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Chapter 9: Service availability, access, usage and effectiveness

'The answers were there before white man come in'

Stories of strength and resilience for responding to violence In Aboriginal and Torres Strait Islander communities

CHAPTER 9
SERVICE AVAILABILITY, ACCESS, USAGE AND EFFECTIVENESS

In this chapter, we outline what the service mapping exercise in each community listed as the notional number of services purported to exist in each community. We also explore community members' and service providers' perceptions of service access, usage and effectiveness in their communities. Using the findings from surveys, focus groups and interviews, we then weave those perceptions with the everyday realities of access to appropriate services, both for community members and service providers. The picture that emerges shows a diversity of service access, usage and effectiveness, and reveals the maze that is navigated, by both community members and service providers.

Services involved in responses to family and community violence

This section reports on service mapping and responses to family violence from CMS interviews and focus groups.

Service mapping

Service mapping findings (Table 16)[43] showed that, in the 18 study communities:

> Ninety-four percent had police based in the community; 6% had police provide outreach services.
> Twenty-eight percent had night patrol; 72% did not.
> Seventy-two percent had a legal service; 22% had a legal service provide outreach services; legal services were absent from 6%.
> Eighty-three percent had a housing service; 11% had a housing service that provided outreach; 6% did not have a housing service.
> Ninety-four percent had a safe house; 6% did not.
> Seventy-eight percent had a shelter, refuge or hostel; 11% received outreach services; 11% had no services.
> One hundred percent had Centrelink.
> Eighty-three percent had an Aboriginal Medical Service or Aboriginal Health Service; 17% did not.
> Eighty-nine percent had a counselling or mental health service; 11% had counselling or mental health outreach services.
> One hundred percent had a family violence service.
> Eighty-nine percent had DOCS services; 11% had DOCS provide outreach services.
> One hundred percent had an Aboriginal/Torres Strait Islander Community-controlled organisation.

Interviews and focus groups

Analysis of the qualitative data showed that participants perceived that numerous services were involved in family and community violence. These were:

> police services (including community policing)
> legal services (including Family Violence Legal Services and Aboriginal Legal Services)
> housing services (including safe houses, shelters, refuges and emergency housing)

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43. The service categories here do not exactly match those identified from the qualitative analysis, because the service mapping and CMS service categories were defined before the qualitative data were analysed. As this chapter describes, the qualitative data showed that 89% of communities had an Aboriginal/Torres Strait Islander Community-controlled organisation or similar service, physically present within the community. Two communities did not have access to any of these services.

> health care services (including Aboriginal/Torres Strait Islander Community-Controlled Health Services, hospitals, mental health services, counselling, alcohol and other drug rehabilitation and detoxification/ withdrawal-programs)

> child protection (including Department of Child Safety [DOCS])

> support groups and programs, including Men's and Women's programs.

Service access

Thirty-nine percent of CMS participants who needed a service or support did not get the help that they needed; of these, 24% stated that they could not get help, and 15% stated that they would not use the available services (Table 21). Participants identified these barriers:

> lack of trust in the service (16%)

> embarrassment or shame (16%)

> wait list too long or appointment not available (14%)

> issues with transport or distance to service (14%)

> lack of awareness of where to go (13%)

> lack of service in the area (11%)

> service opening hours are too short (10%)

> poor customer service (10%)

> lack of cultural appropriateness (9%)

> fear of threats, consequences or more violence (9%)

> fear of losing children (8%)

> cost of service (8%)

> fear of ending relationship (6%)

> language difficulties (5%)

> access restricted because of disability (4%)

> other (5%) (Table 20).

It was more common for participants living in major cities than in regional and remote areas to report barriers relating to the cost of service (12%, 7%, 9% respectively); lack of cultural appropriateness of service (13%, 9%, 6% respectively); shame (21%, 17%, 13% respectively); and lack of awareness of where to go (20%, 10%, 15% respectively) (Table 20).

In general, it was more common for males than females to report barriers, with gender differences relating to the accessibility of services; service opening hours (16% versus 7%); availability of appointments (21% versus 11%); and transport or distance to service (19% versus 11%) (Table 20).

The findings from the CMS qualitative data reflected some of these, and other barriers, as reported below.

Transport

Several participants explained that a lack of access to transport, including not having their own vehicle or driver's licence, prevented them from accessing services or leaving a family violence situation. When asked what they would do in a family violence situation, participants responded:

You'd have to hitchhike or run.

You'd just have to stay there and lump it.

Participants described the importance of providing methods of transport to and from services. This might take the form of a community bus or supporting pathways to drivers' licenses.

Awareness of services

Service availability was measured by service mapping and the CMS. Services in each community were mapped by the study team, with support from local community researchers. CMS participants were asked to look at a prepared list of services and report whether each was based in their community, and/or was

accessible to their community.[44] CMS responses were generally consistent with findings from service mapping, indicating that most community members were aware of services that existed in their community. However, there were some gaps in awareness. Consistent with the qualitative data, the discrepancy in the quantitative and mappings findings may simply reflect a lack of knowledge among some community members and service providers of the services that are available within the community. In the CMS, it was more common for participants living in major cities than those in regional and remote areas to report a lack of awareness of where to go (20%, 10%, 15%, respectively) (Table 16).

Interview and focus group participants identified the need to improve community awareness of available services:

> It's even just knowing about the services and knowing what they do so people know where to go. There's services out there, as you said, but we don't really know much only some that are well known but you don't know the little services that do help out so it'd be good to know.

> There's new services that are available as well that people don't know about, because they're only new to the area and things like that … and they may have been based in [place] or one of the bigger towns, and then seen that there's a need for it to be here, but a lot of people don't know about them.

Community members explained that engagement and interaction with communities were required to increase awareness of services:

> … the service providers that come in there, they need to do their jobs. They walk in a meeting there and say they work for this one and that one, show them where they work. Like, you've got to see them in the community. You never see 'em.

> … they come here for a meeting, they tick their box and they're gone.

Many service providers also acknowledged that there was a need for better engagement between services and community members. Some service providers saw this as the responsibility of the service, whereas others saw this as the responsibility of the community members:

> I know in the Community there is a lot more violence than is being referred to our service, they are suffering in silence. I guess the question is how do we engage better with the community and talk more about violence …

> We have a disconnect between us and the community [We try to engage but they aren't willing or don't know how] … If the community could engage with us.

Participants described cases where community members tried to access services but were ineligible. They spoke of not being able to access a service (such as a refuge) with children, especially multiple children or male children over the maximum allowed age:

> And then of course … if it's a bad DV situation and Mum and the kids need to get out, well if the boy's over six or seven, they're not allowed to be in the refuge.

> That's why a lot of women won't go because, like this one now, she won't go because he keeps one maybe back, she can only have two of them, she can't have the whole three of them at once, so it becomes an issue. It becomes red alert.

People who use alcohol or other drugs are can also be ineligible for some services:

> … if they had two – three beers, you take them to a woman's shelter, they'll say, 'Nuh. She had a beer,' and they send 'em home. And so, the way you look at it the other way … what they're supposed to be helping, they're not really helping, they're sending people back.

Opening hours

Some community members described how the limited service opening hours could impede safety:

> ... twenty-four-hour joint, this was on a Saturday. She couldn't get in until Monday and then she had to go to [place] just to be safe, so in the meantime, her partner's only over the next street, so she's at my house … The services, they're not geared up. She'd be dead by the time she gets there, you know what I mean, by the partner.

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44. We note that the CMS allowed participants to self-define what each service meant and to self-define the boundaries of their community. In addition, some CMS participants might not have been aware of services that did exist within their community. Therefore, different participants within the same site may not have given the same answer for each service.

Sometimes we work with someone for hours and hours and hours just to come up with a plan just to get all the players in the right place at the right time, to have the conversation around a case management plan, what are we going to do now, where do we go from here, what fits best for this client. And often … like if it's three o'clock in the afternoon, the service that we refer them to could be knocked off by the time they can … get there … It's a small town, so there's a good chance they could be easily found by their partner or wherever the violence comes from. So, definitely those sorts of things, we've got nothing immediate that we can say, 'Well, here you are, you're safe.' And that must be a hard one for anyone in that situation I think, if they haven't got family they can turn to, and they may not be safe within their own family situation, is quite often the case.

The need for extended opening hours, to improve accessibility of services for families and to support continuity of care, was echoed by service providers:

Access to twenty-four seven support with follow up so that families can have support when they need it and then can have support from the same team during business hours.

Similarly, responses to the SPS highlighted a lack of availability of services outside normal business hours. The majority were not open on weekends (74%), public holidays (78%), or outside of standard 8am–6pm business hours (67%; Table 23).

Language

Of the CMS participants who needed a service or support in relation to violence but were unable to obtain it, 5% reported that language difficulties were a barrier (Table 20).

One community member described language as a barrier to accessing services, especially where people speak one or more Aboriginal and/or Torres Strait Islander languages and have limited English:

I think language barriers, and particularly cultural barriers, at a personal level create an environment where it can be hard to understand what the clients mean, as body language and nonverbal communication is a large part of Aboriginal culture where I work.

The importance of language to effective service provision is further supported by the SPS results. Sixty-seven percent stated that language was not a barrier to communicating with clients/patients; but 26% said that it was a barrier for some staff, 6% for most staff, and 1% for all staff. Therefore, language was identified as a barrier by one in three (33%) of the service providers interviewed. It was more common for service providers in remote areas to report that language was a barrier (46% reporting that it is a barrier for some, most, or all staff) than in regional areas (26%) or major cities (29%; Table 19). This probably reflects the more common use of Aboriginal and Torres Strait Islander languages among people living in remote areas.

Thirty-eight percent of SPS respondents said that no staff in their service spoke any Aboriginal and/or Torres Strait Islander language with clients/patients. A majority reported that some of their staff did: 46% 'a little bit', 8% 'a fair bit', and 7% 'a lot'. It was more common for SPS respondents working in remote communities to say that staff spoke Aboriginal and/or Torres Strait Islander languages (Table 19). Again, this probably reflects the language use profile in remote, compared with regional and urban settings. These findings suggest that, while Aboriginal and/or Torres Strait Islander language use is more common among service providers working in remote settings, there is a need to increase local language/s training in remote, urban and regional settings.

Service usage

In the SPS, service providers were asked to describe the extent to which their service met the needs of clients/patients who had experienced violence and clients/patients who had used violence. Response options were 'a lot', 'a bit', 'not at all', and 'don't know'. In general, service providers were more positive about their service's ability to meet the needs of clients/patients who had *experienced* violence than about their ability to meet the needs of clients/patients who had *used* violence. The SPS identified a concern about the ability of services in remote communities to meet the needs of those who had experienced, and those who had used, violence.

After experiencing violence

CMS participants were asked whether they ever needed a service or support in relation to violence. Of the 62% who had ever experienced violence, 52% said that they did not need a service or support, and 48% said they did. Among those who had ever experienced violence, it was more common (Table 11) for:

> participants in remote areas to report needing a support or service related to violence (55%) than those living in regional areas (45%) and major cities (45%).

> females rather than males to report needing a support or service related to violence (53%, compared with 39%).

> participants aged 40–49 years to report needing a service or support (55%), followed by those aged 25–29 years (51%), 18–24 years (45%) and 50 years and older (44%); with participants aged 16–17 years (25%) least commonly needing a service or support related to violence.

Of those who needed a support or service, 61% said that they got the help they needed. Among those who had experienced violence and needed a related support or service:

> It was more common for participants in remote (65%) and regional (62%) areas to report getting the support or service they needed, compared with those living in major cities (51%).

> Sixty-three percent of females and 59% of males reported that they got the help that they needed.

> Across age groups, 53–65% of participants reported that they got the help that they needed.

Despite help seeking being commonly reported, there were some people who experienced violence and who did not get the support they needed (24% could not get help and 15% would not use services available (Table 11).

After using violence

Fifty-four percent of CMS participants who had ever felt violent had ever sought help to stop using violence. A further 7% reported that they had not sought help but believed that they needed it; the remaining 39% who had ever felt violent said that they had never sought help. Participants generally did not report great benefit from seeking help: of those who did, only 4% said that it helped 'a lot'; 51% said that it helped 'a little bit' or 'a fair bit', and 46% said that it helped 'not at all'. Among the participants who had ever felt violent (Table 22):

> It was more common for participants in regional areas (58%) and remote areas (57%) to report seeking help to stop using violence, compared with participants in major cities (39%). However, it was more common for participants in major cities to report some benefit from seeking help (66%) than participants from remote areas (57%) or regional areas (51%).

> It was slightly more common for females than males to seek help to stop using violence (58%, compared with 51%) and slightly more common for females than males to report some benefit from seeking help (57%, compared with 52%).

> It was more common for participants aged 40–49 years to seek help than all other age groups (73%, compared with 44–52%).

These align with the SPS findings that service providers are concerned about their effectiveness in supporting clients/patients who have used violence (Table 19). Subsequent sections detail service provider and community member perspectives on these concerns.

Service effectiveness

Service providers were asked to what extent they think the service they work for meets the needs of clients/patients. Response options were 'not at all', 'a bit', 'a lot' and 'don't know'. The SPS findings showed that for clients/patients who had *experienced* violence (Table 19):

> Fifty percent reported that their service met their needs 'a lot', 44% said 'a bit', 3% said 'not at all', and 3% said 'don't know'

> 'A lot' was less common in remote areas (21%), than in major cities (79%). 'A bit' was more common in remote areas (72%), than in major cities (16%). 'Not at all' was more common in remote areas (7%), than in major cities (0%).

The SPS findings showed that, for clients/patients who had *used* violence (Table 19):

> Seventeen percent reported that their service met their needs 'a lot', 55% said 'a bit', 17% said 'not at all', and 12% said 'don't know'

> 'A lot' was less common in remote areas (7%), than in major cities (21%). 'A bit' was more common in remote areas (59%) than in major cities (47%). 'Not at all' was more common remote areas (31%) than in major cities (11%).

Community member interviews and focus groups explored other issues related to service effectiveness. Below, we report on the qualitative findings on liaison, trust, cultural safety, holistic and ongoing care, service capacity, and funding.

Liaison between services

Participants said that liaison between services was often non-existent or limited in their communities. They described shortcomings in co-operation between Aboriginal and Torres Strait Islander and mainstream services. In some cases, service providers' lack of knowledge impeded effective service and referral pathways:

> *Yeah, maybe we should have them come along and say what their levels of service pathways are, what services ... are we not on top of ... I know ... but are we not tapping into their pathways that they have ... and if they don't have pathways, maybe it's time they developed them.*

This lived reality for some participants contrasts with SPS results, which indicate that most services (95%) did liaise with other organisations, at least some of the time: 10% said that this occurs 'sometimes', 40% 'often', 45% 'always', 3% 'rarely', and 1% 'do not know'. It was more common for service providers working in regional areas (51%) and remote areas (46%) to report 'always' liaising with other services than service providers working in major cities (32%). We did not measure the frequency or function of services liaising with other organisations (Table 24).

SPS result suggest that, the more liaison a service had with other services, the more positively it was assessed as meeting the needs of its clients/patients who had experienced violence. Of services that 'always' worked with other services, 61% said that their service supported those who had experienced violence 'a lot', 27% said 'a little' or 'a fair bit', and 2% said 'not at all' (Table 25).

By contrast, of services that 'rarely' worked with other services, 67% said that their service did support those who experienced violence 'a little' or 'a fair bit'; 33% said that 'not at all' (Table 25).

Trust

Community participants spoke about the importance of being able to trust service providers, including wanting to be assured that confidentiality would not be breached. Confidentiality was particularly a concern in smaller communities or in smaller organisations, where the perceived risk of identification was higher. While some participants spoke about the benefits of local service providers who were part of the community and understood the context, other participants thought that it was important to have service providers who were from outside the community, so that service users could confide in someone who was not related and not someone that they would be seeing daily in the community.

Some participants expressed distrust of services run by government. One participant explained that a government-funded service provider could not be trusted:

> *… because they work for the department, simple as.*

It was sometimes suggested that trust was easier when the service was staffed by a local Aboriginal and/or Torres Strait Islander person:

> *By just having our own people [place] that someone can trust. Trust is a big thing too in the communities here, so when it's somebody that we trust they cannot go and blab everyway what we tell them, and then where people can feel safe too and go and talk to that person.*

Trust in services was also established through longevity (that is, the service being in the community and maintaining programs over a long time) and the service's involvement and engagement with the community. Participants repeatedly stressed the importance of being present, and seen, in the community.

Cultural safety

Services with Aboriginal and/or Torres Strait Islander governance, such as Community-controlled organisations, organisations led by Aboriginal and/or Torres Strait Islander staff and organisations guided by Elders, were considered culturally safe. In services without Aboriginal and/or Torres Strait Islander governance, the employment of Aboriginal and Torres Strait Islander people was considered critical to cultural safety and, thereby, the accessibility of services. Aboriginal and Torres Strait Islander services and staff were considered as having a connection to the community and adopting a holistic, all-of-community approach.

Few of the services in the study were Aboriginal and/or Torres Strait Islander-led. Among all the SPS respondents, one in five (19%) worked in a service where more than 75% of staff were Aboriginal and/or Torres Strait Islander people; 30% worked in a service where this proportion was between 25% and 75%; and 51% worked in a service where this proportion was less than 25% (Table 23). Most community members expressed a preference for accessing Aboriginal and Torres Strait Islander-led services. In some cases, participants stated that they would not use services that are not Community-controlled:

> *Some of us don't like going to services run by white fellas – we want to go to Aboriginal agencies.*

Aboriginals working with Aboriginals … For the better of Aboriginals.

Like, you have that connection with your people, and they don't. I always think, you've got to have a connection with your people.

It was most common for Community-controlled organisations to have a higher proportion of Aboriginal and/or Torres Strait Islander staff, with 41% of ACCOs having more than 75% Aboriginal and/or Torres Strait Islander staff. In contrast, only 6% of government services had more than 75% Aboriginal and/or Torres Strait Islander staff (Table 23).

Service providers were asked to report whether they considered their service culturally safe for Aboriginal and Torres Strait Islander people, with the response options of 'a lot', 'a bit', 'not at all' and 'don't know.' Sixty-two percent said 'a lot', 33% responded 'a bit'. Three percent said that their service was 'not at all' culturally safe, and 2% said that 'don't know'. It was most common for respondents to describe their service as culturally safe 'a lot' if they were based in remote (68%) or regional (62%) areas, compared with major cities (53%) (Table 19). SPS respondents' perception of the cultural safety of their service increased with remoteness: 68% from a remote area said that their service was culturally safe 'a lot', compared with 53% from major cities. Overall, 3% stated that their service was 'not at all' culturally safe (Table 19).

These results are consistent with CMS findings that it was more common for community members living in major cities, compared to regional and remote areas, to report that a service was not culturally appropriate (13%, 9%, 6%, respectively) (Table 20).

Participation in cultural activities and/or practices, including speaking an Aboriginal and/or Torres Strait Islander language, was commonly reported by service providers working across all areas. Of the 90% of SPS respondents who said that their staff spent some time on cultural activities and practices; 45% said this was 'a little bit', 31% 'a fair bit', and 13% 'a lot.' Four percent said that staff in their service 'want to, but can't participate in these activities', and 6% said 'not at all' (Table 19).

Of the SPS participants who considered that the service they worked for was 'not at all' culturally safe, one-third reported that their service did not support clients who had experienced violence, and none reported that their service supported these clients 'a lot'. There is a positive relationship (noting that this was not tested for statistical significance) between the time that staff spent on cultural activities and/or practices and the extent to which the service was able to assist clients/patients who have experienced violence (Table 19).

Although 95% of SPS respondents thought that their service was culturally safe, and that 60% of staff participate in Aboriginal and Torres Strait Islander cultural activities (Table 19), some also described impediments to cultural safety:

Not culturally secure, doesn't understand causes of violence from an historical and Aboriginal perspective; doesn't respond in a way that is culturally sensitive; doesn't explore cultural prevention and treatment approaches.

Culture requirements are seen as a hassle and something not to be considered unless they have to be.

Community members described the characteristics of services and service providers that support cultural safety: they take into consideration cultural activities (such as Sorry Business), customs (such as consulting Elders first) and local culture (such as things that are taboo, the meaning of eye contact or the absence of eye contact). They identified Aboriginal Liaison Officers and translators as particularly valuable for services with most non-Indigenous staff. Participants also described the value of incorporating culture into service provision, for example, designing programs around Indigenous cultural activities. They also mentioned visual cues or 'visible culture' that supported cultural safety, such as the name of the organisation and the display of posters related to Aboriginal and Torres Strait Islander people.

Where non-Indigenous people are working in Aboriginal or Torres Strait Islander communities, participants described the importance of understanding local culture and customs in order to enable the provision of culturally safe services (e.g. through cultural awareness training):

More Aboriginal workers; more non-Aboriginal workers who seek to understand the culture, listen to Aboriginal people; willing to acquire new and sometimes confronting knowledge; create and defend a space where Aboriginal people can identify, discuss and resolve their issues.

… staff members need to have that cultural awareness. At a local level, too, like, a few years ago ……Elders come up there yarning, just telling what [the Community] was like back in the old day. … this is what happens here in [the Community]. And it gives them a bit of an understanding of what happens.

SPS participants identified positive strategies that they believed contributed to the cultural safety of their service:

Having Indigenous staff employed at the service and a board of Elders on the management committee, who know their individual culture and environmental culture and who also respect the diverse culture of Indigenous peoples.

All our staff are trained in cultural awareness specific to the areas in the [place] therefore have an understanding of language use, dress codes, women's business matters. This also includes the foods that we cook and offer and have a safe space for women's business at our refuge. The therapeutic activities offered such as nature and narrative therapies are also preferred to clinical interventions for most Aboriginal [and Torres Strait Islander] women.

The need for increased cultural awareness and safety is echoed in the literature about responses to family violence. Several program evaluations highlight cultural safety as essential to a successful program; these include studies on antenatal screening,(88,89) sentencing courts,(90) family law,(91) child protection services,(36) Men's Programs(37) and responding to child sexual abuse.(92) All these evaluations found that cultural safety was vital to successful responses, and many highlight a gap in cultural awareness and safety. Further, several frameworks for responding to family violence in Aboriginal and Torres Strait Islander communities have been developed in the last three years, with community input, and all include cultural awareness and safety as a key principle.(41,93-95)

Holistic and ongoing care

Participants expressed concern that services largely focus on individuals, not families. Both community members and service providers wanted holistic services that address broader psychosocial issues, such as trauma, homelessness, disability, poor mental health and alcohol and other drug use. One person said:

Nobody sat down with us and said, 'What happened? How did this shit go down? Do you guys need some community service support, and if youse are willing to take it, where do you want to be referred?' Just, 'Pack your shit and get out of the house or we're taking your children.'

According to another participant:

There is a need to look at the issue more holistically rather than as a specific or isolated problem.

The need for holistic care was explained in the following way:

This is a complex issue as there is much implicit violence if one considers serious child neglect as such. In our communities where most families are Aboriginal, there are high levels of dysfunction with alcohol, drug dependence (both prescription and illicit), unemployment and mental health impacting on all families; what is missing is a service that can work across the silos of health, legal, education and family services etc.

Another participant spoke of the need for ongoing care:

… once Child Safety pull out, you lose all that services, okay, so there's no ongoing help. So, things might be going great for six to eight weeks … But, things change, you know, in six weeks, you know, you may change, you may relapse with your stress, your depression, your child may have a flashback or something.

Community members stressed the need to prevent violence:

… If someone had of come to us earlier on and said, 'You know what, your relationship is pretty unhealthy, you need to see someone about your issues and why you treat men the way you do, and [person], you need to see someone about your drug use and why you bottle all your feelings up and hide at the end of a needle' and got us to get help separately as well as, you know, like, there's a couple of positive relationship programs that are available.

By the time, sometimes, our services get involved, women are already broken, like their spirit is broken. That's why it's got to happen prior to that, you know, like, they've got to be able to feel that they can go to these services and get help, before they end up where they are with you. And that broken.

SPS participants also described these limitations within their services. For example, many service providers called for more training and capacity to appropriately respond to violence and trauma:

There are some [Aboriginal and Torres Strait Islander] support and healing methodologies that are beyond the scope of our service provision. There are traditional healers, spaces offering a place to sit and talk and connect with Country, ceremonies ... Which we do not offer.

Ongoing staff trauma training, consistent up-skilling in best practice. Quality training and professional staff.

[Training in] how to spot signs of violence. How to appropriately speak with those experiencing violence, especially children. How to design and run programs specifically for those who experience violence.

Access to regular supervision, access to community-based education about mental health, violence, trauma.

The service provider quoted below highlighted the need for appropriate referral pathways:

Yeah, where do they turn, who do they turn to, because if they come into my office with their mum, they're these scared little kids that just stand, say not a word, because they've just witnessed something. And, I can help mum, I'm not a counsellor, you know, I've cried with plenty of them, but I can't counsel these kids, I can't counsel their mum, but we can talk. But, you know, how good it would be to say, 'This person can help you now, and talk to the kids, would you like that?' And that'd be great.

Service capacity

Other barriers to providing optimal care include the fat that services are not designed to meet the complex needs of people who are experiencing or using violence, and that lack of funding inhibits their capacity to extend the service or to integrate effectively with other services. The result is that service providers commonly had to refer clients/patients to other services:

We meet the immediate need for crisis accommodation and support. We do not meet the need of the long-term trauma support and behaviour change. We are often left with no referral source for these services and simply do the best we can.

Given the diverse clients, from young children to the old, and those with disabilities [who are National Disability Insurance Scheme registered], the service aims to meet needs and when unable to, refers on to other providers.

Several SPS respondents described the need to increase service capacity through increasing staffing. Participants noted the limited pool of staff who have relevant training and experience and spoke of the opportunity to build local capacity:

There are major gaps due to understaffing and lack of resources.

It meets the needs of a small number of people but the need is much greater than we can currently meet … building community capacity has to be part of any solution.

The following quote exemplifies the challenging nature of service providers' work:

For Welfare and other government departments to work with and help families to address the issues they are dealing with because with help they can get better but by taking kids into care or locking our men up nothing changes and things get worse … we need help.

Another service provider spoke of challenges they faced, for example, the fact that they were never off duty:

I had a DV offender with mental health problems … he was having a really bad day, was suicidal, went to the hospital. They wouldn't let him in, just gave him a one eight hundred number to ring. So, he ended up on my doorstep, on a Saturday.

Another spoke of their lack of appropriate training:

… even though I just started, my fourth month in there, still haven't fully … like, because we had a worker there who just left, there was no handover. I was just told, 'You're working with these people now.' You've been thrown in the deep end.[45]

Funding

Service provider responses frequently referred to the need for more funding for local programs:

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45. We note here that a member of the Study Advisory Group independently advised (at the meeting on 3 March 2020, reported above) that there was a need for accredited training for service providers.

There is currently no funding for our programs that address these issues [family violence]. The programs have great success, but we need more staff and resources to reach more people.

We are not funded to offer a service so we are unable to offer anything other than immediate relief.

More funding to offer more on-site services instead of always having to refer out.

We try to but cannot meet all needs due to limited resources.

The need is far greater than the resources we have.

Health is always a big gap … There's not enough funding for the amount of health needs that is needed for a region at all …

Training and capacity building does nothing to address the woefully inadequate resourcing required to provide services. Why is there always adequate funding for research, reports, inquiries, workshops, training etc. and so little at the frontline delivery of the services needed by clients?

In addition to program funding, another service provider spoke of the specific need for funding for appropriate salaries:

There is a dearth of experienced and qualified workers due to inadequate funding [competitive tendering is a race to the bottom to provide the cheapest service] that cannot pay appropriate salaries nor meet ongoing support costs of providing services.

Another service provider spoke of the need for funding that allows communities to determine what their own needs and priorities are, how these should be addressed and how to prevent and reduce violence:

More funding for community engagement, and government listening to the community needs, rather than telling a community what it needs, local organisations being funded, rather than large ticket projects.

Conclusion

In this chapter, we have presented an overview of service provision at the time of the surveys, interviews and focus groups. The findings show that, despite services notionally being present in communities, both for services providers and community members, stress the variation between levels of access, usage and effectiveness of those services. In the following chapter we indicate where improvements can be made.