

# How frontline domestic and family violence workforce in Australia kept connected to their clients and each other through the pandemic.

**Practitioner report**



**UNSW**  
SYDNEY



# Executive summary

Australia, like most countries, introduced strict infection control measures to curb the spread of COVID-19 after it was declared a pandemic on the 11th of March, 2020.

People's movement was restricted through physical distancing, border closures and mandatory lockdowns. Many businesses and schools also closed down. There have been international concerns that these restrictions have put people at increased risk of experiencing domestic and family violence (DFV) whilst also reducing their capacity to seek help. Services have had to adapt and innovate to find ways to continue to connect to at risk clients whilst staying COVID-19 safe. There are concerns that adjusting to challenging work conditions has and will continue to take a toll on practitioners' wellbeing.

This report presents the findings of a nation-wide study of the experiences of frontline DFV practitioners in Australia during the early months of COVID-19, funded under UNSW's Rapid Research Initiative. The study explores the perceived impacts of COVID-19 on clients, service adaptations and innovations, and the challenges faced by frontline staff. We draw on insights gained from interviews with 50 practitioners from DFV services between July and October 2020.

Our interviews revealed that clients' experience of DFV changed during COVID-19. The demand for DFV services mostly increased, with the exception of shelters where demand initially decreased. The study highlights that DFV has become more complex and escalated in intensity during COVID-19. Practitioners spoke about how COVID-19 has been used as a tactic for DFV, and that monitoring and technology abuse appear to have worsened during lockdown.

Practitioners felt that services did well to adapt and innovate to stay connected with clients under these circumstances. The four most common service adaptations were 1) shifting to outreach models of care 2) implementing infection control 3) telehealth and digitally enabled service delivery and 4) remote legal support and advocacy. Where possible, frontline practitioners worked remotely in the early months of the pandemic.

Practitioners acknowledged that it has been challenging for them to adjust to COVID-19 conditions. They felt the added stress of being an essential worker in a pandemic on top of already being on the frontlines of the DFV epidemic. Practitioners also found it challenging to adjust to remote working because of the collision of work and home life, vicarious trauma, fatigue, and professional isolation. On the other hand, practitioners highlighted that some COVID-19 adaptations/innovations have been valuable and that they would like to see these carried forward into the 'new normal'. These are listed below as recommendations to inform future service responses.

## Recommendations

- > Flexible working including a blend of working from home and working on site
- > Support for wellbeing initiatives
- > Online and telehealth options for clients
- > Online meetings with colleagues from other services

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# Background

The WHO declared COVID-19 a pandemic on the 11th of March 2020.

Many countries including Australia introduced strict control measures including the closure of borders, people-facing-businesses and most schools. Most states of Australia went into lockdown where individuals were unable to leave their home for reasons other than essential work, exercise, shopping and medical supplies. Physical distancing of 1.5 m was mandated in public spaces.

These control measures have been largely effective at curbing the spread of COVID-19 in Australia. However, there have been substantial social and economic implications that have perpetuated and amplified existing inequities. An estimated 28% of Australian families have suffered losses in jobs or incomes due to business closures and economic downturn (1). Social isolation, fears of COVID-19 and uncertainty in the changing global situation have also had a negative impact on people's mental health (2). Drug and alcohol consumption also increased during lockdown (3).

## **How has COVID-19 impacted domestic and family violence?**

- > There was almost immediate speculation that COVID-19 mitigation measures would have a negative impact on domestic and family violence (DFV) in Australia.
- > It was anticipated DFV would escalate as victim/survivors were confined at home with perpetrators of violence and abuse, and families faced increased stressors related to job losses, anxieties and fears around the pandemic, food shortages, school closures, social isolation and increases in alcohol and drug consumption (4-6).
- > The Bureau of Crime Statistics and Research (BOCSAR) showed that the incidents of DFV reported to the police decreased between March and April, 2020 when New South Wales (NSW) was in lockdown (7). Given the

- heightened risk factors for DFV during COVID-19, it seems unlikely these statistics reflect the true state of affairs. A more feasible explanation is that social isolation measures meant reduced opportunity to report DFV when confined at home with the perpetrator. There is also speculation that COVID-19 physical movement restrictions made it difficult for people experiencing DFV to action safety plans, as they could not seek temporary accommodation with family or friends, were reluctant to enter communal DFV crisis accommodation, and many such services had restrictions on the number of people they could accommodate.
- > Two thirds of women who experienced physical or sexual violence reported it was either the first incidence of violence or an escalation of previous violence (8).

## **Is domestic and family violence being underreported?**

There is evidence of underreporting DFV in Australia from a research survey study of women's experience of DFV during COVID-19.

- > Fifty-six percent of the women who reported experiencing DFV between February – May 2020 (the height of COVID-19) said the police had not been notified about the incident (8).
- > Fifty-eight percent of women who experienced physical or sexual violence and/or coercive control reported at least one incident where they did not seek help because of safety concerns about reporting DFV during COVID-19 when there was high risk they were being monitored by the perpetrator (8).

## **Who is most at risk?**

There is evidence that some groups of people may be at increased risk of DFV during COVID-19, including:

- > People in remote Aboriginal and Torres Strait Islander communities; police reports show that DFV-related assaults increased by up to 25% in remote communities in the Northern Territory in April 2020 compared to the year before (9).
- > Older adults are increasingly reporting abuse from intimate partners, children and grandchildren due to self-isolation (10).
- > Children and young people are at risk of family violence as they were forced by school closures to learn from home during lockdown at a time of magnified family stress (1).
- > People with disabilities may be in lockdown with abusive family members who they depend on for care (11).
- > Low-income earners who work in people-facing roles and in casual employment have been hit the hardest by job and income losses during COVID-19 and subsequently experience financial stress, a risk factor for domestic and family violence. (12).

## **How are services responding?**

Research shows that DFV services worldwide are using similar adaptations and innovations to stay connected to clients during COVID-19, including:

- > Transitioning from face-to-face to telehealth/digital service delivery where possible. Video calls, DFV hotlines, web chats, apps and text are being used to connect to clients (13-15). A study of practitioners in Queensland, Australia, identified many benefits of this telehealth/digital transition including the removal of geographic, time and transport barriers to accessing services (16). On the other hand, researchers and practitioners caution that clients' safety and privacy is at risk when they access telehealth/digital services at home where they can be monitored by the perpetrator (13). Furthermore, practitioners are worried they are missing valuable information about clients' risk level over the phone and internet where it is harder/not possible to read non-verbal cues (16, 17).
- > Strict infection control measures have been introduced in essential services that cannot operate remotely such as shelters. Shelters have had to limit the number of people they house to comply with physical distancing restrictions (4). They have also introduced extra cleaning and provided clients and staff with Personal Protective Equipment (PPE) and personal sanitation packs (14).
- > Family courts worldwide have responded to COVID-19 by introducing remote hearings (14).

## **How has COVID-19 impacted frontline staff?**

There is emerging evidence worldwide to suggest COVID-19 has had a negative impact on the wellbeing of frontline workers in the DFV sector.

- > A UN study found that staff are feeling stretched and overwhelmed as they work extended hours to meet the increasingly complex needs of their growing clientele (4). Practitioners in Victoria, Australia, have said they were often working unpaid overtime, not taking regular breaks and were left feeling fatigued (17).
- > Practitioners have reported that remote working has added to their mental health burden and blurred the boundaries between their personal and professional lives (14, 16, 17). Staff have reported feeling they are on call 24/7 as clients now communicate with them via mobile phone (13). There are also concerns that remote working has had a negative impact on staff's mental health as they experience social isolation and increased risk of vicarious trauma (11, 15). Practitioners in Victoria, Australia, have reported missing the incidental support they receive from their colleagues in the office and feeling lonely working from home (15).



## Our study

Given early evidence that COVID-19 has impacted clients, staff and created barriers to service delivery, this study was developed to understand the experiences of frontline DFV practitioners in Australia during the early months of the pandemic. The study forms part of a wider project examining the sex and gender dimensions on women's health and wellbeing in the context of COVID-19, funded under UNSW's Rapid Response Research initiative. This report presents findings from semi-structured interviews conducted with practitioners from the DFV sector across Australia between July and October 2020. The interviews aimed to explore how the frontline domestic and family violence workforce in Australia kept connected to their clients and each other through the pandemic.

This research aligns with the Fourth Action Plan of the National Plan to Reduce Violence against Women and Their Children 2010-2022. It addresses the Fourth Action Plan's priority to improve the support and service system responses available to women and children experiencing DFV by strengthening the evidence-base informing responses (18). This research will provide evidence to help us understand what support and service responses worked effectively during COVID-19 so we know what works in the 'new normal' and for future crises.

# Methods

To understand how the DFV sector has responded to changing client needs and restrictions around service delivery during COVID-19 we interviewed frontline DFV workers. The interviews focused on five research questions:

1. What has been clients' experience of DFV during COVID-19?
2. How have services adapted and innovated to address clients' needs and comply with COVID-19 restrictions?
3. What have been the challenges for frontline practitioners in implementing these changes?
4. What has worked well in supporting frontline practitioners during COVID-19?
5. What service adaptations do practitioners want to see continued in the 'new normal'?

## Who participated in the interviews?

A total of 50 service providers completed interviews for this study. The research team contacted potential participants in the following two ways:

- 1) Organisations that previously indicated their support for the project were asked to send out a recruitment invitation email on the research team's behalf and to post recruitment advertisements in suitable locations including e-newsletters and the organisation's social media pages.
- 2) Workforce, peak body and policy representatives were purposively identified and contacted through publicly available information and via research participants using snowball sampling. These participants were then contacted directly by the researchers via an email.

Recruitment was ongoing from July 2020 and interviews were carried out until October 2020 by the research team. Participants could choose if the interview was conducted via telephone or online platform (e.g. Microsoft Teams). Each interview lasted approximately 30 minutes. Interviewees were asked to reflect on the impacts of COVID-19 on their clients, themselves as workers and to identify what has been most effective in DFV response during the pandemic, including models of care, programs and service innovations. All participants gave permission for their interviews to be voice recorded and transcribed. Responses from interviews were thematically analysed (19). Figures 1-4 describe the characteristics of the interviewees and the services that participated.

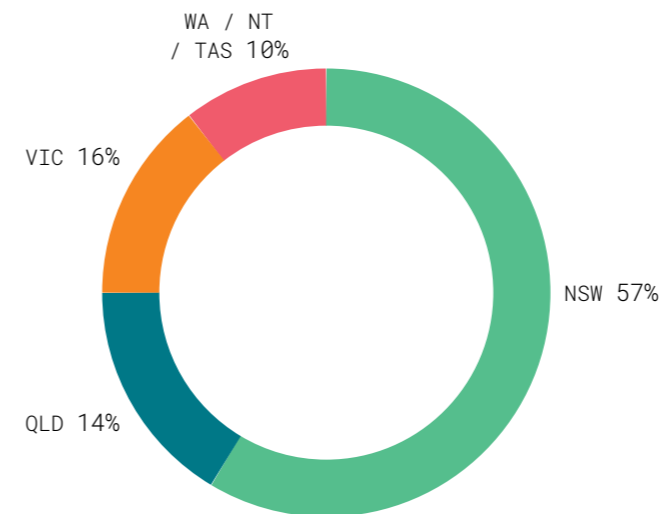


Figure 1 Interviewees by state

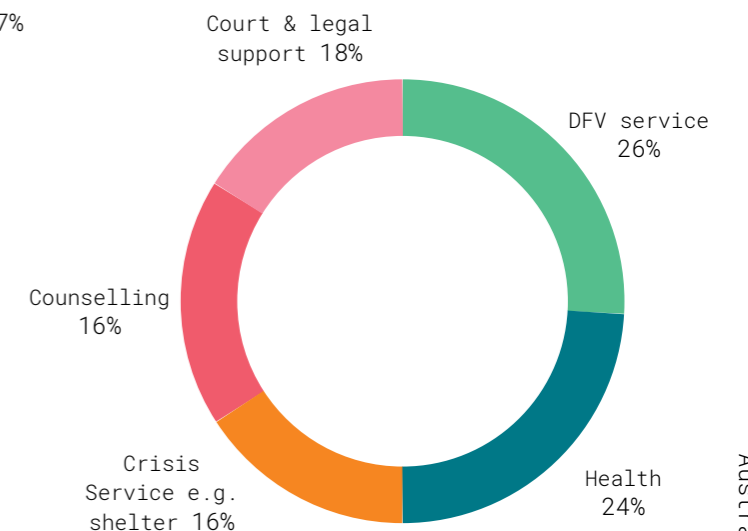


Figure 2 Interviewees by type of service

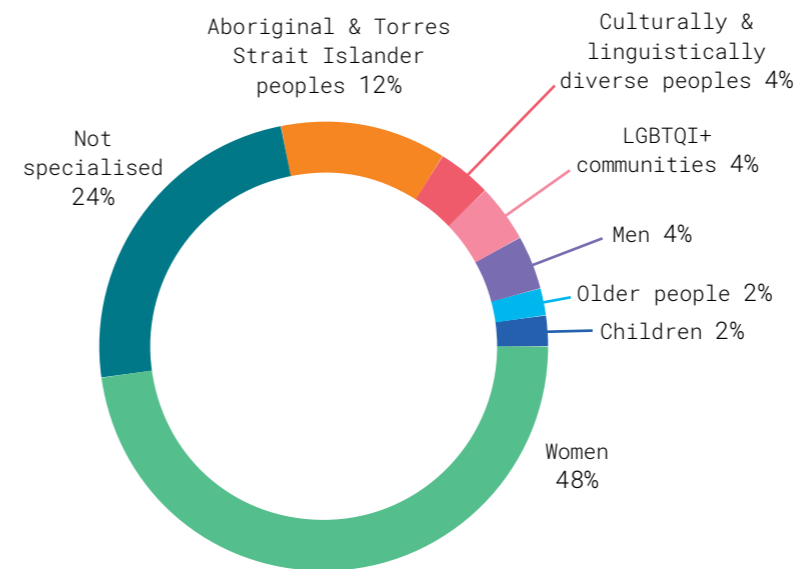


Figure 3 Interviewees by main client group

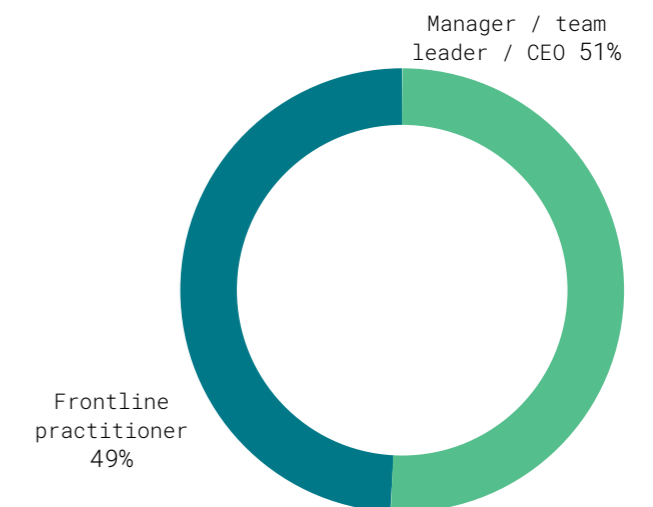


Figure 4 Interviewees by job type

# Findings

## What has been clients' experiences of DFV during COVID-19?

Most interviewees reported that the prevalence of DFV had seemed to increase during COVID-19, whilst some said it had decreased. This perception seemed to differ depending on the type of service the interviewee provided. Staff who worked in shelters reported an initial decrease in the demand for services during COVID-19. They attributed this to clients not wanting to come in to shelters for fear of catching COVID-19.

*"So the first time we went into lockdown, all the clients were really scared, and a lot of them wanted to just return back to family... a lot of clients are actually taking the COVID-19 very seriously."*

On the other hand, interviewees based in health settings reported a large increase in demand for their services during COVID-19. Counsellors consistently reported an increase in men and women in both same-sex and opposite-sex relationships seeking help for DFV, which was commonly attributed to the following:

- > Being confined at home with the perpetrator
- > Being socially isolated from usual support networks such as family, friends, colleagues
- > Mental health issues
- > Job/income losses
- > Insecure housing
- > Increased alcohol and drug use

Given these intersecting risk factors, it was unsurprising that most health care providers reported that cases of DFV were more complex during COVID-19 compared to before. Interviewees commonly expressed that the severity of DFV cases increased during COVID-19. Several service providers reported strangulations and life-threatening incidents of DFV had increased.

*"One of my clients, it was so severe he smashed into the home, like, broke into the home. I won't detail what he did to her, but she called me and she was being nearly killed."*

Many reported an increase in physical and sexual abuse during COVID-19. Some described cases where clients had experienced their first incident of physical or sexual abuse, when previously this abuse had been non-physical.

*"It escalated quite considerably. So for women whose violence was emotional, psychological, that led to physical, and for the women who were already being physically assaulted – it ramped up to what I would classify as attempted murder, where a lot of the women were being choked, strangled and suffocated, where they were holding their heads down in pillows."*

Health and social service providers also reported an increase in rape during COVID-19. They explained this sometimes led to unwanted pregnancies and coercive abortion, adding a further layer of complexity to the abuse that was experienced.

*that, so some of them were reluctant to come in for their antenatal appointments."*

*"There's a lot more controlling, the coercive control. You know, limiting where the partner's going but using COVID as a reason for it... So that isolation, the behaviours that can lead to a woman's isolation. And the stalking, so the monitoring of phones, monitoring of internet."*

Several service providers also spoke about examples where their clients' partner had used COVID-19 as a reason to obstruct access to children and also to create fears around the child's safety.

*"Perpetrators were using COVID restrictions as an excuse not to take the child to school, therefore preventing that contact change over from happening. They were going to the extent of threatening to expose the child deliberately to people that had COVID, just as a threat to the mother."*

Some also spoke about how COVID-19 created situations for financial abuse. Low-income earners were particularly at risk of this financial abuse as some received additional Centrelink payments as part of the government's economic response, however, these extra funds were often controlled by the perpetrator in abusive relationships.

*"With the double payment or being post-payment from Centrelink there was more financial control in terms of trying to control bank accounts and access to finances."*

There were also increases in technology abuse during COVID-19, which was particularly concerning as technology was the main way to report DFV and seek help.

*"One family, I know that when the father has gone to work, he's taken the modem."*

*"The more time they spend together the more monitoring, the more stalking... they'll check their telephones more often, even if they're under their roof, they'll have to explain everything that's happening and they'll actually take their phones, quite often, off them."*

Some observed that more men in opposite-sex relationships were seeking help for emotional abuse during COVID-19 than they were at other times.

*"For the men a lot of the complaints were that these women would pick on particular fears or vulnerabilities that they had shared during their relationship... 'You've lost your job during this*

*"We do abortion here, so we've definitely seen more calls...Heaps more abortions... whether it's sexual assault or reproductive coercion, it does throw into stark relief the lack of access to confidential and free services."*

Many reported that the COVID-19 situation had magnified existing problems with coercive control. They explained that COVID-19 restrictions make it easier for perpetrators to monitor their partners who are confined to the home, and that this poses a significant barrier to help-seeking. Further, COVID-19 was being used as a tactic for coercive control, for example, there were cases of perpetrators threatening that if their partner left the house they'd catch COVID-19 or be fined for breaching public health orders.

*"Some perpetrators will kind of threaten them that you can't get out. If you get out, you'll get the virus. And then, it becomes really difficult for some of my clients."*

*"The first half of the year when there were concerns around COVID in WA, they were reluctant to come in...Some of their partners would be saying that you'll get COVID, things like*

*period because you're not good enough' a lot of that stuff, 'You were never stable.'"*

*"I've not had a male present for physical intimate partner violence. But it has been quite an increase in males presenting for emotional and psychological abuse."*

There were service providers who reported male perpetrators of DFV were struggling to cope with the financial strain, the restrictions of COVID-19 and escalating mental health issues. Some providers reported an increase in suicidal ideation among male perpetrators of DFV compared to before, but not an increase in suicides.

*"We were hearing from the men a whole lot more stress involved in the home. So they were in the home and many of them had lost their jobs. They were finding it very stressful to be in the home with the children and their partners."*

*"We had definite increase in men that experiencing suicidal suggestions."*

Counsellors working with LGBTQI+ people highlighted that the prevalence of physical and emotional violence among people in same-sex relationships appears to have increased during COVID-19. Counsellors spent a greater proportion of their caseload supporting people in same-sex relationships with DFV-related issues during lockdown compared to before.

*"COVID definitely provided a little bit of a hotbed of a rise in these presenting clients [DFV] ... it can have that curve where you're going along with these aggressions and abusers, and then suddenly once it starts becoming physical, then the curve becomes more marked and the abuse, types of physical abuse for instance, gets more dangerous."*

Counsellors working with LGBTQI+ people explained how women in same-sex relationships are at greater risk of financial abuse during a crisis due to the gender pay gap. Job/income losses felt during COVID-19 magnified this risk of financial abuse among women in same-sex couples.

*"Also things in terms of financial difficulties. Again, in terms of females, you've got the layers of being a woman, then identifying as being lesbian, and also being - the discussion around the type of relationship you're having."*

Similar to people in opposite-sex relationships, people in same-sex relationships struggled with their mental health and issues around suicidality in the early months of COVID-19.

*"I would say that I was having and had been having conversations about suicidality and suicidal ideation pretty regularly."*

### **Who was at increased risk?**

It is widely acknowledged that the impacts of the pandemic have not been experienced equally across society, and this has shone a light on existing structural inequities. While women have been unduly impacted, the interviewees also identified the following groups who have been disproportionately impacted by DFV during the pandemic: 1) Aboriginal and Torres Strait Islander peoples; 2) People from culturally and linguistically diverse backgrounds, 3) Older people, 4) Children and young people, 5) People with disabilities.

### **Aboriginal and Torres Strait Islander peoples and communities**

Interviewees working in remote communities in Queensland, Northern Territory, South Australia and Western Australia described the negative impacts of biosecurity zones on people's experience of DFV, which prevented people from leaving remote communities. Practitioners explained how this exacerbated existing problems with physical and sexual violence and how the experience of being

locked into communities by police was severely distressing and retraumatising in the historical and contemporary context of colonisation and experiences of intergenerational trauma.

*"One morning everyone woke up and there were police barriers, physical police barriers at the entrance of the Indigenous communities, which was quite distressing for community members to witness and our workers initially were blocked off from accessing community members."*

*"In some communities in SA on APY<sup>1</sup> lands, they actually only allowed one person per household to actually, like, go to the local store to purchase any groceries or anything. And so the woman couldn't even - wasn't even getting out at all, was stuck in the house and, like they said, it was - the isolation and actually being isolated with the perpetrator, or with the user of violence, and they were getting more frustrated and, of course, the violence just escalated. It was - I'd say a lot of the reports we got were the physical violence definitely escalated."*

### **People from culturally and linguistically diverse backgrounds**

People on temporary visas and those facing language barriers experienced substantial challenges in accessing DFV services during the pandemic. Temporary visas made it prohibitive for women to leave the perpetrator as they were often unable to access temporary or affordable accommodation. Interviewees also observed that those on temporary visas were often likely to be financially dependent on their partners and at heightened risk of financial abuse during the pandemic.

*"We've had a few women who are on temporary visas and we haven't been able to get them into any sort of accommodation option at all. They've been declined temporary and affordable housing options because of their temporary visa status."*

<sup>1</sup> Anangu Pitjantjatjara Yankunytjatjara (APY) is incorporated by the 1981 Anangu Pitjantjatjara Yankunytjatjara Land Rights Act whereby the SA Parliament gave Aboriginal people title to more than 103,000 square kilometres of arid land in the far northwest of South Australia. All Pitjantjatjara, Yankunytjatjara and Ngaanyatjarra people who are traditional owners of any part of the Lands are members of Anangu Pitjantjatjara Yankunytjatjara" Source [anangu.com.au/en/about-us](http://anangu.com.au/en/about-us)



Many practitioners also spoke about how language barriers often prevented women from culturally and linguistically diverse backgrounds reporting DFV to the police. Some practitioners commented the lack of interpreters at police stations was a factor that intensified this language barrier.

*"There is quite a gap in the police service, so they'll often deny the victims access to an interpreter just because of lack of time...so that becomes a barrier to victims' disclosure."*

### **Older people**

Many interviewees reported the number of older people accessing DFV services increased during COVID-19. For those experiencing violence from an intimate partner, this could be either the first incident of violence in a long-term partnership or the escalation of existing violence.

*"This has been the biggest shock for me, but the majority of the victims/survivors that I've been supporting have been women in their 60s and 70s."*

Interviewees from legal and social services spoke about seeing an increase in violence towards older women from their children and grandchildren, including emotional, financial and/or physical abuse.

*"There's verbal and emotional abuse. There's financial abuse, they're trying to get money—that's very common... So, sometimes it's violent, physical violence. Yeah, they're isolated, controlled. And often, parents and grandparents don't feel right in calling the police or have a strong sense of loyalty towards the child. And it has to take quite a lot to make that call."*

### **Children and young people**

Interviewees expressed concerns that a potential increase in child abuse during COVID-19 has gone undetected as children were taken out of schools and were learning from home. Practitioners in child protection explained that they rely on teachers and school staff to detect early signs of child abuse and that without this they were concerned that children at risk were not being identified. Many practitioners felt that the decrease in formal reports of child abuse did not reflect the true situation but rather was symptomatic of underdetection.

*"At the height of the restrictions, there were 30% less child protection reports. Because, children weren't going to school, and therefore weren't under that surveillance."*

*"What we did see though was an increase in neighbours reporting child protection concerns."*

There were also concerns that young people who may have moved out of home would be forced to return due to the job/income losses felt disproportionately by young people during COVID-19.

*"A lot of people reaching out to us as incoming lock down restrictions were advised, saying I just need to know whether there will be a place available for me if things get bad...those calls also potentially came from young women, who might have been living out of home and attending University and working casually and then found out that their jobs were basically going to go, they would have to go back to family situations that were abusive or unsuitable."*

### **People with disabilities**

Practitioners spoke about how some people with disabilities found it difficult to navigate telehealth/digital services and this created a barrier to help-seeking, and that DFV among people with disabilities was going undetected.

*"There's definitely barriers to services for people with disabilities if they can only access them via telecommunications. Many people with disabilities are finding it much easier, but also there's some who won't be finding it easier. So I have concerns about people that I won't be in contact with during this period and people who won't be in contact with any services because they don't own a phone or a computer or they can't access a phone or computer independently, and if they can't access one independently then I have concerns about their safety."*

# How have services adapted and innovated?

There were many ways services innovated and adapted to keep connected and supporting clients and families during COVID-19. The four main areas were 1) Shifting to outreach models of care 2) Infection control 3) Telehealth and digitally enabled service delivery and 4) Remote legal support and advocacy. Each adaptation will be discussed in table 1 in terms of its benefits and challenges.

Service adaptation	Description	Benefits	Challenges
<b>Shifting to outreach models of care</b>	<p>Extended hours to meet the increasing demand - some services went from 9-5 to 24/7 operation.</p> <p>Partnerships with food banks and supporting clients to access food, emergency funding for bills, heaters, blankets and housing.</p> <p>Reconfiguring spaces to accommodate clients and staff, staggered office hours/days and home visits. Maintaining sense of community – smaller groups, meeting outside and regular welfare checks.</p>	<p>A silver lining of the pandemic has been strengthening partnerships between DFV services and community organisations through outreach activities.</p> <p><i>“I know we do [food bank] at the centre where women – where food is delivered and collected, you know, just with this, there’s an increased demand for food.”</i></p> <p><i>“There’s the [name of charity] who is providing food parcels that can be delivered for free once a week to women with no food, no money.”</i></p>	<p>Outreach puts staff at risk of exposure to the virus.</p> <p>Some clients were upset when group activities were cancelled or moved online.</p> <p><i>“So the men since coming back to group have said they missed the group, they missed the interaction weekly and the regularity of it. And they found that they were going into their own heads more when they weren’t coming to group – they were becoming quite stressed and depressed.”</i></p>
<b>Infection Control</b>	<p>Shelters were considered essential services across Australia and continued to operate under COVID-19 conditions with strict infection control measures in place. Shelters introduced rigorous cleaning regimes, provided clients with sanitation packs and staff had to wear PPE. In some cases, shelters reduced occupancy to comply with physical distancing protocols.</p> <p><i>“In terms of physical mask wearing and goggles that’s our policy in terms of face-to-face client contact.”</i></p>	<p>A huge effort was made from a policy and practice perspective to keep the shelters operating, make sure that clients and staff were safe and felt comfortable. These changes are anticipated to have ongoing benefits in terms of hygiene and infection control post-pandemic.</p> <p><i>“All the policies have been changed around how we assess a client coming into the service, with their children. We’ve got a whole list of health questions that we need to ask... no one’s allowed to walk in the door unless they’ve been asked all the questions about, sick, all that, symptoms, hot spots. Temperature taken, the same with staff. If they’re not feeling well, they’re sent home.”</i></p> <p><i>“We increased the cleaning in our refuge. So we used to have fortnightly cleaning...but we now have weekly cleaning and we increased it from two hours to three hours. We give all the women a little pack with wipes and hand sanitiser, and we’ve taken masks to the refuge, and gloves. We had a dishwasher installed... to try and increase hygiene and infection control.”</i></p>	<p>Since COVID-19 is an unknown threat, there were a lot of fears around contracting the virus and women were weighing up the known threat at home versus exposing themselves and their children to the virus by leaving to go to shelters.</p> <p><i>“The first time we went into lockdown, all the clients were really scared, and a lot of them wanted to just return back to family and stay with family.”</i></p> <p><i>“We felt that a lot of women may be just staying within the community, staying within their violent situations, because they didn’t want to leave in case they were affected by the virus.”</i></p> <p>Fewer people could be housed in shelters due to physical distancing restrictions.</p> <p><i>“Usually, I would have six women in a shelter, but I’ve only got four at the moment. So that we do have the space, should we go into lockdown, that they can be not on top of one another and have that distance that they need.”</i></p>

Service adaptation	Description	Benefits	Challenges
<p><b>Telehealth/ Digital support</b></p>	<p>Many services switched from face-to-face to digital/telephone service delivery where possible.</p> <p><i>"We've changed over to providing our services over the phone, and our playgroups and parenting support either through a Facebook group or the newsletter or by phone as well."</i></p> <p><i>"I do some group work via Zoom, so that works quite well. And generally my day to day work is telephone work."</i></p> <p><i>"Mainly phone, yeah, and that was I think a bit of an adjustment for clients because we offer a very flexible service, and we have a lot of face-to-face contact with clients. But I think they did adapt well."</i></p>	<p>Services remained connected to clients whilst keeping both staff and clients safe in terms of physical distancing.</p> <p>For counselling services, many long-term clients preferred telephone counselling over face-to-face counselling as it saved them commuting and they were comfortable at home. Likewise clients who work were able to access counselling/support on the phone while driving to and from work and didn't have to take leave in order to attend support sessions during business hours.</p> <p><i>"I personally from my work saw some increase in engagement. So people with anxiety presentation, for example, found it much easier to engage in counselling. They didn't have to worry about journeys or coming to a new building or anything like that. They were in their own spaces... I would say there's probably a decrease in cancellations. There are some really high levels of engagement."</i></p> <p>Some high-risk clients also preferred telehealth/digital support because it was easy to access.</p> <p><i>"For some people, they actually prefer it, it's easier. I've got one client who is very high-risk at the moment and she actually said to me, if I had to come in I probably wouldn't, and I'd probably be dead by now."</i></p> <p>Telehealth/digital options made it easier for clients in regional and rural areas to access services.</p> <p><i>"I think the benefits that the clients have raised is it's opened up possibilities for people in regional and rural areas. It created a real sense of equality amongst folks."</i></p>	<p>Some clients from low socioeconomic backgrounds didn't have sufficient data allowance in their internet plan to participate in services online.</p> <p><i>"There isn't any video, you know, Teams or Zoom or Skype. Clients don't want it, interestingly. Some of them don't have it. Our population we work with is predominantly the lower socioeconomic, you know. So they don't have it, they don't want, they haven't got much data."</i></p> <p>It was difficult to protect client's privacy and confidentiality remotely when there is high risk they are being monitored during COVID-19.</p> <p><i>"Even if we were speaking with women directly it would often come out that it's supervised, like we have overheard men in the backgrounds prompting them about what to say."</i></p> <p>Practitioners found it harder to build rapport and assess severity of DFV via phone or online compared to face-to-face.</p> <p><i>"I, as a clinician, would rely heavily on body language... Now I'm having to purely rely on voice and their intonation and their pauses and background noises and all of that. So it is very difficult for assessments to be completed. We're missing information."</i></p> <p>Some older clients found it difficult to navigate digital services. Likewise, clients in crisis were also often not in the right head space to navigate digital services.</p> <p><i>"There's the older clientele that have trouble navigating that kind of system, but even when someone's in the head space of just going through a trauma and being in that flight or fight hypervigilance and they're not really, I don't think, able to put plans like that."</i></p>

Service adaptation	Description	Benefits	Challenges
<p><b>Remote legal support and advocacy</b></p>	<p>The legal sector introduced video court appearances. Applications for Apprehensive Violence Orders (AVOs) shifted online.</p> <p><i>"We've also been using things like Microsoft Teams or the court Zoom account for court appearances and so forth."</i></p>	<p>Video court appearances allowed people to attend court whilst eliminating their risk of catching COVID-19.</p> <p>Clients no longer had to be physically present with the perpetrator which reduced their risk of re-traumatisation.</p> <p>Many service providers felt it was easier for clients to apply for AVOs online, though this was mixed.</p> <p><i>"I would imagine actually that a lot of women say that that's a positive because going to court can be really stressful and intimidating, they might see the defendant in normal circumstances and the court environment itself is just intimidating so women might say that that's a good thing, they don't have to go to court."</i></p>	<p>Clients missed the opportunity to come to court for the 'first mention' to provide clear instructions about the type of AVO they wanted. In some cases, this meant they were less likely to get the outcome they wanted.</p> <p><i>"So usually if a person comes to court for what we call the first mention, the first date, they're more likely to get an order that suits them and the matter is less likely to go to hearing which is – both delays the process or prolongs the process and the hearings can be extra stressful for victims."</i></p> <p>Many video court appearances were re-adjudged for periods of up to six months, when normally this would take several weeks.</p> <p><i>"It's more around the matters that are before the court that were re-adjudged for three, four and five and six months, rather than a few weeks after an incident occurred."</i></p> <p>Not all clients have equal opportunity to access online legal services.</p> <p><i>"I think one of the impacts of COVID is it provides a convenient cover for those who want to push a kind of efficiency, which is about automation and online service approach, which will further entrench disadvantage."</i></p> <p>There are concerns this has shifted the burden onto the victim survivor.</p> <p><i>"It's very concerning that there were very significant changes made to the victim support scheme in NSW... The burden has completely shifted from victim services onto the victim survivor. The victim survivor makes their application, they then have 12 months to go off themselves and collect all their evidence themselves."</i></p>

## **What have been the challenges for frontline staff?**

Adjusting to the increased demand for services and the shift to remote working has created challenges for frontline staff both professionally and personally. The main challenges are described below.

### **The realities of being an “essential worker”**

The people that we spoke with were already working on the frontline of the DFV in Australia and were then thrust into the role of essential worker within a global pandemic which was understandably very confronting.

*“It’s a very challenging time to be working as an essential service. We hear a lot about health workers on the frontline. Our staff have been working around the clock.”*

### **Workload and unpaid additional work**

Across the sector there is already a demanding workload, often with many additional hours of unpaid work, and many people felt that these pressures had increased substantially.

*“I guess really it is that concern around workload... I think has been exacerbated during COVID. We always knew that workers in the sector did a lot of unpaid additional work, but again I think that’s a much harder thing to have a line of sight to when people are doing it from their home.”*

### **The collision of work and home life**

Frontline staff spoke about the considerable collision of work and home life as boundaries blurred when they were working remotely, particularly during the learning from home period.

*“(They) were trying to deliver their work by going into the bathroom and having to sit on the toilet to be able to know that they were in a space where the children weren’t coming and going and being potentially exposed to hearing the proceedings.”*

### **Risk (and reality) of vicarious trauma**

There are always risks of vicarious trauma for those responding to domestic and family violence. However these risks were amplified when working remotely with less access to colleagues and less separation from work, and also because the measures that organisations

typically put in place to protect workers can be constrained in a work-from-home arrangement.

*“The measures that organisations put in place to protect workers from things like vicarious trauma are also strained in a work-from-home arrangement.”*

*“Because I’m doing it here it’s like ‘it’ is in my house, the violence is in my house because I’m speaking and I’m hearing it, I’m trying to manage it in my home at my dining table so it just feels like it’s here all the time.”*

### **Fears about the future**

Many people spoke about their worries for the future, both for themselves, their colleagues and mostly their clients in relation to: 1) The realities of insecure funding and short-term contracts; 2) Fears of burning out with the new ways/pace of working; 3) Fear that the DFV situation is going to get worse the longer COVID-19 restrictions continue; and 4) Perception that many of their clients had not been able to make contact and they worried for them and for what was to come.

*“It’s going to get worse when all the pressures of the six months continue to – there’s the cumulative pressure of that, and then going into Christmas which is always a notorious time for DV. We can see it looming. And the tragedy of it all generally speaking is it was completely and utterly predicted. That’s pretty depressing.”*

*“I mean, we’re focusing on this pandemic, but the real pandemic’s been there forever, and it’s not getting better.”*

### **Fatigue from remote working**

Many people spoke about how exhausted they felt from the transition from face-to-face service delivery to digital/telehealth service delivery.

*“It certainly was more taxing from when you’re on the phone and when you’re looking at a screen.”*

### **Professional isolation**

Many people spoke about missing the informal conversations they used to have with their colleagues in the office whilst working from home. Specifically, they missed having the opportunity to do incidental debriefs with colleagues about complex or emotionally distressing cases.

*“You’re not really getting a lot of that incidental exposure to debriefing and exchange of information with your co-workers. I mean, obviously, you’d do that in a very formal setting at your regular meetings and you can make a phone call to a manager or another worker, but it’s really that incidental work, I think, that I found I really missed.”*

## **What worked well to support frontline staff?**

Most organisations in the DFV sector introduced strategies to mitigate the challenges of COVID-19 for frontline staff. Interviewees consistently reported the following strategies worked well to support them in the early months of COVID-19.

### **Keeping connected with colleagues**

Video conferencing platforms such as Zoom and Skype were used to host regular informal catch-ups to keep colleagues connected during the early months of COVID-19.

*“We now have weekly meetings via Skype. We have one with the counsellors, there’s just the three of us now and every fortnight our manager joins in. There’s that, and we also have started up a WhatsApp group where we can communicate informally, and we email quite regularly.”*

### **Additional formal supervision and opportunities to informally debrief**

External supervision is an important formal support for frontline staff in the DFV sector and many people reported they were provided with additional external supervision during the early months of COVID-19. Staff were encouraged to informally debrief with their colleagues via phone, email and videoconferencing.

*“We all access external supervision as clinical practitioners, so I have encouraged the staff to increase their level of external supervision.”*

### **Flexible work that allowed for balancing carer and family responsibilities**

COVID-19 has been an unprecedented time in which many frontline staff have had to balance working from home under an increased workload with children who have been kept home from schools. Many staff have asked their organisation to support them through this challenge by allowing them to work flexible hours.

### **Wellbeing initiatives**

Organisations have arranged social meetings via Zoom and Skype to mitigate the risk of social isolation for frontline staff working from home, for example online social get-togethers and team yoga. Other organisations have shut down for a day so that staff could take time off for their wellbeing and to prevent burn out.

*“For fun times, we have Fri-yay on a Friday afternoon, which featured virtual cocktail hour, and all the consumption of cake.”*

*“We’re actually closing the centre next Friday for a mental health day for staff, just a day off so they can have a long weekend.”*

*“We did quite a number of things, actually... we would have, like, internal professional development... We had yoga at one point.”*

## **What do practitioners want to see continued in the 'new normal'?**

COVID-19 has had some silver linings in terms of learnings that can be taken forward to improve support and service responses in the DFV sector. These are some of the COVID-19 adaptations and innovations that interviewees wanted to see more of in the 'new normal'.

### **Flexible working including a blend of working from home and working on site**

There are some benefits to flexible working that staff would like to see integrated into regular practice. Many interviewees said they would like to see a mix of working from home and working in the office.

*"I don't believe we'll ever go back to having a service that says you can't work from home...And I think that's a good thing for flexibility, for parents and those that are carers, and those potentially with personal needs that require time out from being in a busy work place every day."*

### **Support for wellbeing initiatives and enhanced supervision**

Staff hoped that the COVID-19 situation has raised awareness of the importance of initiatives to support the wellbeing of frontline staff in the DFV sector.

*"I hope that there is a greater awareness of vicarious trauma now. I hope that there is a greater awareness around the need for supervision, and I mean professional supervision, not managerial supervision. That's been a long ongoing problem*

*in the sector that the union has had to battle with around the lack of appropriate supervision or not enough supervision. So I think that there is probably a better awareness now of it, whilst it hasn't been universally dealt with well in people having ready access to that supervision, I think there's possibly a greater awareness that when things get back to normal we can do this."*

### **Digital and telehealth options for clients**

Many practitioners said they would like to see digital and telehealth options continue to be available for clients as they are useful for some clients who have issues physically accessing services for reasons such as living remotely, living with a disability, being ill or being in a high-risk situation.

### **Online meetings with colleagues from other services**

Many interviewees stated that meetings could (and should) continue to be delivered virtually as it was clear that it is often unnecessary to meet face-to-face. Some also felt that connection with colleagues from other services actually increased because meetings moved online.

### **Better collaboration between services**

It was reported that some services have taken COVID-19 as an opportunity to develop partnerships to better meet the holistic needs of clients. However, other practitioners explained that a lot of services are still not working collaboratively and that there is much to do to break down these silos.

# Conclusion

Our study showed that most DFV services (with the exception of shelters) experienced an increase in demand during the early months of COVID-19. Demand at shelters decreased, mirroring the reduction in DFV police reports in Australia. However, practitioners from shelters felt they were not seeing the full extent of DFV cases during COVID-19 as many clients were fearful of COVID-19. Across other services, practitioners echoed concerns that DFV has increased during COVID-19 to an extent that has not yet been fully seen.

Most practitioners reported that the cases they were seeing were more complex and severe during COVID-19. This affirmed findings from Boxall, Morgan & Brown's survey (8), which showed there were escalations of previous violence in Australia in the first half of 2020. Our study expands what is known about the types of violence experienced during the early months of the pandemic in Australia. In contrast to police reports, many practitioners reported seeing an increase in cases involving physical and sexual abuse. There was also a noticeable increase in coercive and controlling behaviours, with COVID-19 being used as a tactic to keep partners at home and prevent help-seeking.

Our study has identified several groups of people whom practitioners considered to be at increased risk of DFV in the early months of the pandemic. This included Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, older people, children and young people, and people

with disabilities. In light of these findings, it is important that policy supports services to respond to the specific needs of people who experience multiple and intersecting barriers to accessing support.

Our study has identified many innovative ways services have adapted during the COVID-19 conditions. The most notable adaptation has been the digital transformation as health, social and legal services have embraced telehealth/digital delivery. The digital transformation was necessary to keep the DFV sector operating during COVID-19 and this change produced some benefits practitioners would like to see continued in the 'new normal'. However, practitioners have emphasised that we cannot rely solely on telehealth/digital models of service delivery as there are limits to quality of care and this approach can create access barriers for high risk people.

Our findings provide insight into the toll the pandemic has taken on the mental health and wellbeing of frontline workers. They are now faced with the added layer of being an essential worker in a pandemic in addition to their roles on the frontline of Australia's DFV epidemic. Many practitioners reported that it was challenging for them to work from home due to the collision of work and home life, vicarious trauma, increased workload and unpaid work, digital fatigue, and professional isolation. Practitioners were also worried about their clients – both now and in the future – as they felt the worst of COVID-19's impact on DFV was yet to come. They were also

concerned about their own wellbeing as they feared burn out from the pace required in this 'new normal'.

For the most part, practitioners were satisfied with how their organisation had adapted to connect with clients, and how they had responded to support staff wellbeing in the early months of COVID-19. Staff who were remote working liked having the opportunity to connect with their colleagues via online platforms, increased external supervision, and the wellbeing initiatives organised by their employer.

Many practitioners want to see wellbeing initiatives carried forward, to mitigate the risk of vicarious trauma that is present within the sector. Where possible, practitioners would like flexible working conditions where they can work from home some days and in the office others. Frontline staff see the value of continuing to offer telehealth and digital support options to clients who face difficulties physically accessing services. Many clients also seemed to prefer online counselling to face-to-face counselling and want to see this offered in the future. Lastly, COVID-19 has provided opportunities for different services to work together in online meetings, and practitioners want to see more of this in the 'new normal'.

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