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# ‘You Are Up Against It Down Here’. Providing Domestic and Family Violence Services in Regional Australia

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## Abstract

Problems associated with recognising and reporting domestic and family violence (DFV) have been well established. Challenges around DFV service provision have been addressed by considering particular types of place, typically metropolitan or rural and remote areas. This article examines DFV services from the perspective of service providers in a regional area around 100 kilometres south of Sydney. In this context, DFV service providers reflected on the barriers and challenges of providing services to two target communities: challenges that were representative of nationwide service experiences but exacerbated by specific regional characteristics. Their experiences suggest that competitive, short-term and innovation-focused funding streams have contributed to a siloed service landscape that clients struggle to navigate. Greater attention to service integration would address many of these challenges.

***Keywords:*** Domestic and family violence; DFV; service challenges; regional Australia.

## Introduction

Domestic and family violence (DFV) is a significant issue in Australia and internationally. Predominantly perpetrated by men against women, it involves one or more forms of harm enacted upon someone in a domestic relationship, which may comprise physical, mental, economic, social or other modes of injury (World Health Organization 2013). A broader definition is used in New South Wales (NSW), where this research is based, and includes violence perpetrated by housemates or between extended family members who have lived or currently live together (see NSW *Crimes [Domestic and Personal Violence] Act 2007*).

Although reporting rates appear to be improving, it is well established that DFV remains significantly under-reported (Voce and Boxall 2018). Nevertheless, the most recently available statistical information is startling. In 2016, around 2.5 million adult Australians reported experiencing physical or sexual violence before the age of 15, with 1 in 6 women and 1 in 16 men having experienced violence from a current or former partner from the time they were 15 (Australian Bureau of Statistics 2017). Moreover, in 2014–2015, one woman was killed by her partner approximately every nine days and one man by his partner every 29 days (Australian Institute of Health and Welfare 2019a). Approximately eight females and two males were hospitalised daily due to intimate partner violence (Australian Institute of Health and Welfare 2018).

Existing research demonstrates that some groups of people are particularly vulnerable to DFV; for instance, rates among Indigenous Australians have been reported as higher than for non-Indigenous Australians (Olsen and Lovett 2016b). In regional areas, 23 per cent of women reported experiencing intimate partner violence compared to 15 per cent of women in metropolitan areas (Australian Institute of Health and Welfare 2019a). However, in 2018, only 54 per cent of women and 32 per cent of men who experienced violence from a current partner sought advice or support following an incident (Australian Institute of Health and Welfare 2018).

There are several challenges associated with the provision of and access to DFV services across Australia. Location matters, with regional, rural and remote areas typically significantly less well resourced (Campo and Tayton 2015; Ragusa 2017). Across Australia and internationally, survivors and service providers in these areas experience different challenges compared to metropolitan areas (Owen and Carrington 2015; Sharma and Vafeas 2021; Wrathall and Herron 2021).

This article presents DFV service providers' experiences and perspectives about delivering DFV services in a regional setting in NSW, Australia. We commence by discussing the different types of DFV services in regional, rural and remote Australia, focusing on the availability of services and characteristics that impact survivors' utilisation of the services. Then, based on a series of interviews conducted with service providers in two specific regional communities in NSW, we examine how service availability and service structure influence DFV service delivery and discuss implications for regional service delivery internationally.

## Service Support

Available DFV support services vary immensely in size, practice and mission (Kulkarni 2018; Lyon, Lane and Menard 2008), from emergency accommodation and intervention to longer-term case management and recovery (Carman, Kay-Lambkin and Burgman 2022). Such a range of services can be challenging for survivors to navigate (Wilcox 2010). This complexity may be an initial access barrier and is particularly concerning given the varied and co-occurring needs of people experiencing DFV. For example, women who have experienced DFV utilise more health services, sometimes well beyond the period of abuse, due to their relatively poor physical and mental health and the ongoing effects of DFV (Australian Institute of Health and Welfare 2018). Survivors are more likely to experience elevated levels of depression, anxiety and post-traumatic stress disorder (Ferrari et al. 2016). Moreover, protracted experiences of trauma as a result of criminal and family court proceedings further contribute to ongoing stress for survivors and add to their already complex needs (Douglas 2018). Homelessness is commonly connected with DFV (Australian Institute of Health and Welfare 2019b) and has been linked to work absenteeism and financial stress (Australian Institute of Health and Welfare 2018). In particular, DFV can trap women into poverty through homelessness, the mental and physical consequences of violence or the abusers' efforts to interfere with job participation (Hahn and Postmus 2014; Krigel and Benjamin 2021). Damaged property, defaulting debts, moving costs and health and justice services can all add to financial stress (Coumarelos 2019). Finally, children and young people who live with DFV have a heightened risk of health issues, re-victimisation and transgenerational violence as a result of experiencing DFV (Jaffe 2000).

DFV is complex to service because the needs of those who experience it are individualised, multifaceted and long term. Needs can cut across safety and recovery at both practical and emotional levels. The initial need for many who seek assistance is accessing information about where to get help (Mission Australia 2019); beyond that, survivors may require a wide range of legal and social services (Neave, Faulkner and Nicholson 2016). In general, access to DFV services is commonly criteria-dependent (Mission Australia 2019), and this too can affect a survivor's eligibility for assistance, even when their needs are identified.

Contemporaneously, 'individual circumstances and multiple identities' relating to gender, culture and ethnicity, education and social status compound or alter the experiences of those seeking help, creating nuances of need (Brenner 2013; O'Neal and Beckman 2017: 645). Research has suggested that assistance should transcend a one-size-fits-all approach and provide services that fit individuals' unique and complex needs (Brenner 2013; Kulkarni 2018). Further, where providers have limited specialised knowledge, cross-sector service and advocacy connections should be created (Kulkarni 2018). However, while services recognise the need to be flexible, many survivors continue to have difficulty identifying service options and accessing support specific to their needs (Francis, Loxton and James 2017).

### *Accessing Services*

Support for people experiencing DFV is available informally through family and friends and formally through a range of service providers. Extant work has identified three primary organisational entry points for DFV survivors seeking formal support. These are (1) justice and statutory services; (2) mainstream services in the sectors of health, education, disabilities, substance abuse, counselling, immigration and employment; and (3) specialist DFV services involving case management, housing, counselling, Indigenous family violence and men's referral services (Australian Institute of Health and Welfare 2018). It is difficult to determine which of these formal entry points is most utilised. Some data are available regarding DFV responses from the justice and statutory sector, hospitals and homelessness services, but there is a gap in consistent and comparable service reporting data from specialist and mainstream services (Australian Institute of Health and Welfare 2018). Those who experience DFV are typically brought into contact with services in four ways: by soft[1], formal and self-referrals or routine screening assessments. DFV survivors have reported they are most likely to seek support informally through a friend or family member and more likely to seek help through a counsellor or support worker than a telephone helpline or crisis accommodation (Australian Bureau of Statistics 2017).

### *Service Specificity*

Socio-cultural dynamics are important when considering help-seeking behaviours. Age, gender, ability, social class, culture and ethnicity not only determine how people see themselves but also influence the forms of help they elicit (Donovan and Hester 2014: 158). For example, individuals with diverse gender identities and/or sexualities have limited tailored assistance and access to mainstream services (Donovan and Barnes 2020; Furman et al. 2017; Xavier et al. 2013), despite their DFV experiences being compounded by discrimination (Barnes and Donovan 2016). How services treat survivors potentially shapes their attitude to services and the extent to which they are regarded as approachable (Barrett and Sheridan 2016). In addition, culturally and linguistically diverse communities require services responsive to their religious and customary needs (Department of Social Services 2015) and may also require additional support for migrant-specific issues like visa restrictions (Mission Australia 2019).

Aboriginal and Torres Strait Islander people face barriers when connecting with services where understandings of kinship and the centrality of family are missing (Olsen and Lovett 2016b). This is particularly the case where interventions separate Indigenous DFV survivors from perpetrators (Olsen and Lovett 2016a) instead of using more holistic measures that include the whole family in the healing process (Blagg et al. 2018). Aboriginal and Torres Strait Islander people may fear their children will be removed in the context of the Stolen Generations[2] (Fiolet et al. 2021), and mainstream services may lack the long-term relationships with communities essential to information sharing (Spangaro et al. 2016).

Despite research showing that the experience of violence can impact young people's development, health and education (Campo 2015), few programs and policies specifically target young people and child survivors of DFV (Alderson, Westmarland and Kelly 2013; Davidson, Harris and Menih 2022). Young people are vulnerable to homelessness because of DFV (Australian Institute of Health and Welfare 2018: 65; Campo 2015).

Although research exists into the needs of those seeking DFV assistance from various subsections of the community, there is a gap in knowledge of DFV service provision and access in different geographical areas, including regional and remote areas. The known barriers faced by women survivors seeking assistance include isolation, shame and financial pressures. Owen and Carrington (2015) suggested these factors would be more likely to affect marginalised individuals regionally due to the scarcity of services and resources.

### *Service Complexity*

Those experiencing DFV often require assistance with various concomitant issues, including physical and mental health, law enforcement and child protection (Women's Legal Service NSW 2017), which involve navigating a complex service landscape. The Australian Institute of Health and Welfare (2019b) has found that 37 per cent of clients who sought specialist housing assistance due to DFV also experienced one or more additional vulnerabilities, such as mental ill health or substance abuse. Research has also suggested that access to services is impeded by complexity and poor collaboration between different DFV service sectors (Hooker et al. 2016; Kaspiew et al. 2017). Kaspiew et al. (2017) found that survivors had difficulties in finding particular services, including counselling for male children, privately affordable programs or long-term support not limited by funding. They also noted that expertise in DFV remains limited in some service sectors, including the family law system, and that siloing and service fragmentation obstruct survivors in their quest for assistance.

Assistance can be dependent on where a survivor first discloses DFV. Survivors may receive inconsistent responses between agencies and service providers, experience limitations in the ability of mainstream services to determine DFV risk or refer to specialist support and find a system ill-equipped to offer streamlined support to survivors with multiple, interdependent needs (Neave, Faulkner and Nicholson 2016). These issues can be exacerbated in regional areas where budgetary pressures have resulted in some reduction in services (Wendt et al. 2017). Service siloing forces DFV survivors with complex needs to navigate a maze of systems during a period of intensified stress (Neave, Faulkner and Nicholson 2016: 9) and engage with multiple services concurrently or successively (Kaspiew et al. 2017), potentially reducing the capacity of those services to provide adequate support and for survivors to recover.

### *Service Barriers in Regional, Rural and Remote Areas*

There are several specific interrelated barriers to DFV service access in regional, rural and remote areas of Australia, including the number, scope and capacity of services; the availability of trauma-informed services; lack of transport; privacy and confidentiality; shame and stigma; and the lack of culturally appropriate services.

Pragmatically, the distance between major service centres (such as large towns or regional cities) and where survivors live make it difficult for people to attend services physically, particularly as fewer public and private (e.g., taxi services) transport options exist in regional settings compared to metropolitan settings (Campo and Tayton 2015; Ragusa 2017).

Survivors have reported concerns about their privacy because in small communities, people who work in services are more likely to know survivors, perpetrators and their families (Campo and Tayton 2015). Consequently, survivors of DFV in these areas may rely more on informal care and support from friends and neighbours (Wendt et al. 2015). Importantly, research has also found that in rural and remote areas, informal supporters can inhibit help-seeking by encouraging survivors to stay with perpetrators. This situation can result in women ‘suffering in silence’ (Wendt et al. 2015: 24). Although some literature about access to DFV services has acknowledged the need to consider metropolitan, regional, rural and remote areas differently, including the nuances within these groups, in practice, the literature tends to collapse these regions together into high-level categories.

In summary, we have highlighted a broad range of general barriers to accessing DFV services and barriers that appear to be specific to survivors located in rural, regional and remote areas and/or from diverse groups. The purpose of this article is to map the contours of two regional communities in the Illawarra, south of Sydney, that service providers have identified as important for enabling or inhibiting DFV service provision and access. Furthermore, we will assess the implications of the data locally and internationally.

## Methodology

This article reports on data collected from interviews with 19 stakeholder groups engaged with DFV-related services in two suburbs in the Shellharbour local government area, situated approximately 100 kilometres south of Sydney on the NSW coast. The suburbs are located in the Illawarra region. Both suburbs are low- to middle-income working-class suburbs established in the 1950s and 1960s, with a combined population of just under 10,000 people (Australian Bureau of Statistics 2021). The two suburbs, Lake Illawarra and Warilla, were selected due to their elevated rates of DFV in the 2017–2019 reporting period, as demonstrated in Table 1, and the broader project was a response to the perceived lack of primary prevention.

***Table 1: DFV rates per 100,000 population*** **(Bureau of Crime Statistics and Research 2019)**

| Reporting period | Lake Illawarra | Warilla | NSW state average |
|---|---|---|---|
| **2017/2018** | 639.9 | 543.2 | 365.2 |
| **2018/2019** | 457 | 513 | 387.1 |

The research was funded by the Illawarra and Shoalhaven Local Health District and was completed in collaboration with the Illawarra Women’s Health Centre. Approval to conduct the research was granted by the Humanities and Social Sciences Human Research Ethics Committee at the University of Wollongong. The project was guided by a Steering Committee comprising representatives from health, government and justice services in the target suburbs.

There were three components to the project. The first was a household survey to understand local attitudes towards and perceptions of DFV. Next, interviews were held with service providers and community leaders in diverse organisations providing services to targeted communities. The interviews aimed to identify the contemporary, local DFV service landscape, understand what services were available and for whom, and identify service gaps and how services worked with the target communities. Finally, we held three community fora with a participant group of interested community members to understand their priorities for primary prevention, considering the local attitudes gathered from survey data and the landscape of services gathered from interview data. This article reports on the service landscape and, therefore, draws exclusively from the interview component of the project.

The research questions (RQ) guiding the interview component of the research design were:

1. *Which DFV services are available in the target suburbs?*
2. *What prevention and intervention programs are being delivered?*
3. *What works effectively to address DFV in the target communities?*
4. *What are the local DFV service gaps?*
5. *How well do the local services cooperate?*
6. *What are the target suburbs' community strengths?*
7. *What are the barriers to DFV prevention in these suburbs?*

Semi-structured interviews are perhaps the most used method of data collection in contemporary social science research (Brinkmann 2014). This form of interviewing enables participants to share perspectives, experiences and expertise (McIntosh and Morse 2015) in a format that is flexible enough to account for each participant's context while also facilitating comparable data via a core set of common prompts (Brinkmann 2014). The semi-structured interviews were aligned with McIntosh and Morse's (2015) descriptive/divergent type because we recognised support providers' unique perspectives and expertise and aimed to uncover points of similarity and difference across support domains.

A sample of key stakeholders in the areas of DFV in the suburbs of Lake Illawarra and Warilla was purposefully selected (Creswell 2013: 228) and invited to participate in this study. Identifying and recruiting stakeholders was a three-step process. First, a list of key stakeholders was compiled at an initial meeting of the project Steering Committee. Key stakeholders met the criteria for inclusion if they were either DFV service providers or community leaders with a specific interest in DFV service responses. These participants had the expertise to respond to the RQs documented above. Next, the initial list of stakeholder organisations or individuals (e.g., community leaders) was checked for currency and to ensure that support was offered in the target communities. Finally, the research team selected stakeholders from as broad a range of support domains as possible to reflect the diversity of the local population and their needs and to 'map' available services in response to RQ1. At this stage, nominated stakeholders were only excluded if they did not provide support for people experiencing DFV in the target communities. The resultant stakeholders represented support domains such as housing, health, legal and justice, local government and community cultural leadership. Stakeholders were invited to participate in an interview by email or telephone contact. Overall, 37 individuals from 19 organisations responded to the invitation and participated in an interview.

All interviews occurred face-to-face, either individually or in small groups, at a venue of the participants' choice and lasted from 30 to 80 minutes. Interviews were conducted by three of the authors (HS, NH and CM). Semi-structured interviews were used to encourage stakeholders to share their breadth of knowledge about available local service providers and the specific services and programs offered (RQ1 and 2) and community strengths (RQ6), and prompting was employed to encourage deeper and more meaningful reflection (DeJonckheere and Vaughn 2019). Interviews were guided by a schedule that corresponded to the RQs. The project Steering Committee provided feedback on the initial draft interview schedule to ensure that the interview questions were understandable to non-research professionals, closely connected to the RQs, and appropriate in the nature and range of information sought.

Interview questions explored the stakeholders' service delivery experiences, specifically concerning service gaps (RQ4), collaboration across services (RQ5), what practices worked well in delivering DFV services and support in the target communities (RQ3) and what barriers prevented effective service support (RQ7). Example interview questions were: *Can you talk us through the domestic and family violence (DFV) services/programs offered by your organisation? What are some of the barriers to engaging your target communities in programs and services? Have you noticed any gaps in DFV services in this area?* Each interview was digitally recorded and transcribed prior to analysis.

Participants had primary roles within their services as counsellors, case workers, child protection workers and health, financial, legal and justice practitioners. Transcripts of the interviews were checked for accuracy and then thematically analysed to find patterns, relationships and associations within the data (Thorne 2016) and answers to the RQs. We applied Braun and Clarke's

(2019) six-step approach to reflexive thematic analysis. Broadly, thematic analysis is a common technique used in qualitative social science research for its ability to generate a rich account of meaning in complex data (Nowell et al. 2017).

Data analysis combined deductive and inductive coding (Braun and Clarke 2019), with initial codes predetermined from the interview guide and additional codes added as ideas emerged in the data. For example, regarding RQ3, data were coded to a general and deductively derived parent node, 'Service effectiveness'. Within this node, child nodes were inductively generated, including 'characteristics of effective programs' and 'effective program engagement techniques'. NVivo 12 software was utilised to categorise and code data into nodes (descriptive and conceptual codes), which were then organised into interconnected and overlapping themes. In theme development, we paid particular attention to shared meaning, with central organising concepts used to move beyond summary descriptions of data (Braun and Clarke 2019). In the following findings section, we present central organising concepts as subsections and discuss underlying concepts and contexts discussed by the interview participants.

## Findings and Discussion

Interview participants described the service and community landscapes shaping DFV work in and around the target communities. This section examines the major characteristics of these landscapes relevant to understanding the challenges and enablers of DFV work.

### *Local Amenities*

Participants referred to local amenities that support or create barriers to accessing DFV services in target communities. A particular example was limited and costly public transport, in that it affected survivors' abilities to seek and obtain assistance for DFV issues, particularly as so many services were in the neighbouring city of Wollongong:

> Even just getting transport to the services. They don't have bus fares or anything like that, so that's going to prevent them from going anywhere, I guess, to get the help. (Housing support 1)

Structural inequality and its consequences, such as poverty, were perceived to be significant barriers in these communities. For instance, financial hardship made it difficult or impossible to physically access services. The average personal weekly income was $492 in Lake Illawarra and $465 in Warilla, compared to $664 on average in NSW (Australian Bureau of Statistics (ABS) 2016a, ABS 2016b). These values equate to 26% less personal income in Lake Illawarra, on average, and 30% less in Warilla compared to the population of NSW, indicating restricted opportunities to access services that require payment or utilise paid transport options. For those who had the resources to use public transport, the services were limited in contrast to major metropolitan areas, adding another barrier to accessing services:

> You are up against it down here. We've got less public transport. (Health support 5)

In the case of these communities, travel restrictions were not related to long distances or because communities were isolated, but rather to accessing a service within a comparatively short distance that nevertheless required the use of transport. This distinction is noteworthy because, while existing studies have cited a link between geographical isolation and inaccessibility of DFV services in rural Australia (Campo and Tayton 2015; Owen and Carrington 2015; Ragusa 2017; Wendt and Hornosty 2010), no studies could be found that specifically considered service access in regional areas. It could be speculated that this lack of information may be due to the homogenising of regional areas with either urban or rural areas when reflecting on aspects of service delivery, as demonstrated in the study by Murray et al. (2019).

### *Local Domestic Violence Services*

Unsurprisingly in a sample of service-provider interviews, the most significant theme that participants discussed related to service provision and service gaps. Stakeholders in this study emphasised that a significant systemic barrier was the siloing of information between services in and around the target communities:

> While there's a lot of talk about integrated service, all the structural pressures force organisations into siloed work. (Health support 8)

Siloing was observed to create barriers by preventing the 'sharing of knowledge and information about clients' (Local government 2), making it harder for customers to navigate service systems. Neave, Faulkner and Nicholson (2016: 144) argued that the fragmentation caused by siloing is a significant barrier to system navigation in a system that continues to 'fail many'—particularly those with diverse needs requiring assistance across a range of issues and service providers.

A related issue was competition for resources, which inhibited collaboration between service providers in the target communities:

> Funding is so tight. They know when they go into the tender process they'll be up against one another, and that is really difficult. Because of the funding being so tight, everyone tries to outdo themselves, and we do this, and we do that, but when you get down to the grassroots, what's happening and what's changing? You can't have cooperation in a competitive environment. (Housing support 1)

Further, funding is commonly provided on a short- or medium-term basis, and this approach was believed to inhibit effective ways of working and the autonomy to direct funding into appropriate programs, supported by the services' expert understanding of local communities and their needs:

> Without sustainable funding for longer than that and broadened in the criteria for how we spend our funding, that's really, really hard. Really hard. (Health support 4)

Additionally, competition in the community for the same limited resources at regular intervals reduces the incentive for and ability of organisations to work together to determine appropriate service delivery models and integrated approaches that best serve their clients rather than their ongoing survival. This outcome is despite the services' willingness to work collaboratively and their recognition of the value of working together.

Beyond siloing, funding requirements sometimes offered an incentive to establish new services. Some participants considered the focus on 'innovation' in service delivery to have the perverse effect of stalling established good practice:

> We are forever being knocked by government funding bodies, and we are calling for innovative solutions, and they actually have told me that our service is best practice; therefore, it's not innovative; therefore, they won't fund it. So, [they are] willing to fund a risky service that they don't know whether it will work, but they know our service will work, but it doesn't classify as innovative. So, that's a gap in the system as far as I'm concerned. (Legal support 1)

A noteworthy aspect of this environment was the variety of organisations and assistance available. Specialist and generalist services, government and not-for-profit services and services addressing different but related needs, such as housing, all make up a complex web of support. In this diverse service environment, services reported different levels of proactive engagement with the community. There are some advantages to this type of service landscape. For example, multiple access and referral points exist in a diverse service landscape, increasing the likelihood of 'no wrong doors'. However, limitations in the suburbs studied included that the service landscape was complicated for participants, many of whom were unaware of all the organisations and programs operating locally and were, therefore, unable to make appropriate referrals. In some instances, this landscape may further silo responses:

> Yeah, without a doubt [there is a lack of connection between services]. We're not relational. It might just be that haphazard. We've lost a lot of our really good DV [domestic violence] workers, but the DV workers were known, and they knew where to refer. Then sometimes, because funding now is so short-lived and so temporary, and just really services a small target group and then it's gone. It's near impossible [to be aware of all options] unless you're really just on the ground all the time. (Health support 1)

The fact that service providers themselves were confused by the variety and complexity of services available also raises a question about the extent to which the service landscape is penetrable for community members.

Despite the plethora of services available in these communities, there were commonly noted gaps in DFV services. Services for children who had experienced DFV, as well as a lack of sufficient numbers of case workers; affordable, safe housing; services for male survivors; services for Aboriginal and Torres Strait Islander survivors staffed by Aboriginal and Torres Strait Islander people; and services that addressed trauma were all noted by multiple participants as lacking:

> It's a gap in the community that no one actually sees the children of DV, with the exception of CPCS, which is Child Protection Counselling Service. (Health support 1)

> We don't have enough support workers. We don't have enough houses. We don't have enough accommodation options for people. We don't have enough spots available in refuges. That's where I think the gaps are. (Housing support 2)

> There's nowhere for men to go, so they struggle. You're losing your manhood if you say you've suffered DV. (Housing support 1)

> If the women are not getting that support for the trauma they have experienced and the health impacts, that is going to go through to the children and keep that trauma in the family. So, to get that trauma addressed is another one of the big holes, one way or the other. (Legal support 1)
>
> There's so limited Aboriginal positions—absolutely ridiculous. There's such a high percentage of Aboriginal women and children experiencing DV, but a service might have one designated Aboriginal worker, if they're lucky enough to fill it. (Local government 1)

Some participants noted issues that compounded service gaps, for example, service eligibility criteria, adding further difficulty for survivors trying to access scarce resources in the area. Participants noted that a service need in one area often disqualified victim-survivors from accessing services in another area:

> There's not enough houses. So, if someone wants to leave, where are they going to go? They're going to drag their four kids out and stay at crisis accommodation at [crisis accommodation targeting homelessness]? Would you want to do that to your kids? I'll tell you another big hole, and I found this absolutely appalling as a mother, if you have teenage children, male, and you're escaping DV, you can't take your son with you. That is disgusting. I would stay in that situation before I'd leave without my 16-year-old son. I find that appalling. (Housing support 3)
>
> It's really difficult to work with somebody that's an alcoholic that consumes up to eight litres of alcohol a day in housing, because they can't go into a refuge, because they can't take alcohol into a refuge, but they can't stop drinking alcohol at that level or get to a safe level very fast, because of their health. That's a huge thing. (Health support 8)

Service gaps were exacerbated by the high demand for services and high needs. The rates of DFV in Lake Illawarra and Warilla have remained high over time and are well above the NSW average. This situation was reflected in participants' comments about high demand from the local community and inadequate resourcing to meet demand:

> I mean, there are services, but it's not enough services. There's never enough services when someone is in crisis. It's really hard for them to find the support that they need. (Local government 2)
>
> What we have is good; however, we just don't have enough of it, if that makes sense? We don't have enough support workers. We don't have enough houses. We don't have enough accommodation options for people. We don't have enough spots available in refuges. That's where I think the gaps are. The gaps are resource-wise, I believe. (Housing support 2)

Several participants noted that the limited resources available tended to be funnelled into crisis support work in preference to other approaches, particularly prevention. In addition to limited available funds causing crucial gaps in crisis service provision, opportunities for early intervention or primary prevention were missed:

> We have known for years, through the young women's program that is run through various high schools, that there's been a gap in terms of working with young men. (Health support 8)
>
> I think they need to be talking about healthy relationships from the very beginning because they're [school students], a captive audience, and the schools have these kids for longer than we do during the week, and it should be incorporated into what is normal behaviour. (Local government 1)

Across the participants, there was strong support for early intervention and primary prevention, especially targeting toxic masculinity and healthy relationships. Schools were regularly named as important sites for prevention. However, concerns echoed the literature about barriers to services. For example, funding focused on 'new' programs able to generate a quick profile is regarded as more politically attractive than investing in long-term primary prevention strategies that may not have a demonstrable impact for 10 or 20 years. Overall, there was concern expressed that without primary prevention, DFV services would remain in a perpetually underfunded cycle, unable to respond to survivors' needs consistently and effectively.

## Conclusion

This paper examined service providers' perspectives on the delivery of services for DFV in two regional communities with high levels of reported DFV. Despite acknowledging that a range of services was available in these communities, providers noted an array of gaps and barriers to effective access and use. Although some of the barriers are the same as those documented across Australia more generally, these were exacerbated by the specific features of regional communities and were challenges specific to non-metropolitan areas. Our study adds to existing literature, as little has been written specifically about regional communities' experiences of addressing DFV. The literature focusing outside metropolitan areas tends to concentrate on rural and remote communities (Farhall, Harris and Woodlock 2020). While the Fourth Action Plan (Commonwealth of Australia

2019) to reduce violence against women and their children notes explicitly the need to address 'the diverse lived experience' of DFV, little has been done specifically to ameliorate the high levels of DFV experienced by women outside metropolitan areas (Community Legal Centres NSW 2021). Consequently, there are calls from the Royal Commission into Family Violence, among others, for priority to be given to addressing DFV in regional, rural and remote communities. Such calls for increased focus have also been accompanied by calls for much-needed funding reforms in the DFV space and integrated service responses (NSW Ministry of Health 2019).

An important implication of the findings presented here is the continued need for integrated services. This need has been recognised locally by the NSW Ministry of Health (2019) in 'The Case for Change' and the subsequent NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework. International research, such as Kulkarni (2018), has similarly documented a complex, gap-laden service system in the US and called for coordinated intersectional responses (see also Zorn et al. 2017 for a regional services' perspective located in Canada). In this way, our study's findings and appropriate responses, while regionally contextualised, resonate with the service landscape beyond Australia.

The NSW Ministry of Health defines integrated services as:

> the provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course. (2019: 7)

This definition synergises with Kulkarni's (2018) work on intersectional trauma-informed DFV services. Both share a survivor/person-centred approach and are based on trauma-informed responses that include providing culturally specific and safe services. The integrated service model has the potential to address several of the barriers described by the participants in this research, although the value of integration remains largely assumed rather than evidenced (Breckenridge et al. 2016). In theory, the integrated model has the potential to reduce competition for funding and enhance collaboration across services. Some of the participants in this research expressed a desire to work more closely with complementary services.

However, it is not yet clear what direct impact an integrated model will have on services in regional settings, survivors' experiences, promoting greater attention to primary prevention, or different service sectors. One of the challenges of integrated service models is that they are commonly limited to a particular service sector, in this case, health. However, this research identifies gaps in other areas, most notably housing and primary prevention initiatives. There is a risk that primary prevention will continue to be neglected and service silos will be replaced by sector silos. Multi-agency responses that deliberately draw together multi-sectoral lead organisations with expertise across primary, secondary and tertiary prevention must form part of any integrated response.

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[1] Soft or warm referrals occur when a service provider plays an active supporting role in connecting clients with appropriate additional service options. For example, with a client's permission, the service provider may contact recommended services on the client's behalf.

[2] For information about the Stolen Generations, please see the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (Australia). (1997) Bringing them home: report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. Sydney: Human Rights and Equal Opportunity Commission. Available from: https://humanrights.gov.au/our-work/bringing-them-home-report-1997

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