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Australian Research Centre in Sex, Health and Society

Responsive pandemic practice: LGBTIQ+ family violence service innovation in Victoria during COVID-19

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Responsive pandemic practice: LGBTIQ+ family violence service innovation in Victoria during COVID-19

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Terminology

We use the acronym LGBTIQ+ to refer to people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and/or other minority genders and sexualities. Variations of the acronym are used occasionally in this report to reflect how communities are described by research participants or represented in other research publications.

We use the term family violence to broadly describe violence that occurs within intimate-partner relationships and/or families of origin. Using this term is an acknowledgment that LGBTIQ+ family violence is part of a broader problem that also encompasses domestic violence and intimate-partner violence.

Many (but not all) of the family violence professionals at Thorne Harbour Health and Switchboard Victoria interviewed for this study identified as LGBTIQ+. Our description of such professionals as peers acknowledges that their roles involve providing support to LGBTIQ+ clients.

Executive summary

About this study

Thorne Harbour Health and Switchboard Victoria, through its Rainbow Door helpline, were instrumental in LGBTIQ+ family violence services undergoing a major transformation throughout 2020-21 in response to COVID-19 and its associated impacts.

This report explores how these two LGBTIQ+ community-controlled organisations in Victoria, Australia, innovated to provide telehealth and other flexible services to victim survivors and perpetrators despite the suspension of almost all in-person family violence services.

Methods

This report draws on data collected in 38 qualitative interviews with 19 LGBTIQ+ family violence sector staff (14 from Thorne Harbour Health and five from Switchboard Victoria's Rainbow Door), 15 victim survivors and four participants of a Men's Behaviour Change Program.

Interviews, conducted in late 2021 and early 2022, asked:

- How did COVID-19-related restrictions reshape the ways in which LGBTIQ+ people engaged with family violence services in Victoria?
- What innovations were introduced to the LGBTIQ+ family violence service model and how might these have met or reshaped client needs within the context of COVID-19 restrictions?
- What emerging and promising practice for family violence service delivery can be promoted across the sector to ensure essential support for LGBTIQ+ communities, including during emergencies?

Key findings

Thorne Harbour Health and Switchboard Victoria designed and delivered flexible, client-centred services to support LGBTIQ+ people experiencing family violence during COVID-19. Telehealth and other flexible options reduced service interruptions during lockdowns, prioritised client safety, were responsive to needs and challenged assumptions about how LGBTIQ+ family violence services should be delivered. Two key factors drove innovation.

First, technology provided the infrastructure for change. Thorne Harbour Health adapted work practices to include Zoom-based counselling and other service options delivered remotely through video, text message, email and telephone. In September 2020, Switchboard Victoria launched the Rainbow Door helpline – with staff working from home during a lockdown – which was inundated with callers seeking help, information and referrals.

Second, both organisations drew on their founding principles – forged amid the HIV/AIDS crisis – to foreground the safety and individual needs of clients during COVID-19-related restrictions and lockdowns. Dedicated staff at both organisations, many of them LGBTIQ+ community members, worked remotely to design and deliver flexible services. Practice innovation reduced service disruption and ensured positive outcomes for many LGBTIQ+ people accessing family violence services during 2020-21. One Thorne Harbour staff member said:

> *There's a real investment for us that goes above and beyond just being a worker … It was personal for our staff and our organisation that we continue to do this for our communities … We felt like this was what we needed to do, so we needed to find a way to do it safely and rapidly. (THH staff)*

Flexible practice meant better service access during COVID-19 for many victim survivors in regional and rural areas, with a disability and/or those living with perpetrators. Improved access for people in rural and regional Victoria meant that organisations such as Thorne Harbour Health operated as a statewide service more than ever before. One client in regional Victoria said:

> *With the mental state that I was in, I don't know if I would have had that motivation [to drive to Melbourne]. Even though things are really bad. And I knew it was helpful for me. But to be driving an hour and a half to two hours into the city – it would have been a full day, basically. (Victim survivor)*

Technology-driven flexible options enabled Thorne Harbour Health and Rainbow Door to provide services that they otherwise might not have during a pandemic, despite limited resources and increasingly fatigued staff members. The challenges of COVID-19 have been such, however, that not all challenges have been met. Waiting lists for services at Thorne Harbour Health grew significantly longer throughout 2020-21 and Rainbow Door staff could not answer the high volume of calls they received.

In the six months from July to December 2019, 65 people spent an average of 13 days on Thorne Harbour Health's waiting list for family violence services. From July to December 2021, 292 people spent an average of 51 days on the waiting list. Longer waits impacted those seeking support. As one victim survivor described:

> *Three months might not seem like a long time. But for someone going through and dealing with family violence, it can feel like the longest time in the world. This length of waiting time might have damaged so many people in so many different ways. (Victim survivor)*

For many LGBTIQ+ community members, the pandemic exacerbated existing issues and created new ones such as loss of work, income and secure housing. Some were placed in perilous situations when they returned to live with their family of origin during COVID-19 lockdowns. The impact of the past two years on LGBTIQ+ community members' health and mental health is yet to be fully understood.

As the uncertainty of the COVID-19 pandemic continues, so, too, do challenges for LGBTIQ+ family violence services. Practitioners providing family violence services from their homes have had to deal with many challenges, such as more complex client needs, isolation from colleagues, less defined boundaries between work and home life, privacy issues and holding more risk. Wellbeing issues for these professionals have included moral injury, burnout, stress and other mental health issues.

This report demonstrates how LGBTIQ+ community-controlled organisations implemented technology-driven flexible practice during a public health

emergency. Insights and experiences of family violence practitioners and service users might be useful to those considering what flexible practice might look like in a world in which COVID-19 is better contained, or in other health or even climate change-induced emergencies.

Recommendations

Our recommendations are driven by:

- A need to strengthen LGBTIQ+ community-controlled organisations in ways that further improve family violence service provision
- A need to value and further develop technology-driven flexible practice in ways that help foreground the individual needs of clients

Our recommendations are summarised as follows (and can be read in full in Chapter Nine):

1. Further develop flexible practice to ensure long-term technology-driven support options
2. Determine additional flexible practice needs for hybrid service delivery and future emergencies/health crises
3. Scale up organisations that deliver LGBTIQ+ family violence services and strengthen referral pathways
4. Further develop workforce capacity in LGBTIQ+ family violence services
5. Strengthen workforce supports to sustain wellbeing and efficacy
6. Develop surge capacity plans for future natural disasters or public health emergencies, acknowledging how LGBTIQ+ communities are impacted

Resourcing of this study

This report was generously funded by Family Safety Victoria, a government agency dedicated to ending family violence.

At a glance:

- LGBTIQ+ community-controlled organisations adapted and created family violence services in response to COVID-19 and its associated impacts
- Innovation was driven by professionals, many of them LGBTIQ+ community members, who drew on the strengths of two organisations founded during the HIV/AIDS crisis
- Technology (video calls, text messages, emails and telephone calls) provided the infrastructure for flexible service delivery during 2020-21, especially during COVID-19-related lockdowns in Melbourne
- Flexible service innovation was client-centred and responsive to the safety needs of individuals, including those living with perpetrators during the pandemic
- Counselling and Men's Behaviour Change Programs were among services adapted for Zoom
- Many LGBTIQ+ community members experienced loss of work, income and secure housing during COVID-19. Some were placed in perilous situations when they returned to live with their family of origin during lockdowns
- Some service transformations have reduced barriers and improved service access for many victim survivors in regional and rural areas, people living with a disability and/or those living with perpetrators. Organisations such as Thorne Harbour Health operated as a statewide service more than ever before
- Innovation reduced some service interruptions and contributed to positive outcomes for many LGBTIQ+ people who accessed family violence services
- Growing waiting lists and increased workloads among dedicated but fatigued staff suggest that LGBTIQ+ family violence services were not adequately resourced to meet demand
- Practitioners providing family violence services from their homes have had to deal with more complex client needs, isolation from colleagues, less defined boundaries between work and home life, privacy issues and holding more risk. Wellbeing issues have included burnout, stress and other mental health challenges
- Flexible practice innovation demonstrates the importance of services adapting to meet the individual needs of clients
- Experiences of flexible practice that meets the diverse needs of LGBTIQ+ communities might help inform responses to future emergencies

1. Introduction and aims

COVID-19 and its associated impacts significantly disrupted face-to-face LGBTIQ+ family violence services in Melbourne, Australia, in 2020-21. As the state of Victoria battled to suppress the virus and its citizens endured more than 260 days of lockdowns while waiting for vaccines (1), LGBTIQ+ community-controlled organisations innovated their family violence services to meet urgent client needs. Driving this innovation was a willingness to challenge existing family violence service practice to limit delays.

This report is a snapshot of how two LGBTIQ+ community-controlled organisations, Thorne Harbour Health and Switchboard Victoria, responded to a public health emergency. It is a story of how Thorne Harbour Health created a new practice model, which prioritised flexible service delivery and was driven by technology such as video calls, emails and text messages. It is also a story of how Switchboard Victoria created LGBTIQ+ peer helpline Rainbow Door during Melbourne's longest lockdown to help address a hidden but growing demand for family violence services and other support.

Drawing on 38 in-depth interviews with 19 family violence service staff, 15 victim survivors and four Men's Behaviour Change Program participants, the report explores the impact of practice innovation at Thorne Harbour Health and Rainbow Door. Interviews, conducted in late 2021 and early 2022, asked:

- How did COVID-19-related restrictions reshape the ways in which LGBTIQ+ people engaged with family violence services in Victoria?
- What innovations were introduced to the LGBTIQ+ family violence service model and how might these have met or reshaped client needs within the context of COVID-19 restrictions?
- What emerging and promising practice for family violence service delivery can be promoted across the sector to ensure essential support for LGBTIQ+ communities, including during emergencies?

We consider how organisational responses affected service engagement and access for clients, including victim survivors who were locked down with perpetrators, under financial stress and/or experiencing mental ill health during 2020-21. We show how telehealth and remote service delivery affected family violence practitioners and other staff members, who navigated significant practice changes while themselves in lockdown for long periods.

In this report, we consider the implementation of flexible LGBTIQ+ family violence service delivery throughout 2020-21. This includes improved access for clients in regional and rural Victoria and better referral pathways. Such examples underscore the importance and value of LGBTIQ+ community-controlled organisations and their commitment to people to whom they serve. Central to this commitment are staff, often from within the community, who shoulder the responsibility for this work.

This report also offers insight into the significant challenges of delivering LGBTIQ+ family violence services during a pandemic. Concerns about the safety of clients, the wellbeing of staff and the quality of programs during 2020-21 are considered. These challenges – some of them ongoing – demonstrate the need for LGBTIQ+ community-controlled organisations like Thorne Harbour Health and Switchboard Victoria to be continually supported to provide specialist LGBTIQ+ family violence services.

Many (but not all) of the family violence professionals at Thorne Harbour Health and Switchboard Victoria interviewed for this study identified as LGBTIQ+. Our description of such professionals as peers acknowledges that their roles involve providing support to LGBTIQ+ clients.

1.1 Report structure

This report explores the rapid transformation and creation of LGBTIQ+ community-controlled family violence services in response to COVID-19. It consists of nine chapters, including this introduction. In the next two chapters, we provide a background to the study, demonstrating the need for more research into LGBTIQ+ family violence and the importance of LGBTIQ+ community-controlled organisations, before describing our research methods.

In Chapter Four, we begin our exploration of Thorne Harbour Health's transition to a flexible service model for family violence services in early 2020. This begins with a focus on organisational values, leadership and the ethical and practical considerations involved in changing from in-person family violence services to a remote and online model. We consider how these changes were designed, communicated and managed.

Chapter Five focuses on Thorne Harbour Health client experiences of family violence services during 2020-21. We consider barriers to accessing services, referral pathways and the convenience, comfort and safety of flexible, responsive service options, especially Zoom-based counselling. We then explore client perceptions of the safety and effectiveness of Thorne Harbour Health's telehealth options during the pandemic, including lockdowns. Highlighted is the impact of expanding waiting lists on clients seeking counselling. We end this chapter with a discussion about ReVisioning, Thorne Harbour Health's Men's Behaviour Change Program, which was adapted for Zoom in response to lockdowns and other physical-distancing measures.

Thorne Harbour Health staff members drive discussion in Chapter Six, in which we explore how technology-driven flexible service was delivered. We focus on how family violence practitioners (and other staff members providing services) changed their work practices, from tailoring how they assessed for risk, to counselling clients remotely from their homes. We explore how effective staff considered adapted practice to be, the impact of change on work-life balance, and what it felt like to "hold more risk"

and assess the safety of clients while working from home.

In Chapter Seven, we focus on the creation of Switchboard Victoria's Rainbow Door, a helpline offering information, support and referrals to LGBTIQ+ people experiencing issues such as family violence. We focus on Rainbow Door's point of difference as a personalised service that works with callers to help find them the right support. We consider the near-constant demand for Rainbow Door's services from its inception in September 2020 to the time of staff interviews for this report in late 2021. Impact on staff members performing their work remotely is also considered, as is the potential for the service to expand.

Chapter Eight draws together insights from all study participants to consider what lessons have been learned from LGBTIQ+ family violence service adaptation during the COVID-19 pandemic. This chapter explores the potential and possibilities of technology and flexible practice as part of a hybrid model of service delivery, which is emerging as a result of changes that occurred in 2020-21.

This leads into Chapter Nine, which provides a summary of the report and recommendations designed for consideration by any agency or body with the capacity to enhance how organisations such as Thorne Harbour Health and Switchboard Victoria deliver specialist LGBTIQ+ family violence services.

2. The context of family violence and service provision to LGBTIQ+ communities

2.1 Context

This report sits at the intersection of LGBTIQ+ family violence service delivery, reform in Victoria's family violence system and technology-driven practice innovation during COVID-19. We consider these topics now in more detail.

2.1.1 Family violence

Family violence has devastating impacts on individuals, families and communities. According to the World Health Organization, one in three women experience physical and/or sexual violence, most often at the hands of an intimate partner (2). Most research into family violence to date has – rightfully – focused on the need to address the high levels of violence inflicted upon women by their male partners or former partners. Thus, an important narrative that underpins much research into family violence and informs most policy responses is that which involves heterosexual men as the perpetrators of violence and heterosexual women as the victims and/or survivors of it (3).

2.1.2 LGBTIQ+ family violence and service access

The framework of gender inequality and men's use of violence is also not the whole story of family violence. Research shows that people identifying as LGBTIQ+ experience family violence at levels similar to that which occurs among the general population (4, 5, 6, 7). LGBTIQ+ people experience violence that is physical, sexual and psychological in nature, and additional abuse relating to their sexual orientation, such as "outing" and homophobia (8, 9). *Private Lives 3*, a survey of some 6800 LGBTIQ+ people in Australia, found that more than 40% of participants had experienced intimate-partner violence and almost 40% had experienced violence from a family member (10).

Accessing support remains difficult for LGBTIQ+ people experiencing family violence. Systems designed specifically for heterosexual cisgender women can present a barrier to LGBTIQ+ people receiving help (11). Systemic inequities, stigma and a limited understanding of violence in LGBTIQ+ relationships have been identified as principal barriers to community members who experience violence finding support (12). Historically, family violence services, health services and shelters have not been prepared to help LGBTIQ+ victim survivors of intimate-partner violence or responded in helpful ways to the abuse they have endured (13). Trans people seeking support have often been excluded or banned from services or had to "pass" as a cisgender woman in order to access them (14).

About 72% of all victim survivors surveyed for *Private Lives 3* had not reported their most recent experience of abuse (10). Of the remainder, almost 19% had reported it to a counsellor or psychologist, about 6% to police and about 1% to an LGBTIQ+ organisation (10). About 35% of those surveyed said they would prefer to access an LGBTIQ+-friendly mainstream family violence service in future, while almost 21% would prefer to seek support through an LGBTIQ+-specific family violence service (10).

Although LGBTIQ+ family violence research emerged as early as the 1980s (15), by 2015, only about only about 3% of research papers on intimate-partner violence focused on LGBTIQ+ populations (5). This report seeks to make a much-needed contribution to a growing area of study.

2.1.3 Family violence policy and services in Victoria, Australia

The state government of Victoria has pledged to improve outcomes for people experiencing family violence and prevent further violence from occurring. Victoria's Royal Commission into Family Violence, tabled in state parliament in 2016, underscored the urgent need to address family violence, including that which LGBTIQ+ people experience, and the damage it causes.

Findings and recommendations emerging from the Royal Commission prompted the Victorian government to embark upon a 10-year strategy to rebuild the family violence system, which it was more than halfway through at the time this report was published (16). Family Safety Victoria, created in 2017, has driven much of the Victorian government response since the Royal Commission and is committed to reform across the whole of government (16). Included in this response is a greater recognition of LGBTIQ+ communities.

The Victorian government's *Everybody Matters: Inclusion and Equity Statement* describes the family violence system as consisting of three parts: the broader family violence system (including government, police, courts, and child and family services); the specialist family violence service system (for example, counselling, advocacy and capacity building, and perpetrator services); and targeted services (LGBTIQ+ and culturally and linguistically diverse communities) (17). The statement outlines three strategic priorities guiding the Victorian government throughout its 10-year strategy: building knowledge, building capacity and capability, and strengthening targeted services (17).

FSV's focus on these strategic priorities in relation to targeted services is evident in its response to Royal Commission recommendations relating to LGBTIQ+ communities. FSV has led implementation of four LGBTIQ+-focused recommendations, including Recommendation 168, related to LGBTIQ+-specific program development, family violence practitioner training, community education and accommodation options (18).

FSV has provided funding to Thorne Harbour Health and Switchboard Victoria to assist in service provision, along with

In this report, we consider telehealth to be a broad range of practices delivered through technology. Our use of telehealth refers to any kind of service-related communication that takes place over video (such as Zoom and Webex), telephone call, SMS (text message) or any other form of instant-messaging platform.

support for Queerspace/Drummond Street Services. Funding to deliver expanded family violence services represents a significant investment in service innovation. Family violence services, particularly those at Thorne Harbour Health, were in their initial phases of scale-up when COVID-19 led to stay-at-home orders and the mass shutdown of workplaces in early 2020.

2.1.4 COVID-19 and LGBTIQ+ family violence

Family violence during COVID-19 has been described as a "shadow pandemic" (19) and a "pandemic within a pandemic" (20). Some family violence services in Australia reported an increase in demand for services during 2020 (21). Forced co-habitation, an inability to seek help outside the home and surveillance by way of technology were exacerbated for victim survivors during lockdowns (22). Some perpetrators effectively weaponised the COVID-19 virus and its associated impacts, using it as a tool of control and coercion (19), adding to the challenges of already reduced social support systems for victim survivors (23).

The impacts of COVID-19 and the necessary health response (including lockdowns) disproportionately impacted on the LBGTIQ community, exacerbating existing inequities and creating new ones (24, 25). Many LGBTIQ+ community members have described experiencing loss of work, income and secure housing and were placed in perilous situations when returning to their family of origin. Given that LGBTIQ+ people experience violence in intimate relationships at similar rates as, or even higher rates than, heterosexual people (26), it is likely that LGBTIQ+ people have also experienced increases in family violence since early 2020. Less is specifically known about the impact of the COVID-19 pandemic on LGBTIQ+ community-controlled organisations that provide family violence services.

2.1.5 Telehealth and remote service delivery

Many service providers adopted or increased telehealth services and remote service delivery in 2020. Stay-at-home orders meant services closed their offices and sent staff home. This significantly affected how family violence services were delivered. As the risk of family violence increased, it became more difficult for people to access services (27). Many frontline services in the mainstream family violence sector adopted telehealth or outreach models of service delivery (28). The speed at which service delivery changed course, and the extent of this shift, "created new opportunities while at the same time pushing service demand and practitioner capacity to its very limits" (27:38).

Rapid adoption of telehealth has presented issues around client safety, staff workload and service quality (28). Managers and practitioners have reported that telehealth options have made services more accessible (29, 30), though concerns have been raised about the limitations of remote services, including in relation to assessing risk and meeting the needs of all clients (30, 27). For many practitioners, providing family violence services from home has significantly impacted their wellbeing (27).

Research focusing on mainstream family violence services shows that telehealth service delivery has the potential to break down barriers and meet client needs beyond the COVID-19 pandemic (29). As an emerging model, one developed in the midst of a pandemic, telehealth has a number of unresolved quality, safety and security issues (29). These challenges need to be addressed.

2.2 LGBTIQ+ community-controlled organisations

This report focuses on Thorne Harbour Health's pivot to a flexible service model to meet the immediate challenges of COVID-19 in March 2020. It also examines Switchboard Victoria and its launch of Rainbow Door, a specialist helpline that provides support for family violence (and other issues), in September 2020. This helpline opened to significant demand.

Thorne Harbour Health and Switchboard Victoria are LGBTIQ+ community-controlled organisations. The term "community-controlled" arose out of civil rights movements and is used by a range of movements internationally. Community-controlled organisations are initiated by, governed by, operated by and accountable to their communities. They are based within their communities and deliver safe services that empower their communities.

In Australia, community control is most commonly associated with Aboriginal and Torres Strait Islander community-controlled organisations, recognising and reflecting Indigenous community ownership and meeting the needs of Aboriginal and Torres Strait Islander peoples. The first reference to Aboriginal "community-controlled" health services was in 1978, although use was not widespread until about 1987, following the establishment of the Aboriginal non-government organisation program. Separately, the term "community controlled" was used in Australia in the early 1970s in references to childcare services at a women's centre in Melbourne, which operated as a feminist and lesbian space, and used in reference to healthcare for lesbians in Sydney around the same time. The first documented use of the term for the Victorian AIDS Council (the previous and legal name of Thorne Harbour Health) was in its annual report of 1987.

Both Thorne Harbour Health and Switchboard Victoria recognise the value and significance of the term "community-controlled" for Indigenous peoples of Australia. They share with Indigenous organisations a belief that services for LGBTIQ+ people are most effective and impactful when they are designed and delivered by organisations that are governed by, led by and accountable to LGBTIQ+ people.

2.2.1 Thorne Harbour Health's family violence services

Thorne Harbour Health began operations in 1983 as the Victorian AIDS Action Committee, before changing its name to the Victorian AIDS Council (31). Initially operating primarily in response to Victoria's HIV/AIDS crisis, Thorne Harbour Health has broadened its services to cater to many of the diverse needs of LGBTIQ+ people (31), including family violence support.

Thorne Harbour Health has a dedicated family violence service as part of its Therapeutic Services and Capacity Building programs (32). The service sits alongside alcohol and drug (AOD) services, counselling services and capacity building and training activities. Clinical and therapeutic-based services and programs are about two-thirds of Thorne Harbour Health's work. Since the 2015 Victorian Royal Commission into Family Violence recommendations were released, Thorne Harbour Health has expanded its family violence programs to include a comprehensive range of specialist LGBTIQ+ family violence programs. This includes perpetrator and victim survivor brokerage; crisis brokerage; crisis response; recovery and case management for victim survivors; therapeutic counselling; perpetrator case management and Men's Behaviour Change Programs.

Family violence practitioners at Thorne Harbour Health perform a range of tasks, including family violence counselling, family violence case management, group work, family safety work (previously known as partner contact work), intake, assessment and safety planning. Staff members also provide secondary consultation and deliver training to external organisations that focusses on family violence and related issues for LGBTIQ+ communities.

2.2.2 Switchboard Victoria's Rainbow Door

Switchboard Victoria formed in 1991 as Gay and Lesbian Switchboard. Inspired by the London Gay Switchboard, the community-controlled organisation operated in Melbourne as a volunteer telephone counselling and referral service (33). Gay and Lesbian Switchboard faced significant obstacles to providing service in its early days, including Telecom refusing to list its number in the White Pages in 1992 (33).

The organisation teamed up with LGBTIQ+ support lines in other states to form QLife in 2013-14, the first national telephone service of its kind (33). About the same time, the organisation changed its name to Switchboard Victoria. Since then, it has continued to provide peer-based support, information and referral services through its helpline, while expanding services in other areas. From Switchboard Victoria's perspective, "community and connection" underpin phone and webchat services, "offering callers a gentle, safe space to connect with another LGBTIQA+ person" (34:11).

Switchboard Victoria also has a community visitors service for older LGBTI community members, a QTIBPoC (queer, trans, intersex, bla(c)k and/or people of colour) program, and a suicide prevention program (33). Switchboard Victoria, along with Thorne Harbour Health, Queerspace/Drummond Street Services and Transgender Victoria, have been part of With Respect, an "integrated services response" to LGBTIQ+ intimate-partner violence (33).

With funding from Family Safety Victoria, Switchboard Victoria launched Rainbow Door in 2020, during a long COVID-19-related enforced lockdown in Melbourne. Rainbow Door operates from 10am-5pm every day and was initially designed in part to provide more options to LGBTIQ+ people outside of QLife's operating times, including in relation to family violence issues.

2.2.3 LGBTIQ+ community-controlled organisations during health crises

Having access to LGBTIQ+ community-controlled services is vital to the health and wellbeing of community members (35, 36). LGBTIQ+ people are reported to under-utilise services relative to the health inequities they experience (36). Community-controlled organisations offer services that are culturally appropriate to the needs of LGBTIQ+ people (36). LGBTIQ+ inclusion, both in community-controlled organisations and mainstream services, has been identified as needing to be driven by "universal policies, systems and processes that establish and demonstrate cultural safety" (36:5).

Both Thorne Harbour Health and Switchboard Victoria were created by LGBTIQ+ communities to support their members during a time of significant adversity – the global HIV/AIDS crisis. LGBTIQ+ peers' strength and solidarity in providing health, mental health and social support to their communities in difficult circumstances is a legacy that both organisations value. In fact, they draw inspiration from it as they seek to continue supporting the contemporary needs of LGBTIQ+ people.

In Switchboard Victoria's 2019-20 annual report (34:12), chief executive officer Joe Ball spoke of the importance of the LGBTIQ+ community-controlled organisation's origins as it confronted the challenges of COVID-19:

> *Throughout the early onset of coronavirus (COVID-19), I turned my thoughts each day to our Switchboard founders, those who built our service during the AIDS pandemic … I thought of their courage and ultimately their resilience to forge something anew, something essential and something ultimately very successful. They created Switchboard, born out of a response to AIDS that continues to this day as a community-controlled organisation for and by our community. It was with their vision and legacy and knowing what they had achieved that enabled us, 29 years on, to respond again to a pandemic.*

3. Methods

Similarly, Thorne Harbour Health embraces its legacy as an LGBTIQ+ community-controlled health and activist organisation providing crucial support during immensely challenging times. In promotional material on its website, Thorne Harbour Health highlights its use of a social model of health that honours the individual's right to "increase control over and improve their health". This model has driven Thorne Harbour Health's approach to HIV/AIDS since the organisation's inception (37).

Thorne Harbour Health also emphasises that its "response to a continually changing epidemic has always been seen as a collective responsibility" (37). This is not only an acknowledgement of the importance of the organisation's past, but it also indicates how important it considers its ongoing role as an LGBTIQ+ community-controlled organisation to be. Furthermore, it is an indicator of how it might respond to future crises.

This report is an opportunity to consider the ongoing importance of LGBTIQ+ community-controlled organisations, especially during significant public health emergencies. It is also a chance to explore how the organisational memory and cultures of Thorne Harbour Health and Switchboard Victoria, developed during the HIV/AIDS crisis of the 1980s, informed their responses to COVID-19 in 2020.

3.1 Study participants

This report presents findings from a qualitative study of LGBTIQ+ family violence service adaptation in response to COVID-19. Driving discussion throughout this report are the insights of staff who provided family violence services and clients who accessed them during 2020-21. These insights were gathered through semi-structured in-depth interviews with 38 participants.

The first phase of this project consisted of interviews with staff at Thorne Harbour Health and Switchboard Victoria's Rainbow Door. Both organisations were identified as playing crucial roles in providing family violence support to LGBTIQ+ people in Victoria and innovating in response to the COVID-19 pandemic.

In total, 14 Thorne Harbour Health staff were interviewed. The family violence team at Thorne Harbour Health includes people in clinical roles, group facilitation, brokerage administration and capacity building and training. Given that the family violence program sits alongside other programs and clients often seek support from Thorne Harbour Health for multiple issues, it was also appropriate to interview staff who provide associated services, such as AOD counselling.

Five employees of Rainbow Door were interviewed. All provided family violence services as part of their helpline roles. This included providing information, making referrals to other services and offering general support to LGBTIQ+ community members in distress.

Fifteen people were interviewed as part of Phase Two. All were victim survivors who accessed Thorne Harbour Health as clients after experiencing family violence. Four people were interviewed in Phase Three. All were participants of ReVisioning, the gay, bisexual, trans and gender diverse and/or queer (GBTQ) Men's Behaviour Change Program at Thorne Harbour Health.

More information about research questions, methods and participants can be found in the Appendix section.

3.2 Use of participant quotations

Participants' direct quotations are used to demonstrate their experiences and drive the discussion. Although we have sought to contextualise participant responses, we have included only minimal demographic information with each quotation. Both Thorne Harbour Health and Switchboard Victoria are small LGBTIQ+ community-controlled organisations that support quite close-knit LGBTIQ+ communities in Victoria. It can be assumed that employees and clients might be at risk of being identified even when they are not named.

For this reason, when directly quoting participants, we not only omit their name (as is standard practice), but also all biographical information about their gender identity, sexual orientation, age, ethnicity and specific job title. This information has been collected and is presented in the Appendix to demonstrate diversity across the sample group. Separating this information from the participants' interview data provides a level of privacy appropriate to a study about family violence situations and associated service provision.

We refer to participants using the categories below. They do not capture the nuanced nature of someone's experience as an employee or a client. For the sake of extra privacy for participants, this is a limitation we are prepared to accept.

- **THH staff:** A Thorne Harbour Health employee, including those with organisational responsibility and/or delivering family violence services and associated services
- **RD staff:** A staff member involved in setting up and/or working on the Rainbow Door helpline
- **Victim survivor:** A victim survivor who has accessed services at Thorne Harbour Health
- **ReVisioning participant:** A participant of the Men's Behaviour Change Program at Thorne Harbour Health

4. Ten years forward in two weeks: Thorne Harbour Health's family violence service response to COVID-19

When COVID-19 forced offices in Melbourne to close and employees to work from home in March 2020, Thorne Harbour Health was one of countless non-profit organisations challenged to find new ways of supporting clients. Like many other services across the state, Thorne Harbour Health did not know when its main office might reopen or under what conditions in-person, face-to-face programs would resume. This type of challenge was significant for all organisations delivering family violence services and prompted a range of innovative and pragmatic responses aimed at reducing service disruption.

Thorne Harbour Health's experience of the HIV/AIDS pandemic meant that it was familiar with the fear and uncertainty arising due to COVID-19 and understood the need for community connection.

With staff and many clients confined to their homes, a big question that Thorne Harbour Health faced was how it would continue to provide family violence services to LGBTIQ+ people in Melbourne and across Victoria who needed them. In answering this question, Thorne Harbour Health entered a new age of technology-driven flexible service delivery. Through swift decision-making, the organisation "turned on a dime", as one staff member said, shifting its family violence program to a remote system rather than suspend services.

Like in other organisations, telehealth quickly became "the norm" (40:4) at Thorne Harbour Health. Technology-driven flexible practice that might have otherwise taken 10 years to integrate into a family violence service model became standard. In this and following chapters, we consider telehealth to be

a broad range of practices delivered through technology. Our use of telehealth refers to any kind of service-related communication that takes place over video (such as Zoom or Webex), telephone call, SMS (text message) or any other instant-messaging platform.

This chapter explores Thorne Harbour Health's response to the COVID-19 pandemic and its impacts on family violence service provision. Drawing on 14 interviews with service managers, practitioners and other staff members, we describe how services were adapted rapidly, what ethical and practical considerations informed these adaptations and how changes were communicated to staff.

4.1 Peer-led service innovation during COVID-19

When COVID-19 cases rose and physical-distancing regulations were introduced in Victoria, service managers at Thorne Harbour sensed the need to move quickly to support clients and staff. Putting everything on hold at a time when victim survivors were perhaps at more risk than ever was not something Thorne Harbour Health considered an option.

Before COVID-19, technology was not widely used to provide support to LGBTIQ+ people in family violence situations. Adapting family violence services for remote delivery was a new way of managing safety for both clients and staff. To move quickly and prevent disruption, Thorne Harbour Health needed to confront barriers to change, deal with risk and embrace uncertainty. This section explores the organisation's shift towards flexible, technology-driven practice with reference to its history as a community-controlled service, its ethical concerns and its logistical challenges.

4.1.1 Organisational memory as a foundation for action

Thorne Harbour Health was founded in the 1980s as the Victorian AIDS Action Committee, in response to another health emergency: the HIV/AIDS crisis. Peers led the organisation's response to that pandemic from the outset. A staff member described their memories of the organisation during the 1990s, recalling:

> *A lot of people were dying at the time and that was a stigma … It [was] a service that was needing to strongly advocate in a very political manner and provide rather intensive support services for people that were nearing the end of their lives. (THH staff)*

As the organisation grew over the next few decades, Thorne Harbour Health's services expanded into other areas. But its ethos – to support its communities, despite the enormity of a challenge – remained. When COVID-19-related measures took effect in 2020, Thorne Harbour Health drew on its "organisational memory" of supporting its community through a crisis.

Service managers resisted suspending family violence services altogether when in-person programs were put on hold. Doing so would have been antithetical to Thorne Harbour Health's history and philosophical underpinnings. A global pandemic such as COVID-19 was another situation that demanded that an LGBTIQ+ community-controlled organisation be there for its community, staff said:

> *Our organisation was founded in responding to a pandemic, so we had an organisational knowledge and history that was instantly available to us that we could draw on to know what needed to happen in this one. Also, because we had the strong connections to our community, when people were panicking, they were looking to our organisation for information and advice and support, and we were able to respond appropriately because we've done this before. (THH staff)*

Driving that response, in terms of family violence services, was a team made up primarily (but not only) of LGBTIQ+ community members. There was an urgency to act to help fellow LGBTIQ+ people – and a burden in doing so, with some describing how "close to home" their work felt as peers. A staff member reflected on how this philosophy translated into action for family violence practitioners:

> *There's a real investment for us that goes above and beyond just being a worker … It was personal for our staff and our organisation that we continue to do this for our communities … We felt like this was what we needed to do, so we needed to find a way to do it safely and rapidly. (THH staff)*

4.1.2 Embracing service innovation, resisting inaction and 'turning on a dime'

Although much was unclear about the unfolding situation, Thorne Harbour Health service managers made quick decisions to avoid significant service delays. This involved an exploration of how services could be extended and changed to reflect the needs of clients in precarious situations prompted or exacerbated by COVID-19. Assumptions about how family violence should be delivered – many of them centred on in-person services as non-negotiable – were challenged. Thorne Harbour Health sought to test how flexible family violence services could be.

It became apparent to staff that service needed to be adapted to provide flexible care to people in their homes or, if they lived with a perpetrator, while they were out walking, using the toilet or even showering. With clients "out of view", staff sought to find new ways of reaching them:

> *The main concerns for us particularly in relation to family violence work was suddenly … how are we going to maintain monitoring and oversight over what's going on? We were extremely worried that some people might be seriously at risk because they suddenly were going to be stuck in a house with a perpetrator, whereas they might have had the ability to leave the house or stay at other places and suddenly they were going to be in lockdown. (THH staff)*

Thorne Harbour Health committed to flexible technology-driven service delivery. Video calls, text messages, phone calls and emails became essential – and highly versatile – tools in meeting the individual needs of clients in a range of situations.

Our organisation was founded in responding to a pandemic, so we had an organisational knowledge and history that was instantly available to us that we could draw on to know what needed to happen in this one.

(THH STAFF)

A staff member said this amounted to a significant practice leap forward:

> *As clinicians and leaders of services, we knew that we were pretty old-school around the ways in which we weren't using technology. We were using technology in our personal lives in ways that we probably ought to have been using them in our professional lives … so, really what the pandemic did was fast-forward all of that and what would have taken another five or 10 years got done literally in two weeks. (THH staff)*

The organisation's history inspired innovation in service delivery in flexible and client-focused ways. The relatively small size of Thorne Harbour Health also made rapid change to its family violence service model possible. The organisation employs about 130 employees, 11 of whom provide family violence-related services directly to clients. An interviewee reflected that:

> *One of the benefits of being an organisation our size is that we're able to be flexible and turn on a dime to respond to issues much more readily than a major health bureaucracy can … Sometimes in public health, the number of layers to get things signed off, it just takes a little bit longer, whereas our organisation was able to respond really quickly. (THH staff)*

4.1.3 Ethical concerns of adaptation

Thorne Harbour Health staff said the risk of inaction during COVID-19 restrictions outweighed the risk of action. But delivering LGBTIQ+ family violence services remotely – effectively from a practitioner's house to a client's house – was a complete reconfiguring of how both client and staff safety were managed. This prompted ethical questions about safe and responsible practice. Thorne Harbour Health had no blueprint to follow; few questions around the safety of technology-driven models for family violence service provision had been answered prior to the pandemic.

Thorne Harbour Health focused on the consequences of a significant practice change for clients and staff. The safety of clients – potentially in lockdown with perpetrators – was central to concerns. So, too, was the safety of staff members who would be providing counselling, delivering Men's Behaviour Change Programs and/or performing intake and assessment procedures from home.

Some staff spoke about the organisation having an "innovative edge" that put it at odds with others in the sector. Some organisations chose to suspend some services rather than shift them online. A staff member recalled a conversation they had about Men's Behaviour Change Programs in 2020, saying:

> *We kept going to [this one organisation] and others to say, "Listen, you are really being stubborn about this online bit – it's going to be a long-term thing … you're over-evaluating the risk … You're creating risk by not having groups." (THH staff)*

Service managers relied on existing principles and frameworks around their practice to guide how they adapted programs. This included ensuring that any service adaptations foregrounded the needs of victim survivors, followed a trauma-informed framework and continued to offer an advocacy platform for people to feel empowered and supported to make decisions. A staff member gave an example of the thought exercises involved:

> *That's one easy question that you can ask yourself: "OK, if we do this, does this still [make] the victim survivor central to everything that we're trying to do and achieve? Yes or no?" … "OK, so if we do this are we supporting a trauma-informed framework?" So, we could go back to the theory to help us work out the practice. (THH staff)*

4.2 A rapid shift to remote service delivery

Steps taken early in the pandemic rapidly transformed how services were delivered thereafter. At the heart of the changes was the integration of more technology into practice. This section details how staff members went from delivering services from Thorne Harbour Health's office to performing their work from their respective homes.

4.2.1 From counselling suite to Zoom room

As work-from-home orders took effect in March 2020, service managers were preparing for a switch to remote work. "I was literally driving around Melbourne to Officeworks to pick up phones and laptop stands to equip staff with the things that they needed to be able to work from home," one staff member said. The family violence team and those in associated roles were given laptop computers and mobile phones and instructed to perform their duties from home.

Zoom, a video-conferencing application, became central to the way programs and services were delivered. Much of the platform's appeal was how user-friendly it was. Thorne Harbour Health began developing guidelines for staff and clients around how to use it. Counselling, case management and group programs were adapted for online delivery. Because it was new territory for the organisation, counsellors, group facilitators and other staff members also had the ability to shape their own telehealth practices. As one staff member reflected:

> *There was no one leader. It was directors saying to managers and team leaders what's going to work and then a lot of the counsellors just took initiative, a lot of the group facilitators took initiative and said, "Hey, we can do this via Zoom" and it just kind of happened. (THH staff)*

As well as engaging in conversations and counselling sessions with clients over Zoom and telephone, Thorne Harbour Health staff members also used instant messaging and email more frequently:

> *Normally we wouldn't have done text as a therapeutic intervention back and forwards, but for clients who were suddenly in houses that weren't safe or where perpetrators were around, they weren't able to freely communicate … They could go in their room and close the door or go to the toilet or have a shower and text from there. (THH staff)*

A challenge was providing accessible services to clients who did not have the financial means or digital literacy to use communicative technology. One staff member said:

> *There was a lot of concern about clients not having access to technology. How were we going to keep in contact with clients who don't have great technology? Also, in terms of family violence, what did it mean for clients who now have less opportunity to seek and get support and were more vulnerable? (THH staff)*

In response, Thorne Harbour Health bought some clients smart devices and helped pay for their data usage. This included clients who, due to the associated impacts of COVID-19, had lost a job or housing and returned to live with perpetrators of violence.

4.2.2 How staff adapted to change

Thorne Harbour Health expanded its employee assistance program, including offering drop-in sessions and mindfulness tools. New communication channels, such as WhatsApp group chats, were introduced for staff aimed at encouraging connection and reducing isolation.

Like workers in many other sectors, Thorne Harbour Health staff found work-from-home orders both surprising and challenging. An accompanying rapid shift in practice felt, for some, like "jumping in the deep end". The enforced changes represented a marked shift in attitudes towards working from home. Prior to the pandemic, some staff members said, family violence service work was not considered something that employees should do from home. One staff member said (about a role they had worked in prior to Thorne Harbour Health):

> *Pre-pandemic there was a real anxiety about having staff work from home and being able to sight them. Of course, that's all gone out the window. (THH staff)*

Despite video-calling platforms being popular in households for various kinds of family and social interaction prior to COVID-19 (41), there was a reluctance in the family violence sector to use them as a means of counselling clients. As a statewide service, Thorne Harbour Health had sometimes supported clients in regional areas over the phone. Occasionally, a practitioner had travelled to see them face to face. Mostly, though, clients were expected to attend Thorne Harbour Health's main office in Melbourne. A staff member reflected on the relatively rigid work practices that had preceded the pandemic, saying:

> *Our service wasn't very adaptable before COVID. The expectation, really, was that people would come into the office, unless it was under extreme circumstances, like they lived really remotely. Occasional phone counselling was the only remote option. There was no discussion or thought around video work. (THH staff)*

A shift to video-based counselling sessions was something some staff had given thought to prior to the pandemic. One Thorne Harbour counsellor, an advocate of technology-integrated practice, said:

> *I used to hear that a lot – that Zoom or Skype are not as good as face-to-face, in-person sessions … I didn't really agree with that because when there is comfort, then why not? I love technology and believe we should be using it more … I've been seeing private clients via Zoom and Skype, so it wasn't a big deal for me at the start, but of course, it was a very quick shift that we had to make … COVID pushed us into the future within a week. (THH staff)*

Our service wasn't very adaptable before COVID. The expectation, really, was that people would come into the office, unless it was under extreme circumstances, like they lived really remotely.

(THH STAFF)

4.2.3 Service design

Improvisation was driving much of Thorne Harbour Health's telehealth model adaptation. Practice was redesigned – swiftly – with the purpose of offering safe service options. Managers, team leaders and practitioners alike were adapting their programs and sessions as they went. One staff member said:

> *There weren't procedures or practice frameworks or guidelines – we were just kind of winging it. There were new things to adapt to, like how we do confidentiality when we're working from home, and how we ensure clients' privacy. (THH staff)*

We discuss these practice changes in more depth in Chapter Six.

By the second half of 2020, Thorne Harbour Health's telehealth model was firmly entrenched. Practice documents had been rewritten, staff needs managed and many ethical, practice and practical dilemmas resolved. In response to a second wave of the COVID-19 virus in Melbourne, the state government enforced another lockdown in July 2020 that lasted 111 days. "As we went in and out of lockdown the level of anxiety went up," a staff member said. "But it was at least familiar, so we just had to follow the principles that we had in place."

A shift to providing telehealth services, particularly counselling, was necessary in terms of continuity during times of remote work. But even early in the pandemic, this shift also appeared to be something that would provide more service options in the long-term. "I see a lot of benefit for our clients in giving them the choice about how they choose to engage with us and that's in line with the ways in which we try and run our services," a staff member said.

4.3 Changes in service delivery

In this section, we provide a preliminary discussion of changes to service delivery at Thorne Harbour Health in three main ways: first, in terms of intake and assessment; second, with reference to counselling provided on Zoom; and third, in relation to ReVisioning, Thorne Harbour Health's Men's Behaviour Change Program. This lays the ground for deeper discussion in Chapters Five and Six about how clients and staff members experienced change.

4.3.1 Intake, assessment and crisis brokerage

When prospective family violence clients present or are referred to Thorne Harbour Health, they are engaged in an intake and assessment process. Intakes consist of collecting demographic information and details of a client's situation, understanding their presenting issues and undertaking risk assessments as needed. Staff are guided by the Multi-Agency Risk Assessment and Management (MARAM) framework, a tool for services to help identify, assess and manage family violence risk (42). Clients are then referred onto specific family violence services at Thorne Harbour Health, such as counselling and/or case management, or to another organisation offering specialist support (for example, housing or child and family services).

Prior to the pandemic, an intake usually took place over the telephone. A face-to-face, in-person assessment at Thorne Harbour Health's main office would then follow. Before the pandemic, in-person assessments provided practitioners an opportunity to build rapport, learn more about the client and observe their presentation, which might include noticing signs of physical injury. An assessment provided a space of safety where client needs were prioritised. With the onset of COVID-19 and its associated impacts, most intake and assessment became part of the remote model, meaning staff evaluated clients' situations and needs over the phone from home. Thorne Harbour had some limited ability to see clients face-to-face in exceptional circumstances, as a staff member described:

> *We still always held in our back pocket that if there was a dire need … that we would see them face to face. Once again, it was coming back to that sort of regulatory juggling – our duty of care around providing a safe workplace for people and managing the health risks, managing the risks to clients. (THH staff)*

An additional challenge was that Thorne Harbour Health relocated its main office from St Kilda Road, Melbourne, to Hoddle Street, Abbotsford in 2020. "We went through this really complex situation where the pandemic slowed down the construction of 200 Hoddle Street," a staff member said. "Our lease expired … so there was no physical building for us to go to."

Later in the pandemic, once the Hoddle Street office opened, some exemptions were granted for clients to be seen onsite. One staff member recalled:

> *If their needs were to meet face to face in the reduced restriction period, we were able to offer face to face in a kind of makeshift tent out the back of Hoddle Street, so it did enable people to come and meet face to face with us. But that hasn't been my experience of people's needs yet. (THH staff)*

Family brokerage was also conducted by way of telephone and email. Brokerage includes flexible support packages, crisis brokerage and perpetrator brokerage. A large part of the brokerage administration work is buying food and clothes vouchers, conducting personal safety audits and helping with housing stability and rent payments. Crisis brokerage can pay for several days' accommodation for someone fleeing violence, for example.

Flexible support packages provide financial help to LGBTIQ+ people "seeking to leave or who have recently left abusive relationships" (32:2). They can cover expenses such as food, clothing, security alarms, mobile phones, some medical costs and housing (43).

4.3.2 Telehealth counselling and case management

Counselling is a central part of Thorne Harbour Health's therapeutic services, including for clients who have experienced family violence. Although some of the organisation's clinics remained open during the pandemic, the difficulties of providing face-to-face counselling in periods of severe

Post-Royal Commission, the landscape around working with perpetrators has improved greatly, so we've been able to solidify pathways.

(THH STAFF)

COVID-19 restrictions made telehealth the most viable option.

> *In terms of therapeutic services, most of what we do is face-to-face support counselling and doing that with masks on is really difficult. So, in lots of ways, actually, Zoom is preferable to sitting in a room with masks. (THH staff)*

Counselling sessions were moved from therapeutic spaces at Thorne Harbour Health's main office to private, password-protected virtual rooms on Zoom. Much counselling was delivered this way from March 2020 until late 2021, a period in which Melbourne was placed into lockdown six times (44).

Typically, Zoom counselling sessions involve one family violence practitioner, working from home, and a client, "zooming in" from a safe enough space, usually their place of residence. Emulating a face-to-face counselling session, the counsellor and client use the audio and video features of Zoom to converse for about an hour. Clients generally receive up to 12 sessions. Due to the speed of the switch to telehealth, few lengthy interruptions in service were experienced during the transition from face-to-face to Zoom, though waiting lists for counselling grew significantly longer throughout 2020-21. This increase in demand is discussed further in Chapter Five.

As the reality of work-from-home requirements and subsequent lockdowns set in, some clients took a break from their programs at Thorne Harbour Health rather than engage via Zoom. It soon became clear, however, that the COVID-19 situation was not a temporary one. A staff member recalled how clients increasingly accepted telehealth as the "new normal":

> *When it became obvious within about two weeks that we're not going back to the office in another four weeks' time, we started to see this really profound shift for people and a real change in the way people were engaging. (THH staff)*

As more people took up technology-driven options, it became apparent that telehealth had some advantages over in-person services.

> *I would say that engagement increased and there were no longer barriers like public transport to getting to an appointment, so it was easier. (THH staff)*

We discuss advantages and disadvantages of technology-driven services in more depth in Chapters Five and Six.

Case management involves identifying goals with clients and working towards reaching them. Goals focus on things such as housing, health, mental health and safety. Case management also includes risk assessment, safety planning and interaction with other services. As one staff member said:

> *There's more work in case management that might not be directly with the client, as opposed to counselling which is very much the space that you have with the client. (THH staff)*

4.3.3 ReVisioning: Men's behaviour change

Another Thorne Harbour Health program that shifted online early in the pandemic was ReVisioning, founded in 2004 as the first Men's Behaviour Change Program with a GBTQ focus and framework in Victoria. The program is for cisgender or transmasculine gay, bisexual and queer men who have used family violence in a relationship (45).

ReVisioning is a 20-session model that aligns with Family Safety Victoria Men's Behaviour Change Minimum Standards (2017). The program holds perpetrators accountable for their use of violence, while prioritising the safety of partners, children and other victim survivors (45). Participants are not considered the primary clients of Thorne Harbour Health – the victim survivors are – meaning the program is about partner advocacy not participant therapy (45). GBTQ men can self-refer to the program, while other participants attend after a referral from the justice system or a health professional (45).

ReVisioning was fully funded following the release of the Royal Commission findings in 2016. This has enabled Thorne Harbour Health to offer ReVisioning on a consistent basis, in conjunction with improved pathways and referrals. One staff member said:

> *Post-Royal Commission, the landscape around working with perpetrators has improved greatly, so we've been able to solidify pathways. It's meant … we're able to offer participants case management and some limited brokerage in order to attend. (THH staff)*

When COVID-19 restrictions were introduced, ReVisioning facilitators believed that suspending the program might have harmful effects on victim survivors:

> *A lot of Men's Behaviour Change Programs were put on pause during that period of time, and a couple of things really made us move forward on this. One was our history of working in a pandemic in the HIV crisis – you don't get a choice to stop. You have to do something, and you have to find a way of doing it because that's what's needed. We knew there was a need, so we were compelled to find a solution. (THH staff)*

While staff members were rightfully concerned about the possible harm that hastily adapted services might have, this reflection from a ReVisioning facilitator demonstrates another considerable threat to safety: inaction. Doing nothing, the interviewee said, would likely be "more dangerous than [doing] something". They reflected:

> *It was a very hard thing to hold: Is it morally or ethically right not to have any kind of contact with the men [in the ReVisioning program] … At the time, none of our participants were living with their partners or their ex-partners … and there were no children involved. We made the decision that we needed to do something rather than nothing. (THH staff)*

The challenges of trying to contact each participant individually on a

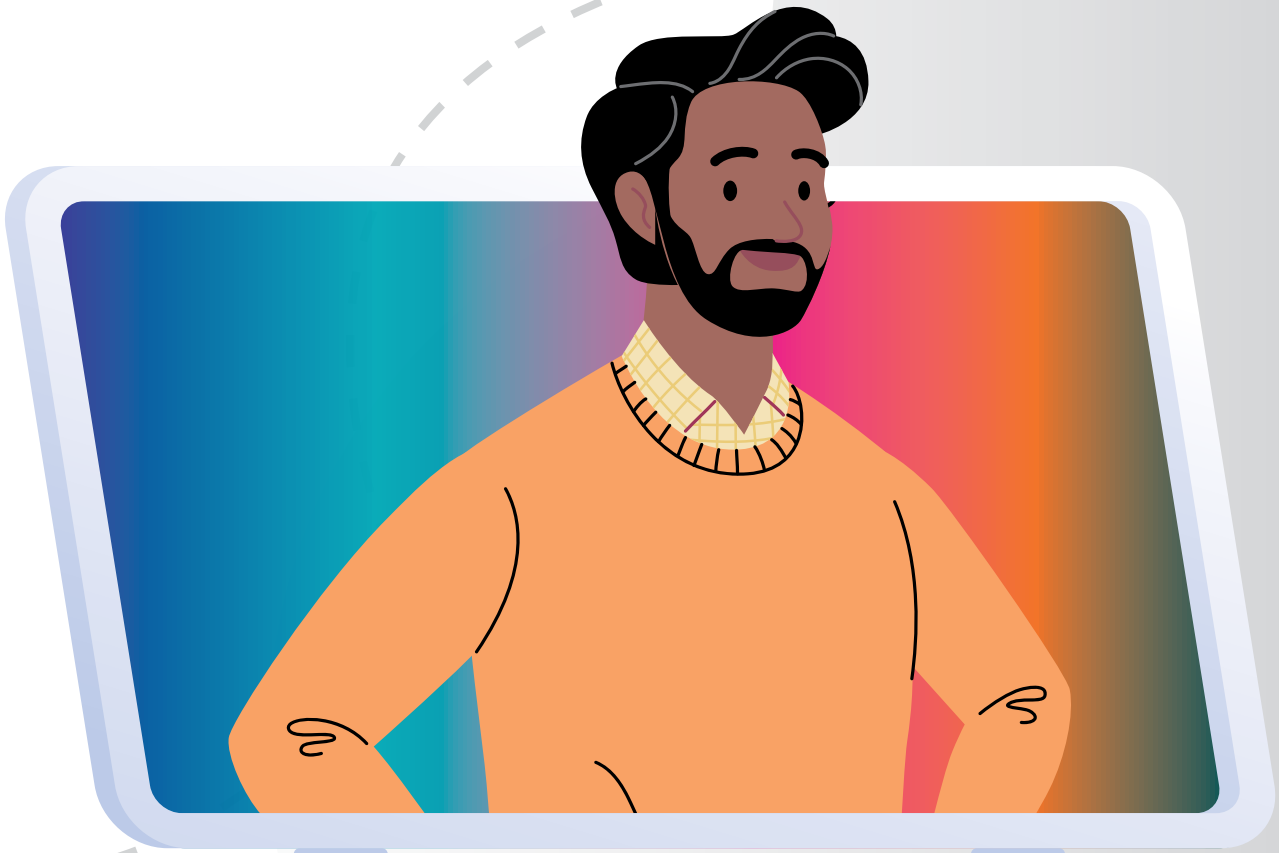
weekly basis with limited staff quickly proved unsustainable. This was a contributing factor to Thorne Harbour Health adapting ReVisioning for Zoom, which challenged guidelines around the importance of such group programs being delivered only in person. Staff said ReVisioning soon became sector leading by being the first program to adapt the model to operate virtually, while maintaining all principles of victim/survivor safety and perpetrator accountability. We discuss ReVisioning's online adaptation in more depth in Chapter Five.

4.4 Summary

Sensing the significant risk of suspending family violence services, Thorne Harbour Health responded swiftly when work-from-home and stay-at-home orders were issued in March 2020. An innovative edge and an LGBTIQ+ community-focused organisational ethos emboldened Thorne Harbour Health to implement more flexible services. Driving this was a commitment to the safety and wellbeing of victim survivors. The organisation made decisions, guided by a trauma-informed framework, that sought to prioritise clients and their best interests. Technology provided the infrastructure for this innovation.

Thorne Harbour Health staff interviewed for this study – most of them LGBTIQ+ community members – helped to rapidly transform the way in which family violence services were provided. The organisation embedded technology into its service model to ensure client engagement and continuity of care. Thorne Harbour Health's willingness to innovate and its relatively small size allowed its family violence team to offer more flexible services through video call, text message and email, in ways that responded to client safety and needs. Zoom was adopted for both one-to-one counselling sessions and ReVisioning. This was a courageous move, one that limited interruptions to services and programs for existing clients. It also challenged assumptions around how family violence services should be delivered.

Change catapulted Thorne Harbour into a new age of LGBTIQ+ family violence service delivery. In a matter of weeks, practical and ethical barriers to video-based family violence service provision had been explored, challenged and broken down. Internal practice guidelines were rewritten. These guidelines – though continuing to evolve – were crucial for staff members as Melbourne went in and out of lockdown in 2020-21 and demand for LGBTIQ+ family violence services increased. The rapid transformation of family violence services at Thorne Harbour Health sets the scene for the next two chapters in which both the experiences of clients accessing services (Chapter Five) and the impact on staff delivering them (Chapter Six) are explored.



5. Zooming in from home: Thorne Harbour Health client engagement and experience during the pandemic

Changes to Thorne Harbour Health's family violence services in response to COVID-19 and associated restrictions significantly impacted how clients engaged with the organisation. This chapter foregrounds the experiences of 15 victim survivors and four ReVisioning participants who accessed Thorne Harbour Health's family violence programs during the pandemic. We also draw on some interviews with Thorne Harbour Health staff members to consider in more detail how COVID-19 changed client engagement and the extent to which increased demand was met.

5.1 Technology challenges, accessibility and convenience

In this section, we consider pandemic-related challenges clients faced while Thorne Harbour Health adapted its programs. We also explore how flexible options, facilitated by technology, made family violence services more accessible and convenient for some clients.

5.1.1 Service engagement barriers and referrals during a pandemic

COVID-19 and physical-distancing requirements changed how LGBTIQ+ people could access support services. Work-from-home arrangements meant many in-person services in the wider

family violence and mental health sectors were suspended. For some LGBTIQ+ people living with perpetrators, this no doubt meant service interruptions or the inability to connect with services at all. The voices of clients who did receive support from Thorne Harbour Health for family violence situations give some indication as to the difficulty of accessing an LGBTIQ+ family violence service during 2020-21.

Even for LGBTIQ+ people not living with perpetrators during lockdowns, connecting with services was often challenging. More than half of the 14 victim survivors interviewed first accessed Thorne Harbour Health's services during the pandemic. Several did so by way of referral from The Orange Door, a service set up by the Victorian government in response to the Royal Commission (46). FSV has rolled out The Orange Door across the state, providing a service that offers crisis support, risk and needs assessment, and safety planning (47).

Other participants came to Thorne Harbour Health through Victoria Police's Victims of Crime, Switchboard Victoria's Rainbow Door, 24-hour support service Safe Steps, a tertiary student support officer or through the Melbourne Magistrates' Court. Some found Thorne Harbour Health's family violence services themselves, including one who was

already accessing Equinox, a trans and gender diverse and non-binary health service at the organisation.

Pathways to Thorne Harbour Health were often tortuous for participants. Systems and services set up to help victim survivors sometimes became barriers to LGBTIQ+ people finding support. Clients spoke of mixed experiences dealing with police and emergency services, with one saying:

> *Some triple-zero calls I've had have been absolutely shocking. By the time I get through all the questions, I would be dead. And then the last triple-zero call I had two days ago was fantastic. Straight to the point. Wonderful. So, it depends on who you get. Some police are horrible, and some are just absolutely gorgeous. (Victim survivor)*

Another client spoke of dealing with multiple mainstream health services that were not aware of the services that Thorne Harbour Health provided:

> *I've been dealing with family violence since … 2019. It was well over a year before I even heard of [Thorne Harbour Health] … So, there are lots of services that are not aware of the other services that exist, or they won't be quite sure of what other services can service people in certain areas. (Victim survivor)*

Some clients said they accessed Thorne Harbour Health only because they had been "lucky" enough to encounter a dedicated professional elsewhere who was aware that the organisation existed. One participant described this with reference to someone who worked at a court:

> *The LGBT family violence court practitioner put me in touch with Thorne Harbour … I felt so lucky. That was like a specific LGBTQI person. I just felt so relieved. Because I didn't want to be dealing with someone that predominantly deals with men who battered women … The way that they would find people is they'd go through and look who was filing for intervention orders. Like two names that were of the same sex … They had to find it themselves, I guess … That was a lifesaver. I don't know how I would have gotten through it if I hadn't had that initial contact with the family violence practitioner. (Victim survivor)*

The above account is part of a recurring theme of participants not realising what support services existed for LGBTIQ+ people before – eventually – being connected with Thorne Harbour Health. Another participant said:

> *Even being part of the queer community … I didn't know that there was any sort of support services … It's opened a door to quite a number of different services and people and places like queer doctors. It's a whole new world. (Victim survivor)*

Clients spoke at length of the importance of being able to access LGBTIQ+-specific services. For some, experiences dealing with Thorne Harbour Health after a family violence incident reinforced just how important LGBTIQ+ services were, especially as mainstream counselling services began being overwhelmed due to the pandemic.

5.1.2 The stress of lockdowns

Thorne Harbour Health introduced technology-driven flexible options in response to a developing public health emergency. For that reason, client experiences of an adapted family violence services model cannot be considered independent of the backdrop to which it was set. That backdrop was Melbourne, and the wider state of Victoria, under the pressure of soaring COVID-19 cases and associated deaths, social isolation, radical changes to work practices and six lockdowns. Telehealth experiences during 2020-21, therefore, are inextricably pandemic experiences.

It is important, then, to consider some of the challenges of COVID-19 (and social-distancing measures introduced to reduce its spread) relevant to clients who engaged with Thorne Harbour Health's new flexible service model. Concerns for clients related not just to situations of family violence, but also to restricted movement, financial stress, housing insecurity, mental health, social isolation and AOD use. The following client quotations capture some of the pandemic's impact on LGBTIQ+ community members' wellbeing:

Even being part of the queer community … I didn't know that there was any sort of support services … It's opened a door to quite a number of different services and people and places like queer doctors. It's a whole new world.

(VICTIM SURVIVOR)

The first lockdown was fun, because there was that air of excitement … by the sixth lockdown, I was like, "Fuck this." I was like, very, very, very, very over it and very depressed. Everyone was, I guess. (Victim survivor)

In terms of depression in the pandemic I think that … the country itself somehow showed a real lack of compassion for people in need and I think that was really evident. (Victim survivor)

Some Thorne Harbour Health staff members spoke of the pandemic exacerbating pre-existing issues for clients. Family violence situations were "put into overdrive". Demand for Thorne Harbour Health's services fluctuated as Melbourne and other parts of Victoria went in and out of lockdown and/or government social support funding changed. Staff members said:

Every time we opened up [after a lockdown], family violence demand would go really high and then every time we went into lockdown, it would drop again. It says that people feel like when they're 24/7 with their perpetrator and there's no demands taking them outside of the house, it's not safe to contact services. They're not wanting to rock the boat. (THH staff)

It was when we went into that really hard lockdown in August [2020] … people's tolerances, people's experiences of violence were changing and … that's where we saw a big increase and we received additional funding throughout that period and top-ups in our brokerage. (THH staff)

5.1.3 Considerations of comfort and accessibility

As uncertainty reigned and services across the board faced high demand, Thorne Harbour Health's flexible service model offered more options for many LGBTIQ+ people experiencing family violence. Access increased for some people with a disability, those living in regional or rural Victoria and clients for whom travelling to Thorne Harbour Health posed concerns. We explore client experiences in these contexts now.

In terms of accessibility for those with a disability, telehealth eliminated the excess time, discomfort and stress associated with travelling to in-person, face-to-face appointments. One participant, who spoke of living with a disability, described the obstacles someone in their position might face travelling to Thorne Harbour Health's office:

I have very limited mobility. So, travelling is difficult … I would have to take the tram from my house. And I would have to walk to the train station … and then there's getting to the place from the train station. (Victim survivor)

Staff said such client experiences have since helped to inform Thorne Harbour Health as it has worked to create a disability action plan that incorporates a range of adaptations and service opportunities to remove barriers for people living with disabilities.

Accessibility also improved significantly for people living outside Melbourne. One staff member said non-metropolitan-based clients had been marginalised, if not excluded, from services prior to COVID-19:

Probably the bulk of our clients [before the pandemic] would be people living in Melbourne or people who are highly resourced and highly motivated to get support for themselves, so there was a whole cohort of folks who perhaps wanted to access service but couldn't because they couldn't spare the time to come to Melbourne and/or didn't have the capacity. (THH staff)

The ability to provide more support to people in regional and rural areas, beyond a basic telephone service, allowed Thorne Harbour Health to be the statewide provider it claimed to be. Expanding to include more clients in places like Mildura, Gippsland, Geelong, Warrnambool and Shepparton was something staff appreciated. "It really used to bother me because we are a state-wide service, and we were only focusing on Melbourne," one staff member said.

For one client interviewed, technology-driven flexible services made access possible during a particularly challenging period of the pandemic. They described:

With the mental state that I was in, I don't know if I would have had that motivation [to drive to Melbourne]. Even though things are really bad. And I knew it was helpful for me. But to be driving an hour and a half to two hours into the city – it would have been a full day, basically. (Victim survivor)

This was the case for other clients, too, as one staff member reflected:

Someone – it was Murray somewhere – said, "I saw your counselling service … because you're online I can access it." So, in terms of regional access, it's been absolutely fantastic for getting people connected. (THH staff)

Technology also helped improve accessibly for clients who had concerns about travelling from their homes to Thorne Harbour Health's office – an important factor as COVID-19 cases increased. Several participants felt anxious entering new places and felt more in control of their environment and service engagement when online. Others had concerns about a perpetrator knowing they were accessing Thorne Harbour Health's services. One said:

It was a lot of psychological manipulation … They knew where I was, why I was going here, and it was very anxiety-inducing … So, for me, the idea of going somewhere where I'd never been before, a waiting room – it was just not something that I was particularly comfortable with. (Victim survivor)

5.1.4 Losing in-person contact but gaining convenience

While greater accessibility may have made Thorne Harbour Health's family violence services more equitable, many clients also benefited from a model that made accessing services more convenient. Many participants spoke about the advantages of Zoom-based counselling in terms of convenience. It is worth making a slight differentiation

between convenience and access, while recognising both as benefits of a flexible model. Improved access addresses crucial barriers to service engagement, whereas increased convenience creates a better and more positive experience of engagement. Both are important and, in some cases, might overlap.

Participants talked about the convenience of being able to book Zoom sessions around their work schedules. Without travel time, a one-hour appointment was literally that: clients could finish an online work meeting or university tutorial at 12pm, be in a Zoom session two minutes later and be ready to resume work at 1pm. As two described:

> *If I had to compare the online experience … access improved because things are a bit more flexible. I didn't need to travel across the city … I hate doing public transport. So, in terms of flexibility and accessibility, for me as a rather sort of privileged person with good technology, that was really good. (Victim survivor)*

> *It is convenient. You don't have to leave the house. You don't have to get fully dressed. There have been advantages of doing everything online. I think it's just the lack of human contact. (Victim survivor)*

That final line – about the lack of human contact – is telling. It underscores the trade-off some participants felt was a feature of engaging in online counselling. The convenience of Zoom made it easier to attend a counselling session, but not everything about the in-person counselling experience could be replicated in the session itself. During a pandemic, however, the convenience took precedence. One participant reflected that:

> *There was one part of it where I would love to have met my counsellor face to face because she was a really lovely person, but on the other side of it, workwise, it was actually better for me to have it on Zoom because I work from home, so it was just easy for me to take time out and do a Zoom call. (Victim survivor)*

The extent to which a telehealth experience was able to be convenient depended also on the safety of a client's home environment, including whether they were living with a perpetrator. We discuss safety in the next section.

5.2 Remote services: Safety, effectiveness and limitations

While a remote service model helped bridge gaps between clients and Thorne Harbour Health, Zoom-based services were not a straightforward substitute for face-to-face programs. In this section, we consider safety concerns that Zoom presented, its perceived effectiveness and limitations and the extent to which client needs were met remotely.

5.2.1 Safe access from home

Staff said most Thorne Harbour Health family violence clients were not living with a perpetrator when receiving counselling support. Clients interviewed were generally able to access programs and services from their homes during 2020-21. Many participants lived in secure housing. Others, however, were in more precarious situations and were concerned about an abuser entering and/or causing them harm in their home.

For victim survivors dealing with an abuser in their home, services they could access seemed limited. One client, who was receiving case management support while on a waiting list for counselling, said Zoom sessions would be difficult in their situation:

> *He wouldn't allow it. He'd be shouting. I can lock myself in my room, but he would come and pound on the door. (Victim survivor)*

Even in situations where clients trusted housemates and family members with whom they lived, achieving privacy when accessing a telehealth service was sometimes challenging. As this client described:

> *I was living with family, so it [home] was safe in that regard. By the same token, you can't share everything with your family. Knowing that they are another wall or two over, it's a different environment than being in a professional setting. (Victim survivor)*

Homelessness and unstable housing also created challenges. One client said they found it difficult to access a full range of services from Thorne Harbour Health due to their housing situation:

> *Safety was my number-one priority. I had to move residence four times. One of the challenges I had with Thorne Harbour, when they finally reached out, was that they said they could not assign me a case manager or a support package because I could not provide them an address. My service was limited to counselling. I find that very disappointing. That the service does not recognise the safety concern in that regards. (Victim survivor)*

Being such a new format meant that some clients were concerned about the digital security of Zoom counselling sessions. This was expressed in two main ways: first, in relation to a private company's access to the data transferred between a client and a practitioner:

> *Look, [Zoom is] a third-party, American company, and we have no guarantee of what any tech company actually does with our data. We just do not know. (Victim survivor)*

Second, concerns were raised about perpetrators hacking into a victim survivor's accounts and surveilling their online activity:

> *There was one point during the pandemic, where I believed that my ex-partner had gotten access to everything… My family violence was very technology based. At one point, I didn't feel safe using Zoom … I didn't understand that this level of abuse was even a thing until what happened to me … I found it quite shocking. (Victim survivor)*

Generally, however, most clients said they were satisfied with Thorne Harbour Health's telehealth services in terms of privacy and safety.

5.2.2 Perceived effectiveness and limitations of Zoom counselling

Due to the variety of Thorne Harbour Health's services, client experiences of telehealth varied. Clients, therefore,

I live in a share house, so this is where I sleep, live and work. Now I'm doing therapy in this space, too. It's a lot harder to separate the different aspects of your life. And you also don't get to leave it afterwards.

(VICTIM SURVIVOR)

had different opinions on how effective remote services were compared with in-person, face-to-face services. The effectiveness of flexible service was most frequently talked about in terms of Zoom-based counselling and the differences between, and similarities to, counselling that took place in a private room at Thorne Harbour Health. Some participants preferred the Zoom format, while others found it limiting and an incomplete replication of in-person counselling. At the very least, all participants who experienced Zoom counselling considered it better than services being suspended.

One challenge of video-based counselling, especially early in the pandemic, was technical issues. Some clients used older computers or mobile phones, had limited digital literacy and/or poor internet connections. As millions of people across Australia shifted to remote work arrangements in early 2020, dropouts, lags and disconnections were commonplace. Many clients felt the impact of this and for some, technical issues remained a feature of their service engagement. Participants commented on the difficulties this presented:

> *Tech issues – especially when the Zoom would cut off because of poor internet connection – that was very, very frustrating. And that's why I sometimes do prefer in-person sessions. Because it keeps the conversation going smoothly. If I have four sessions … it's a 50/50 chance that the Zoom will crash. Especially depending on location. I will have to repeat what I had just said. And it's very emotionally taxing. (Victim survivor)*

> *There were occasional dropouts, which could be jarring. I have auditory processing disorder. Just talking on a computer is fine, but kind of hard. But if there is any lag, it takes five times as much work for me to process. It's harder to have the full therapeutic experience when you're trying really hard to get the raw information that you're being given. We did handle some dropouts with a phone call. And that was a fine compromise. But I do prefer face to face. (Victim survivor)*

Even when the technology worked, some participants believed Zoom compromised the quality of a counselling session. This was explained with reference to the physical space of a counselling room and being in close proximity to a counsellor:

> *The other thing is the therapeutic nature to a place. Even if I hate crossing the city, I'm going to therapy, and I'm in a therapy space, and I'm with my counsellor, and I'm safe. And there is a relationship to the space … I live in a share house, so this is where I sleep, live and work. Now I'm doing therapy in this space, too. It's a lot harder to separate the different aspects of your life. And you also don't get to leave it afterwards. (Victim survivor)*

> *Having a video conversation is not the best. I was able to see the [Thorne Harbour] counsellor face to face in the third or fourth session. It was the first time I was able to cry. [Why?] Number one: It was a location where I felt safe. In a private room, not at home … It's an environment where it's you and your counsellor. You build trust and it's about that human connection. It's a safe environment that encourages opening up and being vulnerable. (Victim survivor)*

One client suggested that counselling should have been triaged as an emergency service during the pandemic and allowed to take place in person. Generally, however, client participants felt that video-based counselling was effective under the circumstances and expected that it had a future as part of a hybrid service model (which is discussed more in Chapter Eight).

A number of participants preferred Zoom-based counselling over in-person counselling, but this was mainly to do with factors peripheral to the session itself. That is, clients found attending the session to be more convenient, safe and accessible (factors discussed earlier):

> *I prefer Zoom, or online, just because it's convenient. And I'm one of the people who even before the pandemic, didn't know why we weren't doing this all the time … There's been a couple sessions where I felt worse off immediately after the session but only because they were just bad sessions. I can't say that doing the sessions in person where I've had that trip home has let me contemplate anything. (Victim survivor)*

Clients generally considered remote services to be adequate and effective substitutes for in-person services – especially during a pandemic – though unable to entirely replicate important aspects of physical co-presence.

5.2.3 Thorne Harbour Health's ability to meet client needs

Most clients interviewed for this study believed Thorne Harbour Health met their needs during COVID-19. Technology contributed to this but so, too, did other factors. The first worth highlighting is the professionalism and commitment of practitioners, counsellors, program facilitators and other workers that clients dealt with directly. Clients often described counsellors as flexible, caring, helpful and intelligent. Some participants said services they had received from Thorne Harbour Health during the pandemic were life-changing – and even lifesaving:

> *Because of them [counsellors at Thorne Harbour and support elsewhere], I kept a little bit of courage. I was thinking of suicide and all those things. I said, "No, I can't do that, because these people are working on me so hard – they*

care about me, they want me to come back to the previous life." So, that's why I just made myself stronger. There was some up and down in between – because it's not easy. (Victim survivor)

Before I went to Thorne Harbour, I was a broken person. I was having so much suicidal ideation. I didn't see why my life was worth it … It's been about being validated as a person … I wasn't validated by my family, or my community, or my country. I was worse than an animal. So, Thorne Harbour validated me as a person with values. It gave me back my pride in myself knowing that I can achieve something. And I think that's so important. (Victim survivor)

Second, the extent to which Thorne Harbour Health was culturally aware was something many clients considered crucial to their needs being met. Almost all clients spoke of the importance of accessing LGBTIQ+-friendly services, saying that being understood and accepted made them feel safe and contributed to improved wellbeing. Not having to educate staff members about LGBTIQ+ identities and issues also made for more efficient service engagement. One client said:

They really understand queer relationships. They really understand queer sexual health. They really understand whatever it is that we're dealing with. You know 100% that they do. (Victim survivor)

Some participants said the organisation's cultural, political and social awareness extended to issues of race, ethnicity, age and socioeconomic status:

It's a bit difficult to access these kinds of services in [my country of origin] because most of the health practitioners are not queer friendly. It's not illegal to be queer, but people just have this stigma towards us. (Victim survivor)

What's been done well has been specific to my counsellor. He really understands and empathises with the situation. He's a member of the LGBTIQ+ community and is a person of colour … To have someone empathise with someone accessing the service is very, very important. (Victim survivor)

The third factor to highlight is management's willingness in some cases to extend a client's counselling program if they deemed their situation severe enough. This flexibility was something some participants believed demonstrated the commitment of Thorne Harbour Health to its community. One participant described their situation, saying:

At the start, I was only meant to have 10 sessions. Thank the Lord, they allowed me to keep extending them, because what was happening was quite ongoing. It was escalating … I'm so grateful that they were willing to be flexible with me and allow me to continue the sessions until I didn't need them … I think my counsellor had to speak to a manager. And then the manager, I guess, would look at situations case by case … I feel like my needs were met. (Victim survivor)

Not all clients interviewed for this study received the support they felt they needed. Some said that Thorne Harbour Health had not approved their requests for more counselling or for faster access to services. Some clients' contact with Thorne Harbour Health began before the pandemic and was also shaped by a pre-pandemic model, while others were still awaiting services so, of course, felt their needs had not yet been met. A couple of clients said they had not received satisfactory responses from service managers to help address their situations, which they found frustrating. Some clients lamented the time it took to receive support, which we discuss in the next section.

What's been done well has been specific to my counsellor. He really understands and empathises with the situation. He's a member of the LGBTIQ+ community and is a person of colour … To have someone empathise with someone accessing the service is very, very important.

(VICTIM SURVIVOR)

5.3 Waiting lists: Surging client demand during COVID-19

A significant barrier to client needs being met were waiting lists for Thorne Harbour Health's services, which grew longer during 2020-21. An uptick in cases and demand for services, coupled with a telehealth model that made services potentially more accessible, contributed to Thorne Harbour Health's family violence services waiting list growing longer. Although many clients spoke of the effectiveness of services, some faced long waits for Zoom-based counselling, for example. This section explores the impact of waiting periods that clients often experienced between the intake and assessment process and the beginning of counselling.

5.3.1 Increase in service demand

Family violence practitioners, and associated staff members, felt the impact of increased demand for Thorne Harbour Health's services during the pandemic. As one staff member recounted:

> *There were a number of factors that increased volume … They tended to be the beginning of a lockdown – we were just inundated … particularly for family violence. (THH staff)*

For LGBTIQ+ community members seeking help, it became challenging to find suitable and culturally safe services. This was in part due to broader demand for mental health services across the community soaring as Melbourne and Victoria more widely spent long periods in lockdown. One client observed that during such times, it was difficult not only to find support, but also to find professionals who cared enough to refer people onto other services:

> *Other counselling organisations that should have been available … just didn't call back … It's that thing of, "Well, we've got all the business we need now" … It just didn't feel good. (Victim survivor)*

Another client talked about the difficulty LGBTIQ+ people faced accessing support services anyway, saying:

> *When I went through the critical incident, it was really confusing and appalling to realise what little support there was available. There are not many services for males or LGBTIQ+ males. To society, it's the male who's the perpetrator and the woman and the child who are affected. Services reflect that … I've reached out and have had services assume that I'm the perpetrator … That's hard. I wouldn't have known how to move forward in that regard without the support of Rainbow Door. (Victim survivor)*

Switchboard Victoria's Rainbow Door (featured in Chapter Seven) made referrals to Thorne Harbour Health's family violence services after the helpline launched in September 2020. An increase in demand from multiple referral pathways heaped pressure on Thorne Harbour Health, which as one staff member described, was already financially stretched when it came to delivering family violence services:

> *There's profound under-funding of specialist LGBTIQ+ family violence responses in this state. When you're looking at LGBTIQ+ people being anywhere from 5-10% of the population, we do not get 5-10% of the family violence dollars in the state of Victoria, so I think that's the beginning place … No doubt, there are people who don't get a service, or a timely service, because there's a waitlist. (THH staff)*

5.3.2 Wait times for counselling

A number of clients interviewed experienced long waits between intake and assessment and being assigned a case manager or counsellor. Waiting periods tended to last from a few weeks to several months. After experiencing violence, many clients were in severe need of support. Waiting weeks or months for counselling was extremely difficult for them. The following quotations demonstrate the distress some clients experienced between a violent incident and their first counselling session:

> *From the critical incident to reaching out to Rainbow Door was maybe a month. It was probably a month to two months before I got a Thorne Harbour counsellor assigned. Due to my mental state, that seemed like the longest time in the world … Three months might not seem like a long time. But for someone going through and dealing with family violence, it can feel like the longest time in the world. This length of waiting time might have damaged so many people in so many different ways. (Victim survivor)*

> *I was crumbling, literally trying to get to work, trying to keep my head above water … The wait time was the biggest thing. And I think that was the most dangerous period for me, and probably the time I needed support … I wasn't getting the fortnightly calls that I was promised, as a check-in. My understanding was there was a staffing issue there … [They weren't] really aware that I was at harm. Self-harm, that is. It was really disappointing, and quite traumatising … I was really in a dark pit. (Victim survivor)*

Staff said that in such situations, they tried their best to help clients through telephone check-ins and case management. Situations in which staff knew of clients' challenging circumstances and were themselves frustrated by the long waits often involved informal counselling. One participant, who was receiving case management while on the waiting list for counselling, described such a situation:

> *She's very calming and very rational … And even though she's looking at safety plans and all that, she's counselling me as well … And I know she's not supposed to be [counselling me]. (Victim survivor)*

Interviews with Thorne Harbour Health staff members also demonstrate how waiting lists expanded. "It's horrendous," said one staff member, referring to long waits for counselling. "I think that's endemic right across the service sector, unfortunately. It's a sign of COVID and the need people have."

Victim survivors in especially severe family violence situations were prioritised for support after their intakes

and assessments. Nonetheless, wait times were lengthy for many clients. One staff member said the waiting list for counselling had about 60-70 people on it, while other staff gave estimations of wait times that varied between three and six months.

Data provided by Thorne Harbour Health shows that in the six months from July to December 2019 (before the pandemic), 65 people spent an average of 13 days on Thorne Harbour Health's waiting list for family violence services. From July to December 2021, 292 people spent an average of 51 days on the waiting list. More people underwent service in the latter period: 424 from July to December 2021, compared with 309 people from July to December 2019.

Staff observed that not only were more people seeking support during the pandemic, but they were also presenting with more complex and acute needs. Some clients received support for longer periods than usual due to external service delays and postponed court hearings. This also contributed to waiting lists growing. Waiting times were concerning for staff members who were trying to find solutions:

> *The wait time for family violence can be up to about three months, and I think the concern about that is anything can happen in three months. (THH staff)*

> *Increasing wait lists does feel like an added stress and pressure. It's unpleasant to know that there's a lot of people on the wait list, especially when we didn't have one before, so that's not been an easy thing to adjust to. At Thorne Harbour Health, the general counselling team have always had a long wait list, but for the family violence team, it was new for us, so it's taken a bit of figuring out, how we manage that and how we hold risk and client safety. So, that feels like added workload and it is more emotionally taxing and stressful. (THH staff)*

Staff in various roles found ways of following up with clients on waiting lists to monitor their situation and provide some, albeit limited, interim support. This "waitlist management" often included a phone call of up to 10 minutes to ask a client for an update on their situation, to offer immediate support and to assure them that they were still on the waiting list. Some staff members were very willing to provide this support but were also concerned at the extent to which it was relied on as a solution. One said:

> *I just didn't realise that we would be holding clients for more than three months … There's quite a long period where you're the point of contact for that client … I'd always want to do the work for clients if there's a role and it's meaningful and it's going to be helpful … but it's definitely something that we have a lot of discussions about: how much we're being asked to do and how much we're sitting with – because in other intake and assessment teams there's not that obligation to hold clients for such a long period. (THH staff)*

5.3.3 Counselling disruptions

Some clients experienced service interruptions due to a change in counsellor at Thorne Harbour Health. While video-based options had improved access, staffing issues – a product of people movement and funding limitations – impacted the continuity of some clients' programs. One participant spoke about a "reset in progress" that occurred due to their first counsellor leaving the organisation and a delay in someone else taking over their case. They said:

> *That was a significant gap of many months … Having the waiting period definitely didn't help. To be totally truthful, I don't remember an awful lot about those periods because I was still in shock from the violence that happened, but it definitely wasn't nice. I don't know if it was damaging … It was a long enough period that the progress reset. With counselling, I was kind of back at square one. (Victim survivor)*

Another client described a similar situation in which they first experienced a wait for counselling then, due to their counsellor leaving Thorne Harbour Health, had to endure a second – much longer – wait for a replacement. The client said Thorne Harbour had recommended other services to access in the interim. The organisation had also provided other support at various stages. But of the initial wait, the client said:

> *That took about a month. The wait time was quite long, actually … I felt very uneasy. I was definitely at one of my lowest points. (Victim survivor)*

The client described the counselling interruption – a period of about three months in which they experienced more abuse – as:

> *Again, the worst time of my life. When [counselling] resumed, I was definitely at even lower than my lowest point, as if that was even possible … If a counsellor isn't available, I don't think that it's an excuse to leave a client waiting for so long. Somebody should just the take the initiative to step in and take over. (Victim survivor)*

These experiences demonstrate the pressure that service disruptions and long waits placed on clients. Even though Thorne Harbour quickly pivoted to a flexible model – thus, avoiding many other service delays – demand stretched the organisation beyond its capacity. This impacted on Thorne Harbour Health's ability to meet the needs of clients, at least as quickly as clients and staff members would have liked.

5.4 Technology and accountability: Reshaping ReVisioning

A feature of Thorne Harbour Health's pandemic response was the adaptation of ReVisioning, its Men's Behaviour Change Program, for a Zoom setting. ReVisioning is a 20-week program that holds participants accountable for the violence they have perpetrated, while also supporting them to change their behaviour.

Prior to the pandemic, ReVisioning sessions were held on a Tuesday night in a room at Thorne Harbour Health. Two facilitators would lead the sessions of up to 15 people, who had either been mandated by a magistrate to attend

We felt a really high level of responsibility to those partners …There wasn't any way that we were going to dilute the accountability for [participants], but there was no framework for how to do this other than in a face-to-face model.

(THH STAFF)

or had chosen to. Like Thorne Harbour Health's other family violence-related services, ReVisioning was offered to participants across Victoria, though attended primarily by GBTQ men who lived in Melbourne. In this section, we explore how Thorne Harbour Health reshaped the program and what this meant for participants.

5.4.1 Background to adaptation

Early in the pandemic, ReVisioning facilitators and service managers deemed it important to adapt the program for online delivery rather than put it on hold. Suspending ReVisioning, they believed, could have potentially harmful effects on community members. The organisation again drew upon its founding principles to make the decision to continue with ReVisioning, despite the challenges. Staff said:

> *Men's Behaviour Change is a program that was never structured to be delivered remotely. In fact, it had a very strong built-in face-to-face mandatory requirement for users of violence as part of the accountability mechanisms. You had to turn up to sessions and be in the room to show that you were on board with this whole behaviour-change concept. So, this created one of the biggest challenges for us around how we were going to manage safety for clients and hold perpetrators accountable during this period of time. (THH staff)*

> *This was a huge conflict we had within the industry and a lot of groups never transitioned to online because of this particular question and it was a huge disservice to the industry. Some people have thousands of people on the waiting list – they've spent two years in violent relationships because they just have nowhere to go. (THH staff)*

FSV worked with No to Violence (NTV), perpetrator services, Magistrates' Court of Victoria and Corrections Victoria to update the perpetrator intervention service guidelines during COVID-19. This resulted in technology-facilitated group sessions becoming part of a "multi-intervention service model" (50). FSV has indicated to authors of this report that most MBC providers transitioned to videoconferencing or telephone services during the restrictions in 2020.

For Thorne Harbour Health, adapting ReVisioning for online delivery came with a duty to prioritise the safety of participants' partners and/or former partners. It also meant ensuring that an online format did not make participants less accountable for their actions. When adapting the program for Zoom, Thorne Harbour Health staff members ensured they made more contact with partners before and after sessions and developed protocols around privacy for those participating in online sessions from home. As one staff member said:

> *We felt a really high level of responsibility to those partners … There wasn't any way that we were going to dilute the accountability for [participants], but there was no framework for how to do this other than in a face-to-face model. (THH staff)*

The facilitators were funded to do extra work to tailor the content for online sessions. This included recording videos, making PowerPoint presentations and generally trying to prepare content two weeks ahead to safeguard against additional challenges that the pandemic might present. The three facilitators delivering ReVisioning sought to engage participants in sessions as though they were still in the same room, while upholding a central tenet of the program: accountability. "We worked really hard to establish guidelines for ourselves," one facilitator said. "We had very specific establishment rules with the group." Staff said the program's principles were later adapted by other services across Victoria.

5.4.2 Accessibility, quality and safety of ReVisioning online

When ReVisioning was shifted to Zoom early in the pandemic, all participants enrolled in the program were brought together with two facilitators in a private online meeting room. To ensure new participants could join ReVisioning as the pandemic (and lockdowns) continued, the program changed to a rolling format. This meant new participants could access the program almost immediately and be surrounded by other participants who had already attended as many as 19 sessions. This not only cut waiting times and encouraged attendance, but also provided participants opportunities to learn from other men who had been in the program longer. One participant said:

> *It was a bit of a mix for me. I think it would have been more helpful if you were with the same people from start to finish … But the good part [was] that it was more accessible for people. You also saw people at the end stage of the program. And in a way, depending on how they go, I guess it could be quite inspiring to see the transformation or the key takeaways from the program itself … It kind of triggered some reflective moments with yourself to see how far you've come and how much more you have to go. (ReVisioning participant)*

Like with counselling, the Zoom format made ReVisioning more accessible to people who lived outside Melbourne and also more convenient for people who worked full-time. One client reflected on how easy it was to attend the program, saying:

One of the benefits from being able to attend the program with Thorne Harbour Health in a virtual capacity was the mitigation of stigma. As an Aboriginal man, I find it difficult accessing services because of the level of shame associated with preconceived notions of First Nations People.

(REVISIONING PARTICIPANT)

> *It actually worked really, really well. For so many reasons. You didn't have to travel. You could log in whenever. You were in more of a comfortable space. And not that I would have been uncomfortable. But I'm sure there would have been a lot of men that would have found it quite difficult to go to a venue. (ReVisioning participant)*

All four ReVisioning participants interviewed had chosen to attend the program. Others, however, were mandated to take part. Facilitators said the online format encouraged those who were less willing to attend to do so:

> *Their ability to come to sessions is that much easier now. Certainly, in terms of ReVisioning, because it's held at 6:00 on a Tuesday night, we sometimes struggled some weeks … People coming from all over Melbourne to St Kilda Road would rock in late. People suddenly didn't have the excuse, "Oh, the traffic was terrible." They just had to switch on their computer at 5.50. (THH staff)*

Participants said that ReVisioning ran well online, though some would have preferred to attend sessions in person. One participant spoke about the limitations of holding group conversations on Zoom, saying:

> *You were able to get more out of the face-to-face sessions. Because of the online Zoom etiquette that you have to adhere to, sometimes you just don't even get to talk, because you're waiting for someone else to finish. And then the moderators will start unpacking that … There were a lot of sessions where it was mostly focused on just a couple of people. And I feel like that might reduce other people's buy-in to the program. (ReVisioning participant)*

While participants generally spoke about how supportive, prepared and professional the facilitators were, one participant suggested the program could be better resourced to provide support outside the sessions themselves:

> *This is where the workload for the facilitators was probably huge. Sometimes I did notice that the facilitator might say, "Hey, I'm going to touch base with you Wednesday or Thursday, and we'll talk about what you've bought up." Then the next week, you'd get on board and the facilitator would go, "Oh, sorry, I didn't get a chance." That happened a couple of times … I think that's just being overwhelmed with work that they face, but there was sometimes a lapse in following through. (ReVisioning participant)*

A few participants talked about the Zoom format making it easier to attend in terms of the potential shame associated with going to a session in person. One said:

> *Going into that building, will someone see you or ask you questions? Will you have to explain to family members and friends why you're travelling to a particular area every Tuesday night? Rather than going, "Hey, I'm going to go watch a movie. No, I'm just going to go have some space in my bedroom, I'm going to chill out." [It's] an easier way of deflecting that until you've dealt with that shame. (ReVisioning participant)*

Another participant said that feeling accepted as a First Nations person in ReVisioning meant they would be more likely to attend another program at Thorne Harbour Health:

> *One of the benefits from being able to attend the program with Thorne Harbour Health in a virtual capacity was the mitigation of stigma. As an Aboriginal man, I find it difficult accessing services because of the level of shame associated with preconceived notions of First Nations People. Being able to attend gave me a sense of amenity; and created a space where I was still able to attend and remain accountable. Shame has played a large part in me historically accessing services … Through the program, I actually feel empowered and encouraged to seek out further help. As direct result of the supportive environment that they created, I would be far more inclined to attend physical programs/ services. (ReVisioning participant)*

These quotations demonstrate perceptions that Thorne Harbour Health shaped ReVisioning into an online program that provided accessibility, quality and safety while still foregrounding accountability, which we discuss in more detail now.

5.4.3 Accountability and online environments

Part of being accountable in ReVisioning is not only attending, but also participating constructively in, 20 sessions of the program. Beyond ensuring participants were engaging with the content, facilitators also expected them to accept responsibility for their behaviour. Even for some participants who had not been mandated to attend, this was difficult, especially early in the program:

> *It felt quite challenging and difficult, because with some of the men, it was quite obvious that the violence they*

enacted arose because of feeling wronged, or in defence of their ego. And I was pretty much in that box, where I felt like I did this violent thing to my ex because of XYZ reasons. Focusing the entire program on accountability made it challenging sometimes and harder to swallow what they were trying to give you. But what I ended up doing was to say, "I can accept that my ex did horrible things to me and, at the same time, accept that [my] violent behaviour needs to change." And that's what I'm going to focus on in this program: How do I ensure that the violent behaviour stops completely? (ReVisioning participant)

Beyond encouraging this type of accountability work, facilitators had the challenge of keeping participants engaged with the Zoom sessions. A participant not being fully focused on the session was, in effect, them avoiding accountability. So, facilitators ensured participants were alone in a room, had their cameras switched on and were not involved in other activities such as watching TV, browsing the internet or messaging someone outside the group. Participants said the facilitators were generally efficient in their handling of this:

You'd be asked to comply and be present, be actively a part of the session – they'd give you an opportunity to do that … I remember there was a gentleman came in one time and he was drunk, and he didn't want to put his camera on, so they asked him publicly and then one of the facilitators dipped out and had a side conversation. They asked him to leave for that session and come back when he was sober. (ReVisioning participant)

Another participant, however, said the Zoom format made it difficult to remain entirely focused on the program:

We were definitely not as focused and as present as we should have been, as we would have been if it was face to face. Because, occasionally, I would see some people were watching TV, because of the way the light changes. You can tell that some people are not very [focused], because often you have to grab their attention multiple times for them to realise that they're being spoken to. And for my part, I was definitely sometimes chatting, or answering emails, going through Facebook reading things. So, I wasn't completely there. But I was always keeping my ear out for whatever was happening in the group chat. (ReVisioning participant)

FSV has indicated to the authors of this report that it recognises challenges of safety and accountability when delivering MBC programs online. It has also said that No to Violence (NTV) intends to provide detailed guidance on online service delivery for perpetrators.

5.5 Summary

COVID-19, associated lockdown measures, lack of awareness of LGBTIQ+ family violence service options and indirect referral pathways made it difficult for victim survivors to access support during 2020-21. Thorne Harbour Health's technology-driven flexible options, developed in response to the pandemic, changed how clients accessed and experienced family violence services. Many participants felt Zoom-based counselling provided a largely effective alternative to in-person counselling, most of which was impossible during lockdowns in Melbourne and across Victoria.

Remote services improved access for many people seeking counselling and other support, breaking down barriers that had prevented engagement. People with disabilities, those living in rural or regional Victoria and clients with concerns about leaving their home were among those who had more access. Zoom-based counselling proved convenient for many people seeking support while working from home. Some clients felt that video calls could not replicate a counselling room in ways that allowed full emotional expression, though many considered them effective in meeting their core needs and providing continuity during COVID-19.

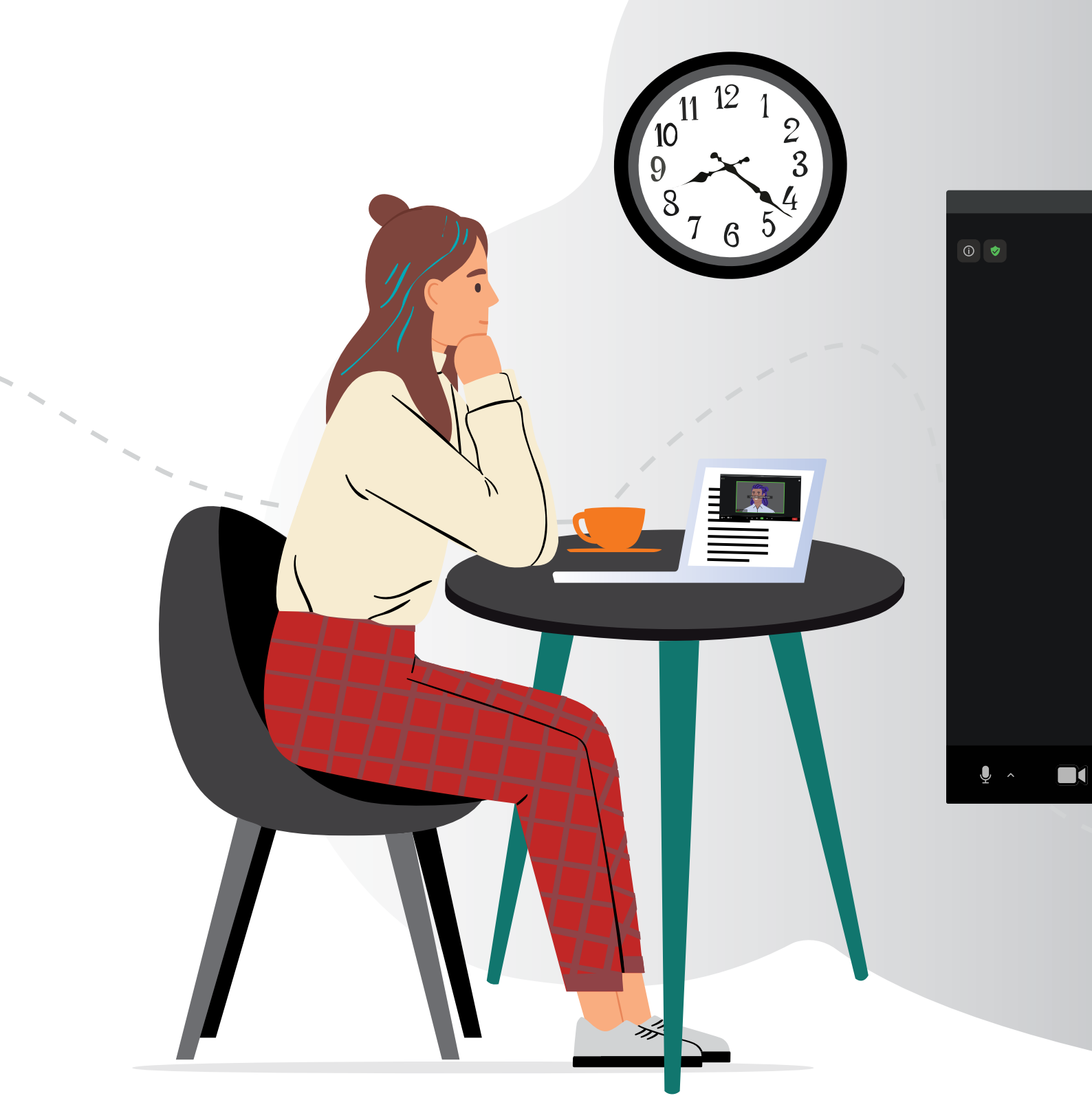
Waiting lists for counselling grew longer during lockdowns. Some clients waited months for counselling after experiencing violence and being assessed by Thorne Harbour Health staff. Waits were distressing for some clients who felt at their lowest point. Distress was compounded when counselling programs were put on hold when a counsellor left Thorne Harbour Health. Counsellors and other public-facing staff members supported clients on waiting lists as best they could but were limited in what they could do.

ReVisioning, Thorne Harbour Health's Men's Behaviour Change Program, was adapted for Zoom. Faced with the challenges of building safety and accountability into its new telehealth model, Thorne Harbour Health created a rolling online program that clients could access quickly and attend easily. Clients interviewed for this study were generally positive about the effectiveness of ReVisioning as an online program.

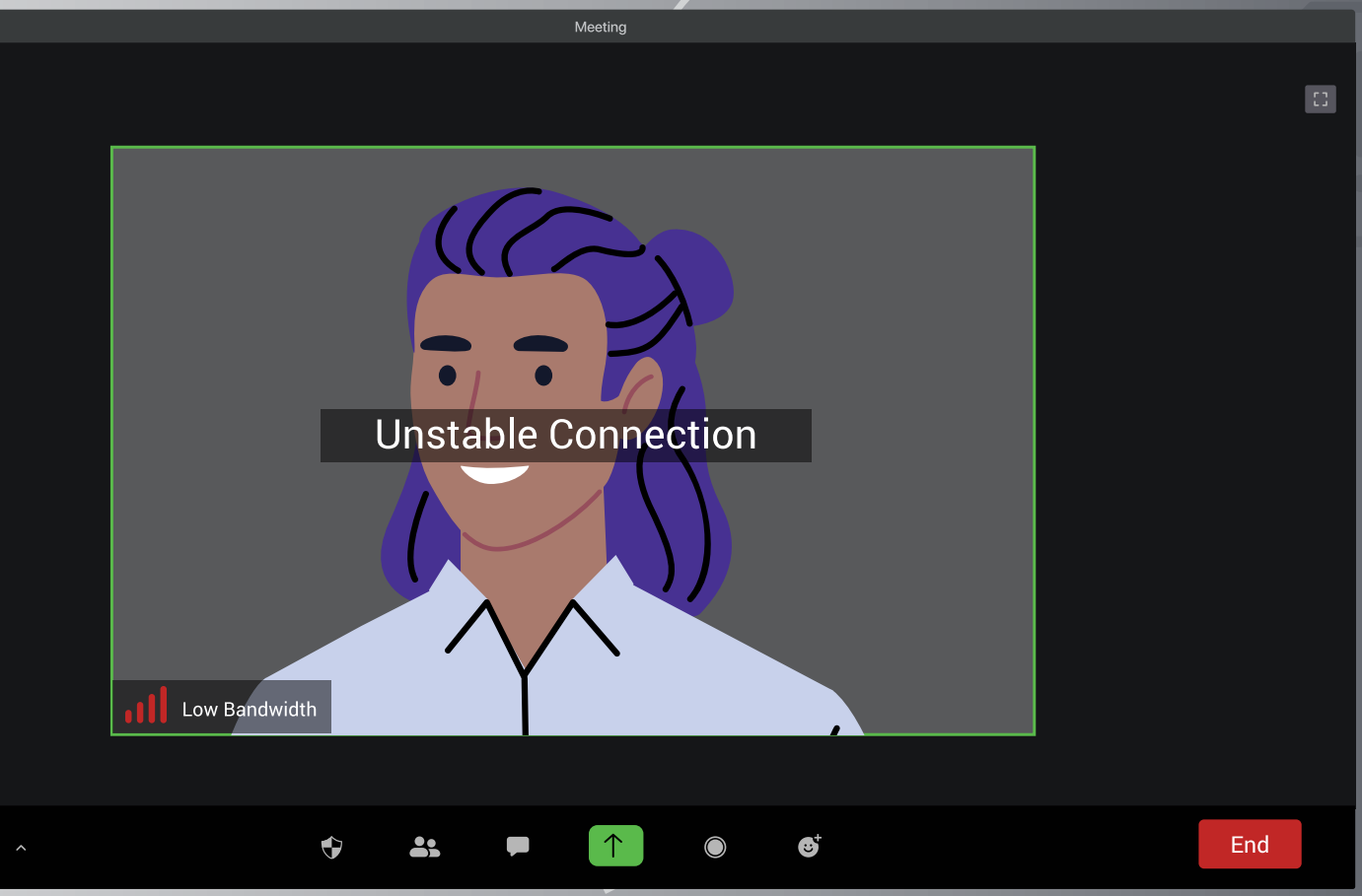
Most participants felt that Thorne Harbour Health adapted quickly, efficiently and constructively to the challenges of the COVID-19 pandemic. As one client said, the transition "wasn't seamless", but clients hardly expected it to be. Experiences of flexible services varied, but most clients interviewed found they were effective (once accessed) and spoke positively of Thorne Harbour Health's efforts to implement them given the challenges faced. The courage shown by Thorne Harbour Health to rapidly adapt services should be recognised as significant in preventing many client situations from worsening.

However, the constraints under which Thorne Harbour Health managed this enormous undertaking meant that not all obstacles could be overcome. This is most obvious in respect to waiting times that clients endured throughout 2020-21. The voices of victim survivors demonstrate these service challenges. Every person on a waiting list during COVID-19 is someone who has experienced immense challenges, often exacerbated by the pandemic. Some victim survivors spoke of being at their lowest point when waiting for support – and those waits were often painfully long.

In the next chapter, we explore how Thorne Harbour Health staff members experienced a shift to remote work.



6. **Flexibility and risk: Thorne Harbour Health staff experiences of providing LGBTIQ+ family violence services during COVID-19**



COVID-19 transformed family violence service delivery at Thorne Harbour Health. A sudden switch to technology-driven practice changed how staff performed their roles, especially in terms of counselling. Staff members began working from home, interacting with clients through video-based platforms, instant messages, emails and/or phone calls. They did so in environments that varied, from comfortable, spacious homes in which spare rooms were converted to offices, to a share house in which the only private space to work was the laundry.

While adapting to significant change, staff dealt with their own challenges of lockdown and increasingly more complex client situations. With change came complexity. On the one hand, staff were relatively free to embrace flexible methods of service delivery and vary their practice. On the other hand, they carried the risk that came with charting this new territory from home. This chapter draws on staff interviews to focus on this flexibility and risk, culminating in a discussion about the impact of rapid change on staff members.

6.1 Organisational culture, adaptation and access

The flexibility of a technology-driven model allowed staff to tailor their work practices to suit individual client needs and the demands of remote work. Underpinning this were practice philosophies that emphasised the importance of community. In this section, we explore some of these practice philosophies before documenting how Thorne Harbour Health staff members reshaped services in response to COVID-19 and associated restrictions.

6.1.1 Practice philosophies

Most Thorne Harbour Health staff members interviewed for this study were themselves part of an LGBTIQ+ community and identified with the organisation's history, commitment and core values. All talked about the importance of LGBTIQ+-specific services, especially for family violence. Visible to them was a need for more-developed and better-funded family violence services in LGBTIQ+ communities. Staff members believed that Thorne Harbour Health occupied an important space in the sector:

> *Thorne Harbour's in a niche position for supporting community … it enables that community to be safe to report, be safe to develop a response that's needed, that mainstream and specialist services don't provide our community, as they don't recognise that same-sex or gender-diverse people are eligible for their service. It fills a strong gap in being a safe and supportive space for people to receive what is rightfully theirs. (THH staff)*

> *I think what's important to me is … working for a queer-specific organisation – and also an organisation that's come from an activist background through the HIV and AIDS epidemic. We've got a lot of autonomy in this role where we can challenge the way that we work and advocate for a better system model, which is good. It's not as top-down … there's always scope to discuss how we can do things better and I quite like that. (THH staff)*

Some staff members said working for Thorne Harbour Health formed part of their commitment to advancing rights and improving outcomes for LGBTIQ+ communities. For several staff, this commitment extended to Indigenous and culturally and linguistically diverse communities. Multiple participants talked about applying an intersectional feminist lens and taking a client-centred approach to their work. More generally, participants spoke of bringing humanism, empathy and positivity to their roles. Like employees at any organisation would, staff members had both praise and criticism for Thorne Harbour Health and the way it functioned. They were, however, unified in their respect for Thorne Harbour Health's commitment to LGBTIQ+ communities.

6.1.2 Staff adapting to remote work

Staff members felt a range of emotions when asked to work remotely in early 2020. For some, a transition to working from home changed little about their role and was managed with few concerns. For others, the shift was a challenging one, requiring significant changes in practice and even prompting a grief response. Staff had to deal with a vanishing divide between work and home, find new ways of communicating with colleagues and learn to seek support from their managers from afar. Over the course of six lockdowns, morale fluctuated. One staff member reflected that:

> *Certainly, to begin with, the morale was pretty good. It was a recognition that we're all in this together and we all need to work together to pull through on it … As time and challenges and circumstances moved forward, that changed … The organisation itself was very aware of that morale, had a whole host of different strategies – some worked, some didn't, and that's cool, because you know we'd never been in this situation before. (THH staff)*

Remote service delivery meant staff were now in their homes when dealing with acute situations, such as when a client was suicidal. At these times, some staff felt the distance between themselves and their colleagues. A few reflected that remote work arrangements meant they could not immediately draw on the skills and knowledge of colleagues that usually surrounded them in an office. One said:

> *A lot of [my] work was phone-based anyway … [but] one of the most challenging things has actually been not being around peers during challenging phone calls, not having someone to go and debrief with afterwards … You can't do that when you're working from home, unless you email someone or call them … That incidental kind of support has gone, and that's been challenging. (THH staff)*

Staff opinions varied as to how supported they felt by Thorne Harbour Health to adapt to the challenges of a rapid switch to telehealth. Some staff at times found it difficult to access support from those higher up in the organisation due to the isolation of remote work, the demands of the pandemic and Thorne Harbour Health's organisational structure. Remote work did not allow for as many informal consultations or connections – such as hallway conversations – that were frequent before COVID-19.

One participant said the organisation stepped up operational and clinical supervision for staff members but reflected that, of course, there could have been more done to help colleagues connect with each other:

> *I think the organisation did really well compared to some other organisations. We were agile and moved really quickly and supported staff quite well. Financially and in terms of resources and tech and chairs and lunch vouchers, that aspect they handled really well. I think they were really limited about what staff needs were from a workplace in terms of connection and meeting with colleagues. Leaving it to individual teams to figure out was too big of an ask considering the workload. There needed to be a better organisational response of, you know, "We're working online and here are the points of connection and here's how your teams need to be structured." (THH staff)*

A lot of [my] work was phone-based anyway … [but] one of the most challenging things has actually been not being around peers during challenging phone calls, not having someone to go and debrief with afterwards … you can't do that when you're working from home, unless you email someone or call them …

(THH STAFF)

Regardless, most recognised the challenges that everyone in the organisation had faced. One participant said:

> *I felt supported and at the same time acknowledge that everybody who sits hierarchically above me was also living through this situation and all had their own lives outside of work and pressures on them just as I had pressures on me … There was a lot of understanding, at least initially, and then I think it got really burnt out. (THH staff)*

6.1.3 How staff tailored practice

In a new technology-driven environment, staff work practices and roles changed. The organisation guided some of this change, while staff also found themselves with more flexibility to tailor their practice to best meet client needs and remote work situations. Usual practice guidelines were more easily challenged and updated. Some staff said peer-based/community approaches to family violence service delivery became central when working from home.

In-person counselling, case management and assessments were shifted online or to telephone. In terms of assessments, primarily conducted face-to-face before the pandemic, staff needed to plan ahead to ensure safety. A participant said that preparation included:

> *Making sure that we're checking in at the start, making sure we're starting that process early on in the intake and saying, "Is your phone line secured, does anyone else have access?" When we're booking the assessment making sure they've got private and secure spaces, they've got good internet. There's a lot of setting it up. (THH staff)*

Not only did the format of assessments have to change, so, too, did staff members' approach to conducting them:

> *If you're doing a face-to-face assessment, it's very much you're working with your clinical judgement and knowledge, and you're able to hold the space, support the client in regard to some difficult conversations that allow you to have a greater understanding of what's going on in the client's life. When you're doing assessment on telephone and Zoom, then your ability to do that is hampered. You're not able to hold that space necessarily, and therefore as an assessor I'm less likely to push things or make further enquiries. I'm very much more led by the client themselves. (THH staff)*

Despite challenges, a staff member said assessment was adapted quickly due to the skill and experience of staff who already did telephone intakes:

> *I think assessment was the easiest to switch because I know they were engaging in some telephone assessments pre-pandemic … Assessment is about information gathering. Rapport isn't as important … so, I think assessment changed really well, and quite quickly. Case management was hard online because for a lot of case management clients, the goals were pretty tricky to achieve if external services were closed … Residential services, hospitals, mental health facilities, drug and alcohol residential facilities. (THH staff)*

Staff members were conscious that they had to change the way they communicated – for example, learning to rely less on non-verbal cues when talking to a client on the phone. They also had to be strategic about how and when to contact victim survivors who might have been living with perpetrators. Text messages became important means of communicating as part of flexible and safe service delivery.

Scheduling an appointment outside work hours was something that some staff said they were more willing to do while working from home during lockdowns, indicating a level of commitment to clients and a blurring of the lines between work and home. In constantly trying to ask what connection looked like for clients and what best served their needs, staff kept reviewing how they worked. This, one staff member said, was aimed at trying to do what was appropriate and good enough for the moment.

Sometimes pragmatism was the best way forward. For example, the simplicity of Zoom was something that some staff said improved service delivery options.

> *One of the things that made it easier is that we just we went with Zoom, which was very easy for clients to use and for staff to use and we didn't freak out about the privacy stuff. We just kind of adapted and eventually Zoom caught up … clients didn't need to download anything. It was really easy. (THH staff)*

Staff also commented on the fact that Thorne Harbour Health set up efficient digital administrative processes, which helped when providing brokerage. Some also suggested that flexible practice – however fitting for 2020-21 – would have to be reviewed and further refined.

6.2 Service delivery challenges: Risk, limitation and delay

In providing telehealth services from home, Thorne Harbour Health staff were dealing with significant risk alone. Contributing to this were changes in client circumstances, the limitations of technology, growing waiting lists for services and the challenges of "holding" clients until they could be offered formal counselling. We now discuss these factors further.

6.2.1 Perceived limitations and challenges of providing remote services

Despite its many benefits, technology-driven flexible service came with limitations and challenges. Staff had to quickly find new ways to run a session or program, create environments in which they could "hold space" for clients, build rapport and assess wellbeing – all remotely. Staff said:

> *It can be harder to establish rapport. There's lots of things that are therapeutic, like you might use silence when you're in a room with someone – it doesn't work the same way on Zoom. But also, things like for drug and alcohol, you can't necessarily check people's wellness or their injecting sites … For family violence, you might not notice if people have an injury or are limping, so there's that visual observation … but also clients are really distracted and find it really hard to focus on something like Zoom or telephone. (THH staff)*

> *[A challenge was to] find a space where clients felt that they could talk. The safety element was hugely impacted, and you had to try and work creatively [to] communicate with the client and at the same time ensure that the conversations that they're having with us are not increasing the likelihood of further family violence … Sometimes it was a matter of texting and waiting 10 minutes and the client has maybe gone just for their daily walk, and then ringing. Sometimes communication happened completely via email. You had to work out different, creative ways of trying to minimise that risk. (THH staff)*

Staff also had to consider how to "book-end" Zoom-based counselling sessions to ensure clients could safely transition between an appointment and other daily activities. A staff member explained how video-based appointments could start and finish abruptly, even when carefully managed:

> *When you're working this way and you've got the leave button at the end of the session, who presses the button to leave? Because it's really abrupt, so you arrive in a session, you're there on the screen and then, bang, you're gone. There's no transition, so how do we then manage transition for clients so that they can ease back into their day or arrive in a session, and it doesn't feel so abrupt? It's not like that when you're working face to face. Clients have the opportunity to gather themselves, to self-regulate a bit, sit in the waiting room, get a cup of tea, before they go on with their day. But when you're in this environment when the Zoom session ends, they're just back in their world instantly. (THH staff)*

Unstable internet connections or inadequate technology presented more challenges. Some clients had older model mobile phones with unreliable cameras and internet connections. Situations were even more difficult if clients were homeless and unable to find private spaces in which to converse. Thorne Harbour Health supported clients with phones, headphones and tablets early in the pandemic to address some of these issues. But challenges remained:

> *Sometimes our clients don't have the best technology and sometimes our clients' technology freezes or crashes or their phone goes from 99% to 1% in five minutes. For a lot of our high-risk clients or low socio-economic clients who don't have money for internet connection, it was impossible. (THH staff)*

Technology's inability to completely bridge the distance between two people in separate locations meant an additional degree of uncertainty about a client's circumstances became an inevitable part of a staff member's work during 2020-21.

6.2.2 Concerns for client safety

Staff members provided support to clients while managing numerous safety concerns. During intakes and assessments, staff were sometimes unsure of a client's immediate surrounds,

Sometimes our clients don't have the best technology and sometimes our clients' technology freezes or crashes or their phone goes from 99% to 1% in five minutes.

(THH STAFF)

including whether a perpetrator was near them. Flexible communicative methods were developed with safety – and uncertainty – in mind, and tailored to the individual client:

> *There was a lot of text-based contact, so trying to find other ways of contact – email contact. You can't arrange to meet someone at the café on the corner if all cafes are closed … [SMS and email] have always been used, but they just got more used, but even that's difficult if someone's checking your phone. (THH staff)*

> *[We have to] make sure that we do assess that risk first up with any phone call or any referral … by not identifying ourselves in the text messages. We have a private number so that it's not known to the perpetrator who's calling … Our long walks have been really helpful. That's where the phone assessment style has worked really well for some of the clients accessing support. (THH staff)*

Staff members said lockdowns seemed to increase the risk to victim survivors, so they worked hard to find ways of determining where perpetrators were in relation to clients. "We just couldn't identify the risk as effectively," one staff member said. In these situations, staff faced challenges to perform their roles when it was unclear whether the client was at immediate risk:

> *The major one that literally always came up was around client risk and client safety and how can you conduct a proper risk assessment if there's a perpetrator or a violent person in the room? What if they're not in a confidential space? I think we get so much from in-person meetings in terms of being able to gauge risk. So, that was the biggest number-one fear: that somebody would go and complete suicide because you haven't been able to assess risk well enough or because they've got someone else there. (THH staff)*

In instances where a client was experiencing violence in their home, staff could sometimes make alternative arrangements, as demonstrated in this account of someone helping a client:

> *I remember this one client clearly because I've done a lot of work with him and it was very complicated and in the middle of the pandemic his family was perpetrating violence … so, he used to go out of the house to talk to me and eventually in the middle of the strictest of lockdowns in 2020, we arranged for him to leave that house. (THH staff)*

Demand for family violence services fluctuated throughout 2020-21. Adding to the uncertainty of some client situations was financial stress. Many clients lost employment during COVID-19-associated lockdowns and experienced housing instability. Financial support from the government, such as the JobKeeper payment, supported some clients during parts, but not all, of 2020-21. Some clients on student and other temporary visas did not receive financial support. One staff member reflected on how the availability of financial support impacted on clients, saying:

> *There was a lot less financial crisis and stress when there was the COVID extra payment. It just made a huge difference. People could find rental accommodation that they hadn't been able to access before. They could pay their bills. There was just a lot less financial stress on clients – it was absolutely noticeable. (THH staff)*

6.2.3 The feeling of holding more risk

Telehealth delivery challenges, isolation from colleagues and the uncertainty of client situations impacted Thorne Harbour Health staff. Many believed that working remotely during the pandemic created situations in which they were required to hold more risk than they would have while working at an office and dealing with clients in person, in the company of managers and other colleagues. In some cases, staff felt they could know only so much about a client's situation from afar, and so they felt limited in what support they could provide. For some, working alone at home meant they were more likely to worry about finding a resolution (inside and outside work hours) rather than debrief with a colleague. These staff accounts describe some of the experiences of holding risk remotely:

> *I can use an example of a client who I was seeing who lived with the perpetrator and the difficulty of working with them remotely was that there wasn't an assurance that the perpetrator wasn't around. At least when the client had an opportunity to come into the office, there was a sense that for two hours of that day that person is safe. The human part of me was like, "I can't even offer them that [during COVID-19]. I can't give them that." (THH staff)*

> *It can feel like you're sitting with everything, you're shouldering all the risk on your own. I've certainly felt that, and I've been doing this family violence work for years now, and it can still sort of feel like I'm sitting with this enormous amount of risk that I just can't carry. (THH staff)*

Another staff member's account of "holding risk" makes a distinction between individuals holding risk and the organisation holding risk:

> *It's incredibly frustrating, especially when you're dealing with the levels of risk. It means that the individual worker feels like they're holding risk, but the organisation as a whole … due to … the pandemic [is] holding more risk than it's accustomed to. (THH staff)*

For this staff member, holding risk related in many ways to waiting lists that increased during the pandemic.

6.3 Impact on family violence service staff

The previous sections have demonstrated the ways in which remote work arrangements, in response to physical-distancing orders and lockdowns, changed how Thorne Harbour Health employees provided family violence services and associated services. Although all staff members interviewed were challenged to some extent by the pandemic and a shift to remote work, some felt the effects of these changes more acutely than others.

In this section, we explore some of the impacts of service delivery during a pandemic on family violence service staff, considering work-home divides, workloads and emotional impacts.

6.3.1 Workspaces and work-home divides

Some staff faced challenges establishing workspaces in their homes. Thorne Harbour Health provided equipment such as laptops and other technology to ensure staff were equipped to work from home. But some had concerns about confidentiality in terms of what other people in their house might overhear and – before Zoom background filters were widely used – concerns about how much of their homes clients could see. Some also worried about Zoom being a third-party platform and the privacy issues that raised. One staff member described the myriad challenges the organisation and its staff faced in establishing remote workspaces that centred on Zoom, saying:

> *[There was] a lot of ethical issues around confidentiality: is Zoom good enough, who holds the risk of that and … more organisational and operational issues: do staff have a safe place to work from, are they well set up, are they going to have a back problem or work from home and have an injury? … For some people it was [worked through], for some people it wasn't. (THH staff)*

A challenge was often finding a place to work at home. Some could perform their roles in a dedicated home office space – perhaps a spare room – while others, living in a share house, were confined to their bedrooms, conscious of confidentiality and privacy and the concern of being overheard by housemates. This created a level of inequality. Several participants mentioned that one Thorne Harbour Health staff member had regularly worked in their laundry. As one explained:

> *I had a staff member working from a laundry, like sitting on her laundry floor. It was the only space in a share house she had and it was cold and it was a really, really awful look. We're like, "We can get you a chair, we can get you a desk." But somebody's still in a laundry going, "It's cold and it's miserable and my housemates all work in the living room and they're not in confidential jobs, so I'm here." That certainly had an impact on service provision and presentation of service to clients. And it wouldn't be fun looking at a small laundry in a share house with a concrete floor going, "Well, I'm here for the next seven hours." (THH staff)*

The organisation did make some arrangements for staff to work from the office; however, not everyone who might have benefited from doing so wanted to use public transport as COVID-19 cases increased in Melbourne.

Creating a mental divide between work and home proved challenging. Several staff members who had previously "not taken work home with them" found it difficult to switch off. Not only were they sitting down at their computer to access emails and do other tasks outside work hours, but they were also finding it difficult to stop thinking of work once they finished. The nature of the experiences that clients disclosed – violence that often occurred in the home – had a particular impact on some staff working from their own sanctuaries and safe spaces:

> *Having to hear or support others around their experiences of trauma from their bedrooms, from their kitchen tables – there was never a sense of escape from the work. The laptop was always there whether it's sitting at the end of your kitchen table or on your dining table or in your loungeroom or, most awfully I think, in the bedroom. (THH staff)*

> *Just the energetic impact of working through this really heavy stuff that's related to violence within queer communities, having that right in the place where you sleep, and it's an intimate kind of personal space – it can feel a bit of a boundary violation. (THH staff)*

Staff also had to adapt to new ways of communicating with colleagues. Many missed incidental conversations with colleagues, including those outside their own team. Some participants said teams became more "siloed" while working from home and staff tended only to talk with their direct teams, often in meetings. Managers set up channels for formal communication and, as mentioned previously, offered various supports to staff and encouraged self-care. One staff member said:

> *In terms of that physical adjustment, it was a bit of a challenge at the start. I think that those teething issues were resolved in the first couple of weeks, though, and we had team meetings and supervisions where we were really supported to think about how we're managing the transition. There was acknowledgement of how weird and different it was. We were encouraged to think about how we do self-care when we're working from home, and how we switch off at the end of the day. (THH staff)*

The difficulty of drawing boundaries between work and home contributed to staff performing work outside hours. This provided some flexibility for staff to meet client needs. But it also meant some were working longer hours:

> *There's so much unboundaried work happening now and I'm a huge perpetrator of checking my emails at 7pm, working on a Sunday, because the computer's just there, so work is kind of always there. The ritual of leaving the office at 5.00, my computer stays there, my phone's off, done. But it's always there and because it's always in your home, it's so much harder to switch off from. (THH staff)*

At the same time, workloads were increasing due to more clients accessing services with more complex needs, disruption in other services, staff departures (and on-boarding delays) as well as the usual challenges associated with trying to support clients on limited budgets. Participants reflected on these issues in various ways, with one saying:

> *My workload went up a lot during COVID. I have gotten my caseload down a little bit … but I've had to work really hard to get that down and advocate to not just load back up again. I think that there*

It just kept creeping up over COVID … It did feel like you can't escape work – it's in your house … you are working with often very traumatised people and it's hard not to become vicariously traumatised and take on that stress.

(THH STAFF)

are increased pressures when our waitlist is so long that we have to take more clients and do more work, but I'm trying to be really mindful of what's sustainable and practical for me. (THH staff)

6.3.2 Emotional impact of remote work

The challenges of an immediate switch to remote service delivery, detailed throughout this chapter, took a toll on staff members. Various factors contributed to the emotional impacts of remote work. Staff experienced isolation from colleagues, held more risk in isolation and dealt with a higher volume and greater complexity of client needs. Moreover, these experiences often occurred while staff members themselves were enduring lockdowns.

The extent to which staff members interviewed for this study felt emotionally affected by the events of 2020-21 varied. Many spoke of the pressure, stress, exhaustion and/or burnout of performing their roles during the pandemic. The following staff accounts reveal some of the emotional realities of delivering family violence services from home, during long periods of uncertainty:

It just kept creeping up over COVID … It did feel like you can't escape work – it's in your house … you are working with often very traumatised people and it's hard not to become vicariously traumatised and take on that stress. We just need to know more about how to manage that. I don't think we came up with the solution. Staff carried a lot of stress and that impacted and sometimes people didn't behave well because they were carrying all that stress … We were all stressed just because we were all in lockdown. (THH staff)

There were some really difficult times for particular team members, and for some people the burnout is coming now and for others it came last year … When people get close to burnout, they start dropping their regular supports and when you're not seeing someone every day or at least every other day, it becomes obvious, "Hey, that person hasn't turned up to supervision for a month. What's going on?" When you touch in, you suddenly realise, "Whoa, OK, something's going on here." … It got lost in the wash. I think communication is far more complex now. (THH staff)

A recurring theme in staff interviews was that family violence workers and those providing associated services had not had much time or enough opportunities to stop and reflect on the events of 2020-21. The above reflections provide a snapshot of the load that many Thorne Harbour Health staff carried, but some felt that the full impact of the pandemic on their work was yet to be fully felt or understood. Besides, the pandemic was not over when interviews took place.

6.4 Summary

Thorne Harbour Health's transition to a telehealth model significantly changed how staff worked, offering them the freedom to implement new practices and to be flexible with service delivery. Circumstances in which telehealth was introduced, however, presented challenges in terms of risk, workload and isolation. Staff members worked from home for large parts of 2020-21, delivering family violence and associated services to clients through video-based platforms, emails, instant messages and/or phone calls. While doing so, staff members dealt with lockdowns and their own housing challenges, sought (unsuccessfully at times) to maintain a divide between work and home, and adapted to new ways of communicating with colleagues.

Thorne Harbour Health staff members dealt with a higher volume of clients, whose challenges the pandemic had often rendered more complex. To try to meet demand, staff found new ways of being flexible with their service delivery. A significant effect of such flexibility was increased access to clients in regional and rural Victoria. New communicative methods were developed with safety, uncertainty and the needs of the individual client in mind. Many staff enjoyed the challenges of delivering technology-driven services and saw the potential of video calls to further transform LGBTIQ+ family violence services. (We consider this more in Chapter Eight.)

On the other hand, the challenges of an immediate switch to remote working arrangements, detailed throughout this chapter, took a significant toll on many staff members. Various factors contributed to the emotional impacts of remote work. The difficulty of drawing boundaries between work and home life contributed to staff performing work outside hours. Staff members felt stretched by the demands of providing services from home, "holding" clients as waiting lists grew ever longer and the uncertainty of the pandemic loomed large.

That many participants believed family violence services were effective throughout COVID-19 lockdowns is testament to the commitment of Thorne Harbour Health's staff members to their clients, peers and community. The decision by service leaders to pivot to flexible service delivery, aided by technology, provided a path forward for family violence practitioners to perform their work. It was a journey – often uncertain and overwhelming – that staff members carried out with courage and resilience.

7. Born in a pandemic: The creation of Switchboard Victoria's Rainbow Door service

During a 111-day state government-enforced COVID-19 lockdown in 2020, LGBTIQ+ community-controlled organisation Switchboard Victoria launched Rainbow Door, a specialist helpline. An important part of Rainbow Door's service is providing information, support and referrals to LGBTIQ+ people experiencing family violence. Rainbow Door was established to complement the existing QLife anonymous helpline, which Switchboard Victoria operates across the state for LGBTIQ+ Health Australia, the national contract holder (48).

When Switchboard Victoria launched Rainbow Door in September 2020, some involved in designing the service expected demand to be steady and to build slowly over time. Instead, staff members were inundated with calls. This chapter explores the creation of Rainbow Door during the challenging events of 2020-21 in Melbourne and across Victoria. Although family violence is our primary focus, we also consider associated challenges to mental health that community members faced. How the helpline was built, how services were delivered remotely, the impact on staff working from home during COVID-19 and the potential for expansion of the service are also explored.

7.1 The Rainbow Door opens during a time of need

When Switchboard Victoria launched Rainbow Door, the phones soon began ringing – and they did not stop. By the time staff members were interviewed for this study in late 2021, the service had experienced almost 15 months of constant demand for services. Rainbow Door had tapped into a need that was even more urgent than those setting up the service had suspected. In this section, we explore how Rainbow Door emerged and what contributed to such high demand for its services from the outset.

7.1.1 Background to Switchboard Victoria's helpline services

An LGBTIQ+ community-controlled organisation, Switchboard Victoria was established in the early 1990s to provide support to community members whose needs were significant yet marginalised. The organisation's birth came amid a global HIV/AIDS pandemic. The origins of Rainbow Door are similar: Switchboard Victoria identified the need for a helpline that provided important support, information and referral options to LGBTIQ+ community members during COVID-19. Staff members involved in setting up Rainbow Door spoke of how fitting it was for a new helpline to emerge as part of a response to another pandemic:

I think Switchboard itself [being] born in a global HIV pandemic in 1991 – it brings out the best in people … We would never have been able to do it [establish Rainbow Door] without funding … but the community really rallied around itself and supported people. (RD staff)

Before COVID-19, Switchboard Victoria provided helpline support to LGBTIQ+ people across the state as part of QLife, a national service. Historically, LGBTIQ+ peers have worked on the QLife helpline on a voluntary basis. As a result of COVID-19, funding allowed Switchboard Victoria's helpline workers to be paid for their work with QLife.

Following the Victorian Royal Commission into Family Violence, Switchboard Victoria was also funded to set up an afterhours phone service specifically for LGBTIQ+ people experiencing intimate-partner violence. That service was part of the state government-funded With Respect program, which also included Thorne Harbour Health, Transgender Victoria and Queerspace/Drummond Street Services (49). Switchboard Victoria ran the afterhours service for 18 hours per week over the course of 12 months, until June 2020, when funding to support service provision was continued in a different way. A Switchboard Victoria staff member described how that service had slowly built into an important resource for LGBTIQ+ people in Melbourne:

By the time that service finished … it was an amazing service. Word got around – and it was word of mouth because there was barely any advertising of the service. So, the first few months that that service was operational, the phone did not ring. (RD staff)

The state government, through Family Safety Victoria, then provided funding that helped Switchboard Victoria launch the Rainbow Door during the pandemic.

7.1.2 COVID-19 and the need for more LGBTIQ+-specific support options

As plans for the new service developed, three staff from the after-hours service were retained and more staff were hired. Switchboard Victoria launched Rainbow Door in late September 2020 with nine staff: a manager, four team leaders and four helpline staff. Although Rainbow Door was always designed as a helpline, the organisation faced the unusual task of developing the service with all its staff, including those freshly hired, working remotely.

Rainbow Door launched offering a range of information, referrals and support to LGBTIQ+ people. It differed from With Respect in that its scope was wider than intimate-partner violence and relationships. Rainbow Door also offered something different from QLife. First, it operated seven days a week, from 10am-6pm (and later 10am-5pm), whereas QLife's hours were 3pm-midnight. Second, rather than being an anonymous helpline, it invited callers to share their names as part of the process of helping them get connected to services that best suited them.

LGBTIQ+ people experiencing various forms of family violence were among Rainbow Door's first clients. Some needed an escape from perpetrators they were living with during lockdowns and were seeking financial and housing support. As one staff member recalled:

I think one of the last calls we took [on the afterhours services], we were locked down in Victoria, we had a caller who needed to get over the border, and we were assisting. We were calling police and getting forms filled out. He was in a car packed with all of his belongings. And there was nowhere for him to stay … That client went from the afterhours service into the Rainbow Door. He effectively was our first client. (RD staff)

Callers to Rainbow Door shared a range of other issues they were experiencing, many of which related to their mental health. Suicidality, sometimes connected to a family violence situation, was also prominent in calls to the service in its early days:

It was really "hit the ground running", so to speak. Oftentimes, there's a lot of suicide content that was coming through to the service as well, which was speaking to the mental impact of everything that was happening to people at the time. (RD staff)

7.1.3 'The phone didn't stop ringing': Demand for Rainbow Door

Rainbow Door staff were aware of the need for family violence support among LGBTIQ+ communities in Melbourne and across Victoria. Awareness of the extent of violence in LGBTIQ+ relationships, research about increasing family violence during lockdowns and the strain on other services during COVID-19 contributed to this understanding. But not all staff members had expected so many calls from the very start.

Demand for the afterhours service had informed expectations at Switchboard Victoria. This was a miscalculation – the demand for Rainbow Door was much greater than anticipated. The phone rang 10 minutes after the service opened, and according to staff (in figurative terms, at least), "it never stopped". Staff members reflected on the challenges of these early times, saying:

We under-costed it … We didn't get the staffing right because we didn't think the phone was going to ring. We were just so wrong about that … We anticipated that when we set up the Rainbow Door, it was going to be fine, because the first couple of months the phone's not going to ring and we'll have all this time, and we'll finish – nothing was finished; it was half built. (RD staff)

Everyone thought it was going to be quiet and I did not … I was like, "This will be really busy and we're going to be cooked" … With Respect was not advertised at all the same … and I just felt that especially with the broad scope of it not just being family violence but a range of issues, it was going to get busy. (RD staff)

As the calls flooded in, Rainbow Door staff had to quickly adapt to provide callers with crucial support, information and referrals:

We were not ready. We were not prepared, and we were overwhelmed. And we did an amazing job, we scrambled. (RD staff)

Everyone thought it was going to be quiet and I did not … I was like, "This will be really busy and we're going to be cooked" … and I just felt that especially with the broad scope of it not just being family violence but a range of issues, it was going to get busy.

(RD STAFF)

7.2 Answering the call: Remote telehealth service delivery during a pandemic

Switchboard Victoria's Rainbow Door was a peer-led response to a critical need for family violence and other services in LGBTIQ+ communities. Hidden challenges, many of them exacerbated by COVID-19 and its associated impacts, were revealed through a deluge of calls to the helpline. Community members embraced a service designed for them by a trusted LGBTIQ+ community-controlled organisation. In this section, we consider how Rainbow Door supported clients in its early stages of operation, how it handled high demand for services and what patterns of client engagement staff observed.

7.2.1 Service delivery during COVID-19

Rainbow Door launched with nine staff, all of whom were LGBTIQ+ community members. Demand for the service and funding capacity allowed this to expand to 16 staff by the time interviews were conducted in late 2021. This expansion, during a time in which Melbourne went in and out of lockdown multiple times, meant staff members joined Rainbow Door without meeting managers or other colleagues in person. With remote work arrangements in place for large parts of 2020-21, Rainbow Door staff performed their work from home.

Accessing Rainbow Door were clients with a range of needs, including those who had experienced family violence, sexual assault, suicidal thoughts and issues with alcohol and other drugs. Although Rainbow Door is broadly considered a "helpline", staff engaged with clients using various communicative media, primarily telephone, SMS and email. Due to their ability to facilitate discreet communication, text messages and email were especially useful ways of interacting with clients experiencing family violence. Unlike Thorne Harbour Health, Rainbow Door did not place video calls at the centre of its remote service model. Staff used video platforms such as Zoom and Microsoft Teams to communicate with each other and external service providers, but rarely for work involving clients.

Rainbow Door's service model is different from QLife and other anonymous helplines in that it collects identifying information from clients. This is to enable case management, build rapport, ensure safety, assist in identifying needs and direct clients to appropriate services. The "warm referral" made possible by Rainbow Door staff knowing who the client is and helping connect them with a suitable service became crucial. As participants explained:

> *Since we know your name, we know your contact details, we can then you link you into services, we can complete applications with you, we can work with you to try to get you into the service. (RD staff)*

> *We can have that ongoing connection with somebody and that ongoing communication in terms of if there's risk involved, we can escalate things because we've got their contact details and where they live … It also means we can do more with people and help them out and have that ongoing thing and wait for services to get back to us to then provide them with more information about linking them into housing or linking them into a different service. (RD staff)*

Rainbow Door became not only an alternative to QLife, but also a complementary service. One staff member explained how people could access both helplines, depending on their needs:

> *We hold these two different services. One's anonymous and confidential, and one's a case management model in Switchboard. So, they're very different. What we offer them is choice, because they can go and call after 3pm any day of the week an anonymous service and say whatever they want, as long as they're not abusive. But also, if they want follow-up, if they want check-in, if they want connectedness in a tangible way, they can access a case management service like the Rainbow Door … And I know that a client will use both services for different things … That choice is really important for people. (RD staff)*

Staff members said Rainbow Door offered callers an "automatic soft-landing place" that was welcoming, free of judgment and LGBTIQ+ friendly. An important part of the referral process for staff was ensuring they connected clients to services that were just as welcoming of LGBTIQ+ people. Rainbow Door focused on tailoring services to what the client wanted. Central to this was the question of whether clients preferred to access specialist LGBTIQ+ services. If so, staff referred them to Thorne Harbour Health or Queerspace/Drummond Street Services, also in Melbourne. Aware of growing waiting lists at other services during the pandemic, staff also helped clients access non-LGBTIQ+-specific organisations. This included Relationship Matters, a not-for-profit counselling service:

> *We have brokerage funding to spend at Relationship Matters. So, we did some capacity building with a team of counsellors there … We've been able to say to people, "While you're waiting for the specialist service, why don't you go and try this other generalist service." So, people have been doing that, some people have had eight, 16, some up to 20 sessions … Other people still want*

the queer service. So, we're able to offer that to them. (RD staff)

As well as having staff attend to the phones, Rainbow Door provided case management, guided by what clients wanted or needed. The service was flexible in how it approached clients with complex mental health needs, including those who had been exited from other services. In other cases, additional support was provided to clients experiencing suicidality. Flexibility was important in such situations. For some clients, Rainbow Door acted not as a referral service but a last resort. Staff, therefore, assessed clients' needs on an individual basis and made themselves available to speak with them regularly. One staff member described how a caller experiencing suicidality might be supported and how that related to options at other services:

Depending on what's going on for that person, often depending on how chronic their suicidality is, we might speak to them every day for a period of time … We didn't imagine that we were going to be holding onto clients a year later, but there's nowhere else for them to go. We're not the perfect service for them because we can't do all the things that they want us to, because we're a helpline, but we can provide them with a connection. (RD staff)

7.2.2 Service demand in the first 15 months

With the phones ringing constantly throughout 2020-21, demand for Rainbow Door's services was overwhelming. Staff sensed that both the LGBTIQ+ support sector and the community it served embraced Rainbow Door and had shared news of it to their networks. Switchboard Victoria's reputation as a "very loved community-controlled organisation", a staff member said, gave clients the confidence to call Rainbow Door, knowing that they would be dealing with a peer who would understand their experience:

You go to any event representing Switchboard and people just love you. There's a lot of respect there, and when we said that we were going to set up this service, people cheered us on. They believed us and they needed us to do it. (RD staff)

Rainbow Door's appeal placed considerable stress on its service model and staff members. The service was originally designed as a helpline, offering callers the chance to speak to someone immediately. At the time of being interviewed, staff members reflected on the fact that Rainbow Door had, instead, often functioned as a callback service:

As content has come through in such a volume, we've not really gotten to a place where we're able to answer all the calls. Oftentimes, it almost seems like we're operating more a callback service where someone leaves a message, and we get back in touch with them. (RD staff)

Because the impacts of COVID-19 were felt right across society, LGBTIQ+ people seeking support for family violence and/or mental health issues had few options in a climate of high demand for services. This was a challenge for Rainbow Door, which had struck a chord with its community but was limited in what it could provide LGBTIQ+ people in need. One staff member described the disappointment in this, saying:

We've come to this perfect storm of when COVID hit, all of the therapeutic private practitioners got booked up, and they've closed their books, they're not taking on any new clients, and that's trans and gender diverse affirmative health care as well. So, for some people in our communities, it's at their most vulnerable point when they need the service the most – it's absolutely not there for them. So, there's no surge capacity for the sector … and that's an interesting question for us at Switchboard because when we advertise our service, we actually don't have a surge capacity. And that's problematic because we raise expectations in community and we invite community to understand what they're experiencing … and then we invite them to start to speak about that or to reach out and ask for help, and it's at that point that we fail them. (RD staff)

Adding to demand for Rainbow Door's services during the pandemic was LGBTIQ+ people contacting the helpline from other Australian states and territories, and even from overseas. Rainbow Door is funded only to provide services in Victoria – but it has a policy of not turning away anyone seeking help. In response to interstate and

Very quickly it was identified that we have way more content than we could ever actually respond to with the number of staff that we have – we have to have more staff …

(RD STAFF)

international callers, staff provided support how they could, by having conversations, sharing information and trying to link callers in with services local to them. "We've been able to carve something to support them because something is better than nothing," one staff member said.

7.2.3 Being able to answer in real-time

Client engagement with Rainbow Door during 2020-21 demonstrates how LGBTIQ+ people in Melbourne and across Victoria were dealing both with challenges relating to COVID-19 and those independent of it. Staff at times used the rainbow analogy not only to describe the diverse gender identities and sexual orientations of helpline callers, but also to demonstrate their diverse needs. They talked about taking calls from community members with family violence, suicidality, mental health access, depression, anxiety and isolation issues, many of them associated with the pandemic, as well as LGBTIQ+ people grieving the loss of a partner, confronting their own end-of-life issues and/or managing a disability. For some clients, historical issues – such as family of origin violence and homelessness – also surfaced when they sought support. Staff said that pressure points, such as lockdowns, seemed to exacerbate mental health and family violence issues.

Demand for services remained constant at the time of interviews. Staff believed the service needed to employ more people to answer calls as they came in and provide additional services:

> *We're essentially a callback service rather than a helpline, so we can't necessarily go on the phone and answer a call … So, someone will call, and they'll leave a message to call us back and then we'll call them back when we can, and that's usually within 24 hours. But, you know, it's a helpline and they would expect that they would get through to someone straight away. (RD staff)*

> *Very quickly it was identified that we have way more content than we could ever actually respond to with the number of staff that we have – we have to have more staff … The model as set out in the start was never intended for team leaders to be answering or returning calls. (RD staff)*

Staff said having more workers at Rainbow Door would help meet demand, including in terms of being able to engage in SMS conversations with those in acute family violence situations. Such interactions were frequently used and provided important safety for clients. However, it generally took longer for staff members to help clients find the most suitable outcomes over text message.

Working with clients over a period time (beyond a single phone call) was an important point of difference from some helplines, including Switchboard Victoria's QLife, and allowed Rainbow Door to offer clients more ongoing support and case management. Providing such services was time consuming and challenging for Rainbow Door's team, even though staffing levels increased over the helpline's first 15 months.

Rainbow Door has provided crucial support to LGBTIQ+ community members since it opened during a lockdown in Melbourne. Staff said it had helped community members escape severe family violence situations and deal with mental health impacts. They also felt it had provided sensitive, culturally aware peer support to a community whose members often have disconnected, unpleasant or discriminatory service experiences. Interviews indicate that better resourcing of Rainbow Door would help it meet demand for services in real-time and provide more holistic ongoing support to clients who need it.

7.3 Managing safety and risk in remote service delivery

Designing and launching a helpline for the LGBTIQ+ community during a pandemic was a significant undertaking for Switchboard Victoria. The challenges of COVID-19 meant Rainbow Door began operations in a time when demand for service was surging, yet only remote working arrangements were possible. In this section, we consider how staff managed safety issues during the service's first 15 months, a period defined by COVID-19-associated risk, uncertainty and physical-distancing orders. We then explore how they dealt with risk in their own homes. The section culminates with an exploration of the impact of remote work on those performing it.

7.3.1 Safety issues and limitations of online environments

Client safety is always a concern in family violence work. For Rainbow Door staff members who answered calls during the service's early weeks and months, the challenges of a pandemic only intensified the need to monitor safety. A staff member described how they were "always assessing and re-assessing risk". For example, client whereabouts and their proximity to perpetrators were frequently of concern:

> *Are they in the house right now? … They might be in the next room or they [the client] might have to work out a way of removing themselves from the house. We'd always check whether it's safe for someone to talk – even outside of the pandemic – and if they're in a safe and comfortable place to have that conversation. (RD staff)*

A limitation to ensuring clients were safe was Rainbow Door staff not being able to answer all calls immediately. Staff said they followed "really clear guidelines around risk" in how they returned calls, ensuring they did so only if clients had indicated it was safe. Calls were sometimes scheduled during clients' daily exercise outings (permitted during lockdowns in Melbourne) and messages were sent to new email accounts that staff helped clients set up without perpetrators knowing. Communicating with clients through instant messages and emails proved, in some cases, safer than phone calls. These flexible options, however, raised concerns about digital security and the extent to which a client could be surveilled. A staff member said:

> *You can text-message someone and no one can hear what you're saying and that's great. Technology can be hacked, though, so there's pros and cons to that, but certainly for younger people, texting is good*

if their parents can't access their phones – that's a really good thing for sure. (RD staff)

Despite significant safety challenges, Rainbow Door was able to help some LGBTIQ+ clients escape violent situations. One staff member explained a situation in which a client was helped to find refuge in another state during Victoria's hardest lockdown, when state borders were closed:

We got people over the border at the height of the most serious lockdown … We were able to do some really good work in terms of keeping people as safe as we could and you could leave for reasons of family violence, that was always the option during COVID. We made sure we put that out on social media. How to do that safely was another thing but during some of those big lockdowns, we actually had COVID motels … Our staff are really, really skilled at assessing risk and really skilled at listening for any red flags that may be there. (RD staff)

7.3.2 Carrying risk and holding clients

Rainbow Door's model, launched during a lockdown, made operations possible and allowed staff to perform their roles from anywhere:

When we set up the Rainbow Door, we knew that we were never going to be in a space together … We hired people that we met on Zoom, that we didn't meet in person for months. So, it was very strange. (RD staff)

Staff were equipped with the technology to answer calls from home. Managers could connect with helpline workers during a call if an interaction with a client was particularly challenging. For their part, clients could not notice any difference between a helpline worker talking to them from their spare room or an office.

Working from home presented challenges for staff. One was the amount of risk that they managed while performing their roles alone in a private space. One staff member said:

Coming into the office and doing the work together, listening to each other … being able to, if need be, hand the phone over – we can't do that on Zoom. (RD staff)

But staff needing support could call on a team leader:

We have the capacity to be on video with someone when they're on a call. We don't always do that but if someone puts in the chat, "Hey, this is a hairy caller" or "There's something going on here – can you please jump on?", we're there in a second and they've got support. (RD staff)

As complex situations presented themselves throughout 2020-21, staff faced challenges to determine whether a caller was alone, assess their wellbeing and establish their location if their safety was at risk. One staff member described the importance of asking clients:

If they have a private space to talk about it – and obviously we can only take their word for that. If anyone else is there that might be using harm or monitoring them. Also, not really pushing people to disclose stuff they don't want to … For younger people, it might involve asking a few more questions about who's there or what the space is like just to determine if it's OK to continue the call … All these things would be there anyway, but there's just more acknowledgement that people are home a lot more. (RD staff)

Another challenge for staff was "holding clients" who were on waiting lists at other organisations, such as Thorne Harbour Health (as detailed in Chapters Five and Six) and Queerspace/Drummond Street Services. As waiting lists grew, Rainbow Door provided clients case management, which included seeking support from alternative services, such as Safe Steps or Relationship Matters, and providing regular "holding calls". Staff members could engage clients and monitor their wellbeing while waiting for openings elsewhere. This could continue for months. Service delays frustrated staff members and added to the pressure Rainbow Door faced to meet demand:

Rainbow Door has responded to that in some regards by providing holding calls. So, we might provide a holding space, a contact once a fortnight or once every few weeks to make sure that that person's still connected and safe – particularly if there's any risk factors that have been identified while they are on those waitlists. So, yes, it absolutely has contributed to the amount of workload on the helpline. (RD staff)

Everywhere obviously has huge waiting lists, so we would often have holding calls for people and provide that interim support while they're waiting to get into their primary service. It's really frustrating that these are the systems that are not given funding to do the work that needs to be done to support people … [Holding calls] can help take pressure off the other services that are around …It's been that kind of preventative support for people, and obviously more is needed because we're super busy as well. (RD staff)

7.3.3 Impact of remote work on staff

Working on an LGBTIQ+ helpline during a pandemic took a toll on Rainbow Door staff members, including in terms of remote work, workloads and the accumulated stress associated with being a peer. Working from home had significant benefits for some staff members, including those who experienced social anxiety or lived with a disability. "It's not lost on people that it's taken this pandemic for us to realise that it's possible to work from home," one staff member said.

Others, however, struggled with the isolation of performing their roles from home. During lockdowns, staff came to appreciate the casual office conversations and spontaneous problem-solving over coffee that they had lost. One staff member believed that the vicarious trauma that staff could experience when performing helpline work was amplified when they took calls at home. Maintaining a divide between work and home was also difficult, especially for those with limited space:

I felt very uncomfortable about my team working in their bedrooms and especially taking the kind of calls

Co-workers appear to be really experiencing a sense of stress in their work … Having to stay late and simply get through the demand – yes, they're getting paid, but ultimately, it's still not a good work-life balance.

(RD STAFF)

that they take and then just turning around and popping into bed kind of thing … I think that we don't yet know the impact of that. (RD staff)

Rainbow Door staff members developed their own rituals and routines that helped them manage the demands of working from home, while virtual supports ensured staff could support helpline employees deal with challenging situations:

After every call, there's a debrief of a call. People's work is checked, so if someone's sending SMSs, we can see them, so they're visible to other people. If an email's being drafted, it's checked. So, it is a team environment in that respect. (RD staff)

Rainbow Door hired more people as the pandemic progressed. This was welcome and helped to take some pressure off staff members. Some interviewed still talked the work being constant. "Quiet times" in terms of calls made to the service were often just as busy for staff members, who engaged in callbacks or undertook case management tasks. The teleweb manager and team leaders often answered and returned calls and some staff members regularly worked overtime.

Co-workers appear to be really experiencing a sense of stress in their work … Having to stay late and simply get through the demand – yes, they're getting paid, but ultimately, it's still not a good work-life balance. (RD staff)

Like clients, staff members were impacted by the threat of COVID-19 and government measures aimed at curbing its spread. During this unusual time, Rainbow Door employees also endured the usual challenges of providing support as peers to LGBTIQ+ people experiencing family violence and mental health issues. Staff members spoke of how LGBTIQ+ peers often saw their own experiences in those of their clients:

Our experience is constantly mirrored with our clients' experience within the queer community, and we might understand some of those people's experiences in that way. We're also experiencing the pandemic and all the grief and difficulties that have gone along with that. It's definitely required new self-care rituals or new boundaries around how I engage with my work. (RD staff)

There's a price to pay in a way for working in a peer service, but I don't know that it's completely recognised. But I think it's really valued by the people who use the service in just knowing that, "Oh, this is so good. I can come here, and I can have conversations with people that I would never feel comfortable having." (RD staff)

We know the toll that this can take. We had some really distressing times when the Rainbow Door first started when a community member died by suicide, and via social media it spread really quickly. That was really a distressing time for staff because we've got mostly pretty young staff who all know each other in that world. (RD staff)

The experience of being a peer was also seen as a source of strength for people working on Rainbow Door, especially during times of remote work. One staff member described how their colleague had reacted to a third person's concerns about the risks of working from home:

[They said:] "Mate … do you realise who you're talking to here? … We're LGBTIQA+ peers – we've been responding to family violence in our living rooms for years. We've been responding to suicidality in our car driving down the road … we've been responding to this in peer support networks for generations, not just in the here and now." So, of course, we've been having those intimate conversations sitting crossed-legged on our beds, in our bedrooms. (RD staff)

7.4 Summary

The launch of Rainbow Door in September 2020 was a response to an urgent need in Victoria's LGBTIQ+ communities. Arriving during a long lockdown and amid ongoing uncertainty about COVID-19, the LGBTIQ+ service instantly struck a chord with community members. As COVID-19 exacerbated existing challenges and created new ones, Rainbow Door provided vital support for people around issues such as family violence and mental health.

Rainbow Door expected to fill an important service gap, providing information, support and referrals to other services. From its launch, however, it could not keep up with demand. What was meant to be a real-time helpline often operated as a callback service. Designing, implementing and running the service were staff members performing their roles from home. They dealt with the challenges of high service demand, long waiting lists at connecting services, exacerbated client situations and their own COVID-19-related experiences.

The impact of Rainbow Door during 2020-21 underscores the importance of LGBTIQ+ community-controlled organisations that can identity their community members' needs and help address them, despite the immense challenges of a pandemic. Rainbow Door's experience in supporting people in family violence situations can inform future work. With further support, the potential exists for Rainbow Door to expand in size, work collaboratively with other services, provide more specialised services in-house and even expand into other states and territories across Australia. We discuss in the next chapter how some of this expansion could conceivably happen.

8. Lessons from a public health emergency: Practice innovation and its future potential

LGBTIQ+ community-controlled organisational responses to the pandemic transformed how clients received family violence services during 2020-21. Thorne Harbour Health and Switchboard Victoria, through its Rainbow Door service, sought to innovate to create new service models driven by flexibility and technology. This chapter considers lessons that have emerged from technology-driven flexible service delivery and how they might inform how LGBTIQ+ family violence services are provided in future.

Drawing on the insights of all 38 participants, we advance our discussion of flexible practice beyond pandemic experiences to consider long-term implications for LGBTIQ+ family violence services. We focus on the potential of flexible models to further shape how services are delivered. We also consider the likelihood of telehealth forming part of a hybrid model of service delivery in a world in which COVID-19 has been effectively managed. The importance of establishing a more robust LGBTIQ+ family violence sector for future public health emergencies is also explored. Discussion builds on insights from the past four chapters and leads into recommendations for further strengthening LGBTIQ+ family violence service delivery in Chapter Nine.

8.1 Hybrid models for a more flexible future

Earlier in this report, we noted that participants' experiences of Zoom-based counselling and telehealth were inextricably pandemic experiences. In this section, we begin to extricate the technology-driven flexible LGBTIQ+ family violence model from COVID-19. This is to acknowledge that such service delivery has an important role to play in a world beyond work-from-home orders and enforced lockdowns.

Although we recognise that the COVID-19 pandemic continued at the time of publication, we look to a future in which telehealth is only one aspect of service delivery. As part of such a model, technology-driven interaction – video calls, emails, text messages and other internet-based options – would not simply be a last resort in a crisis, but an essential component of a variegated, flexible LGBTIQ+ family violence sector. In this section, we consider how practice might further evolve through a hybrid model that combines in-person services and technology in flexible ways to best meet the needs of clients.

8.1.1 Flexibility and accessibility

Clients and staff members interviewed generally believed that flexibility was one of the achievements of family violence service delivery during the pandemic. When uncertainty reigned, flexible services provided some stability and security for clients seeking support, and for those providing it. Experiences of greater accessibility and convenience in previous chapters demonstrate this. This flexibility is something that participants predicted would be a cornerstone of future service delivery.

Thorne Harbour Health clients and staff spoke about this in terms of technology continuing to be used to meet needs, preferably as part of a hybrid service delivery model that would also include in-person, face-to-face services:

> *These kinds of services have to be able to accommodate all needs – different needs from different people. I'm an introverted person and I am more comfortable through Zoom, [so] they have to be able to accommodate that. But on the other hand, there are specific things that cannot be replaced by technology. (Victim survivor)*

> *There have definitely been people in society who have needed Zoom … It's great to have the option, and I think, almost essential to have the option. This day and age ... the technology is there. So why not? (ReVisioning participant)*

Flexible options would also be a response to evolving client needs throughout a support program. As one client said:

> *Sometimes I think it's really important that we have that face-to-face thing at our greatest time of need – which is when we're pretty terrified and we need to access a service … I sat in a room in comfy chairs with [a family violence practitioner] and that's what I needed … But after that, when you can calm down and you're going to be slightly taken care of … personally, I don't think you need to be face to face anymore. (Victim survivor)*

Thorne Harbour Health and Rainbow Door staff members alike believed that flexibility had become essential for professionals and, so, expected remote-work arrangements to continue in some capacity:

> *I would like flexibility and … a choice … Just trust in the staff – we've been managing it for the last 18 months. We can, you know. (THH staff)*

> *We have people with some significant chronic health conditions and disabilities – staff who work on Rainbow Door – and I myself have a disability, so it actually opens up the scope for people … I'd be happy to return to the workplace a few days a week …[but] I also know now that I can work from my computer really successfully from home. (RD staff)*

> *[Switchboard] are open to a hybrid [model] as well, so choosing to either work from home or the office – a mixed model so … having flexible arrangements. (RD staff)*

8.1.2 Technology as part of a hybrid model

Interview participants overwhelmingly believed that telehealth and remote service delivery should continue as part of a hybrid model that also included in-person, face-to-face services. This was irrespective of their own preferred way of accessing or providing family violence services.

Clients predicted that hybrid systems would deliver the "best of both worlds". Having the option of either attending services in person or accessing them remotely catered to individual needs, in terms of access, convenience, safety and recovery. Many clients saw advantages and limitations in both modes of service engagement:

> *A hybrid model could definitely work. There are a lot of instances of family violence where a partner has hacked into someone's phone, or … there's all this spyware, and there's all these things that can be purchased under the guise of it being a parental tracking of your children … In those instances, it does make it unsafe to have all the correspondence be completely technology based. So, hybrid is good because it gives the option for both. (Victim survivor)*

> *I think we will have a hybrid model … A lot of my very chronically ill friends and a lot of very mentally ill friends … I'm sure they found this very good, because if there are some days you can't get out of bed, you can open your laptop … So, they are now getting therapy on the days where they couldn't handle crossing the city … For them, there was an absolute and definitive improvement. (Victim survivor)*

I would like flexibility and … a choice … Just trust in the staff – we've been managing it for the last 18 months. We can, you know.

(THH STAFF)

Thorne Harbour Health staff members also saw a hybrid model as inevitable, for a range of reasons, including due to the continued risk of COVID-19 infection. Staff were already considering the logistics of managing such challenges:

> *I think it should be hybrid … It's really convenient for people not to have to take two buses and a tram to get to wherever. It can be much more convenient, but I think you want to check in face to face with people sometimes. So, maybe once a month, you see someone face to face and then the other one or two sessions you might do online. (THH staff)*

A hybrid model posed specific challenges for group programs such as ReVisioning, as one Thorne Harbour Health staff member noted:

> *We've been talking recently about whether we should go back to split face-to-face or online or do a hybrid where we're dialling in from the conference room, where we've got five people face to face and then 10 people online, particularly for those that are still in the country or rural areas … I think the split focus is going to be difficult … I think if people were given the option, they'll probably stay online. (THH staff)*

A review of telehealth practices would be necessary after the events of 2020-21, many staff believed. A Thorne Harbour Health staff member said:

> *In a post-pandemic world, we wouldn't need to change a huge amount. We need consistency amongst how they operate via policies, staff training for Zoom, maybe a bit more money for technology, so people have consistent technology and can operate it well … It needs to be a hybrid model because while Zoom services and telehealth services were good for the majority of people during the pandemic, for a lot of people they were just so inaccessible, there wasn't great service for them … My preference would be to see people in person, but it's totally up to the client. (THH staff)*

Discussions around a hybrid model's capacity to deliver services statewide, the need to develop additional Zoom guidelines for staff, and striking a balance between working in the office and from home also featured in interviews with Thorne Harbour Health staff.

8.1.3 Advancing flexible models through technology

With participants mostly accepting telehealth services and remote work as inevitable features of a hybrid model, some made suggestions about how they might be improved. A key concern focused on the technology. Some participants were uneasy about counselling sessions and other sensitive conversations between practitioners and clients taking place over Zoom. A Thorne Harbour Health staff member raised concerns about a third-party application being used for family violence services, saying:

> *I mean we're using a private corporation to do this work with clients because there isn't a government-funded telehealth system that we can use effectively, so that's a gap. Zoom improved their privacy and all those sorts of things, but no doubt there would be clients who are not comfortable to use a third-party provider. As an organisation, to have a telehealth model that is coordinated and firewalled … through our state governments or federal governments, that would make much more sense to me, but we don't have one of those yet, so we use Zoom or Microsoft Teams. (THH staff)*

Another Thorne Harbour Health staff member said Healthdirect Australia might be among the suitable alternatives to Zoom:

> *There are video counselling-like teleconferencing platforms that are specifically… for health practitioners. There's an actual waiting room [with] music. The whiteboard function is just way more effective and the way that you can lower your resolution if it's glitching out, so you can still see each other but you don't have to turn your camera off … I think it would be better. (THH staff)*

Staff were concerned that some clients who needed to engage via telehealth still did not have access to adequate technology. A need existed, one staff member said, to continue to invest in communicative devices and equipment for clients:

> *Some of our clients don't even have a smartphone … We purchased a lot of laptops for clients the first year … You've got to be careful it doesn't turn into another "haves and have nots" kind of system. The ability to be able to purchase that equipment for people, which we got in the first year, but you know not thereafter … People thought it was a one-off investment. (THH staff)*

Looking further ahead, one client suggested that LGBTIQ+ family violence services had the potential to incorporate much more advanced technology, including virtual reality, into counselling sessions:

> *It [VR] can probably provide a more comfortable environment. If you want to have your session on the beach, you can do that … I live in a shithole. It's awful … Our landlord is awful … The walls are disgusting … This house is terrible. And I can't imagine other people in a similar situation are going to be living in nice houses, either. I feel like one of the reasons I'm in such a bad mind-frame all the time is because the house that I live in is a dump. Just being in an environment that isn't that. That is also more convenient. (Victim survivor)*

8.1.4 Reviewing and refining practice

Thorne Harbour Health adapted its services for remote delivery at the beginning of a pandemic. Rainbow Door launched during a long lockdown in Melbourne. Both services were overwhelmed by demand for services thereafter. At the time of interviews, in late 2021 and early 2022, staff members from both organisations lamented having had little or no time to reflect on the challenges of flexible and remote work. Demand for family violence support had been constant and client situations severe.

Many sensed that when the COVID-19 situation eased, new practice developed during the pandemic would have to be reviewed and refined. A staff member at Thorne Harbour Health said:

> *We set up this whole telehealth model as a back-of-the-envelope process with good principles but a really rapid process in response to a global crisis. So, that doesn't necessarily translate with what you want in terms of a best-practice model for a non-crisis time … If we're thinking about a time where clients can choose between telehealth or face-to-face work, what we need to do as an organisation is go, "OK, so what kind of clients would telehealth be appropriate for? … What's the principles around our decision-making … [What about] staff if they want to work remotely?" (THH staff)*

For Switchboard Victoria, similar evaluation lay ahead. Due to the helpline being created during a lockdown, however, the thought process would be slightly different. More focus would immediately be on adapting practice for an office environment. One staff member said:

> *Are there ethical guidelines to work out more about working from home? The big thing is that Rainbow Door has never been an organisation where we've worked in an office together, so I think that's going to be the next big challenge. How is this actually going to work when we're together? (RD staff)*

Reviewing and strengthening practice was considered a priority for both Thorne Harbour Health and Rainbow Door from 2022 onwards. Guidelines and procedures around telehealth's role in a hybrid system would affect how clients continued to access services and how (and where) staff worked.

8.2 Establishing more robust systems

In this report, we have demonstrated how Thorne Harbour Health and Rainbow Door have sought to limit the damage of the COVID-19 pandemic on LGBTIQ+ people in Victoria experiencing family violence.

We have helped highlight the strain that the LGBTIQ+ family violence sector has been under more generally. Client and staff experiences also reveal a sector that needs further support and development to ensure it is adequately prepared for the next pandemic or emergency. In this section, we focus on the ways in which LGBTIQ+ family violence service capacity could be further strengthened, how referral pathways could be improved and the importance of more awareness of LGBTIQ+ issues.

8.2.1 Building LGBTIQ+ service capacity: Staff perspectives

Reports of long waiting lists for services, a helpline that cannot answer all its calls and a dearth of qualified professionals reinforce calls for greater provisioning of this sector. A recurring theme in interviews with both Thorne Harbour Health and Rainbow Door staff members was the need to better meet client demand. This was talked about frequently in terms of staffing levels and service capacity:

> *The biggest issue is just how significantly under-resourced the family violence service is, just in general. There's a lot of people being assessed and doing an intake for that service, but there's only five staff and the waitlist is really long. Without putting appropriate resources into more staff, that just won't change. (THH staff)*

> *Yeah, 100% [more people could work on the Rainbow Door helpline] because when there's four people on, it feels great, but there could be more. Also, because it's chronically understaffed there's no backfill. It means that you're catching up … More staff is always going to be helpful because there's not clear pathways for people and there's a lot of advocacy that could potentially happen to get better responses too. (RD staff)*

Resource enhancements would allow Rainbow Door to be more thorough with case management and other services it provides and to potentially expand into other areas of service. Some staff saw the potential for additional services to be built into Rainbow Door's model, widening the service's scope. Ideas included in-house counselling, to complement what other services were offering and to reduce waiting times; system reform that would allow L17 family violence referrals to come directly from the police to Rainbow Door; and more brokerage capacity. Staff members said:

> *It's very obvious that we do need more counselling support available for our communities. We've talked about having just a counselling support service within Rainbow Door … I think that would be helpful because there's huge waiting lists and it's very needed… I do wonder whether having video calls might be helpful for some people as an option … but then that changes what the service is. (RD staff)*

> *Would it be useful to have brokerage if people needed a new phone or basic necessities? … Because sometimes the pathway to things like even private rental assistance is a long time … Not everyone wants to go or can go into refuge or can self-fund or might be so isolated … At the moment, it's like a referral to Thorne Harbour, which definitely try and be as responsive as they can with the limited staff they probably have, but I'm aware that it's not the quickest process. (RD staff)*

> *There could be a time in the future where [L17s] actually come to Rainbow Door and we triage them, and we actually have brokerage, and we have enough staff to do that … I think, eventually, Rainbow Door could absolutely receive those L17's. (RD staff)*

Staff talked about the importance of better pathways into LGBTIQ+ family violence work. This was discussed both in terms of the need to improve tertiary courses aimed at those wanting to enter the workforce and, conversely, the need to prioritise high-quality practical experience over academic qualifications. In any case, retention of quality workers was considered something that needed to be addressed. One Thorne Harbour staff member said:

It's about understanding the dynamic nature of LGBTIQ+ relationships, but also when LGBTIQ+ people have gone through family violence, sensitivity really matters. Having someone who can relate and empathise is really important.

(VICTIM SURVIVOR)

> *There needs to be more investment in workforce development because it's really hard to recruit people … There needs to be a lot of investment in workforce development and wages need to be looked at. Drug and alcohol and family violence people leave to go and get better paid jobs in other sectors – they're not well paid. (THH staff)*

One Thorne Harbour staff member observed that resource constraints were symptomatic of the family violence sector more generally:

> *All family violence services could always use more staff, more funding, so we would definitely benefit from that. But … I think the ratio would probably be pretty similar comparing Thorne Harbour to a mainstream women's service in terms of staff to clients … but we could all use more funding and more staff. (THH staff)*

8.2.2 Building LGBTIQ+ service capacity: Client perspectives

Clients recognised the need for a more flexible, better-resourced LGBTIQ+ family violence sector. Almost all said it was important to access services that were LGBTIQ+ specific. They spoke about such services understanding their needs and, consequently, offering safe and efficient support. This response from a client is reflective of many:

> *It's about understanding the dynamic nature of LGBTIQ+ relationships, but also when LGBTIQ+ people have gone through family violence, sensitivity really matters. Having someone who can relate and empathise is really important. (Victim survivor)*

Clients called for more investment in the LGBTIQ+ family violence sector. This was most often talked about with reference to waiting lists and a desire for longer counselling programs:

> *But if they [Thorne Harbour Health] have been struggling with funding, and they have been struggling with staffing – which is evident – whatever the roots of that are definitely need be solved. … If they had twice as many offices, and twice as many counsellors, and were able to … shorten those waitlists – that might help. (Victim survivor)*

A client in regional Victoria believed that as part of a hybrid model, Thorne Harbour Health should have more in-person presence outside Melbourne:

> *Even if it's just attaching itself two days a week to another service … I would [also] like to see other services around so there's a bit more choice for people within my community. (Victim survivor)*

Many clients were aware of the bigger picture: that support services for LGBTIQ+ people in Victoria were still limited. Some clients, though appreciative of Thorne Harbour Health's support, saw their programs as only one small piece in an incomplete service puzzle. One said:

> *There are not enough resources for LGBTIQ+ people. In Victoria, Thorne Harbour is the only one providing this service at this level. For LGBTIQ+ family violence. Rainbow Door has been created but is not providing the service. They are putting people in touch [with Thorne Harbour]. And they are doing an amazing job for the capacity they have been given. We need to do better as a society … If Rainbow Door was able to provide services, the more resources available, the better. You go online and search. It's generally shelters for women. [When you try to access services], you get rejected or they don't know how to help. (Victim survivor)*

8.2.3 Improving referral pathways and enhancing awareness of LGBTIQ+ family violence concerns

Some clients reported that they found referral pathways to Thorne Harbour Health to be complicated. Many had little knowledge of Thorne Harbour Health prior to accessing its services. They also said that other health services or family violence services had little knowledge of existing LGBTIQ+ family violence and service options. Some clients wished they had known sooner that Thorne Harbour Health even offered family violence services. Wider promotion of services was something many clients said was necessary:

> *I've come across that several times: people don't know what else is available. And it took years before I heard of Thorne Harbour. No one even knew they existed. (Victim survivor)*

> *It's still something new that's being brought into the public psyche – family violence within queer relationships. [Thorne Harbour Health] were the only one that I'd heard of, and I didn't even know that they existed before that, and I was so glad that they did. (Victim survivor)*

These experiences were part of what many participants believed was a lack of awareness of LGBTIQ+ family violence in society more generally. More awareness of LGBTIQ+ experiences and issues was needed, through education and research, clients said.

Prevalent in staff interviews was discussion about how LGBTIQ+ family violence services could better interact with mainstream health and mental health services, police and courts.

> *We just need much, much better support from police and better refuge systems. They were the problems before the pandemic, during the pandemic and they're still there. (THH staff)*

We could learn a lot from a mainstream service … It's about recruiting from those services or hiring people who have that specialist experience. (THH staff)

Throughout the pandemic, staff from both Thorne Harbour Health and Rainbow Door had opportunities to share practice experiences and service innovations. Examples include collaborating with each other, working with No to Violence (NTV) around how to run a Men's Behaviour Change Program (Thorne Harbour Health), attending sector forums and engaging with organisations such as Berry Street.

Dialogue with the wider family violence sector was both an important way of learning from and informing other organisations about practice innovation. A Thorne Harbour Health staff member said:

Most of us in the team attend a whole raft of communities of practice and do a lot of sharing in those kinds of spaces. There was earlier this year the LGBTIQ+ family violence forum, where we certainly presented on service provision during the pandemic and we also did an overview of a really important couple of sessions that we do in ReVisioning on hyper-masculinity. Then we also took that and did a bit of an axis twist and delivered that at a broader mainstream family violence forum in September. Instead of, "How might this be applied to an LGBTIQ+ group?", it was, "How about you take this and apply it to a mainstream group?" (THH staff)

More engagement with service providers and the broader community might be valuable to both organisations as they seek to refine and strengthen practice. Rainbow Door, for example, has developed plans for expansion that centre on collaboration. One staff member explained that:

Our future work is around co-case management and secondary consultations, and … the Rainbow Ticked family violence services – working with them in a meaningful way for them to change their service delivery. And we need them to change the way they operate so that we can work more effectively with them, so that our clients can get access to service. (RD staff)

8.3 Summary

For Thorne Harbour Health and Rainbow Door, the path out of the COVID-19 pandemic remains uncertain. Many lessons, however, have already been learned. In this chapter, we have demonstrated that the experiences of the past two years will help to shape how LGBTIQ+ family violence services are delivered in Victoria henceforth. Technology-driven flexible service options and remote service delivery will likely be part of a hybrid model that foregrounds client needs.

The LGBTIQ+ family violence sector faces many challenges in responding to existing service demands and preparing for future emergencies. Neither Thorne Harbour Health nor Rainbow Door are funded to employ as many staff as are needed to address demand, which has surged in the past two years. Hence, waiting lists have grown significantly longer. Suitably qualified staff, equipped to meet the demands of LGBTIQ+ family violence service delivery, are difficult to find and retain. Consideration is needed on how best to address shortfalls.

Further support for the sector would allow organisations working in LGBTIQ+ family violence service provision to reach more people and provide more comprehensive, tailored support. Those funding the LGBTIQ+ family violence sector should help it prepare for future emergencies, including in terms of developing surge capacity in community-controlled organisations. Promoting awareness of the needs of LGBTIQ+ family violence services and their clients appears a crucial way of continuing to improve referral pathways to Rainbow Door and Thorne Harbour Health.

Both services have demonstrated the value of flexible options for clients and staff. After the events of 2020-21, various work practices – those designed before and during the pandemic – need reviewing to ensure they are efficient, client-centred and sustainable.

We could learn a lot from a mainstream service … It's about recruiting from those services or hiring people who have that specialist experience.

(THH STAFF)

9. **Summary and recommendations**

9.1 Summary

Thorne Harbour Health and Switchboard Victoria, through its Rainbow Door helpline, sought to innovate service delivery in 2020 to reduce the dual impact of family violence and the COVID-19 pandemic on LGBTIQ+ community members. Telehealth and other flexible options reduced service interruptions during lockdowns, prioritised client safety and challenged some assumptions about how LGBTIQ+ family violence services should be delivered. The response of both organisations marked a significant change in how LGBTIQ+ family violence services were delivered in Melbourne and across the state of Victoria.

At the heart of innovation was a flexible service model that used technology in new ways. Work-from-home measures and lockdowns were seized upon by both organisations as opportunities to use Zoom calls, text messages and emails in ways that best catered to the safety and needs of victim survivors – including those locked down with perpetrators – and other service clients. Thorne Harbour Health rapidly built technology into its service model. Counselling and Men's Behaviour Change were among services adapted for Zoom. Switchboard Victoria created and launched the Rainbow Door helpline, allowing staff members to provide information, support and referral services from their homes.

Practice changes and the professionals driving family violence services from their homes doubtless prevented more serious harm from occurring. The two LGBTIQ+ community-controlled organisations, despite their capacity limitations, were well placed to respond to a pandemic, having both been founded during the HIV/AIDS crisis. Their willingness to embrace flexible practice that prioritised the individual safety and needs of clients demonstrates an ethos honed through decades of service to LGBTIQ+ communities. The following quotation from a Rainbow Door staff member describes the LGBTIQ+ community connectedness that underpinned the organisations' pandemic response:

> *There is a small group of people – there's teams at Thorne Harbour, teams at Queerspace, teams at Rainbow Health, us at Switchboard – who are really embedded in doing this work together … I don't think we've been able to celebrate what we've achieved yet … just because we've been so frantic. (RD staff)*

The flexible practice leap forward that has occurred since early 2020 has challenged assumptions about family violence delivery and created new service options for clients, including by increasing access for people with a disability and/or living outside Melbourne. Experiences highlighted in this report provide valuable insight into opportunities to further expand, reshape and redefine practice in preparation for future challenges. These might include emergency events such as floods, fires or other climate-change-induced crises. As a Thorne Harbour Health staff member said:

> *This research is obviously about family violence responses in a COVID situation, but no doubt there will be lessons learned from this that you could apply to any emergency crisis-type situation, whether it's a community struggling with bushfire-related emergencies or flooding or whatever it might be. When you go back to principles of practice and principles of decision making, there's lots of applicability … We know that the connection to community is so life-affirming for people in lots of ways and that when you can provide that culturally safe, self-affirming response to people whatever their identity that's really helpful in terms of recovery. (THH staff)*

The challenges of providing tailored family violence services under such difficult circumstances – an ongoing pandemic, lockdowns and social isolation (to name just a few) – have placed enormous strain on a dedicated but now fatigued workforce. Practitioners providing services from their homes have had to deal with many challenges. These include more complex client needs, isolation from colleagues, less defined boundaries between work and home life, privacy issues and holding more risk. Wellbeing issues for professionals have included burnout, stress and other mental health challenges. Issues facing the LGBTIQ+ family violence sector remain unresolved. Innovation proved valuable in a pandemic but important issues around capacity still need to be addressed. These relate to the length of waiting lists and client safety.

Both Thorne Harbour Health and Rainbow Door have benefited from the Victorian state government's commitment to strengthen services for LGBTIQ+ people as part of a broader 10-year strategy to improve the family violence sector. The services now available to LGBTIQ+ people in Melbourne and other parts of Victoria support in part the state government's claims that it is implementing "nation-leading family violence reforms" (16). However, unmet demand for services during the pandemic indicate that more needs to be done to support LGBTIQ+ people experiencing family violence.

Flexibility and risk featured prominently in the innovation that drove Thorne Harbour Health and Rainbow Door as they responded to COVID-19. Both organisations provided more options for clients to access family violence services in ways that suited individual needs, including with reference to safety, location, proximity to a perpetrator, financial situations and mental health. Both organisations broke new ground in service delivery, supporting clients whose safety was harder to gauge and whose issues COVID-19 exacerbated, all while increased demand lengthened waiting lists and staff members worked from their bedrooms.

Flexibility and risk are important when considering how LGBTIQ+ family violence services go forward. As a remote service delivery model likely makes way for a hybrid system in which technology and in-person services both play essential roles, flexibility should be further embraced and risk further minimised.

Intersectionality and inclusion in LGBTIQ+ family violence services

This report provides a snapshot of the challenges that clients with diverse identities experience when accessing LGBTIQ+ family violence services. Interviews with clients of Thorne Harbour Health and staff members of both organisations demonstrate the importance of flexible service options that consider not only sexual orientation and/or gender identity, but also a range of other factors such as ethnicity, cultural and religious background, visa status, neurodiversity, disability and location.

Clients that Thorne Harbour Health and Rainbow Door provided support to during the pandemic include:

- People whose disability made travelling for services difficult or impossible
- First Nations Australians whose previous experiences of accessing services had been damaging to them
- International students experiencing financial hardship and/or visa uncertainty
- Migrants who faced returning to hostile social environments in their countries of origin
- People from refugee backgrounds whose families did not support their sexual orientation and/or gender identity
- Clients with auditory processing disorder for whom the lag of a video conversation made interaction difficult

Technology has provided more service options for many clients with diverse needs. By cutting out travel and being suitable for a range of settings, video-based counselling has made LGBTIQ+ family violence services more accessible. Telehealth, however, is not a one-size-fits-all remedy to issues of access. For some clients, difficulties accessing, communicating and processing information over Zoom, for example, meant that teleconferencing was yet another barrier to receiving the support that they needed.

This underscores the importance of continuing to prioritise flexibility in the LGBTIQ+ family violence sector as part of a hybrid service model. Meeting the individual needs of LGBTIQ+ clients with diverse backgrounds relies on a willingness to accept technology as having a place alongside in-person support. It also relies on LGBTIQ+ family violence organisations and their practitioners having the flexibility to act when technology is hindering service access for a client.

The effectiveness of flexible options relies in no small way on organisations understanding client needs. This speaks to the importance of LGBTIQ+ community-controlled organisations being able to draw upon the lived experience of professionals to support clients in ways that might transcend sexual orientation and/or gender identity. Interviews demonstrate the value of family violence service staff who understand client experiences of cultural and linguistic diversity, disability and neurodiversity.

9.2 Recommendations

We encourage further support for LGBTIQ+ family violence services to come from any agency or body with the capacity to enhance how Thorne Harbour Health and Switchboard Victoria operate. This includes, but is not limited to, state governments, the federal government, the broader family violence sector, non-governmental organisations (NGOs) and philanthropic enterprises.

We make the following recommendations:

1. **Further develop flexible practice to ensure long-term technology-driven support options**

Seize on the advantages of technology-driven service options, as part of a hybrid LGBTIQ+ family violence service model. Consider further developing the range of features of telehealth that improved access, convenience and safety for clients seeking support. Invest in improvements to the safety, quality and effectiveness of telehealth infrastructure.

Consider developing a private, safe and flexible telehealth platform for all Victorian family violence services. Ensure that it is free as possible from potential third-party interference, is accessible on many devices and provides therapeutic "book-ends" such as virtual waiting rooms. Develop practice with a view of technology being a long-term feature of LGBTIQ+ family violence service delivery. Develop intersectional and ethical frameworks around service provision by considering experiences of flexible service adaption during the pandemic.

2. **Determine additional flexible practice needs for hybrid service delivery and future emergencies/ health crises**

Draw on the experiences of LGBTIQ+ family violence services during COVID-19 to determine the role of technology as part of a hybrid service model in the future. Consider the different needs of referral, intake, assessment, case management and counselling services as part of an everyday hybrid model and, separately, as one that responds to an unfolding health emergency.

Where appropriate, share learnings, practice developments and evaluation of telehealth procedures and experiences during COVID-19 to help drive sector-wide discussion and collaboration between LGBTIQ+ service providers, the wider family violence sector and governments. Consider embedding more flexibility into family violence services, including by exploring options for LGBTIQ+ community-controlled organisations to process police referral forms (L17).

3. **Scale up organisations that deliver LGBTIQ+ family violence services and strengthen referral pathways**

Support organisations to provide more comprehensive and responsive family violence services. Build capacity within LGBTIQ+ community-controlled organisations, such as Thorne Harbour Health and Switchboard Victoria, to provide early intervention to avoid escalation of family violence. Consider how intersectional family violence frameworks might be best utilised in both LGBTIQ+ community-controlled organisations and mainstream services to increase capacity to respond to LGBTIQ+ family violence.

Strengthen referral pathways between LGBTIQ+ family violence services and organisations and agencies that refer or could refer victim survivors to them. These include, but are not limited to, mainstream family violence support services, mental health services, health services, police and courts.

4. **Further develop workforce capacity in LGBTIQ+ family violence services**

Harness the potential benefits of the Victorian Government's delivery of Royal Commission Recommendation 168, which provided funding and other resources to support LGBTIQ+ services and communities. Further strengthen a better funded and trained LGBTIQ+ family violence workforce by focusing on valuing and retaining professionals in the sector.

Consideration around remuneration, workload, supervision and flexibility should inform efforts to retain skilled, empathetic practitioners and other professionals in the long-term, thereby strengthening organisational and sector experience. Focus on using this enhanced expertise and experience to meet a range of client needs with fewer service interruptions.

5. **Strengthen workforce supports to sustain wellbeing and efficacy**

Ensure family violence service delivery is sustainable for those providing it. Develop support mechanisms for staff that reflect how service delivery has transformed since 2020. Focus on understanding and measuring the cumulative effects of the COVID-19 pandemic on family violence professionals and the support they need. Consider the known impacts of remote work, including those demonstrated in this report and develop better understandings of compassion fatigue, moral injury, vicarious trauma and burnout associated with family violence practice.

Pay attention to the ways in which practitioners might be supported to sustain wellbeing and efficacy while delivering hybrid services and in preparation for future public health emergencies. Review and update support mechanisms, especially those drafted before the COVID-19 pandemic, to reflect the post-2020 world.

6. **Develop surge capacity plans for future natural disasters or public health emergencies, acknowledging how LGBTIQ+ communities are impacted**

Ensure organisations that provide LGBTIQ+ family violence services are equipped to deal with the next public health emergency. Consider what a plan that maps out LGBTIQ+ needs during crises might look like, using experiences of the COVID-19 pandemic as a reference point. Upskill LGBTIQ+ community members in peer lived experience roles to meet demand during emergencies. Mobilise relevant professionals working elsewhere in the sector and in other sectors to meet demand. Remunerate those working in the sector to reflect the additional workload, risk and hours involved in their roles during a public health emergency.

To assess needs during a pandemic, consider information sharing across the family violence sector and the health and mental health sectors more generally. Ensure more systems are working collaboratively to address the issues and improve the outcomes of LGBTIQ+ people and others experiencing family violence. Prioritise rapid adaptation and response as part of long-term strategies to address workforce capacity during a public health emergency.

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Appendix

Research questions

We began with three main research questions, each of which included detailed exploration of various sub-topics:

1. **How did COVID-19-related restrictions reshape the ways in which LGBTIQ+ people engaged with family violence services in Victoria?**

Included in this was an exploration of:

a. Changes in risk perception, risk realities and help-seeking behaviours

b. Reconfigured barriers or enablers to service engagement (for example, how remote delivery of services impacted uptake)

c. Changing practices of referral from other health or social care practitioners

d. Motivations for, and experiences of, engaging with an LGBTIQ+-specific service as opposed to other providers

2. **What innovations were introduced to the LGBTIQ+ family violence service model and how might these have met or reshaped client needs within the context of COVID-19 restrictions?**

Included in this was an exploration of:

a. Perception of Thorne Harbour Health and Switchboard Victoria staff as to the nature of service engagement by LGBTIQ+ community members during COVID-19

b. Practice adaptations that were introduced and reflections as to their effectiveness and potential sustainability

c. The capacity of the service model (for example, in terms of staffing, technology and platforms) to rapidly adapt to changing circumstances

3. **What emerging and promising practice for family violence service delivery can be promoted across the sector to ensure essential support for LGBTIQ+ communities, including during emergencies?**

Included in this was an exploration of:

a. Varied approaches that organisations adopted to serve LGBTIQ+ community members and collective challenges to service adaptation

b. Continued capacity and/or evidence building that might be required within the broader family violence sector to recognise and respond to family violence within LGBTIQ+ communities

c. Broader innovation in engaging, and meeting the needs of, LGBTIQ+ communities in the provision of family violence services

Research methods

Researching LGBTIQ+ communities requires sensitivity, not least of all to avoid perpetuating harmful stereotypes of dysfunctionality (38). ARCSHS has a strong commitment to ensuring that LGBTIQ+ communities have a voice not just in research of which they are the subject, but also in guiding the direction of that research. To help achieve both sensitivity and inclusiveness, ARCSHS designed this study in partnership with Thorne Harbour Health and Switchboard Victoria. Report authors and organisational representatives met regularly from August 2021 to July 2022 to discuss progress, direction and outcomes. Researchers sought and gained ethics approval for this study from the La Trobe University Human Research Ethics Committee (HEC21352) and endorsement from Thorne Harbour Health's Community Research Endorsement Panel (THH/CREP 21-016).

Due to the sensitive nature of the topic and the likelihood of participants having experienced trauma, the authors developed participant support protocols to ensure that the wellbeing of those being interviewed was prioritised. This took into consideration that many Thorne Harbour Health and Switchboard Victoria staff are LGBTIQ+ community members. The protocols informed how researchers responded to participant distress during the interview phase. This was of additional concern to researchers due to the highly challenging situations that participants were placed in due to COVID-19.

Phase One: Interviews with Thorne Harbour Health and Rainbow Door staff members

Eligibility

- To be eligible to take part in an interview as a staff member, participants were required to:
- Be aged 18 years or over
- Have provided family violence services or associated services during the COVID-19 pandemic as a staff member of Thorne Harbour Health or Switchboard Victoria's Rainbow Door

Recruitment and interviews

Representatives of both Thorne Harbour Health and Switchboard Victoria helped to identify potential interview participants. Information was shared with staff members about the study and those interested in taking part contacted the first author. The first author and interviewees then scheduled one-to-one interviews. Thorne Harbour Health and Switchboard Victoria representatives involved in recruitment did not have information about who was interviewed, nor did they have access to raw interview data.

Due to ongoing concerns about COVID-19 infection, all interviews took place over Zoom, lasting from 45-90 minutes. Participants were asked questions about:

- Their experiences working at Thorne Harbour Health or Rainbow Door
- Working from home during lockdowns
- Providing family violence services during a pandemic
- How COVID-19 affected client engagement with services
- How service changed
- What role telehealth and remote work might have in the long-term

Audio recordings of the interviews were transcribed and stored on a secure drive at La Trobe University. Transcripts were analysed in NVivo, a qualitative research software suite. Thematic analysis (39) was used to organise data from the transcripts into themes that helped address the research questions.

Participant demographics

In total, 14 Thorne Harbour Health staff were interviewed. Most participants identified as Australian with British, Irish and/or other European ancestry. One participant had Aboriginal ancestry, while another was from South Asia. Participants were highly educated, holding relevant qualifications including bachelor's degrees, master's degrees, diplomas, post-graduate diplomas and graduate certificates. Participants had worked in family violence services or related services from periods that ranged from about six months to more than 20 years. Other demographic characteristics feature in Table 1.

Five employees of Rainbow Door were interviewed. As part of their roles on the helpline, all provided family violence services. Support included providing information, making referrals to other services and offering general help to LGBTIQ+ community members in distress.

All five participants identified as LGBTIQ+ and were, therefore, not only professionals, but also peers to many of the helpline's callers. They identified as Australian with British, Irish and/or other European ancestry. None were Aboriginal or Torres Strait Islander. Participants were highly educated, holding qualifications including bachelor's degrees, master's degrees, diplomas, post-graduate diplomas and certificate IVs. Participants had worked in family violence services or related services from periods that ranged from about two years to 30 years. Other demographic characteristics feature in Table 2.

Table 1. Demographic characteristics of Phase One interview participants (Thorne Harbour Health)

Professional role	**Number**
Family violence practitioner	**5**
Therapeutic services manager	**1**
Intake and assessment clinician	**3**
Family violence services team leader	**1**
AOD co-ordinator	**1**
Brokerage administration worker	**1**
Director of services	**1**
ReVisioning co-facilitator	**1**
Age	
18-29	**2**
30-39	**5**
40-49	**4**
50-59	**2**
60+	**1**
Sexual orientation	
Heterosexual	**2**
Bisexual	**2**
Queer	**3**
Declined to comment	**1**
Did not specify	**1**
LGBTIQ+	**1**
Gay	**2**
Pansexual	**1**
Queer and bisexual	**1**
Gender identity	
Cisgender man	**4**
Cisgender woman	**5**
Trans and gender diverse	**4**
Declined to comment	**1**

Table 2. Demographic characteristics of interview participants of Phase One (Switchboard Victoria)

Professional role	Number
Teleweb manager	1
Rainbow Door helpline worker	2
Practice lead	1
Teleweb team leader	1
Age	
30-39	3
50-59	1
60+	1
Sexual orientation	
Pansexual	1
Dyke	1
Lesbian/queer	1
Gay	1
Queer	1
Gender identity	
Cisgender man	1
Cisgender woman	2
Trans and gender diverse	1
Queer	1

Phase Two: Interviews with clients of Thorne Harbour Health's family violence service

Eligibility

To be eligible to take part in an interview, participants were required to:

- Be aged 18 years or over
- Have accessed Thorne Harbour Health's family violence services as a client (victim survivor) during the COVID-19 pandemic

Recruitment and interviews

As with Phase One, representatives of Thorne Harbour Health identified potential interview participants. In this case, they did so while paying particular attention to the safety and wellbeing of prospective interviewees, and also providing autonomy and choice for clients to speak about their experience. Information was shared with clients about the study and those interested in taking part contacted the first author. The first author and interviewees then scheduled one-to-one interviews. Like in Phase One, Thorne Harbour Health and Switchboard Victoria representatives involved in recruitment did not have information about who was interviewed, nor did they have access to raw interview data.

Interviews followed the same pattern as Phase One, with only questions differing. Phase Two participants were asked about:

- Accessing services at Thorne Harbour Health
- Changing engagement with family violence services during COVID-19
- Accessing services from home
- Effectiveness of telehealth and other online services
- Referral pathways
- The importance of LGBTIQ+-specific services
- How they might like to access family violence services in the future

Although participants were not asked about their experiences of family violence, some provided such details as background. Data storage and analysis was the same as in Phase One.

Participant demographics

Many of the participants in Phase Two identified as Australian, using terms such as "white Australian", "Celtic", "Caucasian", "British" and "Irish" to describe their ancestry and ethnic background. Despite efforts by the researchers and the organisation to include a diverse range of client voices, no participants in this phase were from an Aboriginal or Torres Strait Islander background. We recognise that this is a limitation, and that there are barriers for Aboriginal clients to share their experiences. About one-third of participants were of East, South or Southeast Asian background. Participants lived in Australia, except for one, who had returned to live in Southeast Asia. One participant came from a refugee background.

Ten of the participants described their relationship status as single (8), not in a relationship (1) or divorced (1). Five were engaged (2), in a relationship (2) or polyamorous but currently dating one person (1). Education levels varied, ranging from participants who had left school before completing Year 12, to one participant who held a doctorate. Many were university educated. Other demographic characteristics feature in Table 3.

Table 3. Demographic characteristics of Phase Two interview participants

Age	Number
18-29	5
30-39	3
40-49	3
50-59	2
60+	2
Sexual orientation	
Gay	7
Homosexual	1
Lesbian	3
Queer	1
Bisexual	1
Asexual	1
Preferred not to answer	1
Gender identity	
Male	7
Female	6
Trans and gender diverse	2

Phase Three: Interviews with participants of Thorne Harbour Health's Men's Behaviour Change Program

Eligibility

To be eligible to take part in an interview, participants were required to:

- Be aged 18 years or over
- Have accessed Thorne Harbour Health's family violence services as a participant of ReVisioning during the COVID-19 pandemic

Recruitment and interviews

As with previous phases, representatives of Thorne Harbour Health identified potential interview participants. In this case, they did so while paying particular attention to the safety and wellbeing of potential participants' partners and/or former partners. Recruitment was like Phase Two. Interviews were also conducted the same way, with only the content differing from the previous phases. Phase Three participants were asked questions about:

- Experiences of services at Thorne Harbour Health
- Accessing the ReVisioning program from home
- The effectiveness of telehealth.

Data storage and analysis followed the same pattern as previous phases.

Participant demographics

Of the four participants in Phase Two, one identified as Aboriginal/First Nations Australian, two were white Australian with British, Irish and/or other European ancestry and one was Southeast Asian. Two were engaged and two were single. Education levels varied, ranging from one participant who had left school before completing Year 12, to participants who held a master's degree. Two participants were aged 30-30 and two 40-49. Three were gay and one was queer. All were cisgender male.

La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (Aquila audax) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where ARCSHS is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

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