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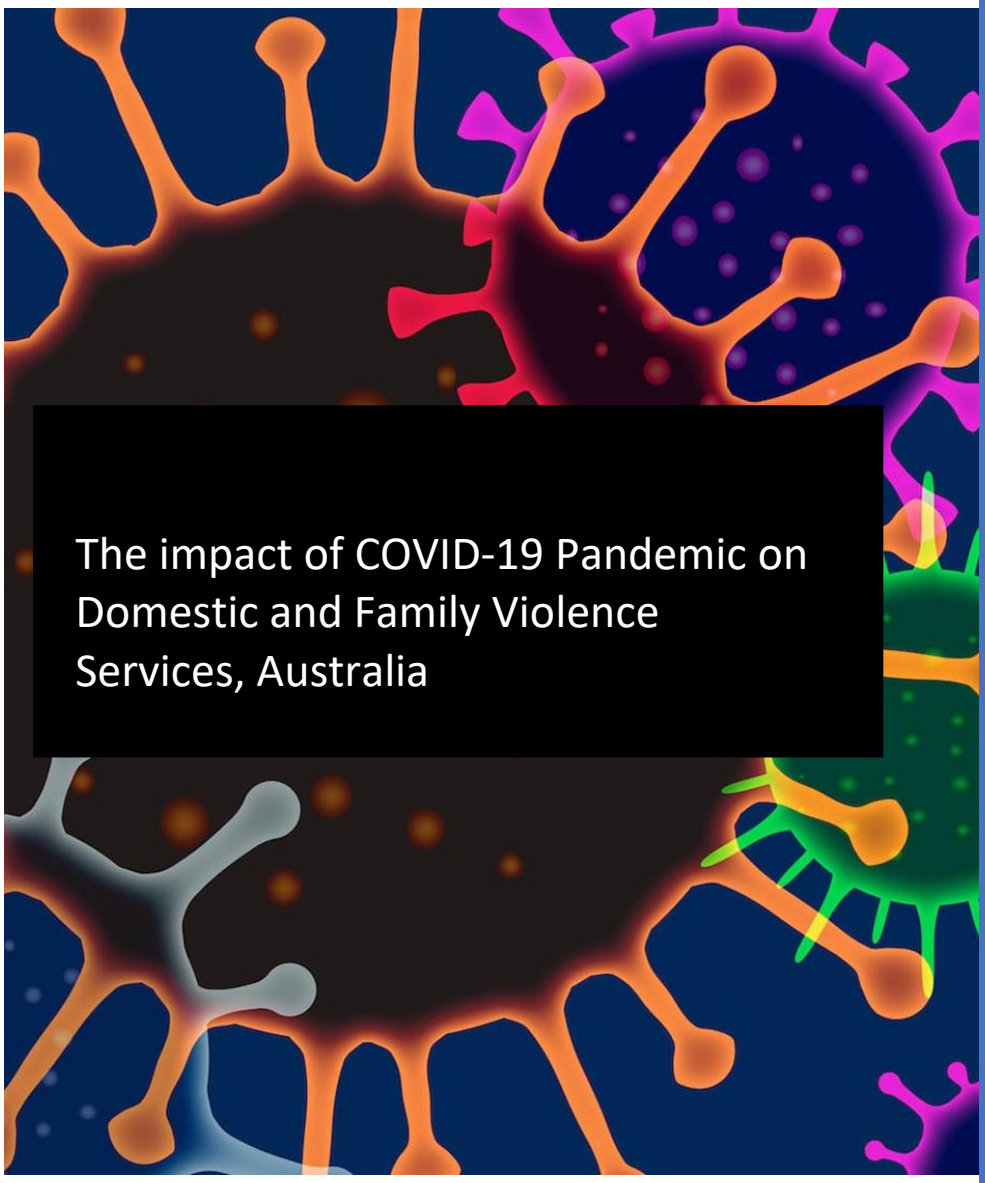

The impact of COVID-19 Pandemic on Domestic and Family Violence Services, Australia

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About the Project

This project, *The Impact of COVID-19 on Domestic and Family Violence Services, Australia* is funded by the Queensland University of Technology Centre for Justice: QUT Ethics Approval Number 2000000404.

QUT Centre for Justice

QUT Centre for Justice is a think tank for social justice that aims to empower and enable citizens, consumers and communities through solutions-oriented research. Our vision is to democratise justice by improving opportunities for health and well-being and enhancing the inclusiveness of work and education while widening access to justice.

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Executive Summary

Early during the pandemic, Australian healthcare and women's safety professionals predicted an 'impending increase' in domestic violence (Foster, 2020; Hegarty & Tarzia, 2020). Advocates also reported concerns about increased complexities and challenges in assisting victims/survivors amidst COVID-19 (Foster, 2020). On the strength of these concerns, a research team from the Queensland University of Technology (QUT) Centre for Justice conducted a nation-wide survey on the impact of COVID-19 on the domestic and family violence (DFV) workforce.

Our survey aimed to assess the impact of COVID-19 pandemic on the domestic violence workforce and their clients. The survey opened on 9 June 2020 and closed on 31 August 2020. Findings based on survey findings of 362 participants from the DFV sector, including 1,507 qualitative responses, confirm the concerns raised early in the COVID-19 pandemic. A huge proportion, 86% of respondents to our survey, reported an increase in the complexity of their client needs, 62% reported increases in the number of clients accessing their services during the COVID-19 pandemic, while 67% of DFV workers reported new clients seeking their help for the first time during the COVID-19 crisis. They also reported increases in controlling behaviours, such as isolation (87%), increased sense of vulnerability (70%), inability to seek outside help (64%), forced to co-habitat with abuser during lock-down (62%), increased fear of monitoring by abuser (49%), increased surveillance (47%) and increased use of technology to intimidate (38%) (see Figure 1). Our report concludes that perpetrators are weaponising COVID-19 lock-down conditions to enhance their coercive and controlling behaviours.

Our survey asked the DFV workforce what extra resources they needed to better cope with a crisis like the COVID-19 pandemic in the future. They emphasised the need for:

- more staff, better technology, technology support and training for workers and clients;
- more thorough and better technology safety checks for clients;
- more Safe Connection mobile phones for clients and better internet connectivity;
- more government funding for crisis and emergency supplies;
- more government funding for emergency and long-term accommodation and housing;
- transport for home delivery of services;
- the continuation of tele-health provisions;
- the continuation of on-line access to courts and justice services; and
- more resources for male perpetrator programs (especially for Indigenous men).

They also need systems to be flexible, especially courts and magistrates and they called for improved policing and better communication and translation services and supports for Culturally and Linguistically Diverse (CALD) communities.

Our report recommends that the Commonwealth Government, in conjunction with the state and territory governments:

1. Undertake disaster management planning for domestic and family violence

2. Provide flexible assistance funding for people experiencing domestic and family violence

3. Undertake domestic violence workforce planning for disaster preparedness

4. Provide finances and resources for services to engage with victim/survivors and their children (and also perpetrators) via remote delivery, especially in the context of disasters

5. Provide technology (hardware and software) resourcing for clients

6. Provide technology training and supports (such as those provided by WESNET and eSafety) for government and non-government agencies responding to DFV

7. Continue and expand funding for WESNET's Safer Connections program

8. Commit to boost funding for social and affordable housing

Figure 1 Survey Findings at a Glance

Introduction

Domestic violence is a key driver of women's inequality, ill-health, subjection and homicide, which the United Nations (2015) has referred to as one of the most significant issues to be addressed in our time. When it became clear that pandemic lock-downs and restrictions were increasing the prevalence of domestic violence across the world, the United Nations Secretary (António Guterres, 2020) called for governments across the globe to urgently 'put women's safety first as they respond to the pandemic'.

Our survey aimed to assess the impact of COVID-19 pandemic on the domestic violence workforce and their clients. Our results add to the growing body of evidence that pandemic conditions are affecting the severity and prevalence of domestic violence in Australia, regardless of whether or not these increases are reflected in reporting rates. A study by the Australian Institute of Criminology of 15,000 women found increases of domestic violence experienced by Australian women during the first three months of the pandemic (Boxall et al., 2020). Two-thirds of the women said that domestic violence had either escalated or started during the COVID-19 pandemic (Boxall et al., 2020: 1). More than a third were unable to seek help or support due concerns about their safety under COVID-19 restrictions (Boxall et al., 2020: 14). This could account for why police and some specialist DFV services data is not necessarily reflecting an increase in reports of domestic violence. Women are trapped with their abusers and unable to seek help. A survey of 166 practitioners undertaken by a team at Monash University found that 59% reported an increase in the frequency and severity of family violence. Additionally, of the practitioners they surveyed, 42% reported an increase in clients seeking assistance for their first experience of domestic violence, and 86% of practitioners reported an increase in the complexity of women's needs (Pfitzner et al., 2020: 10).

These Australian findings mirror findings from international literature that the frequency and severity of domestic violence has been rising during the pandemic (Boserup et al., 2020; Bouillon-Minois et al., 2020; Bradbury-Jones & Isham, 2020; Bradley et al., 2020; Chandan et al., 2020; Froimson et al., 2020; Kofman and Garfin, 2020; Mazza et al., 2020). In the absence of reliable data, most of these studies quote increases in rates to domestic violence help lines of between 15-30% as evidence of an increase in prevalence. According to WHO sources quoted in one study, the EU has seen a rise of 60% in calls to emergency involving domestic violence (Mahase, 2020). Based on data provided by domestic violence refuges in England, Gibson (2020) calculated a weekly average increase of roughly 66% increase in contact through their website, and tenfold increase in contact since the beginning of COVID-19. Campbell (2020) argues the increasing prevalence of DFV is not reflected in official police reports, due to pandemic restrictions which have narrowed the opportunity for victims to report. The dark figure in criminology refers to unreported crime. This figure is already high for DFV, casting more doubt on official police reports (Sacco et al., 2020). Other studies have noted increases in domestic violence homicide rates that have been said to 'more than double' in multiple locations including China and the United Kingdom (Grierson, 2020; Taub, 2020).

Methodology

A research team from the Queensland University of Technology (QUT) Centre for Justice undertook a nation-wide survey of the impact of COVID-19 on the domestic and family violence workforce. A seed funding grant from the QUT Centre of Justice supported the research. The survey was launched on 9 June 2020 and closed on 31 August 2020. It was completed by 362 respondents.

The survey was co-designed with a selected group from the DFV sector in Qld. This ground up (rather than top down) method democratises the relationship between the researchers and the researched (Liamputtong, 2020) and is regarded as an important ethical standard in the sector. The final survey contained 27 questions, of which six were open-ended. It took between 5 and 10 minutes to complete depending on the length of qualitative responses. The survey instrument produced a sizeable data set containing both quantitative and qualitative data.

Ethical requirements stipulated that all participants be provided with enough background information to be able to participate with informed consent. Participants were taken to a landing page within Qualtrics survey. They had to first read a background statement about the purpose of the survey before clicking agree at the bottom of the page. After clicking this button participants were taken to the first set of survey questions which were about demographics. This procedure including the content of the landing page were approved by the QUT Human Research Ethics Committee.

Recruitment

Participants were directly recruited in three ways: 1. Through a contact list created in Qualtrics that included a comprehensive range of non-government organisations and government agencies that deliver specialist and mainstream services and support to people experiencing DFV and people that use violence; 2. Through anonymous links sent via advertising by peak bodies; and 3. Through public invitation to participate via an anonymous link using social media advertising.

Emails were sent to every state and territory peak body for Sexual, Domestic and Family Violence Services, every Head Women's Legal Service in all state capital cities, and specialist national organisations, including ANROWS, 1800 Respect, Australian Council of Social Services (ACOSS), Women's Justice Network, Women's Electoral Lobby, Women's Refuges, Australian Centre for Human Rights, National Aboriginal and Torres Strait Islander Legal Services (NATSILS), and state based specialist NGO services for Indigenous DFV services across Australia. NGOs in the multi-cultural and settlement services sector were also asked to distribute the survey, as the experiences of staff working with CALD communities are particularly important to capture. These peak bodies were asked to distribute the invitation email with a link to the survey to their contact lists. Related sectors including the housing and homelessness sector were also invited to participate in this research with valuable assistance provided by QShelter in Queensland.

Survey Reach

The survey was distributed by email to 253 National, State and Territory agencies in domestic violence and related agencies in law, health, counselling and housing that respond to clients of DFV. The survey was open from 9 June to 31 August 2020. Over 1,000 emails were distributed to sector organisations. Collectively these agencies represent around 10,000 workers in the sector. The survey had the greatest reach in Qld, NSW and Victoria, which were more adversely impacted by COVID-19 and for longer than other jurisdictions.

Limitations

One of the limitations of this survey was attrition: that is the number of respondents who commenced the survey but did not complete their socio-demographics or answer important questions in Section

B. Respondents were advised that incomplete surveys would not be included in the final data set. Following an initial screen of the data, it was noted that some questions did not provide an option for 'Not applicable' or 'Not known'. Given the lower number of projected survey responses, the data was then carefully screened to ensure that informative responses were retained to provide a comprehensive report. While there were 390 participants who commenced the survey, 28 partially completed responses were excluded, resulting in a total of 362 informative responses included in this analysis.

It became apparent early on that the DFV sector was experiencing survey fatigue from the large number of surveys launched around the same time as ours. While we had a target of 500 responses, we closed the survey at the end of August given this wider context.

Another limitation is that our survey results are reliant on the informed opinions of workers in the DFV field. It is reasonable to base findings on the informed opinions of workers in this field, given these organisations routinely collect administrative by-product data. This data was used by these services during the COVID-19 pandemic to issues of concern early on in the pandemic. We undertook this survey as a method of independently triangulating these reports from the sector (see Foster, 2020).

Coding

A total of 1,507 qualitative responses to six questions were downloaded into separate excel sheets for coding (see Table 1). The questions were allocated amongst the team, and were coded using Excel, Word or NVivo. Team members worked in pairs to double code responses within head themes. Thematic analysis is a method for identifying patterns of meaning (Liamputtong, 2020: 260). The head themes were categorised according to patterns formed through inductive reasoning and counted for each question with a qualitative response (Punch, 2014: 222). While team members used different techniques to conduct the coding, by double coding and sharing original data the head themes were triangulated among the research team for consistency. The main issue confronted was the overlap of themes across answers to different questions. This is unavoidable and we have noted this in the analysis.

Table 1 Survey key questions - responses and themes

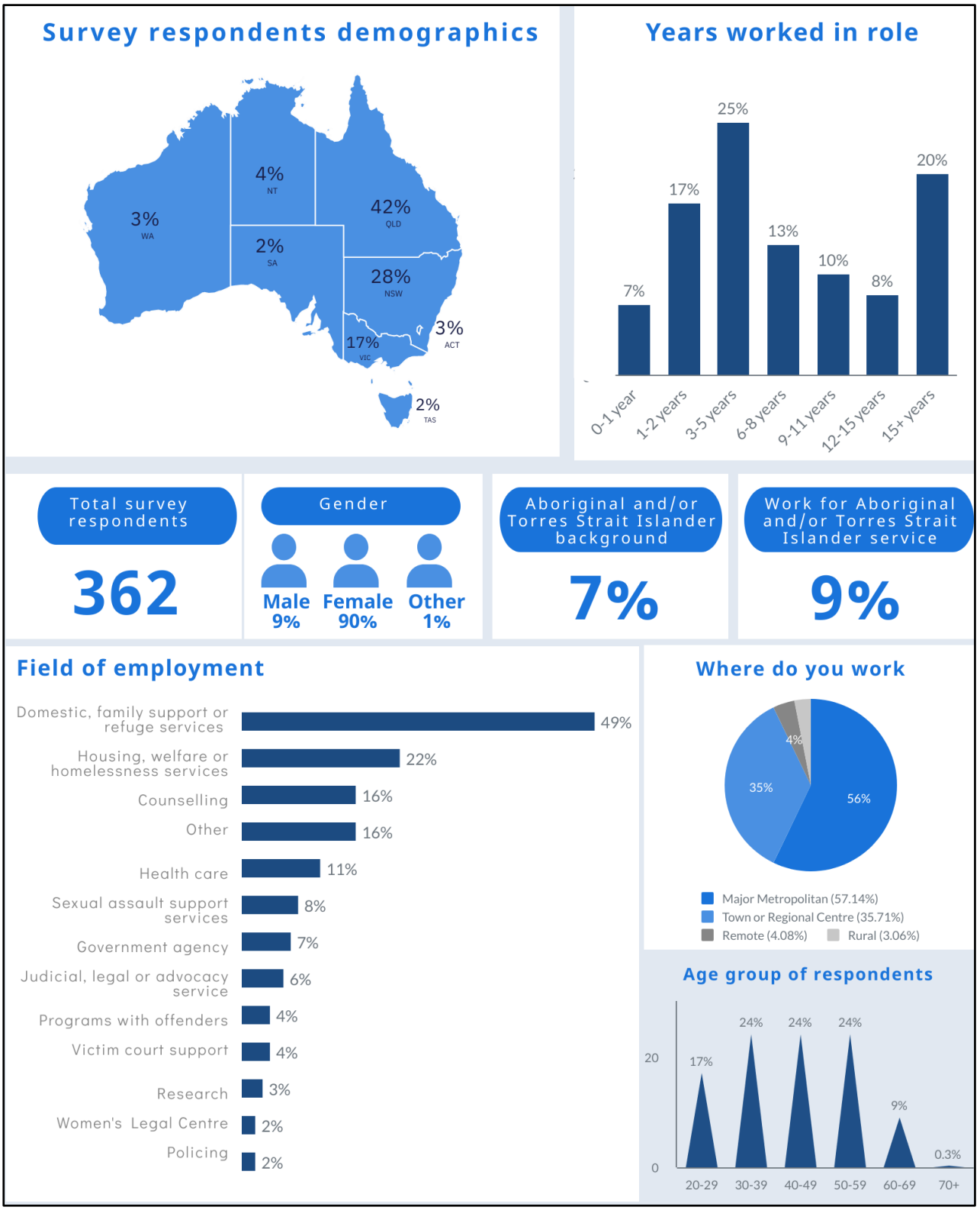
Question	15	17	22	24	26	27
Text Response	213	280	277	273	221	243
Head Themes Coded	4	12	6	4	27	3

Results

Socio-demographics

As shown in Figure 2, most respondents were from Queensland (42%, *n*=151), followed by 28% from New South Wales (*n*=102) and 17% from Victoria (*n*=60). While all states were represented, there were significantly less responses Australia wide, with 4% from the Northern Territory (*n*=14), 3% from Western Australia (*n*=11), 3% from the Australian Capital Territory (*n*=10), and 2% from both South Australia (*n*=7) and Tasmania (*n*=6).

Figure 2 Socio-Demographics of Survey Respondents



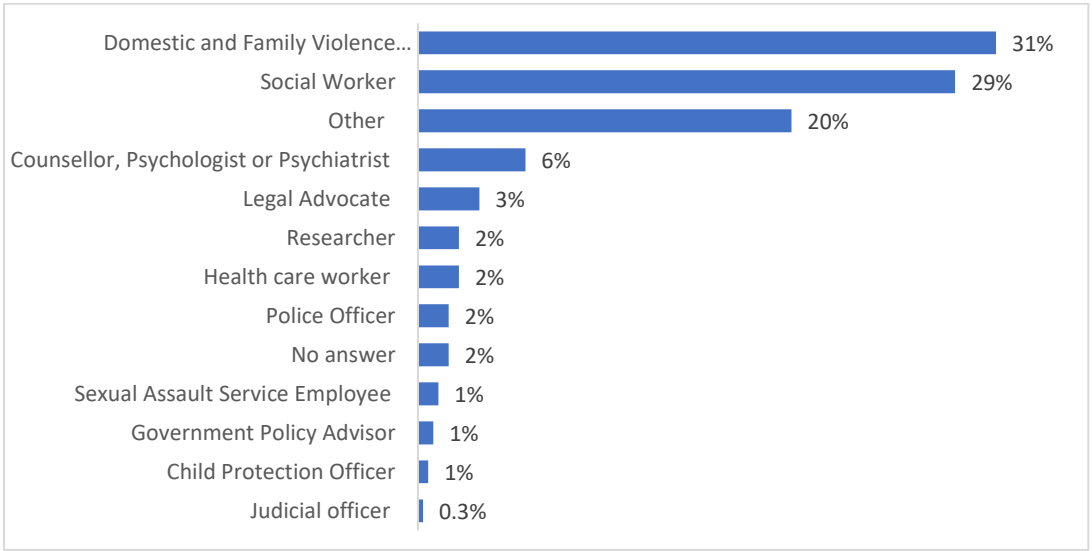
The majority of the 362 survey respondents identified as Female (89.5%, *n*=324), 9.1% were Male (*n*=33) and 1.4% identified as Other (*n*=5). Of these, almost 7% of respondents were Indigenous (*n*=26) and almost 9% work for Indigenous services (*n*=32). The age group of the survey respondents show that 17% of respondents were in the 20-29 year age group (*n*=62), 24% in the age groups 30-39 years (*n*=86), 40-49 years (*n*=88) and 50-59 years (*n*=87), 9% in the 60-69 year age group (*n*=32) and 1 respondent was aged over 70 years. Six respondents did not answer this question.

Survey respondents were asked about their field of employment and were able to choose more than one answer from a range of 12 options. There were 541 responses from 361 respondents. Almost half of all respondents reported they work in domestic, family support or refuge services (49%, *n*=178) (see Figure 2). This was followed by 22% who work in housing, welfare or homelessness services (*n*=78), 16% in counselling (*n*=57), 11% in health care (*n*=41), 8% in sexual assault support services (*n*=28), 7% in government agency (*n*=26), 6% in judicial, legal or advocacy service (*n*=22), 4% in programs with offenders (*n*=15) and in victim court support (*n*=14), 3% in research (*n*=10), and 2% in both women's legal centre (*n*=9) and in Policing (*n*=6). The option of Other was selected by 16% of respondents (*n*=57), and one participant did not answer this question.

Survey respondents reported a wide range of experience working within the DFV sector in their current or related role (see Figure 2). Seven percent have worked less than 12 months (*n*=25), 17% have worked 1-2 years (*n*=61), 25% have worked 3-5 years (*n*=90), 13% have worked 6-8 years (*n*=47), 10% have worked 9-11 years (*n*=37), 8% have worked 12-15 years (*n*=28), and 20% have worked more than 15 years in their current or related role (*n*=74). Overall, this indicates half of the 362 survey respondents (51%) have worked in the DFV sector for more than 5 years, they have access to administrative data collected by their organisation and are well placed to provide accurate responses to the survey.

Almost two-thirds of the survey respondents work in DFV services (31%, *n*=113), or are social workers (29% *n*=105) (see Figure 3). The remaining 40% best describe their role or work as a: counsellor, psychologist or psychiatrist (6%, *n*=21), legal advocate (3%, *n*=12), researcher (2%, *n*=8), health care worker (2%, *n*=8), police officer (2%, *n*=6), sexual assault service employee (1%, *n*=4), government policy advisor (1%, *n*=3), child protection officer (1%, *n*=2), and judicial officer (0.3%, *n*=1). The option of Other was selected by 20% of respondents (*n*=73), and 6 participants did not answer this question.

Figure 3 What vocation best describes your role or job?



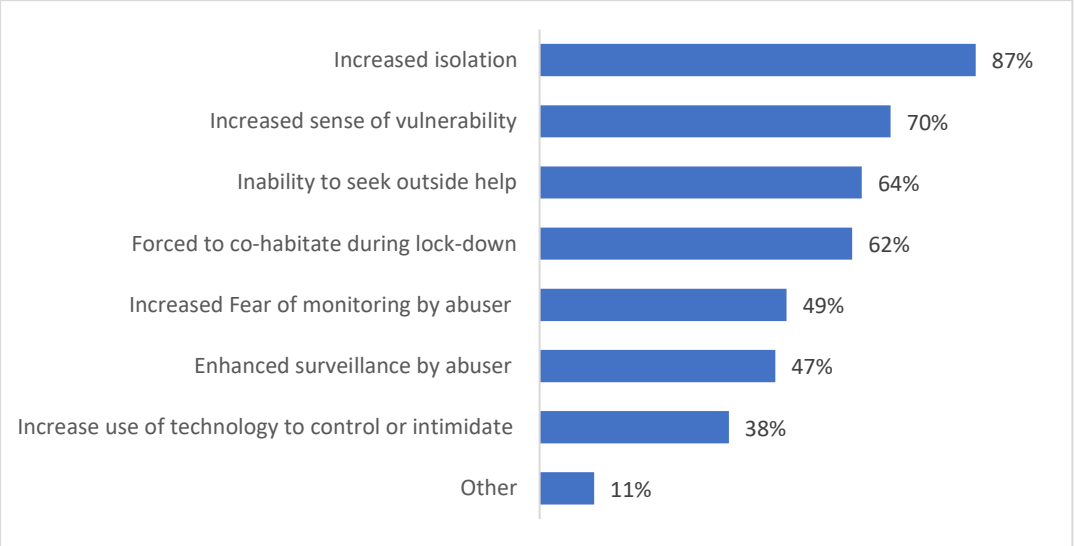
The impact of the COVID-19 pandemic and associated restrictions on clients seeking assistance for a domestic or family violence matter

Almost two-thirds (62%) of service providers reported the COVID-19 pandemic and associated restrictions have increased the number of clients seeking assistance for a domestic or family violence matter. As shown in Figure 1, service providers reported the number of clients seeking assistance were 7% much higher (*n*=27), 29% moderately higher (*n*=104), 26% slightly higher (*n*=94), 26% about the same (*n*=94), 5% slightly lower (*n*=18), 4% moderately lower (*n*=15), and 2% much lower (*n*=6). Four participants did not answer this question. These results are consistent with the findings of other Australian surveys (Boxall et al., 2020; Pfitzner et al., 2020). The results also mirror international research that the frequency and severity of domestic violence has been rising during the pandemic (Boserup et al., 2020; Bouillon-Minois et al., 2020; Bradbury-Jones & Isham, 2020; Bradley et al., 2020; Chandan et al., 2020; Froimson et al., 2020; Kofman and Garfin, 2020; Mazza et al., 2020).

Weaponising COVID-19 to extend controlling and coercive behaviours

Service providers were asked whether any of their clients reporting a domestic family violence matter during the COVID-19 pandemic reported controlling behaviours. A list of seven options were provided, and service providers were able to choose more than one answer, as well as the option to report 'Other' controlling behaviours. Of the 314 service providers who answered this question, overwhelmingly, 87% (*n*=272) reported that increased isolation was the most common controlling behaviour reported by clients of the DFV sector (see Figure 4). The next controlling behaviour reported by almost three-quarters of service providers was an increased sense of vulnerability (70%, *n*=219), followed by 64% who reported the inability to seek outside help (*n*=201), and 62% who were forced to co-habitat during lock-down (*n*=195). Almost half the service providers reported an increased fear of monitoring by the abuser (49%, *n*=154), and enhanced surveillance by the abuser (47%, *n*=147), while 38% reported an increased use of technology to intimidate (*n*=118). Eleven percent of service providers (*n*=34) reported Other controlling behaviours such as financial control and access to children.

Figure 4 Have any of your clients reporting a Domestic Family Violence matter during the COVID-19 Pandemic reported any of the following controlling behaviours?



Support workers reported that abusers have used social distancing, isolation and quarantine processes to extend women's condition of 'unfreedom' (see also Godin, 2020). Similarly, in this survey, two-thirds of the service providers (67%, *n*=242) told us they are aware of changes in how perpetrators are using coercive and controlling behaviours in the current climate. Service providers were then asked to describe these changes. There were 213 responses to this question and 33 themes were used to code responses. In total there were 308 instances of identifying and coding these themes to the dataset, which identified four overarching themes:

1. Perpetrator using COVID-19 to increase control over and coercion of the victim through threats to safety of client and her children, and this being done via a range of media and technology and through custody arrangements (43%).
2. COVID-19 as a reason for increased isolation of DFV victim during lockdown including loss of employment and reduced ability to engage informal and formal support systems impacting client safety (33%).
3. Perpetrator finding new ways to financially abuse and control victim during the pandemic (14%).
4. New ways and more severe emotional and psychological abuse of victim (10%).

Increase in control and coercion

Almost half of the service providers (43%) highlighted and emphasised the growth in the ways perpetrators have coerced and controlled victims during the COVID-19 pandemic. This finding supports the range of national and international literature about the extent to which COVID-19 has increased the range and intensity of abusive behaviour towards women and children (Gibson, 2020; Mazza et al., 2020; Pfitzner et al., 2020; Sullivan, 2020). The coercion and control have been multifaceted through a range of mechanisms and techniques, and it was generally noted that these controlling and coercive behaviours were being experienced with greater intensity and severity. For example:

> *Coercion techniques of isolating and keeping victims in the household have increased, particularly in instances where perpetrator is working from home.*
>
> *They are at home more and able to monitor and surveillance their victim constantly. Stresses are higher. Victims are less able to seek support and safety.*
>
> *Going out and not telling her where he has been, threatening to infect her. If he has contact with children, threatens to infect them. Tells her she can't leave due to restrictions.*

Some service providers highlighted the severity and intensity of violence being perpetrated including an increase in strangulation.

> *Increase in strangulation, level of violence, increase coercive control and using COVID to control.*

Additionally, many service providers highlighted that perpetrators had been using coercion and intimidation through family law and custody arrangements and this was having major impact on the wellbeing of the victim.

> *PERPs are using COVID-19 to control victim survivors movements - keeping them home, stating*

they will have a friend with a confirmed case attend the home so that they fall ill, or threaten to seriously harm/kill the victim survivor if their children become diagnosed with COVID-19.

In post-separation situations involving child access, perpetrators have 'guilt-tripped' victims into giving them more access to children. Some perpetrators have spread rumours about the victims having COVID-19 so as to isolate them further from people.

Withholding children and using COVID as an excuse, even if family court exists.

Increase in isolation

One third of service providers reported that perpetrators used COVID-19 as a reason for increased isolation of the victim, which reduced capacity for the client to connect with the service system. Survivors of domestic violence already experience tremendous isolation and COVID-19 has compounded their experience within the home and quite often with the perpetrator (Bradbury-Jones & Isham, 2020). The reduced capacity within the service system particularly added to the challenges for people experiencing DFV. As exemplified in these responses:

Using COVID as a reason to isolate victims from family and friends and other support services or locking victims out of the home under the guise of COVID-19 infection control.

Locking victims in their rooms, accompanying them to every appointment that they would otherwise not have done.

Using COVID-19 based reasons to perpetrate violence and maintain violence over women, e.g. not allowing them out of the house citing fears of COVID/ accusing women of trying to spread virus to them/ financial control citing COVID-related costs.

They are using the social isolation being at home as a result of working from home or lost jobs, to vent frustration on wife and family, anger, power and control, threats, emotional, verbal and physical abuse.

Increased entrapment, increased reports of strangulations, increased monitoring and isolation, using COVID to rationalise isolation.

Increase in financial abuse

A small percentage of service providers (14%) reported that financial abuse and control were identified as a way many perpetrators were exerting great coercion and control over victims of DFV. This included controlling bank accounts and Centrelink. The financial abuse was also linked to other concerns including threats of loss of accommodation or housing.

Financial – not allowing spending due to possible risk of losing job. Isolation – to further isolate victim/survivor from others. Control – within the home.

Income/Centrelink is with the person doing DFV and using it against the survivors ie not enough money for food etc and to pay bills.

Restrictions on finance – Not able to communicate effectively whilst in lockdown without other person checking phones and media – Eviction from home for short time periods.

> *Stand over tactics being used against the woman to give over additional government benefits that have been paid to them.*

Although financial abuse and control has long been associated with domestic and family violence, it has taken new forms and meaning in the context of survivors' experiences during COVID-19 and the pressures associated with lockdown and related restrictions (Humphreys et al., 2020).

New ways and more severe emotional and psychological abuse

Almost 10% of service providers reported that perpetrators were finding new ways of emotionally and psychologically abusing victims during COVID-19 including ways of "weaponising" COVID-19 and intense monitoring of victims' day to day movements.

> *We are seeing matters with a greater emphasis on psychological abuse and social isolation.*
>
> *Weaponising illness, eg. skipping behaviour change group. Difficult/grey area to navigate.*
>
> *Using children to (psychologically) abuse partners more. Refusing handovers etc and applying extra expectations and duties on mums with home schooling and solving problems.*

These findings demonstrate the extent to which COVID-19 has been used by perpetrators to increase the severity of abuse during the lockdown (Froimson et al., 2020; Humphreys et al., 2020). These new and more severe ways of abusing victims were often associated with other forms of physical and sexual abuse, isolation and control, often associated with many other contextual issues including substance misuse, financial abuse, mental health concerns and broader family violence.

> *Isolation, Technology Facilitated Abuse, Intimate Partner Sexual Violence, Financial abuse, systems abuses, strangulation, withholding, property damage, emotional abuse/gaslighting, using children as weapons, exposing children, targeting children, verbal abuse/degradation, intimidation/aggression, threats to harm/kill, substance use/MH, stalking/harassment - patterns which impact child safety and wellbeing, parenting, intersections/intersectionality's, ecology, family functioning, education, access to services and supports.*
>
> *Increase in reports of deprivation of liberty, financial control, threats to take/withhold children, drug/alcohol abuse, family violence (specifically son to mother violence).*
>
> *In situations where victims live with perpetrators, perpetrators have monitored victims more closely, including victim's communication with others. Some perpetrators have demanded that victims bathe more and have monitored this. One victim stated that she couldn't take a shower without her abuser watching and monitoring her. In post-separation situations involving child access, perpetrators have 'guilt-tripped' victims into giving them more access to children. Some perpetrators have spread rumours about the victims having COVID-19 so as to isolate them further from people.*

Five service providers indicated that the limitations in providing services as a result of COVID-19 meant reduced services for perpetrators, with further flow-on effects:

> *Potential perpetrators- again a decrease in face to face contact has led to less engagement and less opportunities to support perpetrators to be accountable for their use of DV and less opportunity to monitor their use of DV.*

> *The services have had to decrease the men's behaviour programs and have been restricted to go into the remote communities.*

On the basis of the qualitative and quantitative data collected by the survey, we draw the conclusion that perpetrators are weaponising COVID-19 conditions to enhance their coercive and controlling behaviours.

The impact of the COVID-19 pandemic on the complexity of client needs

Advocates and other researchers (Pfitzner et al., 2020) have reported increased complexities and challenges in assisting victims/survivors amidst COVID-19 (Foster, 2020). This was evident in our survey with an overwhelming 86.46% (*n*=313) of service providers reporting the pandemic had increased the complexity of their clients' needs. According to the service providers, ***complexity*** manifested in many forms. It was clear the pandemic has created greater hardship, particularly financial and housing insecurity, linked to job loss, which has correlated with increased stress levels and increased DFV. The social distancing and travel restrictions associated with the pandemic have caused families to be locked down together, also exacerbating stress levels, greater incidences and new forms of family violence to emerge. At the same time, the victims/survivors' access to support services was limited, with restrictions meaning that other supports from personal and community networks were also cut off. The complexity associated with COVID-19 has therefore resulted in circumstances that promote an intensification of violence and increased vulnerability of victims/survivors. Compounding these difficulties, the restrictions create multiple barriers that make it more difficult for victims/survivors to leave violent relationships. Consequently, another complexity indicated by the findings is that the pandemic has had severe adverse consequences for people's mental health and emotional well-being.

> *The urgency increases as they have no reprieve and also stress in families increases as job loss and fear combine into stress which comes out as poor controlling behaviour.*

Increase in domestic violence

Perhaps not surprisingly, in relation to the question about complexity, 13.1% (*n*=41) of service providers indicated that victims/survivors who were locked down and isolated with violent partners resulted in an increase in DFV, including an increase in coercive and controlling behaviours. This aligns with other research during that pandemic that has found more than half the women who had DFV prior to COVID-19 indicated that 'the violence had become more frequent or severe since the start of the pandemic' (AIC, 2020 n.p.; See also Boxall et al., 2020; Pfitzner et al., 2020). Supporting this, our study similarly revealed that being stuck at home with the perpetrator created a pressure cooker type situation that resulted in worsening violence. As this service provider explains:

> *For some women, the abuse they experienced during COVID-19 related lock-down/social isolation periods was more extreme and this has added significant trauma to their experiences.*

Similarly, another service provider notes:

> *An increase in severity of abuse (many more incidents of physical violence and extreme behaviours.*

In addition, the responses indicate there were particular ways that perpetrators used the pandemic to bolster control over victims/survivors and increase their vulnerability. As these service providers indicate:

> *Perp using COVID as a reason to re-engage with client or using it as a tool to gain control.*
>
> *Perpetrators using the unstable social climate to create fear and helplessness in victims.*
>
> *Perpetrators not returning children after an access visit and using pandemic fears as an excuse.*

Responses also highlighted the precarity and vulnerability COVID-19 has created, even for women who had managed to leave violent relationships. One service provider, for example, referred to a situation in which a woman who was 'more vulnerable due to immunity' became more dependent on a violent ex-partner during the pandemic. As they explain:

> *Her ex takes full advantage encouraging her dependence on him for groceries and support given he lives few mins down the road. She recognises how volatile and vulnerable she is to him taking advantage of her but feels stuck with no other options for support.*

Greater hardship and increased difficulty for victims/survivors to leave violent relationships

The increased vulnerability for victims/survivors created by the pandemic was no doubt exacerbated by the increased hardship, which was noted by nearly 30% (*n*=88) of service providers. Of the 88 responses who referenced increased hardship, just over 30% (*n*=35) specifically noted that service users were experiencing increased financial distress and limited access to basic supplies. As the following responses attest:

> *Access to food was an issue for families during the lockdown.*
>
> *Many clients are on low or no income, have no independent transport, limited access to essential items such as toilet paper, food staples etc*.

As indicated by Pfitzner et al.'s 2020 Victorian study, we similarly found that increased financial hardship faced by service users was linked by some respondents to an increase in violence. As this service provider states:

> *During COVID-19 many unfortunate events happened, a number of people became unemployed this resulted in financial problem for many. There have been clients who seek counselling because their partner is becoming violent just because they are not able to earn money. And in most cases they are not even eligible for benefits from Centrelink.*

While increased financial hardship linked to lack of job security was an impact of COVID-19 across Australia (Biddle et al., 2020), service providers' responses particularly highlighted how financial distress during COVID had made it more for difficult for victims/survivors to leave a violent relationship. As these responses indicate:

> *Employment and income-related issues, fear to make any big decisions or life changes.*

Increased unemployment. Fewer options to leave an unsafe environment.

In some cases, financial hardship had resulted in victims/survivors

> *losing employment [and therefore] - returning to live with the perpetrator to survive financially*.

While financial distress compounds other dimensions of disadvantage (as a number of responses highlighted the vulnerability of women who are on temporary visas, for example), other responses suggested that:

> *Financial stress … [is] more common for all age groups and demographics during COVID-19.*

Intimately connected to financial hardship is homelessness (ACOSS, 2020). Increased housing instability was also frequently named as an issue in our study by 22.88% (*n*=26*)* of service providers who identified greater levels of hardship among service users. As these service providers state:

> *Victims/survivors can no longer afford to pay for rent. Or some are left homeless and there is already a demand on housing services. Some need urgent assistance in material aid being isolated with the perpetrator.*
>
> *Less options; no housing options for moving out of crisis; many people looking for the same outcome.*
>
> *Homelessness is rising due to COVID-19. FV victims are finding it hard to stay with perps in isolation, and need temporary or long term housing. There are hundreds of people in hotels with nowhere to go.*

As with financial insecurity, lack of access to emergency housing and other alternative accommodation was also identified by service providers as making it more difficult for victims/survivors to leave a violent relationship. Service providers referred to refuges being closed or severely limited in the services they could offer victims/survivors. Increased barriers to finding stable accommodation were also flagged. Service providers also noted concerns about housing options that related to being potentially exposed to the virus. As these responses indicate:

> *Less options for emergency housing or fear of going into communal housing in shelters - so less likely to leave abusive relationship people are now placed in emergency accommodation motels that are full of offenders and drug use and are not suitable for children.*
>
> *Harder to leave due to not wanting to go to refuge due to fear of contracting COVID.*
>
> *Options to leave are limited- refuges full, friends' family don't want them to come.*

Of the 88 service providers who indicated greater hardship was one of the complexities faced by service users, 11.36% (*n*=10) commented on restrictions related to COVID-19 resulting in interstate borders being closed, travel restrictions and a lack of access to transport created further barriers to victims/survivors being able to leave. The following responses illustrate some of these challenges:

> *The inability for women to cross borders has at times meant they have no alternative then to remain in the family home.*

> *Victims who have also stated they are concerned about breaking rules if they leave regarding moving out the home or not knowing if they are allowed to travel between areas to stay with friends (this was primarily when the regional border controls were in place).*
>
> *Harder to leave due to lack of transport or not being able to travel.*

Perhaps not surprisingly, these complexities were compounded for women outside of metropolitan areas. As this service provider explains:

> *Vulnerability has increased. More barriers to have them relocated out of remote areas with nil transport options.*

Generally, there was a sense that these combined factors made it more difficult for victims/survivors to leave a violent relationship during COVID-19. As these service providers intimate, for example:

> *Had to stay with perp, no f2f psych, less support and abuse has no relief.*
>
> *Victim survivors are refraining from separating at this time due to feeling 'stuck' and unable to seek and engage in the support they need.*
>
> *Safety becomes more heightened as perpetrators are in the home so leaving is more difficult and accessing supports is harder.*

Other hardships noted were complexities associated with border restrictions affecting custody arrangements, working from home arrangements creating more stress on families – leading to increased violence, children at home and the challenges of home schooling, and concerns about the virus. Increased vulnerability, increased exposure to violence, greater hardship, all making it more difficult for victims/survivors to escape domestic violence, occurred at the same time supports from outside the family contracted.

Reduction in supports available for victims/survivors

Almost half of the service providers (47.28%, *n*=148) who answered this question, identified a key aspect of complexity during the pandemic manifested in the lack of formal support services being available and accessible due to COVID-19 restrictions (see also Pfitzner et al., 2020, for example). Of those respondents that noted less access or availability to support as a feature of complexity faced by service users during COVID-19, an overwhelming 88.51% (*n*=131) noted concerns about service users having less access to formal support services. The findings suggest there are two main reasons for this. The first reason, cited by more than half of the service providers relates to restrictions of formal supports during COVID-19 (51.15%, *n*=67). The second reason noted by almost 30% of service providers (*n*=39) relates to victims/survivors being less able to access supports due to increased control and surveillance by the perpetrator, and increased proximity and exposure to the perpetrator, especially when restrictions resulted in lockdowns.

As reported by a study of DFV during the pandemic in Victoria (Pfitzner et al., 2020), our study also shows formal support services normally available for victims/survivors were greatly reduced during the COVID-19 pandemic on a national scale. Specifically, service providers noted restricted access to housing and accommodation services, material aid services, police, Family Law courts, drug and alcohol intervention programs including inpatient detox and rehab, outreach services, and men's

behaviour change programs and other formal support services. With many services closed, those that remained open, albeit in a limited capacity, were placed under immense pressure. Due to the need for many front-line practitioners to work remotely because of social distancing requirements, several respondents commented on the impact of longer waiting lists to access services, and protracted hold times when trying to access services by phone. For example, one service provider described difficulties with contacting services in terms of 'phone ping pong.' Another service provider explained:

> *Some services have altered to decrease risk of infection but made it harder for women to access them safely i.e. only by phone or online.*

Just over one third (35.82%, *n*=24) of service providers who noted the lack of formal support services specifically commented on the difficulties of having no or limited 'face to face' services. As this service provider comments:

> *With limited face to face support occurring and primarily telephone support, this has increased complexity of client needs as many other services are not responding in the way they normally would - it is much more difficult for victim survivors to now access housing, medical, therapeutic, material aid support etc, which is impacting on mental health.*

Changes in service provision such as not being about to undertake home visits with clients was also noted as a significant concern. As this service provider states:

> *No home visits to check in, less privacy for support, phone support, cannot see client for marks or non-verbal communication. Perp may be there.*

This comment also captures the other main reason why accessing formal supports was more difficult for victims/survivors of domestic violence during COVID-19.

The other main reason for victims/survivors experiencing a decreased capacity in being able to access support from formal support services was due to increased control/proximity/surveillance from perpetrator, which was noted by just under 30% (*n*=39) of the responses (see also Campbell, 2020; Pfitzner et al., 2020). Many service providers commented on the women being more cut off from services due to being isolated with the perpetrator as a result of COVID-19. As these responses capture:

> *Seeking support outside the home is much more complex, problematic and risky when the abuser is in isolation with the victim, in their home.*

> *Access to the availability of options for calling for assistance have been severely impacted. The women are no longer able to make calls while in lockdown with the perpetrator.*

> *Women unable to come to appointments, women unable to contact services due to perpetrators being at home and constantly monitoring.*

Similarly, many service providers indicated that lockdown conditions had resulted in victims/survivors having less opportunities to access support either privately or safely. As this person observed:

> *Clients were stuck at home with the other party and that made it more difficult for them to seek help and for us to provide it in a safe way because clients had not space in which to make or receive private calls or correspondence.*

This service provider similarly speaks to the same challenges, noting it is:

> *Harder to be able to contact women and assist to keep them safe or escape due to perpetrators always being around in the home monitoring communication…*

Increased monitoring, surveillance and control due to being locked down with the perpetrator not only influenced victims/survivors' options to contact formal support services, but additionally reduced the options for how those support services could contact women. As this service provider states:

> *It is harder to get women the support… Before COVID if services couldn't contact a woman by phone, they would cold call to her address. Now they don't do that.*

The other factor complicating victims/survivors' access to formal support was having children at home. As these responses attest:

> *Victim survivors are less able to engage in support over the phone due to the perpetrator being home more often and potentially also having children in their care.*
>
> *Difficulty accessing support services privately/safely due to perpetrator being present; having children home from school (increased stress, increased risk to children, less space for victims to access support*
>
> *Limited opportunity to complete safety plans or exit plans with perpetrators and children being in the home.*

A further 14.5% (*n*=19) noted the increased difficulty for victims/survivors to access formal support services but did not indicate whether this was due to services being more limited, perpetrators in the home restricting access to services, or something else.

Compounding victims/survivors' reduced access to formal supports, 11.5% (*n*=17) of service providers indicated that service users simultaneously experienced a reduced lack of support from personal networks (e.g. friend, family and social supports) and supports from community services generally (including schools, libraries, and religious communities). This resonates with Mazza et al.'s (2020) research who similarly talked about the difficulties victims/survivors of DFV have in accessing other support networks (peers, colleagues, extended family, etc). Some responses from our study noted that social distancing restrictions have meant that women were less able to access family, friends and other personal networks for practical help when trying to escape violence. For example:

> *The usual safety networks outside the family for children and women are not there…*
>
> *Clients have been unable to return to their communities. Families are less likely to allow multiple people to couch surf.*

Other responses have focused more on the reduced emotional support that comes from restricted access to friends and family:

> *Restricting women and children from leaving the refuge accommodation to visit family and friends is hard for women going through trauma or with other family obligations.*
>
> *COVID-19 has added an extra layer of … grief and loss due to reduced contact with important people.*

With access to personal support networks removed, many victims/survivors literally had only narrow moments to leave the home to be away from the perpetrator:

> *Zero access to friends/family using their only means of leaving the house (school drop offs, groceries etc).*

Some didn't have this at all:

> *Less opportunity to access support on the phone, more stressed as woman has to be more vigilant about when/whom she contacts for support, no respite from abuse.*

Ultimately, a picture emerging from the data shows that many women were trapped in violent relationships, with much less access to support than before the pandemic. If they were able to connect with formal support, they were often seeking to manage the violence rather that planning to leave. As this service provider states:

> *Victims are unwilling to report violence or cause any further impact to the perpetrator. They are seeking advice to handle the violence rather than seek safety.*

Increased adverse impacts for mental health

With these factors combining to produce a rather appalling landscape for victims/survivors of domestic violence, it was clear from service providers that the mental health of service users had been adversely impacted by COVID-19 in multiple ways. This finding has been supported generally among Australian families during the pandemic (Mazza et al., 2020; Pfitzner et al., 2020; Westrupp et al., 2020). In relation to the question about complexity, more than 20% (*n*=67) of respondents indicated that services users' mental health had been negatively impacted by COVID-19. Of these, more than 40% (*n*=27) noted increased anxiety. For example, as these responses indicate:

> *Women carry an additional layer of stress and anxiety due to the pandemic.*
>
> *COVID-19 seems to have increased anxiety and exacerbated mental health issues for many clients.*

Some responses were more articulate about the intersection between COVID-19, domestic violence and mental health, for example:

> *Increase in anxiety levels affecting ability to be out in the community for shopping etc; increased concern about being out in the community; wearing of masks can be triggering for women, especially those who have been suffocated/strangled.*

Anxiety, agoraphobia, depression, fear, isolation, suicidal ideation, increased substance use/abuse were all identified by service providers as exacerbating mental health issues due to a range of precipitating factors , which is consistent with the findings of other studies (ACOSS, 2020; Mazza et

al., 2020; Pfitzner et al., 2020; Tran et al., 2020; Westrupp et al., 2020). As these responses from our study further explain:

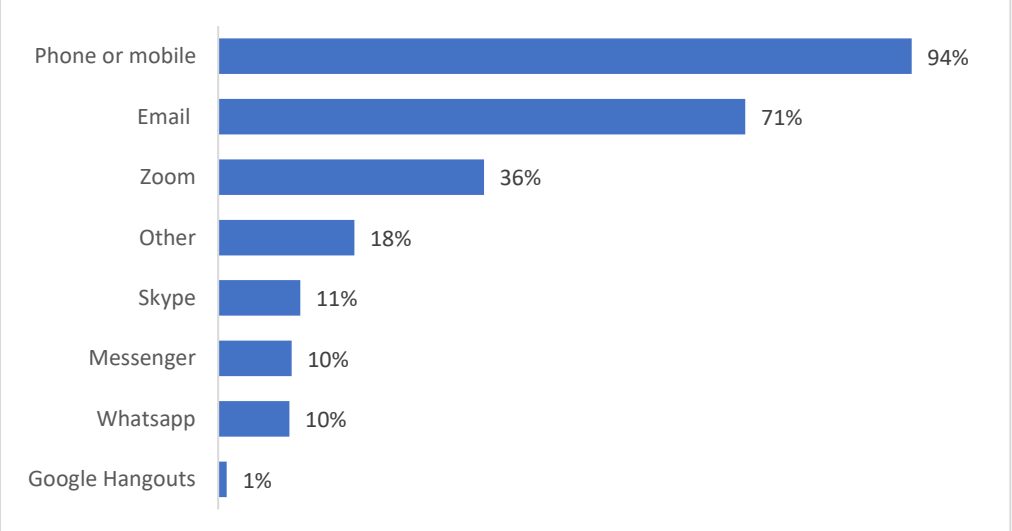
> *Financial worries due to loss of employment, increased alcohol and drug use, increased anxiety and depression for both perpetrators and victims.*
>
> *The added stressors of working from home, children being home schooled as well as elevation of tension in the house and mental health decline has contributed in an increased the complexity.*

Technological provision and supports for clients and service providers

During quarantine periods the restriction on face-to-face contact for social distancing meant that services which previously relied upon face-to-face communication had to switch rapidly to remote delivery to maintain operations. Challenges with clients accessing technology were noted by 349 service providers, as just over three quarters of clients (77%, *n*=277) used technology to access DFV services. Service providers were further asked 'Which technologies have you and your clients been reliant on to support clients during the COVID-19 Pandemic?'. A list of nine options were provided, and service providers were able to choose more than one answer, as well as the option of Other. Of the 342 service providers who answered this question, the vast majority (94%, *n*=321) reported they were reliant on phones or mobiles to support clients during the COVID-19 pandemic (see Figure 4). Service providers also reported that email was used by almost three quarters of DFV services (71%, *n*=244) to support clients, while Zoom was used half as much in comparison (36%, *n*=123). Other technologies used significantly less include Skype (11%, *n*=38), Messenger (10%, *n*=34), Whatsapp (10%, *n*=33) and Google Hangouts (1%, *n*=4). Almost one-fifth of service providers (18%, *n*=63) reported that 'Other' technologies relied on during this time include: MS Teams, PEXIP, WeChat, Gruveo, Service website, Telehealth, Slack, Post and Goto.

Service providers were asked about challenges they had faced when using technologies to support clients. There were 277 responses to this question. Given the significant role of technology during the COVID-19 pandemic, the entire data set was reviewed to identify and capture how technology has been used for both service providers and their clients.

Figure 5 Which technologies have you been reliant on to support clients during the COVID-19 Pandemic?



Technology-facilitated abuse

Service providers noted technology-facilitated abuse was one form of harm experienced by clients they assisted as part of broader "*power and control tactics in the household*" (Douglas et al., 2019). Australian research into the experiences of victims/survivors has shown that perpetrators are incorporating various technologies into patterns of abuse to enact control and violence (Woodlock, 2017; Dragiewicz et al., 2019) and this was reflected in the survey. Some service providers suggested that there had been an "*increase in technology abuse*"; "*much higher level of technology abuse*" and surveillance through technology since the COVID-19 outbreak. Specific mention was made of the following strategies engaged by perpetrators:

Breaking devices and limiting or controlling victims/survivors' access to devices or digital media

Service providers reported that "*especially at the height of the lockdown*", perpetrators were "*using COVID directly as a tactic of control and isolation*", including in regard to technology. Perpetrator access to phones, computers and passwords for accounts was a concern to service providers. For example:

> *In the current climate, with more time in the home, perpetrators were able to control their partners' access to assistance via phone / internet, and were not allowing use of computers, smart phone for communication to friends and family*.

Use of technology to monitor or stalk victims/survivors

Service providers noted instances where perpetrators:

> *place[d] cameras around the home to monitor Client when he is not at home*.

> *used phone apps, including installing apps on victim-survivor devices that they claimed were for COVID-19 tracing.*

Monitoring victims/survivors' use of technology

Perpetrators were reportedly monitoring victims/survivors' devices (phones, computers) as well as email accounts and social media profiles. Their presence in the home afforded them "*increased ability*" to conduct these checks.

Using technology to shield perpetrator identity

One service provider noted:

> *Perpetrators using technology to shield their identity when contacting victim-survivors, by use of fake or 'alias' social media profiles, removing identifying names or numbers when messaging or making phone calls.*

Compromised privacy and safety

Service providers emphasised that victims/survivors' privacy and safety when using technology was severely restricted where they were unable to leave the home either because they were based in jurisdictions under lockdown, were isolating or quarantining. Additionally, they spoke of cases where perpetrators used the threat of COVID-19 to isolate women and discourage or restrict them from leaving the home. In these circumstances, the presence of perpetrators made help-seeking difficult or impossible, offering more opportunities to oversee and monitor victims/survivors' use of technology. This reflects Victorian research into responses to domestic and family violence during COVID-19 which also indicated that remote contact compromised the presumption of confidentiality due to the presence of the perpetrator or their potential use of surveillance technologies (Pfizner et al., 2020). For example, there were many reports that:

> *Perpetrators were actively monitoring and restricting victim-survivor's use of technology and engagement with workers.*
>
> *They are being watched 24/7 which made it impossible to work with clients.*
>
> *Clients are no longer able to make calls while in lockdown with the perpetrator*.

Essentially, as one service provider summarised:

> *Victim-survivors have limited opportunities to engage informal support (friends or family), or to access phones or have any safe time to call, [and are] not able to connect with family/friends outside the home*.

The presence of perpetrators meant that victims/survivors also were also often unable to engage DFV services, legal assistance or formal supports (police), as these statements demonstrate:

> *Victims have a harder time obtaining access to services and [are]unable to call police.*
>
> *They also may not have a private space to speak on the phone to a lawyer whilst at home.*
>
> *Often victims are less inclined to call the police when the perpetrator is around.*
>
> *The perpetrator is there in the background listening, hence limited (or no) opportunity during lockdown for the women to ask for help or discuss what's happening.*

Service providers worried about victims/survivors' safety during technology based consultations and appointments, as they were:

> *unaware of who else is around in the home, and*
>
> *if there were other people in the room*
>
> *family members [who] can monitor the conversation*.

Service providers were tasked with:

> *checking [the] perpetrator is not able to listen in to the session*.

A further privacy challenge was the presence of children in the home and the absence of childcare during session (which was heightened when schools were closed and parents and carers were homeschooling). Service providers were concerned about:

> *Children listening to mum's phone conversations in the background.*
>
> *The potential impacts on children, hearing disclosures of violence*.

This hindered the victims/survivor's ability to engage with service providers. As one service provider lamented:

> *Clients were often interrupted during telehealth sessions by children.*

The presence of children in the home also limited the time and space for victims/survivors to confidentially engage with services.

Service providers shared that they were not able to ascertain the tech-safety of victims/survivors, and some noted they had "*ineffective technology security*". Some service providers commented that people were "*not answering private number calls*". This was said to be a particular issue for Aboriginal and Torres Strait Islander victims/survivors who "*often won't answer the phone when the caller is 'unidentified' - fearful that it's 'the welfare' or police*".

Barriers to remote service

When using communication technologies during remote delivery, some service providers noted they were able to use these technologies to manage the shift to remote work. For example, service providers who had positive experiences noted that either the transition was smooth, or it had opened up new opportunities for tech-facilitated service delivery:

> *It has actually been surprising smoother than we thought it would be. We have increased step by step e-safety strategies with each contact. But overall it has worked well.*
>
> *Modernising our service delivery using increased technology has been a positive change.*
>
> *All positive especially for telehealth access.*
>
> *It has been difficult using digital platforms for groups. However, working with young people engagement has increased using the digital platforms.*

However, when asked about the challenges for remote service a consistent theme that emerged was barriers to help-seeking and support via technology facilitated remote services. Service providers who reported challenges indicated that clients were unable to access remote services because they were unable to afford devices/data/credit, had poor internet connections/phone services and limited technological skills or comfort with technology.

Lack of access to devices, credit and data

Service providers who reported challenges noted that a central barrier to remote services was a lack of access to necessary devices. These service providers indicated that some clients did not have computers, laptops, phones needed to engage with services remotely:

> *Clients often do not have access to a computer, internet, printing or scanning services.*

> *Clients that do not have a phone were unable to come to our office if they needed us, we could not check in with them.*

Moreover, where clients did have access to a device, some service providers indicated they were unable to afford the credit, internet data or Wifi to participate in video conferencing or phone meetings:

> *Clients don't have credit/can't afford internet/data.*

> *Most families don't have data packages or home Wifi, most don't have laptops or devices to support facetime meetings such as zoom or Teams.*

> *Video technology requires a fair amount of data which has prevented some clients from using this, some of my clients do not have access to technology.*

While services made the shift to remote work and some reported positive outcomes, the lack of access to both devices, phone credit and data needed to access services remotely was a key challenge. This reflects wider calls for enhanced affordability of telecommunication devices for DFV victims/survivors and greater recognition of and response to the digital divide as a critical issue for DFV in Australia (Dragiewicz et al., 2019).

Poor internet connections and phone reception

An additional barrier reported by service providers was poor internet connections and phone reception. They indicated that poor internet connections were disrupted and not only compromised access but also the quality of communications with service providers.

> *Disrupted internet connections have resulted in lagging video-chats, which of course negatively impacted the woman's experience.*

Access to a stable connection and phone service was identified as a particular problem for those living in rural and remote areas where phone and internet connections were unstable:

> *Being able to access services with long wait times for phone services the use of internet is unreliable in remote communities.*

Participants noted this was a particular issue for remote Aboriginal communities, as some of these communities '*don't have mobile phone coverage'* and lost access to face to face services due to travel restrictions:

> *Our Service, while based in a regional town, also cover remote indigenous communities. People living there may not have access to phones, reliable internet, or computers. These communities also had travel restrictions in place, as such many services were not able to conduct regular visits to the area.*

This affirms extant research into the role of technology and domestic violence in Australia which has shown that the digital divide for rural Australians creates gaps in domestic violence service provision (Dragiewicz et al., 2020).

Technological skills and experience

In addition to lacking access to necessary devices and credit/data due to affordability, service providers who reported challenges also noted that some clients didn't have access to the technological skills needed to shift to an online/remote service deliver environment:

> *But also access to phone/internet and/or knowledge/capacity on how to use those things.*

As noted by the following statement, limited technological skills and also comfort with communication and digital technologies was a barrier for clients to access new mechanisms of communication in remote service delivery:

> *Some women are not confident using technology so didn't take it up as a contact option.*

Not only did this compromise some client's access to services but the ways in which services could be delivered in a remote environment. COVID-19 was described as:

> *mak[ing] everything harder and more complex using tech that people did not have or understand* as *clients struggle to use some conferencing programs such as zoom.*

As noted above, issues with access to devices or access to technological skills was particularly pronounced for specific groups. Some service providers noted that access to tech-remote services was challenging for CALD groups for whom English is a second language:

> *CALD clients - use of phone interpreters only have posed issues. Only way to communicate with clients who do not speak English. Face to face is much easier to communicate.*

Moreover, some service providers noted that access to tech-remote service delivery was challenging for older and elderly clients who may not have had access to devices or the knowledge of video conferencing or email services:

> *Working with older people, too many don't know how to use it, and are unable to learn, requiring assistance of others if available.*

Workload

Service providers also noted that the use of digital and communication technologies resulted in an increased workload. This included increased volume in calls and emails and time required to manage a digital transition:

> *Trying to get everyone on the phone and additional meetings around COVID issues and feeding information up to government task forces has meant more of our time is taken up and have struggled to stay on top of file work, working from saw us working longer hours than usual, our virtual private network did not handle us all working from home so could not access electronic client files.*

This also included increased time and resources required to set up remote services and teach clients how to access and use them due to the pre-existing lack of access to digital and communication technologies:

> *Very time-consuming ensuring technologies are setup and clients know how to use them.*

> *They don't have the equipment. They have to use staff equipment. This is not ideal in this situation. Often they don't have email so it's up to workers to manage what they need.*

Additionally, as building rapport was identified as a core issue in remote service delivery one service provider noted that more time was needed to build trust, supply information and engage with clients in this context.

Impacts of COVID-19 restrictions on the provision of services

Survey respondents were asked if there were other ways that social distancing, self-isolation or quarantine restrictions had impacted on the provision of their services. Not surprising, the majority of 347 service providers (79%, *n*=286) were impacted in other ways during the pandemic, and 273 service providers described how the COVID-19 pandemic had impacted on the operations and delivery of their service. Service providers spoke about their services needing to close or significantly reduce their service delivery due to either the lockdown measures or social distancing required for those who remained open. The impact of responding to COVID-19 meant that services had to adapt quickly, and this put pressure on the resourcing and staffing of organisations, with the majority of services citing safety concerns held by service providers for those most vulnerable to DFV. In the midst of the changing nature of service delivery, there were also some positives to emerge.

Significant reduction of services

A significant reduction of services was identified by 36% of these respondents and given that the majority were DFV services, service providers reported being concerned for the safety of women and children. This meant that service providers were not able to continue face to face counselling, group work or transportation of clients. For example:

> *We have not been able to run Behaviour Change Groups or counsel our children clients who have been impacted by DFV.*

> *Two of our service shop fronts closed, no group work, little child and family work, courts closed.*

Those services that continued to see clients directly talked about the effort and time involved in abiding by the COVID-19 restrictions, which created distance between service providers and clients in the initial periods and delayed the service response time. A few service providers stated:

Ability to engage on a human level due to wearing of PPE - very sterile environment - delayed community service provision due to awaiting results.

Cumbersome wearing of PPE, unable to sit and chat with clients in relaxed atmosphere of our facility, need for strict regulated areas to meet, increased hygiene measures, everything takes a lot longer as areas have to be wiped down after use.

There have been many physical changes to the office and the face-to-face service has been limited. On one occasion, I have had to turn away a client from the physical site whose ex-partner had tried to stab them that morning, as she had been experiencing flu-like symptoms.

During initial lockdown, there was also a reduction in public meeting places traditionally used in outreach DFV services and for many services this meant a targeting or 'triaging of services' for clients deemed most at risk due to violence. Less space in women's refuges meant an increased reliance on motels and restricted movement meant some entire communities were shut down. Other issues were:

Triaging face to face client outreach, lack of public space options to meet new clients and an increase in online meeting outreach.

Refuges taking one family at a time, increased reliance on motels.

With remote Aboriginal communities shut down, women couldn't come into Alice Springs to visit the service.

As an outreach worker, social distancing has impacted the type of outreach considered 'essential'. My client group have high levels of complexity in their experiences of mental health, substance use and other vulnerability markers and are used to assertive outreach, regular contact and high levels of support. COVID has meant that this type of support has had to be modified and reduced to 'essential' circumstances, which has meant less face to face service delivery. This has had a significant impact on some clients.

Those services who remained open, reported a major increase in demand and uptake of services.

Our service was one of the few that continued with F2F and outreach work which meant increased demand due to other services not being open.

We offer free services so uptake has increased. Many may not know this.

Went from group program to individual sessions, increased workload.

This meant that services had to adapt quickly to the changing needs both of service users and the mode of delivery they were able to provide during restrictions to cope with demand whilst holding everyone's safety as their top priority. These changes will be discussed in the following section.

Significant changes to service delivery

Significant changes to service delivery were identified by 28% of service providers. Most commonly, services described moving their operations to telephone and online platforms, which changed the nature and the scope of the counselling, therapeutic work and men's behaviour change programs.

> *We don't do deep therapy over technology its more holding a space and doing crisis and psychoeducation rather than trauma therapy.*
>
> *Very few services I would often refer into are operating at full capacity; majority of the work is currently emotionally holding the client.*
>
> *It has completely changed the way we are able to support and ensure victims survivors safety.*

This was identified as a specific issue for clients with complex trauma. Service providers spoke of 'holding' their clients as therapy was interrupted, home visits were not able to be done, communication was difficult and client needs were changing. This raised concerns for organisations who were not able to conduct their service delivery in the usual way.

> *The High Risk Team catchment extends from Mount Isa, to Doomadgee, Mornington Island, Cloncurry and Normanton…we [were] unable to conduct home visits to clients outside of The Gulf until biosecurity restrictions were eased on in the first week of July. This was extremely challenging for contacting individuals who lived in Aboriginal communities who didn't have access to phones (no credit/no phone / no reception) who we would usually only be able to contact by home visits.*
>
> *We are normally a face to face service. Since COVID-19 we are finding calls to clients can take longer if we are able to speak and their needs are more complex and more crisis / immediate needs.*

In the context of domestic violence, these changes greatly impacted on organisational risk assessment processes. Conducting risk assessments is not done in a technical way as actuarial models are limited in the context of domestic violence (see McNamara et al., 2019). Instead, professional workers are using a range of skills when doing (holistic) risk assessments (Stanley & Humphreys, 2014) that may not translate easily to online platforms. Additionally, technologies were identified as limited in terms of providing an environment where service providers could read nuances in cues, body language, and facial expressions.

> *We are all working from home which makes it harder to pick up on nuances when talking to families.*
>
> *Face to face appointments provide us with the opportunity to further assess as to the risk associated i.e. displaying out of character behaviours, non-verbal behaviours etc.*
>
> *Inability to work in a way that ensures the confidentiality and safety that face to face work can provide.*
>
> *Have to do as much as possible over the phone. Minimal outreach unless there is no phone contact. No going into properties so unable to make holistic assessments.*
>
> *Lack of face to face interaction can prevent being able to monitor their current state, inability for Court staff to see fear when applying for orders.*

Tech-remote services were also described as impersonal, uncomfortable and complicated for clients and limited for building rapport and trust. This was further complicated by the fact clients could be subject to 'phone tag' when attempting to get in contact with services. Overall, service providers

indicated that due to these challenges some clients did not engage with services, answer phones, respond to messages or participate in online spaces set up by services.

Impact on staff

Concerns were raised in late March 2020 by a survey undertaken by the Women's Safety NSW (Foster, 2020) about the impact of COVID-19 on front-line staff in the DFV sector. This survey found that: 52.2% experienced higher pressures at work; 52.2% had feelings of isolation while working from home; 43.5% experienced difficulties working from home or staying safe at work; and 17.4% felt they had insufficient capacity to meet service demand (Foster 2020: 7).

Comments from our survey participants indicated the service providers were in great need of additional support to better cope with the impact of disaster on the prevalence and complexity of DFV. A recurrent theme was the lack of adequate technology resourcing or training as previously discussed. The impact on staff identified by 13% of respondents highlighted the increased workloads generated mostly from the time spent cleaning and sanitising; rotating of teams due to space restrictions; and the difficulties that result in planning and coordination.

> *Our Service has had to ensure that all sites have the sanitisers installed and numerous staff and board meetings held, which incorporated the implementation of the COVID-19 policy and procedure manual, and most importantly the education process to the clients about safety to themselves and their children during the pandemic.*

Service providers spoke of the emotional toll arising from domestic violence safety concerns for clients; the dislocation of normal routine and the adjustments of carrying on service delivery in the midst of a pandemic, which generated their own health concerns and fear of the future.

> *Increased staff anxiety, lowered staff levels, unable to perform some methods of support and advocacy because of risk, limited staff and funding to deal with increased service need.*
>
> *Constant change and lack of certainty has made it difficult to plan ahead for programs and groups and constant changes have worn staff down.*
>
> *After our office closed, workers provided support from home working environments. Supervision, debriefing after emotional client telephe [sic] support sessions was unavailable. This along with regional lockdowns had a severe impact on my wellbeing. For the first time in many years of community development / support work, I felt truly alone. The day that geographical restrictions were imposed, was the day I felt my well being plummet.*

Some service providers identified vicarious trauma and isolation as one of the challenges of both shifting to tech-remote service delivery and working from home alone and without the necessary supports or boundaries available:

> *Working from home is hell. I am experiencing vicarious trauma from taking sexual assault calls from my bedroom.*

Perceived increased risk of violence and exclusion to vulnerable persons

Some service providers (16%) spoke about their perceived increased risk of violence and exclusion to vulnerable persons they were supporting. Children, older people, homeless people, ethnically diverse populations, those with a disability or mental illness, women living in DV situations were all identified in reports of negative impacts during the pandemic, some of which will be further discussed below.

> *Home-schooling placed significant stress on mothers and affected their ability to engage with support services. A lot of time was spent on non-DV related discussions instead - strain on parent-child relationship and mothers' high levels of stress.*
>
> *Lack of informal safety planning with children in the playground.*
>
> *AUSLAN interpreters hard to get for face to face meetings.*
>
> *We have seen less CALD women in particular accessing the service.*

Accessing support was identified as the biggest challenge for vulnerable populations as the service system, which had been set up to accommodate their need to 'drop in', had been disrupted.

> *Normally our building location has an open door policy for disadvantaged people. They know they can walk in without having an appointment. Sometimes they call in just for an informal yarn with a person of trust. Closure of the office would have resulted in community members feeling even more isolated.*
>
> *We have had many drop ins, people who may have had their phone taken or broken by the perpetrator. People who as a result of lockdown have only felt safe once they leave the home and wanting to engage at the office which they are able to access when they go "shopping".*

The service delivery restrictions have also increased the visibility of accessing a service, which could also deter people from contacting or place them at greater risk because of that contact.

> *Limit to number of people in reception leads to people not wanting to come for fear of being turned away or waiting a long time outside for their turn. This increases their public profile of being at the service and makes it less private.*

Overwhelmingly the service providers identified concerns about increased risk of violence to women during COVID-19 in various ways already discussed. In addition, about 5% of service providers spoke of **court as the final safety net** and saw the changes during the pandemic potentially meant greater risk for women.

> *Local court hearings reduced, sentencing impacts (reluctance to impose custodial sentences and preference for community-based orders).*
>
> *Inability to get documents signed and witnessed. Difficulty in getting DV Applications signed and witnessed as every court registry had different procedures.*

Service providers also spoke about the impact of COVID-19 on family law processes and the increased risk this presented for women and children.

Perpetrators are trying to change their parole conditions so that they can have contact with the victims and Corrections are becoming more aware of how to tighten the perpetrators conditions - well done Corrections.

Positive impacts of COVID-19

Finally, around 4% of respondents spoke of **positive impacts that have emerged** through COVID-19. The survey sample included service providers from health, housing, law and community support organisations and there were positive changes identified across all these locations. Positive changes include enhanced safety for women in a medical context, less stressful in a legal context, innovations in service delivery which emerge from being forced into considering practising 'differently'.

No visitor policy in hospital means that perpetrators cannot be present during examination and assessment of victims in the ED.

Court is not requiring attendance so less threatening and overwhelming for clients… perpetrator has less impact [on victim].

Staff having to work from home during self-isolation, but possibly we have become more efficient with less travel time.

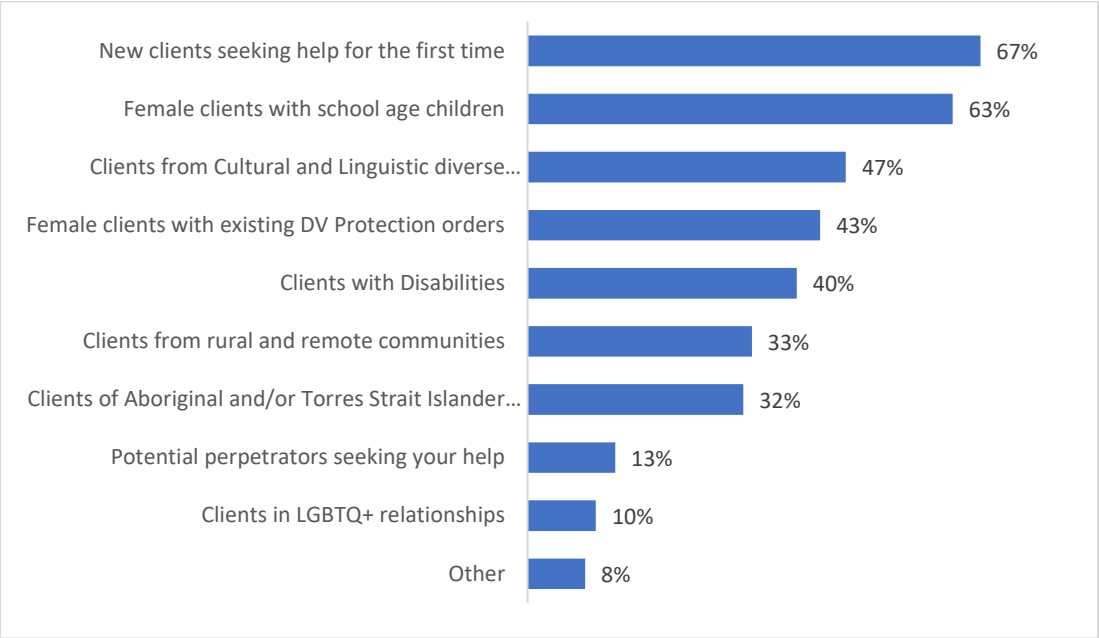
We have developed technological ways to provide services that we would have provided in person before - eg transferring funds to accounts for ER, leaving vouchers for food in motel for [clients].

We have had very reduced face-to-face contact. But interestingly we have found that the women have remained engaged and the same supports, protections and goals set by the women have been achieved. Our contact has been more frequent but for shorter periods and I think it is less burdensome then spending an hour at an appointment. The one area that we are reviewing is how we support children remotely as this has not been as easy. But we are confident that we will come up with strategies to address this.

The COVID-19 pandemic and impacts on clients

Perhaps one of the most concerning of our findings is that 67% of 318 service providers (*n*=212) reported new clients seeking their help for the first time during the COVID-19 crisis (see Figure 6). This is a significant finding, indicating that pandemic conditions are likely affecting the rate of domestic violence. Additionally, mirroring what has been noted in international media reports and research, experts reported that the frequency and severity of domestic violence is rising. Elsewhere, this has resulted in domestic violence homicides rates that have been said to more than double in multiple locations including China and the United Kingdom (Grierson, 2020; Taub, 2020). The United Nations Secretary (António Guterres, 2020) has called for governments across the globe to urgently 'put women's safety first as they respond to the pandemic'. These survey results are also consistent with the increases of domestic violence experienced by Australian women reported by the Australian Institute on Criminology (Boxall et al., 2020).

Figure 6 Has the COVID-19 Pandemic had any particular impact on any of the following?



Not surprisingly, female clients with school age children were reported to be the next most impacted by the COVID-19 pandemic (63%, *n*=199) (see Figure 6). Almost half of the 318 service providers (47%, *n*=149) reported that clients from CALD communities were also impacted. This was followed by female clients with existing DV protection orders (43%, *n*=137), then clients with disabilities (40%, *n*=126). One third of service providers reported that COVID-19 had particularly impacted clients from rural and remote communities (33%, *n*=105) and clients of Aboriginal and/or Torres Strait Islander descent (32%, *n*=101). A smaller percentage reported to be impacted were potential perpetrators seeking help (13%, *n*=41), clients in LGBTIQ+ relationships (10%, *n*=32), while 8% (*n*=27) selected the option of Other.

Service providers were then asked about the specific impacts that COVID-19 had on a range of different social groups, including those mentioned above. There were 221 responses, with respondents identifying unique challenges and experiences faced by a range of groups including new clients; women with school age children; CALD communities, people with disabilities; people in rural, regional, and remote areas; Aboriginal and Torres Strait Islander people; LGBTIQ+ communities; people experiencing socio-economic disadvantage; older people; and perpetrators. The key experiences for each of these groups is outlined below.

New clients

Nine service providers reported that COVID-19 restrictions posed particular challenges to providing services to new clients. Four service providers also indicated that the COVID-19 context had led to an increase in new clients:

> *New Clients - Significant Increase in new Clients seeking support either self-referral or new Police Referrals.*

We have had an increase of the number of clients making contact with our service for the first time.

Five service providers reported that COVID-19 restrictions on the delivery of their services impacted new clients in particular because most new clients benefited from a more personal, face-to-face engagement, particularly in the early stages of their access to services:

New clients - therapeutic relationship is fractured.

New clients don't know the systems and it is hard to navigate without face to face eg. not attending court with them or police station with them.

Difficult to establish rapport with new clients without the face to face interaction.

New clients are finding it very difficult to come forward fearful due to increased monitoring of them.

Women with school age children

Almost one third of service providers (28%, *n*=62) indicated that COVID-19 restrictions had unique impacts on women with parenting responsibilities. Some noted a general increase in stress and anxiety because of the intensity of parenting responsibilities (particularly home schooling), potentially increasing the risk of violence:

Mothers with school age children - This has caused significant increase in their role as a caregiver and has added to the already high stress levels experienced by mothers with existing vulnerability to stress and anxiety.

Women have struggled to manage their children's emotions whilst their children have not had face to face counselling, some woman [sic] have been coerced to try to vary orders, perpetrators have not been able to attend behaviour change groups

Relationships became far worse due to ex partners not wanting to abide by COVID-19 lockdown and claiming to it was being used to keep them away from their children thus causing extreme DV situations.

Women with school aged children have less time to attend to their own mental health.

Extra pressure on traumatised families to be locked down together and having to navigate complexities of online learning alongside poor self regulation.

COVID-19 restrictions also impacted on access to services and the quality of the services that were provided. For example, service providers suggested that the presence of a partner at home or children in the vicinity of any counselling or support session limited the freedom to talk about the violence and provide the necessary support:

Having their children with them limits their ability to attend court, police and time to engage with other services.

Children are at home during phone calls, and it is difficult for them to engage without exposing children to the trauma of the content discussed.

Children are almost always present, limiting conversations either in length or content.

Service providers also indicated that COVID-19 restrictions saw the use of access to children as a tactic of abuse intensified:

The fear of the unknown and the reactions to COVID have resulted in withholding children, more monitoring partners on technology esp [sic] in appointments

The pandemic has impacted the way parents can access their children. During the closures the family law court encouraged families to follow their court orders but very few did. As our Children's Contact Centres were closed to clients many used this excuse not to allow the other parent to see their child/ren.

Systems abuse used in FLC, children being withheld from protective parent or protective parent coerced and manipulated into handing over the children.

CALD communities

A small percentage (10%, *n*=23) of service providers indicated that CALD communities encountered unique impacts as a result of the COVID-19 restrictions. The issues most reported concerned the limitations service providers encountered in delivering services to CALD communities and maintaining their engagement with these communities. Specifically, communication barriers were identified as a key issue:

Language barriers have been a challenge with phone-based sessions.

Culturally diverse clients - hard to understand what exactly is going on, unable to have in-person interpreters available in some instances, interpreting services are very busy at the moment, so I have had to pre-book interpreters in some cases to ensure one was available for phone appointments I was having with clients.

Migrants prefer face-face contact as the grasp of English on the phone is harder. Its also harder to trust a service provider that you have never met face-face. Trust is everything for migrants and refugees.

Service providers also identified the factors that might increase the vulnerability of members of CALD communities to DFV in the COVID-19 context:

COVID resources are not available in native languages or take longer to get translated. COVID resources are not in simple English.

Lack of supports for women from migrant backgrounds on temporary visas when they've lost work due to COVID.

CALD Women on temporary visas do not have the knowledge or ability to access support. They may not have their own phones or access to monies or leave their homes as they have been monitored by OP.

People with disabilities

Similarly, 10% of service providers (*n*=23) indicated that the COVID-19 restrictions have had specific impacts for people with disabilities. Four service providers indicated that there had been an increase in violence towards people with disabilities, particularly due to the increased vulnerability that results from restrictions to accessing services:

Persons with disability reliant on partner as carer this used as a threat that if perpetrator left there would be no care for partner subjected to abuse as community in lock down.

Clients with disabilities - overall increase in tension and perpetrator more likely to be at home - if client wants to leave - very limited refuge options which can accommodate specific needs.

The challenges that people with disabilities faced accessing services was noted by seven service providers. They indicated that the shift to services provided online was particularly difficult and introduced barriers to service provision, primarily because the shift online did not account for their disability or health condition:

Clients with disabilities appear to have had increased difficulty contacting services due to accessibility issues (e.g. deaf clients who cannot attend offices for face-to-face contact due to COVID-19 and cannot use the phone).

NDIS workers declining to do face to face work has meant some women miss out on services.

Clients with disabilities have reported having issues with support workers not showing up for shifts or cancelling shifts.

Clients with Disabilities - In home supports cancelled, leaving clients more vulnerable.

Four service providers also noted that people with disabilities were experiencing social and cultural isolation in the COVID-19 restrictions, which led to be uniquely vulnerable to DFV:

Greater increase in challenging behaviours from disabled clients - as at home for months (No school / no therapy intervention).

New rates of depression and loss of money due to loss of casual job for mentally ill clients.

People living in rural, regional, and remote contexts

Thirteen service providers reported that COVID-19 restrictions impacted uniquely on people living in rural, regional, and remote areas. Three noted the impact that restrictions had on the access that victims and perpetrators had to services, and the ability to provide services.

> *In rural and regional communities, legal/social services can be limited and if they are running on a lesser capacity this decreases the ability of people to access service… Also, due to lockdown restrictions, individuals may not know where to go if they were to flee as they were not able to go to family, friends or a hotel.*

> *Less resources in rural areas, harder for women to reach out with partner at home, more stress and tension.*

> *Women in RRR areas have even less access to services now with the curtailment of services visiting from the city. They are a group significantly impacted by the reduction and the redesign of service delivery models.*

> *COVID restrictions have placed hard limits on intaking new clients and reaching remote clients.*

Seven service providers noted that online and other technologies being utilised to provide services was a key limitation they encountered, with '*unreliable technology*' being encountered in their engagement with rural clients.

One service provider also indicated that rural clients were experiencing greater social and cultural isolation, which again could increase their vulnerability or limit their ability to access help:

> *Clients feeling isolated in rural areas or with a disability and mental health.*

Aboriginal and Torres Strait Islander people

A small percentage (10%, *n*=22) of service providers indicated that COVID-19 restrictions had specific impacts on Indigenous communities. The issue that service providers noted most prominently was the impact of lockdowns on, and restrictions on entry into, Indigenous communities. These either reduced or increased the risk of violence, and limited the ability of service providers to continue providing services to those communities:

> *Lockdown of Aboriginal communities has actually either quarantined the violence user in community and kept her safe or locked her into community with him.*

> *Community lock downs particularly for remote Aboriginal and Torres Strait Islander communities meaning limited ability to facilitate evacuation or safety planning.*

> *Clients and ATSI clients from remote communities have not been able to travel to service due to Bio security Act.*

As many services had to shift to providing services online or through other technologies, this also limited the access that Indigenous communities had to these services:

> *A large number of Aboriginal and Torres Strait Island victims do not own or have accesses to a devices. Eg. a Phone.*

This shift in service provision was made even more complex because of the multiple healthcare needs of Indigenous clients, in addition to their needs in the DFV context:

> *Aboriginal clients have serious comorbidities which is concerning that this time, the access to Aboriginal specific healthcare is a distance away from where they live so they need to travel in via public transport which places them at risk.*

Social and cultural isolation also increased as a result of lockdowns and restrictions in these communities:

> *Indigenous women feel culturally disconnected. CALD women need interpreters and more isolated.*

> *Our ATSI participants are off the radar and not engaging, we cannot get them on the phone or responding to any communication.*

LGBTIQ+ communities

Three respondents indicated that LGBTIQ+ communities encountered unique impacts from COVID-19 restrictions. Lesbian, gay, bisexual, transgender, intersex, queer, + (LGBTIQ+[i]) survivors experience violence at similar or greater levels to heterosexual, cisgender women (Donovan & Hester, 2014; Lay et al., 2018). There is concern among LGBTIQ+ communities about the impact of isolation and lockdowns on rates of domestic/family violence. A small number of service providers to our survey (10%, *n*=32) confirmed this impact on LGBTIQ+ communities.

One service provider indicated that they had observed '*a slight increase*' in violence in these communities. Another noted that the situation highlighted the limited services and resources that specifically cater to LGBTQ people:

> *Lack of appropriate emergency housing for gay and transgender men*.

A final respondent noted that as a group with '*existing trauma*' that encounters negative social stereotypes, LGBTIQ+ people might experience COVID-19 related restrictions differently. It may reinforce what one respondent identified as the '*stigma/abject/contagion shame*' that some LGBTIQ+ people experience in relation to their HIV status, particularly because of notions of contagion and disease have a heightened presence in the public consciousness.

Socio-economically disadvantaged communities

Thirteen service providers noted that the COVID-19 situation has impacted on socio-economically disadvantaged communities in particular ways. One service provider indicated that they had observed an increase in violence among those who were disadvantaged, as a direct result of '*job loss*', which led to '*even more time with perp, less $, stress in household, home schooling, more gaslighting*'.

Six service providers reported that socio-economic disadvantage also impacted on an individual's ability to access services:

Some clients limited by low literacy. Some clients not used to using email and lacked access to email.

People who have lost jobs and having to go to Centrelink for the first time having issues to navigate the process.

New people/ families experiencing homelessness for the first time are facing longest wait times ever for support.

Furthermore, six service providers reported that unemployment or insecure employment as a result of COVID-19 has increased the stress and tension in households and thus increased the vulnerability of some people to DFV:

Clients often working in casual jobs which have been highly affected by COVID-19 and no access to income support. Some returning to perpetators due to feeling like there is limited support for them.

Loss of jobs and income, increased stressed [sic] on families.

Older people

Two service providers indicated the specific impact that COVID-19 restrictions had on DFV for older people. Both noted specifically that the shift to providing services online and through new technologies limited the access that older clients had to them:

Some older people didn't know how to download ZOOM - despite our willingness to try and talk them through it or email instructions.

Older CALD people face additional barriers as they become more socially isolated during pandemic, and they're [sic] lack of skills when it comes to use technology equipment when accessing service. I know some of my client learned how to use zoom meeting from the beginning and take them very long time to get use [sic] to it, so now they are able to use zoom to attend sessions.

Resources needed to strengthen the DFV sector to better cope with Disaster

Finally, we asked the DFV workforce 'What extra resources or supports do you/your organisation need to better cope with a crisis like COVID-19 Pandemic in the future?'. Two thirds of survey respondents answered this question (67%, *n*=243). Most respondents considered more than one resource or support required for a future crisis event, however 100% of their responses fell within four categories: staffing; services; equipment and technology; and technological assistance and support.

Staffing

Not surprisingly, almost one third of respondents (29%) spoke about the need to have **more trained frontline staff** to work during a future pandemic. This was a reflection on both the changing nature of

the work under COVID-19 plus the increased need for domestic violence services. Service providers identified issues relating to worker and client safety; the need for organisations to have a planned response to a pandemic; and the need for a supply of locum crisis staff to support the increased workload in domestic violence services. Those in specialist programs identified the need to evaluate and plan for continuing services during pandemics when transitioning to online delivery, as this was problematic.

Organisations that were marginally funded, such as Neighbourhood or Community Centres who are primarily staffed by volunteers, struggled to provide support to their communities and in some situations, they remained the only emergency service option available to their communities.

> *Community Neighbourhood Centres are currently not recognised as frontline workers even though we were opened as emergency services during the lockdowns as we dispense emergency relief, offer counselling, in addition to providing support through our living skills programs. Due to our limited funding and the lock-down we lost 45 volunteers without whom we are unable to offer our range of services. This left one worker offering Emergency relief which made it impossible to meet this need as required.*

The need for more trained locum staff was commonly identified by Domestic Violence crisis services who were often the only services remaining open and were not able to source appropriate staff at short notice. This had an impact on worker and client safety.

> *More funding for outreach [workers] and to have locum staff to provide relief for existing staff from the constant toll of dealing with clients who have complex needs and are highly traumatised.*

> *The agencies we refer clients to need to be better resourced. They had clients on wait lists and had to prioritise the high-risk clients. In the meantime those who had been identified by police and referred for supports had further incidents prior to receiving that help because they were on a wait list. Police in the DV unit worked 10-11 hours shifts with no additional pay just to keep ahead of the reporting requirements and additional monitoring of the high-risk clients.*

Service providers identified the need for planned responses to future pandemics embedded into organisational policies as a future requirement. This included being trained in the use of Personal Protective Equipment (PPE) as well as *more clarity and consistency of safety limitations* within the changing context of something like COVID-19. Many reported confusion in terms of service delivery and the restrictions that emerged and being unable to find clarity at the government funding level as the below example shows.

> *Also, we had NO direction from the funding body regarding closing down, restricting access etc. It was quite negligent as no public servant wanted to make a decision on important issues. We were told Children's Contact Services are "critical" services so we closed as were deemed not "essential". That's the only guidance I had from the Federal Government funding body. The rest I gleaned from other services and State Government to create pandemic policies and procedures including screening checklists of clients and additional service agreements to ensure that families would follow our new procedures.*

Building organisational capacity to cope with future events was a common theme and many service providers believed that preparing staff for change situations was essential for ongoing staff and client wellbeing.

> *I believe my organisation needs to learn coping strategies around adjusting to stressful change. Workers returned to work too early in my opinion, purely because they struggled to adjust to working from home. I think organisations need to adapt to a 'new normal' and more flexible ways of working, post-COVID-19. Extra clinical supervision may be necessary for some staff during periods of lock down. Personally, I learned that there are other ways of working, particularly non-client work that doesn't require face to face interaction that actually offer me more work-life balance.*

There were some service providers who identified difficulties in moving their programs online and cited the need to evaluate their program's overall efficacy with this change. This was articulated by those service providers delivering Men's Behaviour Change Programs (MBCP) who transitioned clients to online one on one rather than group mode. There was some concern around the validity in this and there was a need to review the service delivery as the changes brought about through COVID-19 raised issues of funding and support.

> *Research into validity of remote behaviour change group delivery.*
>
> *Our MBCP is not funded for one on one counselling, having delivered this intervention we now see that we need to be also funded for this service to better service men with disability, CALD men and ATSI men who need additional support pre during and post group.*

Services

The second area identified by almost one quarter of service providers (24%) were the **services that are needed** both now, and in the future, to better cope with a crisis or pandemic. Overwhelmingly, the need for a robustly funded social housing system was identified both as a protective factor and as a key learning in terms of a future service response. Also, service providers identified the need for higher level service coordination or systemic flexibility to respond to future crises and emerging brokerage services as essential to facilitating that flexibility.

Many service providers cited examples of new brokerage services that emerged during the lockdown period and believe that these services were integral in responding to the changing needs and conditions. Brokerage funds are provided by the Department of Housing and Public Works to some organisations under the Homelessness Program and are used within a case management context to enable clients to access a range of goods and services only when direct service delivery, case coordination, or referrals cannot supply the goods or services (Department of Housing and Public Works, 2018). Service providers cited services which enabled rapid and targeted responses based on individual needs, as being an essential part of a future service system flexibility required in a future crisis or pandemic.

> *Systemic flexibility - eg, (some) courts permitted documents to be filed via email without being witnessed. Court appearances by phone. Brokerage funding helped to be able to assist clients move quickly (this should be available all the time not just in a pandemic).*

Long term flexible/emergency relief funding specifically for DV Services.

More brokerage for emergency accommodation and emergency relief.

Overwhelmingly though, 65% of service providers identified the need for more and improved social housing and accommodation services as both a preventative factor and a systemic response to keep women safe. There was an acknowledgement that those who were vulnerable to violence before the pandemic, were often living in unsuitable/unstable accommodation or had few affordable alternative options and that exacerbated their risk of further violence under COVID-19. Service providers identified that a housing supply that is affordable and appropriate to the needs of women and other vulnerable people is necessary now, and in the future, to provide options and prevent women returning to violent environments.

The government needs to fund housing. We can be given more support, material aid, more workers, but essentially people cannot live safe from violence without affordable housing.

Additional staff would be great but there is a real need for more affordable housing in the Townsville region and there is a need for supported semi-independent living for those who need assistance but are ineligible for NDIS or Aged care.

The need to focus on the supply and design of crisis accommodation services that could better respond to a pandemic was also identified by service providers. Many respondents identified the space limitations in shelters that increased the turn-away rate of women needing refuge. Service providers reported that without affordable housing options, women often stayed in an unsafe environment.

We desperately need more crisis accommodation that is self-contained. Most Refuges are communal style houses with shared common areas. There has been minimal investment in DV Crisis accommodation since the 90s. We have 4 Refuges and only one has self-contained units. During COVID this service could operate at full capacity while the others had to significantly reduce occupancy to maintain social distancing and other health directives. We have been turning away approximately one in every two women for years at refuges in Australia. The pandemic increased this turn-away rate.

Equipment and technology

The greatest response (47%) in terms of future resources required, was the need for **equipment** to operate under new and changed conditions. Not surprisingly, this was overwhelmingly about the need for upgraded, new and/or more sophisticated technology that was used to connect, assess the safety of clients and provide a buffer for both staff and clients from the isolation that COVID-19 presented the sector with. COVID-19 specific requirements such as the need for greater office or public spaces to respect social distancing plus the need for PPE equipment was also identified.

Technology resourcing was reportedly lacking in the majority of organisations, with a need for "*more IT equipment and software*"; "*better technology*"; "*better technology set-up[s]*" to perform roles, including delivery of face-to-face services, remotely (both in the office and from worker's homes). This includes:

- Computers, tablets or phones with cameras and microphones with internet capabilities

- Camera attachments for existing computers
- Phone (including smartphone) and video-conferencing systems and equipment
- Printers
- Software and free or funded access to information and communication technology platforms "*that are safe and secure*"
- Online delivery materials / transition of offline to online materials, including "*translated resources*" for CALD victims/survivors
- Digital thermometers

Many service providers identified their organisations as being under-prepared in terms of equipment required in responding to COVID-19 and this placed pressure on staffing and organisational resources, considering the timeframes that they were working under.

> *As a community legal centre we are funded to deliver services but get limited funding to cover other disbursements such as technology upgrades which was very noticeable during this time.*
>
> *Extra tech supplies for our staff such as laptops, printers, work mobiles etc that allow us to work remotely.*
>
> *Computers/laptops. We were only provided with phones and needed to purchase our own computer.*
>
> *The other gap was technology and training around using technology - by the time orders were filled and staff were trained, the crisis was well underway - again, hopefully now we are better prepared for any future pandemics.*

The equipment requirements for staff predominantly focused on developing new systems of operation which were able to take account of confidentiality and security concerns.

> *Access to secure online information delivery systems, ability to provide remote court support.*
>
> *Improved technology. Case management app?*

Service providers were also very concerned that clients have access to technology and "safe phones" which may not have been possible due to affordability or supply issues.

> *More tech support for the families who cannot afford the data plans.*
>
> *More devices, especially smart phones. Every woman needs their own.*
>
> *More phones to send to regional communities (I believe department of housing and public works had a small initiative for this) but it needs to be much larger scale - people need to be able to remain in contact to stay safe.*
>
> *Ability to provide phones to clients (this is difficult both financially and technically due to ID and other requirements). Better telecommunications in remote areas (phone and internet reception can be poor). Better forward planning with regard to how to maintain services in the area.*

> *Support to provide technology safe services - check phones & accounts, protocols for safe technology facilitated counselling.*

Clients encountered other difficulties with ensuring there was 'ongoing free/funded access to use online platforms that are safe and secure' (Harris, 2020). This is complicated by the presence of perpetrators in the home and the possibility that email, social media accounts and internet access is viewed or has been compromised by perpetrators (see Harris, 2020).

Service providers expressed limited access to and limitations with available technologies (including those with cameras and microphones to enable more face-to-face contact with clients), reliable/strong internet connections, phone credit, data, appropriate reception and technological support. Technology provides a vital channel to access clients in the event of disaster (not only the COVID-19 pandemic, but floods, fires and droughts) and further access points for victims/survivors with disabilities and in regional, rural and remote locations (Harris, Dragiewicz & Woodlock, forthcoming).

In addressing technological needs of the sector and victims/survivors, attention needs to be given to the 'digital divide' (discrepancies in skills, capability and connectivity). Service providers emphasised that, for instance:

> *The vast majority of clients have not been able to use videoconferencing, no data, no computer, no smart phone or no skill in this.*

Access to technology and the internet can be reduced in many locations (including in regional, rural and remote areas) and for certain groups (Harris, 2016). For example, service providers indicated that older and elderly clients were particularly disadvantaged as they did not have access to technology, and they were unfamiliar with how to use technologies like Zoom, email and SMS. Therefore, ensuring affordable, accessible access to information communication technologies is critical.

Technology training and upskilling service providers

Most service providers cited the use of technology as enabling them to adapt their service delivery to clients during the COVID-19 pandemic. However, service providers noted the need for training and upskilling was necessary as "*some of our staff are challenged with technology*". Even those more comfortable with technologies emphasised that they would benefit from guidance in how to most effectively use technology to engage with clients. Attempts to build their own or organisational capacity in this arena was said to be "*generally time intensive*" and not always possible, remotely.

Service providers reported that many clients had limited access to hardware and software needed to engage with services, which "*means they are shut out of telehealth / health services' delivery via technology*". Consequently, they advocated for the "*purchase of virtual technological systems and mobile devices to provide to clients in times of emergencies such as COVID-19*" and "*better technology and more money to support clients to access better resources for support and/or more (safe outreach)"*. Otherwise, service providers cautioned that victims/survivors may need to rely on ex-partners to access services, digitally.

WESNET has been funded to March 2021 to provide 'Safe Connections' phones (assisted by Telstra). Under the 'Safe Connections' program women victims/survivors are given a new, safe smartphone. This is vital where their existing phone has been destroyed, taken or compromised by a perpetrator (for instance through tracking apps). This program was consistently mentioned by service providers as providing a lifeline for women seeking to exit violent relationships, as it provides a secure channel to access informal and formal supports. It is also a secure channel that service providers can use to contact clients, which is important given the privacy and security issues earlier flagged. "*Most clients do not have phones*" one participant remarked, and so "*we might be putting them at risk incase [sic] there is a missed call or message that can be seen by the perpetrator - if they are still together*". Without additional and ongoing funding past March 2021, WESNET is not able to add further agencies to the program. Given the reach of Safe Connections and how frequently service providers mentioned it, this is a significant issue (which has been elsewhere documented in Australian studies, see Dragiewicz et al., 2019; Harris, Dragiewicz & Woodlock, forthcoming). These survey findings support the view the Safe Connections phone programs should be continued.

Provision of phone credit or data was recommended by service providers, as clients may not have access to the internet - "*some clients could not afford to pay [for access to the] internet*" - or "*phone credit to call me back*". This would provide clients with opportunities to access informal and formal supports and also channels for service providers to contact clients. Service providers suggest "*sim cards for video conferencing that go in their cards for the meetings would help*" and that ideally these could "*be topped up by us but not them yet would not be able to rack up debt*".

Enhanced connectivity for both clients and service providers was seen as essential. Service providers emphasised that issues with connectivity (discussed earlier) more generally and in certain areas (like regional, rural and remote locations) must be addressed. Service providers noted that they needed "*reliable NBN*" and remarked on (as earlier discussed) existing "*black spots where phone and email is challenging*", *"reception issues and client anxiety [regarding] reliability of the internet"*; *"POOR RECEPTION*" that needed to be bolstered.

Financial resources for remote delivery

As well as resources and training to deliver services using technology, service providers noted there was financial support needed to do this, including to upgrade technologies. Services that might not be classed as 'essential' (like community legal centres) received "*limited funding to cover other disbursements such as technology which was very noticeable during this time*". Service providers also suggested that funding was needed to hire more service providers (such as facilitators) to conduct sessions with perpetrators. Many service providers noted that client needs could be more complex and that there were significant barriers to clients accessing and workers providing assistance, thus additional workers were needed for longer sessions.

Flexible Assistance Funding

Service providers emphasised the importance of flexible assistance funding (also referred to as brokerage funding and emergency relief funding) in responding to the needs of people experiencing DFV. Funding is currently sourced from a range of different government agencies and program areas

and also by private/charitable organisations. These often have different access criteria and eligibility. Some relevant quotes from service providers demonstrate the value and utility of flexible assistance funding to people experiencing DFV and service providers who are assisting these people. Responses included:

> *Brokerage monies have been amazing.*
>
> *Extra funding to assist with essentials like accommodation/school fees/medical expenses for the most vulnerable so clients can have a choice and options to be able to leave an unsafe relationship.*
>
> *Community Neighbourhood Centres … operated as emergency services during the lock-down as we dispensed emergency relief, offer counselling, in additional to providing support through our living skills programs. Due to our limited funding and the lock-down we lost 45 volunteers without whom we are unable to offer our range of services. This left one worker offering Emergency relief which made it impossible to meet this need as required.*
>
> *More brokerage to allow clients to utilise data/smart phones/technology.*
>
> *Qld govt offered additional brokerage from 1 May-30 Sept—would be better to extend the time frame until 28 Feb 2021 to realistically deal with aftermath of this pandemic.*

Summary of resources needed

Our survey asked the DFV workforce what extra resources they needed to better cope with a crisis like the COVID-19 pandemic in the future. The details of these responses have been set out above. In summary, the DFV workforce emphasised the need for:

- more staff, better technology and technology support and training for workers and clients;
- more thorough and better technology safety checks for client;
- more Safe Connection mobile phones for clients and better internet connectivity;
- more government funding for crisis and emergency supplies;
- more government funding for emergency and long-term accommodation and housing;
- transport for home delivery of services;
- the continuation of tele-health provisions;
- the continuation of on-line access to courts and justice services; and
- more resources for male perpetrator programs (especially for Indigenous men).

They also need systems to be flexible, especially courts and magistrates and they called for improved policing and better communication and translation services and supports for CALD communities. Our recommendations address these needs.

Recommendations

Early during the pandemic, Australian healthcare and women's safety professionals predicted an 'impending increase' in domestic violence (Foster, 2020; Hegarty & Tarzia, 2020). Advocates also reported concerns about increased complexities and challenges in assisting victims/survivors amidst COVID-19 (Foster, 2020). The research we have undertaken on the impact of COVID-19 pandemic based on survey findings of 362 participants from the DFV sector, including 1,507 qualitative responses, confirm the concerns raised early in the COVID-19 pandemic. We believe the data we have provides the evidence base to support the following eight key recommendations.

1. Undertake disaster management planning for domestic and family violence

The Commonwealth Government, in conjunction with the State and territory governments, urgently revamp disaster management frameworks and guidelines to:

- Plan, in collaboration with the family violence and support sectors, for spikes in DFV in preparedness, response and recovery phases;
- Provide for additional funding for domestic and family violence services through adjusting scope and eligibility of *National Disaster Response and Relief Arrangements*;
- Adjust personal disaster planning guides and tools, and communications strategies, to provide enhanced safe access to information about domestic and family violence services and supports.

2. Provide flexible assistance funding for people experiencing domestic and family violence

The Commonwealth Government in cooperation with the State and territory governments fast track the delivery of a robust and contemporary *National Flexible Funding Assistance Scheme* for people experiencing domestic and family violence. This funding should be independent of Centrelink or other entitlements and should be tax-free. This will be achieved by:

- The Commonwealth Government immediately and significantly increasing the recurrent funding available for this purpose in 2020/21 and forward budget estimates until 2030;
- State and territory governments reviewing existing flexible funding initiatives, and related initiatives, with the view to ensuring processes and practices are person-centred and are implemented with the objective of delivering timely assistance to people experiencing domestic and family violence with minimal barriers.

This should be carried out within the context of the policy drivers contained in the *National Plan to Reduce Violence against Women and their Children 2010-2022* and current Action Plan and policy positioning for a new national strategy from 2022.

Jurisdictions, such as Victoria and Queensland, have commenced flexible assistance funding initiatives for people experiencing DFV. Victoria has been operating such an initiative since 2015 with findings from an evaluation identifying the initiative as a life changing opportunity. Queensland has recently commenced a modest scheme as part of their *Queensland Housing Strategy 2017-2027*. These survey findings support the view that there needs to be greater resource allocation and a supporting policy

and program framework to accompany a *National Flexible Funding Assistance Scheme* for people experiencing DFV.

3. Undertake domestic violence workforce planning for disaster preparedness

The Commonwealth Government, in conjunction with the State and territory Governments, urgently revamp the workforce planning and disaster preparedness needs of the DFV sector. These plans need to take an intersectional approach that recognises the diversity of the needs of different cohorts of services to cater for DFV victims with disabilities, from CALD, LGBTIQ, Aboriginal and Torres Strait Islander communities, rural and regional communities, women with school age children, pregnant women, older Australians and new clients.

4. Provide finances and resources for services to engage with victim/survivors and their children (and also perpetrators) via remote delivery, especially in the context of disasters

The Commonwealth Government, in conjunction with the State and territory governments should provide finances and resources for services to engage with victim/survivors and their children (and also perpetrators) via remote delivery, especially in the context of disasters. This includes:

- Tablets, phones, video-conferencing systems and printers
- Software and free or funded safe and secure information communication technology platforms
- Online delivery materials

5. Provide technology (hardware and software) resourcing for clients

The Commonwealth Government, in conjunction with the State and territory governments should provide technology (hardware and software) resourcing for clients. This includes:

- Phones and in particular, phones provided through WESNET's (assisted by Telstra) 'Safe Connections' program
- Other devices such as tablets to enable video contact with support workers
- Phone credit or data
- Hardware and software to ensure telehealth and health services could be engaged by clients

6. Provide technology training and supports (such as those provided by WESNET and eSafety) for government and non-government agencies responding to DFV

The Commonwealth Government in conjunction with the State and territory governments should provide resourcing for technology training and supports (such as those provided by WESNET and eSafety) for government and non-government agencies responding to DFV. To prepare and assist agencies to:

- Safely use technology in service provision
- Effectively use technology in service provision, including in groups and one-on-one settings and when engaging specific cohorts (such as elderly clients, culturally and linguistically diverse clients, clients with disabilities and children)

- Recognise and respond to technology-facilitated abuse (as part of broader experiences of DFV)
- Conduct risk and safety assessments in relation to victim/survivor use of technology

7. Provide continue and expand funding for WESNET's Safer Connections program

Enhanced connectivity is essential to ensure workers and victim/survivors can use technology to: seek or provide information, support and develop safety plans and respond to DFV. To aid the provision of resources and training, we note that there is an urgent need to continue and expand funding for WESNET's operations, including the Safer Connections program which provides phones and credit for female victim/survivors. This program sees the provision of a new phone to victim/survivors which are 'safe' as they are provided by WESNET-trained frontline workers who are specifically up-skilled in tech safety. The training ensures that workers can assist women in activating and setting up a new phone as well as in addressing risk and safety planning in relation to technology-facilitated abuse. The success of this program is in the provision of phones and the specialist tech-safety training for frontline workers who provide them. Tenuous funding and the funding cuts WESNET faces jeopardise the effectiveness of this program, preparedness of workers and ultimately, women's safety.

8. Commit to boost funding for social and affordable housing

The Commonwealth Government, in conjunction with the State and territory governments, urgently commit to boost investment in social and affordable housing, especially for women and children experiencing domestic and family, as part of the national recovery plan. There is an urgent need for both emergency and long-term accommodation and housing. There is also a need for refuges to accommodate families with pets and to provide living arrangements that enable social distancing.

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End Notes

[i] The plus sign is appended to acknowledge that the LGBTIQ community extends beyond these identities to include over 14 other recognised identities, such as gender non-conforming, genderqueer, pansexual, asexual.