulnerable to online communities that exploit their grievance.
- Men do not relate to currently used DFV language. Outreach must use male-specific language and channels.
- Three intervention points need strengthening: visibility, workplace programs, and front-line worker education.
- State coercive control legislation (NSW, QLD) will require tools capable of identifying male victims.

³⁵ ANROWS. (2026). Evidence to Action: Consultation Paper, Priority Area 2, pp. 31-32, 45-46.



Institutional isolation for male victim-survivors needs to be addressed

The gap analysis in Priority Area 1 identifies a severe shortage of dedicated services for male victim-survivors.

A male victim-survivor of family violence who seeks help today encounters a service landscape that was not built for him. At present, there is limited government-funded public awareness campaign directed at male victim-survivors of family violence.

The outreach infrastructure that has been predominately built for female victim-survivors across decades of sustained investment (including community campaigns, service branding, public education, and media presence) has limited equivalent for men³⁶.

When a man cannot find support that recognises his experience, he becomes isolated. He cannot:

- **name what is happening to him** because the language available does not describe it.
- **find a service designed for him** because dedicated services barely exist.
- **disclose to friends or family because the cultural expectation** is that men are strong, self-reliant, and not victims.

The shame of his experience and the absence of anywhere to take it combine to produce a profound isolation that deepens the longer it continues.

What isolated men encounter when they search for help

When a male victim searches for help using terms like 'men domestic violence' or 'men family violence,' the results can be dominated by perpetrator programs, behaviour change referrals, and content framed around men as users of violence.

A man in crisis, searching for support, encounters content that frames him as the problem. This compounds the shame he already carries and actively discourages help-seeking through healthy alternatives to manosphere content.

³⁶ The appointment of a Federal Special Envoy for Men, and State Minister for Men are small steps in the right direction, though much further is needed



Mensline Australia is the most commonly recommended service for men experiencing relationship issues (classified as a General DFV service in the analysis as it focuses on relationship and mental health issues).

It's family violence page presents 12 articles, of which

- 7 are oriented toward men who use violence (including behaviour change programs, common excuses for violence, and time-out techniques).
- 2 address men experiencing violence.

It's home page focuses on men's anger management, stress and anxiety issues, and how to be a better partner.

A male victim-survivor arriving at this service encounters perpetrator-focused content before victim-focused content.

The service most frequently cited as support for male victims leads with the assumption that the man reading it is the perpetrator.

Institutional isolation opens the door to the manosphere

For men who persist in searching and find no dedicated victim service, they feel isolated and rejected by the very institutions that are designed to support victims of DFV.

The content layer that is currently most aligned to the language they use (outside of services like Stand Again), and does not position a victim as a perpetrator is the manosphere.

The journey from 'I need help' to 'the system is against me', to 'the manosphere is the only place that understands me' can happen in a single search session.

Research confirms that this kind of isolation is dangerous. When individuals feel alienated from mainstream society and cannot find a safe, tailored community, they experience a crisis of belonging that extremist groups are designed to exploit.³⁷

The Consultation Paper identifies misogyny and gender-based violent extremism as an emerging area of concern.³⁸ Research also shows that boys and young men often

³⁷ Radicalisation literature. See Doherty et al. (2026, footnote 34) and the broader literature on social exclusion and radicalisation pathways.

³⁸ ANROWS. (2026). Evidence to Action: Consultation Paper, Second Action Plan, p. 13.



disengage from harmful online communities, such as the manosphere, when they gain access to supportive communities and positive models.³⁹

There is an investment gap in outreach for male victim-survivors

Services for female victim-survivors have benefited from over two decades of sustained public investment in awareness campaigns, destigmatisation, and help-seeking pathways.

This investment has produced positive and measurable results (though it is likely more is still required). Demand for services like 1800RESPECT continues to grow, police reporting rates are increasing, and women are increasingly disclosing to family and friends. The current capture rate for female victim-survivors reflects the cumulative effect of this sustained effort.

At present, no equivalent investment has been made for male victim-survivors. ABS data shows that men reach out for help at comparable rates to women (61% of men versus 63% of women who experienced previous partner violence sought advice or support).⁴⁰

The engagement rate between male victim-survivors and dedicated DFV services is nonetheless negligible, because dedicated services barely exist.

Men are reaching out and finding almost nothing designed for them.

Visible, healthy alternatives are needed

Dedicated services and visible, government-backed outreach provide the healthy alternative.

They give men a credible, health-focused pathway at the point of highest vulnerability. They reduce the institutional-isolation that makes radicalisation possible.

Funding dedicated prevention and early intervention for male victim-survivors is an investment in three outcomes:

- **reaching men before their experience of abuse becomes entrenched,**
- **providing safe pathways** when they do reach out, and

³⁹ Doherty, L., Dowling, C., & Dickens, M. (2026). Disengagement from online misogynistic incel communities. AIC, Trends & Issues No. 727.

⁴⁰ ABS Personal Safety Survey 2021-22, via AIHW (2024), Family, Domestic and Sexual Violence Summary. 61% of men and 63% of women who experienced physical and/or sexual violence by a previous partner sought advice or support. Data for men experiencing current partner violence is not available.



- reducing the **risk that institutional isolation drives men toward harmful alternatives.**

Men are already seeking help.

Building dedicated services is necessary but not sufficient. Those services must be visible, delivered in language men relate to, and accessible through channels men use.

A population that has learned through experience that the system has nothing for them will not discover new services without sustained, targeted outreach.

Outreach to male victim-survivors requires proportionally greater investment in the early years to establish baseline awareness, develop effective messaging, and build the trust that the DFV service landscape is evolving to meet their unique needs.

Government funded outreach from grounded male victim-survivor services like Stand Again provide a prevention investment.

Three intervention points need strengthening

To achieve these outcomes, three distinct intervention points require investment. Each addresses a different stage in the prevention and early intervention spectrum and reaches men through different mechanisms.

1. Visibility and awareness (prevention)

Government supported outreach that aligns to the language men actually use

Until outreach is designed around the language men use, male victim-survivors will continue to find relationship advice that keeps them in abusive dynamics, or extreme content that radicalises their institutional isolation and grievance, before they find a dedicated service.

A national outreach strategy for male victim-survivors would address this gap through campaigns designed for the language, channels, and settings where men are most likely to be reached.

This is distinct from workplace programs (which reach men in a specific setting) and front-line worker education (which equips professionals to identify men).

Public awareness campaigns reach the general population and normalise help-seeking for men at a societal.



Investment in outreach to male victim-survivors is likely to be high at the outset. So that it can:

- **Identify language that resonates** with male victim-survivors
- **Combat existing stereotypes about male victim-survivors**
- Work to **address the current sentiment of institutional isolation** from existing Government services

2. Workplace programs (prevention and early intervention)

The Consultation Paper identifies workplaces as key prevention settings.⁴¹ Family violence is a recognised psychosocial hazard under WHS legislation.⁴²

Male victim-survivor workplace programs are almost absent today

Currently, dedicated workplace DFV programs designed for male victim-survivors are almost entirely absent from the Australian landscape. Stand Again is one of the only providers who recently launched workplace support packages that include male-specific awareness training, physical resources, and pathways to specialist coaching.

Scaling models such as this would embed early intervention in the places where men already are, meeting the Second Action Plan's commitment to 'embedding initiatives where people live, work, learn and connect.

The workplace is where the indicators of family violence are most visible outside the family unit.

For male victim-survivors, common indicators in the workplace include:

- sustained **performance decline**,
- increased presenteeism,
- extended **overtime or overworking as a coping** or avoidance mechanism,
- **withdrawal** from colleagues,
- unexplained absences, and
- changes in **behaviour or emotional regulation**.

⁴¹ ANROWS. (2026). Evidence to Action: Consultation Paper, Priority Area 2, pp. 31-32, 45-46.

⁴² Safe Work Australia. (2024). Managing Psychosocial Hazards at Work: Code of Practice.



Workplace programs are a critical intervention point for men

Without specific training, these indicators are typically attributed to stress, burnout, or disengagement rather than explored as potential signs of family violence.

For men experiencing coercive control, the workplace may be the only environment where they regularly interact with other adults without the abuser's oversight.

This makes the workplace the single most promising early intervention setting for reaching male victim-survivors.

Workplace psychosocial safety legislation, now in force across every Australian jurisdiction, creates both the obligation and the framework for employers to respond.

Employers are required to identify and manage psychosocial hazards, including family violence. Effective workplace programs:

- equip people leaders with the **capability to recognise indicators**,
- have safe conversations, and
- **connect employees to specialist DFV support.**

Workplace programs provide physical resources in common areas that signal to employees that support exists, using language designed to reach men rather than the standard DFV terminology that research confirms men do not relate to.

3. Front-line worker identification and referral (early intervention)

Frontline workers require specialised training to recognise male victim presentations

GPs, mental health professionals, police, legal practitioners, and community service workers are often the first formal point of contact for a man experiencing family violence.

In many cases, these practitioners have not received training on identifying male victimisation.

When a man presents to a GP describing sleep disruption, anxiety, and difficulty concentrating, the GP may treat the symptoms without exploring whether family violence is contributing.

When a man contacts a legal service seeking advice on separation, the intake worker may not recognise controlling dynamics as coercive control.



1 in 7 men experience emotional abuse, which coercive control legislation directly addressed

Research confirms that frontline professionals routinely misread male trauma symptoms such as withdrawal or overwork as aggression or relationship stress, rather than identifying them as indicators of coercive control.⁴³

Research on the prevalence of coercive control in family services confirms that emotional abuse and coercive control are the most common forms of family violence encountered by practitioners, yet these non-physical forms are often subtle and unrecognised.⁴⁴

Criminalisation of coercive control without equitable screening tools

The criminalisation of coercive control⁴⁵, also represents a significant shift in Australia's legal response to family violence.

For these laws to achieve their intended purpose, the workforce responsible for identifying and responding to coercive control must be equipped to recognise it across all presentations.

The current absence of validated screening tools for male, same sex, youth and elder presentations creates a foreseeable risk: that the new laws are applied inequitably, with victims remaining unidentified within the system designed to protect them.

This risk is immediate and growing as implementation progresses – this is explored further in the Response to Priority Area 5 detailed later in this submission.

Front-line workers will need the capability to identify coercive control in male, gender diverse, elder and youth victims.⁴⁶

Without this capability, the justice system will struggle to apply these new laws equitably.

⁴³ Huntley, A. et al. (2020). Help seeking by male victims of DVA: an integrated mixed methods synthesis. BMC Health Services Research, 20, 1693 (2020)

⁴⁴ Uniting. (2025). Policy Brief: Family Violence in Family Services Evaluation Report, July 2025.

⁴⁵ Criminal Legislation Amendment (Coercive Control) Act 2022 (NSW); Criminal Code (Coercive Control) Amendment Act 2024 (QLD).

⁴⁶ Stand Again has published works on coercive control towards men, and developed a scalable coercive control assessment framework that can be adapted to females, same sex, youth and elders and can support these jurisdictions in enhancing their capabilities and understanding here



What the Second Action Plan should do

<p>Recommendation</p> <p>4</p> <p><i>Addresses Q2 and Q3</i></p>	<p>Commission research into effective messaging for male victims of family violence to:</p> <ul style="list-style-type: none"> • Overcome cultural and societal barriers to men help seeking. • Address the perception gap where male victim-survivors believe no government-supported services exist for them. • Educate men on experiences of men abused by intimate partners – including recognising coercive control and physical abuse • Validate men’s experience of abuse • Effectively direct men to healthy alternative content and DFV service providers
<p>Recommendation</p> <p>5</p> <p><i>Addresses Q1 and Q2</i></p>	<p>Develop and launch a national outreach strategy for male victim-survivors using insights from Recommendation 4, so that it:</p> <ul style="list-style-type: none"> • Uses language mostly likely to resonate with men • Uses channels, and settings designed to reach men where they are • Supports and extends the reach of the existing and emerging dedicated male victim-survivor service providers
<p>Recommendation</p> <p>6</p> <p><i>Addresses Q2 and Q4</i></p>	<p>Fund workplace-based prevention and early intervention programs that:</p> <ul style="list-style-type: none"> • Utilises insights from Recommendation 4, and 9 (detailed later in this report) • Educate workplaces on male victim presentations within the workplace • Provides workplaces with resources and tools to enable their employees to pursue appropriate pathways to specialist support



Recommendation**7***Addresses Q3 and Q5***Include male victimisation in front-line worker education, that:**

- Utilises insights from Recommendations 9 & 10 (detailed later in this report)
- Educates frontline workers (e.g. healthcare practitioners and police) on approaches to recognise and distinguish a male victim of family violence from a perpetrator
- Educates legal and community services on male victim presentation.
- Provides frontline workers with resources and tools to enable them to guide male victims to appropriate pathways to specialist support



A man with dark hair and a beard is shown in profile, looking out a window. The lighting is soft and natural, coming from the window. There are two dark blue circular overlays containing text. The main text at the bottom is in white on a dark background.

Fear
Obligation
Guilt

Social
Isolation
Financial Control
Logistical / Legal
Constraints
Identity
Erosion

Male victims of abuse present differently – understanding this will strengthen Governments ability to service its citizens and reduce the risk of suicide



Response to Priority Area 5: System Integration and Workforce

"Drawing on an integrated system and a connected and capable workforce that utilises trauma and violence-informed approaches across multi-sector services and programs."

This response addresses the consultation questions:⁴⁷

- What workforce capabilities, supports, or conditions are most needed to strengthen prevention, early intervention, response and recovery?
- What evidence, workforce or system gaps should the Second Action Plan prioritise?

Key points

- The evidence base for how male victim-survivors present to services is less developed than for female victim-survivors. This limits the effectiveness of current screening and assessment tools.
- International reviews have identified the absence of validated tools for male populations as a gap.
- Male victim-survivors present through mechanisms shaped by cultural norms around masculinity, including anticipatory self-regulation, obligation-driven compliance, and emotional containment.
- These presentations require specific capability to recognise.
- Extending the evidence base and developing validated tools for male presentations would strengthen the integrated system response the Second Action Plan seeks to build.

⁴⁷ ANROWS. (2026). Evidence to Action: Consultation Paper, Priority Area 5, pp. 39-40, 50-51.



The evidence base for male presentations is underdeveloped

The National Plan's commitment to a connected and capable workforce requires that practitioners have access to evidence-informed tools across the populations they serve.

Significant progress has been made in developing screening and assessment capability for female victim-survivors. The evidence base for male victim-survivor presentations is less developed, and the tools available to practitioners reflect this.

The screening and assessment instruments most commonly used in Australian and international practice were developed for and validated on female populations:

- **The Composite Abuse Scale**⁴⁸, developed in Brisbane and widely used in Australian primary care, was validated on 1,836 women GP patients.
- **The Checklist of Controlling Behaviors**⁴⁹ was validated on 2,135 women in DV shelters.
- The **DASH risk checklist** and the **Women's Experience with Battering Scale** were similarly developed with female-only samples.

Two brief screening tools have been tested on male samples. The HITS, originally validated on 160 women, was subsequently tested on 95 men (78 non-victims and 17 self-identified victims).⁵⁰

However, both are brief triage instruments of three to four items and neither assesses coercive control.

In 2018, the U.S. Preventive Services Task Force identified the absence of valid, reliable screening tools for intimate partner violence in men as a gap.⁵¹ This remains the case internationally.

⁴⁸ Hegarty, K., Sheehan, M., & Schonfeld, C. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the Composite Abuse Scale. *Journal of Family Violence*, 14(4), 399–415. Hegarty, K., Bush, R., & Sheehan, M. (2005). The Composite Abuse Scale: Further development and assessment of reliability and validity. *Violence and Victims*, 20(5), 529–547. Validated on 1,836 women GP patients in Brisbane. Zero male participants.

⁴⁹ Lehmann, P., Simmons, C.A., & Pillai, V.K. (2012). The validation of the Checklist of Controlling Behaviors (CCB): Assessing coercive control in abusive relationships. *Violence Against Women*, 18(8), 913–933. Validated on 2,135 women in DV shelters. Zero male participants.

⁵⁰ Sherin, K.M. et al. (1998). HITS: A short domestic violence screening tool. *Family Medicine*, 30, 508–512. Shakil, A. et al. (2005). Validation of the HITS with males. *Family Medicine*, 37(3), 193–198.

⁵¹ U.S. Preventive Services Task Force. (2018). Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: Recommendation statement. *JAMA*, 320(16), 1678–1687.



The Second Action Plan has an opportunity to lead in addressing this gap by investing in the development of validated, population-specific tools for male victim-survivors.

How male victim-survivors present to services

Understanding how male victim-survivors present is essential to building workforce capability that serves all victim-survivors effectively. Research provides a foundation for this understanding.

Research found that men seeking help for intimate partner violence reported significant delays between the onset of abuse and help-seeking:

- **Obligation-related barriers** (responsibility to family, belief that a man should be able to handle it) were identified as the primary obstacles.
- Research also found that **male socialisation norms** including self-reliance, stoicism, and the provider identity actively suppress self-identification as a victim.⁵²

These cultural norms shape how male victim-survivors present when they do reach services:

- **Fear** in male victims typically manifests as fear of consequences (custody loss, false allegations, financial ruin) rather than fear of physical harm.⁵³ This presents as anticipatory self-regulation:
 - monitoring behaviour,
 - pre-empting escalation,
 - absorbing discomfort to maintain stability.
 - When fear is operational rather than expressive, it requires specific practitioner capability to recognise.
- **Obligation** drives compliance that can appear voluntary. The provider role, the protector role, the belief that a good man stays - these are culturally reinforced expectations that coercive control exploits.
 - When a man adapts to an abusive dynamic rather than resists it, his behaviour may be interpreted as choice rather than constraint without further exploration.
- **Guilt** prevents recognition. Male victim-survivors frequently believe they are the source of the relationship's difficulties.

⁵² Douglas, E.M., & Hines, D.A. (2011). The helpseeking experiences of men who sustain intimate partner violence: An overlooked population and implications for practice. *Journal of Family Violence*, 26(6), 473–485.

⁵³ Hines, D.A., & Douglas, E.M. (2010). Intimate terrorism by women towards men: Does it exist? *Journal of Aggression, Conflict and Peace Research*, 2(3), 36–56.



- They minimise their experience and qualify their accounts.
- This self-blame is a product of the abuse itself, but without specific training, practitioners may take it at face value.

There is also a timing consideration relevant to assessment. Early in abuse, a man is more likely to minimise what is happening. His account may be vague, qualified, and self-blaming.

Later in recovery, after professional support and reflection, he may present with greater clarity and insight.

Both presentations carry a risk of being misread (the first as absence of harm, the second as defensiveness) if the practitioner is not equipped to assess recovery stage alongside presentation.

The link between misidentification and suicide risk

Where assessment processes do not account for male presentations, there is a risk that a male victim-survivor is either not identified and received appropriate support or identified as a potential perpetrator rather than recognised as someone seeking help.

The consequences of this misidentification extend beyond the immediate assessment. A man who has sought help and been reframed as a source of harm experiences institutional invalidation that compounds the identity erosion coercive control has already produced. It reinforces the shame and self-doubt that are products of the abuse itself.

For men who have experienced prolonged coercive control, this institutional response can confirm the belief (cultivated by their abuser) that they are the problem and that no one will believe them.

Men account for approximately 75% of suicide deaths in Australia.⁵⁴ The National Suicide Prevention Strategy 2025–2035 identifies family violence as a risk factor for suicidal distress.

The National Suicide and Self-Harm Monitoring System documents the correlation between relationship breakdown, institutional invalidation, and suicidal distress.⁵⁵

Strengthening the capability of assessment frameworks to accurately identify male victim-survivors would directly support Australia's suicide prevention objectives.

⁵⁴ National Suicide Prevention Office. (2025). National Suicide Prevention Strategy 2025–2035. Australian Government.

⁵⁵ AIHW. National Suicide and Self-Harm Monitoring System. aihw.gov.au/suicide-self-harm-monitoring.



Strengthening assessment capability for male presentations

Building on the existing assessment frameworks to include male presentations would strengthen the integrated system response the Second Action Plan seeks to achieve.

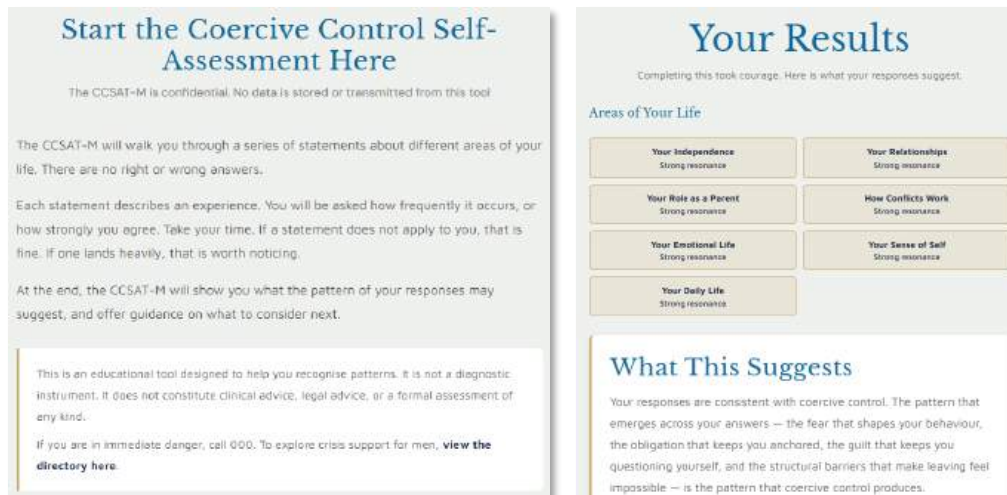
A specific capability gap exists in distinguishing male victim presentations from male perpetrator presentations.

When a man presents as guarded, emotionally contained, or focused on practical outcomes, a practitioner needs structured guidance to explore whether this reflects a victim who has been conditioned to suppress distress or a perpetrator who is managing his presentation.

Coercive control assessment for male victim-survivors is in its infancy

Stand Again has developed the CCSAT-M (Coercive Control Self-Assessment Tool for Men) – potentially the first self-assessment instrument designed for male victims of coercive control.

Figure 3: Start and end screen for the CCSAT-M



The CCSAT-M uses experiential prompts organised by life domain and interpreted through a detection model that identifies the architecture of control rather than counting discrete behaviours.

The detection model used three-layers:

1. **FOG (Fear, Obligation, Guilt)** – identifying the internal control mechanism through which coercive control operates on the victim



2. **Dependency Enclosure** - detecting structural entrapment across four dimensions: financial control, social isolation, identity erosion, and legal/logistical binding
3. **Domain Resonance** - measuring the breadth of impact across seven life domains

Weighted scoring across these layers directs the individual to one of three pathways:

- general relationship support,
- seeking an independent professional opinion, or
- a pattern consistent with coercive control.

CCSAT-M is designed to be extended to other genders and identifies

The underlying detection model is gender-neutral and is currently in early-stage exploration with HeadsUpGuys at the University of British Columbia, Canada.

The CCSAT-M was designed as the first in a family of population-specific tools (CCSAT), with the framework extendable to:

- **female victims** (CCSAT-F),
- **young people** in dating relationships (CCSAT-Y),
- **same-sex** relationships (CCSAT-SS),
- **parent-child** coercive control (CCSAT-PC), and
- **elder** abuse (CCSAT-E).

The CCSAT-M methodology is documented and available on request as a resource⁵⁶ for the development of validated, peer-reviewed screening tools.

Evidence base on coercive control assessment required

The 2021 Parliamentary Inquiry recommended research into male victimisation. The CCSAT-M methodology paper identifies five areas where the evidence base requires development to support this work:

1. documentation of male victim presentations,
2. documentation of service responses to male victims,
3. screening tool validation for male populations,
4. recovery-stage effects on assessment, and
5. risk pathways in misidentified victims

⁵⁶ Stand Again. (2026). CCSAT-M: Coercive Control Self-Assessment Tool for Men — Methodology Paper. Available on request from standagain.com.au.



Each of these areas represents an opportunity for the Second Action Plan to extend the evidence base.

The evidence base for female perpetrator behaviour is underdeveloped

The gap analysis identified an estimated 1.4 million female perpetrators⁵⁷ of partner violence nationally, served by 5 behaviour change programs concentrated in VIC and WA.

The evidence base for how female abusive behaviours present, what healthy alternative behaviours look like, and what approaches are effective in supporting behaviour change for female perpetrators is limited.

Male experiences of coercive control from a female perpetrator have limited documentation

The existing frameworks do not currently provide this guidance, and extending them to do so would reduce reliance on subjective assessment⁵⁸.

Current perpetrator behaviour change programs in Australia were designed for male perpetrators. The language, frameworks, and therapeutic approaches used in these programs reflect male patterns of violence and control.

Extending these programs to female perpetrators without adaptation is unlikely to be effective.

Dedicated research into female perpetrator behaviour is required to inform the design of targeted behaviour change programs that can be scaled across the jurisdictions where no provision currently exists.

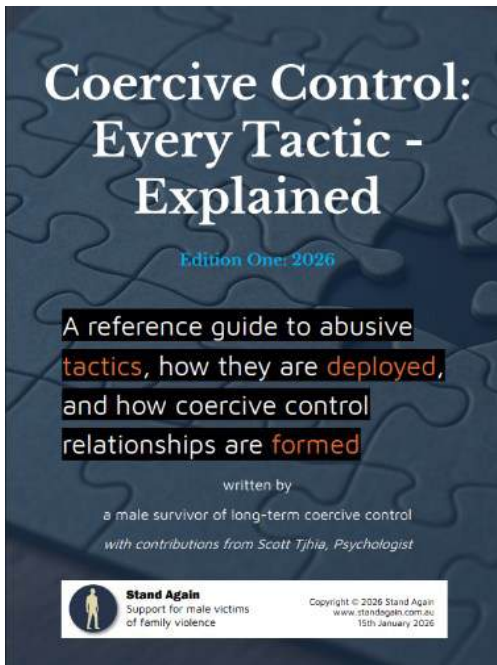
Stand Again has published detailed analysis of coercive control tactics that may support this effort.

⁵⁷ ABS data shows 94.6% of male victims and 1.7% of female victims experienced partner violence from a female partner. Combined, this represents an estimated 1.43 million instances of female-perpetrated partner violence requiring accountability pathways. This figure is a demand estimate based on victim-reported prevalence and does not adjust for cases where multiple victims may report the same perpetrator.

⁵⁸ Assessment not based on peer reviewed evidence of male victimisation, and instead based on subjective assessment on the translation of female victimisation to male presentation.



Figure 4: Book Cover, Coercive Control – Every Tactic Explained 2026.



Stand Again's published analysis of over 100 coercive control tactics document specific patterns of deployment against male victims that are not currently included in assessment frameworks, including the weaponisation of children, maternal superiority, legal and institutional abuse, financial control, and identity erosion through sustained emotional manipulation.⁵⁹

Incorporating an understanding of these patterns into practitioner training would support more accurate identification.

⁵⁹ Stand Again & Tjhia, S. (2026). Coercive Control: Every Tactic Explained. Stand Again.



What the Second Action Plan should do

<p>Recommendation</p> <p>8</p> <p><i>Addresses Q1 and Q6</i></p>	<p>Commission research into the relationship between assessment outcomes, institutional invalidation, and suicide risk in male victim-survivors to understand:</p> <ul style="list-style-type: none"> • the correlation between male victim of DFVs experience of failed help seeking and suicide risk • the correlation of miss attribution as a perpetrator and suicide risk • effective clinical practice and institutional policy in reducing the risk of male suicide
<p>Recommendation</p> <p>9</p> <p><i>Addresses Q1 and Q6</i></p>	<p>Commission research into the relationship between DFV and increased risk of suicide in female victim-survivors, to understand:</p> <ul style="list-style-type: none"> • the effectiveness of existing tailored DFV related suicide prevention services • what research and support gaps existing 4 tailored DFV suicide services recommend • how to scale up and enhance existing tailored DFV suicide related services for females
<p>Recommendation</p> <p>10</p> <p><i>Addresses Q5 and Q6</i></p>	<p>Commission research into male victim-survivor presentations including:</p> <ul style="list-style-type: none"> • how fear, obligation, guilt, and emotional containment manifest in male victims, • how dependency enclosure (financial, legal, identity, and social abuse occurs for male victims) – NB Stand Again has existing resources to support for these areas • approaches to increase the confidence in distinguishing a male victim from male perpetrator • areas in current assessment tools that may need improvement to better assess all victims of DFV (female, male, or either)



<p>Recommendation</p> <p>11</p> <p><i>Addresses Q5 and Q6</i></p>	<p>Fund the development and validation of screening tools designed for male victim-survivor populations:</p> <ul style="list-style-type: none">• Utilise existing frameworks such as the CCSAT-M developed by Stand Again as a starting point• Extend existing risk assessment and intake frameworks to include structured guidance for identifying male presentations and distinguishing male victims from male perpetrators• Test the screening tools (in collaboration with other jurisdictions such as Canada and the UK who are also exploring male victim assessment tools) to validate they provide front line workers, psychologists, and case managers with increased confidence in distinguishing between male victims and perpetrators
<p>Recommendation</p> <p>12</p> <p><i>Addresses Q4 and Q6</i></p>	<p>Commission research into female perpetrators behaviour and intervention including:</p> <ul style="list-style-type: none">• how female abusive behaviours present• what healthy alternative behaviours may look like• what interventions (language, channels, tools, approaches) are required to support behaviour change for female perpetrators



About Stand Again

Stand Again is one of approximately five dedicated male victim of DFV services in Australia. It operates nationally and provides support for men who have experienced family violence or coercive control from an intimate partner.

Services:

- **Trauma-informed 1:1 coaching** for male victim-survivors of family violence
- **Educational content**, including books and free resources and tools
- **Professional CPD development workshops** for family lawyers and clinicians
- **Workplace support packages** for organisations supporting their employees
- **Self-assessment tools** for male victims of coercive control

Relationships:

- Member of the **Australian Men's Health Forum (AMHF)**, Australia's peak body for men's health
- Member of the **Domestic Abuse Victims International Alliance (DAVIA)**, alongside more than 200 domestic violence services globally
- Affiliated with the **Women's Justice League**, a not-for-profit organisation supporting female victims of domestic violence
- Recognised by the **Federal Special Envoy for Men's Health, Dan Repacholi MP**, who acknowledged Stand Again's work through official communications ("Mate, You Good?" newsletter).

Publications on male family violence and recovery:

- **Coercive Control: Every Tactic Explained**, documenting over 100 coercive control tactics, written for a clinical and legal audience
- **Reaching Him: Guidance for Families and Friends of Men Lost in an Abusive Relationship**, supporting parents and friends in reaching male victims
- **Reconnecting with Your Feelings After Abuse**, supporting victim-survivors with emotional healing

Stand Again receives no government funding for its services or operations.





Stand Again

Support for male victims of family violence
& coercive control

Memberships:



Published Works:



www.standagain.com.au

ABN 75 563 353 277

Appendix A: Service Chain Analysis

Stand Again conducted an original analysis of DFV service provision in Australia. The initial desktop audit reviewed over 700 database listings from the 1800RESPECT directory. To establish a clean baseline of unique entities, this pool was filtered to remove duplicate entries and individual regional office locations, resulting in a final dataset of 336 distinct DFV service providers mapped against 19 service functions.

Methodology

Services were deduplicated by organisation (eliminating multiple office location within each state), classified by State services, primary segment focus, and mapped against service lines providers across five lifecycle phases: prevention, early intervention, response, recovery and healing, and accountability.

All service lines counted are explicitly domestic and family violence services. General mental health, homelessness, legal aid, and financial services that are not specifically aligned to DFV clients were excluded.

It is noted that 32 of the 237 female victim-survivor services also operate men's behaviour change programs. These are counted under the female victim-survivor segment for their primary purpose, with the behaviour change service line recorded separately. 13 organisations were classified as Male Perpetrator. 2 providers were categorised as dedicated male victim-survivor providers for the purpose of this analysis, despite indications they primarily serviced male perpetrators.

Service line definitions

Prevention: Activities that raise awareness, change attitudes, or build community capacity to prevent DFV before it occurs.

- **Public Education and Awareness:** Campaigns, resources, or programs designed to raise community awareness of DFV.
- **Workplace Programs:** DFV awareness or support programs delivered in workplace settings.
- **Specialist Workforce Development:** Training, CPD, or professional development for DFV practitioners.
- **Research:** Activities that explore and generating evidence on DFV.



Early Intervention: Activities that identify risk, support disclosure, and connect individuals to services at the earliest opportunity.

- **Self-Assessment Tools:** Victim-facing tools that support individuals to identify whether they are experiencing DFV.
- **Practitioner Screening Tools:** Validated tools used by practitioners to assess DFV risk.
- **Crisis Helplines:** Phone, live chat, or online video chat crisis support services specifically for DFV.
- **Case Management and Referral:** Intake, case management, risk assessment and service referrals for victims of DFV.

Response: Crisis and immediate support services for individuals currently experiencing or fleeing DFV.

- **Crisis Accommodation:** Emergency housing specifically for people or animals escaping DFV.
- **Specialist Counselling:** DFV-specific therapeutic support from trained practitioners.
- **Generalist Counselling:** Non-DFV-specialist counselling that may include DFV as part of its scope.
- **Legal Support:** Dedicated DFV legal advice, court advocacy, or legal representation.
- **Financial Support:** DFV-specific emergency relief, financial counselling, or material aid (such as food).
- **Suicide Prevention:** DFV-specific suicide prevention, intervention, or postvention services.

Recovery and Healing: Ongoing support that assists victim-survivors to rebuild safety, wellbeing, and independence after DFV.

- **Ongoing Support:** Non-crisis DFV support including groups, wellbeing programs, and recovery services.
- **Peer Support Networks:** Facilitated peer support specifically for DFV victim-survivors.
- **Advocacy and Policy Representation:** Organisations providing systemic advocacy or policy work on DFV.

Accountability: Programs that address the behaviour of people who use physical violence or coercive control, supporting behaviour change and holding perpetrators to account.

- **Men's Behaviour Change Programs:** Programs for men who use abuse or violence.
- **Women's Behaviour Change Programs:** Programs for women who use abuse or violence.



Category definitions

- **Female Victim-Survivor:** Organisation explicitly serves female victim-survivors as its primary purpose.
- **General DFV Service:** Organisation does not use gendered language or provides services that are broad in nature with DFV supplementary, not primary to its purpose.
- **Male Victim-Survivor:** Organisation explicitly serves male victim-survivors as its primary purpose.
- **Male Perpetrator:** Organisation provides behaviour change programs for men who use violence as their primary purpose.
- **Female Perpetrator:** Organisation provides behaviour change programs for women who use violence as their primary purpose.
- **Pets / Animals DFV Service:** Organisation provides crisis accommodation, fostering, or support for animals impacted by family violence.

Estimated populations by segment

The following population estimates were used to normalise service provision across segments. These are estimates derived from publicly available ABS data and should be treated as indicative.

- **Female victim-survivors (2,701,600):** ABS Personal Safety Survey 2021-22. Women aged 18 years and over who have experienced violence, emotional abuse, or economic abuse by a cohabiting partner since the age of 15.
- **Male victim-survivors (1,457,800):** ABS Personal Safety Survey 2021-22. Men aged 18 years and over who have experienced violence, emotional abuse, or economic abuse by a cohabiting partner since the age of 15.
- **Male perpetrators (estimated 2,773,377):** Derived from ABS data showing 98.3% of female victims of partner violence experienced it from a male partner, and 5.4% of male victims experienced it from a male partner.
 - Applied as: $(2,701,600 \times 98.3\%) + (1,457,800 \times 5.4\%) = 2,655,673 + 78,721 = 2,734,394$.
 - *Note: this estimates the number of victims who experienced male-perpetrated partner violence, used as a proxy for the affected population male perpetrator services are designed to serve. It does not estimate the number of individual male perpetrators, as one perpetrator may have multiple victims across relationships.*
- **Female perpetrators (estimated 1,425,006):** Derived from ABS data showing 94.6% of male victims of partner violence experienced it from a female partner, and 1.7% of female victims experienced it from a female partner.



- Applied as: $(1,457,800 \times 94.6\%) + (2,701,600 \times 1.7\%) = 1,379,079 + 45,927 = 1,425,006$. Same proxy methodology as above.
- *Note: this estimates the number of victims who experienced female-perpetrated partner violence, used as a proxy for the affected population female perpetrator services are designed to serve. It does not estimate the number of individual female perpetrators, as one perpetrator may have multiple victims across relationships.*
- **Pets and animals in DFV-affected households (estimated 1,972,168):**
Derived from Animal Medicines Australia reporting that 69% of Australian households own at least one pet (2022 survey), applied to the estimated number of households affected by DFV. This is an indicative estimate only. No ABS data exists on the number of animals specifically impacted by family violence.
- **State-level distribution:** National population estimates were distributed across states and territories using ABS 2021 Census population proportions. This assumes victimisation and perpetration rates are uniformly distributed relative to population. In practice, rates vary by jurisdiction. State-level figures should be treated as indicative estimates to support comparative analysis, not as precise measures.

Limitations

- Excluded elder-specific, youth-specific services, LGBTQI specific services
- Excluded courts and police stations
- Organisation count only
- No assessment of service capacity (staffing, caseload, waitlists)
- State-level coverage captured but sub-state (rural v metro) distribution not assessed
- Classification based on publicly available website information (June 2026)
- Some General DFV services may serve primarily one gender in practice, categorisation based on language on the website – further exploration required
- Does not include adjacent systems (housing, mental health, legal aid)
- Organisations sharing a name across states treated as separate where independently governed



Appendix Table 1: Count of Service Providers per Segment, per State or Territory

Segment		General DFV	Female Victim	Male Victim	Pets/Animals
Coverage					
National	Est. Pop	4,159K	2,702K	1,458K	1,972K
	No. Providers	2	7	2	2
NSW	Est. Pop	1,409K	915K	494K	915K
	No. Providers	17	95	0	6
	Gap	TBC	Over by 3	49	TBC
VIC	Est. Pop	1,028K	668K	360K	668K
	No. Providers	16	30	0	5
	Gap	TBC	37	36	TBC
QLD	Est. Pop	771K	501K	270K	501K
	No. Providers	8	36	1	4
	Gap	TBC	14	26	TBC
WA	Est. Pop	411K	267K	144K	267K
	No. Providers	6	30	1	1
	Gap	TBC	Over by 3	13	TBC
SA	Est. Pop	324K	211K	114K	211K
	No. Providers	3	14	0	1
	Gap	TBC	7	11	TBC
ACT	Est. Pop	69K	45K	24K	45K
	No. Providers	4	5	1	1
	Gap	TBC	0	1	TBC
TAS	Est. Pop	102K	66K	36K	66K
	No. Providers	1	9	0	2
	Gap	TBC	Over by 2	3	TBC
NT	Est. Pop	44K	28K	15K	28K
	No. Providers	1	11	0	0
	Gap	TBC	Over by 8	1	TBC



Appendix Table 2: Total Service Provider Coverage per Segment, per Service Line

Segment / Service Line	General DFV	Female Victim	Male Victim	Pets/Animals	Female Perpetrator Only	Male Perpetrator Only
Estimated Population	4,159K	2,702K	1,458K	1,972K	1,425K	2,773K
No. Service Providers	58	237	5	22	1	13
PREVENTION						
Public Education & Awareness	14	67	2	2		
Workplace Programs	1	10	1			1
Specialist Workforce Development	5	21	1			1
Research	1	10	1			
EARLY INTERVENTION						
Self Assessment Tools	2	6	1			
Practitioner Screening Tools	5	14				
Crisis Helplines	7	18	1			
Case Management & Referrals	12	58				
RESPONSE						
Crisis Accommodation & Home Safety	7	71	1	20		
Specialist Counselling	29	153	5	1		3
Generalist Counselling	13	14	1			
Legal Support	15	70				
Financial Support	16	28				
Suicide Prevention (DFV-specific)	1	4				
RECOVERY AND HEALING						
Ongoing Support	4	45	1			1
Peer Support Networks	4	43	1			
Advocacy & Policy Representation	8	49	1	2		1
ACCOUNTABILITY						
Men's Behaviour Change Programs	8	32	3			11
Women's Behaviour Change Programs	3	1			1	



Appendix Table 3: Total Service Provider Coverage, Female Perpetrator Only Focus, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	1,425K	483K	352K	264K	141K	111K	24K	35K	15K
No. Service Providers	-	-	1	-	-	-	-	-	-
PREVENTION									
Public Education & Awareness									
Workplace Programs									
Specialist Workforce Development									
Research									
EARLY INTERVENTION									
Self Assessment Tools									
Practitioner Screening Tools									
Crisis Helplines									
Case Management & Referrals									
RESPONSE									
Crisis Accommodation & Home Safety									
Specialist Counselling									
Generalist Counselling									
Legal Support									
Financial Support									
Suicide Prevention (DFV-specific)									
RECOVERY AND HEALING									
Ongoing Support									
Peer Support Networks									
Advocacy & Policy Representation									
ACCOUNTABILITY									
Men's Behaviour Change Programs									
Women's Behaviour Change Programs			1						



Appendix Table 4: Total Service Provider Coverage, Female Victim Focus, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	2,702K	915K	668K	501K	267K	211K	45K	66K	28K
No. Service Providers	7	95	30	36	30	14	5	9	11
PREVENTION									
Public Education & Awareness	2	25	7	11	7	5	2	5	3
Workplace Programs	1	3	3			2			1
Specialist Workforce Development	1	6	4	3	2	3		1	1
Research	3	3	2			1			1
EARLY INTERVENTION									
Self Assessment Tools	1	3	1			1			
Practitioner Screening Tools	1	6	4	2		1			
Crisis Helplines	2	3	2	4	2	3	1		1
Case Management & Referrals	2	27	8	9	6	1		2	3
RESPONSE									
Crisis Accommodation & Home Safety	2	30	5	8	14	3	2	2	5
Specialist Counselling	5	61	22	28	17	7	2	6	5
Generalist Counselling		2	1	4	2	5			
Legal Support	1	39	4	9	7	2	2	3	3
Financial Support	2	12	3	3	5	2	1		
Suicide Prevention (DFV-specific)		2		1					1
RECOVERY AND HEALING									
Ongoing Support	2	24	5	8	3	1	1		1
Peer Support Networks	1	19	6	6	4	3	1	2	1
Advocacy & Policy Representation	1	20	10	6	4	3	2	1	2
ACCOUNTABILITY									
Men's Behaviour Change Programs	2	5	10	9	3	1	1		1
Women's Behaviour Change Programs					1				



Appendix Table 5: Total Service Provider Coverage, Male Victim Focus, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	1,458K	494K	360K	270K	144K	114K	24K	36K	15K
No. Service Providers	2	-	-	1	1	-	1	-	-
PREVENTION									
Public Education & Awareness	2								
Workplace Programs	1								
Specialist Workforce Development	1								
Research	1								
EARLY INTERVENTION									
Self Assessment Tools	1								
Practitioner Screening Tools									
Crisis Helplines				1					
Case Management & Referrals									
RESPONSE									
Crisis Accommodation & Home Safety							1		
Specialist Counselling	2			1	1		1		
Generalist Counselling							1		
Legal Support									
Financial Support									
Suicide Prevention (DFV-specific)									
RECOVERY AND HEALING									
Ongoing Support	1								
Peer Support Networks	1								
Advocacy & Policy Representation	1								
ACCOUNTABILITY									
Men's Behaviour Change Programs				1	1		1		
Women's Behaviour Change Programs									



Appendix Table 6: Total Service Provider Coverage, No Gender Specified, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	4,159K	1,409K	1,028K	771K	411K	324K	69K	102K	44K
No. Service Providers	2	17	16	8	6	3	4	1	1
PREVENTION									
Public Education & Awareness	1	3	5	1	3	1			
Workplace Programs	1								
Specialist Workforce Development		1	1	2		1			
Research			1						
EARLY INTERVENTION									
Self Assessment Tools			1		1				
Practitioner Screening Tools	1		2	1	1				
Crisis Helplines	2	1	2	1	1				
Case Management & Referrals		2	5	1		1	2	1	
RESPONSE									
Crisis Accommodation & Home Safety		2	2	2			1		
Specialist Counselling	1	6	11	5	3	1	2		
Generalist Counselling	1	4	5	1	1		1		
Legal Support		6	6		1		1	1	
Financial Support		3	6	2	1		2	1	1
Suicide Prevention (DFV-specific)					1				
RECOVERY AND HEALING									
Ongoing Support		3					1		
Peer Support Networks	1	1	2						
Advocacy & Policy Representation		3	1	2	1		1		
ACCOUNTABILITY									
Men's Behaviour Change Programs	1	1	3	1		1		1	
Women's Behaviour Change Programs			3						



Appendix Table 7: Total Service Provider Coverage, Male Perpetrator Only Focus, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	2,773K	915K	668K	501K	267K	211K	45K	66K	28K
No. Service Providers	1	2	4	4	2	-	-	-	-
PREVENTION									
Public Education & Awareness									
Workplace Programs			1						
Specialist Workforce Development			1						
Research									
EARLY INTERVENTION									
Self Assessment Tools									
Practitioner Screening Tools									
Crisis Helplines									
Case Management & Referrals									
RESPONSE									
Crisis Accommodation & Home Safety									
Specialist Counselling			1	2					
Generalist Counselling									
Legal Support									
Financial Support									
Suicide Prevention (DFV-specific)									
RECOVERY AND HEALING									
Ongoing Support			1						
Peer Support Networks									
Advocacy & Policy Representation			1						
ACCOUNTABILITY									
Men's Behaviour Change Programs	1	2	4	2	2				
Women's Behaviour Change Programs									



Appendix Table 8: Total Service Provider Coverage, Pet & Animal Impacted Focus, by State

Service Function	National	NSW	VIC	QLD	WA	SA	ACT	TAS	NT
Estimated Population	1,972K	915K	668K	501K	267K	211K	45K	66K	28K
No. Service Providers	2	6	5	4	1	1	1	2	-
PREVENTION									
Public Education & Awareness		1				1			
Workplace Programs									
Specialist Workforce Development									
Research									
EARLY INTERVENTION									
Self Assessment Tools									
Practitioner Screening Tools									
Crisis Helplines									
Case Management & Referrals									
RESPONSE									
Crisis Accommodation & Home Safety	2	4	5	4	1	1	1	2	
Specialist Counselling		1							
Generalist Counselling									
Legal Support									
Financial Support									
Suicide Prevention (DFV-specific)									
RECOVERY AND HEALING									
Ongoing Support									
Peer Support Networks									
Advocacy & Policy Representation		1				1			
ACCOUNTABILITY									
Men's Behaviour Change Programs									
Women's Behaviour Change Programs									



Appendix B: Victim-Survivor Cost to Economy

1. Generalist mental health cycling

\$1,149,822,784/year

Per unit calculation:

10 psychology sessions × \$93 Medicare rebate = \$930

+ 4 GP consultations × \$41.40 Medicare rebate = \$165.60

+ 10 sessions × \$100 average out-of-pocket = \$1,000.

Total per person per year = \$2,095.60 (rounded to \$2,096)

Population:

1,457,800 male victims × 61% help-seeking = 889,258

+ 330,000 female victims in gap × 63% help-seeking = 207,900.

Total seeking help = 1,097,158.

Assumed 50% access mental health services = 548,579

Calculation: 548,579 × \$2,096 = \$1,149,822,784

Sources: Medicare Benefits Schedule 2025; ABS PSS 2021-22 via AIHW (2024)

2. Family court escalation

\$3,000,000,000/year

Per unit calculation:

Average cost of \$50,000 per party (midpoint between \$15,000 straightforward and \$80,000-\$120,000 high conflict)

Population:

Estimated 60,000 parties per year in DFV-related family court matters attributable to the identified service gap

Calculation: 60,000 × \$50,000 = \$3,000,000,000



Sources: Ignify Legal (2026); Federal Circuit and Family Court annual reporting

Note: This is the largest and most uncertain estimate. The 60,000 figure assumes approximately 30,000 matters per year where unaddressed DFV is a contributing factor to escalation.

Recommendation 1 should include demand analysis to refine this estimate.

3. Specialist homelessness services

\$239,200,000/year

Per unit calculation:

\$5,200 per client (total government SHS expenditure \$1.5B ÷ 289,000 clients)

Population:

115,000 DFV clients represent 40% of SHS presentations.

Estimated 46,000 of these are attributable to the service gaps identified in this submission (40% of 115,000)

Calculation: 46,000 × \$5,200 = \$239,200,000

Sources: AIHW Specialist Homelessness Services Annual Report 2024-25; Productivity Commission Report on Government Services 2023-24

4. Workers compensation psychological injury

\$2,308,336,000/year

Per unit:

\$288,542 average per psychological injury claim (NSW 2024-25)

Population:

Estimated 8,000 psychological injury claims per year where DFV is a contributing psychosocial factor

Calculation: 8,000 × \$288,542 = \$2,308,336,000

Sources: NSW Treasurer's Workers Compensation Ministerial Statement, March 2025; Safe Work Australia

Note: Family violence is a recognised psychosocial hazard under WHS legislation. The 8,000 figure is an estimate of the proportion of psychological injury claims where unaddressed DFV contributes to the claim.



5. Suicide

\$510,000,000/year

Per unit:

\$1,700,000 per death

Population:

Approximately 3,000 suicide deaths per year in Australia,

75% male (~2,250).

Estimated 300 deaths per year where DFV is a contributing factor across male and female victims

Calculation: 300 × \$1,700,000 = \$510,000,000

Sources: Suicide Prevention Australia (2024); ABS Causes of Death 2023; National Suicide Prevention Strategy 2025–2035

Total: \$7,207,358,784 per year

Note: All affected population estimates are based on stated assumptions applied to published data.

These estimates should be validated through the demand analysis proposed in Recommendation 1.

