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Responding to women experiencing domestic and family violence during the COVID-19 pandemic: Exploring experiences and impacts of remote service delivery in Australia

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Abstract

The COVID-19 health pandemic has increased women's vulnerability to all forms of domestic and family violence (DFV). In the first weeks of March 2020, most Australian states and territories, like many other jurisdictions, entered into a period of government-directed restrictions including stay-at-home orders, physical distancing limitations and closure of a significant number of community services. With more people confined to their homes, the risk of DFV increased at the same time as access to support services was reduced. In this article, we present the findings of two surveys conducted in the Australian states of Victoria and Queensland to explore the professional experiences of practitioners supporting women experiencing violence during the pandemic. Our analysis offers new insights into the ways in which practitioners pivoted their services to respond remotely to women experiencing violence and the challenges of effectively undertaking safety planning and risk assessment without face-to-face contact. The second half of this article examines the implications of remote service delivery on practitioner mental health and well-being. The findings have global relevance and reveal the critical need to prioritize well-being supports for DFV practitioners in crisis response plans.

KEYWORDS

COVID-19, domestic violence, family support, practitioner well-being, remote service delivery

1 | INTRODUCTION

The COVID-19 pandemic has exacerbated existing gender inequalities in workforces and homes worldwide. As the pandemic has progressed the differential impacts of the crisis on women and men has become increasingly apparent (John et al., 2020; Milford & Anderson, 2020). Globally, the interplay of situational stressors related to the pandemic and measures implemented to reduce community spread of COVID-19 have created new opportunities for violence against

women. Increased caring responsibilities together with financial stress, job insecurity, social isolation and disruptions to support networks and services have heightened the risk of violence against women and children in the home (Morgan & Boxall, 2020; Peterman et al., 2020; van Gelder et al., 2020). Due to variation in terminology across Australian jurisdictions, this paper uses the term 'domestic and family violence' (DFV) to refer to any behaviour within an intimate or domestic relationship that is violent, abusive, controlling and/or threatening (Australian Bureau of Statistics, 2009). While men can be

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victims of DFV, research demonstrates that DFV is predominantly perpetrated by men against women and their children (Cox, 2016; Victims Support Agency, 2012). Recognizing the safety risks posed by the global lockdowns in April 2020 the United Nations declared violence against women the “shadow pandemic” (UN Women, 2020).

While times of crisis and natural disasters are associated with increased violence against women and children, violence against women was already at crisis levels in Australia before the outbreak of COVID-19 (Parkinson & Zara, 2013; Peterman et al., 2020; True, 2013; United Nations Interregional Crime and Justice Research Institute (UNICRI), 2015). Prior to the pandemic, national census data studies show that 16% of Australian women aged 15 and over report being victims of physical partner violence and 5.1% report being victims of sexual violence perpetrated by a current or former partner (Australian Bureau of Statistics, 2016). On average, one woman a week is killed by male violence, typically a current or former partner (Cussen & Bryant, 2015). The ensuing pressure on the DFV support sector has been acutely felt by specialist workers and increasingly recognized in recent years (Victorian Government, 2015). A 2017 Victorian DFV workforce census found that almost one third of specialist DFV practitioners were considering leaving their job due to burn out, a common observation in service delivery with clients affected by trauma and abuse, including DFV (Family Safety Victoria, 2017). Research shows that working with clients affected by DFV can take a significant toll on practitioners leading to vicarious trauma, burnout, hopelessness and decreasing job satisfaction (Choi, 2017; Iliffe & Steed, 2000).

This article presents the findings from an Australian study which sought to better understand emerging issues and trends in responses to DFV during the early stages of the pandemic through the professional experiences and views of frontline DFV practitioners. Our research investigated the impact of the Australian lockdowns during April and May 2020 on practitioners responding to DFV and their experiences of providing remote support during the crisis. The study draws on data from two Australian states, Queensland and Victoria.ⁱ This article begins with an overview of how the COVID-19 pandemic has heightened DFV in Australia. We then outline the methods employed in the two exploratory surveys and report on the qualitative survey findings. Our findings focus on service adaptations during the COVID-19 restrictions and the impact of delivering remote support to women experiencing DFV during the lockdowns on help-seeking behaviours and practitioner well-being. We build on previous work examining connections between worker burnout, decreasing job satisfaction and neoliberal policies that marginalize work in the community services fields (see, *inter alia*, Mann, 2005; Reynolds, 2011).

1.1 | The COVID-19 pandemic and DFV in Australia

Australia, like many other countries, entered into a period of government-directed lockdown in March 2020, including stay-at-home orders and movement restrictions designed to curb the spread

of the coronavirus. Throughout the year evidence of an increase in the prevalence and severity of DFV across Australia emerged (Boxall et al., 2020; Carrington et al., 2020; Pfitzner, Fitz-Gibbon, Meyer, & True, 2020; Pfitzner, Fitz-Gibbon, & True, 2020). A national online survey of 1,500 women conducted by the Australian Institute of Criminology from 6 May to 1 June 2020 found that in the first 3 months of the government-directed lockdown, 4.2% of all women and 8.2% of women in cohabiting relationships had experienced physical violence (Boxall et al., 2020). The study also found that 2.2% of all women and 4.2% of cohabiting women had experienced sexual violence during this period (Boxall et al., 2020). Among the women who reported experiencing DFV during lockdown, many experienced multiple forms of violence (68.3%) (Boxall et al., 2020). The most common forms of DFV reported were pushing, grabbing or shoving (71.7%), having things thrown at them, slapping, biting, kicking or hitting (52.7%) and sexual violence (47.1%) (Boxall et al., 2020). Rates of coercive control were higher for cohabiting women who reported three or more forms of emotionally abusive, harassing and controlling behaviours since the onset of the pandemic, compared with only 5.8% of all women reporting (Boxall et al., 2020).

Victoria Police data also reveal an increase in police reported DFV during the pandemic. Monthly year-to-date Victoria Police recorded family violence showed a steady increase in family violence incidents in 2020 compared to 2019 (Rmandic et al., 2020). This was counter to previous seasonal trends in Victorian family violence police data which generally recorded lower numbers of family violence incidents during the autumn/winter months (May–July) and higher numbers in the summer. June 2020 saw a 15% increase in police recorded family violence incidents compared to June 2019 (Rmandic et al., 2020). In contrast, family violence incidents were only 7% higher in February 2020 (prior to shutdown) than February 2019. Similarly, April to June 2020 saw a 17% increase in breaches of Family Violence Intervention Orders compared to the same period in the previous year (Rmandic et al., 2020).

The increase in DFV reported by Australian women during the initial period of the pandemic mirrors emerging evidence among academics and media commentators internationally including in the United States (Piquero et al., 2020), England and Wales (Townsend, 2020) and Europe (Mahase, 2020). Data released by the United Nations Population Fund (UNFPA) (2020) at the outset of COVID-19 predicted that for every 3 months of lockdown an additional 15 million cases of DFV would occur worldwide.

2 | METHOD

The findings reported in this article are drawn from two exploratory surveys of practitioners' perspectives on the impact of COVID-19 on women experiencing DFV and the specialist DFV service sector, including practitioner experiences of providing support during the pandemic in the Australian states of Queensland and Victoria. The Queensland state survey was developed and administered by the Queensland Domestic Violence Services Network (QDVSN) and open

to Queensland practitioners working for specialist DFV services from 8 May to 22 May 2020. This survey combined a series of short demographic questions with multiple choice questions. The questions invited practitioners to reflect on the impact of COVID-19 on their clients' needs, experiences of violence and service gaps and their service delivery and individual experiences as frontline practitioners during this time. Survey participants could choose to answer some or all of the survey questions and were able to select multiple answer options for some questions. The de-identified Queensland state survey data were shared with the researchers for secondary analysis.

The authors developed the Victorian anonymous online survey combining a series of short demographic questions with rating scale and open-ended questions. Respondents could choose to answer some or all of the survey questions. The questions invited practitioners to reflect on the impact of COVID-19 restrictions on women's experiences of violence and the practitioners' experiences of providing family response services during this time including practice changes and service adaptations. The survey ran from 23 April 2020 to 24 May 2020. Information about the study and a link to the online survey were distributed electronically through social media outlets (including Twitter and LinkedIn), through the Monash Gender and Family Violence Prevention Centre network, and by providing information about the research and survey directly to relevant agencies in Victoria.

2.1 | Survey participants

One hundred and seventeen DFV practitioners completed the Queensland survey. Respondents most commonly worked in regional Queensland ($n = 51$) followed by inner-metropolitan ($n = 30$), outer-metropolitan ($n = 28$), rural ($n = 12$) and remote Queensland ($n = 2$). The QDVSN designed survey did not ask about practitioners' years of experience in the DFV sector. Most of the 166 Victorian practitioners surveyed worked in child and family services (33%, $n = 48$) and specialist family and sexual violence services (29%, $n = 42$). Victorian respondents' experience working with DFV clients ranged from less than 1 year to 37 years with an average of 2.9 years and a median of 6.5 years ($n = 119$). The Victorian survey respondents worked across 49 local government areas (LGAs) in Victoria. The most commonly identified work locations were Greater Geelong ($n = 26$), Colac Otway ($n = 16$), Surf Coast ($n = 15$) and Queenscliff ($n = 13$)—all outside of the Melbourne (state capital) metropolitan area.

2.2 | Survey data analysis

This article reports on our analysis of the open-ended responses to the Queensland and Victorian surveys. The quantitative findings have been published elsewhere (see Pfitzner, Fitz-Gibbon, Meyer, & True, 2020; Pfitzner, Fitz-Gibbon, & True, 2020). The two qualitative survey datasets are analysed alongside each other in this article to produce cross-jurisdictional understandings of the impact of

COVID-19 restrictions on specialist practitioners' experiences during the pandemic. The qualitative survey data were thematically analysed to develop a rich description of practitioners' experiences of remotely providing support to women experiencing violence during the pandemic as well as the well-being implications for practitioners (Lincoln & Guba, 1985). Drawing on Bazeley (2013) and Miles and Huberman (1994), we engaged in a two-stage coding process using NVivo 12. First level coding involved descriptive coding labelling passages of data with codes summarizing data segments (Bazeley, 2013; Miles & Huberman, 1994). Second-level coding built on these summaries, refining, interpreting and grouping them into smaller analytical categories, themes or constructs (Bazeley, 2013; Miles & Huberman, 1994). This phase explored the interrelatedness of data within and across themes to construct meaningful explanations (Bazeley, 2013). This two-stage coding process is cyclical with researchers constantly moving from data to description to analysis (Bazeley, 2013; Miles & Huberman, 1994).

3 | FINDINGS

Our survey data analysis reveals that DFV services in Victoria and Queensland were required to pivot their operations at the outset of the first wave transitioning to remote service delivery to align with the COVID-19 government-imposed restrictions. Some of the reported remote-service practices were developed specifically in response to the pandemic while others utilized and upscaled existing models. Significantly, responding to DFV from home during the COVID-19 restrictions had a detrimental impact on the well-being of many practitioners. These research findings are explored under three headings: service adaptations during COVID-19 restrictions, the challenges of remotely responding to DFV during COVID-19 and the impact of the COVID-19 restrictions on practitioners' well-being.

3.1 | Service adaptations during COVID-19 restrictions

In Australia, and countries, pandemic control measures necessitated a sudden pivot to remote service delivery models for DFV specialist practitioners. In Queensland and Victoria this necessitated a transition from predominantly face-to-face service delivery to reliance on video, web, message and phone-based services that could be delivered remotely to comply with each state's COVID-19 restrictions. Some practitioners reported that their organizations sought to integrate DFV response into essential services permitted to remain open during the lockdown, such as General Practice clinics, childcare services and Centrelink (an Australian Federal Government agency that provides social security benefits). Practitioners said that these touchpoints offered face-to-face access to women and children experiencing violence but otherwise unable or unwilling to seek help remotely. One practitioner described this hybrid approach:

We have managed to deliver our program (via Zoom) by arranging for the mother of a child in a family violence situation to engage in the program whilst attending childcare so [they are] away from the perpetrators. (Victorian practitioner, child and family services)

In Victoria, DFV organizations utilized a partnership with an all-women run rideshare company, Shebah, to transport women and children to safe houses and alternative accommodation during the pandemic. They also utilized the 'SheDrops' goods delivery service (provided by Shebah) to deliver items to women experiencing violence who were unable to leave their homes during the COVID-19 restrictions. Similar goods delivery partnerships in Queensland supported women and children experiencing violence. Reflecting on the range of practice adaptations necessitated by the restrictions, one practitioner commented that:

Use of express post and couriers to get things to women ASAP when we have no face to face and car at the moment. Working with other agencies to get things delivered and needs met. I think we have seen some great responses from some Child Safety staff [in our local area] at this time. Child Safety Officers taking families toiletries, food and blankets at night while motelling. (Queensland practitioner, specialist DFV services)

Numerous Victorian and Queensland practitioners reported that reduced privacy in homes during lockdown had restricted women's opportunities to seek help and increased safety concerns. Practitioners explained that consequently organizations created new alert systems for women to signal they were at risk or needed support. These alerts include the use of code words in telephone and text communication as well as physical signals.¹¹ Similarly practitioners adapted their risk identification and assessment processes, describing innovative remote approaches including doing 'house tours' via video call with victim-survivors to gain an understanding of their environment as important context for risk assessment and safety planning.

Several practitioners observed that during lockdown there had been an increase in perpetrator surveillance of communication devices and online activities. Consequently, some organizations began using encrypted web-based video call services that do not require users to download apps to their devices. Likewise, other practitioners explained how they had developed creative ways to communicate safely with clients. For example service providers opted for text messaging and the use of non-identifying service labels to ensure that communication with clients did not raise perpetrator suspicions about victims' help-seeking or potential separation plans. As one practitioner explained:

Booking shorter appointments with less time in between and texting clients from [a] non-identifiable phone using generic-like text messaging to ascertain

when safe to call ... Especially with increased phone monitoring and perpetrator inability to confirm appointment through current GP clinic due to privacy law. All clients have been happy with this system. (Queensland practitioner, specialist DFV services)

The pivot to remote service delivery was not unique to DFV services responding to women and children experiencing violence. Some Queensland services for men who use violence also reported a transition to remote service delivery models during this period. For example, Queensland practitioners reported that they had transitioned to remote delivery of men's behaviour change programmes (MBCP) and (ex)partner contact to ensure the safety of women and children linked to men in such programmes during the restrictions. These practitioners said that transition to remote delivery had overcome some of the geographical and time constraints previously associated with face-to-face client meetings:

Obtaining Women's Advocate Consent for men who are newly referred or waitlisted when we would normally not be engaging the aggrieved until after the assessment and as the man is coming closer to attending group, Women's Advocate Consent is usually gained during the face-to-face assessment with the perpetrator. This is adding increased oversight and links for victims with our women's advocate to respond to risk in real time. Allocating our additional funds to the Women's Advocate role we feel has had the potential to improve safety for many more women. (Queensland practitioner, specialist DFV services)

There were other benefits reported by men's service practitioners. For example, practitioners working with men enrolled in behaviour change programmes described new opportunities for service engagement via remote platforms:

Online groups for men are working well. COVID-19 provided the opportunity to open up the online groups for men that were restricted from accessing face to face. (Queensland practitioner, specialist DFV services)

Several practitioners across both surveys recognized the value of some of the remote practices adopted during the restrictions, noting that they had greatly benefited clients and may be useful to retain beyond the pandemic, particularly where they lead to improved service accessibility. For example, discussing the use of video-conferencing platforms to deliver services two practitioners explained that:

Giving families the option to deliver online therapy is an opportunity for families who are time poor, don't have to sit in after-school traffic while mother is busy

attending to other matters in the home, offers vulnerable families a way to receive therapy for their children when they don't have the costs to be able to make it into the centre are benefits of online therapy. (Queensland practitioner, specialist DFV services)

I find that lots of barriers are solved when we do video calls, [including] more engagement from clients (don't worry about travel time, car, petrol money, parking costs). (Queensland practitioner, specialist DFV services)

These practitioners and others highlighted the need for adequate resourcing of such adaptations to support the continuation of flexible service delivery models. The flexibility of DFV support offered during lockdown is succinctly captured by the following practitioner:

We have needed to be more flexible and responsive by doing things like driving to regional areas to do ER [emergency response] drop-offs and meeting women in their homes to assist with installation of safety upgrades. This is way beyond what we normally have capacity for but has been necessary due to lack of other timely options. It would be great to have the resources to be this responsive moving forward. (Queensland practitioner, specialist DFV services)

These practitioner views demonstrate the ways in which the initial lockdowns in Queensland and Victoria necessitated DFV practitioners to adapt their practices to enhance the accessibility and effectiveness of support services. Innovations largely involved pivoting in-person services to remote delivery using phone-, message- and virtual-based platforms. While it is not yet possible to formally evaluate the merits of adapted practices, it is important to note the potential for these practice innovations to improve service accessibility and delivery, particularly for clients in remote geographic areas and those where chronic illness, disability or caring responsibilities inhibit traditional face-to-face service use.

3.2 | The challenges of remotely responding to domestic and family violence during the COVID-19 restrictions

Practitioners in Victoria and Queensland described the challenges of pivoting to remote service delivery models during a period of increased demand. In particular practitioners emphasized the difficulty of effectively maintaining contact with clients and ensuring continuity of support during lockdown. Practitioners reported that lack of confidentiality when seeking help remotely, combined with the increased presence of perpetrators in the home, reduced women's help-seeking abilities during this period. This viewpoint is captured in the following practitioner survey excerpts:

Clients' inability to communicate safely/communicating with the client and potentially placing their safety at risk. Clients unable to answer phone at scheduled contact time due to perpetrator presence ... balancing provision of service with keeping clients safe within their environment. (Victorian practitioner, health services)

Perpetrator in the home, unable to leave home due to COVID-19 restrictions, children in the home. The list goes on. (Victorian practitioner, mental health services)

It [the lockdowns] has reduced their ability to seek support, maintain support or speak freely and safely to a service or worker. (Victorian practitioner, child and family services)

3.2.1 | Continuity of DFV support services

Many practitioners highlighted the challenges of ensuring continuity of DFV support services during the pandemic. Practitioners described the impact of reduced help-seeking opportunities as manifesting in several ways, including decreased calls for help from women and a lack of call-backs to services following initial referral or point of contact. Survey responses revealed that practitioners were acutely aware of the risks faced by women who were isolated at home with their abuser during the lockdown and consequently unable to make contact with a support service:

We are having women unable to use their phones or internet to contact services. Women have gone to the supermarket, petrol stations, phone boxes, neighbours, asking for assistance to call family violence services. (Victorian practitioner, homelessness services)

We are deeply concerned for the women who are unable to contact us at the moment ... women have been struggling without face-to-face support at police stations and courts. (Victorian practitioner, child and family services)

Aligning with reported reduction in demand for some family violence services in Victoria and across Australia during the first national wave of COVID-19 (Tuohy, 2020), practitioners reported that 'stay at home' restrictions facilitated perpetrators' ability to isolate women experiencing violence further inhibiting victim-survivors' access to support and help. As one practitioner noted:

It has been much easier for the perpetrator to get the victim/survivor to isolate from friends and family. (Victorian practitioner, child and family services)

3.2.2 | Reduced privacy in homes

Practitioners highlighted the challenge of having open and honest communication when delivering support remotely.

It is hard to know whether the perpetrator is in the room as you can't see much on zoom. (Victorian practitioner, child and family services)

Not being able to see services face to face has definitely impacted on women's ability to seek help—very hard to discuss family violence when the perpetrator is sitting in the room with you listening to your call. (Victorian practitioner, child and family services)

One practitioner recalled an incident with a client who was being 'shadowed' by her abuser:

This has been a major issue and has impacted on victims' ability to disclose particularly in high risk cases. Victims are closely monitored by the perpetrator and one recent instance my client described her limitations in answering the phone as the perpetrator 'shadowed' her constantly and she was required to report the content of her conversations. (Victorian practitioner, health services)

Overall, Victorian practitioners reflected that while necessary from a public health perspective COVID-19 restrictions had a two-fold effect on DFV help-seeking: limiting opportunities for people experiencing DFV to safely contact support services and restricting their ability to communicate frankly when contact was made. Similar reports of women's reduced ability to seek help were made by Queensland practitioners many of whom noted that there were 'less safe times to talk or seek assistance as perpetrator working from home' and explained that women were 'unable to talk due to perpetrator being at home'. Like their Victorian counterparts, many Queensland practitioners observed increased monitoring and isolation of clients by perpetrators during the lockdowns describing how home confinement reduced women's access to help:

The themes coming from clients are that there is no escape from the perpetrator. Before she would at least get some time when he is at work or out but now what I'm hearing is that he is home all the time and that means more abuse and no reprieve. (Queensland practitioner, specialist DFV services)

This was felt to be in large part due to constant surveillance by perpetrators during this period, a factor which Victorian practitioners

identified as severely restricting women's use of phone line support services to make disclosures during the lockdown period:

Partners who are monitoring phone use now have an increased amount of power and control in this domain as the phone is now quite literally the only connection with the outside world. (Victorian practitioner, specialist family and sexual violence services)

Women have been very concerned about their phone calls being overheard and not having a safe space to speak freely. Women have often ended phone calls, changed the topic or called back later when it is safe to talk. (Victorian practitioner, child and family services)

Lockdown has created more severe abusive situations for victims ... with no support from outside, with their phones at times taken away, their calls monitored by the perpetrator. (Victorian practitioner, mental health services)

The (mis)use of technology to monitor and perpetrate different forms of DFV is being increasingly recognized beyond the context of COVID (Harris & Woodlock, 2019). These findings lend further weight to the growing body of work that calls for increased awareness among women of the ways in which technology can be manipulated to cause harm and inhibit help-seeking. Furthermore, one practitioner expressed a concern that the level of control exhibited during this time and the ease of achieving isolation may have longer term consequences for women's ability to help seeking beyond the lockdown period:

I am concerned about women's diminished capacity to reach out for support after perpetrators have had an extended period of time to exert and reinforce their power and control in the home. (Queensland practitioner, specialist DFV services)

This viewpoint is important as it recognizes potential long-term impacts of DFV experienced during this time and recognizes the harms associated with experiences of control and social isolation, two forms of violence embedded in Stark's (2007) conceptualization of coercive control and increasingly recognized as severe forms of DFV. Concerningly, recent national research by the Australian Institute of Criminology found that social isolation was associated with an increased risk of violence for women in cohabiting relationships during the pandemic (Morgan & Boxall, 2020). As Australia, and other countries, move out of the period of restrictions it will be essential for specialist practitioners to develop strategies to support women who have experienced these often invisible, but incredibly pervasive, forms of DFV during COVID-19.

3.2.3 | The pitfalls of remote risk assessment and safety planning

Beyond the specific challenge of access to services, some practitioners described ways in which pandemic control measures have negatively impacted upon safety planning practices. For example, one practitioner said that increased the presence of perpetrators in homes during lockdowns had eroded safety plans:

It's made it significantly harder for women to manage abusive partner's behaviour. Pre-COVID, there was much more opportunity for self-care and management of safety using the community, outside jobs, time alone, kids in school/day care. All of these supports and ways of managing time around the abusive partner have gone out the window. (Victorian practitioner, specialist family and sexual violence services)

Other practitioners from Queensland and Victoria highlighted the barriers to actioning safety plans during this period:

[There is a] lack of opportunity to plan a safe exit and to access service (previously partner worked, now due to job loss constant 24/7 monitoring). (Queensland practitioner, specialist domestic and family violence services).

More barriers to creating safety plans: [fewer] excuses to leave the house; reduced opportunity to move house for people trying to leave violent living situations; difficulty keeping up with changes to services, and finding support[s] due to closures and services being overwhelmed; increased need for material aid with less availability. (Victorian practitioner, LGBTQIA + referral services)

While practitioners acknowledged the crucial need for remote service delivery in lieu of face-to-face supports, they simultaneously lamented the loss of the visual cues usually provided through face-to-face work and highlighted the difficulty of assessing risk and determining protective factors remotely. These challenges associated with absence of in-person supports for women experiencing violence are captured in the following survey excerpts from Victorian and Queensland practitioners:

Being able to have a conversation—it's difficult to really understand the patterns and dynamics of the violence when there is less time to speak and barriers to engagement. (Victorian practitioner, specialist family and sexual violence services)

The lack of face-to-face feels as though it is impacting on rapport building and trust. (Victorian practitioner, child and family services)

Missing the assessment information which you get from working face to face and in the home. You can't see the hole in the wall, the bruise on her jaw, the fear in the kid's eyes when dad's name is mentioned. (Queensland practitioner, specialist DFV services)

These comments indicate that loss of the visual cues provided through face-to-face work acutely impacted the perceived effectiveness of support provided during the lockdown. In addition to the impact that the pandemic and transition to remote work has had on service accessibility and client relationships, practitioners also reflected on the organizational challenges encountered at the outset of the restrictions. Australian DFV services had no shared blueprint for widescale remote working and had to rapidly transition to remote service delivery models on an organization by organization basis. Many managers who participated in this research described their struggles with sourcing equipment and technology to support service delivery from home and navigating the challenges of remote information sharing and client privacy. As one Queensland practitioner explained:

COVID-19 has posed challenges such as adjusting to working from home, providing workers with equipment to work from home. Normally my team are co-located within another service so working from home has posed challenges in communication and sharing of information. (Queensland practitioner, specialist DFV services)

Similarly, a Victorian practitioner explained:

Staff are using a range of devices and network access to deliver services remotely (personal and work computers, work and personal mobile phones and home data plans). Some staff and women have great difficulties accessing phone and internet due to their rural location. (Victorian practitioner, specialist family and sexual violence services)

These comments illustrate the ways in which lockdown conditions inhibited the effectiveness of remote consultations.

3.2.4 | The invisibility of children living with DFV

The invisibility of children in service responses to adult experiences of DFV remains an ongoing concern in service reforms more broadly (Family Violence Reform Implementation Monitor, 2021). Victorian practitioners in the current study raised specific concerns that COVID restrictions further invisibilized children living with family violence. These practitioners discussed how household and service delivery restrictions affected the engagement of families and children in

ongoing service delivery and as a result increased the invisibility of children's risk to relevant support services:

Limited support available for families, no eyes on children and little opportunity to work with them. (Victorian practitioner, specialist family and sexual violence services)

Unable to provide counselling for children. (Victorian practitioner, specialist family and sexual violence services)

Practitioners said that children are harder to engage via remote service delivery, in part due to their preference for face-to-face support and in part due virtual counselling sessions being less suitable for younger children:

Children not receiving support as they prefer face to face contact as opposed to online support. (Victorian practitioner, specialist family and sexual violence services)

Hard to therapeutically engage with young children through the use of Zoom services. (Queensland practitioner, specialist DFV services)

Specific reference was made by one practitioner to the challenges associated with delivering school based child counselling and related support services during the pandemic:

As a child and family counsellor a lot of my work has been in schools. COVID-19 has impacted how I can successfully deliver child support services due to 'approved school programs' (e.g. I can't use zoom) and organising a private room and supervision for children while I deliver a phone counselling session. (Queensland practitioner, specialist DFV services)

The challenges and concerns raised by practitioners in both states around keeping children visible, engaged and supported during the pandemic highlight that children living with DFV became increasingly invisible and, as a result, vulnerable, during that time.

3.3 | The impact of the COVID-19 lockdowns on practitioner well-being

Survey data from both states revealed that the transition to remote work alongside an increased demand for DFV services during the COVID-19 restrictions contributed to additional pressure and stress for DFV practitioners working from home during this period. The well-being of workers in essential care services has been an

increasingly recognized issue during the pandemic, particularly in relation to frontline health care professionals (Dow, 2020; Kinman et al., 2020; Sainato, 2020). The decline in mental well-being among health care workers since the outbreak of COVID-19 has been associated with the challenges of working in a high-risk environment and the need to adapt to increased work volume as well as changing conditions and safety protocols (Chua et al., 2020; Kinman et al., 2020). Since the outbreak of the pandemic the mental health and well-being of the DFV workforce has received limited attention compared to other essential workers.

Although it was not a planned focus of the surveys, many practitioners explained they were experiencing added stress due to safety concerns about clients isolating in homes with their abusers and a perceived inability to adequately offer support and safety options. For example, discussing the challenges of responding to DFV during the COVID-19 restrictions one practitioner commented:

Increased stress on clinicians due to the pressure to not place the client at greater risk of harm when delivering an adapted service model whilst the client is in isolation with the perpetrator. (Victorian practitioner, health services)

Similarly, other practitioners discussed the challenges of supporting women experiencing DFV during the pandemic including that increased safety concerns during the lockdown led workers to feel the weight of managing risk at this time. The stress felt by those within the sector during this period is well captured in the comments of one practitioner:

I feel like we are all in a bubble that is set to burst very soon, in terms of capacity. And when it does burst, I don't know what it will look like but I know who will pay the ultimate price—victims. (Queensland practitioner, specialist DFV services)

Echoing this, many practitioners observed that they were working longer hours to meet the increased demand on the sector and expressed concerns about potential burnout. As two practitioners commented:

I'm working unpaid overtime and skipping lunch breaks most of the time. What we're doing from home is unsustainable. Staff are fatigued. (Queensland practitioner, specialist DFV services)

I have already used a week of personal leave due to potential burn out. The impact on domestic violence workers needs to be considered by government. (Queensland practitioner, specialist DFV services)

Given that this is a sector that has not traditionally delivered services from home and/or offered workplace flexibility, several practitioners

highlighted the challenges which arise in maintaining professional and personal boundaries when your home becomes your workspace:

It has been difficult separating work and home while we are working from home. I have incorporated a physical transition from when I start and finish work. I go for a walk or have a shower or stand in my garden to mentally and physically separate the two. (Queensland practitioner, specialist DFV services)

Boundaries for me personally—work computers at home [and] more likely to checking emails out of business hours because of concern for the family wanting to see a response to be reassured they are ok. (Victorian practitioner, education)

While an acknowledgement of the challenges of working from home during this period is important, this research also affords the opportunity to share early learnings on initiatives that have been implemented by organizations to support worker well-being during this remote work. Many practitioners reported that their workplaces had instituted team catch ups via web-based platforms, such as Zoom and Microsoft Teams, in an effort to ensure regular contact with colleagues:

Using an app like “Teams” has helped keep regular contact with my team, it has enabled us to continue to have morning musters and team meetings. We have also used similar software to carry our integrated response meetings with multiple agencies. (Queensland practitioner, specialist DFV services)

I believe virtual meetings through mediums such as Teams have immense value and that WFH [working from home] is able to be done in most roles. (Queensland practitioner, specialist DFV services)

Practitioners commented that virtual catch ups and meetings with colleagues helped to sustain their connectivity as a team and supported their well-being:

Regular team lunches and catch-ups via video call to stay connected and help prevent burn out. (Queensland practitioner, specialist DFV services)

I feel like my workplace has been incredibly supportive and when I'm working from home I still have team members to debrief with by phone or video chat which has helped keep me sane. (Queensland practitioner, specialist DFV services)

A small number of practitioners also specifically noted that working remotely provided greater opportunities to participate in training

during the lockdowns because of increased online delivery. As two commented:

Training via Zoom has allowed staff to be able to attend more training opportunities. (Queensland practitioner, specialist DFV services)

It's great to have webinars and online training sessions more readily available from other services so we can connect with each other and learn about what we all do. (Queensland practitioner, specialist DFV services)

These reflections indicate that rapid transition to remote service delivery and working from home took a significant toll on the DFV practitioners. In particular, safety concerns for clients confined to homes with their abuser caused additional stress. Many practitioners let their workday expand to accommodate high demand and increased workloads, seeing burnout as inevitable. Notably, working from home during the pandemic caused blurring of boundaries between work and home life, derailing longstanding practices put in place to safeguard practitioner well-being and ensure self-care. Establishing opportunities for collegiality and remote peer support appeared crucial for DFV practitioners working during this period.

4 | DISCUSSION AND CONCLUSION: IMPLICATIONS BEYOND THE PANDEMIC

Much attention has been drawn to the increased risk of violence against women and children during the pandemic. This study uniquely focused on the consequences of providing remote support to women experiencing DFV during the COVID-19 restrictions in Australia and the impact of working during the pandemic on practitioner well-being. It reveals the ways in which the COVID-19 lockdowns in Victoria and Queensland have created additional barriers for help-seeking for women experiencing violence while also necessitating a sudden pivot to remote service delivery during this time of heightened demand. The required pivot in service delivery has created new opportunities for service models while at the same time pushing service demand and practitioner capacity to its very limits. Practitioners across both Australian states detailed significant service innovation developed to improve accessibility during the restrictions. However, nearly all of the practitioners in this study emphasized the considerable challenges of keeping women and children safe remotely. In particular, they mentioned the difficulties of remotely assessing clients' risk and safety in their homes during a time when privacy and confidentiality could not be guaranteed and challenges around engaging children in remote and technology facilitated service delivery. These findings are significant in the context of the pandemic as they contribute early insights into one country's provision of DFV services during this period. As other countries continue to grapple with the spread of the coronavirus and the need for government enforced lockdowns, this research provides detailed practice-based insights into opportunities and challenges associated with remote service delivery.

There has been sustained media coverage in Australia of the heightened risk of DFV since the beginning of the COVID-19 restrictions, yet the implications of these restrictions on the mental health and well-being of practitioners responding to women and children experiencing violence has largely been overlooked. As the findings presented in this article reveal, service delivery from home during lockdown has significantly impacted DFV practitioner well-being. While prior research highlighted the significant risk of vicarious trauma and burnout among DFV specialist practitioners in general (Illiffe & Steed, 2000), our study emphasizes the risk of adverse effects on practitioner well-being during the pandemic. Our findings underscore the critical importance of access to regular supervision that supports self-care, balanced workloads and opportunities to debrief, especially at times where work-life boundaries are undermined by working from home. With DFV specialist workers carrying the burden of risk identification and monitoring for many clients, investing in adequate practitioner support and supervision must be a priority. Given the high prevalence of DFV across Australia (and elsewhere) there is a need to ensure the well-being of specialist practitioners delivering safety supports to women and children experiencing violence are preserved and prioritized. This is an essential workforce within and beyond the pandemic.

Data collection for this research was undertaken during the first period of national restrictions in Australia. Since then several Australian states and territories have returned to lockdown including Victoria where residents have spent over 200 days in lockdown since the pandemic began. At the time of writing several countries including England and some US states were under periods of heavy restrictions on daily life. These restrictions have now eased in many jurisdictions. In this context, the future impact of the coronavirus is uncertain and the degree to which governments in Australia and worldwide will need to continue to move in and out of restrictions cannot be predicted. The need for effective remote delivery of services to those experiencing violence is key to ensuring women and children's safety during the pandemic. This article contributes early insights into that practice. Further research examining the effectiveness of remote models of support for DFV practitioners is required and would provide valuable insights for practice and policy in other times of crises and natural disasters. While deemed necessary during the pandemic, remote service delivery models should not be embraced without careful planning. More evidence is required to better understand the effectiveness of remotely engaging men in behaviour change interventions and how best to keep perpetrators visible to accountability systems at times when direct oversight is reduced (Fitz-Gibbon et al., 2020). With increasing evidence of the escalation of violence during this period, there will be a greater need than ever before to ensure that the services and practitioners that keep women safe are effectively delivered, resourced and sustainably designed.

ETHICS STATEMENT

Ethics approval for both the Victorian and Queensland studies were received through the Monash University Human Research Ethics Committee.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

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ENDNOTES

ⁱ The state of Victoria is roughly the same land size as the United Kingdom and is a relatively small Australian state (Geoscience Australia, 2020). In comparison, Queensland covers an area of around 1.7 million square kilometres including many isolated and remote communities as well as large cities.

ⁱⁱ While practitioners shared specific details of these alert systems with us, the effectiveness of alert systems depends on activation without perpetrators' knowledge and we have not included specific details of alert systems in this article.

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